# Health Seeking Behaviour of Rural and Urban Santals of Bankura District, West Bengal

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*KEYWORDS:* Socio-economic status. Choice of treatment. Santals. Bankura district. Rural-urban residence.

*ABSTRACT:* Present cross-sectional study aimed to explore the health seeking behaviour and its relationship with socio-economic status of the Santals residing in rural and urban areas of West Bengal. Demographic, socio-economic and health seeking behaviour data of 340 adult Santals of either sex were collected using pre-tested questionnaire/schedule. Descriptive statistics and multivariate logistic regression were used to analyze the data. Results show disparities exist in socio-economic status of rural and urban people. Allopath treatment is predominant in both rural and urban areas but rural people prefer to visit Government health centre for cheap/free treatment whereas urban people choose to visit private allopath practitioners because of faith/effectiveness. Few individuals have reliance in treatment of homeopath practitioners and traditional healer. Occupation and economic status show significant association with health seeking behaviour of this group. The finding depicted health seeking behavior of an indigenous group where occupation and economic status play crucial role.

## INTRODUCTION

Comparatively poorer health status and health care utilization of the scheduled tribes than general population were of great concern in India (Government of India, 2017), as it hampers the goal of the nation to provide universal access to good quality health care service with minimal cost to ensure better health and well being of every citizen (National Health Policy, 2017). It is documented that, health need of scheduled tribe people is different from the rest and they require special provision as well as additional care to diminish the gap in health status and health care utilization (Kumar *et al.*, 2020). Again, it is required to know the health seeking behaviour as it determine largely the health care utilization (Shaikh and Hatcher, 2005) and the health status. Health seeking behaviour has been

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defined as any action undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy (Ward *et al.,* '97). Generally, the determinants of health seeking behaviour had been discussed with reference to specific communicable diseases like malaria (Mazumdar, 2011), tuberculosis (Samal, 2016); and non-communicable diseases like cancer (Rath *et al.*, 2018), diabetes (Abidin *et al.*, 2014), where socio-economic status were reported to play a key role. Other scholars studied health seeking behaviour in terms of health care utilization in Government as well as in private sectors and reported caste, education and economic status as determinant factors for choice between Government or private health care (Rout *et al.*, 2019); along with factors like severity of diseases, duration of hospitalization (Chatterjee *et al.*, 2019) and area of living (Oladipo, 2014). Few studies discuss health seeking behaviour of a specific community and reported demographic, socio-economic status (Adam and Aigbokhaode, 2018; Musoke *et al.*, 2014), medical pluralism (Inoue and Umezaki, 2016), relationship with family and peer (Eley *et al.*, 2019), ethnicity and traditional health beliefs (Roy *et al.*, 2004) were important factors.

It is generally attributed that diverse scheduled tribe population have their own traditional system of medicine and own care seeking behaviour (Rahman *et al*., 2012). However, the attentions, which are paying to popularise the traditional system of medicine is targeted towards mass of India, and the traditional medical knowledge of several indigenous population were largely ignored (Sen and Chakraborty, 2017). Few scholars (Mohapatra, 2019; Raushan and Acharya, 2019; Gandhi *et al.*, 2017) documented traditional medicine, health belief and practices of different indigenous groups in India, but their health seeking behaviour with their changing socio-economic context was largely omitted. Some studies documented health seeking behaviour of scheduled tribe population but the studies were scanty and mostly scattered (Raushan and Acharya, 2019; Gandhi *et al.*, 2017). In view, the present study aimed to explore the health seeking behaviour of the Santals residing in rural and urban areas of West Bengal and to find out relationship of socio-economic status with health seeking behaviour of the studied population.

## MATERIALS & METHODS

### *Area and Population*

Present cross-sectional study was conducted among the Santals residing in rural and urban settlements of West Bengal. Data on the rural group was collected from four adjacent small villages under Barjora block of Bankura district, while Santals of Santragachi Press quarter area, under Howrah Municipal Corporation, was considered as the urban group. In the present study greater socio-economic heterogeneity in terms of education, occupation and income was observed between rural and urban groups but socio-economic homogeneity was observed within the group of same habitat. To seek Government health care services, the participants in rural area went to Primary health centre (PHC) at Chhandar or Beliatore bazaar and for critical cases they need to go to Bankura Sammilani Medical College. Available private health care services for them include allopath and homeopath doctors at Beliatore bazaar. On the other, urban participants occasionally availed nearby Government health centre and for any health crisis they move to Government or private hospitals at Kolkata. Private allopath, homeopath practitioners, pharmacists, and physiotherapist are easily available in this area.

