



Health Care Seeking Behavior among Indigenous People in Rural Areas of Dinajpur, Bangladesh

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ABSTRACT

Health seeking behavior is considered the primary and most vital step toward the medication of any health related complexity. A large number of ethnic minority communities live in the Chittagong Hill Tracts (CHT) districts, but others live in a few other parts of the country. Till now there are no such type of study conducted in rural areas, Dinajpur, Bangladesh. A cross sectional study explored to know the health seeking behavior among indigenous people in rural areas of Dinajpur, Bangladesh. Participants were 323 (52.9% are male and 47.1% are female) indigenous people of some races respondent 65.3% are Santal, 28.5% respondents are Urao, 4% respondents are Malo, 0.9% respondents are Borman, 0.9% respondents are Mahato, and 0.3% respondents are Mundari in Sadar Dinajpur of Bangladesh aged between 18 to 65 years ($M=32.1455, \pm 11.4582$ years). Data was obtained by respondent survey and analysis was done by using descriptive statistics. Maximum of the respondents 17.6% was suffering from respondents general weakness, 17.6% respondents was suffering from common cold and 12.79 % respondents was suffering from skin problem. All of the respondents had taken treatment. And about 78.5% respondents were taken allopathic treatment, 14.1% respondents were taken homeopathic treatment, 3% respondents were taken herbal treatment, 2.2% respondents were taken home remedies/ traditional treatment. Positive finding is that among all of the respondents 40.6% respondents had taken treatment from government hospital, 35% respondents had taken treatment from missionari private hospital/ clinic. 86.1% respondents had health care center in their locality and 41.6% respondents had to face long waiting time in access to health care services. Further research is required to minimize the problems in access to health care and maximize the health seeking behavior and health status among the indigenous people.

Keywords: *Healthcare seeking behaviour, indigenous people, rural people, Bangladesh.*

INTRODUCTION

The terms "tribal group," also means ethnic minorities and indigenous people, namely a social and cultural identity that is distinct from dominant groups in society. United Nations human rights bodies, ILO (International Labor Organization), the World Bank and international law apply four criteria to distinguish indigenous people. Indigenous peoples usually live within (or maintain attachments to) geographically distinct ancestral territories. They tend to maintain distinct social, economic, and political institutions within their territories. They typically aspire to remain distinct culturally, geographically and institutionally, rather than assimilate fully into a national society. They self-identify as indigenous or tribal.¹⁻³

Bangladesh, one of the most densely-populated areas in the world, has about 160 million people in a land area of 55,598 square miles (147,570 square km)⁴. A large number of ethnic minority communities live in the Chittagong Hill Tracts (CHT) districts, but others live in a few other parts of the country. About one-third are residents of the plains in the north-western Rajshahi Division⁵. A study reports that "almost 92 percent *Adivasis*(indigenous people) of the North Bengal, most of them Santals, work as day laborers either throughout the year or part of it" ⁶. They inhabited the plain land of north Bengal, mainly in 16 districts including greater Rajshahi, Rangpur, Dinajpur, Pabna and Bogra of Bangladesh. Apart from North Bengal, Santals also inhabit tea gardens (plantations) of greater Sylhet and Chittagong, especially the hilly district of Khagrachari, and south-west part of Sundarban area⁷. Researcher and activists of Santal community claimed that apart from Bangladesh, a large number of Santals live in Bihar and Assam states of India, and Nepal

and Bhutan. It is claimed that the total number of Santals in the world is about 70 million⁸. The total population of Dinajpur district is 29, 90,128 whereas the number of the Santal population living here is 49,861 which is 1.67% of the district's total population (Population census 2011).

Health seeking behavior is considered the primary and most vital step toward the medication of any health related complexity⁹. It is well explored that, healthcare seeking behaviors and local practicing knowledge requires considering in intervention to bring better health output in a variety of context¹⁰. By understanding the conceptualization of people of cause of their any disease and the perception on any particular health related problem helps to explore their health seeking behavior¹¹. It is widely acknowledged that, exploring the health seeking behavior in different socio-economic levels of any community is crucial for proper planning and implementing of effective health services, particularly for poor community¹². Socioeconomic status is having greater impact on health care utilization especially in developing countries that is documented in many studies. For instance, wealthier families are about twice time take health care service from formal and informal practitioners¹³. Socioeconomic factors including educational level, economic conditions, cultural beliefs, residence location etc. play a significant role to determine health care behavior of a community overall¹⁴. Low socioeconomic status is a common barrier to get health services for people and those direct and indirect factors are- doctor fees, cost of transport, medicine etc¹³. It is found from empirical studies from Bangladesh and few other countries that, socio-economic condition is considerable factors of health care seeking behavior for a community¹⁵. From this mentioned backdrops, it is necessary to understand the health seeking behavior and explore the socioeconomic determinants on this especially low economic community. Therefore, this study has been conducted in rural area of Bangladesh to identify the socioeconomic factors and phenomenon of rural community on their health care seeking behavior. By doing this, any new socioeconomic factors might include that can open a new door for policy makers to make effective and timely health intervention model.

