

## Factors Influencing Health-Seeking Behaviour of Tribal Women of Rüzazho Village, Nagaland: A Qualitative Study

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### Abstract

This paper delves into the health-seeking behaviour of tribal women of Rüzazho village in the Phek district of Nagaland. In the course of a three-month study involving 89 women aged 23 to 70, selected via snowball sampling, data were collected using a structured interview schedule. The schedule covered demographic information, recent illnesses suffered, and treatment preferences. Contrary to previous research, this study found that demographic factors like age, education, and income did not significantly influence health-seeking behaviour. Instead, the locally used classification of illness and identifying its type on the basis of one's perception, experience, interpretation, and severity played crucial roles in shaping this behaviour.

*Keywords:* Health-seeking behaviour, tribal women, illness causation, decision-making, social and cultural.

### INTRODUCTION

Throughout human history, health and disease have always been major concerns for human beings. It has led every human society, regardless of its level of development, to form its own conception about what it means to live healthy and how to perceive health and disease. The importance of prioritizing health for individuals and communities has given rise to diverse medical systems, each offering a unique perspective and theoretical interpretation. The multiplicity of perspectives gives rise to a spectrum of approaches and behaviours as individuals and communities endeavour to uphold their well-being, commonly referred to as 'health-seeking behaviours' (HSB). It is the concept that refers to people's actions to maintain their health or seek healthcare services when they experience symptoms of illness or disease (Kleinman *et al.*, 1978). It undergoes a dynamic progression, unfolding through phases of self-assessment of symptoms, self-care interventions, consultations with family members and among social circles, and ultimately seeking guidance from traditional or alternative healers and professionals. This process is intricately connected with the formation of an integrated

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structure based on a person's identity and lived encounters, amalgamating diverse social, cultural, personal, socioeconomic, sociodemographic components, availability and accessibility of healthcare services, and environmental influences (Farmer, 2004; Anderson, 2014; Fatma and Ramamohana, 2022). For instance, cultural belief system strongly influences healthcare decisions within a community like the Karbi in Assam, their supernatural beliefs impacting treatment choices to a significant extent (Mazumder, 2021). It has been noted that in cases of Tuberculosis, self-medication and private practitioners are initial choices (Samal, 2016). Limited access to public healthcare in rural Gadchiroli leads to reliance on traditional doctors (Bang *et al.*, 2022). At another level, education and self-esteem positively impact health-seeking behaviour among Gujjar women (Sharma *et al.*, 2014). Diverse health-seeking behaviours are observed among Indian tribes who often rely on traditional healers due to geographical isolation, distance, cost, and service quality (Gandhi *et al.*, 2017; Venkatramana and Latheef, 2019). That sociodemographic factors influence maternal health-seeking behaviour can be exemplified by insufficient public awareness about diarrhea, causing the spread of the disease (Patil and Dixit, 2018). Traditional values shape tribal healthcare decisions, posing challenges when choosing between traditional practices and modern healthcare (Jacob, 2014). Among many examples, mention may be made of the hill-dwelling tribal pregnant women in Kashmir who had to face various impediments, including sociocultural conditioning effects and healthcare system-related challenges (Zahoor *et al.*, 2020).

In the light of this background knowledge, it may be worthwhile to study the health practices of different communities and specific sections of population, particularly tribal women who, in their unique health conditions related to such functions as child rearing and performing family-specific roles and activities, are often hindered by discrimination stemming from sociocultural prejudices to access quality healthcare services. Health-seeking behaviour is, after all, a pivotal factor influencing women's health (Reddy *et al.*, 2020). In pursuit of this goal, this paper explores the health-seeking behaviours of Rüzazho women as a special category of women in the Phek district of Nagaland. The analysis of the findings from the study also unfolds the underlying dynamics of health-seeking behaviour through the application of three significant theoretical perspectives: the Health Belief Model (Hochbaum, 1952), Social Cognitive Theory (Bandura, 1998), and Andersen's Behavioural Model of Health Services Use (Kehrer, 1972; Andersen and Newman, 1973). These frameworks serve as useful lenses to explore and interpret the patterns and intricacies of healthcare utilisation. By employing these theoretical frameworks, the study aims to explore and analyze the factors that determine how

Rüzazho women access and utilise healthcare services, in the process offering a more comprehensive understanding of healthcare-seeking behaviours with a greater degree of applicability.

