

AN EMPIRICAL STUDY ON HEALTH SEEKING BEHAVIOUR CONSIDERING SOCIO-ECONOMIC AND DEMOGRAPHIC FACTORS OF THE TRIBAL COMMUNITIES IN THE DISTRICT OF ALIPURDUAR, WEST BENGAL #

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BACKGROUND:

Generally, socio-economic and demographic (SED) factors (income, health occupation, housing, education, age, marital status, gender etc.) affect the utilisation of healthcare services. For example, various studies point out to the severity of illnesses being remarkably dependent on socio-economic status. Poor socio-economic statuses immensely affect the degree of morbidity as well as mortality. The health status of the tribal communities is pathetic for the reason that their health seeking behaviour is extremely different from the rest. Generally, tribal communities population is scattered in remote isolated areas, leading to their unfortunate isolation from the mainstream socio-economic activities. Poor educational attainment and accompaniment economic activities often compound the health problems of these communities. In this paper, we studied the utilisation of healthcare services and explored how their SED factors influence their health seeking behavior (HSB) of the tribal communities in the district of Alipurduar, West Bengal. This present study strives to present the picture of their HSB, keeping in consideration their respective SED background in the district of Alipurduar. A multi-stage sampling method was adopted during the field survey that was conducted over 540 households or 2296 persons focusing mainly on their morbidity patterns and their utilization of healthcare services during their respective ailments. Out of 2296 respondents, 1285 people fell sick during the reference period of one year (2021-22). Only 926 illness cases utilised the healthcare services (percentage of healthcare services utilisation was 72.06). A remarkable variation in utilisation of healthcare services is observed depending on SED factors as well as the source of care, type of care and system of medicine utilised. All the illness cases did not utilise the healthcare services, due to variations in SED characteristics of the tribal communities. Utilisation of healthcare services of the communities is also influenced by several other factors such as the source of care, type of care and system of medicine utilised during the reference period.

Keywords: Morbidity, tribal communities, utilisation, healthcare services, Alipurduar.

INTRODUCTION

The term *health* is considered a 'slippery concept' that has not been defined clearly up till now (Smith R., 2002). According to the "World Health Organisation" (WHO), health is referred to as "state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity"

(WHO, 1946). It means a person, if considered healthy, should not be afflicted with any disease or impairment and that he or she can cope with all the wants of daily life. For maintaining a disease free life, an appropriate healthcare system utilisation plays a vital role. The most important determining factor of health is health care which is shaped by the health care services. The utilisation of healthcare services is also considered as a type of individual behavior (Andersen & Newman, 2005). The use of health care services is known as utilisation of health care. Health-care services are needed to diagnose, and improve disease or injury as well as to obtain information about the status and forecast of health. The most important determinants of health care utilisation

include health status and the need for health-care services to improve or maintain health. Interestingly, several studies have argued that the health status of a population is positively associated with the increase in utilisation of all types healthcare services, viz. chemist shop visits, physician visits, and hospitalisation (Hershey et al. 1975; Hulka and Wheat 1985; Muller 1986). Utilisation of healthcare services is heterogeneous. It may be either high or low quality, appropriate or inappropriate, high or low cost. Indeed, the utilisation of a health care system may also depend on educational levels, economic factors, cultural beliefs and practices (Musoke et al, 2014). Additionally, Raj and Nayak mentioned some factors such as socio-cultural life, beliefs, norms, tradition, economic life, awareness, availability, and accessibility of health services (Raj and Nayak, 2018). Various studies have also pointed out that poor health care utilisation is directly associated with the availability of services, quality of care and self-belief in healthcare provider among various sections of the people (Gulati et.al, 2010; Gumber et.al, 2011; Raushan & Mutharayappa, 2014). Health seeking behaviour of the tribal communities is in a grave situation. Generally, they inhabit isolated remote areas, leading to isolation from the mainstream socio-economic activities. Lack of educational and economic attainment further compound their health problems. Marrone (2007) found that most of these communities like to dwell in isolated remote rural areas, having less access to ambulatory services, and acute and specialized health care. Moreover, their health and health seeking behaviour are always influenced by their rigid social beliefs and cultural practices (Bhatia & Behera, 2017). The provision of preventive, curative, and rehabilitative health care services depend not only in their availability and accessibility but also in awareness and attitude of the people and various inter-woven social structure that determine the making of choice (Bhattarai et al, 2015). Health seeking behaviour of a community primarily depends on the demographic and socio-economic condition of the sick person (Ghosh et al, 2016).

