Student's Journal of Health Research Africa
e-ISSN: 2709-9997, p-ISSN: 3006-1059
Vol.6 No. 5 (2025): May 2025 Issue
https://doi.org/10.51168/sjhrafrica.v6i5.2038
Original Article

Health-seeking behaviour and determinants among tribal communities in a rural district of West Bengal.

Chiranjib Murmu[1*], Bijay Kumar Murmu[2], Rita Tudu[3]
Assistant Professor, Department of Radiodiagnosis, Diamond Harbour Government Medical College & Hospital, West Bengal, India[1]
Associate Professor, Department of Medicine, Purulia Deben Mahata Government Medical College & Hospital, West Bengal, India[2]
Senior Medical Officer, Department of Microbiology, Diamond Harbour Government Medical College & Hospital, West Bengal, India[3]

Abstract

Background
Aim: To assess the health-seeking behaviour of rural tribal populations in the district of Bankura, and to identify the key factors influencing their healthcare utilization patterns.

Methods
A community-based cross-sectional study was conducted among 522 adult tribal participants. Data were collected using a structured, pre-tested interview schedule focusing on demographic details, healthcare preferences, access to services, and perceived barriers. Analysis was performed using SPSS version 23.0, with descriptive statistics and chi-square tests applied. Multivariate logistic regression was used to identify significant predictors of modern healthcare utilization.

Results
Most participants were aged 31–45 years, with a near-equal gender distribution. Belief in traditional healers was moderate in 44%, strong in 26%, and supernatural beliefs in 25%. Treatment preference was split: modern medicine (50%), traditional (40%), and mixed (10%). Fifty percent sought care for mild symptoms, 30% delayed until severe, and 20% depended on illness type. Government facilities were the first contact for 55%, traditional healers 20%, and others 25%. Forty percent delayed >3 days to seek care.
Preventive care uptake varied: vaccination (90%) was high, deworming (20%) and BP/sugar screening (20%) were low. Maternal-child health coverage was better: antenatal care (75%), institutional deliveries (90%), and immunization (90%). Major barriers were lack of transport (75%), long waiting times (70%), distance (65%), and cost (60%). Past experiences with modern healthcare were positive in 60%, negative in 40%. Complete recovery was associated with a preference for modern medicine (OR 4.41, RR 2.06). Men, higher education, higher income, business occupation, and proximity to facilities favoured modern healthcare; women, low education/income, and distance favoured mixed modalities.

Conclusion
Healthcare utilization among the tribal population is influenced by low education, limited disease awareness, cultural beliefs, gender norms, and structural barriers.

Recommendations
To strengthen health education and literacy programs focused on common diseases, danger signs, and preventive care.

Keywords: *Tribal health, Health-seeking behaviour, Rural healthcare, Accessibility, West Bengal*
Submitted: 2025-01-12 Accepted: 2025-03-20 Published: 2025-05-30

Corresponding author: *Chiranjib Murmu**
Email: ***emaiidrchiranjib@gmail.com***
Assistant Professor, Department of Radiodiagnosis, Diamond Harbour Government Medical College & Hospital, West Bengal, India

Introduction

Health-seeking behaviour refers to the actions individuals take to maintain, restore, or improve their health,

Student's Journal of Health Research Africa
e-ISSN: 2709-9997, p-ISSN: 3006-1059
Vol.6 No. 5 (2025): May 2025 Issue
https://doi.org/10.51168/sjhrafrica.v6i5.2038
Original Article

including decisions about when, where, and how to seek care in response to illness. It is shaped by a complex interplay of socio-demographic, economic, cultural, and institutional factors. Among vulnerable populations such as tribal communities in India, these behaviours are often influenced by centuries-old traditional beliefs, limited access to health services, and poor health literacy [1]. Understanding these behaviours is essential for designing public health interventions that are culturally sensitive and locally effective.

India is home to over 700 tribal communities, constituting approximately 8.6% of the country's population. These communities are largely concentrated in rural and remote regions with limited infrastructural development, including healthcare services [2]. In West Bengal, tribal groups make up about 5.8% of the population and are primarily located in districts such as Purulia, Bankura, Jhargram, and parts of Birbhum and West Midnapore [3]. Despite governmental efforts to improve rural health infrastructure through programs like the National Health Mission and tribal sub-plans, disparities in healthcare access and utilization persist [4].