The majority of the tribal population (778,425) lived in rural settings, where many practiced shifting cultivation. They differed in their social organization, marriage customs, birth and death rites, food, and other social customs from the people of the rest of the country. They spoke Tibeto-Burman languages. In the mid-1980s, the percentage distribution of tribal population by religion was Hindu 24, Buddhist 44, Christian 13, and others 19. The four largest tribes were the Chakmas, Marmas (or Maghs), Tipperas (or Tipras), and Mrus (or Moorangs). The tribes tended to intermingle and could be distinguished from one another more by differences in their dialect, dress, and customs than by tribal cohesion.¹⁶

In many parts of the world the majority of the populations are the descendants of immigrants who arrived there within the last few hundred years. Living alongside of them, and in a minority, are the so-called indigenous (or aboriginal) people who are the descendants of people who lived there in more ancient times. Indigenous people all over the world are historically subjugated and discriminated against, which is explicitly and implicitly affecting their health status. Studies reveal that indigenous/ethnic population experience more health related problems and inequalities' than mainstream population. In particular, indigenous people or ethnic minorities are adversely affected by various health problems where Blood Pressure and Diabetes rates are significantly higher. Health of indigenous people is poorer than the non-indigenous people across the world which is also true in the Bangladesh context.

Bangladesh is a land of mixed ethnicity. After Chakma, Marma and Garo, Santal's are the important tribal populations of Bangladesh. Total number of tribal population of Bangladesh is 1410169 which are less than 1% of the total population, comprising more than 30 different ancestries. In Santals a total of 12 clans are found. They are: Hansduk, Murmu, Hembron, Soren, Kisku, Tudu, Marndi, Baski, Besra, Chonre, Puria and Bedea. They have their own language, culture and social pattern's, which are clearly distinct from those of other tribes. Agriculture is their main source of livelihood. Their principle food items are rice, fish and vegetable. They also eat crabs, pork, chicken, beef and meat of squirrels, jute spinach (nalita), wild potatoes, fruits, roots of young shoots, flowers, mashroom, eggs of ducks, chickens, birds and turtle. Most of the Santals are animist. Haunting and collecting foods from forest were their primitive economic activities. Liquor distilled from putrefied rice called hadia or (pachai) is their favorite drink. They are excessively addicted to tobacco, alcohol and wines prepared locally by themselves. They cannot think of performing any religious or social ceremony without drinking wine. Few studies have so far been conducted among the tribal population on the prevalence of diabetes and cardiovascular risk factors. Some studies have been done

on the tribal population of hill tracts in Chittagong and Mymensingh but no study has been carried out in Santal population of Dinajpur yet.¹⁷

Health and nutrition are important elements in the development process. Adequate nutrition enhances physical health, thereby improves immune systems and reproductive health fitness. Both nutrition and health increases life expectancy, which is known to be important for development¹⁸. Although primarily health is a function of nutritional status, other factors like availability, quality and cost of health care services, living standards, sanitary conditions, quality of drinking water and economic condition are also important¹⁹. With the significant development in treatments and medical services, people have become highly aware and cautious about their health and fitness. In tribal societies the concept of health, fitness and diseases varies between different tribal groups. In a tribal habitat, a person is usually considered to be afflicted with some diseases if he/she is incapable of doing the routine work, i.e., incapacitation from work is the universal index of poor health. Thus the concept of ill health becomes a functional one and not clinical. Reproductive health is also very poor among most of the tribal communities. Health problems prevalent in tribal areas include endemic infectious diseases like malaria, tuberculosis, and diarrheal diseases, apart from malnutrition and anemia. What is worrying is that the prevalence of chronic diseases such as hypertension and diabetes mellitus, hitherto rare in these populations, is rising, and stroke and heart disease are now the leading causes of death.

Most of the tribes are living below poverty line and don't spend much on health care. They have common tendency to under report their illness and among them the rate of utilization of public health services is very low. These tribal communities have high maternal mortality and infant mortality rates with high prevalence of infectious diseases like Dengue fever, Malaria, Pneumonia and Tuberculosis. There are historical reasons for their poor economic and societal status and their rights and demands have been progressively neglected in policy discourses.