## **METHODOLOGY**

### *Area of study and selection*

Rüzazho is a Chakhesang Naga village located in the eastern part of Nagaland, southwest of the district headquarters, Phek. It is positioned approximately 79 kilometers away from the state capital, Kohima, and 37 kilometers from the district headquarters. It has a total population of 2,848 individuals residing in 736 households, which comprise 1,435 males (50.4%) and 1,413 females (49.6%), with an overall literacy rate of 70% (Census Report, 2011). This village was chosen as the study site for two key considerations. Firstly, it houses a functional Government Primary Health Centre (PHC) inaugurated in 2008, providing essential medical services as a reference point for comparing traditional and modern healthcare practices. The PHC employs 11 staff members and offers various services, including outpatient and inpatient care, emergency services, immunization, antenatal care, postnatal care, minor operation theatre, family planning services, diagnostic tests, and referral services provided through an ambulance, besides taking up other government-sponsored schemes for pregnant women. Secondly, although it is a Christian village, the presence of traditional healers, particularly faith healers (FHs), adds depth to the healthcare landscape. These healers cater to ailments believed to have supernatural origins and are sought after by locals and neighbouring villagers. This duality in the healthcare scenario offers a unique opportunity to explore the interaction between conventional and indigenous healing practices, shedding light on the healthcare choices made by the villagers.

### *Selection of participants and duration of fieldwork*

Data for the study in question were collected from 89 women, between 23 and 70 years of age. They were identified through the snowball sampling method. The method allowed the researcher to use key informants to locate one or two more informants in the population, based on whom some more individuals could be selected for interviewing. From informant to informant, the sampling grows with each interview. The empirical phase of this research was meticulously executed over three months, commencing on January 3, 2023, and culminating on April 10. The initial week of fieldwork was dedicated to establishing a strong groundwork for the investigation to be carried out. During this crucial phase, the researcher was engaged in insightful discussions with the village Chairman and esteemed elders, who served as primary

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conduits to indigenous knowledge, establishing its historical context and community dynamics. Their wisdom was pivotal in framing the research within the functional limit of the local group. In the subsequent weeks, the research methodology encompassed a series of intensive interviews with local informants. These interactions, conducted over consecutive days, were instrumental in capturing the nuanced perspectives, experiences, and narratives of tribal women concerning their health-seeking behaviours.

### *Methods of data collection and analysis*

The primary data were collected through a face-to-face interview with the help of an interview schedule and the case study method. The interview schedule included questions related to basic personal information (age, age at marriage, with or without husband, education, income, and number of children, etc.) and topic-related questions such as the illnesses suffered in the past one to two years, treatment approaches, decision making, etc. The questions were asked specifically about the health problems the women had suffered from in the past one to two years to ensure their recall of the illness was accurate and their experience was still fresh. The analysis was performed manually in three sequential stages. Initially, information collected in the local language was translated into English. Subsequently, the researcher ensured the comprehensive visibility of all data and created duplicate copies stored in separate locations to prevent potential data loss. In the second phase, data were organised into themes with sub-themes. For example, under the theme 'types of treatment sought,' sub-themes such as 'traditional healers,' 'professional healers,' and 'self or popular care' were reproduced. Next, data were descriptively presented by the researcher by referring to field notes, verbatim quotes, and previous works on the related topic, while assuring the respondents that their names had been changed to maintain anonymity. In the third and final step, data interpretation encompassed inputs from health care utilisation theories, establishing cause-and-effect relationships, making inferences, ascribing significance, and addressing specific instances that supported or contradicted the existing studies.

## **FINDINGS AND DISCUSSION**

### *Age, education, and income*

As mentioned earlier, 89 participants were involved in this study. Among them, 15 (16.85%) women were in the 20-30 years age category, 20 (22.47%) were aged 31-40 years, 26 (29.21%) were between 41-50 years, 16 (17.98%) were in the 51-60 years, and 12 (13.48%) were in the 61-70 years age group. In the field of education, 29 (32.6%) were illiterate, 18 (20.2%) had

completed lower primary education, 16 (18%) had upper primary education, another 16 (18%) had secondary education, and 10 (11.2%) had higher secondary education. In terms of monthly family income, 33 (37.1%) were in the category INR 2000-3000, 19 (21.3%) in INR 4000-5000, 12 (13.5%) each in INR 6000-7000 and 9000-10000, and 13 (14.6%) in the INR 13000 and above.