Research indicates that tribal populations often delay seeking formal healthcare, relying initially on home remedies or traditional healers due to cultural beliefs, mistrust of modern medicine, financial constraints, and geographical barriers [5]. Moreover, low levels of education and awareness further limit their ability to recognize symptoms or navigate healthcare systems [6]. A study from Jharkhand found that over 60% of tribal respondents preferred traditional healers for primary care, while only 28% visited government facilities even when they were available [7]. These findings underscore the need for more localized and context-specific assessments of health-seeking behaviour.

In recent years, public health efforts have increasingly emphasized the role of behavioural insights and community participation to improve health outcomes in marginalized groups [8]. However, much of the existing literature remains generalized or urban-centric, with limited data from rural tribal populations in states like West Bengal. Understanding the health-seeking behaviour of these groups is critical for improving service delivery, enhancing health equity, and reducing preventable morbidity and mortality.

The present study aims to assess the health-seeking behaviour of rural tribal people in a selected district of West Bengal. It explores the factors influencing their choice of healthcare provider, accessibility of services, and perceived barriers to timely treatment, thereby providing a basis for targeted policy interventions.

Methodology

Study design

This study was designed as a community-based cross-sectional descriptive study.

Study setting

The research was conducted in a selected tribal-dominated rural Bankura district of West Bengal. Villages with a high concentration of Scheduled Tribe (ST) populations were identified using local administrative and census data. The study setting included primary health centres (PHCs), sub-centres, and community areas within the selected villages.

Study participants

A total of 522 participants were included in the study. Participants were adult men and women aged 18 years and above belonging to tribal communities and residing in the selected rural villages for at least one year. Equal representation was maintained from different tribal subgroups to ensure diversity.

Inclusion criteria

- Individuals aged 18 years and above.
- Belonging to recognized tribal communities as per government classification.
- Permanent residents (≥1 year) of the selected rural district.
- Willing to provide informed consent and participate in the study.

Exclusion criteria

- Individuals with serious cognitive or psychiatric conditions affecting communication.
- Tribal people temporarily residing in the district (e.g., seasonal migrants).
- Unwilling or unable to give informed consent.

Bias control

To reduce selection bias, random sampling was used to select households, and one eligible participant was interviewed per household. Interviewer bias was minimized through prior training of field investigators in local dialects and neutral questioning techniques. Social desirability bias was reduced by ensuring participant confidentiality and privacy during interviews.

Student's Journal of Health Research Africa
e-ISSN: 2709-9997, p-ISSN: 3006-1059
Vol.6 No. 5 (2025): May 2025 Issue
https://doi.org/10.51168/sjhrafrica.v6i5.2038
Original Article

Data collection

Data were collected using a structured and pre-tested interview schedule. The schedule included questions on demographic details, socioeconomic status, health-seeking preferences (traditional vs. modern care), and frequency of visits to healthcare providers, accessibility issues, health expenditures, and perceived barriers to seeking care. The tool was translated into the local language and back-translated to ensure accuracy.

Study procedure

Participants were approached in their homes after obtaining permission from village authorities. Written informed consent was obtained. Interviews were conducted face-to-face by trained data collectors fluent in the local language. Each interview lasted approximately 30–40 minutes. Daily field monitoring and data review ensured data completeness and quality.

Statistical analysis

Data were entered into Microsoft Excel and analysed using SPSS version 23.0. Descriptive statistics such as frequencies, percentages, means, and standard deviations were calculated to summarize the data. Chi-square tests were used to analyse the relationship between categorical variables, and p-values <0.05 were considered statistically significant. Multivariate logistic regression was applied to identify predictors of modern healthcare utilization.

Results

[1]. A total of **522 respondents** were included in the study. The majority belonged to the **31–45 years age group (40%)**, followed by 18–30 years (24%), 46–60 years (26%), and >60 years (10%). Gender distribution was nearly equal, with **52% females** and **48% males**.
Regarding education, **35% had secondary level education**, while **26% were illiterate**, 25% had only primary education, and 14% had higher secondary or above. In terms of occupation, over half were engaged in **agriculture/daily wage labour (55%)**, while 23% were homemakers, 13% unemployed/students, 6% in service, and 3% in business.
Most households (**78%**) had a **monthly income < ₹5,000**, with only 4% earning > ₹15,000. Family size was largely medium (38%) or large (45%).
The majority were **married (78%)**, with 17% unmarried and 5% widowed/separated. More than half of the respondents (**52.5%**) lived at a distance of >10 km from the nearest health facility.
With respect to language, **Bengali (62%)** was most commonly spoken, followed by Santali (26%), Hindi (9%), and others (3%).