Every culture has its own distinct explanations of health and illness. In the Santali language, the sense of health was termed as beskinjabe. A person is considered as healthy if he/she is able to do the work expected as per gender and age. The physical appearance of body implies health as good or bad. Fever is the often cited example indicating bad health. According to the traditional healers, the running of nerves, pulse rate, color of the urine, color of the eye, etc. indicate whether one is healthy or ill. Weakness of the body also indicates ill health. Alcoholic intake is metaphorically cited as an illness in their community, owing to its consequences on family and community; it is also claimed that alcohol intake leads to several other diseases. They said that health is not anything other than the present condition of the body. 'Health' means the physical condition, and it is no longer linked with the mental or social condition. According to them, the absence of any disease or illness is termed as good health; if fever is present in the body, it is considered that health is not good. Thus, the concept of health refers only to physical health. Broadly, the concept of health and illness varied according to the gender owing to the physical structure of the body, in addition to gender-related roles in society. According to them, illness is attributed to more than one cause and, hence, they seek different types of treatment from different sources, depending on the type of illness.²⁰

Research has shown that 45 per cent of Bangladeshi's tribal population defecates in the open and 33 per cent does not have access to a clean source of drinking water. Insanitary conditions, ignorance, lack of health education and poor access to healthcare facilities are the main factors responsible for the poor health of tribal. Further, displacement from their traditional forest homes and natural source of food and lack of livelihoods makes them dependent on the public distribution system (PDS) and other government handouts for survival. Most tribal groups are traditionally hunter-gatherers and not accustomed to agriculture their diets, therefore, are now severely limited in fruits and vegetables as well as good sources of protein (including fish and meat). Polished rice and cereals available through the PDS have replaced diverse dietary food baskets.¹⁹

RESEARCH QUESTION

What is the status of health care seeking behavior of indigenous people in rural areas of Dinajpur district, Bangladesh?

OBJECTIVES OF THE STUDY

General Objective: To find out the health care seeking behavior among indigenous people in Dinajpur district, Bangladesh.

Specific Objectives

- To identify the health care seeking behaviour of the indigenous people.
- To determine the status of access to health service of the indigenous people.
- To find out the socio-demographic characteristics of the indigenous people.

OPERATIONAL DEFINITIONS

Health care seeking behavior: Health care seeking behavior is a particular aspect of help seeking behavior. It is clear that people differ in willingness to seek help from health care services. Some go readily for treatment, others only when in great pain and in advanced stages of ill health.

Indigenous people: Indigenous people are people defined in international or national legislation as having a set of specific rights based on their historical ties to a particular territory, and their cultural or historical distinctiveness from other populations that are often politically dominant.

Unqualified allopathic: Persons not having the skills, knowledge, or experience needed to do a particular job or activity.

Para professional: Person to whom a particular aspect of a professional task is delegated but who is not licensed to practice as a fully qualified professional.

List of Variables:

Socio-demographic factors:

- Age
- Sex
- Race
- Religion
- Education
- Family member
- Occupation
- Monthly family income

Health Status:

- Illness pattern

Factor affecting in access to healthcare services:

- Environment
- Communication
- Transport system
- Cost of health care

Health care seeking

- Home remedies / traditional
- Unqualified allopathic
- Para-professional
- Qualified allopathic
- Homeopathy
- None (No treatment)

METHODOLOGY

Study Area: Study was conducted in the Sadar upazila at Dinajpur district, Bangladesh.

Study Period & Duration: Four months, from September, 2016 to December, 2016

Study Population: The study population was the indigenous people in the Sadar upazila in Dinajpur district.

Study Design: The study design was a Cross sectional study in which survey questionnaires were administered.

Sample Size:

The sample size was determined by using the conventional formula:

$$n = z^2pq/d^2$$

Where,

n = required sample size

z= the standard normal deviate usually set at 1.96 which corresponds to 95% level.

p = 65% =0.65

A Study on Ethnic minorities of the Chittagong Hill Tract, by Syed Mashud Ahmed showed that around 60 – 70% tribal people seek health care from unqualified allopath. (Asia Pacific Journal of Public Health, research article 2001).The median value of the percentage of health seeking behavior of ethnic group is 65%.²²

$$q = 1-p (1- 0.65) = 0.35$$

d=degree of accuracy desired, usually set at 0.05%.

Now, required sample size is

$$n = z^2pq/ d^2$$

$$= (1.96)^2 * (0.60) * 0.35 * (0.5)$$

$$(0.05)^2$$

$$= (3.8416 * 0.60 * 0.35) / 0.0025$$

$$= 322.69$$

$$= 323$$

Sampling Technique: There are 13 upazila where 49861 indigenous people live in Dinajpur district. Sadar upazila was selected by using Simple Random Sampling Technique (SRS).Then Sampling collection started from a village named Mirjapur (in front of Shuihari mission gate) and then continue randomly to one (house no. 1) after another household of indigenous peoples. Data was collected from that respondent who were fulfilling the inclusion criteria.

Selection Criteria:

Inclusion criteria: All Indigenous people living in Sadar upazila in Dinajpur district.

Exclusion criteria: Physically and mentally ill indigenous peoples who were within 18 to 65 years.

Data Collection Method: Data were collect through interviewer administered semi structured questionnaire. Data collection was started from Shuihari Mission Gate, house no 1 which was indigenous people's house and then from house no 4 and then it was continued randomly. Questionnaire was finalized after pre tested before going to actual study population.

