A STUDY ON THE ROLE OF EDUCATION IN ACCESSING HEALTHCARE SERVICES IN RURAL COMMUNITY, SPECIAL REFERENCE TO SARSENOT, DONKAMOKAM, WEST KARBI ANGLONG

A Dissertation Submitted to the Department of Social work for the fulfilment of the requirement for the award of the degree of Master of Social Work (MSW).

Submitted to:

Department of Social Work

MSSV, Guwahati Unit

Submitted by:

Abolon Beypi

MSW, 4th Semester

Roll no. MSW-19/23

Registration No. MSSV-0023-008-001608

Session: 2023-25

MAHAPURUSHA SRIMANTA SANKARADEVA VISWAVIDYALAYA

GUWAHATI, UNIT

RUPNAGAR-781032

A STUDY ON THE ROLE OF EDUCATION IN ACCESSING HEALTHCARE SERVICES IN RURAL COMMUNITY, SPECIAL REFERENCE TO SARSENOT, DONKAMOKAM, WEST KARBI ANGLONG

A Dissertation Submitted to the Department of Social work for the fulfilment of the requirement for the award of the degree of Master of Social Work (MSW).

Submitted to:

Department of Social Work

MSSV, Guwahati Unit

Submitted by:

Abolon Beypi

MSW, 4th Semester

Roll no. MSW-19/23

Registration No. MSSV-0023-008-001608

Session: 2023-25

MAHAPURUSHA SRIMANTA SANKARADEVA VISWAVIDYALAYA

GUWAHATI UNIT

RUPNAGAR-781032

মহাপুৰুষ শ্ৰীমন্ত শঙ্কৰদেৱ বিশ্ববিদ্যালয়

MAHAPURUSHA SRIMANTA SANKARADEVA VISWAVIDYALAYA

[RecognizedUnderSection2 (f) ofUGCAct, 1956] GUWAHATI

CONSTITUENT UNIT

Sankari Sanskriti Kendra, Rupnagar, Bhangagarh, Guwahati-781032, Assam

Department of Social Work

CERTIFICATE

I have the pleasure to certify that **Miss Abolon Beypi,** MSW 4th semester student bearing Roll No. **MSW-19/23** with Registration No. **MSSV-0023-008-001608** of **2023** has successfully completed the dissertation entitled "**The role of education in accessing healthcare services in rural community with special reference to Sarsenot, Donkamokam, West Karbi Anglong**". She has made a successful completion of this research by her own.

I wish her a bright future.

(Dr.DeepshikhaCarpenter)
HOD (i/c)
Department of Social Work
Guwahati Unit, MSSV,
Nagaon

Head (i/c)
Dept. of Social Work
MSSV

Dr. Deepshikha Carpenter, HOD (i/c)
Mobile No: 7637887130
Email-deepshahacarpenter@mssv.ac.in

মহাপুৰুষ শ্ৰীমন্ত শঙ্কৰদেৱ বিশ্ববিদ্যালয়

MAHAPURUSHA SRIMANTA SANKARADEVA VISWAVIDYALAYA

[RecognizedUnderSection2 (f) of UGC Act, 1956]

GUWAHATI CONSTITUENT UNIT

Sankari Sanskriti Kendra, Rupnagar, Bhangagarh, Guwahati-781032, Assam

Department of Social Work

CERTIFICATE OF SUPERVISOR

This is to certify that **Miss Abolon Beypi** student of MSW 4 semester bearing Roll No**. MSW-19/23** with Registration No. **MSSV-0023- 008-001608** of **2023**, MSSV, Guwahati unit has successfully carried out his dissertation entitled "**The role of education in accessing healthcare services in rural community with special reference to Sarsenot, Donkamokam, West Karbi Anglong**" as a student researcher under my supervision and guidance for the partial fulfillment of the requirement for the award of the degree of **MASTER OF SOCIAL WORK (MSW).**

The work reported in this research has not been submitted elsewhere and the facts presented here are true to the best of my knowledge.

I wish her all the very best for her future Endeavour.

Dipshikha 11/06/2025

Dipshikha Boruah
Teaching Associate
Department of Social Work
Guwahati Unit, MSSV, Nagaon

Research Supervisor
Dept. of Social Work
MSSV

Place: MSSV, Guwahati Unit
Date: 11/06/25

MAHAPURUSHA SRIMANTA SANKARADEVA VISWAVIDYALAYA

GUWAHATI UNIT

Department of Social Work

Date: 03.06.2025

Plagiarism verification Certificate

Title of the Research Project: The Role of education in accessing healthcare services in rural community with Special reference to Sarsenot, Donkamokam, West Karbi Anglong

Total Page: 71

Researcher: Abolon Beypi

Supervisor: Dipshikha Boruah

Department: Social Work

This is to certify that the above Research Project (Dissertation) was scanned for similarity detection in SmallSEO software tool. The softcopy of the Research Project on which the Plagiarism Check has been carried out is the identical softcopy of the hardcopy, which is being submitted for evaluation. The Process and outcome of the Plagiarism Check is given below:

Analyzed document: ABOLONMSW1923

Submitted on: 03-06-2025

Time: 03:05 PM

Submitted by: Ms. Dipshikha Boruah

Submitter email: dipshikhaboruah541@gmail.com

Total Word Count: 13739

Similarity Index: 3.55%

Analysis address: dipshikhaboruah541@gmail.com

The complete thesis/dissertation submitted by the student researcher, the Analysis Report and the Exported report from Original Profile have been shared with the Library in-charge for review through e-mail.

Dipshikha 11/06/2025

Analyzed by- Dipshikha Boruah

Date: 03-06-2025

Place: Guwahati

(Signature of supervisor)

Department of Social Work

MSSV, Guwahati Unit

DECLARATION OF ORIGINALITY

I, **Abolon Beypi**, student of 4th semester, Department of Social Work (Roll No. MSW-19/23 and Registration No. **MSSV-0023-008-001608**, Guwahati Unit, Mahapurusha Srimanta Sankaradeva Viswavidyalaya (MSSV), Nagaon do hereby declare that this dissertation, entitled **"The Role of education in accessing healthcare services in rural community with Special reference to Sarsenot, Donkamokam, West Karbi Anglong"** is an original work of mine and is the result of my own intellectual efforts, under the guidance of **Dipshikha Boruah**, Teaching Associate, Department of Social Work, MSSV, Guwahati Unit. I acknowledge and cite the entire original source (i.e., key documents and authors names) that helped me in writing this research project. I am not violating any author's copyright. I do hereby also declare that the contents of this dissertation have never been submitted to this or any other university (either in part or fully) for award of any degree.

Abolon Beypi 11/06/25

Abolon Beypi

MSS-19/23

MSSV-0023-008-001608

Place: Guwahati, Assam

ACKNOWLEDGEMENT

Words often fall short when it comes to expressing heartfelt gratitude, for true appreciation comes from deep within. With immense sincerity, I take this opportunity to express my gratitude to all those who contributed to the successful completion of this study.

First and foremost, I extend my deepest gratitude to my Research Guide, Dipsikha Boruah Assistant Professor, Department of Social Work, Mahapurusha Srimanta Sankaradeva Viswavidyalaya (MSSV), whose unwavering support, insightful guidance, and constant encouragement were instrumental throughout this research journey. Her mentorship has been a cornerstone of this study.

A heartfelt thank you goes to all the respondents who willingly shared their experiences and perspectives. This study would not have been possible without their active participation and honest contributions.

I am equally thankful to my friends and well-wishers, whose moral support and encouragement have helped me stay motivated during challenging times. I am also grateful to the MSSV, Guwahati Unit, for offering me the platform and necessary resources to carry out this study effectively.

My deepest appreciation is reserved for my parents. Their unwavering emotional and financial support, along with their constant encouragement, has been my greatest source of strength throughout this academic journey.

Abolon Beypi

Roll No. MSW-19/23

Registration No. MSSV-0023-008-001608

Place: MSSV Guwahati Unit.

Abstract

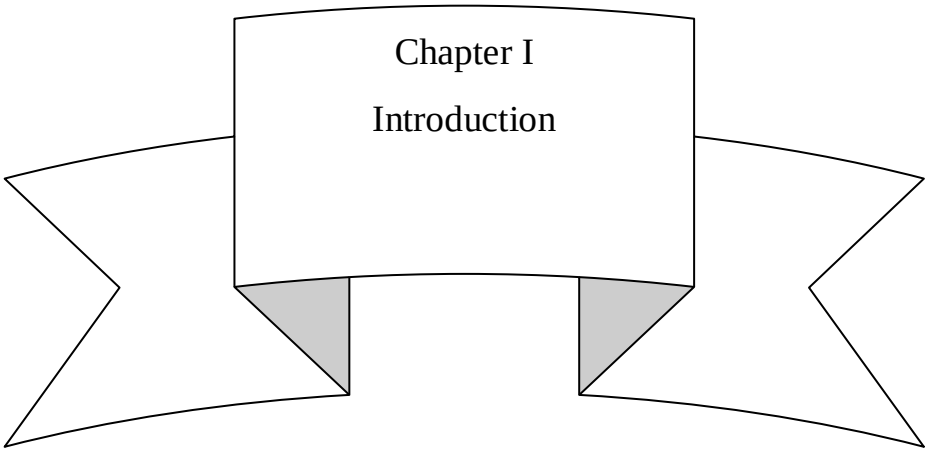
Education is the systematic process to foster learning that enables individuals to gain knowledge, develop skills, and adopt values, ethics, beliefs, and behaviours. It is important for personal growth, societal advancement, and economic development. In rural communities, where resources are limited and not easily found, old and traditional beliefs often shape decisions, for which education can be the bridge to gain better knowledge on health. This study explores the pivotal role of education in facilitating access to healthcare services within rural communities, with a focus on Sarsenot village in West Karbi Anglong. Drawing from a comprehensive literature review and primary data, the research underscores that education particularly health literacy significantly influences individuals' ability to seek, understand, and utilize healthcare services. Studies from various contexts highlight how formal education improves health outcomes, empowers individuals to make informed decisions, and reduces dependency on traditional practices. In the surveyed community, while a majority of respondents had received formal education; substantial gaps remained in health knowledge, confidence in understanding medical information, and awareness of available services. Barriers such as transportation challenges, financial constraints, and lack of health insurance were more prevalent among less-educated individuals. The findings emphasize that education not only raises awareness of disease prevention and early treatment but also enables communities to navigate complex healthcare systems more effectively. The study advocates for integrating culturally relevant health education into school curricula, enhancing digital literacy, and expanding community outreach through health workers and volunteers. Ultimately, improving education levels in rural areas is essential for achieving equitable healthcare access and fostering sustainable community well-being.

Keywords: Education, Healthcare Access, Health Literacy, Rural Communities, Formal Health Education, Health-Seeking Behaviors, Barriers to Healthcare, Healthcare Awareness, Socioeconomic Factors, Preventive Care.

LIST OF TABLES

LIST OF FIGURES

TABLE OF CONTENTS


Chapter I
Introduction

Introduction

Education is the systematic process to foster learning that enables individuals to gain knowledge, develop skills, and adopt values, ethics, beliefs, and behaviours. It plays a major role for personal/interpersonal growth, advancement in the society, and development of the economic.

Different forms of Education

- Formal Education: It is the structured and organized learning that takes place within an institution like schools, colleges and universities.
- Informal Education: This type of education occurs naturally through our daily experiences, interactions and self directed exploration.
- Non-formal Education: It consist of both structured and organized learning system that occurs outside the traditional formal education system.

In rural communities, resources are not easily found and are limited, and they mostly follow old and traditional beliefs, for which education can be the bridge to gain better knowledge on health. When people have access to knowledge, they're more likely to spot early warning signs of illness, value preventive care, and seek help before it's too late. Yet, in many villages and remote areas, low literacy rates, deep-rooted myths, and a lack of health awareness keep families from the care they need which sometimes results with devastating consequences.

Education open doors, as well as saves live. Educated people/person can better understand the advice of doctors, navigate confusing healthcare systems, and make choices that protect their families than that of the uneducated ones. Educated communities are stronger to that of the uneducated ones as they question harmful stigmas, follow healthier habits, and look for better clinics and hospitals. By investing in education, especially programs that teach people about health, we can close the gap between cities and villages, ensuring no one is left behind when it comes to medical care.

Education in healthcare services is important for training skilled professionals, improving patient care, and advancing medical research. It includes formal academic programs, clinical training, continuing education, and public health awareness.

Importance of Healthcare Education

- Improves Patient Outcomes
- Advances Medical Research
- Addresses Workforce Shortages
- Promotes Preventive Care
- Ensures Compliance and Ethics

Modern Trends in Healthcare Education

- Simulation-Based Training (Virtual reality, mannequins for practice).
- E-Learning & Telemedicine Training (Online medical courses, remote diagnostics).
- Interprofessional Education (IPE)
- Artificial intelligence & Big Data in Medical Training
- Global Health Education

1.1 Operational Definition

- **Education:** The systematic and uniform practice of teaching, educating and learning, that takes place in both formal and informal settings. This structured approach differs from more casual or alternative forms of learning that occur through everyday life experiences, like community development initiatives or the knowledge children gain naturally from their family relationships.
- **Healthcare**: Healthcare refers to maintaining or improving people's health through preventing, identifying, treating, and managing diseases, injuries, and both physical and mental conditions. This essential service is provided by medical professionals and various health specialists working together.

- **Community**: A group of people consisting of any size where the members lives in a specific area or locality, share the same geographical areas and have a common cultural and historical heritage.
- **Rural community:** They are the indigenous people mostly living in the hilly areas, characterized by lower population density, smaller settlements, and a strong connection to agriculture, nature, or traditional ways of life. These communities play an important role in national economies, food production, and cultural heritage but often face various challenges like language barriers and cultural shock.

1.2 Statement of the problem

This study explores the role of education in accessing healthcare services in Sarsenot which is a village located in Donkamokam, West Karbi Anglong. There is development in the particular area but due to certain barriers, healthcare accessibility is still not prevail and isn't fulfilled. There is no enough education regarding healthcare services as it can be seen that most of the people have no idea about some diseases. It can be caused due to the lack of government educations, awareness and programs.

Despite significant progress in recognizing the barriers to healthcare accessibility in rural communities, the influence of education remains inadequately explored. It remains unclear how educational attainment affects an individual's healthcare decision-making, health promotion practises, and capability to utilize healthcare services effectively. This study is significant as it seeks to highlight how low literacy levels can hinder awareness about available health services, preventive care, treatment options. This study targets this gap by examining the relationship between education and healthcare access. It also aims to contribute toward building a more equitable health system where rural communities like can access quality healthcare without hindrance. Proper access to education can bridge the gap in health-seeking behaviour by empowering individuals with knowledge about diseases, preventive measures, and

available healthcare services. Educated individuals are more likely to recognize symptoms early, make informed health decisions, and actively engage with healthcare systems, ultimately improving community health outcomes.

1.3 Significance of the study

The significant contribution of this study rests on understanding how education affects healthcare access in rural communities. The findings are vital for healthcare stakeholders as it offers insights into addressing access disparities. Policymakers can use the knowledge to design education-based solutions to augment healthcare accessibility and equity.

This study is important to find how education in healthcare services helps the people of the community. It also highlights how education influences the ability of individuals in rural communities to access and utilize healthcare services. In many rural areas, barriers such as lack of information, low health literacy, and limited awareness of available medical services contribute to poor health outcomes. By understanding the role education plays in overcoming these barriers, policymakers, educators, and healthcare providers can develop targeted interventions to improve public health. This understanding can drive community-based awareness programs, integrate health education into local school curricula, and promote adult learning initiatives focused on health literacy. Furthermore, enhancing educational outreach can empower individuals to take preventive actions, seek timely medical attention, and participate in health-promoting activities. Ultimately, such efforts contribute to building a resilient, informed community capable of achieving better health outcomes.

1.4 Objectives of the study

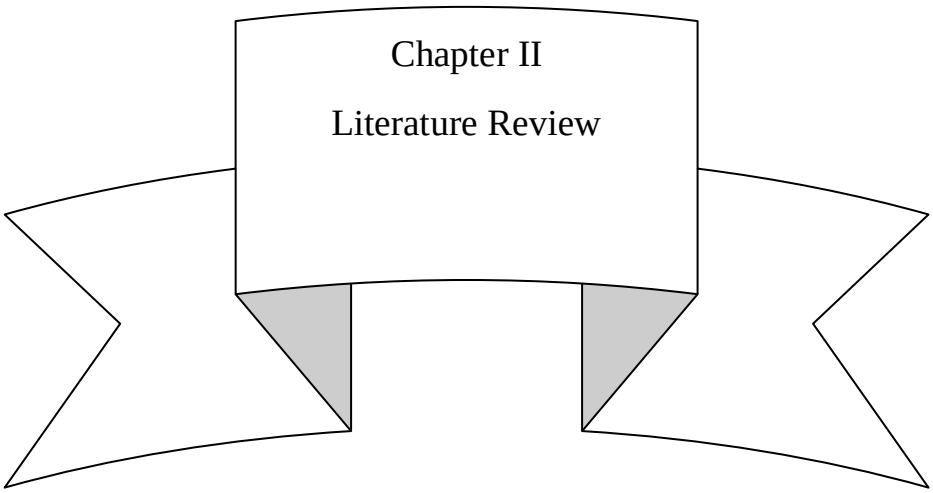
1. To assess the impact on education of health care services in rural community.

2. To understand the influence of education in health seeking behaviours.

3. To explore the barriers faced by individuals with lower educational levels.

1.5 Research Questions

- What challenges do individuals with various educational levels encounter while accessing healthcare services in rural areas?
- How does education influence health literacy in rural populations?
- Does education level affect the preference for healthcare provider choice in rural communities?


Chapter II
Literature Review

Literature Review

Tayebi Z. et al. (2024) conducted a study on *"The requirement of providing health education for rural people through electronics methods: the experiences and perspectives of community health workers"* it explore the growing necessity of integrating electronic/digital education into health education, particularly for rural populations. Traditional health education methods, primarily face-to-face instruction and printed materials, are insufficient to address modern educational needs. The study focuses on community health workers (Behvarzan) in Iran, who play a crucial role in delivering primary healthcare services to rural communities. These health workers operate in Health Houses (HHs) and cater to diverse target groups, from children to the elderly, as well as specific groups such as students and workers. The article argues that incorporating e-learning methods can significantly enhance the effectiveness of health education. Digital tools offer flexibility, improved accessibility, and increased engagement for both educators and learners. Global studies, including those from Guinea, Afghanistan, and Zimbabwe, support the effectiveness of digital education in improving healthcare workers' knowledge and performance. Moreover, the COVID-19 pandemic accelerated the adoption of electronic learning methods, providing valuable insights into their practical application. The study emphasizes the importance of understanding the perspectives of Behvarzan in implementing digital education systematically. By identifying their needs and challenges, health education programs can be better tailored for rural populations. Overall, the article effectively underscores the potential of e-learning in transforming health education, particularly in underserved areas

Rose J et al (2023) conducted a study on "*Investing in Health Education to Reduce Rural Health Disparities'* which explores the significant health disparities faced by rural populations, which make up nearly half of the global population, due to limited access to healthcare and poorer outcomes compared to urban areas. It emphasizes the crucial role of nurses in addressing these disparities, positioning them not only as healthcare providers but also as community development practitioners who must

understand rural health challenges. The Community Health Assessment Sustainable Education (CHASE) model is introduced as a framework for preparing nursing students to engage with rural communities, encouraging them to assess health needs and develop sustainable strategies. The paper advocates for integrating community development into nursing education, training students to collaborate with rural communities while focusing on both clinical skills and community engagement. A case study in Bishop's Castle, Shropshire, UK, illustrates how nursing students from New Zealand and Australia worked together to assess the community's health needs and create health promotion resources. The use of film as a tool for community assessment is also discussed, showing how it helped students understand rural life and health challenges. The paper concludes by calling for continued research and collaboration in rural nursing education, suggesting the CHASE model as a way to prepare students to address rural health disparities effectively.

