
Health-Seeking Behavior of Rural Ethnic Women in Bangladesh: A critical analysis through intersectional lens

Faraha Nawaz

University of Rajshahi, Bangladesh, faraha.nawaz@gmail.com

Atia Nowshin Bushra

Department of Public Administration University of Rajshahi Bangladesh

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RESEARCH ARTICLE

Exploring Health-Seeking Behavior of Rural Ethnic Women: Bangladesh Context

Faraha Nawaz*, Atia N. Bushra

Department of Public Administration, University of Rajshahi, Bangladesh

Abstract

The paper aims to investigate the health seeking behavior of rural ethnic women in Bangladesh through the lens of intersectionality. The paper sheds light on the healthcare seeking behavior of rural ethnic women by exploring the barriers of their healthcare accessibility, role of community organizations and traditional healers in shaping health seeking behavior, analyzing the impact of education, health literacy and healthcare awareness, and evaluating the role of family and community level power imbalance over the health seeking behavior of rural ethnic women. The study is based on both primary and secondary data. The findings of the paper highlight that various social and cultural factors, including gender, ethnicity, and socio-economic status, intersected to influence health seeking behavior among rural ethnic women in Bangladesh. Access to healthcare was found to be limited due to a lack of resources, transportation, and information. The paper argues that Community organizations and traditional healers played a minimal yet important role in shaping health seeking behavior, while the existing power imbalance in the family and community level has been found to be associated with health seeking behavior. The paper concludes the importance of addressing the multiple and intersecting factors that shape health seeking behavior among rural ethnic women in Bangladesh.

Keywords: Health-seeking behavior, Rural ethnic women, Social determinants of health, Intersectionality, Bangladesh

1. Introduction

Health-seeking behavior refers to the actions taken by individuals to maintain or improve their health, including the use of health services, self-care practices, and seeking the advice of others. It is a critical aspect of health and well-being, as it affects an individual's ability to access health care and improve their health outcomes. Thus, understanding health-seeking behavior is fundamental for improving access to health care, reducing health disparities, and promoting health equity. Health-seeking behavior of a person or a community is subject to a number of socio-culture specific and identity related factors such as age, gender, ethnicity, health beliefs, social norms, social structure, education attainment and finally, the level of social support (Adhikari & Rijal, 2014; Hossain, 2020). Based on these factors, the health-seeking

behavior of a group of people differs from another creating different healthcare access and health outcomes. As a result, those who belong to a disadvantaged social group, end up in poor health practices and limited healthcare accessibility. The situation worsens when a disadvantaged person is a member of multiple social categories that limit or poses potential to limit positive health behavior.

In the context of Bangladesh, understanding the health-seeking behaviors of rural ethnic women is crucial for addressing health disparities and improving overall health outcomes of rural ethnic women. The present study explores the experience of rural ethnic women in Bangladesh who are subject to multiple social identities (gender, ethnicity, and geographical location) that pushes them to limited healthcare access and poor health outcomes. Existing studies have revealed that rural ethnic women in Bangladesh face numerous challenges in

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* Corresponding author.
E-mail address: faraha.nawaz@gmail.com (F. Nawaz).

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accessing healthcare services, including geographical barriers, poverty, cultural barriers, and limited health literacy (Kumar & Singha, 2019; Rahman et al., 2012; Kabir et al., 2019; Rahman et al., 2021). These challenges shape the health behavior of rural ethnic women by preventing them from seeking necessary health care, leading to poor health outcomes and reduced quality of life. Moreover, traditional beliefs and cultural practices often play a significant role in shaping the health-seeking behaviors of rural ethnic women. However, existing scholarships on the health-seeking behavior of rural ethnic women are mainly unidimensional and lack a comprehensive analysis of this issue from an intersectional viewpoint. In addition, for a number of the existing literature, health-seeking behavior of rural ethnic women was not the major focus. Rather, it was given minimal attention in the overall discussion of health-seeking behavior of a wider ethnic community (Rahman et al., 2012; Kumar & Singha, 2019).

Existing studies have further revealed that the health-seeking practices of rural ethnic women in Bangladesh are influenced by a complex interplay of demographic, socio-cultural, health-related, and access to healthcare services factors (Rahman et al., 2012, Kumar & Singha, 2019). Majority of the existing studies on the healthcare of indigenous communities of Bangladesh have focused on the indigenous communities living in the Chittagong Hill Tracts areas¹ (Kabir et al., 2019; Rahman et al., 2012; Uddin et al., 2013) and considered both male and female members of the community lacking a gendered analysis of their health issues. Some studies have analyzed the healthcare needs and behavior of selected vulnerable groups such as the older adult population of the indigenous communities (Rahman et al., 2021). Very few of the existing studies have partially discussed the health behavior of rural women and rural ethnic women. But these studies have failed to draw a comprehensive picture of the health behavior of rural ethnic women considering their intersectional identity and how their intersectional identity influences their health-seeking behavior.

Under the above circumstances, this study is designed to address and analyze the health-seeking behavior of rural ethnic women, and the role of social determinants, intersectional identity and community organization on their health-seeking behavior. Women have unique healthcare needs

than that of men and women experience a lot of difficulties in making healthcare decisions in a patriarchal society like Bangladesh. Adding to this, most of the existing literature has failed to take into consideration the needs, expectations and experience of women and their health-seeking behavior. This study aims at exploring the health-seeking behavior of rural ethnic women of northern Bangladesh, taking rural Santal women as a unit of analysis. As majority of the existing literature has ignored the healthcare experience of ethnic women living in the plain land of Bangladesh, this study by addressing the health-seeking behavior of Santal women will add value and new insights to the existing body of knowledge.

