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Determinants of Healthcare Utilization in Rural Nagaland, India: The Case of Yanmhon Village in Wokha District

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ABSTRACT

Despite improvement in national health policies and programs, the health performances in Nagaland are among the lowest in the country. The intra state disparity in healthcare facilities and treatment still exist in the state. This paper provides an in-depth analysis on the healthcare utilization as influenced by various underlying factors. Thirteen households and one health personnel were selected based on purposive and random sampling in Yanmhon old village of Wokha district, Nagaland. Semi structured interview schedule gathered the data during July, 2024. The present study informed that while the public health centre exhibited no financial barrier, peoples' health needs cannot be satisfactorily met. Villagers were deprived of healthcare services either due to non-availability of basic necessities or absence of health personnel in the village primary health centre. In times of healthcare utilization outside the village, the social determinants through family and community intervention were observed. The health service limitations are compensated by the community's arrangements. The study thus suggests an inclusive approach for an equitable healthcare delivery.

Keywords: health, rural, determinants, healthcare utilization, healthcare infrastructure

INTRODUCTION

Rural healthcare in India that comes in the form of primary health care had been a long-time government's initiative. Meanwhile, people in the rural areas still struggle to not get a decent service. Provision of primary care through Sub Centres (SC) and Primary Health Centres (PHC) cannot be depended fully due to ill-equipped infrastructure and absenteeism and irregularity of health personnel in these setups. [1] Another factor is the problem of the unequal distribution of health facilities between the urban core and the periphery. [2] These issues could be connected to concerns such as the provision of basic health services that are usually target based, thus appear specific in purpose. [3] The relevant details leading to unequal distribution geographically, healthcare utilization patterns and determinants of those areas need exploration as to why things remain as they are.

Healthcare utilization refers to the use of available healthcare services such as hospital resources, personal care, home resources, and physician resources. [4] Commonly, these utilizations or non-utilizations are not automatically chosen but

various factors stand in between the perceived illness and the end behaviour as suggested by studies of diverse subjects. Studies on determinants of healthcare utilization had been extensively studied across India, using both primary, [3,5] and secondary statistics and surveys [4,6,7] among others. Northeast region-specific studies [8,9] and Nagaland [10] have also been conducted over the years, findings of which are varied. Determinants not only influence health but also healthcare utilization at the degrees of individual and community. The influences can be through varied forms, not limiting to one significant factor.

Looking at the health outcomes through the lens of maternal health like four or more Ante Natal Care (ANC) and Post Natal Care (PNC), the northeast region of India has the lowest performers. [7] It becomes an important topic of study in Nagaland where vital health indicators such as number of ANC visits to government health facilities (21%) is lowest in the region and among the states in India. [11] These recent data trends do not reflect the level of emphasis projected by the national government. Understanding the determinants of healthcare utilization can unfold underlying potential and challenges between people and healthcare services.

The northeast region of India comprised of eight states characterized by diverse geography, terrain, social and ethnic structures. [9] The largest proportion of Scheduled Tribes (ST) in India is concentrated in this region. [10] The region also has differential prevalence of ailments among the states. Number of persons suffering from any ailment is highest in Sikkim and Mizoram states with 94/1000 and lowest in Meghalaya with 10/1000. [9] Huge variation can be observed in this regard. Regionally, it is rural in character, including the state under study such that health becomes an essential for their everyday functioning so is the respective healthcare facilities. Thus, institutionally the functioning of the health centres are crucial in determining immediate healthcare utilization of the concerned.

In the case of Nagaland, the state assembly passed the 'Nagaland Communitisation of Public Institutions and Services Act' in 2002. This act came up with the realization of the tradition and culture endowed rich social capital and community spirit, absence of caste and social discrimination in the state. There exist strong tribal and village community bonds, the grassroot administration been placed upon the traditional village councils. Communitisation of health sector specifically implies handing of ownership and management of health institutions and services on the community by forming Village Health Committee (VHC) (reference). In this case the communitisation implies a self-sustaining, community-oriented strategy aimed at addressing peoples' basic developmental needs. [12] Till date, the act has been implemented widely in the state with mixed results across targeted sectors. When such practice is in place, the extend of its impact on the healthcare utilization of the rural people needs to be understood.