Santals are the largest *scheduled tribe (ST)* community of West Bengal who are distributed in most of the districts and they are the third largest STs in India (Census of India, 2011). Santals has "Proto-Australoid" ethnic identity (Guha, '44), they originated from Santal Parganas of eastern India, settled agriculturalist by occupation, speak 'Santali' which belongs to the Mundari branch of the 'Austro-Asiatic' language family (Mukherjee, '62). They traditionally have their own medical system which includes medicine man who had knowledge regarding specific ailments/symptoms and its curative measures. Participants of both rural and urban settings have faith on their traditional medicine system, but urban people rarely avail it.

### *Sample Collection*

Complete enumeration of the household had been done for demographic and socio-economic data for both the group. Health seeking behaviour data

was collected from a total of 340 adult individuals (including 180 males and 160 females), who voluntarily agreed to participate in the study. To avoid inter-observer error one of the authors (BMD) was collected the entire data. The nature, objectives and importance of the study were explained to all of the study participants and written consent was obtained from the head of the household prior to data collection. The study was conducted following the guidelines of the Ethics Committee on Human Experimentation, Indian Statistical Institute. Socio-demographic data were collected through standard household questionnaire/ schedule, which include age, sex, place of birth, marital status, educational status, occupation for all the household members. Data on household assets, item-wise monthly household expenditure and other household characteristics were also collected. Later Wealth Index Score (WIS) was calculated for each household based on household characteristics and assets data following the standard procedure of National Family Health Survey 3 (IIPS & Macro International, 2007). Health seeking behaviour data were collected using a pre-tested questionnaire/ schedule, specially designed for the present purpose. The questionnaire/schedule was tested several times in different field areas (Das, 2015; Roy *et al.*, 2010) and modified accordingly before using it. Health seeking behaviour data includes beliefs, attitudes and practices regarding health care issues and health care utilization behaviour at times of participant's health crisis.

### *Classification of Data*

Age was categorized into 3 age cohorts i.e. 18-39 years, 40-59 years and 60 years and above; Place of living as rural and urban; Marital status was classified as married, unmarried and widowed/divorced/ separated; Educational level as non-literate, upto secondary and above secondary; Occupational types were categorized as manually active (cultivation/ daily wage/ labour) and sedentarily active (salaried/ household work/ business/ dependent/ unemployed); Economic status was classified as low ($\leq$ -0.821), medium (-0.822 to 0.898) and high ($\geq$ 0.899) on the basis of Wealth Index Score.

### *Statistical Analysis*

Descriptive statistics used to know the distribution of socio-demographic characteristics and health seeking behaviour by place of living and by sex. Binary multivariate logistic regression analyses have been used to examine the association between the choice of health care personnel and socio-demographic variables. Here, the choice of Government allopath, Private allopath and Homeopath & others health care personnel used as dichotomous dependent variables (Yes vs. No) and socio-demographic variables were considered as independent variables. All the independent variables were categorical as described earlier. For most of the categorical independent variable, the category with the highest frequency was considered as reference category and the association of other categories with the dependent variable were presented in terms of odds ratios (OR) and 95% confidence interval (CI) level. All statistical analyses have been done using SPSS software 16.0 (SPSS Inc., Chicago, IL, USA) and MS Excel 2010.

## RESULTS

TABLE 1

*Demographic and socio-economic characteristics of the studied Santals*

| Socio-demographic characteristics | Rural | | Urban | |
|---|---|---|---|---|
| | Males(N=93) % | Females (N=116) % | Males (N=87) % | Females(N=44) % |
| *Age-groups* | | | | |
| 18-39 years | 38.71 | 55.17 | 36.78 | 45.45 |
| 40-59 years | 39.78 | 28.45 | 51.72 | 54.55 |
| 60 years & above | 21.51 | 16.38 | 11.49 | – |
| *Marital status* | | | | |
| Married | 89.25 | 68.97 | 77.01 | 88.64 |
| Unmarried | 7.53 | 7.76 | 22.99 | 6.82 |
| Widowed/Divorced/Separated | 3.23 | 23.28 | – | 4.55 |

| | | | | |
|---|---|---|---|---|
| *Educational level* | | | | |
| Non-literate | 35.48 | 66.38 | – | 6.82 |
| Upto secondary | 59.14 | 29.31 | 18.39 | 61.36 |
| Above secondary | 5.38 | 4.31 | 81.61 | 31.82 |
| *Occupational types* | | | | |
| Manually active | 83.87 | 54.31 | – | – |
| Sedentarily active | 16.13 | 45.69 | 100.00 | 100.00 |
| *Economic status* (Wealth Index Score) | | | | |
| Low ($\leq$ - 0.821) | 53.76 | 53.45 | – | – |
| Medium (- 0.822 to 0.898) | 46.24 | 46.55 | 13.79 | 13.64 |
| High ($\geq$ 0.899) | – | – | 86.21 | 86.36 |