Zegeye B. et al(2021) in the article "*Breaking barriers to healthcare access: A multilevel analysis of individual- and community-level factors affecting women's access to healthcare services in Benin*." Explores the healthcare access barriers for women in Benin, emphasizing the significant role of socioeconomic factors in shaping access to healthcare services. Using data from the 2017-2018 Benin Demographic and Health Survey, the study highlights that financial barriers, particularly out-of-pocket expenses, are the most significant obstacles. Women's and their husbands' educational levels, economic status, and marital status also influence healthcare access. The findings show that 60.4% of women face challenges accessing healthcare, with regional disparities and community literacy levels playing important roles. Women in communities with higher literacy faced fewer barriers. The paper calls for policies to empower both women and men through education and economic opportunities and stresses the need for targeted interventions in areas with poor healthcare access. It also suggests working with religious leaders to improve health-seeking behaviors.

Jones et al. (2020) conducted a study on *"The case for integrated health and community literacy to achieve transformational community engagement and improved*

health outcomes: an inclusive approach to addressing rural and remote health inequities and community healthcare expectation" explores the ongoing health challenges faced by rural and remote communities in Australia, where despite significant investments, these populations continue to experience poor health outcomes and limited access to healthcare services, a problem also observed in countries like Canada and the United States. The paper emphasizes the importance of health literacy, defined as the ability to obtain and understand basic health information for informed decision-making, with the World Health Organization recognizing it as a combination of cognitive and social skills. The authors argue that focusing only on individual health literacy overlooks the broader community context, advocating for a shift towards integrated health and community literacy, where health personnel engage with communities as equal partners. They introduce a conceptual framework aligning community literacy with health literacy, suggesting that improving community literacy among health personnel can lead to better engagement and outcomes. Six principles underpin this approach, including the need for tailored responses, understanding community contexts, and fostering trust. The paper highlights the need to address social determinants of health through collective action and calls for further research on the impact of community literacy initiatives to address health inequities in rural and remote areas.

Navarro, M. D. (2020) in the article "*Patients' empowerment and the role of patients' education. Journal of Patient Education and Counselling,"* explore the relationship between patient empowerment and education, emphasizing the critical role education plays in empowering patients to take control of their health. The paper highlights that informed patients are better able to make decisions regarding their treatment plans, adhere to medical advice, and engage in self-management practices. Empowerment is viewed as a process by which patients gain the skills, knowledge, and confidence to navigate the healthcare system effectively. The author argues that patient education programs are essential for improving health outcomes, reducing hospital readmissions, and enhancing the overall quality of life for patients. The paper also discusses the challenges in implementing effective education programs, including overcoming

health literacy barriers and ensuring that educational content is accessible and relevant to diverse patient populations. Navarro calls for more structured, patient-centred education interventions that cater to the individual needs of patients to improve both their healthcare experiences and outcomes.

David R Steeb. et al. (2019) conducted a study on *"Connecting Rural and Global Health Education for workforce development"* which explore the global shortage of healthcare workers, particularly in rural areas, and the impact this has on health equity and achieving the 2030 Sustainable Development Goals. Despite half of the world's population living in rural regions, only 23% of healthcare workers serve these areas, contributing to significant health disparities. Factors such as epidemiologic transitions, migration patterns, and insufficient educational opportunities exacerbate the rural healthcare workforce crisis. The article highlights how global health education, which often takes place in rural settings, can be leveraged to encourage future healthcare professionals to work in underserved areas. Medical students who participate in global health programs tend to develop a strong sense of commitment to working with marginalized populations, which aligns with the World Health Organization's (WHO) recommendations for rural workforce development. However, many academic institutions are based in urban settings, making rural training less accessible. To bridge this gap, academic programs can integrate global and rural health curricula, expand experiential learning opportunities, and foster partnerships with local health organizations. By strengthening these connections, global health education can serve as a powerful tool to address workforce shortages and improve healthcare access in rural communities worldwide.

Bright T. et al (2018) in the article "*Systematic review of strategies to increase access to health services among children over five in low- and middle-income countries."* explores a systematic review of strategies to improve healthcare access for children over five years old in low- and middle-income countries (LMICs), a demographic often overlooked in global health strategies. The review includes studies evaluating healthcare utilization, immunization uptake, and medication compliance,

from countries such as Nicaragua, Brazil, Turkey, India, and Uganda. The interventions assessed include education, incentives, outreach, SMS reminders, and multi-component strategies. The review found that all interventions reported positive outcomes, though the quality of evidence varied, with some studies being weak due to small sample sizes and lack of control for confounding factors. The paper highlights the need for further research on the effectiveness of different interventions, the contextual factors influencing success, and cost-effectiveness assessments to guide policy decisions. It also discusses barriers like financial constraints and lack of awareness and how educational programs have shown promise in improving attitudes towards healthcare. Overall, while effective strategies exist, the evidence base remains limited, and more high-quality studies are needed.

Zajacova A. & Lawrence E. M. (2018) in the article "*The relationship between education and health: Reducing disparities through a contextual approach".* explores the significant relationship between education and health, noting that individuals with higher educational attainment generally experience better health outcomes and longer lives compared to those with less education. This disparity, they argue, is growing over time. The authors stress the importance of understanding the contexts in which education impacts health and assert that education should be viewed not just as an outcome but as an ongoing process that influences health throughout an individual's life. The paper reviews three key theoretical perspectives: Fundamental Cause Theory, Human Capital Theory, and the Signaling Perspective. The empirical evidence presented demonstrates that the more schooling an individual attains, the better their health outcomes, with variations based on gender, race, and other demographic factors. The paper also identifies several pathways through which education affects health, including economic factors, health behaviors, and social support. The authors advocate for future research that incorporates broader social and historical contexts to inform policies aimed at reducing educational and health disparities.

Jansen T.et al (2018) in the article "*The role of health literacy in explaining the association between educational attainment and the use of out-of-hours primary care*

services in chronically ill people". Explores the role of health literacy in explaining how educational attainment influences the use of out-of-hours primary care services among chronically ill individuals. The study, which employed a survey design, suggests that health literacy acts as a mediating factor in the relationship between education and healthcare utilization. Individuals with higher levels of education and better health literacy were more likely to use out-of-hours services appropriately, as they were better equipped to navigate the healthcare system and understand the need for timely care. The authors highlight that individuals with low health literacy face greater challenges in accessing healthcare services, even when they have higher educational attainment. The findings suggest that improving health literacy could enhance healthcare utilization and reduce disparities in access to essential services, particularly for chronically ill populations. The study emphasizes the need for targeted health literacy interventions to improve the equitable use of healthcare services, especially among vulnerable groups.

Cornwell M. (2017) in the article "*The effect of a school-based health center on access to care in a rural community"* explores the impact of School-Based Health Centers (SBHCs) on health access, quality of care, and academic performance. A systematic review of 46 studies revealed that students utilizing SBHCs had better academic outcomes, including higher GPAs, improved grade promotion rates, and reduced school suspension and dropout rates. The review highlights the health challenges faced by children from low-income communities, such as poor health outcomes, increased school absenteeism due to illness, and a lack of regular healthcare providers. SBHCs are shown to improve health outcomes by increasing vaccination rates, preventative screenings, and contraceptive use, while also reducing emergency department visits and hospital admissions, particularly for minority adolescents in underserved areas. SBHCs are perceived as more accessible and provide better-coordinated care than traditional primary care clinics, with higher satisfaction rates among adolescents and parents. The financial benefits of SBHCs are also significant, with savings for Medicaid patients due to reduced costs related to lost productivity, travel, and emergency care. The literature supports the effectiveness of SBHCs in

enhancing healthcare access, improving health outcomes, and boosting academic performance, particularly in underserved communities.

Van Vliet K. et al (2017) conducted a study on "*Education for future health care: A radical shift in perception, learning and action".* Explores the need for a radical shift in health care education to prepare professionals for future demands. This shift is driven by changing demographics, technological advancements, and evolving health concepts. They highlight two reports commissioned by the Dutch Health Ministry, which explore necessary changes in health care professions and education across various sectors, including hospital care, mental health, and public health. The authors emphasize the use of a mixed-methods research approach, combining qualitative methods (such as interviews) with quantitative techniques (e.g., predictive modeling), to understand the changing health care landscape. A significant finding is the growing number of older adults, particularly those over 80 years old, living independently despite chronic conditions. The paper stresses the importance of digital health technologies in transforming health care delivery and education, supporting self-management and continuous learning. The authors recommend developing a national framework for cooperation among stakeholders to address future health care challenges effectively.

Hudon C. et al (2016) in the article "*Medical education for equity in health: A participatory action research involving persons living in poverty and healthcare professionals"* explores the role of medical education in promoting health equity, with a focus on a participatory action research project involving persons living in poverty and healthcare professionals. The study highlights the importance of engaging marginalized populations in the design and implementation of medical education programs to foster a deeper understanding of their health needs and challenges. The authors argue that integrating the perspectives of underserved communities into medical curricula is essential to addressing health disparities and improving patient care. The research found that collaboration between healthcare professionals and individuals from disadvantaged backgrounds led to the development of educational

strategies that were more responsive to the realities of poverty. Additionally, the study underscores the need for medical education to move beyond traditional approaches, encouraging students to address social determinants of health and to practice with a more inclusive, empathetic approach. The findings suggest that such participatory models can enhance both healthcare providers' attitudes and their ability to deliver equitable care.

Przybylska D et al (2014) in the article "*Health education as an important tool in the healthcare syste"*. It explores the critical role of health education in promoting health, shaping individual behaviors, and improving outcomes. Health education positively influences recovery and prevention by transferring knowledge and skills. Family medicine is identified as a key area for initiating health-oriented attitudes, with primary care physicians regarded as the most trusted source of health information. The paper traces the historical development of health education in Poland since the 1980s, integrating it into public health strategies. Preventive measures have gained focus in response to civilization-related health issues, addressing both individual behaviors and broader social and political factors. The study suggests that effective health education can reduce healthcare costs by improving patient outcomes, though challenges like organizational issues and limited consultation time hinder its implementation. It concludes by emphasizing the crucial role of primary care physicians in health education, supporting the principle that prevention is better than cure.

White F (2013) in the article *"The Imperative of Public Health Education: A Global Perspective"* explores the critical need for a well-structured, competency-based public health education system to address global health challenges effectively. White emphasizes that public health is inherently multidisciplinary and requires professionals who are not only technically proficient but also culturally sensitive and adaptable to diverse local contexts. He advocates for educational frameworks that are evidence-driven and aligned with the specific health needs of populations, ensuring that public health strategies are both relevant and effective. The article also highlights the importance of investing in educational capacities that can produce a workforce capable

of implementing sustainable health interventions. By fostering a global perspective in public health education, White argues, we can better prepare professionals to tackle health disparities and promote well-being across different societies.

Bryant R. (2011) in the article "*Promoting access to health care: A nursing role and responsibility*." it explores the crucial role of nurses in enhancing access to healthcare, especially for underserved populations. The paper emphasizes that access to healthcare is a key determinant of health outcomes, noting that individuals who need care most often face the greatest barriers, leading to significant health inequities based on gender and socioeconomic status. The International Council of Nurses (ICN) acknowledges that social determinants, including access to well-resourced healthcare, significantly influence health outcomes. Bryant discusses the professional responsibility of nurses to advocate for equitable access, highlighting their unique position to identify and address barriers such as geographic, structural, socio-economic, or cultural factors. The paper stresses the importance of strengthening primary health care systems, with the World Health Organization urging investment in primary care and the nursing workforce. The theme for International Nurses Day 2011, "Closing the gap: increasing access and equity," underscores the vital role nurses play in ensuring healthcare access for marginalized groups. Bryant's work advocates for systemic changes to promote healthcare equity.

Levine R.A et al (2011) in the article *"Maternal Literacy and Health Care in Three Countries: A Preliminary Report"* explore how maternal literacy influences health behaviours across Mexico, Zambia, and Nepal. Initially sceptical about literacy's impact, the researchers incorporated direct literacy assessments into their study, revealing that even minimal schooling significantly enhanced mothers' abilities to comprehend health information. This understanding translated into better health decisions for their children. The study underscores that literacy, rather than just years of schooling, is pivotal in enabling mothers to navigate healthcare systems and utilize services effectively. By highlighting the direct link between literacy skills and health

outcomes, the research advocates for educational interventions that prioritize literacy development to improve maternal and child health globally.

Adams R. J. (2010) in the article "*Improving health outcomes with better patient understanding and education"* it explore the importance of health education and patient engagement in improving health outcomes. The paper highlights a significant gap between expected and actual patient behaviors in healthcare participation, pointing out that many interventions aimed at enhancing self-care have shown positive results, such as increased self-efficacy and patient satisfaction. Health literacy is identified as a key factor in improving health outcomes, with low health literacy often leading to poor health outcomes and inadequate self-management. The paper introduces the concept of "choice architecture," which involves creating environments that encourage healthier choices without restricting freedom, presenting it as a promising area for future research in patient behavior. The RE-AIM framework, which evaluates public health programs based on reach, effectiveness, adoption, implementation, and maintenance, is also discussed as a useful tool for assessing health interventions. While self-management programs have shown short-term benefits, Adams calls for more research on their long-term effects and the factors influencing participation across different socioeconomic groups. The paper concludes that healthcare systems should adopt a proactive approach by improving health literacy and patient engagement through accessible environments and tailored communication strategies.

LeVine R. A.& Rowe M. L. (2009) in the article "*Maternal literacy and child health in less-developed countries: Evidence, processes, and limitations* "explores the relationship between maternal literacy and child health in less-developed countries, arguing that maternal education is a crucial determinant of child health outcomes. The paper discusses how maternal literacy impacts various health behaviors, such as seeking healthcare, understanding health information, and making informed decisions about nutrition and sanitation. The authors emphasize the mechanisms through which maternal education influences child health, including improved communication with healthcare providers, better use of available health resources, and a stronger ability to

navigate health systems. However, the paper also identifies significant limitations in the current body of evidence, including the difficulty of isolating the effects of literacy from other socio-economic factors and the lack of longitudinal studies to capture the long-term impacts. Despite these challenges, LeVine and Rowe argue that improving maternal literacy can be a powerful strategy for enhancing child health in low-income countries and advocate for policy interventions that prioritize educational programs for women.

Regidor E. et al (2008) in the article "*Socioeconomic patterns in the use of public and private health services and equity in health care"* explores socioeconomic patterns in the use of public and private health services, emphasizing the importance of equity in health care access and outcomes. The study focuses on how socioeconomic factors influence the utilization of different types of health services, with a particular focus on disparities between public and private sectors. The authors argue that socioeconomic inequalities are a significant determinant in health care access, with individuals from lower socioeconomic groups being more likely to rely on public health services. They discuss the role of various structural and institutional factors in perpetuating these disparities and the challenges in achieving equitable health care access across different population groups. The paper highlights the need for policy interventions that address these disparities by improving access to quality public health services and reducing financial barriers that prevent lower-income individuals from accessing necessary care. The authors also call for a comprehensive understanding of the social determinants of health and the broader implications for health system reforms.

O.M Robyn et al (2008) in the article *"Dimensions of Patient Empowerment: Implications for Professional Services Marketing"* explores how patient empowerment influences healthcare service delivery. The authors identify three key dimensions of empowerment: patient participation, patient control, and patient education. They argue that these elements, when considered collectively, can enhance the management of professional services that require significant client input. The study emphasizes the need for healthcare providers to adopt a more collaborative approach, encouraging

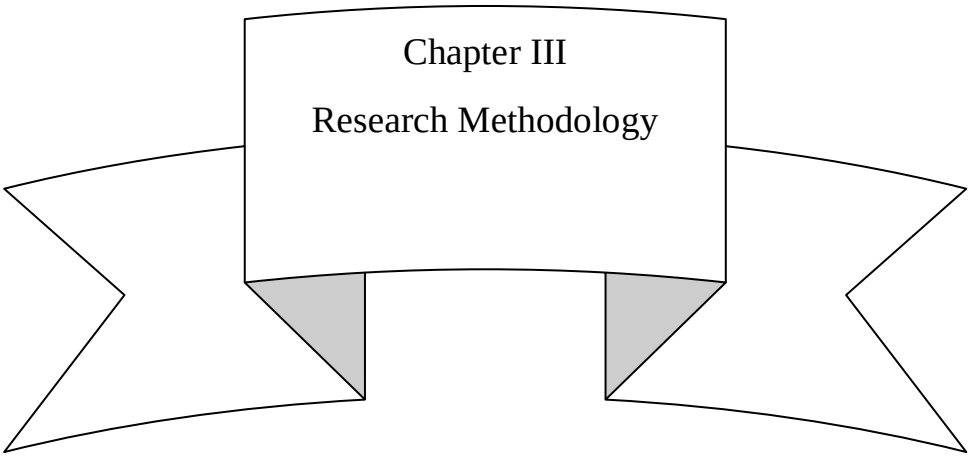
active patient involvement in decision-making processes. By integrating these empowerment dimensions, healthcare services can improve patient satisfaction and outcomes. The article suggests that marketing strategies should reflect this shift towards patient-centered care, promoting transparency and shared responsibility between patients and providers. Overall, the research provides valuable insights into the evolving dynamics of patient-provider relationships and the importance of empowering patients within the healthcare system

Lindelow M. (2004) in the article *"Health care decisions as a family matter: Intra-household education externalities and the utilization of health services"* explores the relationship between education and health care choices, with a focus on maternity care and child immunizations. The paper expands on existing literature that links education to the utilization of health services, primarily focusing on individual or maternal education. It critiques traditional studies that overlook the educational backgrounds of other household members, emphasizing the broader impact of household education. The paper draws from two major strands of literature: human capital investments in health production and education externalities, suggesting that the education of one household member can positively influence the health behaviors of others. Anthropological studies are also referenced, highlighting how cultural beliefs and values affect health decisions, particularly in developing countries. Lindelow argues for a broader understanding of intra-household education externalities, where the educational achievements of all household members influence health care choices. Despite challenges in empirical analysis, the paper concludes that education is a crucial determinant of health service utilization.

Cooper S.& Ensor T. (2004) conducted a study on "*Overcoming barriers to health service access and influencing the demand side through purchasing*." Explores the imbalance in the literature regarding barriers to healthcare access and the interventions designed to address these barriers. While extensive research has identified factors such as financial constraints, distance, and cultural differences as barriers, fewer studies evaluate effective strategies to overcome them. The paper emphasizes that demand-

side barriers, particularly in low-income countries, are critical, with challenges like poor transportation and lack of health service knowledge hindering access. Successful interventions often involve community input, ensuring culturally sensitive solutions. The authors highlight that demand-side strategies, particularly in areas like obstetric care and family planning, must be accompanied by improvements in service quality to be effective. Additionally, the small-scale nature of many interventions makes it difficult to generalize findings, underscoring the need for more robust evaluations of intervention effectiveness and sustainability. The paper calls for a comprehensive approach addressing both barriers and interventions.