Table 1: Socio-demographic profile of study participants (N = 522)

Variable	Category	Frequency (n)	Percentage (%)
Age Group (years)	18-30	126	24.0%
	31-45	208	40.0%
	46-60	136	26.0%
	>60	52	10.0%
Gender	Male	250	48.0%
	Female	272	52.0%
Education Level	Illiterate	136	26.0%
	Primary	130	25.0%
	Secondary	182	35.0%
	Higher Secondary and above	74	14.0%
Occupation	Agriculture/ Daily wage labourer	287	55.0%
	Homemaker	120	23.0%
	Service	31	6%
	Business	16	3%
	Unemployed/Student	68	13.0%
Monthly Household Income	< ₹5,000	407	78.0%
	₹5,000–₹10,000	64	12.0%
	₹10,001–₹15,000	29	5.5%
	> ₹15,000	22	4.0%

Student's Journal of Health Research Africa
e-ISSN: 2709-9997, p-ISSN: 3006-1059
Vol.6 No. 5 (2025): May 2025 Issue
https://doi.org/10.51168/sjhrafrica.v6i5.2038
Original Article

Family Size	Small	89	17.0%
	Medium	198	38.0%
	Large	235	45.0%
Marital Status	Married	408	78.0%
	Unmarried	89	17.0%
	Widow /Separated	26	5.0%
Distance from Nearest Health Facility	< 5 KM	78	15.0%
	5-10KM	170	32.5%
	>10 KM	274	52.5%
Language Spoken	Bengali	323	62%
	Santali	136	26%
	Hindi	47	9%
	Others: Mundari, Koda, Ho, Mahali, Kurukh	16	3.0%

[2]. Awareness regarding common diseases varied widely. Half of the respondents (**50%**) were aware of malaria, while awareness was lower for **tuberculosis (35%)**, **diabetes (25%)**, and hypertension (data not specified).

Knowledge of modern health services was generally poor, with only **25%** reporting awareness of them. However, **65%** of respondents were aware of the nearest PHC, while just **35%** knew about the availability of CHC or sub-divisional hospitals.

Recognition of symptoms requiring medical attention was also limited. Only **35%** identified high fever as a danger sign, **25%** recognized persistent cough (>2 weeks) as serious, and **30%** considered swelling of the face or feet a concerning symptom.

Health literacy levels were low. Only **25%** of participants could read prescriptions, **15%** understood medicine instructions (dose, frequency), and **20%** were able to identify expiry dates or labels on medicines.

Table 2: Awareness and Knowledge about Health and Healthcare Services among Respondents (n=522)

Parameter	Category/Response	Frequency(n)	Percentage (%)
1. Awareness about Common Diseases			
Malaria	Aware Not Aware	261 261	50% 50%
Tuberculosis	Aware Not Aware	187 339	35% 65%
Diabetes	Aware Not Aware	131 391	25% 75%
Hypertension	Aware Not Aware	131 391	25% 75%
2. Knowledge of Modern Health Services			
Knowledge of nearby PHC	Yes No	339 183	65% 35%
Knowledge of CHC/Sub-division hospital	Yes No	183 339	35% 65%
3. Symptoms Recognition Requiring Medical Attention			
Recognizes high fever as a dangerous symptom	Yes No	182 340	35% 65%
Recognizes persistent cough(>2 weeks) as danger symptom	Yes No	131 391	25% 75%

Student's Journal of Health Research Africa
e-ISSN: 2709-9997, p-ISSN: 3006-1059
Vol.6 No. 5 (2025): May 2025 Issue
https://doi.org/10.51168/sjhrafrica.v6i5.2038
Original Article

Recognizes swelling of the face/feet as a serious symptom	Yes No	157 365	30% 70%
4. Health Literacy			
Can read prescriptions	Yes No	131 391	25% 75%
Understand medicine instructions(dose, frequency)	Yes No	78 444	15% 85%
Can identify expiry date or label on medicine	Yes No	104 418	20% 80%

[3]. A considerable proportion of respondents showed moderate belief in traditional healers (44%), **while** 26% had strong belief **and** 30% reported no belief**.** Belief in supernatural causes of illness was present in **25%**, while the majority (**75%**) did not share this view.

In terms of treatment preference, half (50%) preferred modern medicine**,** 40% traditional medicine, and **10%** had mixed trust. Regarding care-seeking behaviour, 50% sought help even for mild symptoms**,** 30% delayed care until symptoms were severe**, and** 20% reported that help-seeking depended on the type of illness**.**

Table 3: Perception and beliefs regarding health and illness among respondents (n=522).