2. Literature review and contribution of this study

Health-seeking behavior is a series of curative practices undertaken by a person in order to redress any unexpected health condition that has been perceived as illness. It is defined as a combination of decisions which is a subject to individuals and/or household behavior, community norms, and expectations as well as the characteristics and behavior of the health providers (Ihaji et al., 2014 as cited in Oberoi et al., 2016). The behavior of seeking health care is determined by the interplay and equilibrium among various factors, including health requirements, health resources, and socio-economic, cultural, political, and situational aspects. (Adhikari & Rijal, 2014). Health-seeking behavior of a community is largely influenced by the socio-economic and cultural realities of that community, because, forces and systems of social determination shape the collective conditions in which people are born, grow and live (World Health Organization, 2008). In addition, the social determinants of health as identified by Health Canada (1998) includes income and social status, social support networks, education, employment and working conditions, physical and social environment, biology and genetic endowment, personal health practices and coping skills, healthy child development, healthy services, gender, and culture (Hossain, 2020) have significant influence over the health seeking behavior of a community. Evidence from the existing studies on healthcare equity suggest that healthcare-seeking behavior is influenced by various factors such as age, gender, peer network, cultural practices, belief systems, and socio-

¹ The Chittagong Hill Tracts is a region located in southeastern Bangladesh, bordering Myanmar and India. The region is known for its distinct geography and diverse ethnic communities. There are three districts in the Chittagong Hill Tracts- Rangamati, Bandarban, and Khagrachari.

economic status (Kabir et al., 2019) and tackling the social determinants of health can lead to reductions in health disparities (Williams et al., 2008). This is especially true for rural ethnic women, who experience healthcare disparities on multiple levels due to their ethnic and gender identity.

In addition to the social determinants of health, Ramesh (2021) by drawing evidence from Shrilanka has argued that ethnicity, various forms of identity affiliation (such as religion, caste, and language), social norms, and level of education) have strong influence over citizen's ability to access public services including healthcare. Other studies like Abuelgasim et al. (2020) have expressed that ethnic minorities were disproportionately affected by the COVID-19 pandemic, and have experienced worse health outcomes compared to other non-ethnic groups. According to this study, poor health outcomes of minority ethnic group was a result of limited access to healthcare, poor living conditions, and educational and linguistic obstacles in adopting preventative measures. Existing studies on the healthcare of rural ethnic women also revealed that health-seeking behavior of the rural ethnic women of Bangladesh is strongly associated with their gender, ethnicity, and other social determinants of health. Ethnic women in Bangladesh are more vulnerable to diseases and enjoy poor healthcare accessibility regardless of their age, and healthcare needs. One study by Rahman et al. (2021) on the health and wellbeing of indigenous older adults of Bangladesh argues that indigenous older women of Bangladesh are more likely to suffer from chronic diseases and multimorbidity due to their disadvantaged position in the community. Another study by Tarafder and Sultan (2014) suggests that the majority of the rural indigenous women (95% of their study respondents) do not prefer to consult male doctors to seek reproductive healthcare due to cultural and socio-cultural values. In addition, indigenous women in Bangladesh enjoy little control over their reproductive health related decision-making as they have to obey their in-laws and elderly women in this regard. Similar findings are proposed by Rahman et al. (2012) as they suggest that gender play a role in making decisions in households regarding health matters and treatment-seeking and adolescent girls of the ethnic communities living in the CHT is completely dependent upon the decisions of senior family members (Rahman et al., 2012). Thus, similar to social determinants of health, gender and ethnic identity of indigenous women has a role to play in their access to healthcare.

Although, health-seeking behavior of ethnic communities of Bangladesh has been addressed in

the existing scholarly works, the majority of the existing studies on this issue do not address the unique healthcare needs and challenges of healthcare accessibility experienced by rural ethnic women. Some studies that have included the healthcare needs and experience of rural ethnic women in their wider discussion, have focused on those residing in Chittagong Hill Tracts of Bangladesh, and ignored those ethnic communities that are living in the northern part of the country. In addition, none of the existing studies have adopted an intersectional lens to study the healthcare seeking, healthcare needs, accessibility, and challenges of rural ethnic women of Bangladesh. Rural ethnic women, as a community, experience multiple disadvantages in seeking healthcare, due to their ethnic and gender identity. But there is a significant gap in the existing body of knowledge as none of the previous studies on the healthcare of rural ethnic women in Bangladesh have analyzed the interplay of gender, ethnicity, social determinants of health, and the health-seeking behavior of rural ethnic women in Bangladesh. Thus, this study, by exploring the healthcare-seeking behavior of the Santal women of Bangladesh from an intersectional lens, will contribute to the existing body of knowledge.

2.1. Objectives and methodologies

The objective of the study is to investigate how the intersectional identity factors are affecting the healthcare seeking behavior of rural ethnic women in Bangladesh. This broad objective can be broken down into following specific objectives-

- i) To assess how intersectional factors of gender and ethnicity shape the healthcare needs and perception of rural ethnic women in Bangladesh.
- ii) to explore whether intersectional factors of gender and ethnicity promote or restrict the healthcare accessibility of rural ethnic women, and
- iii) to analyze the complex interplay of social determinants of health and intersectionality in determining the health-seeking behavior of rural ethnic women in Bangladesh.

The study has employed a qualitative research design to gather in-depth and rich data on the health-seeking behavior of rural ethnic women in Bangladesh. Purposive network sampling techniques are used to select 30 rural ethnic women of Santal tribe living in northern Bangladesh

(Chapainawabganj district). Primary data of this study is collected through in-depth interviews, focus group discussions, and observation methods. The in-depth interviews and focus group discussion are conducted with rural ethnic women who have sought healthcare services in the past. The observations are conducted at formal and informal healthcare facilities. Collected data are analyzed using thematic analysis techniques. Intersectionality theory is used to analyze the interplay of multiple factors such as gender, ethnicity, education, and socio-economic status on health seeking behavior among rural ethnic women in Bangladesh. The theory has helped to understand the complex and interrelated experiences of rural ethnic women and their health seeking behavior. The participants of this study were informed of the purpose of the study and their rights to confidentiality. Informed consent was obtained from each participant before data collection.