Elo I. T. (1992) conducted a study on *"Utilization of maternal health-care services in Peru: The role of women's education. University of Pennsylvania*." Explores the relationship between women's education and the utilization of maternal health-care services in Peru. The paper highlights maternal education as a key determinant of health outcomes for mothers and children. Previous studies show a strong positive correlation between maternal education and child survival rates, even when controlling for household socioeconomic status, emphasizing education's role in improving health outcomes. Educating women leads to shifts in family dynamics, enhancing decision-making power, resource allocation, and health knowledge, which increases the demand for modern health services. However, the effects of maternal education on health service utilization are often confounded by factors such as the mother's childhood background, socioeconomic status, and access to healthcare. Using data from the 1986 Peruvian Demographic and Health Survey, Elo finds significant disparities in health-service utilization, with rural women facing greater challenges in accessing healthcare compared to urban women. The paper underscores the importance of improving women's education to enhance maternal and child health in developing countries.


Chapter III
Research Methodology

Research methodology

A research methodology refers to the systematic approaches and processes employed to gather and examine data related to a particular research subject. It involves planning and structuring a study to meet its goals by applying chosen research techniques. This framework encompasses key elements such as research design, methods for collecting and analyzing data, and the broader structure guiding the research process.

The researcher use Quantitative method to the study for the role of education in accessing healthcare services in rural communities as it aims to measure variables, test hypotheses, and identify patterns or relationships using numerical data. This approach allows for objective and generalizable findings.

3.1 Theoretical Framework

Health Belief Model (HBM)

The health belief model is psychological framework developed in the 1950s to help explain and predict health related behaviours, especially in the uptake of health services. It is widely used in public health to design interventions and understand why people do or do not take preventive health actions. It is used to explain and predict individuals potentially behaviour, attitude and belief on their health.

Education influences health beliefs and behaviours by increasing awareness of disease risks, benefits of medical care, and reducing perceived barriers to healthcare access. Rural communities with better education are more likely to seek preventive care, vaccinations, and early treatment.

Health Belief Model is related to this study as it helps to explain how education influences rural communities by shedding light on how people perceive health and make decisions about seeking care, Health related behaviour by examine individuals

specification and institute It will also improve the rural residents in perceiving health risks, understand the benefits of care, overcome barriers and take action confidently.

3.2 Research design

Research design serves as the methodological framework that determines how a study will systematically investigate its research questions while maintaining validity and ethical standards. This particular study will employ a quantitative research methodology utilizing a descriptive design approach. The quantitative method involves collecting numerical information and applying statistical techniques to examine rural populations, yielding concrete data about their demographic composition, economic conditions, health status, and infrastructure development. Such an approach enables researchers to detect patterns, establish comparisons between groups, and generate evidence to support policy formulation. The descriptive research design specifically aims to provide an accurate representation of characteristics within a population or phenomenon.

The researcher chose a quantitative method with descriptive research design as the primary goal of this study is the objectify measures and describe patterns, trends, or relationships within a specific population or phenomenon. The quantitative approach allows collecting numerical data, which can be statistically analysed to provide clear, precise and measurable insights.

3.3 Universe of the study

The study focuses on Sarsenot, Donkamokam, West Karbi Anglongthe study will focus mainly residing in the area for interviews of all age group.

The researcher chose this particular area as it can be seen by the researcher that Sarsenot reflects the typical economic and cultural condition found in remote tribal villages. The community still faces challenges such as low literacy rates, limited awareness of health rights and services, language barriers and deeply rooted traditional beliefs and influence health-seeking behaviour.

By focusing on Sarsenot, The study aims to uncover the specific educational and social factors hindering health excess, providing a micro level understanding that can inform macro level rural health and education policies not only in Karbi Anglong not one in similar rural area across India.

.

Figure: Map of Sarsenot (Google Map)
https://maps.app.goo.gl/Bm4wMys3Fg6sMLhk6?g_st=aw

3.4 Sampling Techniques

Sampling is the process of selecting a representative subset of a population for study. In rural contexts, unique challenges (e.g., geographic dispersion, cultural diversity) require careful method selection.

Simple random sampling: Simple random sampling (SRS) is a basic probability method where every member of the population has an equal and independent chance

of being selected. It ensures unbiased representation and is widely used in rural studies when researchers need generalizable data. In a simple random sample, every member of the population has an equal chance of being selected. A sampling frame should include the whole population.

The researcher choose this particular sampling technique, Simple random sampling as it gives every individual in the target population an equal chance of being selected, which help to reduce bias and increase the representativeness of the sample. This method is especially suitable for this study as it can ensure that the data collected reflects the general views and experiences of the village without favouring any individual.

3.5 Sample size

Sample size refers to the number of individuals, observations, or data points included in a research study. It is a critical aspect of study design because it affects the reliability, accuracy, and generalizability of the findings.32 respondent will be used for the research study.

The researcher selected 32 respondents based on the goals of the study, and to ensure a manageable yet meaningful representation of the target population. Given the scope, time and resource limitations of the research, 32 participants provide a sufficient baseline for identifying patterns and drawing initial conclusion using descriptive statistics.

Additionally, in quantitative descriptive studies, a sample of 32 respondent is often considered the minimum acceptable number for basic statistical analysis.

3.6 Data collection (tools and techniques)

The researcher used structured questionnaires as a tool for data collection.

Structured questionnaire are a quantitative data collection method where researchers ask fixed, pre-determined questions in a standardized format. They are useful for gathering uniform, comparable data across rural respondents.

The researcher used the combination to ensure the accuracy, depth and reliability of the data collected in the study. Since the entire 32 respondent will be asked the same set of pre-determined questions, it reduces biases and allows for comparison of responses.

This method is also effective in ensuring clarity and understanding, especially in rural settings where literacy levels may vary.

3.7 Tools for analysis of data

The researcher organised and coded the data using MS excel and Google form , a quantitative data analysis program to make the procedure easier.

3.8 ETHICAL CONSIDERATION AND CONSENT

Ethical considerations are the principles that ensure research is conducted responsibly, protecting participants' rights, dignity, and well-being.

Informed Consent: Informed consent is a critical ethical requirement ensuring that participants voluntarily agree to take part in research after understanding its purpose, risks, and benefits. In rural communities, obtaining informed consent requires cultural sensitivity, clear communication, and trust-building due to potential literacy, language, or distrust barriers. Participants must fully understand the purpose of the study and voluntarily agree to participate.

Confidentiality: Confidentiality refers to the ethical obligation to protect participants' personal information from unauthorized disclosure. In rural communities, where

populations are small, interconnected, and often distrustful of outsiders maintaining confidentiality is critical but also challenging. Personal information of the respondent shared should be kept private and not disclose without permission.

3.9 LIMITATIONS

1. Geographical Constraints: The study focuses on Sarsenot area, limiting the generalizability of results to other areas.
2. Data Collection Constraints: The study's reliance on qualitative and quantitative data collection methods, such as interviews and surveys, may be subject to certain limitations, including response biases, sample representativeness, and data validity.
3. Time and Resource Constraints: The study may be constrained by limitations in terms of time, budget, and resources available for data collection, analysis, and interpretation. As a result, the depth and scope of the research may be restricted, potentially impacting the comprehensiveness of the findings and the ability to explore certain aspects in detail.

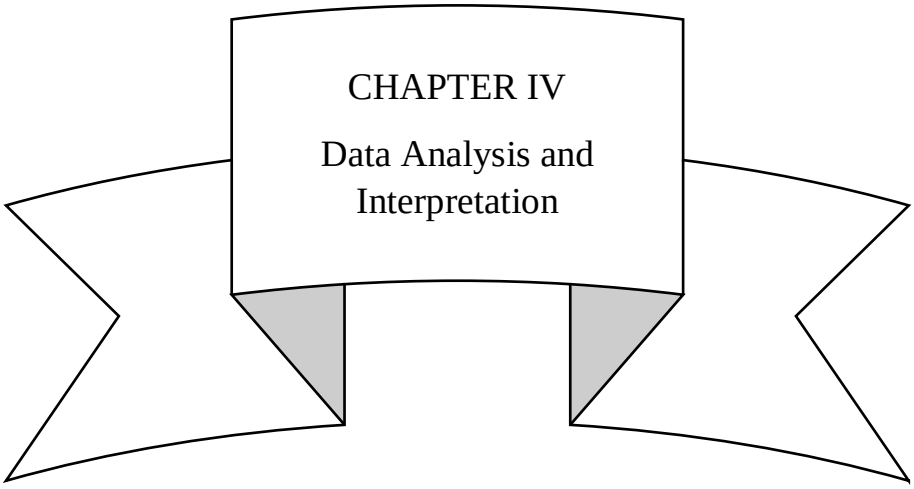
3.10 Inclusive and Exclusive criteria

Inclusive criteria will include

1 Participants of all age group.
2 Individuals residing in Sarsenot Village, West Karbi Anglong.
3 Both the genders male and female and other gender identities.
4 Willing participants who voluntarily agree to participate in the study.

Exclusive criteria will include

1. Non-resident respondence.
2. Poor health Condition individuals.
3. Unwilling participants.


CHAPTER IV
Data Analysis and
Interpretation

Analysis and interpretation

4.1 Demographic profile of the respondents

4.1.1 Age of the respondents

Serial number	Age of the respondent	Number of respondent	Percentage
1	Below 15	0	
2	15-20	21	65.62%
3	20-25	8	25%
4	25-30	3	9.37%
5	Above 30	0	
14	Total	32	100%

It is shown that, there are total 32 respondents from which the age of 15-20 has the most respondents that is 21 in total with the percentage of 65.62% and the least are the age of 25-30 that is 3 in total, occupying 9.37%. From the above, it is found that majority of the respondent were between the age of 15-20 years. Despite of selecting all age groups, only the age of 15-30 were interested in doing the questionnaire.

4.1.2 Gender of the respondents

Serial number	Gender	Number of respondents	Percentage
1	Male	8	25%
2	Female	24	75%
3	Total	32	100%

The above shows that there are 32 respondents, where 24 are Female and 8 are male.

4.1.3 Qualification of the respondents

Qualification	Number of respondents	Percentage
Below Matriculation	2	6.25%
HSLC	Nil	
Higher Secondary	12	37.5%
Graduate	17	53.125%
Post Graduate	1	3.125%
Total	32	100%

The above chart shows that 53.125% are of the respondents are graduate student, 37.5% are from Higher secondary qualified, whereas 6.25% are below matriculation student and3.125% is Post graduate student.

This distribution indicates that the survey responses are predominantly from Hugher secondary and graduates with minimal representation from below matriculation and individual with post graduate.

4.2 Objectives no 1: To examine the impact on education of healthcare services in rural communities

4.2.1 Person receiving formal health education

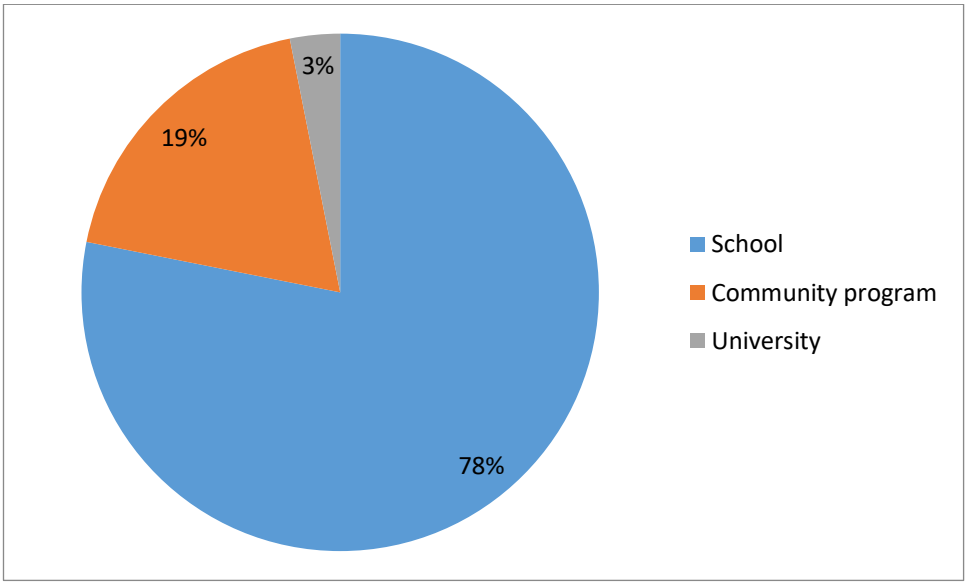


Fig no: 4.2.1: Person receiving formal health education

Through the data as shown above about 78% of person had received formal education even though the village belongs to rural area while 19% received through community program which mostly focuses on providing basic education to the rural population and the rest 3% received through universities.

In this chart, it can be seen that all of the respondents have received formal health education, where most of the respondents receive formal health education in their school days which is 78.1% and the rest are from Community program and University.

4.2.2 Importance of formal education in providing healthcare access to rural community

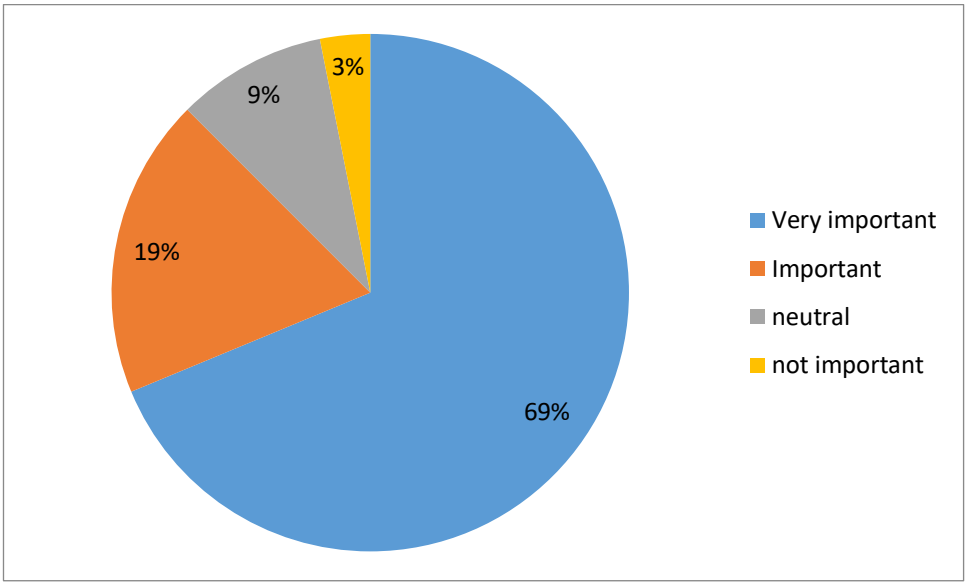


Fig no. 4.2.2: Importance of formal education in providing healthcare services

The chart shows that 69% of respondent believed that formal education is very important, 19% thinks it's important, 9% thinks it's neutral and the remaining 3% thinks it's not important.

Most of the respondent believed that formal education is important in providing and accessing healthcare in the rural areas as it helps them in knowing various medical schemes and facilities and awareness regarding healthcare services. While few of the respondent think that formal education is not important as they wants to carry on with their cultural and traditional based knowledge regarding healthcare.

4.2.3 Awareness of available healthcare providers

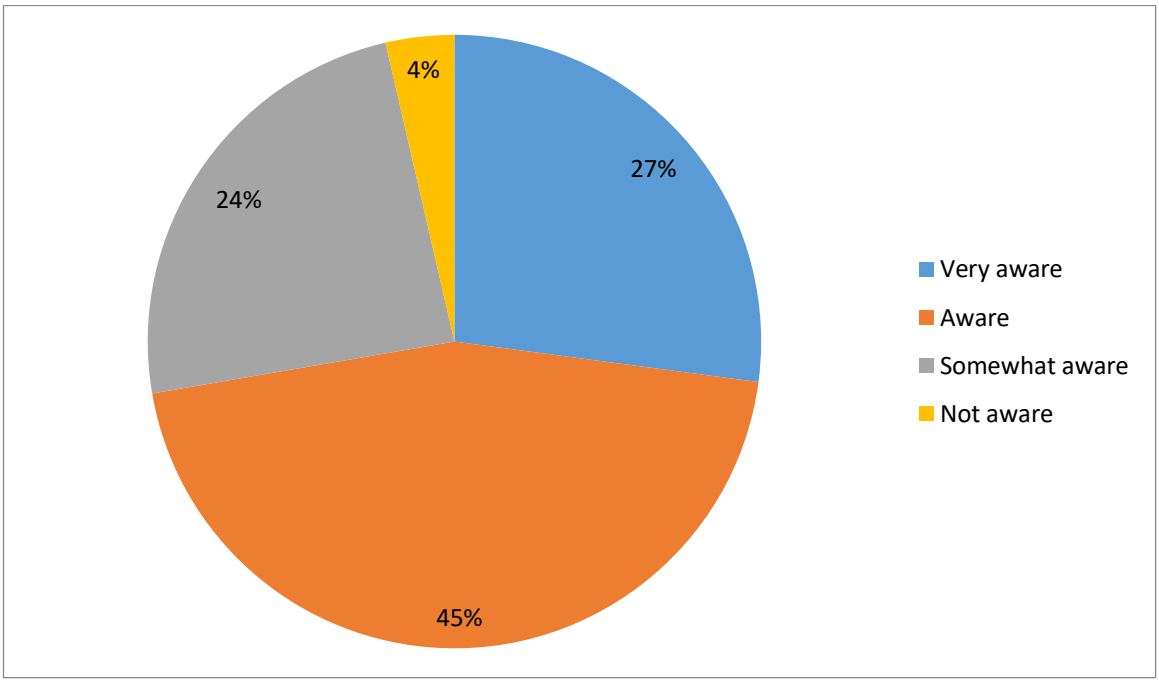


Fig no: 4.2.3: Awareness of available healthcare providers

By the chart above, it can be seen that 46.9% of people are aware of the availability of healthcare providers, 28.1% are very aware and 25% are somewhat aware.

Almost maximum numbers of respondent are aware of the healthcare providers due to visit of such providers during the difficult time, while few of them are somewhat aware due to lack of much awareness and education related to healthcare services in the community.

4.2.4 Confidence in understanding healthcare information

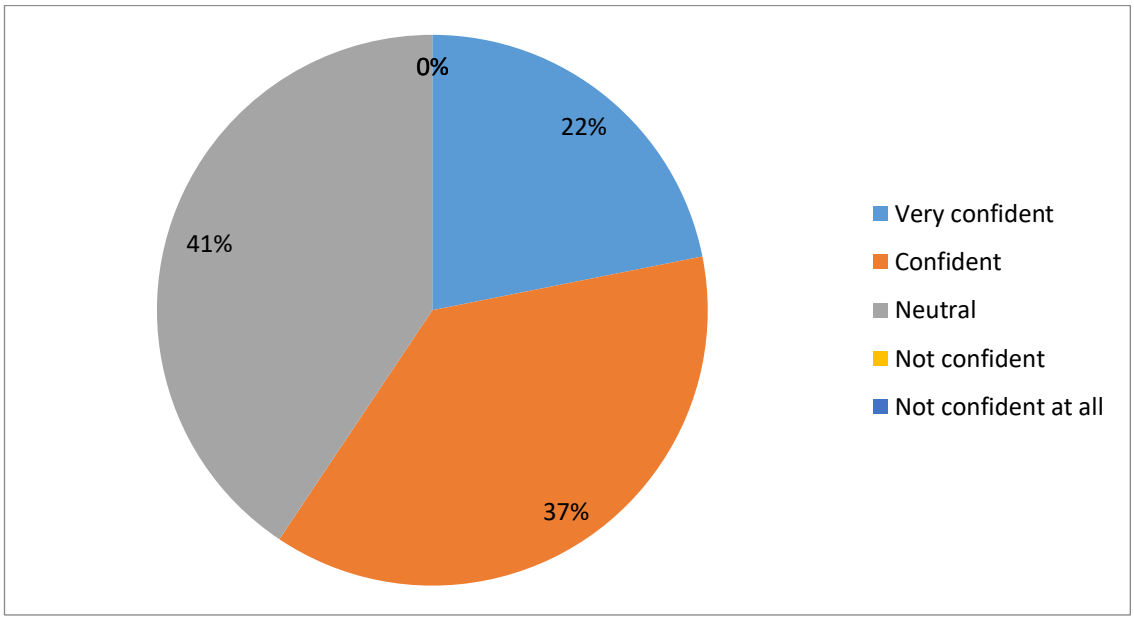


Fig no. 4.2.4: Confidence in understanding healthcare information

The above chart represents that 40.6% respondents are neutral, 37.5% are confident and 21.9% are very confident in understanding the Heath information provided by healthcare professionals.