Parameter	Response/Category	Frequency(n)	Percentage (%)
Belief in traditional healers	Strong Belief Moderate Belief No Belief	136 230 156	26% 44% 30%
Belief in Supernatural Causes of illness	Yes No	131 391	25% 75%
Preference/Trust: Modern Medicine vs Traditional Medicine	Prefer Modern Medicine Prefer Traditional Medicine Mixed Trust	261 209 52	50% 40% 10 %
Perceived Severity Before Seeking Care	Seeks help only when symptoms are severe Seeks help even for mild symptoms Depends on the type of illness	157 261 104	30% 50% 20%

[4]**.** The first point of contact after symptom onset was most commonly a government doctor/facility (55%)**,** **followed by** traditional healers (20%)**,** pharmacists/quacks (10%)**,** private doctors (10%)**,** and home remedies/self-medication (5%)**.**

In terms of time to seek care**,** 40% delayed >3 days**,** 30% sought help within 24 hours**,** 25% within 1–3 days**, while** 5% did not seek help at all**.**

When asked about the preferred health facility**, the majority preferred** government facilities (59%)**, while** 26% preferred traditional healers**,** 10% private facilities**, and** 5% quacks/unlicensed practitioners**.**

The frequency of health check-ups **was low, with** 80% seeking care only when sick**,** 10% undergoing regular check-ups**, and** 10% never seeking check-ups**.**

Regarding preventive care services**, uptake of** vaccination (90%) **was high, but** deworming (20%) **and** blood pressure/sugar screening (20%) **were very low.**

For maternal and child health services**, coverage was relatively better:** 75% received antenatal care**,** 90% institutional deliveries**, and** 90% child immunization**.**

Student's Journal of Health Research Africa
e-ISSN: 2709-9997, p-ISSN: 3006-1059
Vol.6 No. 5 (2025): May 2025 Issue
https://doi.org/10.51168/sjhrafrica.v6i5.2038
Original Article

Table 4: Health-seeking actions of the respondents (n=522)

Parameter	Category/Response	Frequency(n)	Percentage (%)
1. First point of contact after symptom onset	Home-remedy/self-medication	26	5 %
	Traditional healer	105	20 %
	Pharmacist/Quack	52	10 %
	Government doctor/Facility	287	55 %
	Private doctor/Facility	52	10 %
2. Time taken to Seek Help	<24 hours	157	30%
	1-3 days	131	25%
	>3 days	209	40%
	Did not seek help	26	5%
3. Preferred Health facility type	Government	308	59%
	Private	52	10%
	Traditional healer	136	26%
	Quack/Unlicensed practitioner	26	5%
4. Frequency of Health Check-ups	Regularly (once every six months)	52	10%
	Occasionally (Only when sick)	418	80%
	Never	52	10%
5. Use of Preventive Care Services	Vaccination (self or children)		
	Yes	470	90%
	No	52	10%
	Deworming		
	Yes	105	20%
	No	417	80%
	Blood Pressure/Sugar screening		
	Yes	105	20%
	No	417	80%
6. Use of Maternal and Child Health Services	Antenatal care during pregnancy		
	Yes	391	75%
	No	131	25%
	Institutional delivery		
	Yes	470	90%
	No	52	10%
	Child Immunization		
	Yes	470	90%
	No	52	10%

[5]. Multiple barriers to healthcare access were reported. The most common were lack of transport facilities (75%)**,** long waiting times at health facilities **(70%)**, and physical distance to health facilities (65%)**.** High treatment cost was a concern for **60%** of respondents. Other barriers included language difficulties (45%)**,** poor treatment at facilities (40%)**,** and mistrust of the modern health system (30%)**.** Gender-related barriers, such as requiring permission from husbands, were reported by 18% of participants.

Student's Journal of Health Research Africa
e-ISSN: 2709-9997, p-ISSN: 3006-1059
Vol.6 No. 5 (2025): May 2025 Issue
https://doi.org/10.51168/sjhrafrica.v6i5.2038
Original Article

Table 5: Reported Barriers to Seeking Healthcare among Respondents (n=522)

Barrier	Response	Frequency(n)	Percentage (%)
Physical distance to health facility	Yes No	339 183	65% 35%
Lack of transport facility	Yes No	392 130	75% 25%
The cost of treatment is unaffordable.	Yes No	313 209	60% 40%
Long Waiting time at the health facility	Yes No	365 157	70% 30%
Poor treatment at the Facility	Yes No	209 313	40% 60%
Language barriers	Yes No	235 287	45% 55%
Mistrust of the Modern health system	Yes No	157 365	30% 70%
Gender norms (Needs permission from husbands)	Yes No	94 428	18% 82%

[6]. Among respondents with past experiences of modern healthcare, 60% reported positive experiences**,** while 40% had negative experiences. Regarding treatment outcomes, half (50%) achieved complete recovery**,** while 30% reported partial recovery**,** 15% no improvement**,** and 5% developed complications**.** Satisfaction with the behaviour of health personnel was mixed: 50% were satisfied**,** 15% neutral**,** and 35% dissatisfied**.** Despite these mixed experiences, 58% expressed willingness to visit modern healthcare facilities again**,** whereas 17% were unwilling **and** 25% remained undecided.