REVIEWS OF LITERATURE OF THE STUDY:

According to Moore, behavioral science generally explains that an individual's behaviour is functionally related to characteristics of the individual himself, characteristics of the interaction of the individual with the environment and social factors (Moore, 1969). Andersen and Newman, in their model "healthcare services utilisation" identified factors influencing utilisation of health services. According to the study, utilisation of health services is a function of three factors: Predisposing factors, Enabling factors and Need factors. Predisposing (Socio-demographic and cultural) factors include education, occupation, ethnicity, social networks, social interactions, culture, health beliefs age and gender of an individual that represent propensity to utilise healthcare services. Enabling (economic) factors, the means of obtaining healthcare services, includes income, health insurance, a regular source of care, travel, available health facilities and service providers, etc., represent the resources that may make easy access to services, while the need (health outcomes) factors generate the need for health care services including disease conditions, physical conditions and restricted activity (Andersen & Newman, 1973). This behavioral model predicts that utilisation of health service of an individual is influenced by a sequence of predisposing, enabling, and need factors (Alkhawaldeh et al, 2003). Similarly, Shaikh & Hatcher also pointed out that health-seeking behaviour of an individual is influenced by various factors such as socio-demographic characteristics, awareness and perceptions of existing services, illness patterns, and characteristics of an individual's neighbouring health services system (Shaikh & Hatcher, 2005). Healthcare seeking behavior of the tribal communities is extremely different from the rest. Most of the reasons for non utilisation are cultural factors followed by the long distance to cover owing to the geographical remoteness and residing in the isolated reserve forest areas (Gandhi et al, 2017).

The tribal communities are backward regarding the national average on several health indicators because they are not integrated into the national mainstream of socio-economic activities having lower educational (41% Illiteracy) and economic attainment (41% BPL). Consequently, they suffer triple burden of disease; namely, communicable diseases, non-communicable diseases, malnutrition, mental health, and addictions which are complicated by poor health seeking behaviour (Kumar et al, 2020). Low level of utilisation of health care of the tribal people is common for their illiteracy, poor hygiene and poor infrastructure (Gigoo et al system while illiterate tribal people are more exposed to the traditional method of treatment, which is available near their home (Mishra R and Mishra N, 2006). But irrespective of educational status, they still make use of traditional medicines or self-medication for all diseases of ordinary sickness like tooth pain, menstrual disorder and scabies (Tekhre et al 2009).

OBJECTIVES:

Strive to present the picture of their health seeking behavior (HSB), keeping in consideration their respective SED and other background in the district of Alipurduar.

Sample size Determination

The analysis of the present study was done on the basis of primary data. Therefore, primary data from 2290 persons or 540 households of the tribal communities in the district of Alipurduar, West Bengal was collected through interview with the help of a suitable questionnaire. During data collection, a multi-stage sampling method was used. A total of 1285 illness cases were found. Based on 1285 illness cases, the whole study is analysed in the study area. We defined communicable and maternal diseases as GI, non-communicable diseases as GII and injuries as GIII.

RESULT AND DISCUSSION:

Socio- Economic and Demographic Characteristics of Participants

Overall, 2296 participants were interviewed. The study participants belong to the tribal communities. Majority (57.7%) of the respondents were Christians. About 48.95% respondents were females. About 34.81% of the respondents are tea garden worker. A majority of households' monthly income lies in the range of Rs. 3000-5999.