Research studies noted that a focus on primary health care and addressing determinants of health helps in the reduction of health inequities, not limiting to health sector. [13] Nagaland's rugged terrain, poor connectivity, inadequate public and private transport had a considerable bearing on the community's healthcare utilization. [10] Most social lives experiences that enrich peoples' healthcare practices remained invisible in quantified data. Health outcomes are not an independent measure of one's health. Arrays of factors lie in such productions. While secondary official data and literatures of secondary data based statistical analyses had been referred, the present study mainly link to empirical findings to connect or disconnect by bringing in objectives-based field data. Combination of both information can potentially improve healthcare provision to the population. The study was undertaken in rural Nagaland to understand the

determinants influencing healthcare utilization amidst existing primary health centre.

Healthcare infrastructure in Nagaland

There are 11 district hospitals, 42 community health centres, 164 primary health centres, 643 sub centres, 49 health and wellness centres in Nagaland. The data for 2024-2025 showed an increase in all the health centres. [14] The medical personnel also increased during this period compared to the previous data, except with the decrease of nurse. With regard to the inpatient treatment in the hospitals and health centres there was a decrease compared to the previous report but the outdoor patient treatment had increased. [14] As per the NFHS-5 (2019-2021) the percentage of households that do not generally use government health facilities in Nagaland was 29.2 % lesser than the national 49.9 %. The reasons for this were no nearby facility 37.1% (national 40.2%), health personnel often absent 13.2% (national 15.0%), poor quality of care 31.3 % (national 47.6%), all lower than the national level. [11] These data are the state's overall report, empirical studies are thus required to shed light on the real status of health centres particularly in the rural areas. The rural healthcare utilization patterns cannot be sidelined as these are connected to the overall health outcomes at the state level.

Objectives: The main objectives of the study are:

1. To present the status of healthcare services in rural Nagaland, and
2. To understand peoples' healthcare utilization in rural areas.

MATERIALS & METHODS

The study was conducted at Yanmhon old, the farthest village with a Primary Health Centre (PHC) of Wokha district, Nagaland. The unit of the study was the household. Data were collected from 30% of the existing households i.e., 13 households and one health personnel in July, 2024. Tools of data collection were semi structured interview schedule and ethnographic observations. On gaining access to the field, respondents were selected based on purposive and simple random sampling. Respondents included the general population, village governing authorities and healthcare providers. Interviews took place in the house of the respondents. Questions were asked aligning with the stated objectives. Field notes, photos and recordings with the respondents' permission were maintained. Interview length ranged from 30 minutes to 1 hour 40 minutes. Interviews were conducted in the respondents' local dialect, later transcribed and translated to English simultaneously.

Village profile

The present study is located in Yanmhon old village of Wokha district, Nagaland. The district is situated in the mid-west of Nagaland and predominantly inhabited by the Lotha Naga tribes. The studied village is located in a hilly terrain bordering Assam's Golaghat district. It is 130 kms far from its district Wokha. The village was selected as it is the farthest from the district headquarter with a PHC. The village has diverse socio-economic groups, though belonging to one Christian Baptist denomination. The village is predominantly an agricultural community and is governed by the village council headed by a council chairman. Electricity irregularity was a regular phenomenon in the village which was experienced even during the field study. The Jal Jeevan Mission is not yet operational in the village, hence people mostly depend on rain water during monsoon, or fetch from the village pond. The village road starting from the foot hill was narrow and largely mud soiled. It appeared to have unattended for some years. As the filed visit co-incited the monsoon season, mudslides were encountered during the journey. Such occurrences according to the villagers were regular creating inconveniences to travel for their daily and health related activities. There is no public

transport facility. Bikes are popularly owned by the villagers. The village has one government primary school and one government Middle School. With regard to a health facility the village has a primary health center.

Statistical Analysis

Data were entered in the Microsoft excel sheet to perform statistical analysis through table and charts. In-depth interviews were analysed through transcript-based analysis. Relevant information of similarities and differences were identified and expressed through verbatim quotes wherever required. This research is not confined to any particular illness but of general healthcare practices in the studied village.