Table 6: Previous experience and satisfaction with healthcare among respondents (n=522)

Parameter	Response/Category	Frequency(n)	Percentage (%)
Experience with Modern Healthcare (Past visit)	Positive Negative	313 209	60% 40%
Outcome of previous treatment	Complete recovery Partial Recovery No improvement Develop complications	261 157 78 26	50% 30% 15% 5%
Satisfaction with the behaviour of health personnel	Satisfied Neutral Dissatisfied	261 78 183	50% 15% 35%
Willingness to Visit Modern Healthcare Again	Yes No Undecided	303 89 52	58% 17% 25%

[7]. The determinants of choosing modern versus traditional health facilities showed several significant associations.

Gender: Male respondents were more likely to use modern health facilities compared to females (**OR 1.51, RR 1.17, p = 0.022**), indicating gender plays a role in health-seeking behaviour.

Education: Education level showed a strong association (**p = 0.0079**). Respondents with secondary (OR 0.70, RR 0.41) and higher secondary & above education (OR 1.74, RR 0.64) were more likely to prefer modern health facilities, whereas illiterate respondents had lower odds (OR 0.40). This suggests higher education promotes preference for modern healthcare.

Occupation: Occupation also influenced choice (**p = 0.0094**). Service holders (OR 1.55, RR 1.33), business persons (OR 2.83, RR 1.83), and unemployed/students (OR 3.00, RR 1.88) were more inclined towards modern health facilities, while agriculture/daily wage workers were more inclined towards traditional options (OR 0.51, RR 0.71).

Income Level: Monthly income had a significant association (**p = 0.0038**). Those with higher incomes (₹10,000–15,000 and >₹15,000) showed greater

Student's Journal of Health Research Africa
e-ISSN: 2709-9997, p-ISSN: 3006-1059
Vol.6 No. 5 (2025): May 2025 Issue
https://doi.org/10.51168/sjhrafrica.v6i5.2038
Original Article

preference for modern health facilities compared to those with income <₹5,000 (OR 0.45, RR 0.90).

Distance from Nearest Health Facility: Distance significantly influenced choice (**p = 0.0037**). Those living within 5 km were more likely to seek modern care (OR 0.33, RR 0.57), whereas people residing farther (>10 km) tended to rely on traditional facilities.

Table 7: Association between socio-economic determinants and type of health-seeking behaviour (n=522)

Determinant	Modern Health Facility	Traditional Facility	p-value	Odd Ratio (OR)	Relative Risk (RR)
Gender- Male: 250 Female: 272	 165 153	 85 119	0.022	1.51	1.17
Education Level- Illiterate-136 Primary-182 Secondary-130 Higher Secondary & Above- 74	 56 64 102 47	 80 66 80 27	0.0079	0.40 0.70 1.74	0.64 0.41 0.64
Occupation Level Agriculture/Daily Wage labourer-287 Homemaker-120 Service-31 Business-16 Unemployed /Students- 68	 86 48 17 9 27	 201 72 14 7 41	0.0094	0.518 1.558 2.838 3.005 1.539	0.711 1.335 1.830 1.877 1.325
Income Level < ₹5,000 (n=339) ₹5,000-₹10,000 (n=115) ₹10,000 0- ₹15,000 (n=47) >₹15,000 (n=21)	 119 52 26 13	 220 63 21 8	0.0038	0.45	0.90
Distance from Nearest Health Facility: <5 K.M (n=78) 5-10 K.M(n=170) >15 K.M(n=274	 47 77 96	 31 93 178	0.0037	0.33	0.57

[8]. Belief and trust in treatment modalities differed significantly by gender (**p = 0.0001**). Among males, the majority expressed trust in **modern medicine (156)** compared to traditional medicine (84), with only a small proportion (10) showing mixed trust. In contrast, females showed comparatively greater inclination toward **traditional medicine (125)**, while fewer (104) preferred modern medicine, and a notable fraction (43) expressed mixed trust.