Distribution of Illness Episodes by Category of disease in terms of Utilisation Pattern of the morbid people:

Table: 1 explored that the tribal communities in rural people of Alipurduar district are in the advanced stage of epidemiological transition. Because households of these communities are found to be highly morbid due to Group II category diseases i.e., non-communicable diseases (721 i.e., 57.11 percent) as compared to Group I category diseases viz. communicable, maternal, prenatal and nutritional conditions (536 i.e., 41.71 percent) followed by Group III category diseases i.e., intentional and unintentional injuries (28 i.e., 2.18 percent), indicating heavy disease burden among the tribal communities. It is particularly worrying to note that persons with non-communicable diseases are less likely to report at least one healthcare services provider compared to those with communicable diseases. Table 1 revealed that only 58.25 percent non-communicable diseases are utilised, whereas more than 90 percent of communicable diseases and 75 percent of injuries are utilised healthcare services. But this result indicates the opposite picture of other studies (Ghosh, 2018; Ameh et al, 2014; and Agyemang-Duah et al, 2020) in which they showed that people with non-communicable diseases are more likely to utilise healthcare services as compared to those who are with infectious communicable diseases. However, out of total of 1285 illness cases, 926 cases

(i.e. 72.06 percent) utilised at least one healthcare facility and the rest of 359 illness cases (i.e. 27.94 percent) are not utilised during the reference period of one year, indicating lowest utilisation rate of healthcare facilities. Less utilisation or non utilisation of healthcare services for non- communicable diseases followed by communicable diseases in the present study could be due to variations in socio-economic and demographic aspects of the tribal communities of the district.

Table 1: Distribution of Illness Cases by Category of disease in terms Utilisation and non-utilisation Healthcare services of the Morbid People:

Characteristics	Group I		Group II		Group III		Total	
	n	%	n	%	n	%	n	%
Illness cases	536	41.71	721	57.11	28	2.18	1285	100
Illness cases utilised health facilities	484	90.30	421	58.25	21	75	926	72.06
Illness cases utilised health facilities	52	9.30	300	41.75	07	25	359	27.94

Source: Self-elaboration with survey Data, Note: Group I: Communicable, maternal, prenatal and nutritional conditions; Group II: Non communicable diseases; Group III: Injuries and accidents and n: number of illness cases.

Utilisation of Healthcare Services in terms of Gender, Age and Marital status of the morbid person of the district:

Table 2 highlights that a quite difference can be found in utilisation of healthcare facilities according to gender. Out of 926 illness cases comprising 449 males and 477 females are found to be utilised healthcare services. Percentage of utilisation of healthcare facilities for males and females is 72.30 percent and 71.84 percent respectively which show slight gender inequality in utilisation of healthcare of the tribal people. For more than 27 percent of illness cases of males and 28.16 percent of females, tribal people have not contacted any healthcare services during the reference period of one year. From the table of age-wise distribution, it is apparent that utilisation of health facilities gets lower with the increases in the age of the tribal communities. Data reveals that the maximum utilisation rate of healthcare facilities is observed in the age group 'up to 4 years' children followed by the age group 5-14 (87.42 percent), 15-24(81.43 percent) , 45-59 (77.08 percent) 25-44(68.52 percent), and 60+ (59.16 percent).

Table 2 Utilisation of Healthcare Services in terms of Gender, Age and Marital status of the morbid person of the district:

Characteristics of the subjects	Illness Cases	Illness Cases Utilised Healthcare services	Percent of Utilisation	Illness Cases Not-utilised Healthcare services	Percent of non-utilisation of Healthcare services
Gender					
Male	621	449	72.30	172	27.70
Female	664	477	71.84	187	28.16

Total	1285	926	72.06	359	27.94
Age					
Up to 4	81	74	88.10	07	11.90
5-14	159	139	87.42	20	12.58
15-24	140	114	81.43	26	18.57
25-44	378	259	68.52	118	31.48
45-59	336	227	77.08	110	32.92
60 and above	191	113	59.16	78	40.84
Total	1285	926	72.06	359	27.94
Marital status					
Unmarried	385	331	85.97	54	14.03
Married	729	497	68.18	232	31.82
Divorcee/Widow w/Widower	171	98	57.31	73	42.69
Total	1285	926	72.06	359	27.94

Source: Self-elaboration with survey data

Utilisation of Healthcare services in terms of Religion, Educational status and Household Size of the sick persons.