Table 1 shows the demographic and socio-economic characteristics of the studied Santals by place of living and sex. Out of total 209 rural participants, 44.50% were males and 55.50% were females; similarly out of 131 urban participants 66.41% were males and 33.59% were females. Higher percentage of rural participants belong to the age group of 18-39 years (38.71% males and 55.17% females), followed by 40-59 years (39.78% males and 28.45% females) and 60 years & above (21.51% males and 16.38% females). In case of urban participants, majority of them belong to the age group of 40-59 years (51.72% males and 54.55% females) and 18-39 years (36.78% males and 45.45% females). An overwhelming majority of participants were married in both rural (89.25% males and 68.97% females) and urban (77.01% males and 88.64% females) areas and rest of 20% individuals were either unmarried or widowed/divorced/separated. Majority of the rural individuals were non-literate (35.48% males and 66.38% females) and had education upto secondary (class I-X) (59.14% males and 29.31% females), while majority of urban individuals had education above secondary (class X) (81.61% males and 31.82% females) and upto secondary (class I-X) level (18.61% males and 61.36% females). On the basis of occupational types, higher percentage of rural participants were engaged in manually active work (83.87% males and 54.31% females) and rest sedentarily active (16.13% males and 45.69% females), compared to cent percent sedentarily active (100.00% males and 100.00% females) urban participants. Economic status in terms of wealth index score of the Santals indicates that rural individuals belong to low (53.76% males and 53.45% females) and medium (46.24% males and 46.55% females) economic groups, while urban individuals belong to high (86.21% males and 86.36% females) and medium (13.79% males and 13.64% females) economic groups.

TABLE 2

*Nearby available health facilities reported by participants*

| Available Health facilities | | Rural | | Urban | |
|---|---|---|---|---|---|
| | | Males(N=93) | Females(N=116) | Males(N=87) | Females(N=44) |
| *Setup* | *Types of medicine* | % | % | % | % |
| Government | Allopath practitioner | 93.55 | 76.72 | 33.33 | 31.82 |
| Private | Allopath practitioner | 4.30 | 14.66 | 63.22 | 61.36 |
| | Homeopath practitioner | 1.08 | 6.90 | 1.15 | 6.82 |
| | Traditional Healer/Quack | – | 0.86 | 1.15 | – |
| | Pharmacist | – | – | 1.15 | – |
| | No answer | 1.08 | 0.86 | – | – |

Table 2 shows the nearby health facilities as reported by the participants. An overwhelming majority of rural participants reported that they have access to allopath practitioner (93.55% males and 76.72% females) at nearby Government health care units followed by allopath practitioner (4.30% males and 14.66% females), homeopath practitioner (1.08% males and 6.90% females) and traditional healer (only 0.86% females) in private setup. On the other, higher percentage of urban participants reported that they can have access to allopath practitioner (63.22% males and 61.36% females) in nearby private chambers, followed by allopath practitioner (33.33% males and 31.82% females) at nearby Government health care units, homeopath practitioner (1.15% males and 6.82% females), pharmacist (only 1.15%

males) and traditional healer (only 1.15% males) in private setup.

TABLE 3

*Choice of health personnel for treatment of ailments/symptoms/diseases and reasons behind their respective choices*