RESULT

Socio demographic characteristics of the respondents and their households

Data were collected from 13 households. The gender of the household respondents comprised of 6 (46.15%) were males and 7 (53.85%) were females. For marital status 9 (69.23%) were currently married, 1 (7.69%) unmarried and 3 (23.08%) were widowed. Age of the respondents between 20-39 were 5 (38.46%), between 40-59 were 5 (38.46%), between 60-79 was 1 (7.69%) and between 80-99 were 2 (15.38%). Concerning education till primary was 1 (7.69%), middle school was 1 (7.69%), high school were 8 (61.54%), B. Com was 1 (7.69%). All the respondents' households comprise of nuclear family, 10 (76.92%) households had kutcha house and 3 (23.08%) households had pucca house. Regrading number of household members 1 (7.69%) widowed respondent 87 years lives alone, 2 (15.38%) households have two members, 2 (15.38%) households have three members, 3 (23.08%) households have four members, 4 (30.77%) households have six members and 1 (7.69%) household with seven members. The monthly household income was 6 (46.15%) households had an income between 500-5,499, then 4 (30.77%) between 5,500-10,499, and 3 (23.08%) between 15,500-20,499. Among these, only 2 (15.38%) households i.e., one pensioner and a church leader had a regular source of income, while the majority of 11 (84.62%) households had an irregular income source. With the exception of the widowed respondent, the remaining 12 households owned a bike. With regard to land owning, all the interviewed households live in their own land with two or more extra land for agricultural, farming or plantation purposes. Religion wise all were Christians. Within the village the distance to the primary health centre ranged from half a kilometer to 1 km. Three eligible households were availing the old age pension scheme. All the households have ration card and Ayushman Bharat health card but none has availed the scheme till the time of field study.

Healthcare utilization

Among the thirteen households interviewed, nine household members reported to have used healthcare services outside the village between 2019 to 2024. The illnesses mentioned were two cases of gastritis, two hypertensions, one for pneumonia, one sinusitis case, two for fever, and one female reproductive issue. Four households out of nine have availed private hospital at Dimapur, four treated from private pharmacy in Assam and only one utilized public hospital at Dimapur. Illness wise treatment procedure included tablet and injection course for a week to a month and surgery for sinusitis and ovary surgery. The medical expenditure they recalled were rupees 500, 1000, 3000, 10,000, 12,000, 15,000 and one lakh. These are without transportation and other miscellaneous costs. None had used the health card but managed by their own with contributions from relatives, villagers and church. The remaining four households though do not visit healthcare services in the recent past, they use home remedies and first aid allopathic medicines.

Table 1: Details of the household member's healthcare utilization (n=9)

			Healthcare utilization		
Gender	**Allopathic: private: Assam pharmacy**	**Allopathic: private: Dimapur Eden hospital**	**Allopathic: private: Dimapur Metro hospital**	**Allopathic: public: Dimapur district hospital**	**Total**
Female	2	1	2		5
Male	3			1	4
Total	5	1	2	1	9
Age					
1.2	1				1
13	1				1
29	1				1
30				1	1
35	1				1
44			1		1
59	1				1
83		1			1
84			1		1
Total	5	1	2	1	9
Type of illness					
Fever	1				1
Gastritis	1				1
Gastritis and weakness		1			1
Hypertension	1		1		2
Malaria typhoid	1				1
Ovary operation			1		1
Pneumonia	1				1
Sinusitis				1	1
Total	5	1	2	1	9
500		1			1
3,000	2				2
5,000	1		1	1	3
6,000	1				1
8,000			1		1
20,000	1				1
Total	5	1	2	1	9
Expenditure					
500	2				2
1000	1				1
3000	1				1
10000	1	1			2
12000			1		1
15000				1	1
100000			1		1
Total	5	1	2	1	9

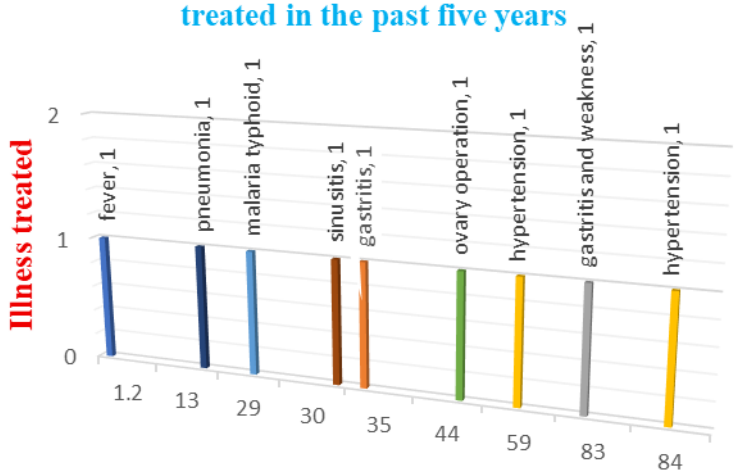
Source: field data, 2024

Household member's socio demographic characteristics and healthcare utilization

Age: from the households who had reported of any healthcare utilization in the past five years dated back from the year of the field work, members or patients were from different ages (table 1). Gastritis and hypertension had two cases each yet from different ages. For gastritis the members were aged 35 and 83, hypertensions were