Data management: All questionnaires were checked for its completeness and correctness. Data were entered into SPSS data sheet.

Data Analysis Plan: The analysis was done by the help of SPSS (Statistical package for social science) Windows software program.

RESULTS

Table 1: Distribution of the respondents according to age (n= 323)

Age	Frequency (n)	Percentage (%)
Upto 25 years	118	36.5
26 to 40 years	132	40.9
41 to 55 years	59	18.3
More than 55 years	14	4.3
Total	323	100.0

(Mean ± SD= 32.1455± 11.4582)

Table shows that, majority of the respondents 40.9% were within 26 to 40 years, 36.5 % were less than 25 years, 18.3% were within 41 to 55 years and 4.3% were in more than 55 years old.

Table 2: Distribution of the respondents according to sex (n=323)

Sex	Frequency (n)	Percentage (%)
Male	171	52.9
Female	152	47.1
Total	323	100.0

Table shows that, majority of the respondents 52.9% were male and 47.1% were female.

Table 3: Distribution of the respondents according to race (n=323)

Race	Frequency (n)	Percentage (%)
Borman	3	.9
Mahato	3	.9
Malo	13	4.0
Mundari	1	.3
Santal	211	65.3
Urao	92	28.5
Total	323	100.0

Table shows that majority of the respondent 65.3% were Santal, 28.5% respondents were Urao, 4% respondents were Malo, 0.9% respondents were Borman, 0.9% respondents were Mahato, and 0.3% respondents were Mundari.

Table 4: Distribution of the respondents according to religion (n=323)

Religion	Frequency (n)	Percentage (%)
Hinduism	45	13.9
Christian	278	86.1
Total	323	100.0

Table shows that majority of the respondents 86.9% were Christian, 13.9% respondents were Hinduism.

Table 5: Distribution of the respondents according to educational qualification (n=323)

Educational status	Frequency (n)	Percentage (%)
Bachelor and above	54	16.7
HSC	54	16.7
SSC	37	11.5
Primary	64	19.8
Illiterate	114	35.3
Total	323	100.0

Table shows that 35.3% respondents were illiterate, 19.8% respondents got primary education, 16.7% were HSC pass, 16.7% respondents were Bachelor and above and 11.5% respondents were SSC passed.

Table 6: Distribution of the respondents according to occupation (n=323)

Occupation	Frequency (n)	Percentage (%)
Housewife	103	31.9
Businessman	4	1.2
Service	36	11.1
Farmer	75	23.2
Student	67	20.7
Day labour	14	4.3
Others	24	7.4
Total	323	100.0

Table shows that 31.9% respondents were housewives, 23.2% respondents were farmer, 20.2% respondents were student, 11.1% were service holder, 7.4% respondents were other, 4.3% respondents were day labour and 1.2% respondents were businessmen.

Table 7: Distribution of the respondents according to family members (n=323)

Family member	Frequency (n)	Percentage (%)
Less than 4	87	26.9
5 to 8	232	71.8
More then8	4	1.2
Total	323	100.0

Table shows that 71.8% of the respondents had 5 to 8 members, 26.9% respondents had about 4 members and 1.2% respondents had more than 8 family members.

Table 8: Distribution of the respondents according to monthly family income (n=323)

Monthly family income	Frequency (n)	Percentage (%)
Upto 5000 tk	158	48.9
6000 to 10000 tk	102	31.6
11000 to 15000 tk	34	10.5
16000 to 20000 tk	17	5.3
21000 to 25000 tk	7	2.2
>25000 tk	5	.15
Total	323	100.0

(Mean \pm SD= 8007.3034 \pm SD=6097.0623)

Table shows that 48.9% respondents had up to 5000 tk., 31.6% respondents had 6000 to 10000 tk., 10.5% respondents had 11000tk to 15000tk, 5.3% respondents had 16000tk to 20000tk, 2.2% respondents had 21000tk to 25000tk , 0.9% respondents 26000tk to 30000tk and 0.6% respondents had more than 30000tk per month family income.

Table 9: Distribution of the respondents according to financial support (n=323)

Financial Support	Frequency (n)	Percentage (%)
Yes	37	11.5
No	286	88.5
Total	323	100.0

Table shows that 88.2% respondents had no financial support and 11.8% respondents got financial support.

Table 10: Distribution of the respondents according to the name of the financial support (n=37)

From Where	Frequency (n)	Percentage (%)
RDA	8	2.5
UNDP	6	1.9
WV	15	4.6
YMC	8	2.5

Table shows that 4.6% respondents got financial support from World Vision (WV), 2.5% respondents got financial support from Rural Development Association (RDA), 2.5% respondents got financial support from YMC, 1.9% respondents got financial support from United Nation's Developmental Program.