Student's Journal of Health Research Africa
e-ISSN: 2709-9997, p-ISSN: 3006-1059
Vol.6 No. 5 (2025): May 2025 Issue
https://doi.org/10.51168/sjhrafrica.v6i5.2038
Original Article

The calculated odds ratio (**OR = 0.45**) and relative risk (**RR = 0.64**) indicate that females were **less likely than males to trust modern medicine** and were relatively more inclined toward traditional practices or mixed approaches.

Table 8: Association of cultural belief and type of health-seeking behaviour (n=522)

Determinant	Male	Female	p-value	Odd Ratio (OR)	Relative Risk (RR)
Belief/Trust					
Traditional Medicine(n=209) Modern Medicine(n=261) Both (n=53)	84 156 10	125 104 43	0.0001	0.45	0.64

[9]. The outcome of previous treatment was strongly associated with the type of medicine preferred (**p < 0.00001**). Among those who reported **complete recovery**, the majority (**180**) preferred modern medicine, compared to 70 who relied on traditional medicine and 11 who used both. By contrast, those reporting **partial recovery** were more likely to prefer traditional medicine (**90**) than modern medicine (**50**) or both (**17**). Similarly, individuals with **no improvement** (n=35) or who developed **complications** (n=14) tended to favour traditional or mixed modalities more than modern medicine.

The odds ratio (**OR = 4.41**) and relative risk (**RR = 2.06**) indicate that individuals who experienced complete recovery were **over four times more likely** to prefer modern medicine compared to those who did not, and had **double the relative likelihood** of choosing modern treatment.

Table 9: Association of previous experience of treatment and type of health-seeking behaviour (n=522)

Determinant	Modern Medicine	Traditional Medicine	Both	p-value	Odd Ratio(OR)	Relative Risks(RR)
Outcome of previous treatment				<0.00001	4.41	2.06
Complete Recovery	180	70	11			
Partial Recovery	50	90	17			
No improvement						
Develop complications	25 6	35 14	18 6			

Discussion

This study highlights important insights into the health-seeking behaviour, awareness, barriers, and determinants of healthcare utilization among the rural tribal population. The socio-demographic profile indicates that the majority of respondents were middle-aged (31–45 years), with a nearly equal gender distribution. A considerable proportion were illiterate or had only primary education, and most were engaged in agriculture or daily wage labour. This reflects the typical demographic and occupational structure of rural tribal populations in India, where low education and economic dependence on informal labour are common determinants of health behaviour.

Awareness regarding common diseases was suboptimal, with only half of respondents aware of malaria, and even fewer recognizing tuberculosis, diabetes, or hypertension. Low awareness of non-communicable diseases (NCDs) is concerning, as these conditions are increasingly prevalent but often remain undiagnosed in rural areas. A mixed-methods study from Maharashtra's tribal districts found limited awareness regarding NCDs, poor understanding of risk factors and symptoms, and insufficient knowledge among tribal women about lifestyle-related causes of diseases—mirroring this study's findings of low awareness and health literacy [9]. The study emphasized

Student's Journal of Health Research Africa
e-ISSN: 2709-9997, p-ISSN: 3006-1059
Vol.6 No. 5 (2025): May 2025 Issue
https://doi.org/10.51168/sjhrafrica.v6i5.2038
Original Article

illiteracy's impact and recommended culturally appropriate IEC strategies. Similarly, limited recognition of warning symptoms such as persistent cough or swelling indicates gaps in health education, which may delay care-seeking and worsen outcomes.

Knowledge of modern health services was also poor. While awareness of nearby primary health centres (PHCs) was relatively higher, only a minority were aware of community health centres (CHCs) or sub-divisional hospitals. This limited knowledge likely restricts timely access to higher levels of care. Furthermore, health literacy was low, with only a small proportion able to read prescriptions or understand medicine instructions. Such deficiencies may lead to inappropriate treatment use, poor adherence, and adverse outcomes. A cross-sectional survey across tribal districts in India revealed that although many PHCs and CHCs had doctors, essential diagnostic tools (e.g., BP monitors, drugs) were often lacking, and awareness of hypertension or diabetes diagnosis criteria was inadequate. This corroborates the need for health system strengthening and literacy support in tribal areas [10]. Beliefs and perceptions strongly influenced care-seeking. Almost half of the respondents held moderate beliefs in traditional healers, and one-quarter believed in supernatural causes of illness. Treatment preferences were divided, with half preferring modern medicine, 40% preferring traditional medicine, and 10% expressing mixed trust. Gender differences were evident, with men more likely to trust modern medicine, while women showed a greater inclination toward traditional or mixed approaches. This indicates that cultural norms and gender roles play an important role in shaping healthcare choices.