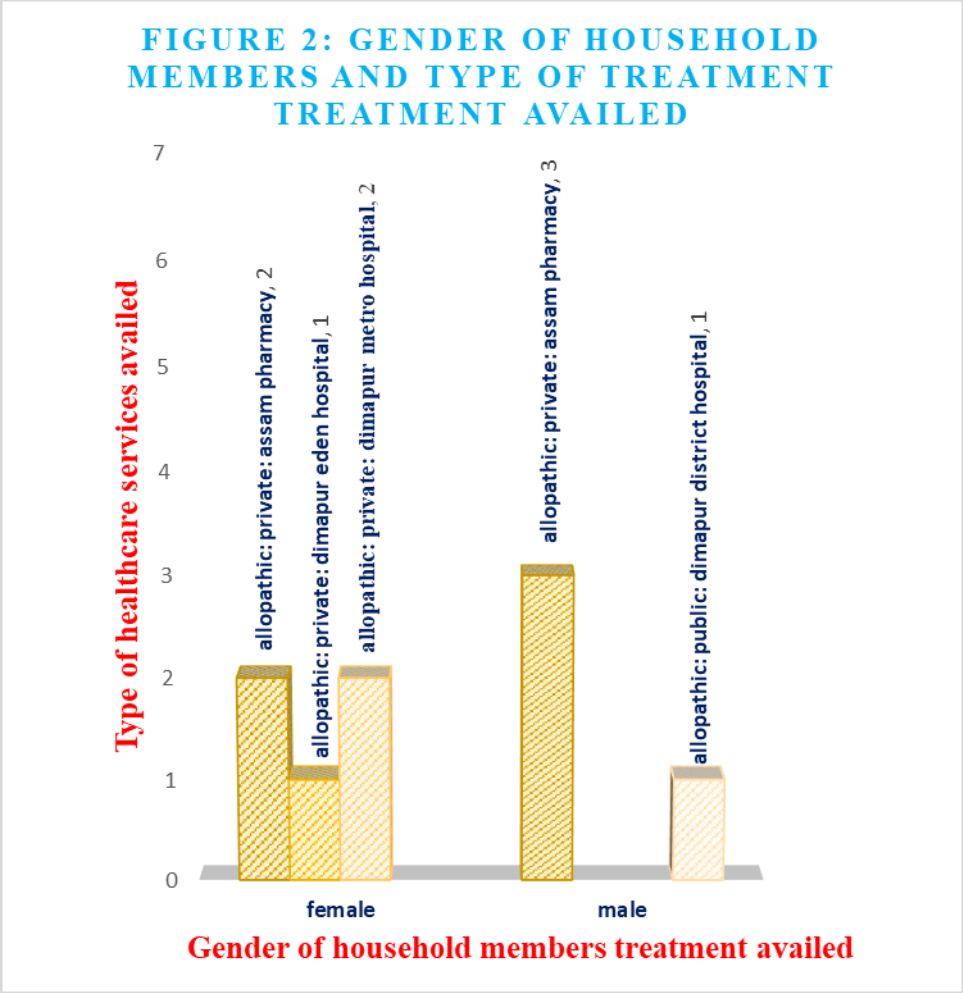
aged 59 and 84. Regarding the type of facility availed across age it was observed that five households out of nine, had utilized private pharmacy in the neighbouring area of Assam state the youngest being 1 year and the oldest was 59 years. Three members aged 44, 83 and 84 had utilized private hospital in the nearest district Dimapur within the state. Only one member aged 30 utilized government hospital in Dimapur district. Healthcare expenditure showed variation among the different ages ranging from rupees five hundred to one lakh. Two members of ages 35 and 59 spent rupees five hundred each and 44 years had incurred the highest expenditure (refer figure 1).

Figure 1: Household member age and type of illness treated in the past five years