Utilisation of healthcare services is mostly influenced by the education (predisposing factors) of an individual (Andersen and Newman, 1973). Therefore; data from table 3 of the present study assures that people with lesser education are less likely to opt for utilisation of healthcare services as compared to their highly educated counterparts. It is seen that 89.47 percent of graduated and higher educated persons have utilised healthcare services from any facility, whereas less than 66 percent of illiterate persons and

87.80 percent of moderately educated persons (those who completed higher secondary education) have opted for utilisation of healthcare facilities. Furthermore, data highlighted that healthcare services utilisation by Hindu household was 72.12 percent of illness cases and that was 71.92 by Christen household indicating that there is no significant difference in utilisation of healthcare services by religion among the tribal communities of the district. Utilisation of healthcare according to household size shows that percentage of utilisation of care for small size families (household size is up to 4) is lower (70.25 percent) than that of large family (household size is greater than 4) (73.93 percent). But if we look at the pattern of utilisation in the type of family, we can see dissimilarity in household size. Utilisation of healthcare of joint family is lowest (70.80 percent) and the same of the nuclear family is highest (73.12 percent)

Table: 3 Utilisation of Healthcare Facilities in terms of Religion, Educational status and Household Size of the sick persons

Characteristics of the subjects	Illness Cases	Illness cases utilised(HCS)	% of cases Utilisation of(HCS)	Illness Cases Not-utilised(HCS)	% of cases with non-utilisation of (HCS)
Educational status					
Illiterate	794	524	65.99	270	34.01
Primary	168	138	82.14	30	17.86
UP	153	125	81.70	27	18.30
Secondary	110	86	78.18	24	21.92
HS	41	36	87.80	5	12.20
Graduation and above	19	17	89.47	3	10.53
Total	1285	926	72.06	359	27.94
Religion					
Hindu	936	675	72.12	261	27.88
Christen	349	251	71.92	102	28.08
Household Size					
Up to 4	652	458	70.25	194	29.75
5 and above	633	468	73.93	165	26.07
Type of Family					
Nuclear	696	509	73.12	187	26.88
Joint	589	417	70.80	172	29.2

Source: Self-elaboration with survey data. Note: UP= Upper Primary HS= Higher Secondary and HCS=Healthcare services.

Utilisation of Healthcare Services according to Occupation and Monthly Income of the Households: Table 4 shows the health seeking behaviour of the morbid people in terms of occupation and monthly income of the Households. Table 4 shows that percentage of utilisation for students including children, is highest (88.47 Percent). Generally, major income source of tribal people depends mainly on three occupations: agricultural activities, employment in tea garden and day labour. Data also reveals that those family members whose major source of household income is from tea garden workers utilised highest percentage of healthcare service (i.e. 71.43 percent), followed by agriculture (i.e. 66.21 percent) and day labour (i.e. 62.06 Percent). The establishment of the tea garden hospitals may be a possible reason for the high utilization of care among garden workers. It was further worked out that utilisation of healthcare services by households belonging to monthly income equal and less than Rs. 5000 was lowest (i.e. 61.08 percent) and same was highest by households having monthly income more than Rs. 10,000 (i.e. 88.64 percent) followed by those households whose monthly income Rs. 5001-7500 (i.e. 74.88 percent) and Rs. 7501-10000 (i.e. 78.76 percent) indicating that utilisation of healthcare services by higher income groups is comparatively higher than the other counter parts as depicted in Table 4.