Some of the respondent were neutral towards understanding the health information provided by healthcare professionals as there are some scientific terms which makes them difficult to understand and affects their confident, while more than half of the respondent are confident as they are qualified and received formal education which help them in understanding the health information provided by the healthcare professionals.

4.2.5 Respondents' access in healthcare services when experiencing health issue.

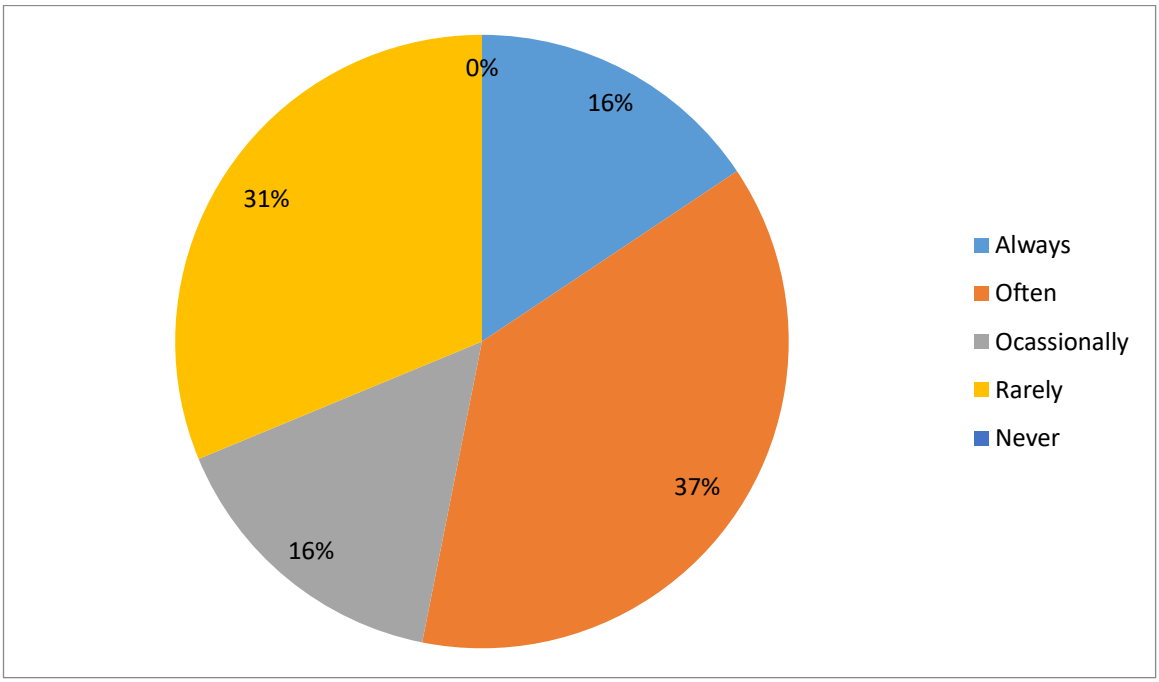


Fig no. 4.2.5: Access in healthcare services

The chart shows that 37% often access to healthcare services, 31% rarely access to healthcare services, 16% always access to healthcare services and again 16% of the respondents occasionally access to healthcare services when experiencing health issue.

According to the respondent statistic, all of them have the access to the health care even though the frequencies vary depending in the respondent will. Most of them have access to health care as they're available and affordable whereas some of them doesn't get access to such due to lack of awareness, stigma and long waiting lines.

4.2.6 Likely to participate in health education program

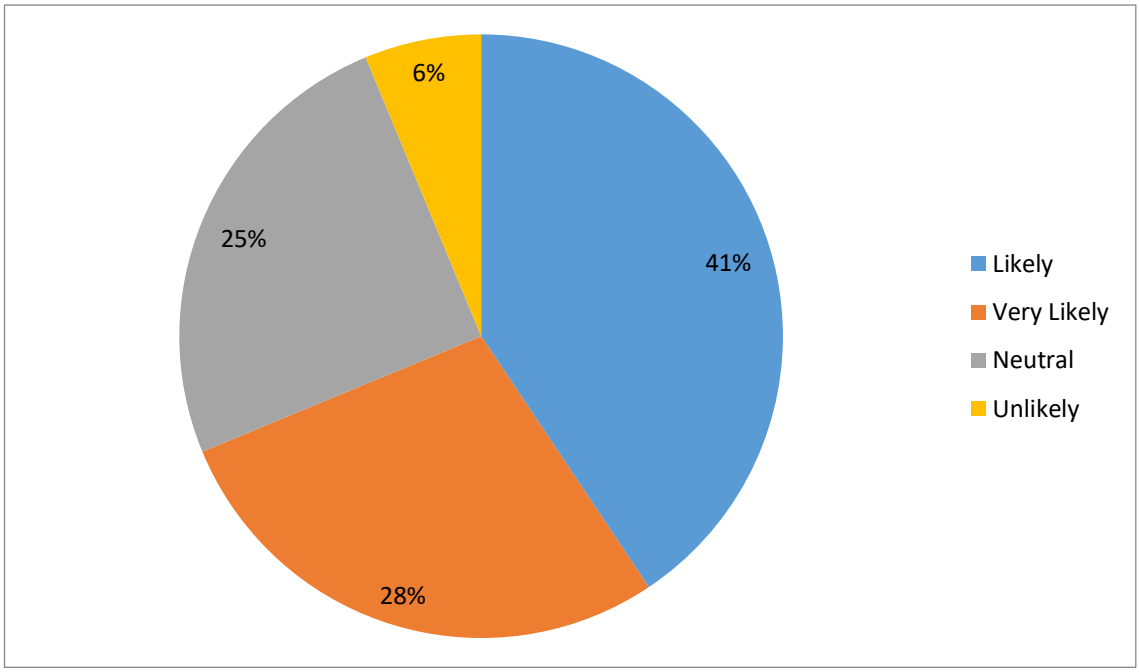


Fig no. 4.2.6: Likely to participate in health education program

From the above chart, 41% are likely to participate in health education programs, 28% are very likely to, 25% are neutral and 6% are unlikely to participate in health education programs if they were made available in the community.

As per response most of the respondent are likely to participate in the health education program as it would help them in accessing health related services as well as health education based knowledge while few are unlikely to participate due to cultural based issues.

4.2.7 Participation of community members in health education workshops

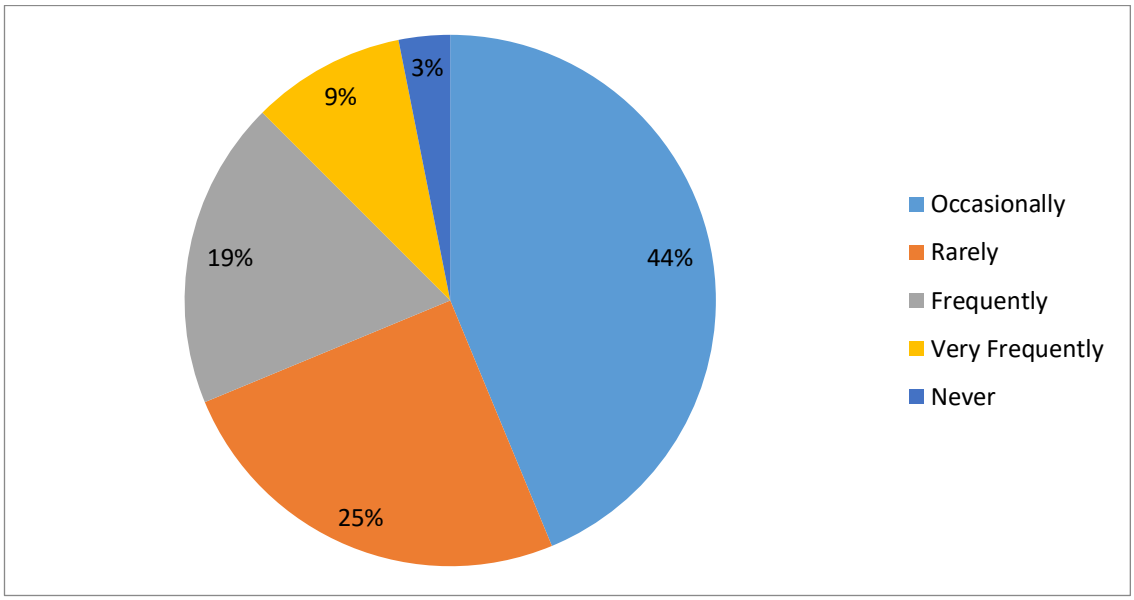


Fig no. 4.2.7: Participation of community members

The above charts represents that 44% occasionally attend, 25% rarely attend, 19% frequently attend, 9% very frequently attend, and 3% never attend to health education workshop of training program.

As per response from the respondent most of them participate very frequently, and occasionally to gain knowledge and skills about health whereas some rarely and never participate due to time constraints, and lack of awareness.

4.2.8 General knowledge of available healthcare in the community

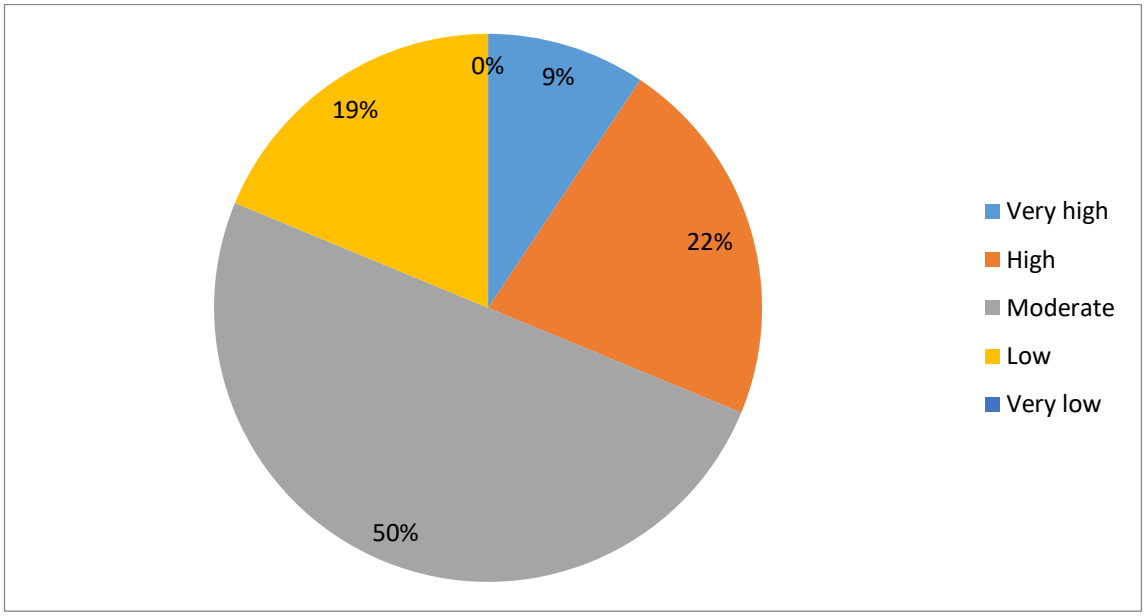


Fig no 4.2.8: General knowledge of available resources

From the chart its shows that 50% ie most of the respondent have moderate knowledge on available healthcare services due to their visits in difficult time. While 22% have high knowledge due to their higher level of education and 9% have really good knowledge due to their participation in various health programmes, and 19% have low knowledge due to their lack of education in their respective field of healthcare services.

Most of the respondents have a moderate general knowledge of available healthcare in the community through schools, colleges and community health programs whereas few of them have low general knowledge due to information gaps like limited access to education, language barriers

4.2.9 Quality of healthcare education

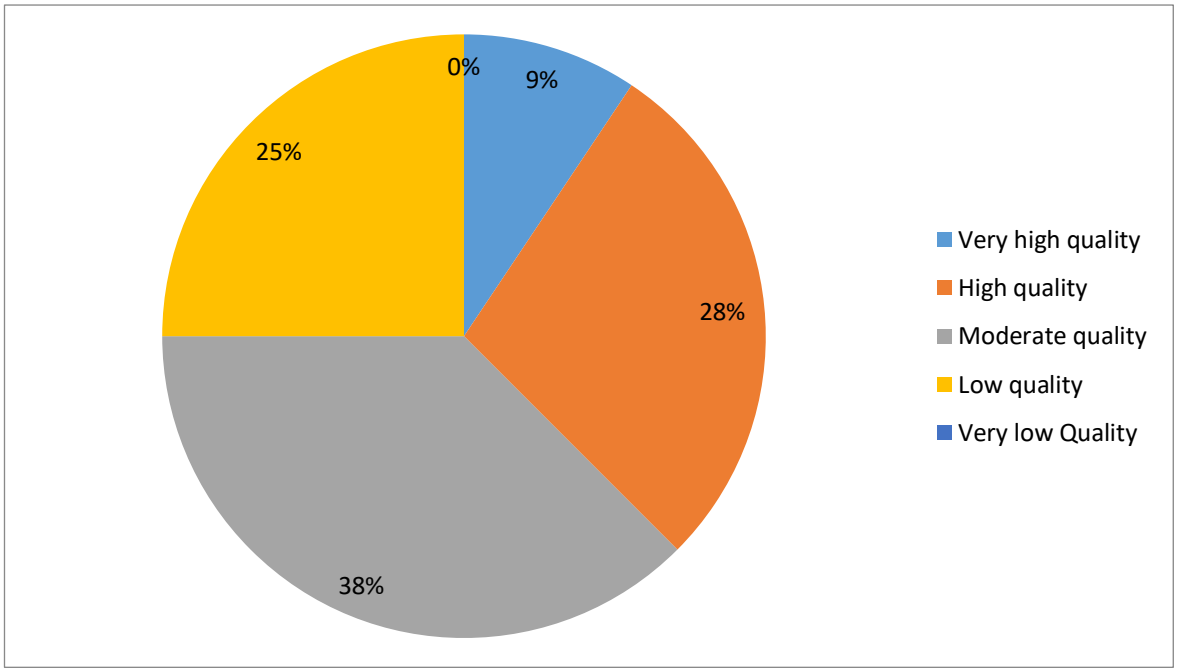


Fig no. 4.2.9: Quality of healthcare education

As per the response collected 38% rated the quality of healthcare education in schools or local community programmes while 9% have rated very high quality, 28% rated as high quality, and 25% have rated low quality.

The respondent have rated the quality of healthcare education in schools and or local community high due to the accessibility factors and awareness on healthcare while the 25% have rated it low due to their lack of such education healthcare based knowledge.

4.3 Objective number 2: To understand the influence of education in health seeking behaviours of rural community

4.3.1 Improvement of health services through education

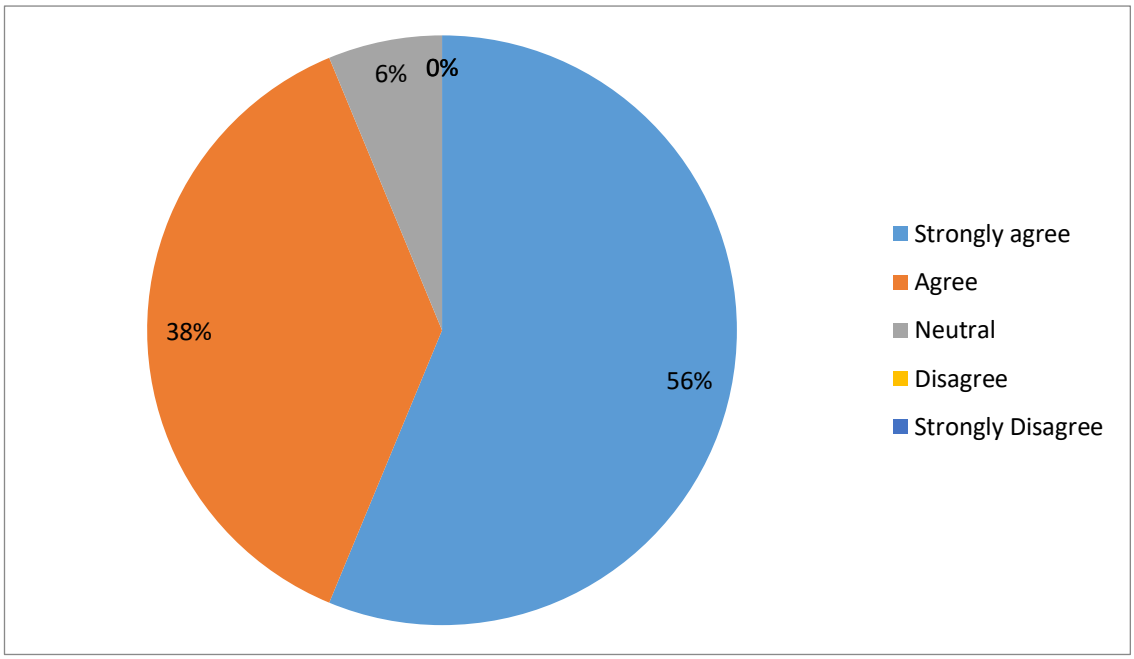


Fig no 4.3.1: Improvement of health services through education

From the above chart, it can be seen that 56% strongly agree, 38% agree and the rest 6% are neutral with better education would improve access to healthcare services in the community.

Through the chart analysis all the respondent totally agreed on the impact education has and how it influence the healthcare system as it raise awareness, promotes prevention and fosters healthy practices.