2.2. Theoretical framework and conceptual model

Rural ethnic women face unique challenges in seeking health care, including limited access to resources, transportation difficulties, language barriers and limited institutional support. Moreover, they are also often subjected to discrimination and stigma based on their intersectional identity, which consists of ethnicity, rural residency, and gender. Therefore, to understand the health seeking behavior of a community, it is necessary to explore the role of intersectionality in shaping their health-seeking behavior along with different aspects of social determinants of health (socioeconomic status, cultural beliefs, and experiences of discrimination and stigma), their interconnectedness and how they come together to generate disadvantage and impediments to healthcare accessibility for this community. In this regard, the intersectionality theory of [Crenshaw \(1989\)](#) provides the most appropriate framework to study and gain a more nuanced understanding of the complex health-seeking behavior and diverse factors that contribute to the health care seeking of rural ethnic women.

The underlying assumption of intersectionality framework is that human beings are exposed to multiple identity factors that intersect and/or overlap to produce a more complex identity, based on which they are either discriminated against or privileged in a socio-political setting. Intersectionality views a number of identities in combination rather than in seeing each in isolation. Although the term has begun its journey to address sexual and racial injustice, it now encompasses other identity

factors including gender, sexuality, class, ability, nationality, citizenship, religion, and body type. In short, intersectionality is a prism to observe how multiple forms of inequality operate together and exacerbate one another ([UN Women, 2020](#)).

Intersectionality as a framework provides a comprehensive understanding of the complex and interrelated systems of oppression and privilege experienced by individuals based on their race, gender, class, and sexuality, among other factors ([Crenshaw, 1989](#)). Intersectionality theory, in the study of health-seeking behavior, examines the interconnected and mutually reinforcing systems of oppression and privilege in the access to healthcare based on factors such as race, gender, class, and sexuality. This framework recognizes that individuals experience multiple and intersecting forms of oppression and privilege, which can influence their health-seeking behavior by affecting their access to health care and their health outcomes. In the context of this study, the intersectionality framework can provide a more nuanced understanding of the diverse experiences of rural ethnic women in seeking health care and the complex factors that contribute to those experiences.

Current legal system of Bangladesh addresses women as a homogenous group which they are not. Experiences of women in a society differ based on their affiliation to varying social class, status, age and ethnicity. These different aspects of their identity result in different healthcare needs, ability and experience of a woman as a member of the society. For instance, one study by [Rahman et al. \(2021\)](#) has found a higher prevalence of chronic diseases and multimorbidity among the indigenous women in Bangladesh than the older men and young women population of the study area due to their disadvantaged position in the community. A number of other studies provide evidence for the dependence of ethnic adolescent girls and married women on the elderly members of their family for their health-related decision making and treatment ([Kabir et al., 2019](#); [Rahman et al., 2012](#); [Tarafder & Sultan, 2014](#)).

Evidence from the existing studies suggest that considering women as a homogenous group is just not enough to address their vulnerability context properly as their healthcare needs, context and realities differ extensively. Women belonging to multiple disadvantaged categories (i.e.- gender and ethnicity) face extended risk of disease and possess minimal access to healthcare resources and services. But there is a serious lack of studies that investigate the healthcare needs of women, taking into account the multiple aspects of their intersectional identity that contribute in shaping their healthcare-seeking

behavior, healthcare needs and accessibility. Thus, adopting an intersectional framework to assess the healthcare seeking behavior of rural ethnic women will allow this study to initiate a discussion and an analysis of diverse inequality as well as the existing power imbalances that somewhat restrict the healthcare access to rural ethnic women in Bangladesh. Moreover, this study will take into account the power imbalance in the family and community level that limits women's access to healthcare and shapes their health-seeking behavior.

Existing studies have revealed that the health-seeking practices of rural ethnic women in Bangladesh are influenced by a complex interplay of demographic, socio-cultural, financial, community related, health-related, knowledge and awareness related and access to healthcare services factors. The demographic characteristics of rural ethnic women, such as their age, gender, ethnicity, education level, income, and occupation, play a significant role in determining their health-seeking behaviors. When multiple factors of vulnerability from the demographic characteristics come together and form an intersectional identity, the severity of disadvantage exponentially increases. Socio-cultural factors, such as cultural norms, beliefs, and attitudes towards health and illness, and reliance on traditional healers also influence the health-seeking behaviors of rural ethnic women in Bangladesh. Health-related factors, such as women's health status, health behaviors, health beliefs, and knowledge

about health and illness, also play a significant role in their health-seeking practices. Access to healthcare services is also a critical factor that influences the health-seeking practices of rural ethnic women in Bangladesh. Affordability, availability, approachability, behavior of the patients and the doctor and utilization of health services determine the access to healthcare for the rural ethnic women (Akter et al., 2020; Kumar & Singha, 2019; Rahman et al., 2012). Women who live in areas with limited access to quality healthcare services may be less likely to seek care, as they may not have access to the services they need.