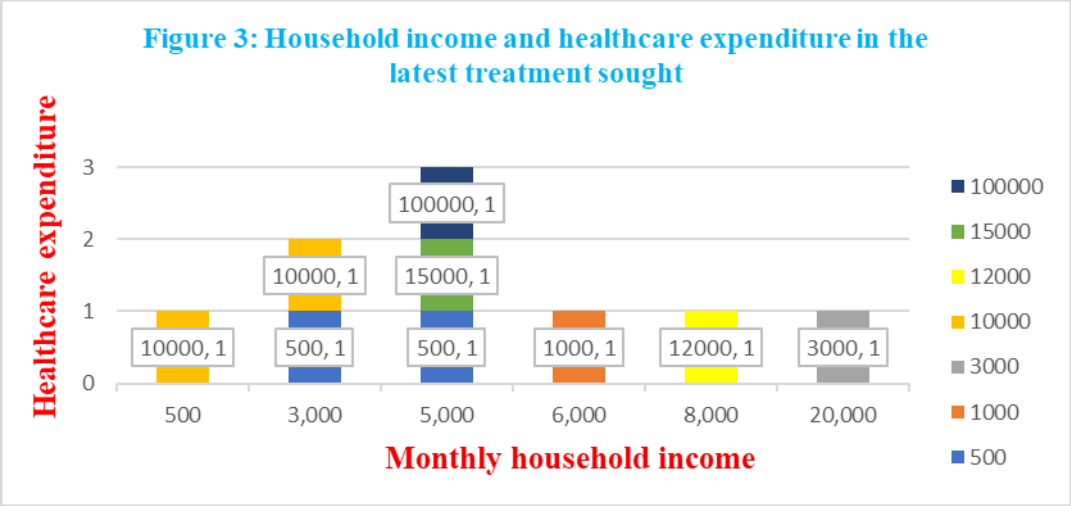
Source: field data, 2024

Gender: There were four males and five female household members who reported to have availed healthcare. The illnesses experienced between the genders were mostly unsimilar except for gastritis of one case each. Females reported two cases of hypertension, pneumonia and reproductive related matter. Males reported cases of malaria, common fever and sinusitis. The type of facility accessed were mixed, where females utilized the private pharmacy in the nearby area and private hospital at Dimapur. Males utilized nearby private pharmacy and government hospital at Dimapur. The reason for utilizing different healthcare facilities was based on illness severity thus seeking the required facilities. For instance, the two cases of hypertension by female member were treated at different health facilities, also two cases of gastritis of male and female were treated at different locations all depending on required attention. Regarding health expenditure variation between males and females is minimal. The least expense reported was rupees five hundred in two cases of male and female. No difference in the intermediary range of expenditure between the genders. Higher expenditure came with the severity and the type of healthcare provider where private utilization has incurred the highest with the fact that it was a surgical case. Meanwhile, as per the household records, minor surgery at a government facility had a lesser expenditure (reference figure 2).



Source: field data, 2024

Household Income: The monthly household income ranged from five hundred to twenty thousand. For monthly household income and type of illness treated, different illnesses were reported across levels of earnings. At the same time, even the same income earning households treated for different illnesses or few had the same illness but different income levels. This shows scattered illness experiences regardless of household income. Type of facilities sought by income levels showed that two households with same income had utilized the same private healthcare in the nearby area from the village. On the other hand, three households with same monthly income all had availed different services. Here, income did not influence in utilizing similar healthcare services. In terms of income and expenditure for healthcare utilization it is found that households with same monthly income had different healthcare spendings or even the lowest earning household had spent more than the highest earning household in the studied sample. Households with same income of five thousand monthly had differential spendings of 500, 15,000 and 1,00,000. In this section, severity and availability in times of need is observed. Regardless of income for illnesses considered as not serious were treated from the nearby health facilities by any household. When urgently needed, even the village health personnel for free treatment were not demanded. Instead seek out for treatment at their own cost as depicted in the figure 3.



Source: field data, 2024

The above findings convey a significant difference in the type of healthcare utilization i.e., 8 privates against one government healthcare services. In terms of preference of a particular type of healthcare services there are no significant effect by age, gender, or income. The type of healthcare service sought was distributed across the socio demographic characteristics. Availability, distance and facilities needed for particular illness treatment were found to be the major driver of their utilization pattern. The socio-demographic determinants presented thus far, the succeeding sections is devoted on the broader social intervention in times of health needs.

Villagers' understanding of health

Health as a source of livelihood

Health is vividly understood as a mean of occupationally induced livelihood. In this regard, health is employed for as a survival prospect. This particular necessity is expressed through the views mentioned by the respondents:

"We work and eat even when there is minor illness, so good health is that… laughs, for minor we can still work right?" (female, aged 48)

"It is because of health we can get anything for survival right… with health we work and eat, so I think like that." (female, 59 years)

The villagers' sole dependence for livelihood is their own health, where productivity and earnings were based mainly on physical and manual work. As a means for survival, good health may not always imply absence of illness. Minor health issues are not a hindrance as long as one can work. Alternative source of earning for the community except agricultural activities is limited or not available at all.

Health as functionality and prosperity

The respondents understood health as the ability to function. This corresponds to fulfilment of own plans or participation in social activities. It also is not limited to earning alone but health as functionality for common interest.