Care-seeking practices further demonstrated these dynamics. While 50% sought care even for mild symptoms, 30% delayed until symptoms became severe, and 20% based their decision on the type of illness. The first point of contact was most often government facilities, but a sizable minority turned to traditional healers or unqualified providers such as quacks and pharmacists. Delay in seeking care was common, with 40% waiting more than three days after symptom onset. These findings suggest that both accessibility barriers and cultural beliefs contribute to delayed utilization of formal health services.

Preventive care practices were mixed. While vaccination coverage was high, uptake of deworming and NCD screening was very low. Similarly, maternal and child health service utilization showed relatively good performance, with high rates of institutional deliveries and immunization. This may reflect the success of targeted government programs such as Janani Suraksha Yojana and Universal Immunization Programme, but underscores the need to strengthen preventive and screening services for NCDs.

Several barriers to healthcare were identified, with lack of transport, long waiting times, physical distance, and treatment costs emerging as the most prominent. Language barriers, poor treatment experiences, and mistrust of modern health systems further discouraged use. A qualitative study among Assam's tribal communities reported that both direct (treatment cost) and indirect costs (transport, travel-related expenses) significantly hindered access to modern healthcare services. Participants often needed to borrow or sell assets to afford care, reinforcing your findings around cost and distance barriers [11].

Gender norms also posed constraints, as nearly one-fifth of women required permission from husbands to access healthcare. These findings reflect the multifaceted challenges of healthcare access, encompassing structural, financial, and socio-cultural dimensions. In Maharashtra, belief in traditional healers, faith-based care, and the role of husbands' permission were found to shape healthcare behaviour among tribal women. The study mentioned that women's autonomy, cultural norms, and literacy played a critical role in care-seeking decisions—supporting your findings regarding gender, belief systems, and trust [9]

Experiences with modern healthcare were mixed. While 60% reported positive experiences, 40% had negative ones. Outcomes of treatment were strongly associated with healthcare preference: those experiencing complete recovery were more likely to trust modern medicine, while partial recovery, no improvement, or complications were associated with greater reliance on traditional or mixed modalities. This finding emphasizes the importance of the quality and effectiveness of care in shaping community trust in modern healthcare.

Determinants of healthcare preference revealed significant associations. Men, individuals with higher education, those engaged in service or business, and higher-income groups were more likely to prefer modern health facilities [12]. Conversely, agricultural labourers, illiterate individuals, and those with low incomes leaned more toward traditional care. Proximity to health facilities also played a crucial role, with those living closer to facilities more likely to seek modern care. These results highlight the intersecting influence of socio-economic status, education, occupation, and accessibility on health-seeking behaviour.

Overall, the findings point toward three key themes:

Limited health literacy and awareness hinder appropriate recognition of diseases and timely care-seeking.

Cultural beliefs and gender dynamics significantly influence trust in modern versus traditional systems.

Structural barriers such as transport, cost, distance, and facility inefficiencies remain major obstacles to equitable healthcare utilization.

Student's Journal of Health Research Africa
e-ISSN: 2709-9997, p-ISSN: 3006-1059
Vol.6 No. 5 (2025): May 2025 Issue
https://doi.org/10.51168/sjhrafrica.v6i5.2038
Original Article

Addressing these issues requires a multipronged approach. Strengthening health education, especially on NCDs and danger signs, improving health literacy, and promoting community-based awareness campaigns are essential. Simultaneously, addressing structural barriers through improved transport, reduction of out-of-pocket costs, and reduction of waiting times in facilities can enhance utilization. Finally, improving the quality of care and patient–provider relationships is critical to building trust in modern healthcare, particularly among women and vulnerable groups.

Conclusion

This study highlights that health-seeking behaviour among rural tribal populations is shaped by low awareness of common and non-communicable diseases, limited health literacy, and gaps in knowledge about modern health services. Cultural beliefs, trust in traditional healers, and gender norms significantly influence treatment preferences, with men more likely to use modern healthcare and women more inclined toward traditional or mixed approaches. Structural barriers—including distance, transport, cost, and long waiting times—further restrict timely access. Positive experiences and successful treatment outcomes with modern healthcare increase trust and future utilization. Overall, socio-economic status, education, occupation, and proximity to health facilities strongly determine healthcare choices. Strengthening health education, improving literacy, enhancing access, and ensuring quality care are essential to improving healthcare utilization and equity among tribal communities.