Table: 4 Utilisation of Healthcare Services according to Occupation and Monthly Income of the Households:

Characteristics of the subjects	Illness Cases	Illness cases utilised HCSs	% of cases utilised HCSs	Illness cases not-utilised HCSs	% of cases not-utilised HCSs
Occupation of the Households					
Agriculture	145	96	66.21	49	33.79
*T.G worker	238	170	71.43	68	28.57
# Day labour	253	157	62.06	96	37.94
Household work	255	184	72.16	71	27.84
YStudent	295	261	88.47	34	11.53
Pension(Old aged)	97	57	58.76	40	41.24
Service	02	1	50	01	50
Total	1285	926	72.06	359	27.94
Major sources of income of the Households					
Agriculture	326	232	71.17	94	28.82
Tea garden worker	537	412	76.72	125	23.28
Day labour	389	257	66.07	132	33.93
Service & Business	33	25	75.76	8	24.24
Total	1285	926	72.06	539	27.94
Monthly Income of the Households(Rs.)					
Less than 5000	442	270	61.08	172	38.92
5000-7500	430	322	74.88	108	25.12
7501-10000	325	256	78.76	69	21.24
10000+	88	78	88.64	10	12
Total	1285	926	72.06	359	27.94

Source: Self-elaboration with survey data, Here, Tea Garden Worker including permanent and casual #=Day labour includes Wage labour/ Toto driver/Raj mistri/ Casual Labour/Old aged and old aged pension holder/rural grocery/Wood collector, Y = Students including child and HCSs=Healthcare services.

Distribution of Illness Episodes by Category of disease in terms of Type, Source and Pattern of care Utilisation of the Morbid People:

Table 5 shows the distribution of illness episodes by category of disease in terms of type, source and pattern of care utilisation of the morbid people of tribal communities of Alipurduar district. From the table of type of care, it is seen that 29.75 percent of morbid people with communicable diseases (i.e.,

Group I) have reported for treatment in public healthcare institutions, 60.95 percent have reported in private healthcare institutions and 9.30 percent have used self-medication/home remedies. For the treatment of Group II diseases (i.e., non-communicable diseases), 31.12 percent people have opted to utilise healthcare services in public healthcare institutions, 67.69 percent in private healthcare institutions,

1.19 percent have used self-medication/home remedies. Further, regarding utilisation for Group III category disease (i.e., intentional and unintentional injuries) 19.05 percent of people have used to utilise public healthcare, 76.19 percent of people in private healthcare institutions and 4.76 percent have used self-medication/home remedies. These results revealed that private facilities are preferred to public healthcare facilities for the utilisation of all category diseases. The high dependence on modern sources was found among people with communicable diseases compared to traditional sources. The majority or 89.26 percent people with Group I category diseases are dependent on the modern sources and only 10.74 percent people with the same have utilised traditional sources. About 87.40 percent people having GII category diseases (i.e., non-communicable diseases) preferred modern sources, while 12.60 percent preferred traditional sources. For Group III category diseases 57.14 percent patient preferred modern sources, while 42.86 percent of patients preferred traditional sources. Results indicate that modern sources for utilisation of all category diseases are more popular than the traditional and other sources. It is also seen that allopathic, ayurvedic and homeopathy systems of medicine was utilised for 86.37 percent, 12.60 percent and 1.03 percent of Group I category respectively. On the other hand, 72.44 percent, 23.52 percent and 4.04 percent people with Group II category illness preferred allopathic, ayurvedic and homeopathy system of medicine respectively. It is also seen that the preference for the ayurvedic system of medicine was comparatively high for the treatment of Group III category illness episodes (i.e., intentional and unintentional injuries) whereas the utilisation of homeopathy for the treatment of Group III category illness episodes was nil (i.e., 0 percent).

Table 5: Distribution of Illness cases by Category of disease in terms of Type, Source and Pattern of care Utilisation of the Morbid People

Source: Self-elaboration with survey data.