"Health is when one can do anything, can fulfil own plans." (female, aged 46)

"We can do anything with good health." (male, aged 60)

Health as a means of prosperity is expressed by the common adage "health is wealth." Health to them encompasses everything, since it enables one to carry out any activity. The respondents affirmed stating that:

"Everything is in health, with health we can do anything…" (female, 85 years)

"When we have good health, we can fulfil own plans and wishes like the saying health is wealth." (male, aged 60)

"Health is wealth just that… laughs..." (female, 59 years)

Their needs and realization of everyday chores were in compliance to health. The expressions about health are the fulfilment of their daily activities as an individual and community. The essence of broad perspective on health is captured in the stated universal idiom.

State of mind

Not only is health understood from physical experiences but the respondents attach health to one's state of mind and emotional wellbeing. Consequently, health enables to perform efficiently their physical work activities, i.e., mainly agricultural and farming by keeping one in a stable mindset. It was expressed by stating that:

"It (health) gives happiness." (female, aged 87)

"Having good health gives us happiness." (male, aged 60)

"Health gives happiness. Through health we can fulfil own activities." (male, aged 47)

The importance of health extends beyond physical health. The balance of the physical and abstract state of mind is crucial for their productive life. Villagers' broad attachment to health is not just individual and physical but anything that are interlinked.

Determinants of Healthcare utilization

Emergency driven healthcare seeking behaviour or Severity of illness

As per the interview responses the healthcare seeking behaviour is influenced by the illness severity. In this sense, minor illnesses can be done home self-treatment, avail basic medicines from the health centre when the health personnel are available. The nearby assam facilities can also be availed. Hence, they consider such cases as not serious ones, thus healthy. Only when they go for treatment in far places like Dimapur for cases beyond their control, they consider such situation as serious ones. As mentioned by respondents:

"*For seasonal and common illnesses local homemade medicines are used, but for serious cases that continues for longer period allopathic medicines are used at the same time."* (male, aged 39)

"For minor home treatment and for major cases take the patient to health centre or hospital." (female, aged 59)

These reflect the perception of health as absence of serious illnesses as the respondents stated. Serious illness is synonymous to treatment in better facilities, often in urban areas. This is the peak in which the concept of being ill is understood from the respondents' point of view. The need factor by an individual was realized thus, acted upon. Reasons for not availing healthcare facilities is due to the illness as not considered serious and unavailability of healthcare services in the rural areas. [9]

Knowledge of providers

Having the knowledge of where and who treats certain illness make the villagers to avail particular treatment provider/s. This may be within the village or nearby towns, which prompts them to avail the services without much delay. They narrated as:

"In case of snake or insect bite, own first aid is to apply vicks, else we go to Assam and treat from the kaviraj, they use black stone to suck the venom out." (female, aged 59)

"For jaundice, first aid is stinky beans tree bark soaked with sugar, oroxylum indicum commonly called Indian trumpet tree bark soak with sugar and drink. Then go to medical treatment if serious. We go to Assam for treatment, some go to kaviraj, wear necklace made of fresh medicinal plants or herbal roots. To let it suck the illness it is rolled down from the head and take out from the feet." (male, aged 60)

"For malaria initially we take stop ache, paracetamol, then medical treatment outside if no improvement." (female, aged 48)

Better facility outside

Healthcare seeking also has an inclination for better facilities which are usually located in towns and urban areas. When the village health centre fails to meet the health needs

of the people, the advanced facilities outside act as a pulling factor. Better medical facilities have an influence on the healthcare seeking behaviour of the villagers. Respondents stated such as:

"We go to Dimapur if not assam, since doctor and nurse are not stationed in the village. They are not available in the village all the time so we cannot treat from the health centre health personnel. They come occasionally at that time we are not ill, so we cannot go without any reason." (male, aged 35)

"When illness is serious, we go to Dimapur due to better facility." (male, aged 39).

The longing to treat from the village health centre can be understood from the narratives. It is the first service to approach which remained nonfunctional most part of the year.

Distance and shared destination

In availing healthcare services, distance is also taken into account by the villagers. The advantage of close proximity helps in accessing healthcare facilities for the villagers. In some cases, the nearest pharmacy or hospital with modest facility is sought first before going to farther places. Not only the villagers themselves prefer shorter distance but even health personnel do make similar referrals. These were noted as:

"Since it was not a serious illness, we went to the pharmacy in Assam as it is nearby the village." (female, aged 25)

"For first aid we keep and can be shared among us but for injection we need trained health personnel so we go to Horopani in assam, the nearest that is 13 kms or 1 hour." (male, aged 39)

"We went to a nearby and convenient Assam as we can return the same day." (female aged 48)

"For ultrasound the villagers are referred to Dimapur due to shorter distance than the district headquarters." (health centre, ANM)

Regardless of cost involved in the nearby private health facilities, what the villagers need is the nearest healthcare for immediate treatment according to the case at hand. Timely need based and distance matters if they have to meet free public treatment which is farther.