The conceptual model of this study, as shown in Fig. 1, suggests that ethnicity, gender and geographic location intersect with each other and form an intersecting identity of rural ethnic women. This intersectional identity of rural ethnic women then determines their health behavior, as well as their access to and utilization of formal healthcare services. In parallel to the intersectional identity factors, social determinants of health such as access to resources, gravity of institutional and social support, knowledge and health literacy, health beliefs and need perceptions and cultural norms also play a significant role in determining the health-seeking behavior of a community. The social determinants of health and the intersectional identity factors, both influence each other in a way that, marginalized intersectional identity of a person, result in poor access and healthcare seeking behavior. And the

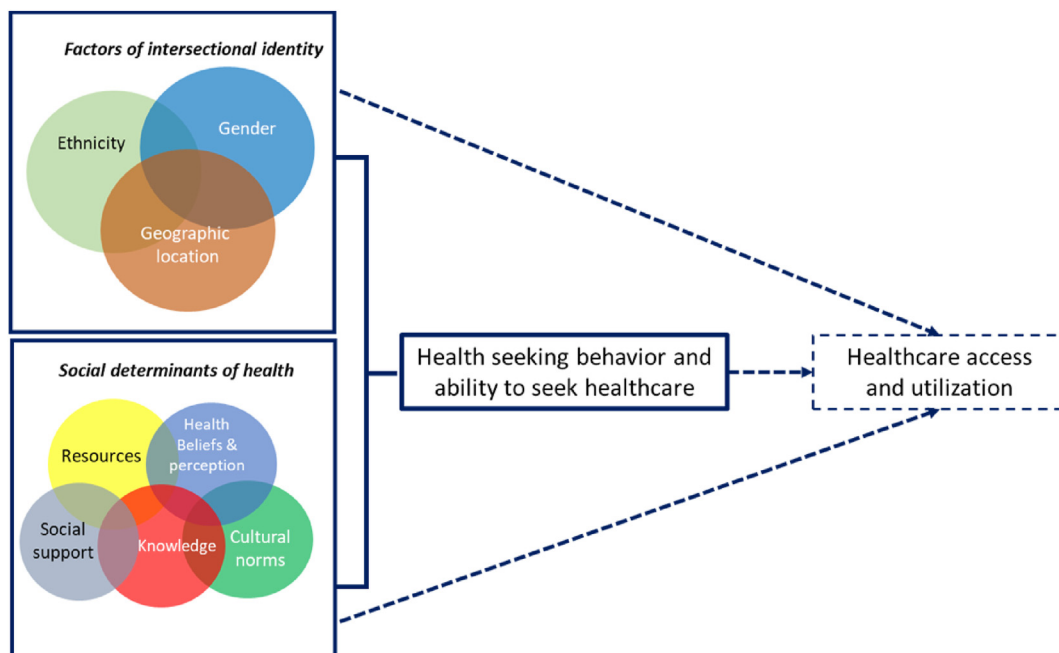


Fig. 1. Conceptual model of the study. Source: Authors

complex interplay of these factors results in the ultimate healthcare practice and healthcare utilization of the rural ethnic women.

Ethnic minorities, globally enjoy poor access to resources and education (Botticello & Olufunmilyo West, 2022; Olarewaju & Olarewaju, 2020; APA, 2017). Moreover, their health-seeking practices are largely influenced by traditional beliefs, cultural norms, and supernatural forces (Thummapol et al., 2018). Existing studies on ethnic communities' healthcare have revealed that, intersection of gender and ethnic identity, along with disadvantaged locational factors result in poor accessibility to healthcare services (Habib et al., 2021; Thummapol et al., 2018). For instance, Habib et al. (2021) have revealed that rural women in Pakistan face several obstacles related to geographical location in accessing healthcare including negative attitudes towards independent travel, and lengthy travel times. Similar is proposed by Thummapol et al. (2018) as they have found transportation challenges due to the rural and mountainous geography to be a major barrier to healthcare access for indigenous women living in rural Thailand.

In addition, the level of knowledge and education attainment, in ethnic communities, have been found to have positively associated with healthcare awareness and health-seeking (Badolato et al., 2022; Kumar Sarkar & Singha, 2019). Some other studies have revealed the positive relation between the level of social support and the healthcare utilization of ethnic minorities (Dahlan et al., 2019; Thummapol et al., 2018). In each interrelations between healthcare and ethnicity, gender comes into play to put ethnic women in a disadvantaged position in health-seeking (Dahlan et al., 2019; Thummapol et al., 2018; Habib et al., 2021; Kumar Sarkar & Singha, 2019; Tarafder & Sultan, 2014). Thus, intersectional identity factors have close relation with social-determinants of health as ethnic minorities in general enjoy poor access to healthcare resources and along with other socio-economic variables that limit their access to healthcare, and limits their ability to recognize their healthcare needs.

2.3. Healthcare decision making and mobility

Field investigation of this study has revealed a strong correlation between the ethnicity, gender and healthcare decision-making of the respondents. During the interviews and FGD sessions, it was found that the mobility of the Santal women is very low, which hinders and delays their health-care seeking. Also, Santal women are reliant on their older or male family members for going to the

healthcare facilities which are at a distant location. Santals have a patriarchal social structure in which the male members dominate the community affairs and decision making. Santal women, even though make significant contributions to the family income, end up enjoying little autonomy in the decision-making (Uddin & Arefin, 2007). In this context, one respondent of this study has reported-

“I have never visited anywhere outside this village for healthcare, let alone traveling. Women of my village rarely go outside the locality for healthcare as we have healthcare options (informal) available.” (In-depth interviews with SWL-1 on December 12, 2021).

The previous studies also agree on ethnic women's poor participation in health-related decision making and their poor mobility in shaping their health-seeking behavior as well.

Existing scholarly works provide rich evidence to argue that ethnic women in general enjoy limited control and power over their health-related decision making as gender, age and ethnicity play a significant role in making decisions in households regarding health matters and treatment-seeking (Rahman et al., 2012). Tarafder and Sultan (2014) in their study on the reproductive health beliefs of rural indigenous women of Bangladesh have found that gender inequality and power differences in the community level contribute to women having limited control over their reproductive health as women in rural Bangladesh are obliged to obey their in-laws and elderly women, in the birth giving and delivery process. The influence of social and familial beliefs on women's reproductive care is channeled through elders, in-laws, and traditional healers, which can have life-threatening consequences for both the women and their unborn children (Tarafder & Sultan, 2014).