4.3.2 Health information

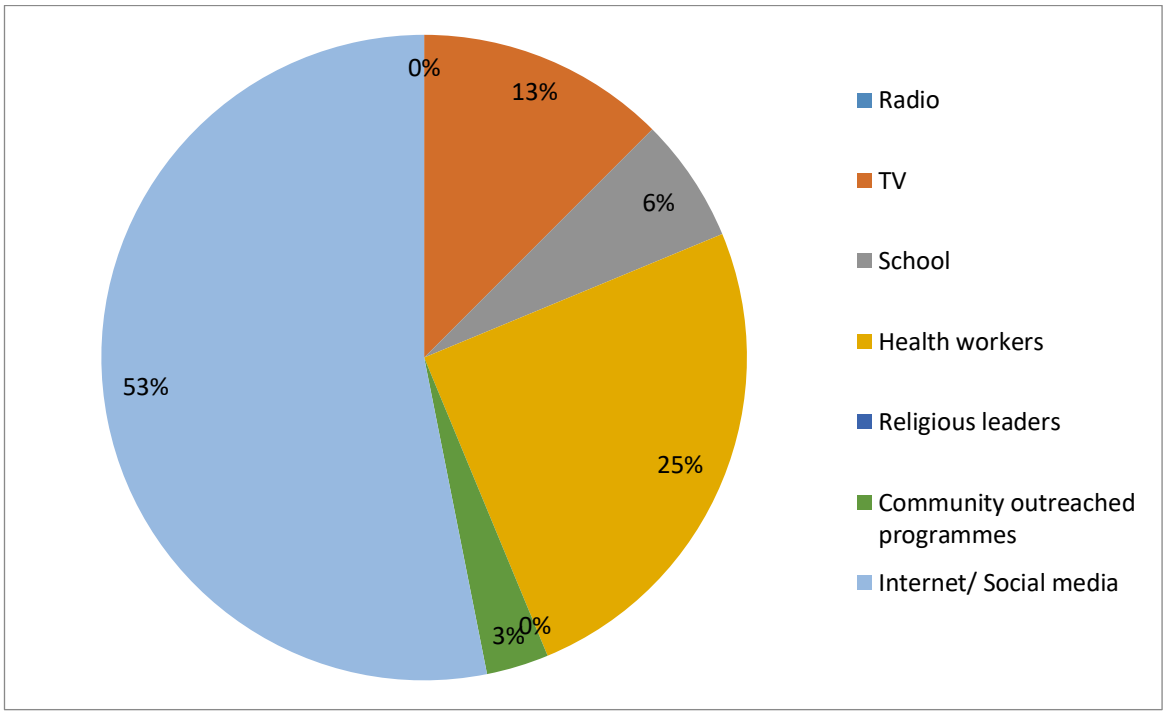


Fig no. 4.3.2: Health information

The chart above shows that 53% get information from Internet/Social Media, 25% from Health workers, 13% from TV, and the rest are from Schools and Community outreach programs.

The respondents choose Internet/social media as a health information agent as most of the respondents have access to such sources, while 25% from health workers like ASHA workers and other health volunteers, 13% are from news channel like broadcast breaking health news and health officials explanation on health, whereas some of them get the information from Schools where they learned hygiene, reproductive health, and health prevention.

4.3.3 Change of health behaviour

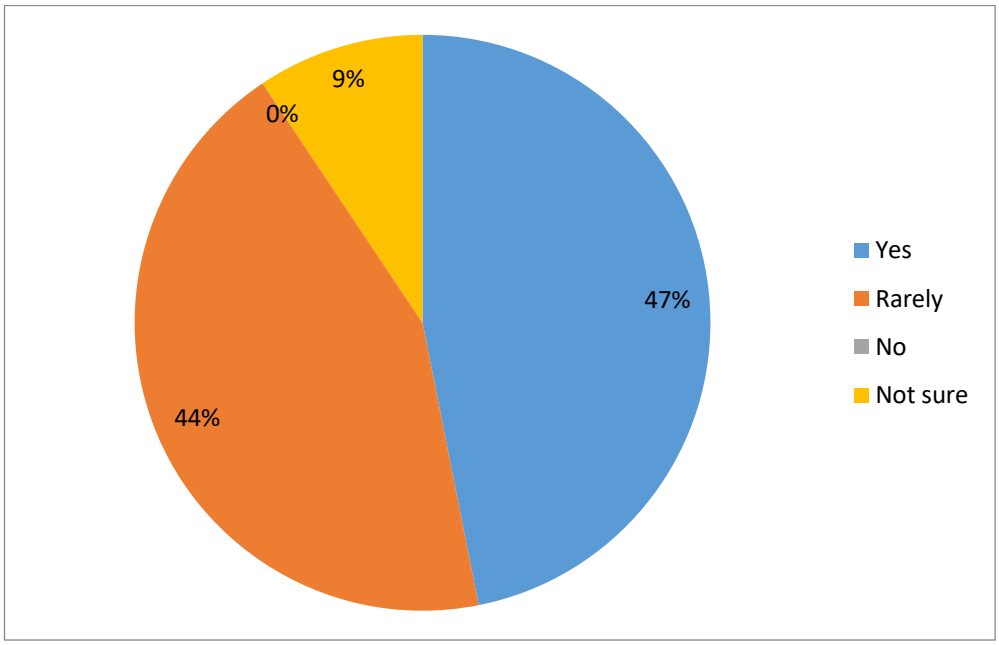


Fig no. 4.3.3: Change of health behaviour

The chart represents that 47% change their health behaviour, 44% rarely change their health behaviour and 9% are not sure about change in their health behaviour of what they learnt in school.

About 47% have respondent that they have changed their health behaviour due to their awareness and education provided to them in schools due to the new emerging various health problems. While 44% have rarely changed due to their choice of living their regular and healthy life and only quite few respondents of 9% are not sure about their change due to their lack of knowledge.

4.3.4 Avoiding medical services due to cost

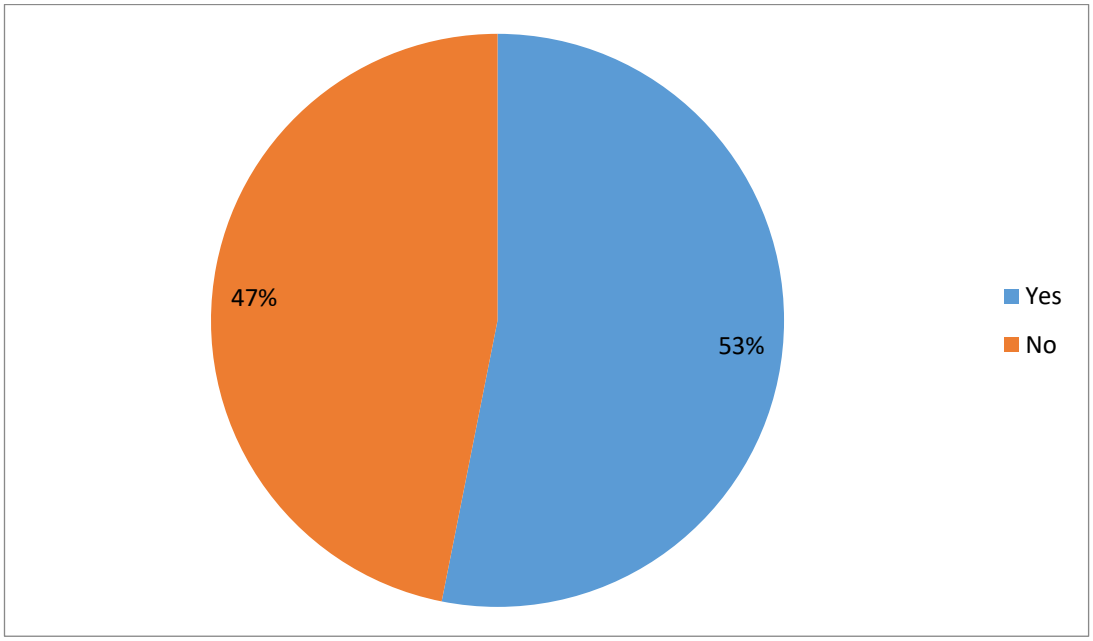


Fig no. 4.3.4: Avoiding medical services due to cost

From the chart above, 53% avoid medical services due to cost, whereas the remaining 47% doesn't avoid medical services due to cost.

About 53% avoided medical treatment due to cost, as most of the respondent hails from a rural areas of Donkamokam where agriculture is main source of income, while 47% do not avoid medical treatment due to cost as they believe health is more important in order to live a longer life.

4.3.5 Nature of Health worker

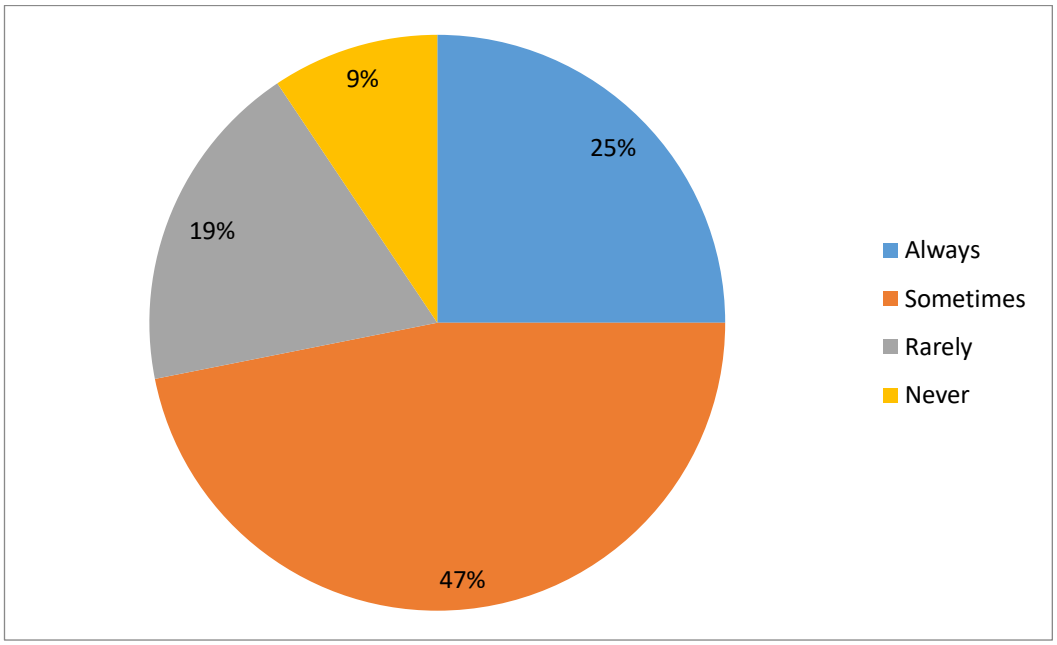


Fig no. 4.3.5: Nature of health worker

The above chart shows that 47% of the health workers are sometimes, 25% always, 19% rarely and 9% are never approachable and respectful.

According to the response from the respondents the health workers are sometimes 47% approachable and respectful while sometimes they are somewhat harsh due to their work load and stress while 13% are rarely approachable due to their busy schedule, 25% of response have approachable and respectful health worker due to their inclusive nature and only 9% are harsh and never approachable as they try to maintain their superiority in the community.

4.3.6 Knowledge about the instruction of healthcare given by doctors/nurses regarding treatment

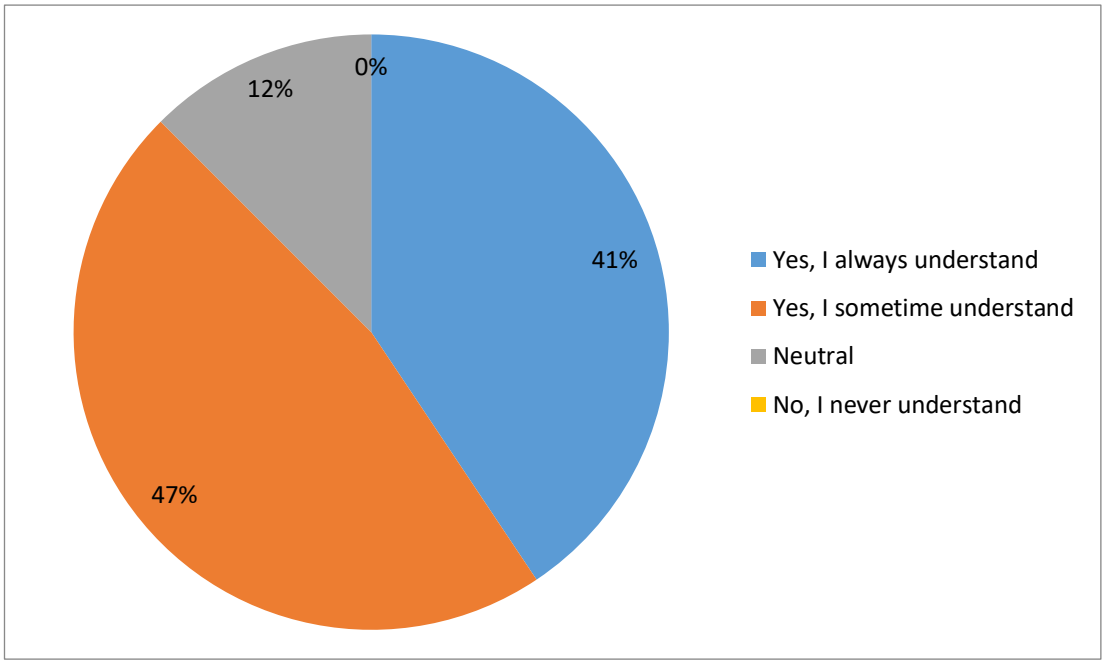


Fig no 4.3.6: Knowledge about the instruction of healthcare

The chart represents that 47% sometimes understand, 41% always understand and 12% are neutral in understanding the instructions given by doctors/nurses regarding treatment.

According to the response 41% of the respondent understand the instruction given by doctors or nurses due to their knowledge in health services through their level of education, while 47% sometimes understand due to various causes like lengthy explanation which results to confusion and anxiety during visits while 12% have neutral response on it due to the language barriers (like instruction aren't in patient's primary language).

4.3.7 Completion of full course prescription medicine

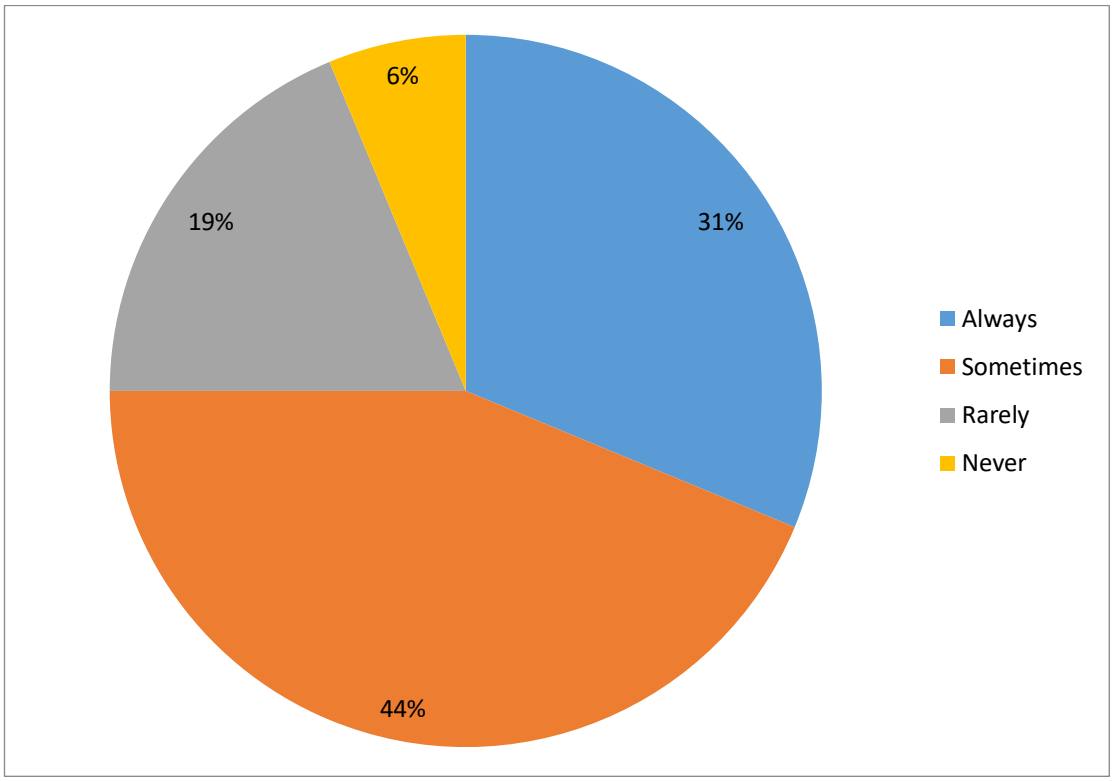


Fig no. 4.3.7: Completion of full course prescription medicine

The above chart shows that 44% sometimes complete, 31% always complete, and 19% rarely complete and the rest 6% never complete the full course prescription medication.

As per the response from the respondents only 31% always complete the full course of prescription medication due to their consciousness towards their health, while 44% sometimes do not follow full course due to their laziness, busy work schedule and other activities and while only really few respondent do not follow full course of medication due to their dependency on traditional medicine.

4.3.8First action when family members are ill

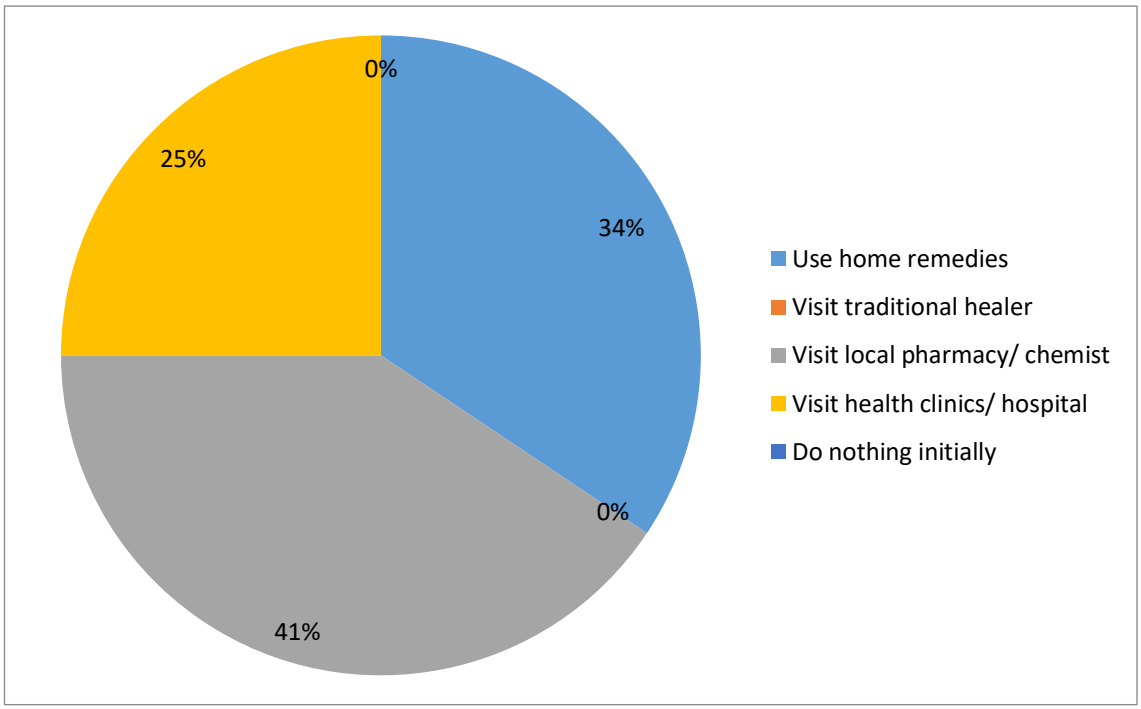


Fig no. 4.3.8: First action when family members are ill

The chart shows that 41% visit local pharmacy or chemist, 34% use home remedies, 25% visit health clinic/hospitals when their family members are ill.

From the response 41% of the respondent often visits local pharmacy or chemist as they are easily accessible in their community, while 25% respondent prefer visiting health clinic and hospitals for better treatment and services and 34% use home remedies for curable and preventable as it's organic.