Another influencing factor of seeking healthcare services is the referral idea. There is sharing of knowledge about healthcare destination among the community. The past experiences of some persuades the needy in availing the services. As they mentioned:

"I came to know that hospital from others in the village." (female, aged 46)

"The hospital was referred to me by fellow villagers." (male, aged 34).

"I went there because the pharmacy is common in the area." (female, aged 59)

This is verified by the villagers going to the same hospitals though for different illnesses. Community beliefs and trust of a health service delivery based on their past experiences help their fellow villagers in availing the same services. Such suggestions serve as a timely help as well as encouragement in healthcare utilization. Meanwhile bad experience may create tendency in discouraging healthcare utilization for others. A sense of belongingness gets extended even outside the village, in this case, through seeking healthcare services (see figure 2).

Community intervention

The act of community service during ill health helps in seeking timely healthcare service for those in need. Besides monetary aids, transportation, hospital and voluntary arrangements are also made. Interventions come from the Church, the village community, relatives, and different groups or unions. Such help rendered were mentioned as:

"Whenever someone is ill, there are contributions from the church, village councils and other groups in cash or kind, vehicular arrangement also." (female, aged 59)

"During such times (referring to illness period) there are family and community contributions." (female, aged 46)
"These days there is a realization of health as important so there is helping among the villagers also when needed to go for treatment outside." (male, aged 39).
The involvement of the community alongside family and relatives help the villagers avail healthcare services outside the village, thereby seek timely healthcare. Strong community sentiment attachment is displayed in times of need.

Constraints on healthcare utilization

Road and connectivity

Factors that hinder healthcare seeking behaviour include the poor road condition. As pointed by the respondents, it delays their treatment due to non-feasibility of free movement. There are also cases of missing opportunities in attending medical camps due to unfavourable road condition. The grievances expressed were:
"When ill we cannot go immediately due to bad road condition." (female, aged 85)
"Since we have to go outside, we face problem because of the pathetic road condition." (male, aged 60)
"Those who cannot go down to attend health camp miss the opportunity. Their grievance is the road condition." (male, aged 39)
Even as community aids in providing personnel vehicles or bikes, the pathetic road condition does not make it convenient for timely travel. Whenever demanded the village community takes charge of weeding, clearing and repair of the village roads so to be serviceable. Yet, there is risky involvement of vehicular breakdown or even accidental cases due to the hilly terrain of the region. All these add unwanted worrisome to the already suffering patients.
Another major issue in availing healthcare services is the lack of transportation. [10] Since the village does not have a public transportation facility, people face problem to travel beyond the village. Patients and pregnant women are the hardest sufferers. Although the households own a bike, its limited capacity cannot suffice the challenge. The various reasons related to this were:
"Transportation fare costs rupees 500 from the village till the nearest health facility in Assam." (female, aged 87)
"Since the health personnel do not stay in the village, when we fall ill, we face problem since we have to go outside." (female, aged 25).
The non availability of ambulance in the village health centre further aggravate the situation in the most urgent hour. The mention of ambulance was not heard throughout the data collection period from any single respondent. It is supposed to have been included for a functional primary health centre as per the IPHS norm. [15] When the basic primary facilities could not be committed to the people, an ambulance service remained a distant dream. This dilapidated health centre burdened the villagers to access healthcare service within and outside the village.

Dysfunctional health centre

The dysfunctional village health centre adds to the constraint of healthcare seeking behaviour. Due to its almost non-functional condition, the villagers are denied of accessing the healthcare when in need. Most of the treatments which could otherwise be done here are left unattended. Thus, retard their overall healthcare needs. They pointed out that:
"The PHC lacks basic amenities, no health issues can be treated here, so when ill, people go outside, there is no one to provide treatment in the village." (female, aged 46)
"Most child deliveries are performed at Dimapur due to poor health facility in the village." (male, aged 50)
The case of health personnel absenteeism and irregularity have constantly denied healthcare services in the village. [1] The norm set by the Indian Public Health Standard (IPHS) for human resources and infrastructure appeared only in paper. During the field visit no health personnel

were in station and the village PHC remained shut. There were expired medicines and the overall health centre was in a dilapidated condition requiring immediate maintenance.