Drawing evidence from the adolescent girls of CHT, Rahman et al. (2012) have argued that the same as Tarafder and Sultan (2014) as they have revealed that healthcare seeking of the adolescent girls of the ethnic communities living in the CHT is completely dependent upon the decisions of senior family members (Rahman et al., 2012). Kabir et al. (2019) has found the same as they have found that the decision to seek care in the extremely poor household residing in the CHT is usually made by the household head, often a working-age male. Women, children, and elderly members are more likely to seek care from informal healthcare providers. (Kabir et al., 2019). In addition, traditional beliefs surrounding postpartum and pregnancy, linked to fears of malicious spirits, strong belief in the traditional healers, and influence of in-laws and

elders restrict women's movement and a number of other activities. (Tarafder & Sultan, 2014). Such cultural norms have historically been used to exercise power over women and resulted in their disadvantaged status in the family and community.

In addition, many ethnic communities in Bangladesh live in remote and isolated areas, where access to health care is limited. The lack of transportation and the long distances to health care facilities can result in a delay in seeking treatment. Studies on the ethnic people living in the Chittagong Hill Tracts have identified the impassable hilly roads to be a major barrier for the ethnic people in accessing healthcare (Akter et al., 2020; Islam & Odland, 2011; Kabir et al., 2019; Rahman et al., 2012). Also, poor transportation is a common barrier to the utilization of professional care service in rural Bangladesh (Story et al., 2012; Uddin et al., 2013). The poor mobility of Santal women, however, can be attributed to different causes than what was found in the existing studies.

In opposition to most of the previous studies on the healthcare of ethnic people, geographical location is not a major health-seeking barrier for Santal women because most of them reside in the northern part of the country which is mostly plain land and the roads and transportation of the study area was well developed. Thus, the respondents of this study have shared different responses than that of the other studies on their poor mobility. One respondent has asserted-

“We live 4 km away from the town where most of the hospitals are. Since we have good roads and transportation is available, we can easily visit there. But those who cannot afford the transportation costs suffer a lot.” (In-depth interviews with SWRH-4 on December 12, 2021).

Findings of this study are in disagreement with another study by Mannan (2013), in which he has argued that physical accessibility is not a barrier to healthcare access in rural Bangladesh anymore because of the decentralization of the healthcare service delivery system in Bangladesh. Field investigation suggests that his claim is true in case of Santal men and non-ethnic women but not for the Santal women. Findings of this study make it evident that Santal women have poorer access to transportation and mobility than that of Santal men and non-ethnic women due to the unequal power distribution in the family and the society, which hinder their physical access to healthcare, even to the decentralized local level public healthcare facilities. One respondent of this study has expressed that-

“Many of the Santal men have bi-cycles which they can use to visit hospitals. But that is not the case for us women. We often do not have enough money to pay for the van fare and it is difficult to walk to the hospital when ill.” (In-depth interviews with SWRH-11 on December 12, 2021).

In addition to this, some existing studies have found that beliefs and cultural norms play a significant role in restricting the movement of women during pregnancy and postpartum period, with women staying indoors for 40 days after giving birth (Tarafder & Sultan, 2014). This practice is often followed without understanding the rationale behind it and is advised by elderly women and mothers-in-law. Additionally, there is a belief that women become purified only after 40 days and are secluded from the family, not allowed to cook and participate in religious practices until then. This is a common practice for both ethnic and non-ethnic communities living in rural Bangladesh. This practice limits women's mobility and free movement, discouraging them to stay at home. The field investigation of the present study suggests similar findings as similar practice has been observed among Santal women.

2.4. Financial solvency and healthcare access

Globally, women in general enjoy little control over wider financial system as well as their personal finance (Haider et al., 2018). This poor financial control is reflected on their limited affordability to healthcare. Affordability, along with availability and accessibility of healthcare has been identified as an important determinant of healthcare-seeking of the ethnic people of Bangladesh as well (Kumar Sarkar & Singha, 2019; Rahman et al., 2012). A study by Molla and Chi (2017) suggests that most of the people of Bangladesh rely on out-of-pocket payments for their healthcare expenses. The Santals and other ethnic communities are no exception to this. Relying heavily on household income results in inequitable healthcare access and the financial burden of healthcare affect the living standards of the people. In addition to the above-mentioned studies, Akter et al. (2020) has argued that concerns over healthcare costs and unofficial costs in the so-called free healthcare facilities are keeping the ethnic women of Chittagong Hill Tracts (CHT) from seeking quality healthcare from private healthcare facilities in the country. The empirical data of the present study supports the arguments made in the previously existed literature.

Field investigation of this study reveals that high cost of medical treatment and transportation, as well

as other associated costs, often discourage ethnic women to seek medical care. One respondent has expressed that

“I used to go to the missionary hospital earlier. But they have increased their fees to 150 BDT from last year We have nothing to do even if it angers us greatly. Healthcare is a matter of money. Everything else is less important.” (In-depth interviews with SWL-7 on December 14, 2021).

As reported by this respondent, the extremely poor segment of the population is less likely to seek formal healthcare. This finding is much similar to what Kabir et al. (2019) have found. According to their study, extreme poverty leads a population to rely more on informal care providers and self-medication (Kabir et al., 2019). Thus, financial affordability plays a major role in shaping health-seeking behavior of ethnic women pushing them to affordable informal healthcare services. Adding to this, field investigation of this study also suggests that financial insolvency of Santal women have made them more vulnerable and weakened their position in their health-related decision making. One of the primary effects of this can be seen in the decreased food intake and poor allocation of money on healthcare of Santal women.

One respondent has reported-

“I gave birth to a cesarean baby. My family were not ready for the cesar in the beginning but then the doctors had to convince my husband and mother-in-law explaining the possible harm my child and I might go through in a normal delivery.” (In-depth interviews with SWL-6 on December 12, 2021).