Subjects	Group I		Group II		Group III	
	No. of illness cases	Percent	No. of illness cases	Percent	No. of illness cases	Percent
Type of Care						
Public	144	29.75	131	31.12	04	19.05
Private	295	60.95	285	67.69	16	76.19
Self-medication/Home remedy	45	9.30	05	1.19	01	4.76
Total	484	100	421	100	21	100
Pattern of Care						
Modern	423	87.40	324	76.96	12	57.14
Traditional	61	12.60	97	23.04	09	42.86
Total	484	100	421	100	21	100

System of Care						
Allopath	418	86.37	305	72.44	12	57.14
Ayurveda	61	12.60	99	23.52	09	42.86
Homeopath	05	1.03	17	4.04	00	00
Total	484	100	421	100	21	100

Source: Self-elaboration with survey data.

CONCLUSION:

Tribal communities are highly diseases prone having a high degree of morbidity and mortality which affects their health seeking behaviour. Health status of the communities is further compounded by low earnings, illiteracy, hostile environment, carelessness of diseases, high degree of tolerance, poor sanitation, lack of safe drinking water, faith in traditional beliefs, etc. Despite the availability of healthcare facilities, all illness cases were not utilised the healthcare services, variation in socio-economic and demographic background of the people could be the probable reason. Though there is no significant gender discrimination in utilisation of healthcare services for treatment of all ailments, disparities are found in different age groups and marital statuses. High utilisation of healthcare services by children up to 4 years old followed by 5 to 14 years old might be due to more sacrifice of the family members for their small children. The results clearly reveal that a higher percentage of utilisation of healthcare services found among the children as compared to highly aged people indicating sacrifice of elderly or parents for their child as well as provision of availability of child healthcare facilities. On the other hand, low utilisation of healthcare service by highly aged people could be due to being highly dependent on other members of the family. The sharp difference can be seen in utilisation pattern according to marital status. If we look at the family size, we notice that utilisation of healthcare is higher in big families and that is lower in small families prevailing among the sampled population of the district. Findings of the study exposed that occupational status and income of the households influence health care service utilisation among the tribal communities. To some extent, health seeking behaviour of the individual is influenced by several other factors such as pattern of utilisation, source of care and system of medicine utilised during the reference period. From the findings, it is revealed that private healthcare services were more accepted than public healthcare services in utilisation of healthcare services for all categories of diseases. Furthermore, modern healthcare services were more utilised than the traditional healthcare services for all categories of diseases prevailing among the tribal communities. If we look at the system of medicine, we see that most of the diseases have been treated with an allopathy system. However, the preference of ayurvedic system of medicine is comparatively high for the treatment of intentional and unintentional injuries. Therefore, to bring about equity in healthcare utilisation, there is a need to consider the improvement of the socio-economic status of the communities, which may be possible by adopting compulsory education, and creating employment opportunities by implementing poverty alleviation programmes.

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REFERENCE :

1. Agyemang-Duah,W, Peprah,C., Arthur-Holmes,F.,2020. Predictors of healthcare utilisation among poor older people under the livelihood empowerment against poverty programme in the Atwima Nwabiagya District of Ghana. *BMC Geriatr* **20**, 79(2020).