4.3.9 Decision about seeking healthcare

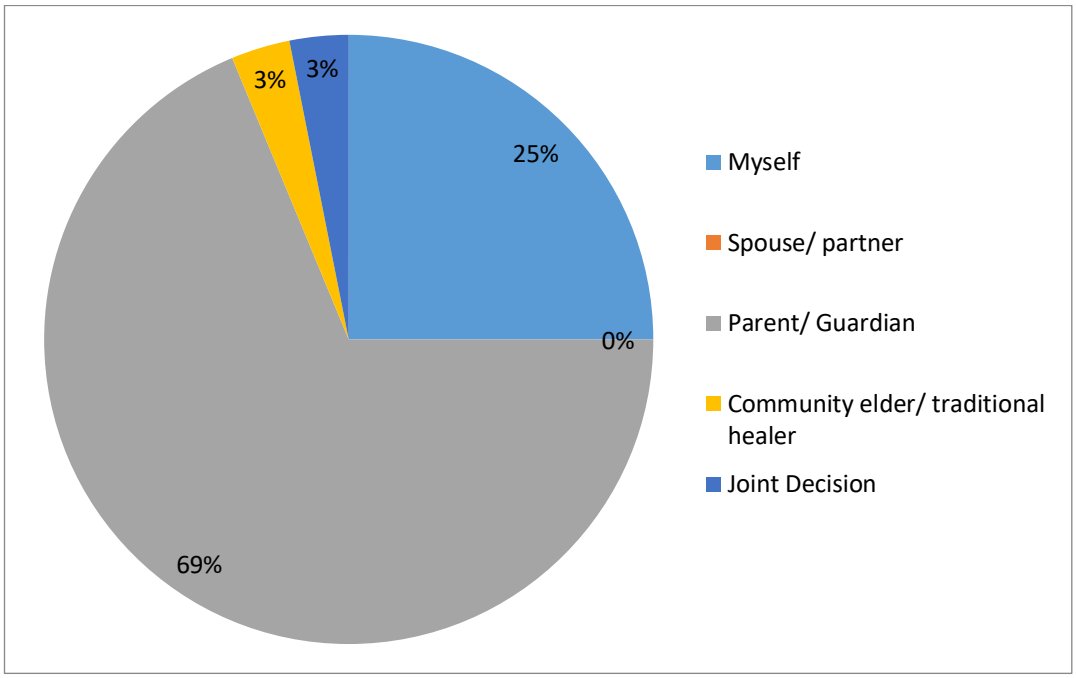


Fig no 4.3.9: Decision about seeking healthcare

The chart shows that 69% prefer parent/guardian, 25% by themselves and the rest by joint decision and community elder/traditional healer in the decision making while seeking healthcare.

The majority of the response i.e. 69% usually prefer parents or guardians in their household for seeking healthcare because in their community parents or guardians plays a major role in decision making for the betterment of the family members, while 25% are dependent on making their own decision for seeking healthcare as they prefer to wait for a moment rather than taking a quick decision and other depends on the community elder and prefer joint decision as they can discussed and put up their points before taking decision.

4.4 Objectives number 3: To explore the barriers faced by individual with lower education levels

4.4.1 Availability of healthcare information

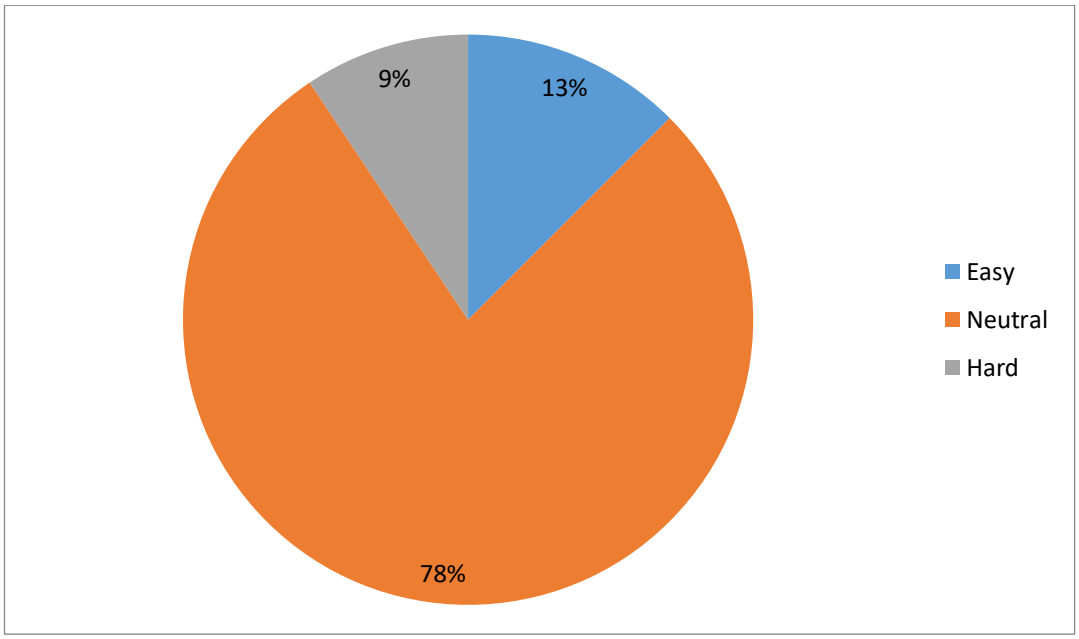


Fig no 4.4.1: Availability of healthcare information

The chart represents that 78% are neutral, 13% finds easy and 9% find it hard of the availability healthcare information.

78.1% of the respondents finds healthcare information neutral because there exist various diseases or healthcare problems and programmes which is really hard to gain information about it, while I2.5% finds it's easy due to their easy access towards various social media platform and internet, and 9.4% find it hard due to their lack of knowledge and sources.

4.4.2 Primary reason for not visiting healthcare services

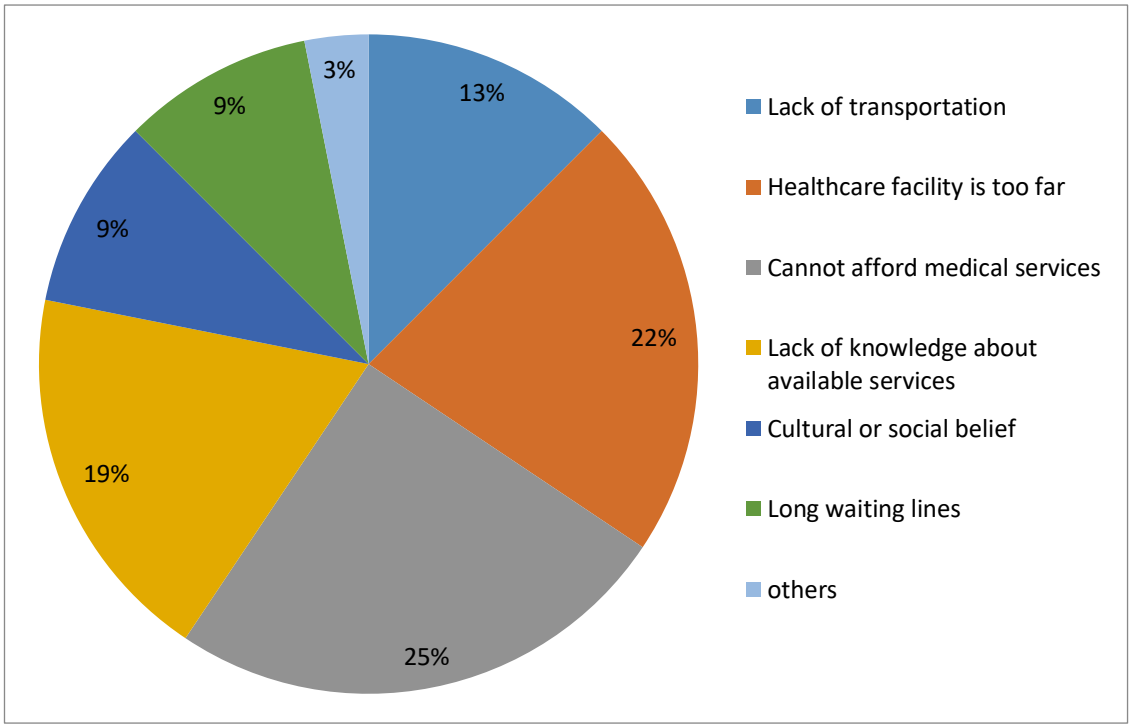


Fig no 4.4.2: Primary reason for not visiting healthcare services

22% of the respondents were far away from the healthcare facility which makes them difficult in accessing the healthcare facilities when needed, 25% of the respondents are unable to afford medical services due to the lack of income source as they can't afford high charges. 19% lacks knowledge about available services. The others 9% and 9% doesn't want to visit healthcare services due to fear of mistreatment by doctors, cultural believes and traditions while the rest doesn't feel like visiting.

4.4.3 Barriers of accessing health care services

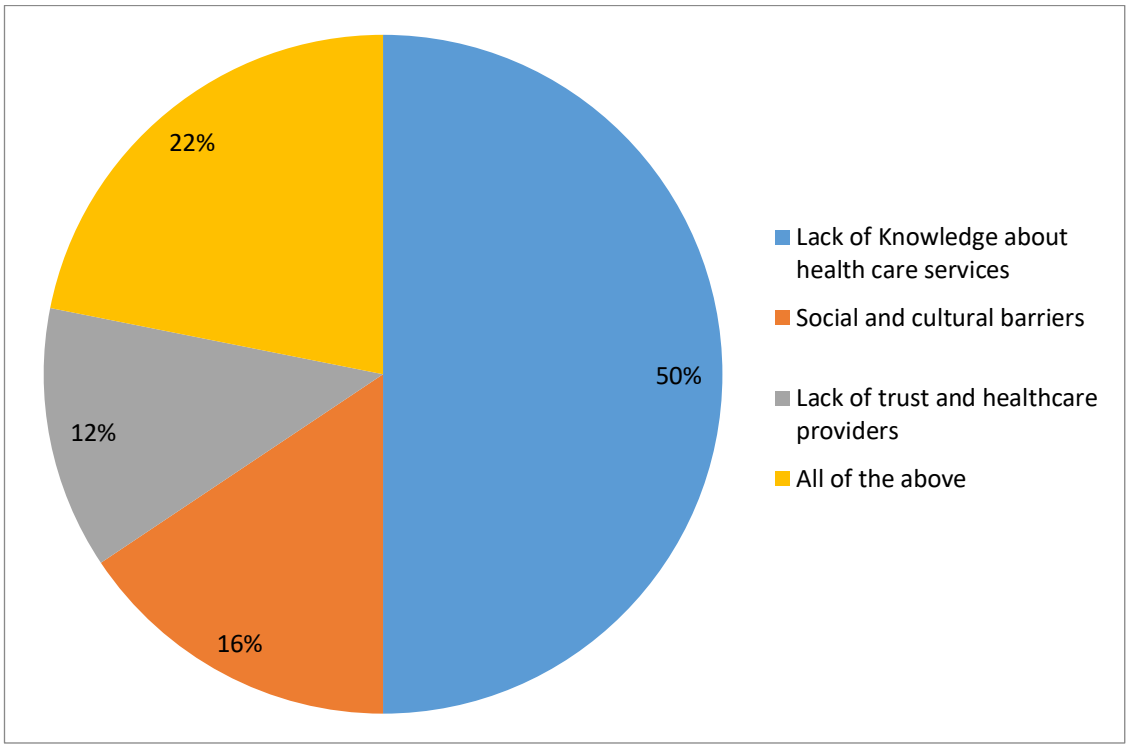


Fig no 4.4.3: Barriers of accessing healthcare services

From the above chart 50% of the response, the major barrier that prevents them from accessing healthcare services is due to lack of knowledge, health education and programmes about healthcare services and 12% response is due to lack of trust in healthcare providers which arouse a fear in people in accessing healthcare.

4.4.4 Transportation challenges

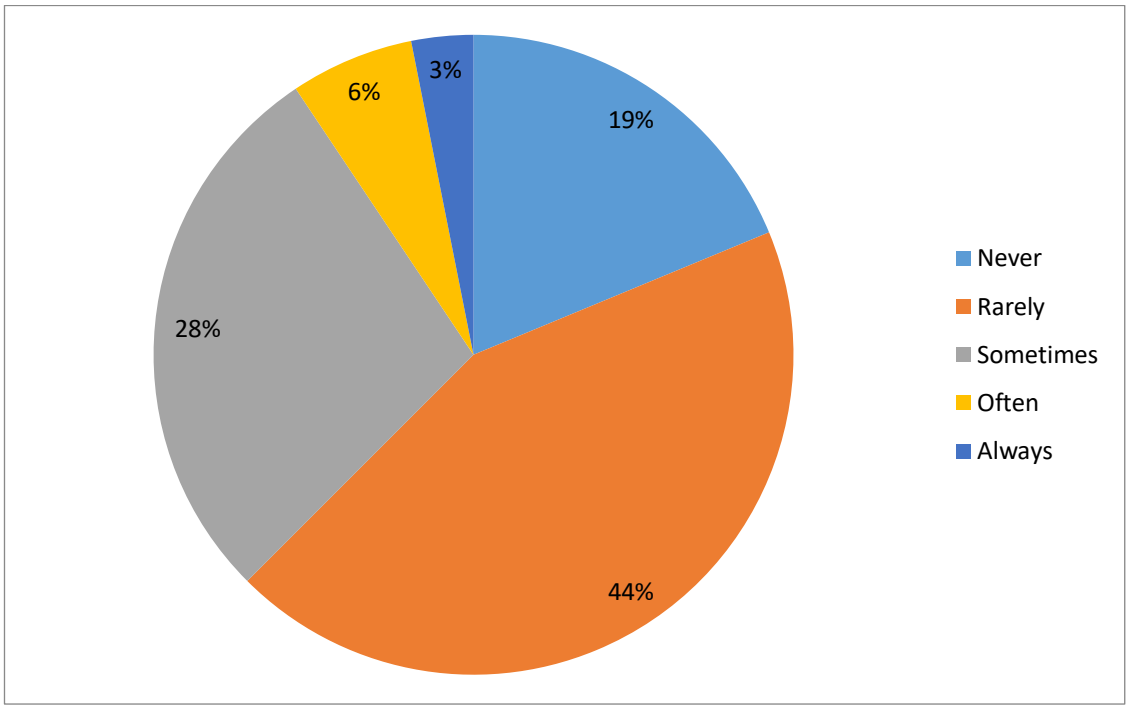


Fig no 4.4.4: Transportation challenges

From the chart above 44% rarely, 28% sometimes, 19% never and the rest often or always face transportation problem to access healthcare services.

Most of the responses have rarely faced but in less frequency due to the development of the roads in the area which leads to the healthcare facilities while only very few responses faced challenges in transportation to reach healthcare facilities due to their house located in far remote areas.

4.4.5 Mobilizing for better healthcare services

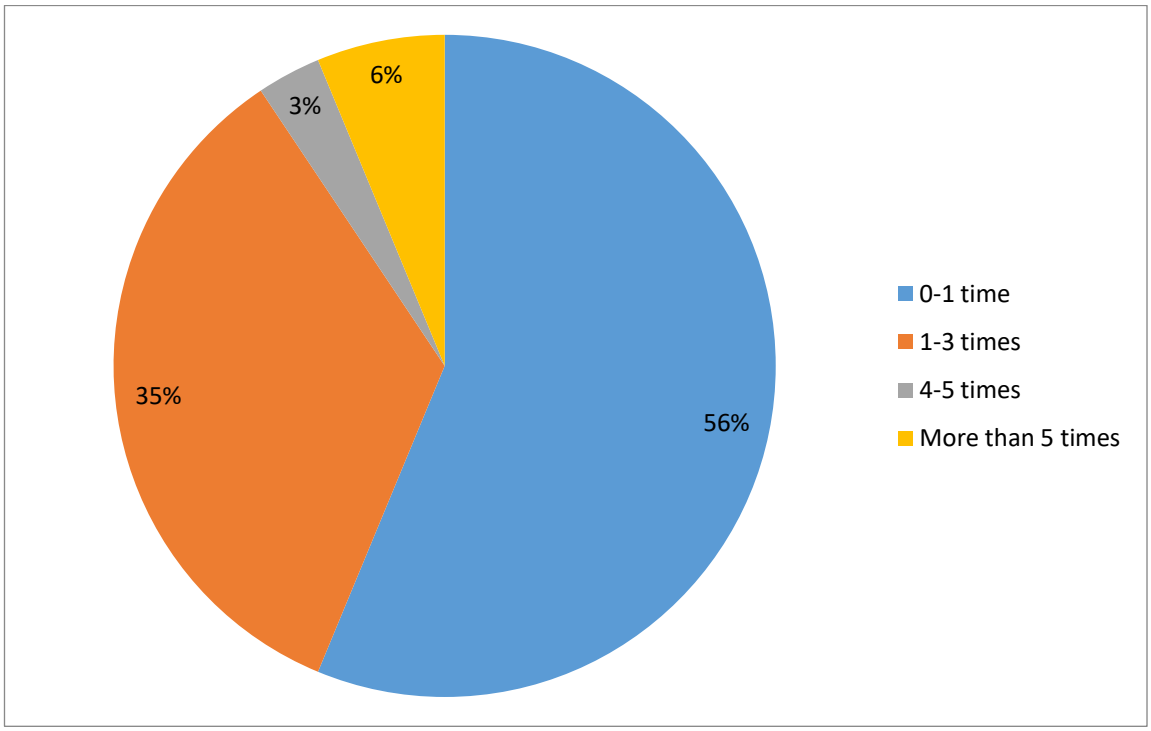


Fig no 4.4.5: Mobilizing of better healthcare services

The above chart represents 56% travelled 0-1time, 35% travelled 1-3 times in different town or cities to access healthcare services.

From the above chart and response from the respondent quite rare numbers of time where the respondents travel more than 4 times that too for seeking a better health care services in outside of the village while most of them prefer their primary health care centres for seeking out for their healthcare due to the easily available resources.

4.4.6 Supply and Stocks of healthcare facility

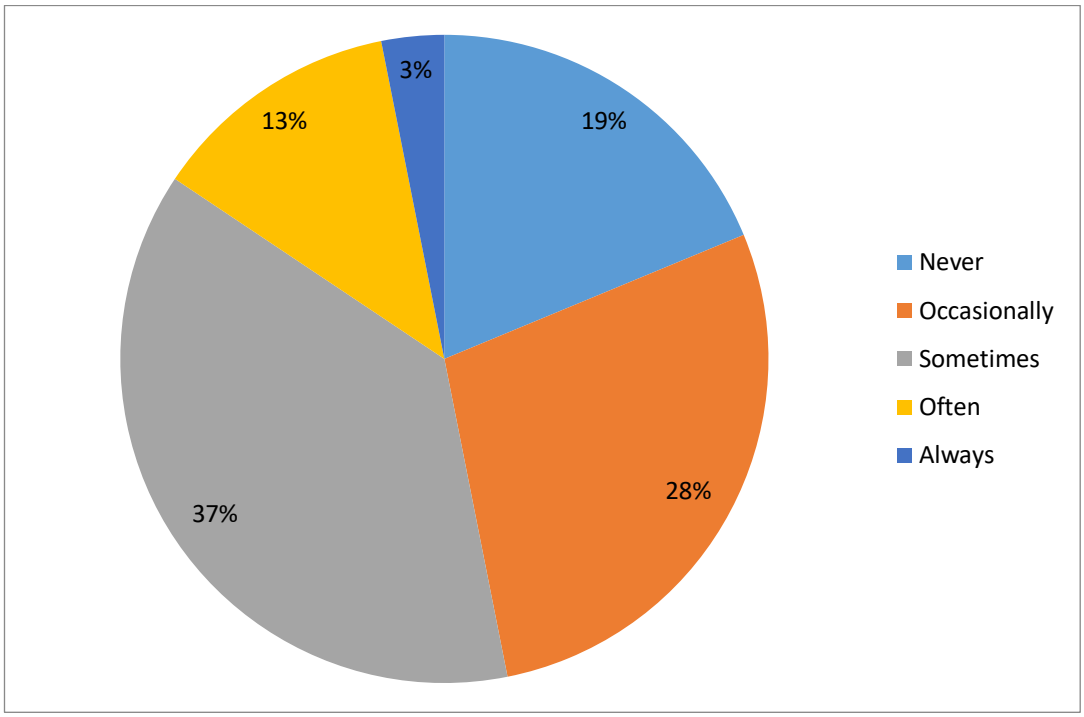


Fig no 4.4.6: Supply and stocks of healthcare facility

The chart shows that 37% sometimes, 28% occasionally, 19% never, 13% often and the rest 3% always find supplies and stock of healthcare facility in their community.