Table 11: Distribution of the respondents according to present health problems (if any, during data collection) (n=323)

Present Health problem	Frequency (n)	Percentage (%)
Yes	135	41.8
No	188	58.2
Total	323	100.0

Table shows that 58.2% respondents had health problem and 41.8% respondents had health problem.

Table 12: Distribution of the respondents according to types of health problems at present (n=135)

Health problem	Responses	
	N	Percent
Skin problem	29	12.79%
Common cold	40	17.6%
High blood pressure	35	15.4%
Allergy	13	5.7%
Pain/Ache	20	8.8%
Asthma	4	1.8%
Diabetes	15	6.61%
Headache	24	10.6%
general weakness	40	17.6%
Others	7	3.1%

Table shows that 17.6% respondents had suffered common cold, 17.6% respondents had suffered general from weakness, 15.4% respondents had suffered from high blood pressure, 12.79% respondents had skin problem, 10.6% respondents had suffered from headache, 8.8% respondents had suffered from pain/ache, 6.61% respondents had diabetes, 5.7% respondents had allergy, 3.1% respondents had others health problems and 1.8% respondents had suffered from asthma.

Table13: Distribution of the respondents according to history of taking treatment (n=135)

Take treatment	Frequency (n)	Percentage (%)
Yes	135	100
No	0	0
Total	135	100.0

Table shows that 100% respondents had taken treatment.

Table 14: Distribution of the respondents according to times of taking treatment (n=135)

Treatment taken	Frequency (n)	Percentage (%)
0-3 times	95	70.3

4-8 times	39	29.0
more than 8 times	1	.7
Total	135	100.0

Table shows that 70.3% respondents had taken treatment 0 to 3 times in last 12 months, 29% respondents had taken treatment 4-8 times in last 12 months, 0.7% respondents had taken treatment more than 8 times in last 12 months.

Table 15: Distribution of the respondents according to the type of last time treatment (n=135)

Treatment type	Frequency (n)	Percentage (%)
Allopathic	106	78.5
Herbal	4	3.0
Homeopathic	19	14.1
Jharfuk/ Kobiraj	2	1.5
Home remedies / Traditinal	3	2.2
Others	1	.7

Table shows that 78.5% respondents were taken allopathic treatment, 14.1% respondents were taken homeopathic treatment, 3% respondents were taken herbal treatment, 2.2% respondents were taken home remedies/ traditional treatment, 1.5% respondents were taken jharfuk/ kobiraj treatment, and 0.7% respondents were taken others type of treatment.

Table 16: Distribution of the according to treatment taken by the by whom (n=135)

By whom last time treatment taken	Frequency(n)	Percentage (%)
MBBS doctor	100	74.0
Dentist	4	2.96
Kobiraj	2	1.48
Herbal Practitioner	4	2.96
Homeopathy practitioner	19	14.06
Traditional healer	1	0.74
Medicine shopkeeper	2	1.48
Self-medication	3	2.22

Table shows that 74% respondents had taken treatment from MBBS doctors, 14.06% respondents had taken treatment from homeopathy practitioner, 2.96% respondents had taken treatment from dentist, 2.96 % respondents had taken treatment from herbal practitioner, 2.22% respondents had self medication, 1.48% respondents had taken treatment from kobiraj, 1.48% respondents had taken treatment from medicine shopkeeper and 0.74% respondents had taken treatment from traditional healer.

Table 17: Distribution of the respondents according to improvement from last treatment (n=323)

Improvement from treatment	Frequency (n)	Percentage (%)
Yes	131	97.0
No	4	3.0
Total	135	100.0

Table shows that 97% respondent got improvement and 3% respondents didn't get improvement from the last time treatment taken by the respondents.

Table 18: Distribution of the respondents according to side effects from the last treatment (n=135)

Side effect from treatment	Frequency (n)	Percentage (%)
Yes	15	11.1
No	120	88.9
Total	135	100.0

Table shows that 11.1% of the respondents felt side effects from the last time treatment and 88.9% of the respondents did not feel any side effects from the last time treatment.

Table 19: Frequency distribution of the side effects of the last time treatment among the respondents (n=19)

Side effects	Responses	
	N	Percent
Nausea	3	16.7%
Vomiting	4	22.2%
Insomnia	2	11.1%
Sleepiness	3	16.7%
General Weakness	6	33.3%

Table shows that 33.3% respondents had suffered from general weakness, 22.2% respondents had suffered from vomiting, 16.7% respondents had suffered from sleepiness, 16.7% respondents had suffered from nausea and 11.1 % respondents had suffered from insomnia.

Table 20: Distribution of the respondents according to influence (n=135)

Distribution of the respondents according to inspired by someone to take treatment	Frequency(n)	Percentage (%)
Yes	77	57.0
No	58	43.0
Total	135	100.0

Table shows that 57.0% respondents got influence and 43.0% respondents didn't get any influence.