2. Alkhawaldeh A., ALBashtawy M., Rayan A., Abdalrahim A., Musa A., Eshah N., Abu Khait A., Qaddumi J., Khraisat O., ALBashtawy S.2023. "Application and Use of Andersen's Behavioral Model as Theoretical Framework: A Systematic Literature Review from 2012–2021". Iran J Public Health, 52(7), pp.1346-1354.
3. Ameh, S., Gómez-Olivé, FX., Kahn K., Tollman, S.M., Klipstein-Grobusch, K. 2014. Predictors of healthcare use by adults 50 years and over in a rural south African setting. Global Health Action; 7(1), pp.1–11.
4. Andersen, R.M., Newman, J.F. , 1973 .Societal and individual determinants of medical care utilization in the United States. Milbank Memorial Fund Quarterly– Health and Society, 51(1), pp.95-124.
5. Andersen, R., and Newman, J. F. ,2005. Societal and Individual Determinants of Medical Care Utilization in the United States. The Milbank Quarterly, 83(4), pp. 1-28.
6. Bhatia.V. , Behera.P., (2017) Tribal Health Care: The Unaddressed Aspect in Indian Health System. Indian Journal of Community & Family Medicine , 3 (2), 1-3.
7. Bhattarai, S., Parajuli, SB., Rayamajhi RB, Paudel IS, Jha N.,2005. Clinical Health Seeking Behavior and Utilization of Health Care Services in Eastern Hilly Region of Nepal. JCMS Nepal. 11(2), 8-16.
8. David.M, Boynton.P, Butler.C, Musoke .MB,2014. Health seeking behaviour and challenges in utilising health facilities in Wakiso district, Uganda African Health Sciences .14 (4),December 2014.
9. Gandhi.S., Verma,VR.,Dash,UD (2017) Healthseekingbehaviour among particularly vulnerable tribal groups: A case study of Nilgiris. Journal of Public Health and Epidemiology Vol. 9(4), 74-83.
10. Gigoo AP. (2009) Health Issues and Health Seeking Behaviour of Tribal Population, Jharkhand: MHFW, Government of Jharkhand.
11. Gulati, S. C., Singh, R., Raushan, R., Arundhati (2010) Evaluation study of NRHM in seven states of India. Evaluation study report submitted to Planning Commission. New Delhi: Government of India, Planning Commision.
12. Gumber. A., Dhak, B., & Lalitha, N. (2011). Trends and patterns in healthcare use and treatment cost in India during 1986 and 2004 (MPRA Paper No. 50354). Munich: Munich Personal RePEc Archive.
13. Ghosh, S.(2018) Health Seeking Behaviour of North Bengal: A study of the effect of Socio-economic and Demographic characteristics on the healthcare facilities in Siliguri MunicipalCorporation area(SMCA).GJRA-Global Journal for Research Economic analysis7(8), pp.129-131.
14. Hershey, JC., Luft HS, Gianaris, JM .(1975) Making sense out of utilization data. Med Care 13:838– 854. <https://europepmc.org/abstract/med/1181496>.
15. Hulka, BS., Wheat, JR .(1985) Patterns of utilization: the patient perspective. Med Care 23:438–460 <https://www.ncbi.nlm.nih.gov/pubmed/4010347>.
16. Kumar, MM., Pathak ,VK., Ruikar M(2020) Tribal population in India: A public health challenge and road to future. J Family Med Prim Care. 9(2):pp508-512.
17. Marrone .S., 2007. Understanding barriers to health care: a review of disparities in health care services among indigenous populations. Int. J. Circumpolar Health, 66(3), pp.188-198.

18. Moore Wilbert E. 1969. Social Structure and Behavior. In: Lindzey Gardner, Aronson Elliot., editors. *The Handbook of Social Psychology*. 2nd edition. Vol. 4. Reading, Massachusetts: Addison- Wesley; pp. 283–322. [[Google Scholar](#)]
19. Muller, C., 1986. Review of twenty years of research on medical care utilization. *Health Serv Res* 21:129–144. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1068940/>
20. Musoke, D., Boynton, P., Butler, C., Musoke, MB. 2014. Health seeking behaviour and challenges in utilising health facilities in Wakiso district. *Uganda African Health Sciences*, 14(4), December 2014.
21. Raj, P., Nayak, KV. (2018) Health Status and Health Seeking Behaviour of Oraon Female Adolescents in Jharkhand. *International Journal of Social Science Citation*, 7(3), 387-396.
22. Raushan. R., & Mutharayappa, R. (2014) Social disparity in curative care: Determining factors across social groups in rural India. *Journal of Social and Economic Development*, 16(2), 204–225.
23. Shaikh BT, Hatcher J. (2005) Health seeking behaviour and health service utilization in Pakistan: challenging the policy makers. *J Public Health Oxf Engl*. 2005; 27(1):49–54.
24. Tekhre, Varadarajan YL, Alkha S. 2009. Indigenous health practices among Andhra tribals. *Health and Population: Perspectives and Issues*. 32(1), 47-53.