Most of them find the supplies and medication out of stock due to the slow rate of supplies and lack of stocks of medical supplies in the local health care facility. While only few find it always out of stalk when they reached out for the medicinal supplies and other services.

4.4.7 Possession of healthcare insurance

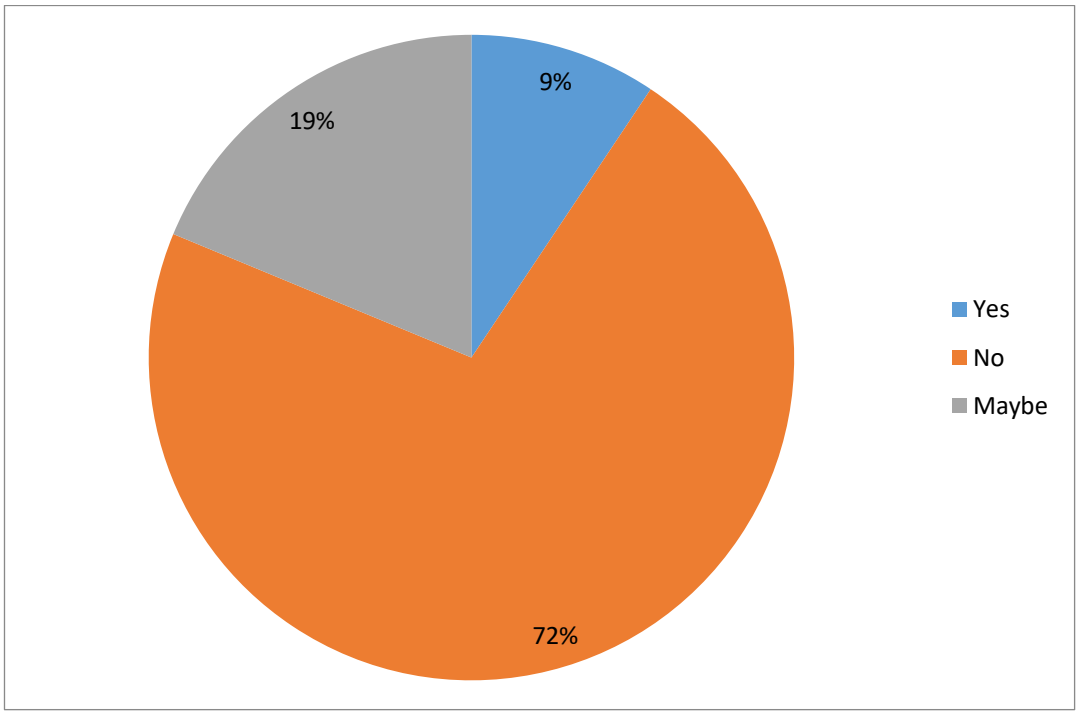


Fig no 4.4.7: Possession of healthcare insurance

The chart represents that 72% doesn't have healthcare insurance, 19% are not sure whereas 9% possessed a healthcare insurance.

Due to the lack of the awareness among the respondents they response a high 72% have no health insurance on them or their family members, only a handful of response of 9% have insurance due to working as an government employee.

4.4.8 Reason for not having Healthcare insurance

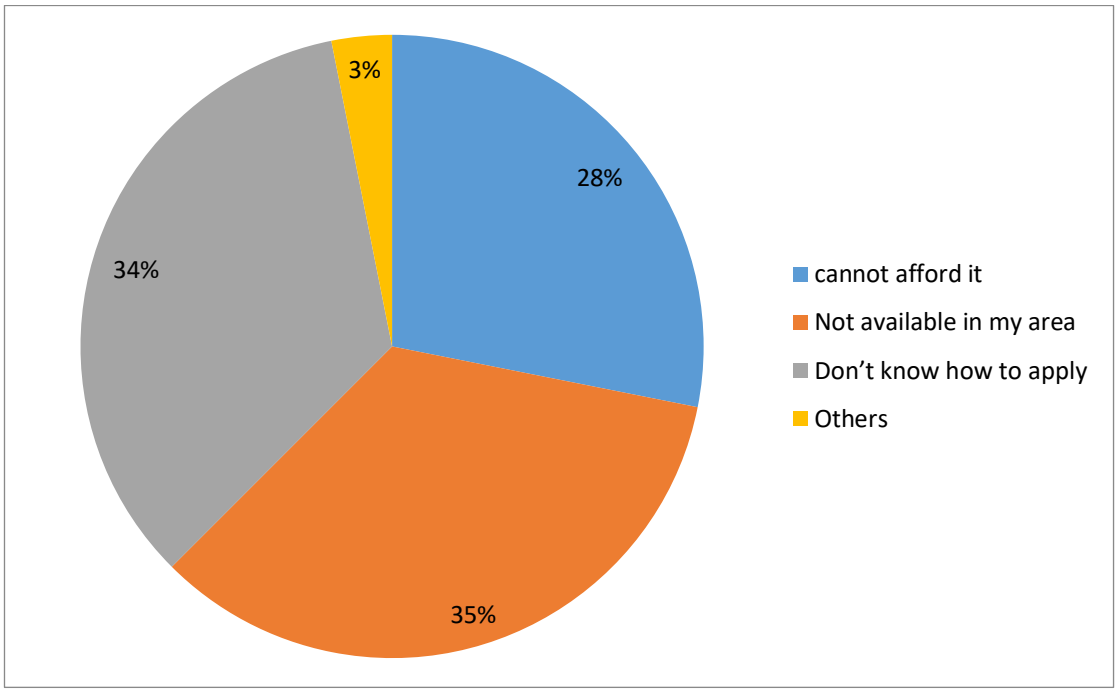


Fig no 4.4.8: Reason for not having Healthcare insurance

The chart shows that 35% doesn't have healthcare insurance due to unavailability in the area, 34% doesn't have as they don't know how to apply, 28% doesn't have healthcare insurance due to not being able to afford it and the rest doesn't have as they don't need it.

The main reason behind the respondents unavailing the healthcare insurance is due to several factors like availability, affordability, doesn't know about the process of applying and while others don't need it. The above charts show the statistical charts of the response.

4.4.9 Tips for easier access to healthcare in the community

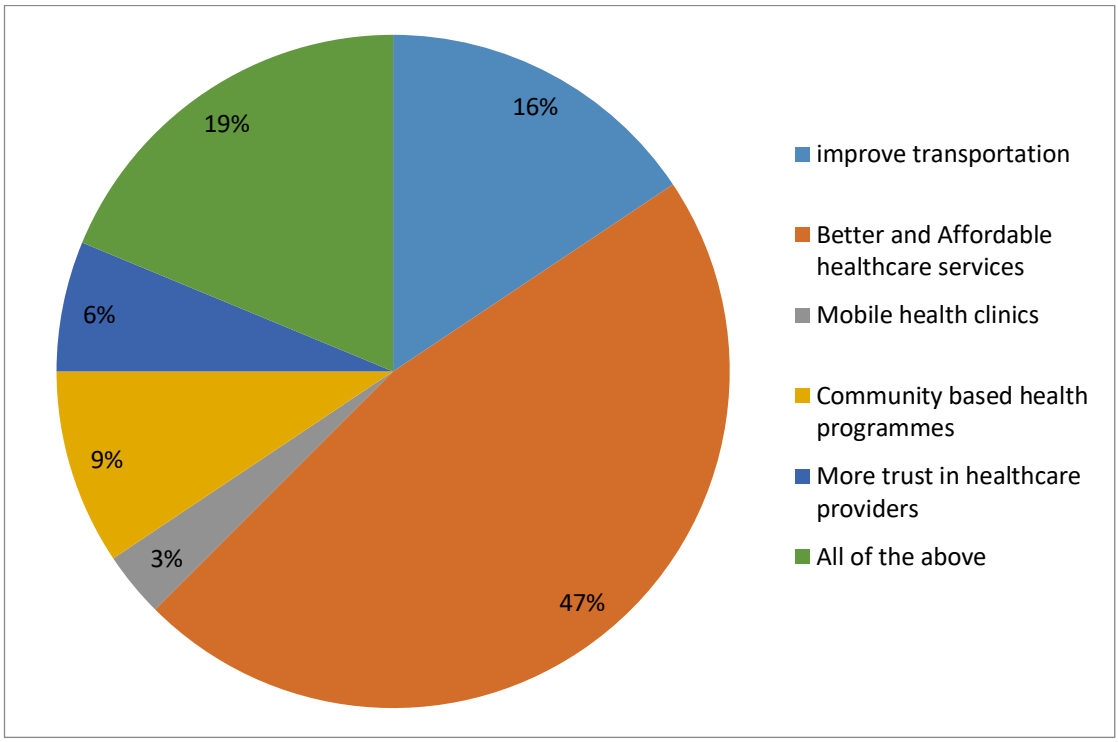
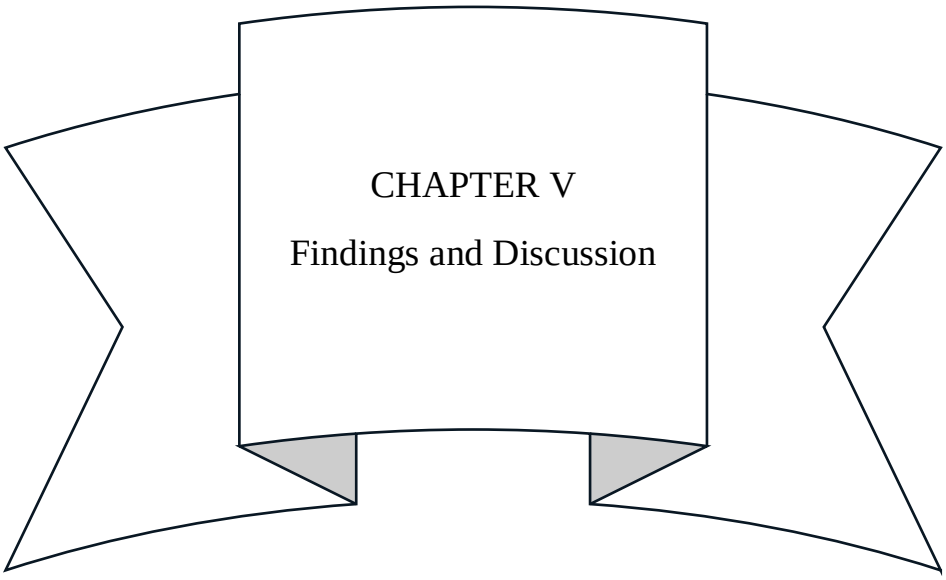


Fig no 4.4.9: Tips for easier access to healthcare

The chart shows 47% think better and affordable healthcare services, 16% think improve transportation, 9% think community-based health programs, 9% think mobile health clinics and more trust in healthcare providers for easier access to healthcare in the community. About 19% recommended all of the options for easier access to healthcare in the community.

According to the response from the respondent factors like improved transportation, better and affordable healthcare services, mobile health clinics, community based health programs, trust in healthcare providers. Where maximum of the response prefer the better and affordable healthcare services to access healthcare services as the areas is mostly rural and would be helpful.


CHAPTER V
Findings and Discussion

5.1 Finding

The researcher finds the following during the study of the particular topic. They are

5.1.1 Demographic Overview of Respondents

The study surveyed individuals from rural communities of Sarsenot, where all age group are given the opportunity to response, but among these, the age group of 18-22 years are mostly predominant. Specifically, 31.3% of respondents were 18 years old, which shows a significant portion of participants, were young adults. This demographic is important as it reflects the perspectives of individuals who are either studying in higher education or entering the workforce, making their healthcare awareness and access particularly relevant for future policy improvements.

5.1.2 Education Levels Among Respondents

A huge amount of participants were college or university students (56.3%), followed by secondary school attendees (37.5%). This distribution suggests that the surveyed population was relatively educated, which may influence their ability to understand the healthcare-related information and find a way to medical services. However, the presence of an important percentage of secondary school students also underscores the need for healthcare education initiatives that will adapt to younger individuals who may not yet have advanced knowledge of medical systems.

5.1.3 Formal Health Education and Its Role in Healthcare Access

The research revealed that 78.1% of respondents had received formal health education, primarily during their school days. This finding gives the higher values of educational institutions in distributing essential health knowledge. Formal health education prepare

individuals with the foundation understanding that is needed to make informed decisions regarding of medical care, preventive measures, and available healthcare resources.

Moreover, 68.8% of participants acknowledged that formal education plays an important role in accessing healthcare services. Educated individuals are more likely to understand medical schemes, healthcare information, and utilize available services effectively. The relation between education and healthcare accessibility gives importance of integrating health literacy into school curriculum, particularly in rural areas where medical resources may still be limited.

5.1.4 Awareness of Healthcare Providers and Services

The study found that 47% of respondents were aware of the healthcare providers available in their communities. Many gained this awareness through previous visits during illnesses or medical emergencies. While this indicates a reasonable level of familiarity with local healthcare facilities, it also suggests that nearly half of the respondents may lack sufficient knowledge about alternative or specialized medical services.

Additionally, when assessing respondents' confidence in understanding healthcare information, only 37.5% reported feeling fully capable of comprehending medical details, while 40.6% remained neutral. This uncertainty may stem from the use of complex medical terminology or insufficient health education, pointing to the need for simplified health communication strategies in rural areas.

5.1.5 Patterns of Healthcare Access and Utilization

The research uncovered varied patterns in healthcare access among rural residents. Approximately 37.5% of respondents reported accessing healthcare services frequently, whereas 31.3% did so rarely. This disparity may be attributed to factors such as availability of medical facilities, financial constraints, or personal health literacy levels. Understanding these patterns is essential for policymakers to identify gaps in healthcare delivery and implement targeted interventions to improve service utilization.

5.1.6 Willingness to Participate in Health Education Programs

A promising finding was that 40.6% of respondents expressed a high likelihood of participating in health education programs. This positive attitude toward health-related learning indicates a potential avenue for community-based initiatives that can enhance medical knowledge and promote preventive care. By organizing workshops, seminars, and awareness campaigns, healthcare providers and educators can further engage rural populations in improving their health outcomes.

5.1.7 Barriers Faced by Individuals with Lower Education Levels

The study also explored the challenges encountered by less-educated individuals in accessing healthcare.

Key barriers

1. Transportation Issues: The people of rural areas often face infrastructural deficiencies, making it difficult for residents to reach healthcare facilities.
2. Financial Constraints: Some of the people residing from the village couldn't afford particular services, mainly the person without a health insurance.

It is required to have a multi-faced approach to address the following barriers, including community health worker programs, mobile clinics, and subsidized healthcare schemes to ensure equitable access for all rural inhabitants.

5.1.8 Healthcare Insurance Awareness and Coverage

Most of the respondents, i.e. 71.9% of respondents did not possess health insurance. This high percentage underlines a critical gap in financial protection against medical expenses. The main reasons for this lack of coverage may include insufficient awareness of insurance options, affordability issues, or mistrust in insurance systems. Improving and fostering insurance literacy through targeted campaigns and introducing low-cost insurance plans could mainly improve healthcare accessibility in rural regions.

5.2 Discussion

This study set out to examine how education influences healthcare access in a rural setting, with a specific focus on Sarsenot village in West Karbi Anglong. The findings provide valuable understanding into how levels of education can vary, awareness, and socio-cultural factors infer bisect to shape healthcare-seeking behaviour and service utilization. This chapter explains the findings through the lens of the Health Belief Model and existing literature, drawing connections between education, health literacy, and barriers to healthcare access.

5.2.1 Education and Healthcare Access

The study confirms a strong relation between formal education and healthcare access. Approximately 78.1% of respondents addressed receiving some form of formal health education, with the majority gaining the knowledge through school-based curricula. Among them, 68.8% acknowledged that formal education significantly helped them to access healthcare services. These findings coordinate with the literature such as Adams (2010), who emphasizes the role of health literacy in improving patient outcomes and facilitating informed medical decisions.

Higher educational attainment appeared to foster greater confidence in understanding medical information. Although only 37.5% of participants felt confident in interpreting healthcare details, the subgroup predominantly comprised college and secondary school students, highlighting education's role in shaping comprehension. The Health Belief Model supports this observation, suggesting that individuals who perceive fewer barriers and understand the benefits of care are more likely to engage in health-seeking behaviours.

5.2.2 Health-Seeking Behaviour and Decision-Making

Education also influenced patterns of health-seeking behaviour. Participants with formal education reported a greater inclination to visit healthcare providers or local chemists when ill. Specifically, 40.6% opted for pharmacies, 25% visited clinics, and 34.4% relied on home remedies. This trend reflects partial medical pluralism, where biomedical and traditional approaches coexist. Notably, those with higher educational levels were more likely to adopt biomedical solutions, indicating a shift away from exclusive dependence on traditional remedies.

However, decision-making was still significantly influenced by familial structures and cultural norms. A majority (68.8%) of respondents indicated that parents or guardians made healthcare decisions, reaffirming findings by Lindelow (2004) and Elo (1992),

which note the influence of household dynamics on health behaviour, particularly in traditional communities.

5.2.3 Gaps in Health Literacy Despite Formal Education

While the majority of respondents had formal education, only a limited number reported full confidence in understanding instructions given by health professionals. Approximately 46.9% “sometimes” understood medical advice, and 12.5% reported difficulty, primarily due to complex terminology and language barriers. This points to a crucial gap in functional healthliteracythe ability to comprehend and act on medical information. As Jansen et al. (2018) argue, merely attaining educational qualifications does not guarantee effective navigation of healthcare systems.

This gap underscores the need for context-specific health education that goes beyond technical jargon, particularly in linguistically diverse rural settings. Strategies like visual aids, local dialect interpretation, and simplified brochures could enhance comprehension and compliance, especially among semi-literate populations.

5.2.4 Role of Digital and Informal Sources of Information

Interestingly, the internet and social media emerged as significant sources of health information, accounting for 53.1% of the responses. This is consistent with the work of Tayebi et al. (2024), who advocate for integrating digital education into rural health frameworks. However, this reliance raises concerns regarding the accuracy and credibility of online content, especially in areas where formal health education is limited or outdated. Only 25% of respondents received information directly from health workers, suggesting a gap in community outreach and the potential underutilization of trained personnel like ASHA workers.

5.2.5 Barriers Faced by Individuals with Lower Education Levels

The study also illuminated stark barriers encountered by less-educated individuals. Lack of awareness (50%), poor understanding of available services (18.8%), and transportation challenges (43.8%) were frequently cited. These findings are echoed in studies by Zegeye et al. (2021) and Cornwell (2017), who emphasize the compounded disadvantages rural populations face due to education-related inequalities.

The high rate of individuals lacking health insurance (71.9%) further complicates access. The main reasons cited were lack of information (34.4%), affordability (28.1%), and unavailability (34.4%). This reinforces the need for targeted insurance literacy programs that demystify the application process and highlight the benefits of coverage.