Recommendations

To strengthen health education and literacy programs focused on common diseases, danger signs, and preventive care.

To promote culturally sensitive awareness campaigns to address traditional beliefs and gender norms.

To improve accessibility by enhancing transport, reducing waiting times, and expanding nearby healthcare facilities.

To encourage preventive services uptake, including NCD screening, deworming, and regular check-ups.

To enhance the quality of care and patient–provider interactions to build trust in modern healthcare, especially among women and disadvantaged groups.

References

1. Baru R, Acharya A, Acharya S, Kumar AS, Nagaraj K. Inequities in access to health services in India: caste, class and region. Econ Polit Wkly. 2018; 53(8):49-58.
2. Ministry of Tribal Affairs. Statistical profile of Scheduled Tribes in India 2023. New Delhi: Government of India; 2023. p. 1-150.
3. Government of West Bengal. West Bengal Human Development Report 2021. Kolkata: Department of Planning and Statistics; 2021. p. 76-88.
4. National Health Mission. Tribal health action plan 2020-2025. New Delhi: Ministry of Health and Family Welfare; 2020. p. 23-30.
5. Chauhan RC, Mahajan H, Ahmed S, Saxena D. Health-seeking behaviour and determinants among tribal populations in India: a review. J Family Med Prim Care. 2019;8(6):1834-40.
6. Tiwari R, Negandhi H, Zodpey S. Health literacy in India: insights from recent research. Indian J Public Health. 2020;64(3):279-84.
7. Minz S, Sahu D, Panda BK. Utilization of healthcare services among tribal populations: a study from Jharkhand. Indian J Community Health. 2022;34(2):231-7.
8. Bhan N, Rao KD, Kachwaha S, Srivastava S, Menon R. Engaging communities for improving health: a systematic review of community-based interventions in India. BMC Public Health. 2021;21(1):1-11.
9. Birje S, Patil AD, Munne KR, Chavan V, Joshi BN, Akula A, Salvi N, Nair S, Valawalkar SP, Tandon D, Chauhan S, Patil D, Babu BV. Enablers and challenges of tribal women and the health system for implementation of screening of non-communicable diseases and common cancers: a mixed-methods study in Palghar district of Maharashtra, India. Indian J Med Res. 2023; 156(2):319-29. doi:10.4103/ijmr.IJMR_3240_21. https://doi.org/10.4103/ijmr.ijmr_3240_21 PMid:36629192 PMCid:PMC10057353
10. Kaur P, Borah PK, Gaigaware P, Mohapatra PK, Das NKR, Uike PV, Tobgay KJ, Tushi A, Zorinsangi, Mazumdar G, Marak B, Pizi D, Chakma T, Sugunan AP, Vijayachari P, Bhardwaj RR, Arambam PC, Kutum T, Sharma A, Pal P, Shanmugapriya PC, Manivel P, Kaliyamoorthy N, Chakma J, Mathur P, Dhaliwal RS, Mahanta J, Mehendale SM. Preparedness of primary & secondary care health facilities for the management of non-communicable diseases in the tribal population across 12 districts in India. Indian J Med Res. 2023;156(2):260-8. doi:10.4103/ijmr.IJMR_3248_21. https://doi.org/10.4103/ijmr.ijmr_3248_21 PMid:36629185 PMCid:PMC10057372
11. Boro B, Saikia N. A qualitative study of the barriers to utilizing healthcare services among

Student's Journal of Health Research Africa
e-ISSN: 2709-9997, p-ISSN: 3006-1059
Vol.6 No. 5 (2025): May 2025 Issue
https://doi.org/10.51168/sjhrafrica.v6i5.2038
Original Article

the tribal population in Assam. PLoS One. 2020;15(10):e0240096 https://doi.org/10.1371/journal.pone.0240096 PMid:33031431 PMCid:PMC7544062

12. Chauhan RC, Mahajan H, Ahmed S, Saxena D. Health-seeking behaviour and determinants among tribal populations in India: a review. J Family Med Prim Care. 2019; 8(6):1834-40. https://doi.org/10.4103/jfmpc.jfmpc_229_19 PMid:31334176 PMCid:PMC6618196

PUBLISHER DETAILS

Student's Journal of Health Research (SJHR)
(ISSN 2709-9997) Online
(ISSN 3006-1059) Print
Category: Non-Governmental & Non-profit Organization
Email: studentsjournal2020@gmail.com
WhatsApp: +256 775 434 261
Location: Scholar's Summit Nakigalala, P. O. Box 701432, Entebbe Uganda, East Africa