Table 21: Distribution of the respondents according to influencer (n=77)

Inspired person	Responses	
	N	Percent
Husband/Wife	21	21.6%
Other family member	47	48.5%
Relatives	12	12.4%
Friends	10	10.3%
Neighbors	4	4.1%
Religious Leader	3	3.1%

Table shows that 48.5% respondents were inspired by other family member, 21.6% respondents were inspired by husband/wife, 12.4% respondents were inspired by relatives, 10.3% respondents were inspired by friends, 4.1% respondents were inspired by neighbors and 3.1% respondents were inspired by religious leader

Table 22: Distribution of the respondent according to history of ever seeking treatment (n=323)

Take treatment	Frequency (n)	Percentage (%)
Yes	323	100
No	0	0
Total	323	100.0

Table shows that 100% of the respondents had seek health care.

Table 23: Distribution of the respondents according to choice of treatment place (n=323)

Usually take treatment	Responses	
	N	Percent
Government Hospital	206	40.3%
Missionaries private Hospital/clinic	179	35.0%
Traditional/Home remedies	34	6.7%
Paraprofessional	25	4.9%
Qualified allopath	18	3.5%
Unqualified allopath	10	2.0%
Homeopathy	39	7.6%

Table shows that 40.3% respondents usually took their treatment from government hospital, 35.0% respondents usually took their treatment from missionaries, private hospital/ clinic, 7.6% respondents usually took their treatment from homeopathy treatment, 6.7% respondents usually took their treatment from traditional/ home remedies, 4.9% respondents usually took their treatment from paraprofessional, 3.5% respondents usually took their treatment from qualified allopath and 2.0% respondents usually took their treatment from unqualified allopath.

Table 24: Distribution of the according to reason to choose Govt. hospital (n=206)

Causes of specific treatment	Responses	
	N	Percent
Better treatment/service is good	134	44.56%
Low cost	59	19.3%
Always available	18	5.98%
Known health care personnel	37	12.29%
Near to home	23	7.64%
Referred by others	28	9.3%
Others	2	0.66%

Table shows that 44.56% respondents chose government hospital for better treatment/service is good, 19.3% respondents chose government for low cost, 12.29% respondents chose government for known health care personnel, 5.98% respondents chose government for always available, 9.3% respondents chose government because they were referred by others, 7.64% respondents chose government because it was near to their home, and 1.1% respondents chose government hospital for others causes.

Table 25: Distribution of the according to reason to choose missionary private hospital or clinic (n=179)

Causes of specific treatment	Responses	
	N	Percent
Better treatment/service is good	116	44.6%
Low cost	51	19.61%
Always available	33	12.69%
Known health care personnel	32	12.3%
Near to home	20	7.6%
Referred by others	7	2.7%
Others	1	0.5%

Table shows that 44.6% respondents chose missionary private hospital or clinic centre for better treatment/ service is good, 19.61% respondents chose missionary private hospital or clinic centre for low cost, 12.69% respondents chose missionary private hospital or clinic centre for always available, 12.3% respondents chose missionary private hospital or clinic centre for known health care personnel, 7.6% respondents chose missionary private hospital or clinic centre because it was near to their home, 2.7% respondents chose missionary private hospital or clinic centre because they were referred by others and 0.5% respondents chose missionary private hospital or clinic centre for others causes.

Table 26: Distribution of the respondents according to presence of the health care center in the locality (n=323)

Local health care centre	Frequency(n)	Percentage (%)
Yes	278	86.1
No	45	13.9
Total	323	100.0

Table shows that 86.1% respondents had health care center in their locality and 13.9% respondents had no health care center in their locality.

Table 27: Distribution of the respondents according to treatment place distance of the treatment place (n=323)

Distance of the treatment place	Frequency(n)	Percentage (%)
0 to 5 km	264	81.7
6 to 10 km	26	8.0
11 to 15 km	16	5.0
16 to 20 km	16	5.0
More than 20 km	1	.3
Total	323	100.0

Table shows that 81.7% respondents had 0 to 5 km distance to the treatment place from their locality, 8% respondents had 6 to 10 km distance to the treatment place from their locality, 5% respondents had 11 to 15 km distance to the treatment place from their locality, 5% respondents had 16 to 20 km distance to the treatment place from their locality, 0.3% respondents had 20km or more distance to the treatment place from their locality.

Table 28: Distribution of the respondents according to time to reach to the health care centre (n=323)

Reaching time of healthcare center	Frequency(n)	Percentage (%)
0 to 5 hours	307	95.1
6 to 10 hours	12	3.7
11 to 15 hours	1	.3
16 to 20 hours	2	.6
More than 20 hours	1	.3
Total	323	100.0

Table shows that 95.1% respondents need 0 to 5 hours to reach to the health care center, 3.7% respondents need 6 to 10 hours to reach to the health care center, 0.6% respondents need 16 to 20 hours to reach to the health care center, 0.3% respondents need 11 to 15 hours to reach to the health care center, 0.3% respondents need 20 hours or more to reach to the health care center,.