Moreover, 53.1% of participants reported avoiding medical care due to costs. For a population dependent largely on agriculture with limited disposable income, this represents a critical barrier. Education, when paired with financial literacy and access to low-cost insurance schemes, can alleviate this issue and promote timely medical intervention.

5.2.6 Health Education Programs: Participation and Impact

Despite challenges, the study reveals a promising willingness to engage in health education programs. Around 68.7% of respondents were either likely or very likely to participate in such initiatives. Furthermore, 56.3% strongly believed that improved education could enhance healthcare services. These results provide a strong basis for initiating school-based and community-level health awareness campaigns tailored to rural realities.

The occasional participation of 43.8% in health workshops highlights logistical or motivational barriers such as time constraints, cultural attitudes, or perceived irrelevance. Bridging this gap requires making health education locally relevant and

accessible, perhaps by integrating it with popular community events or traditional gatherings.

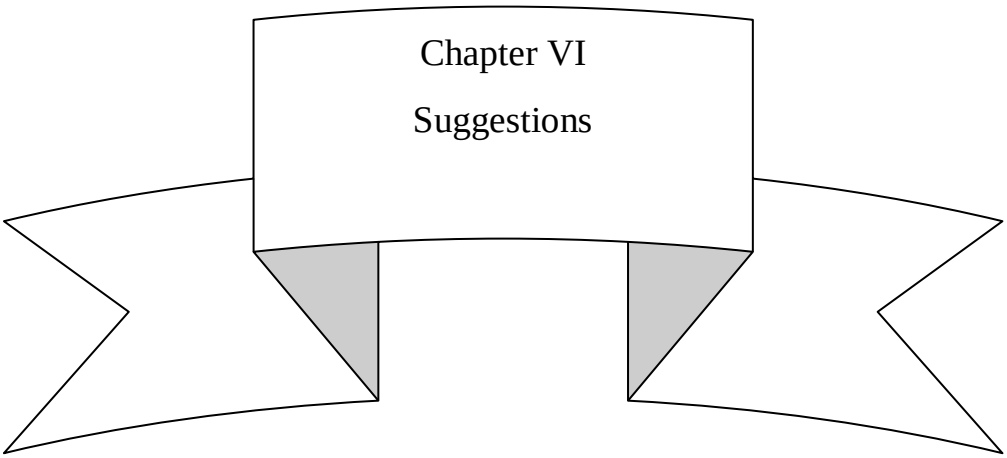
5.2.7 Perceived Quality of Health Education

The study also looks upon the perceptions of the quality of healthcare education. While 37.5% rated it as “high” and 28.1% as “very high,” a significant 25% considered it “low.” This discrepancy may be attributed to inconsistent educational delivery, outdated materials, or the absence of interactive learning. Przybylska et al. (2014) stress that health education must be engaging, culturally grounded, and updated regularly to retain its effectiveness.

The lack of consistent supplies and medicine at local health centers further erodes trust in healthcare systems. About 37.5% of respondents noted periodic stockouts, which can deter future visits and encourage a return to traditional practices. This highlights the interconnectedness of healthcare education, service delivery, and infrastructure support.

The findings align closely with the Health Belief Model (HBM), which put forward that individuals’ actions depend on perceived susceptibility, severity, benefits, and barriers. Respondents with higher education were more likely to recognize disease symptoms, believe in the effectiveness of treatment, and take proactive health measures. On the other hand, those with lower education levels perceived more barriers, whether financial, informational, or cultural.

The model's relevance is further supported by the observation that fear of mistreatment (reported by 9.4%) and cultural beliefs still deter health-seeking behaviour, even in educated individuals. These points to the need for culturally sensitive interventions that merge traditional values with modern healthcare ideals.


Chapter VI
Suggestions

6.1 Suggestion

6.1.1 Integrate Health Education in School Curriculum

Introduction of age-appropriate, cultural and traditional relevant health education in schools. The topics shall include hygiene, nutrition, disease prevention, mental health, sexual and reproductive health, and navigating the healthcare system. Partner with local health departments to ensure accuracy and relevance.

6.1.2 Community Health Literacy Campaigns

Launch village-wide awareness drives using local languages, visuals, and storytelling methods. Include street plays, radio programs, wall paintings, and village announcements to educate all age groups. Collaborate with community elders and religious leaders to increase community trust and participation.

6.1.3 Digital Health Literacy Programs

Provide training on how to access and evaluate online health information like e-learning and webinars.

6.1.4 Mobile Health Clinics and Health Camps

Organize monthly or quarterly mobile clinics that offer free checkups, vaccinations, and health education sessions. Conduct specialized health camps for maternal and child care, chronic diseases, and mental health.

6.1.5 Subsidized Health Insurance Enrolment Drives

Facilitate on-the-spot enrolment in government or community-based health insurance schemes. Conduct sessions explaining the benefits, claim process, and coverage in simple terms.

6.1.6 Transportation Support for Health Access

Create a community transport fund or service (e.g., shared vans) to help residents reach distant health centres. Collaborate with NGOs or government schemes that fund emergency transportation in rural areas.

6.1.7 Train and Empower Local Health Workers (ASHA, ANM, CHWs)

Provide refresher courses in communication, cultural sensitivity, and first-aid care. Equip them with flipcharts, tablets, and pictorial guides for easier education delivery.

6.1.8 Village Health Volunteer Program

Encourage youth and educated villagers to become part-time health volunteers. Volunteers can guide others on medical appointments, follow-up treatments, and medication adherence.

6.1.9 Feedback and Grievance Redress System

Establish a simple, anonymous complaint/suggestion box at health centres. Review complaints monthly to improve service quality and build trust in healthcare systems.

6.1.10 Engage Traditional Healers and Elders

Rather than excluding traditional healers, involve them in health campaigns to bridge modern and traditional practices. Educate them on when to refer cases to formal health services.

6.1.11 Gender-Inclusive Health Education

Conduct separate and combined health sessions for men, women, and youth to address unique concerns. Promote women's autonomy in healthcare decisions through family counselling and mother's groups.

6.1.12 Use of Local Media and Folk Arts

Promote health education through community songs, local dramas, and folk storytelling that incorporate health messages. Broadcast health tips via community loudspeakers or village-level radio stations.

Conclusion

In conclusion, Education plays an important role in improving access to healthcare servicesin Sarsenot, a village of Donkamokam, West Karbi Anglong. Due to limited health awareness, traditional beliefs, and low literacy levels, people often find it hard to seek timely medical care, leading to preventable health complications. Education empowers individuals with knowledge about disease prevention, importance of early diagnosis, and available medical treatments, thereby linking the gap between rural communities and healthcare facilities. By promoting health literacy through community-based education programs, training local health workers, and integrating traditional beliefs with modern medical knowledge, access to healthcare can be significantly improved. Strengthening educational initiatives in Sarsenot village can lead to better health outcomes, reduced stigma around illnesses, and an overall enhancement in the quality of life for the community. Investing in education is, therefore, a vital step toward ensuring equitable and sustainable healthcare access in rural areas.

To complete the research, the researcher uses Quantitative method which is a numerical data collection and statistical analysis as it helps the researcher get objective and measurable data like providing hard numbers (percentages) for precise analysis and also help in getting structured data collection through surveys. The researcher also used Simple random sampling while conducting the survey which is a probability sampling technique that gives every participant the equal rights to participate. It helps as it is unbiased and reduced sampling errors. This overall process helps to find a confidently report means, percentages and distributions.

This analysis underscores the profound impact of healthcare education on rural communities, demonstrating that higher education levels correlate with better healthcare access and understanding. However, significant challenges remain, particularly for less-educated individuals who face barriers such as limited health knowledge, transportation difficulties, and financial constraints. To bridge these gaps,

policymakers must prioritize health education programs, improve insurance awareness, and develop infrastructure to facilitate easier access to medical services. By addressing these issues, rural communities can achieve greater health equity and improved overall well-being.

References

- Adams, R. J. (2010). Improving health outcomes with better patient understanding and education. Risk Management and Healthcare Policy, 3, 61–72. https://www.tandfonline.com/doi/full/10.2147/RMHP.S7500
- Aragie, H., Negash, H. K., Getnet, M., Tesfaye, W., Gela, Y. Y., Asefa, T., ... & Endale, H. T. (2025). Barriers to healthcare access: A multilevel analysis of individual-and community-level factors affecting female youths' access to healthcare services in Senegal. BMC Health Services Research, 25(1), 607. https://link.springer.com/article/10.1186/s12913-025-12761-2
- Bright, T., Felix, L., Kuper, H., & Polack, S. (2017). A systematic review of strategies to increase access to health services among children in low and middle income countries. BMC Health Services Research, 17, 1–19. https://link.springer.com/article/10.1186/s12913-017-2180-9
- Bryant, R. (2011). Promoting access to health care: a nursing role and responsibility. International Nursing Review, 58(4). https://openurl.ebsco.com/EPDB%3Agcd%3A12%3A33384348/detailv2?sid=ebsco%3Aplink%3Ascholar&id=ebsco%3Agcd%3A104599547
- Cornwell, M. (2018). The effect of a school-based health center on access to care in a rural community. https://uknowledge.uky.edu/dnp_etds/225/
- Elo, I. T. (1992). Utilization of maternal health-care services in Peru: The role of women's education. Health Transition Review, 2(1), 49–69. https://www.jstor.org/stable/40652032
- Ensor, T., & Cooper, S. (2004). Overcoming barriers to health service access and influencing the demand side through purchasing. World Bank. https://documents1.worldbank.org/curated/en/633391468762937183/pdf/315980HNP0EnsorOvercomingBarriersFinal.pdf
- Hosseini, S. H., Tayebi, Z., Amerzadeh, M., Pouragha, B., Hatefnia, E., Moeini-Mostofi, S., ... & Poormoosa, Y. (2024). The requirements of providing health education for rural people through electronic methods: the

experiences and perspectives of community health workers. BMC Medical Education, 24(1), 1075. https://link.springer.com/article/10.1186/s12909-024-06073-y

- Hudon, C., Loignon, C., Grabovschi, C., Bush, P., Lambert, M., Goulet, É., ... & Fournier, N. (2016). Medical education for equity in health: a participatory action research involving persons living in poverty and healthcare professionals. BMC Medical Education, 16, 1–9. https://link.springer.com/article/10.1186/s12909-016-0630-4
- Jansen, T., Rademakers, J., Waverijn, G., Verheij, R., Osborne, R., & Heijmans, M. (2018). The role of health literacy in explaining the association between educational attainment and the use of out-of-hours primary care services in chronically ill people: a survey study. BMC Health Services Research, 18, 1–13. https://link.springer.com/article/10.1186/s12913-018-3197-4
- Jones, D., Lyle, D., McAllister, L., Randall, S., Dyson, R., White, D., ... & Rowe, A. (2020). The case for integrated health and community literacy to achieve transformational community engagement and improved health outcomes. Primary Health Care Research & Development, 21, e57. https://www.cambridge.org/core/journals/primary-health-care-research-and-development/article/case-for-integrated-health-and-community-literacy/CB074BF09F4515C3FD33E0B905B96542
- LeVine, R. A., & Rowe, M. L. (2009). Maternal literacy and child health in less-developed countries: Evidence, processes, and limitations. Journal of Developmental & Behavioral Pediatrics, 30(4), 340–349. https://journals.lww.com/jrnldbp/citation/2009/08000/maternal_literacy_and_child_health_in.12.aspx
- LeVine, R. A., LeVine, S., Schnell-Anzola, B., Rowe, M. L., & Dexter, E. (2011). Literacy and mothering: How women's schooling changes the lives of the world's children. Oxford University Press. https://www.jstor.org/stable/40652132

- Lindelöw, M. (2004). Health care decisions as a family matter: Intrahousehold education externalities and the utilization of health services (Vol. 3324). World Bank Publications. https://books.google.co.in/books?id=1FtRybyxn5YC
- Navarro, M. D. (2020). Patients' empowerment and the role of patients' education. Medical Research Archives, 8(12). https://esmed.org/MRA/mra/article/view/2306
- Ouschan, R., Sweeney, J. C., & Johnson, L. W. (2000). Dimensions of patient empowerment: Implications for professional services marketing. Health Marketing Quarterly, 18(1–2), 99–114. https://www.tandfonline.com/doi/abs/10.1300/J026v18n01_08
- Przybylska, D., Borzęcki, A., Drop, B., Przybylski, P., & Drop, K. (2014). Health education as an important tool in the healthcare system. Polish Journal of Public Health, 124(3), 145–147. https://czasopisma.umlub.pl/pjph/article/view/1667
- Regidor, E., Martínez, D., Calle, M. E., Astasio, P., Ortega, P., & Domínguez, V. (2008). Socioeconomic patterns in the use of public and private health services and equity in health care. BMC Health Services Research, 8, 1–9. https://link.springer.com/article/10.1186/1472-6963-8-183
- Ross, J., Mann, S., & Emond, K. (2023). Investing in health education to reduce rural health disparities. https://opal.latrobe.edu.au/articles/chapter/Investing_in_Health_Education_to_Reduce_Rural_Health_Disparities/24803271?file=43801308
- Steeb, D. R., Dascanio, S. A., & Kiser, S. N. (2019). Connecting rural and global health education for workforce development. The American Journal of Tropical Medicine and Hygiene, 101(3), 479. https://pmc.ncbi.nlm.nih.gov/articles/PMC6726954/
- Van Vliet, K., Roodbol, P., Chorus, A., & Ossebaard, H. (2017). Education for future health care: A radical shift in perception, learning and action. International Journal of Healthcare, 4(1), 1–4. https://www.researchgate.net/publication/321653741

- White, F. (2013). The imperative of public health education: A global perspective. Medical Principles and Practice, 22(6), 515–529. https://karger.com/mpp/article/22/6/515/203612
- Zajacova, A., & Lawrence, E. M. (2018). The relationship between education and health: Reducing disparities through a contextual approach. Annual Review of Public Health, 39(1), 273–289. https://www.annualreviews.org/content/journals/10.1146/annurev-publhealth-031816-044628
- Zegeye, B., El-Khatib, Z., Ameyaw, E. K., Seidu, A. A., Ahinkorah, B. O., Keetile, M., & Yaya, S. (2021). Breaking barriers to healthcare access: A multilevel analysis of individual- and community-level factors affecting women's access to healthcare services in Benin. International Journal of Environmental Research and Public Health, 18(2), 750. https://www.mdpi.com/1660-4601/18/2/750.

APPENDIX

Informed Consent

I, Abolon Beypi, a student of the Social Work Department, Mahapurusha Srimanta Sankaradeva Viswavidyalaya, Guwahati Unit, promise that this interview schedule will only be used for my dissertation titled, "*The Role of education in accessing healthcare services in rural community with Special reference to Sarsenot, Donkamokam, West Karbi Anglong"* under the supervision Dipsikha Boruah, Teaching Associate, Department of Social Work, MSSV, Guwahati Unit. I assure you that your answers will be kept confidential and used solely for educational purposes. Therefore, I kindly request your valuable input in responding to the following set of questions

Abolon Beypi
MSW 4th semester
Dept. of Social Work

QUESTIONNAIRE

Objective 1

To examine the impact on education of healthcare services in rural community

1. Have you received education? If yes to what
    - No formal education
    - Primary school new line
    - Secondary school
    - College university
    - Vocational technical training
2. Have you ever received formal health education? If yes, from where
    - School
    - Community program
    - Others (specify)
3. How important do you believe formal education is in providing healthcare access in the rural areas?
    - Very important
    - Important
    - Neutral
    - Not important
    - Not important at all.
4. How aware are you of the available healthcare provider in your community(Eg: clinics, hospitals, pharmacies)
    - Very aware
    - Aware
    - Somewhataware
    - Not aware
    - Not sure
5. How confident are you in understanding the health information provided by healthcare professionals?
    - Very confident
    - Confident
    - Neutral
    - Not confident
    - Not confident at all
6. How often do you access healthcare services when you experienced health issue?
    - Always
    - Often
    - Occasionally
    - Rarely

- Never

7. How likely are you to participate in health education programs if they were made available in your community?
    - Very likely
    - Likely
    - Neutral
    - Unlikely
    - Very unlikely
8. How often do people in your community attend health education workshop of training program?
    - Very frequently
    - Frequently
    - Occasionally
    - Rarely
    - Never
9. How would you rate your general knowledge of available healthcare services in your community?
    - Very high
    - High
    - Moderate
    - Low
    - Very low
10. How would you rate the quality of healthcare education available in schools or local community programs in your area?
    - Very high quality
    - High quality
    - Moderate quality
    - Low quality
    - Very low quality
11. Do you feel that better education would improve access to healthcare services in your community?
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree

Objective 2

To understand the influence of education in health seeking behaviours of rural community

1. Where do you mostly get health information from?

- Radio
- TV
- School
- Health workers
- Religious leaders
- Community outreach programs
- Internet/social media

2. Have you change your health behaviour(Eg: hygiene, diet, exercise) because of what you learn at school?
    - Yes
    - Rarely
    - No
    - Not sure
3. Have you ever avoided medical treatment due to cost?
    - Yes
    - No
4. Are health workers in your area approachable and respectful?
    - Always
    - Sometimes
    - Rarely
    - Never
5. Do you understand instructions given by doctors/nurses regarding treatment?
    - Yes, I always understand
    - Yes I sometimes understand
    - Neutral
    - No, I never understand
6. Do you complete the full course of prescription medication?
    - Always
    - Sometimes
    - Rarely
    - Never
7. When do you or a family member feels ill, what is your first action?
    - Use home remedies
    - Visit traditional healer
    - Visit local pharmacy or chemist
    - Visit health clinic/hospital
    - Do nothing initially
8. In your household, who usually makes decisions about seeking health care?
    - Myself
    - Spouse/ Partner
    - Parent/Guardian
    - Community elder/Traditional leader
    - Joint decision

Objective 3

To explore the barriers faced by individual with lower educational levels

1. How easy it is for you to find healthcare information (example: services, symptoms, treatment) In your community?
   - Easy
   - Neutral
   - Difficult
2. What is your primary reason for not visiting health care services when needed?
   - Lack of transportation
   - Healthcare facility is too far
   - Cannot afford medical services
   - Lack of knowledge about available services
   - Cultural or social beliefs
   - Long waiting times
   - Others (please specify)
3. What do you think is the biggest barrier preventing people in your community from accessing healthcare services?
   - Lack of knowledge about healthcare services
   - Social and cultural barriers lack of accessibility
   - Lack of trust kind healthcare providers in healthcare providers
   - All of the above
   - Other specify
4. How often do you face challenges indexing transportation to reach health care facilities?
   - Never
   - Rarely
   - Sometimes
   - Often
   - Always
5. In the past 12 months, have you travelled outside your village or town to see a healthcare professional? If yes specify
   - 0-1 time
   - 1- 3 times
   - 4- 5 times
   - More than 5 times
6. How often are medical supplies and medication out of stock in your local healthcare facility?
   - Never
   - Rarely
   - Sometimes
   - Often
   - Always

7. Are you currently covered by any health insurance? If yes specify
   - Yes
   - No
8. If you do not have healthcare insurance what is the main reason?
   - Cannot afford it new line
   - Not available in my area
   - Don't know how to apply
   - Others (please specify)
9. What would make it easier for you or others in your community to access healthcare services?
   - Improve transportation
   - Better and affordable healthcare services
   - Mobile health clinics
   - Community- Base health programs
   - More trust in healthcare providers
   - All of the above
   - Others (specify please)