| Choice of health personnel & reasons | | Rural | Urban | | |
|---|---|---|---|---|---|
| | | Males(N=93) | Females(N=116) | Males(N=87) | Females(N=44) |
| Setup | Types of health personnel | % | % | % | % |
| Government | *Allopath practitioner* | *63.44* | *36.21* | *14.94* | *9.09* |
| | More severity* | – | 2.59 | 1.15 | – |
| | Faith/Effectiveness | 6.45 | 2.59 | – | 2.27 |
| | Nearest | 4.30 | 5.17 | 1.15 | 2.27 |
| | Cheap/Free treatment cost | 48.39 | 24.14 | 12.64 | 4.55 |
| | Initiate treatment Immediately | 2.15 | 1.72 | – | – |
| | Quick recovery | 2.15 | | – | – |
| Private | *Allopath practitioner* | ***11.83*** | ***22.41*** | ***63.22*** | ***79.55*** |
| | More severity* | 2.15 | – | 3.45 | 4.55 |
| | Faith/Effectiveness | 7.53 | 17.24 | 33.33 | 45.45 |
| | Nearest | – | 0.86 | 14.94 | 22.73 |
| | Advanced treatment | – | – | 4.60 | 4.55 |
| | Initiate treatment immediately | 1.08 | – | 3.45 | 2.27 |
| | Quick recovery | 1.08 | 4.31 | 3.45 | – |
| | *Homeopath practitioner* | ***8.60*** | ***25.86*** | ***8.05*** | ***9.09*** |
| | Less severity* | 1.08 | 4.30 | 4.60 | " |
| | Faith/Effectiveness | 2.15 | 11.21 | 3.45 | 6.82 |
| | Nearest | 4.30 | 6.90 | – | – |
| | Cheap treatment cost | 1.08 | 2.59 | – | – |
| | No Side Effect | – | 0.86 | – | 2.27 |
| | *Pharmacist* | ***3.23*** | ***3.45*** | ***12.64*** | ***2.27*** |
| | Less severity* | 2.15 | 2.59 | 6.89 | 2.27 |
| | Nearest | 1.08 | 0.86 | 5.75 | – |
| | *Traditional healer/Quack* | ***12.90*** | ***12.07*** | ***1.15*** | – |
| | Faith/Effectiveness | – | 0.86 | – | – |
| | Taking immediate care for treatment | 12.90 | 11.21 | 1.15 | – |

*Severity of ailment/disease as perceived by the study participants

Table 3 reveals the response regarding the choice of health personnel for treatment of ailments/ symptoms/diseases of the Santals and reasons behind their respective choices. Higher percentages of rural individuals prefer allopath doctors at Government hospital (63.44% males and 36.21% females), followed by allopath (private) practitioner (11.83% males and 22.41% females), homeopath practitioner (8.60% males and 25.86% females), traditional healers who practice ayurveda (12.90% males and 12.07% females) and pharmacist (3.23% males and 3.45% females) for the treatment of their ailments/diseases. While, an overwhelming majority of urban individuals go to private allopath practitioner (63.22% males and 79.55% females) during ailments/diseases, followed by allopath doctors at Government set up (14.94% males and 9.09% females), private homeopath practitioner (8.05% males and 9.09% females) and pharmacists (12.64% males and 2.27% females) for their treatment.

Besides, both rural and urban Santals reported cheap/free treatment cost (48.39% rural males and 24.14% rural females; 12.64% urban males and 4.55% urban females) was one of the major reasons for using Government hospital doctors during their illness. A fair percentage of rural individuals opted it for nearby availability (4.30% males and 5.17 % females) and their faith or effectiveness of treatment on aliments/ diseases (6.45% males and 2.59% females). Higher percentage of participants reported that they want to consult 'private allopath practitioner' during their illness because of their faith or effectiveness (7.53% rural males and 17.24% rural females; 33.33% urban males and 45.45% urban females), it was also easily available to nearby private chambers (only 0.86% rural females; 14.94% urban males and 22.73% urban females). Few other individuals reported that 'allopath' is the advanced treatment procedure (only 4.60% urban males and 4.55% urban females), generally used for more severe ailments/diseases (only 2.15% rural males; 3.45% urban males and 4.55% urban females) and when needs quick recovery (1.08% rural males and 4.31% rural females; 3.45% urban

males). Santals opted for homeopath practitioner as it seemed to be more effective (2.15% rural males and 11.21% rural females; 3.45% urban males and 6.82% urban females), available in nearest place (4.30% rural males and 6.90% rural females only) as well as for the ailments/diseases that seemed to be less severe (1.08% rural males and 4.30% rural females; 4.60% urban males only). A certain percentage of rural individuals reported that its cost of treatment was cheap (1.08% males and 2.59% females). Both the group of Santals chose pharmacist because of their perception about the severity (2.15% rural males and 2.59% rural females; 6.89% urban males and 2.27% urban females) of ailment/disease (which was less severe) and it was nearer (1.08% rural males and 0.86% rural females; 5.75% urban males only) to their home. While majority of the rural individuals opined that for taking immediate treatment and care they seek help from traditional healer/quack (12.90% males and 11.21% females) in the locality.