Table 29: Frequency distributions of the health care provider come to visit to the respondents (n=323)

Healthcare Provider	Frequency(n)	Percentage (%)
Yes	102	31.6
No	221	68.4
Total	323	100.0

Table shows that 68.4% respondents said that health care provider didn't come to visit them and 31.6% respondents said that health care provider come to visit them.

Table 30: Distribution of the respondents according to time health care provider come to visit (n=102)

When do come to visit	Frequency(n)	Percentage (%)
Weekly	23	7.1
Fortnightly	11	3.4
Monthly	57	17.6
Yearly	11	3.4

Table shows that 17.6% respondents said that the health care provider come to visit them monthly, 7.1% respondents said that the health care provider come to visit them weekly, 3.4% respondents said that the health care provider come to visit them fortnightly and 3.4% respondents said that the health care provider come to visit them yearly.

Table 31: Distribution of the respondent according to ever facing any problem in seeking health care (n=323)

Problem in access to healthcare services	Frequency(n)	Percentage (%)
Yes	60	18.6
No	263	81.4
Total	323	100.0

Tale shows that 81.6% respondents hadn't face problem in access to healthcare services and 18.4% respondents faced problem in access to healthcare services

Table 32: Frequency distribution of the problems faced by the respondents in access to health care services (n=60)

Problem facing in access to healthcare	Responses	
	N	Percent
Availability of health care centre	21	27.3%
Long waiting time	32	41.6%
Road condition	1	1.3%
Availability of vehicles	4	5.2%
Cost of care	12	15.6%
Distance and physical access	1	1.3%
Language problem	1	1.3%
Cannot trust	1	1.3%
Competing priorities	1	1.3%
Fear to seek care	1	1.3%
Bad past experience	1	1.3%
Cultural / religious obligation	1	1.3%

Table shows that 41.6% respondents had to face long waiting time in access to health care services, 27.3% respondents had to face problem with lack of availability of the health care centre in access to health care services, 15.6% respondents had to face problem with cost of care in access to health care services, 5.2% respondents had to face vehicles problem in access to health care services, 1.3% respondents had to face problem with road condition in access to health care services, 1.3% respondents had to face problem with fear to seek health care, 1.3% respondents had bad experience regarding health care services, 1.3% respondents had to face problem with competing priorities in access health care services, 1.3% respondents could trust on health care services, 1.3% respondents faced language problem in access health care services, 1.3% respondents had to face problem with distance and physical access in access to health care services and 1.3% respondents had to face problem with cultural / religious obligation.

Table 33: Frequency distribution of the fixed physician for the respondent's family (n=323)

Fixed physician	Frequency(n)	Percentage (%)
Yes	81	25.1
No	242	74.9
Total	323	100.0

Table shows that 74.9% respondents had on fixed physician for their family and 25.1% respondents had fixed physician for their family.

Table 34: Frequency distribution of the type of fixed physician for the respondent's family (n=81)

Type of physician	Frequency(n)	Percentage (%)
MBBS doctor	50	15.5
Therapist	2	.6
Nurse	2	.6
Herbal doctor	3	.9
Homeopathy doctor	5	1.5
Village doctor	18	5.6
Religious leader	1	.3

Table shows that 15.5% respondents had fixed MBBS doctors for their family, 5.6% respondents had fixed village doctors for their family, 1.5% respondents had fixed homeopathy doctors for their family, .9% respondents had fixed herbal doctors for their family, .6% respondents had fixed therapist for their family, .6% respondents had fixed nurse for their family, .3% respondents had fixed religious leader for their family.

DISCUSSION

This descriptive type of cross sectional study was conducted among 323 both male and female in to find out their choice of treatment in Dinajpur district. Majority 52.9 % respondents were male and 47.1 % were female. There was some Hindu among the indigenous respondents in Sadar upazila, Dinajpur district. The majority of the respondents 86.9% were Christian, 13.9% respondents were Hinduism. Majority of the respondents 40.9% were within 26 to 40 years old. And mean age of the respondents was 32.1455 years (± 11.4582 years). Majority of the respondent 65.3% were Santal and 28.5% respondents were Urao and minority 0.3% respondents were Mundari.

Most of the respondents 35.3% have no education and majority of the respondents 31.9% were housewives, 23.2% respondents were farmer, 20.2% respondents were student, 11.1% were service holder, 7.4% respondents were other , 4.3% respondents were day labour and 1.2% respondents were businessmen.

Most of the respondents 48.9% had upto 5000 tk and 31.6% respondents had 6000 to 10000 tk per month family income and majority of the respondents and 71.8% had 5 to 8 members. About 88.2% respondents had no financial support and 11.8% respondents got financial support. Most of the respondent's 4.6% respondents got financial support from World Vision (WV) and majority 58.2% family members had health problem.