Yet another respondent has added

“I cannot make my healthcare seeking decision alone. I need my husband to accompany me to the hospital. I also need his assistance in the healthcare expenses.” (In-depth interviews with SWRH-3 on November 2, 2021).

Similar results are found in the existing studies as Story et al. (2012) have found lack of money to be a common barrier to the utilization of professional delivery care for rural women. Moreover, in a study by Rahman et al. (2021) 85% of respondents have reported to delay seeking treatment due to poverty. Difficulties in mobilizing funds for medical treatment forces the ethnic communities to use their savings for daily expenses resulting in compromise in daily food consumption, children's expenses, and other important expenditures, hindering the potential for improving their lives and livelihoods. As a long-term consequence of decreasing food

consumption, household's health of the ethnic people deteriorates putting them at risk of illness (Kabir et al., 2019).

2.5. Healthcare perception and need recognition

Ethnic women, in general, have a negative perception about the formal healthcare system of the country. Traditional beliefs and misconceptions about reproductive health are prevalent in rural Bangladesh due to lack of education. These beliefs are reinforced by poverty and poor social and familial infrastructure (Tarafder & Sultan, 2014). Because of their superstitions and misconceptions about modern healthcare, rural ethnic women are often skeptical about modern treatment. One study by Story et al. (2012) have found that perceived danger of childbirth is common barriers to the utilization of professional delivery care in rural Bangladesh. Another study by Akter et al. (2020) have asserted that fears related to medical intervention such as C-section is demotivating Bangladeshi ethnic women to undergo modern treatment during their pregnancy and after giving birth.

The field investigation of this study has exposed that Santal women rarely recognize their healthcare needs and their healthcare perception is often improper. Recognizing healthcare needs is a prerequisite for healthcare seeking. This negligence in need recognition and inappropriate health perception is a result of a combination of factors including financial affordability, lack of education and awareness, poor healthcare literacy, lack of information, health perception, and previous encounter with health providers. These factors, in the first place, determine whether the Santal women will consider taking treatment for a health issue or they will ignore their healthcare needs.

One female respondent interviewed has asserted that she thinks modern medicines and healthcare are useless and vile, as according to her, they create more health problems than they heal. In her own words-

“Going to a doctor causes more illness than not going. Doctors, by giving the patients so many medicines to his patients, harm the patients' help ... I think traditional healthcare is more efficient than modern treatment.” (In-depth interviews with SWL-2 on December 14, 2021).

Another respondent has added that-

“I have two sons, both of them were born at home. I was absolutely alright in both of my delivery cases without any formal care. I don't know why all of a

sudden pregnant women in our community are seeking medical care. One of the reasons may be the increase of hospitals in our area in recent times.” (In-depth interviews with SWRH-1 on November 02, 2021).

In addition to the above argument, the quality of available health services and behavior of health providers also play a noteworthy role in shaping the healthcare seeking behavior of the ethnic women. Evidence from the existing studies suggest that perceptions of the quality and manner of treatment and communication can override costs when it comes to provider-preference (Rahman et al., 2012). Moreover, Uddin et al. (2013) have revealed that the type of illness and the perceived causes of illness are important factors in determining the choice of healthcare provider in Bangladesh. In addition, Akter et al. (2020) have argued that the maltreatment by the hospital staff demotivates the ethnic women to access facility delivery services.

2.6. Cultural norms, myths and traditional healthcare practices

Traditional healthcare practices and cultural norms play an important role in the health-seeking behavior of indigenous people in Bangladesh (Rahman et al., 2012). To meet their healthcare needs, Santal women rely on traditional healthcare practices, such as the use of traditional healers, herbal remedies, and spiritual practices. This dependence on traditional healthcare practices can be attributed to a lack of access to formal health care services and the cultural acceptability of these practices. Religious beliefs, rituals and traditional healers play a key role in the care-seeking process of ethnic women (Kabir et al., 2019; Rahman et al., 2012, 2021). In addition, Ali et al. (2016) have identified traditional beliefs, perceptions, myths and superstitions about the sickness to be some additional factors to influence health-seeking behavior of rural ethnic women in Bangladesh (Ali et al., 2016). The abovementioned factors along with their socio-cultural norms make these practices more acceptable and trusted by the community. This trust in traditional healthcare practices motivates Santal women to make earlier and more frequent health-seeking compared to seeking care from formal health care services.

Existing studies provide strong evidence on ethnic women's reliance on traditional healers for health-care. Tribal people are heavily reliant on the *baddya*, *dakhtars* (local healthcare providers who lack any formal medical training), drug-sellers, and

homeopathic practitioners for treatment (Rahman et al., 2012, 2021; Tarafder & Sultan, 2014; Uddin et al., 2013). This preference over informal and traditional healer is motivated by the low healthcare costs, possibility of delayed payment, ease of access and consistent availability of healthcare services and the strong faith of the ethnic people on the ability of the traditional healers who belong to the same community as them (Tarafder & Sultan, 2014).

The field investigation of the present study has revealed that Santal women believe in the necessity of working hard during pregnancy in order to give birth to a healthy child. Health is a natural state to them and the Santals perceive illness as an unnatural state which is caused by supernatural forces. They rely on indigenous methods and *kabiraj* to fight with such supernatural forces sometimes. *Kabiraj* or *baddya* had historically played a crucial role in the treatment of the health issues of the Santals. It was widely believed by the Santals that these *baddya* can seek the blessing of their ancestors and other supernatural forces to cure their illness (Kumar Sarkar & Singha, 2019; Tarafder & Sultan, 2014). In addition, Rahman et al. (2012) have found the use of modern health services among adolescent girls to be very low, with the *baddya* and *homeopaths* being the main source of treatment for menstrual complications. Despite the high prevalence of traditional healthcare practices among ethnic women as captured in the existing literature, the present study has identified a significant decrease in the traditional healthcare practices in recent years.