TABLE 4

*Results of binary multivariate logistic regression for the choice of Private and Government health care personnel with respect to different demographic and socio-economic characteristics of the Santals*

| Variables | Multivariate Logistic Regression Models | | |
|---|---|---|---|
| | Government Allopath Practitioner Odds Ratio (95% CI) | Private Allopath Practitioner Odds Ratio (95% CI) | Homeopath and Other Practitioner Odds Ratio (95% CI) |
| Place of living | | | |
| Rural | Ref. | Ref. | Ref. |
| Urban | 0.415 (0.094 – 1.824) | 2.445 (0.712 – 8.396) | 0.782 (0.222 – 2.753) |
| Age-groups | | | |
| 18-39 years | Ref. | Ref. | Ref. |
| 40-59 years | 0.953 (0.512 – 1.774) | 0.961 (0.477 – 1.934) | 1.032 (0.568 – 1.873) |
| 60 years and above | 1.789 (0.675 – 4.737) | 0.802 (0.273 – 2.355) | 0.617 (0.224 – 1.700) |
| Sex | | | |
| Male | Ref. | Ref. | Ref. |
| Female | 0.569 (0.298 – 1.087) | 1.640 (0.802 – 3.350) | 1.173 (0.632 – 2.180) |
| Marital status | | | |
| Married | Ref. | Ref. | Ref. |
| Unmarried | 0.572 (0.211 – 1.551) | 0.708 (0.267 – 1.877) | 2.216 (0.918 – 5.349) |
| Widowed/Divorced/Separated | 0.694 (0.253 – 1.905) | 0.883 (0.293 – 2.663) | 1.505 (0.591 – 3.836) |
| Educational status | | | |
| Non-literate | Ref. | Ref. | Ref. |
| Up to secondary | 1.776 (0.893 – 3.534) | 0.508 (0.209 – 1.236) | 0.756 (0.388 – 1.472) |
| Above secondary | 2.408 (0.702 – 8.260) | 0.538 (0.160 – 1.805) | 0.692 (0.223 – 2.153) |
| Occupational types | | | |
| Manually active | Ref. | Ref. | Ref. |
| Sedentarily active | 0.336** (0.153 – 0.735) | 3.368** (1.369 – 8.282) | 1.359 (0.635 – 2.910) |
| Economic status (Wealth Index Score) | | | |
| Low (d" - 0.821) | Ref. | Ref. | Ref. |
| Medium (- 0.822 to 0.898) | 0.504* (0.274 – 0.927) | 3.983** (1.716 – 9.244) | 0.870 (0.475 – 1.593) |
| High (e" 0.899) | 0.305 (0.063 – 1.484) | 8.364** (2.087 – 33.524) | 0.429 (0.110 – 1.674) |
| R Square (Nagelkerke) | 0.299 | 0.417 | 0.080 |
| Model correctly predicted | 73.8% | 77.1% | 72.9% |

* $p < 0.05$, ** $p < 0.01$; Ref.: reference category

Table 4 shows the results of binary multivariate logistic regression for the choice of private and Government health care personnel with respect to different demographic and socio-economic characteristics of the Santals (pooled data). In this analysis the binary variable 'choice of different health care personnel' was considered as the dependent variable and different demographic and socio-economic variables along with place of living were considered as independent variables. Here, three different logistic regression models were used to find out significant association between dependents and independent variables. In first model, results of multivariate logistic regression analysis show significant association of Government allopath practitioner with occupational types (sedentarily active, OR= 0.336, $p < 0.01$) and economic status in terms of wealth index score (medium, OR= 0.504, $p < 0.05$) of the study participants. However, in case of multivariate logistic regression model for private

allopath practitioner, among all independent variables only occupational types and economic status were found to be significantly associated with choice of private health care practioners. Individuals with 'Medium' (OR= 3.983, $p < 0.01$) and 'high' (OR= 8.364, $p < 0.01$) economic group were more likely to avail private allopath practitioner than their 'low' economic group counterparts. Participants who were engaged in sedentary occupation (OR=3.368, $p < 0.01$) were more likely to opt private allopath practitioner than participants who engaged in manual activity. In case of multivariate logistic regression model for homeopath and other practitioner, none of the socio-demographic variables were found to be significantly associated with choice of private health care personnel. R Square values and correctly prediction of models were higher in second multivariate enter model ($R^2 = 0.417$ and 77.1%) than other two models.