Almost 58.2% respondents had health problem and 41.8% respondents had no health problem. Maximum 19.4% respondents had suffered from skin problem, 17.6% respondents had suffered from common cold and 17.6% respondents had suffered from general weakness,

Among all of the respondents 100% had taken treatment and among them 70.3% respondents had taken treatment 0 to 3 times in last 12 months and the respondents about 78.5% were taken allopathic treatment and among them 74% respondents had taken treatment from MBBS doctor and 97% respondents got improvement. Maximum 57% respondents got inspiration and among them about 48.5% respondents were inspired by other family member. Among them 14.1% of the respondents felt side effects from the last time treatment. Among them most of the respondents 33.3% had suffered from general weakness.

About 40.6% respondents usually took their treatment from government hospital and 35% respondents usually took their treatment from missionaries, private hospital/ clinic. And majority 44.56% respondents chose government hospital for better treatment/service is good and 44.56% respondents chose missionary hospital for low cost.

Maximum 86.1% respondents had health care center in their locality and about 95.1% respondents need 0 to 5 hours to reach to the health care center.

Most of the respondents, about 68.4% respondents said that health care provider didn't come to visit them and 31.6% respondents said that health care provider come to visit them. Among them 17.6% respondents said that the health care provider come to visit them monthly,

Maximum 81.4% respondents hadn't face problem in access to healthcare services and 18.6% respondents faced problem in access to healthcare services and among them maximum 41.6% respondents had to face long waiting time in access to health care services.

Among all of the respondents about 74.9% respondents had on fixed physician for their family and 25.1% respondents had fixed physician for their family and among them 61.7% respondents had fixed MBBS doctors for their family.

At the point of end, there are some compare the result with the districts of Bangladesh and other countries having similar socio demographic and health service and people's health status.

Firstly, in Ahemed Fazle Hassan,²¹ Shah Ehsan Habib, M Matiur Rahman, Jalal Uddin, Md. Abdur Rahman's study, their findings showed that the utilization of modern medicine is moderate among Marma, Tanchangya and Tripura groups. The other reasons lead to reluctance of people to go to Govt. hospitals/qualified allopath/doctors: unawareness of the modern medicine/modern treatment facilities, economic vulnerability, and lack of education, transportation problem/lack of transportation facilities, predominance of reliance on religious beliefs and customs regarding healing practices and predominance of reliance on.

On the other hand, in this study the findings showed that maximum 40.3% respondents treatment choice was government hospital and 35% indigenous respondents usually took their treatment from missionaries, private hospital/ clinic in Sadar upazila, Dinajpur district.

Secondly, In Saswat Kumar Pradhan's Study (in 2013)²² "Health and Health Seeking Behavior among the Tribals: A Case Study in Sundargarh District of Odisha" showed that the cause of illness and healing system are found to be associated with the magico-religious beliefs and it was also revealed that the factors like age, sex, education of the patient. It was observed in the field that around 40% women used to be consulted by their male counterpart while taking any decision relating to the treatment.

On the other hand this study showed that about 40.3% respondents usually took their treatment from government hospital and 35% respondents usually took their treatment from missionaries, private hospital/ clinic. About 48.5% respondents were inspired by other family member, 21.6% respondents were inspired by husband/wife, 12.4% respondents were inspired by relatives, 10.3% respondents were inspired by friends, 4.1% respondents were inspired by neighbors and 3.1% respondents were inspired by religious leader.

CONCLUSION

In the socio demographic related data majority of the respondent 40.9% were ages 26-40 years. Most of them were Santal 65.3% and 86.1% is christian and average 48.9% had monthly income level less than 5000 tk.

The majority respondent had one or more health problem. Around 12.89% respondent had skin problem and 17.6% had general weakness and, 17.6% had common cold, 10.6% headache, 15.4% had hypertension, 8.8% had pain, 6.61% had diabetes, 5.7% had allergy problem, 1.8% were suffering from asthma and 3.1% had others health problems.

Health services are provided both through public and private sectors. Patients can play a distinct role in protecting their health, choosing appropriate treatments for episodes of ill health and managing chronic disease.

This study showed that all of the respondents took treatment and majority 40.0% respondents chose government hospital and 35 % respondents chose missionary private hospital/ clinic. 40.6% respondents chose Govt. hospital for better treatment and 40.56% respondents also chose missionary private hospital/ clinic for better treatment. 86.1% respondents had health care center in their locality and 87.1% respondents home distance from health care center was less than 5 km. 18.6% respondents were faced problem to seek health care and among them about 41.6% respondents were faced long waiting time.

RECOMMENDATIONS

This study was conducted in a selected area of Dinajpur District which might not reflect the actual scenario of the whole country. Therefore, further large scale study is recommended.

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