In this context, one respondent of this study has asserted-

“... People now-a-days prefer to go to the allopaths and nearby clinics more than *baddya* and *kabiraj*. Traditional healers have been very hard to spot in our locality for a while now. Maybe it is due to the availability of alternative methods and health providers.” (In-depth interviews with SWRH-12 on 12 December 2021).

Another respondent has added-“We only go to *baddya* when someone behaves like crazy and unstable. Homeopathic and allopathic treatments available here cannot cure madness, but the blessings of our ancestors' spirit can.” (In-depth interviews with SWRH-5 on December 14, 2021).

In addition to this, some other studies have identified language barrier to be a significant factor for the indigenous women to rely on traditional healthcare practices instead of formal medications (Islam & Odland, 2011). Traditional healers provide health services in the local language, which helps to bridge the language barriers that often discourage

indigenous people from seeking care. Most of the ethnic people, however, know the Bengali language along with their mother tongue. Thus, language barrier is less likely to be a barrier in health-seeking. But, as some ethnic women feel shy and could not explain their problems properly to the doctor, this still remains an issue (Islam & Odland, 2011).

Even though the respondents of this study have reported to shift their preference of health-seeking from traditional healers, many of the study respondents still rely on their traditional indigenous knowledge on natural medicine and preventive care.

One respondent has asserted

“I have learned herbal treatment from my grandmother and use it to help myself along with my community members. This ancient knowledge is effective and low cost unlike most of the modern medicines.” (In-depth interviews with SWL-11 on December 12, 2021).

In addition to the findings of the present study, existing studies have argued that traditional healers are preferred by the rural ethnic women for their reproductive health care because they are thought to be a one-stop solution for their reproductive health needs (Tarafder & Sultan, 2014). Moreover, 95% of the study respondents of Tarafder and Sultan (2014), who were rural indigenous women, have reported to not prefer to consult male doctors due to cultural and socio-cultural values (Tarafder & Sultan, 2014). However, findings of the present study are not in agreement with the findings of Tarafder and Sultan (2014). Majority of the respondents of the present study have reported their discomfort to see a male doctor. In this context, one respondent has expressed-

“.... I don't feel comfortable to see a male doctor for gynecological problems. But there is no female doctors in our village so I have no choice than going to the male doctors” (In-depth interviews with SWL-13 on 12 December 2021).

Another respondent has added-

“I do not face any obstacles from my husband or family to see a male doctor. However, it is not always liked by the elderly members of our community. The quality of treatment, behavior of the doctor and the fees are the most important factors in making the choice. Also, female doctors are not always available and waiting for them can delay treatment.” (In-depth interviews with SWL-7 on December 12, 2021).

While traditional healers and informal healthcare practitioners offer benefits in terms of accessibility,

affordability, and cultural acceptability, they lack necessary knowledge and skills to provide safe and effective treatments to their communities. Kumar Sarkar and Singha (2019) in their study have found that, majority of the Santal respondents of their study have reported trust in the effectiveness of modern medicines, given their quick healing power. However, in practice, the majority of the Santal families rely on other traditional treatment methods on the initial stage of their sickness, such as homeopathy and herbal treatment. Furthermore, Rahman et al. (2012) in their study have argued that the use of modern health services among the adolescent girls was very low, with the *baddya* and *homeopaths* being the main source of treatment for menstrual complications. Adolescent girls are required to be accompanied by a male relative to the health facilities, which hindered their healthcare accessibility even more. (Rahman et al., 2012).

2.7. Education, awareness and health literacy

Education is identified as a key determinant of health-seeking behavior of the ethnic communities in Bangladesh. Studies have revealed that education attainment is positively correlated to health-seeking behavior and healthcare accessibility (Kumar & Singha, 2019; Rahman et al., 2012). However, the cost of education and healthcare significantly contribute to increase human poverty, worsening healthcare accessibility of a community (Ahmed, 2014). In addition, knowledge about the disease and available healthcare is inadequate among the ethnic women (Akter et al., 2020). However, the field investigation of the present study has found otherwise. In the case of rural ethnic women, their intersectional identity comes into play and influences other factors relating to their health behavior.

The field investigation of this study has revealed that institutional education attainment has mixed effects over the health-seeking behavior of the Santal women. For the Santal women, education has little significance on their healthcare accessibility and health-seeking behavior. Both educated and uneducated Santal women of this study have reported similar kinds of health behavior and health-seeking experiences during the FGD sessions of this study.

One respondent has reported-

“..... We Santals are less likely to get ill and seek healthcare. We visit a doctor only when the illness is intense.” (Focus Group Discussion on December 14, 2021).

Another respondent has reported-

“Education doesn't bring much change to a Santal woman's life For many of us, healthcare seeking is highly dominated by our in-laws and poverty. Those who have the money, get the better treatment. Not those who have better education” (Focus Group Discussion on December 14, 2021).

This finding of the study significantly differs from the earlier studies as the earlier studies have established a positive correlation between education attainment and the health-seeking behavior of ethnic women. Kumar & Singha, 2019 and Rahman et al. (2012) have reported that ethnic women with higher levels of education and literacy are more likely to seek out and use formal healthcare services. This may be due to a greater understanding of the importance of preventative care and the availability of modern healthcare services, as well as the ability to navigate and understand the healthcare system. Similar argument was made by Rahman et al. (2021) as 15% of their study respondents have delayed seeking treatment with lack of knowledge being the main causes of delay.