Financial constraint

The impact of financial issue in delaying response to illness has been pointed out generally as well as an individual experience. In addition to people's perception of minor illness as not needing medical attention, one's financial status also stands as a constraint in seeking early treatment. The bite of financial constraint from the ground came as:

"Going outside involves money so until serious villagers do not go for treatment." (female, aged 46)

"We cannot go immediately for treatment due to financial condition." (female, aged 85)

"Everyone cannot afford to go outside anytime and goes only when serious." (male, aged 34).

Financial factor is seen as a constraint for seeking instant treatment for perceived small health issues. As expressed here, the respondents think of illness as minor at the onset more than their ability or inability to pay. Thus, delay in seeking treatment until serious is influenced by their pre conceived notion that every health problem does not require immediate treatment but after days of observation at the household level.

DISCUSSION

The present study explored people's understanding of health and role of varying determinants in healthcare utilization. The status of healthcare services in rural Nagaland had been reflected through the peoples' experiences. Regarding understanding of health, the villagers' attachment of health in terms of functionality is connected to the findings of another study in a rural community in Southern Nigeria good health is associated with social and economic development. [16] Even among the agricultural workers in Belgaum district India health is viewed based on occupation productivity. [17] Being from an agricultural community the value of one's health for one's activities is recognised by the villagers in the present study.

In the present study majority used the private healthcare services within and outside the state. Out of the 9 household who had healthcare utilization record, 8 households (88.89%) have availed private healthcare services and 1 household (11.1%) utilized public hospital at Dimapur. This contradicts the NFHS-5 report of only 29.9% not using government health facilities in the studied state. The present empirical finding relates to the study in rural Karnataka [4], India where most people utilize private facilities. The reasons were similar to the illness as not serious and due to non-availability of specific health services. [8] The perceived non-serious cases, were treated from the nearby facilities which are mostly private pharmacies. The distance factor was also considered in this regard. Sharing of others past experiences too served as a guide. The reasons for going to particular providers were through suggestions and referrals from family members, relatives, known people, and fellow villagers. This is affirmed from what is seen as a community intervention in the present study. The immediate social intervention plays a significant role in the lives of the villagers in healthcare utilization to the extent that other factors become secondary. Sharing of knowledge, experiences and extending helping hand in terms of cash and kind even making necessary arrangements formed important determinants of healthcare utilization.

Regarding constraints on people's healthcare seeking, the under equipped health centre deprives the villagers of even basic healthcare amenities thus snatch their health rights. It seemed to be more concerned with the routine vaccination programs. This situation is no different from the existing findings that users have the perception that the ANM is concerned more

towards family planning and immunization to reach set targets, leaving out other activities within the job specification. [5] Thus, making people depend on outside services even for basic health care at their own cost. Although contributions may come from different sources at one point, it is important to know that their economic burden increases substantially in the long run as they rely more on the private providers outside. [18] Bad Road conditions and lack of public transportation in the village further complicated healthcare accessibility. [10] Multiple factors which are unnatural were identified in the studied village, thereby impede healthcare utilization.

In the present study, the norm of IPHS remained unfulfilled and the goal to reduce out of pocket expenditure has no positive outcome as people spent more than their monthly household income as presented earlier (figure 3). The study also showed an institutional limitation of healthcare to women when policies advocate regular ANC and institutional delivery, the services are unavailable for the eligible women. The overall official data overshadow the contextual and spatial differences overlooking the poor health infrastructure altogether. Ultimately, taking into consideration the mentioned determinants based on empirical evidence can enhance the rural health centres thereby improve overall state's health outcome. This invites initiative transcending a single department or sector.

The limitations of the present study are it being a cross-sectional study and confinement to one health centre. Future research can incorporate longitudinal studies and comparative study of two rural health centres or between urban and rural health facilities.

CONCLUSION

The envisioned structure of healthcare service provision through different health activities and health personnel still remain far from achievement. This study revealed such a case that in spite of a public health centre in the village, seeking healthcare outside is more prominent for minor issues. The study highlighted presence of various determinants as enablers and constraints in seeking treatment. These in turn make the healthcare utilization multidimensional at the individual, household and community level. The determinants of healthcare utilization in this study had a profound role but this utilization can get limited without desired interventions and with increased illness incidences. In addition to the enabling social determinants of healthcare utilization, contribution from the village health centre also matters significantly. This is suggestive to accommodate those who continue medication after taking treatment from outside. The strengthening of the existing health centre and basic amenities like road and transportation need urgent attention from concerned stake holders.

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