## DISCUSSION

Indigenous group like Santals traditionally rely on their own healing system but the effect of changing socio-economic circumstances as well as availability of modern treatment on their seek health behaviour is a less explored area. Thus, the present study tries to know health seeking behaviour and its relationship with socio-economic status of the Santals residing in rural and urban areas of West Bengal. There were extreme disparities between the groups in terms of educational, occupational and economic status. Available health facilities include allopath, homeopath treatment along with pharmacy, quack doctor but rarely the traditional healer. As a result, Santals of either group mostly reported to visit allopath treatment in health need, although rural people frequently visit nearby Government health centre mainly for cheap/ free cost of treatment while urban people visit private allopath practitioner mostly for faith/effectiveness in their treatment. The socio-economic condition in terms of occupation and economic status were significantly associated with their health seeking behaviour. The study indicates that this indigenous group were becoming habituated with allopath treatment where economic condition effects in choice between government and private.

Santals of both the area depends largely on allopath practitioners for treatment, but rural people visit largely at Government health centres while majority of urban people prefer private allopath practitioners followed by allopath practitioners at Government health centres. The finding is corroborative with other studies among rural (Kumar *et al.*, 2019) and urban peoples (Patil *et al.*, 2016) and the behaviour was similar between tribal and non-tribal population (Moosan *et al.*, 2019; Josh *et al.*, 2014). Studying national representative sample at two time points, Jana and Basu (2017) reported allopath treatment at private centre was dominant mode of treatment in India, but seeking care from Government health centre increases. It seems, availability of mode of treatment play a role in this behaviour of the study participants, as the nearest available health centre for rural people was Government health setup while for urban people it was private allopath practitioners. It was documented that number of Government health care units increases in recent decades and extend its facilities at rural and remote areas and also among urban poor (National Health Policy, 2017).

In the present study Santals of both the residential group preferred Government health care because of cheap/free treatment cost, which is corroborative with other studies among rural population of India (Chauhan *et al.*, 2015). Also, fair percentage of rural individuals opted it for nearby availability and their faith or effectiveness of treatment on aliments/diseases. However, larger percentage of urban people chooses private health care which is corroborative with trend among scheduled tribes of India (Raushan and Acharya, 2019). Urban study participants visit private practitioners because of their faith or effectiveness on doctors and their prescribed medicine and easy access. They also argued that the treatments were effective during severe ailments/ diseases and when needs quick recovery. This finding was in line with other studies, who reported urban people of higher educational and economic status seek private health care because of its quick service and effectiveness (Rout *et al.*, 2019; Levesque *et al.*, 2006).

Apart from Allopath practitioners, a good percentage of individuals, especially women visit private Homeopath practitioners. They reported Homeopath treatment was effective for minor ailments, cheap in cost and easily available. Comparatively higher

percentage of urban people also reported to bring medicine as per the suggestion of pharmacist in minor ailments/diseases. Rural people also visit traditional healer for treatment. Medical pluralism is prevalent in Indian health system, where Mazumdar and Gupta (2007) reported allopath treatment is first choice, failure of which leads to avail other mode of treatments and it was observed among indigenous population also (Albert *et al.*, 2015). However, Sheehan (2009) argued lack of availability, quality of care forced people to choose alternate health options. These findings were partly corroborative with the present study, where allopath treatment is the popular choice, but people also choose alternate treatment for minor ailments because of its cheap cost and easy availability. Results of multivariate logistic regression show that individuals with sedentary occupation were less likely and individuals with medium economic status were less likely to choose allopath treatment at Government sector whereas people with sedentary occupation, medium to high economic status were more likely to choose treatment from private allopath sector. Other studies (Li *et al.*, 2020; Ahmed *et al.*, 2005) in developing countries also reported economic status play crucial role in determining health seeking behavior, thus partially corroborative with the present study.

## CONCLUSION

The study was an attempt to explore health seeking behaviour and its relationship with socio-economic status of a single ethnic group living in two distinctive areas with socio-economic disparities between them and reported similarities in faith mostly regarding mode of treatment but distinctiveness in availing facilities mostly due to socio-economic diversities. The study limits itself with the information collected from the participants only and omitted views of health practitioners, who may had a better knowledge regarding the matter. Again, the study based largely on quantitative data and detail insight of the participants was beyond the ability of the study. Still, the study gives a trend regarding health seeking behaviour of an indigenous population, which will be helpful in future for policy formulation.

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