In addition to the earlier studies, Uddin et al. (2013) have found that the popularity of self-care or home remedy among the ethnic communities in Bangladesh reflects their increased health literacy along with poverty. However, the field investigation of the present study suggests that the popularity of home remedy is resulting from poor accessibility and affordability of formal healthcare, and not from increased health literacy. And in most cases, self-care or home remedy practice of Santal women does not follow any scientific methods. Rather, at home, they are likely to adopt informal and traditional care practices. In this regard, when asked about pregnancy and child delivery, one respondent has expressed-

“We usually perform child delivery ourselves with or without the help of our village dhaii. It never caused any problems in the past. However, in recent times, many Santal girls are preferring cesarean delivery over normal delivery.” (In-depth interviews with SWRH-6 on November 02, 2021).

Moreover, the utilization of quality of health information has a significant impact over the health seeking behavior of ethnic women living in the rural Bangladesh where availability of health information is scarce. In addition, the ethnic communities in Bangladesh often have low levels of awareness about their health issues and a limited understanding of the benefits of formal health care

services. This lack of awareness result in a low utilization of health care services and a delay in seeking treatment (Rahman et al., 2021). In the field investigation, it was found that sometimes, even though the health information are visible and accessible to the Santal women, they could rarely utilize it due to their lack of education and intersectional identity. One Santal woman has reported that-

“..... I cannot go to the Nachol medical (the Upazila Health Complex of Nachol), without my husband or son. Without them I cannot understand the doctor's instructions.” (In-depth interviews with SWRH-3 on 02 November 2021).

2.8. Extent of social support in health-seeking

This study has explored the extent of social support Santal women enjoy in accessing healthcare. It is found in the field investigation that, community level organizations of Santal have a narrow focus on credit provision, skill development training and income generating activities. Some other activities of the community organizations revolve around ensuring social protection and cash benefits to the vulnerable members of the community. However, it does not play any direct or indirect role in the healthcare accessibility and health-seeking behavior of the Santal women. And it does not provide any kind of healthcare support to the community as well. Lack of knowledge and health awareness has been identified as the underlying cause behind it.

The field investigation reveals that the gravity of social support is another significant determinant of the health-seeking behavior of Santal women. Villages in which Santal women have strong community organization are more likely to seek healthcare and good health status than that of other villages with weak communities. The role of community in shaping health behavior is limited in caregiving activities during an episode of illness of a community member. They rarely provide financial support and good consultation due to their poverty and poor understanding about health issues.

Local organizations like co-operative societies, microcredit and training organizations of Santals are found to provides loans and skill development trainings to the Santal women and encourage them to save money. However, loans are given in productive and income generating areas only, and not in healthcare. Adding to this, community leaders of Santal pose a misconception and faulty perception about the healthcare needs of the community members.

The following statement is a clear indication of their failure to recognize and understand healthcare needs and its importance.

“...Santals in general have a very strong immunity. So, they do not need much medical assistance. During COVID-19 outbreak, most of the Santals did not wear a mask and none of them got affected by the virus.” (In-depth interviews with KII-3 on 2 November 2021).

Another respondent has asserted that-

“... My husband and I had to take a loan of 50,000 Taka from my relatives, neighbors and NGOs during my child delivery as I had pregnancy complications. Without borrowing this money, I could not afford healthcare.” (In-depth interviews with SWL-3 on December 12, 2021).

The respondents of this study have expressed their preference towards borrowing from relatives and friends due to its easy accessibility and zero interest. Although borrowing from NGOs and other microfinance organizations have been reported, the field investigation has revealed that micro finance institutions that were active in the study area have no scheme for healthcare loans. The loan recipients have to hide their original intent to have credit from the formal institutions. This finding is in partial disagreement with Kabir et al. (2019) as they have found that Caritas provides support to extremely poor patients through its social safety-net program with a BDT 1000 (US\$ 12) primary treatment cost.

Another respondent has expressed her thoughts on community support as-

“As our village is very small, we take care of each other when ill and accompany them to the hospital if needed. I have learned from my grandmother to use herbal medicines. With my knowledge I can reduce the intensity of diseases.” (In-depth interviews with SWRH-4 on November 2, 2021).

The gravity of social and institutional support is different for non-ethnic women and Santal men because of their better access to micro-credit and financial institutions. On top of that, in a patriarchal social setting, Santal men enjoy leverage and greater autonomy in healthcare decision making and respond quickly to their healthcare needs. On female respondent has expressed her views on the greater access to healthcare of Santal men as follows-

“Healthcare needs of both male-female, child-elderly members of our family are given equal importance. Treatment is sought based on the intensity of the treatment. But as men are more outgoing, expressive and hold membership of somity, going to the doctor is

easier for them” (In-depth interviews with SWRH-4 on November 2, 2021).

Evidence from both the field investigation and existing literature are in harmony with the fact that community practices and peer influence along with poor financial support motivates Santals women to choose informal and traditional healers, homeopaths, and untrained village quacks. There is poor evidence in the existing literature on the role of community over the health care seeking of ethnic women. However, Story et al. (2012) have revealed that a husband's social support and social norms are associated with his wife's use of delivery care and male involvement in pregnancy and childbirth and good spousal communication are associated with increased use of maternal health services. Another study by Rahman et al. (2021) exposed that many older indigenous women suffer from cervical cancer and fistula, but face social barriers to seeking outside medical help.

3. Conclusion

To improve the health-seeking behaviors of rural ethnic women in Bangladesh, it is necessary to address the underlying social and economic determinants of health as well as their intersectional identity which exposed them to grave healthcare threats. This includes improving access to education and health information, increasing financial resources for these communities, and providing social support to help women make informed decisions about their health. Additionally, addressing cultural barriers and promoting culturally-sensitive healthcare services can help to improve health outcomes among rural ethnic women in Bangladesh. In conclusion, understanding the health-seeking behaviors of rural ethnic women in Bangladesh is essential for addressing health disparities and improving overall health outcomes in these communities. Addressing the social and economic determinants of health and promoting culturally-sensitive healthcare services can help to improve health-seeking behaviors and health outcomes among rural ethnic women in Bangladesh.

Conflict of interest

There is no conflict of interest.

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