A number of studies (Das *et al.*, 2018; Kumar *et al.*, 2019; Patra and Bandyopadhyay, 2020; Gupta *et al.*, 2022; Chetti *et al.*, 2024) suggest that demographic and socioeconomic factors like age, education, and income significantly influence individuals' perceptions of health and healthcare-seeking behaviour. For example, in a study among the Santals, it was found that socioeconomic status, more specifically, occupation and income, significantly influenced health-seeking behaviour. The study revealed that this indigenous tribal group has increasingly been leaning towards allopathic treatment, indicating that economic factors were instrumental behind their choice between government and private healthcare (Das *et al.*, 2021). However, the women in the present study did not conform to these trends. What is particularly important in the present context is that the findings of this study reflect the specific experiences of a selected group of women of different ages. The sampling technique followed here limits the generalizability of the results, and as such, the data presented should be interpreted as illustrative rather than representative of a broader populace. For instance, while explaining her age-related dependency, the respondent Mulu (aged 70) confessed,

"I had diarrhea and fever for nearly a week, but didn't see a doctor or traditional healer. My husband prepared medicinal food, and when my condition worsened, my son-in-law called a nurse who treated me with a glucose drip. My family played a crucial role in deciding when and where to seek medical help."

Khruswu, aged 23, offered another perspective:

"For my cold allergy, I followed self-care at home. Even otherwise, my ailment improves after winter. So I could avoid medical treatment. However, when I suspected poisoning by witchcraft, I visited a traditional healer, fearing the effects of evil spirits."

Similarly, the educational attainment of the informants in this study differs from the findings of previous studies. A relatively high percentage of illiterate individuals (32.6%) in the sample did not necessarily correspond with the kind of medical care they sought. Additionally, although the sample of this study included a significant proportion of individuals who had completed secondary and higher secondary education, their health-seeking behaviour did not seem to align

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with the expectations generally associated with higher education levels. For instance, Zolu, who had completed the 10<sup>th</sup> grade, said,

"Lately, I've been coping with high blood pressure and dizziness by getting medication from the Primary Health Centre (PHC) and adjusting my diet. Given its effectiveness in the context of our village, I had my doubts and turned to the traditional healer for suspected poisoning."

Vero, with a KG B-grade education, took her health-seeking decisions following a similar approach,

"When I had a toothache, I got temporary relief from painkillers at the village PHC before seeking treatment at the hospital in Kohima. But I consulted the traditional healer for a suspected supernatural influence on an ear ailment affecting my hearing. The healer confirmed my suspicion, finding a stone placed by an evil spirit obstructing my ear. Consulting the traditional healer first is preferred in such cases."

Probably, the root of conservatism lies deeper. The income distribution among the participants also challenges conventional wisdom. While some of the previous research hinted at a link between higher income and better access to healthcare and a greater willingness to seek medical care, this study demonstrates that income does not directly contribute to a higher rate of professional healthcare seekers. For instance, Vepraro, who was 58 years old, having a 9<sup>th</sup>-grade education and a monthly income of Rs. 30,000, continued with her faith in the traditional healing system,

"When I have back pain, I start with home remedies, turn to the traditional healer for a massage if it persists, and often find relief without medication. Severe ankle pain directed me to seek the TH's help, which could successfully remove stones responsible for it and believed to be caused by an evil spirit. Suspected witchcraft poisoning prompts reliance on the TH, as conventional treatments aren't effective against supernatural-induced symptoms."

Lhuro, aged 50, with an 8<sup>th</sup>-grade education and a monthly income of Rs. 8000, shared her point of view,

"When fatigued or struggling to walk, I check for low blood pressure at the PHC and take a rest. Medication stabilizes my blood pressure and eases fatigue. But for suspected poisoning, I consult the traditional healer, who confirms and removes the poison, providing instant relief."

Although demographic factors like age, education, and income are generally believed to influence health-seeking behaviour, this study has found that the practices followed by women often deviate from these expected trends. Younger participants tend to rely on self-care and family support, while older participants show greater trust in traditional healers or a mix of traditional and modern treatments. Education could not necessarily be correlated with a preference for biomedical care, as many participants with varying educational levels continue to rely on traditional healers, especially on issues perceived as supernatural interferences. Income also cannot automatically be linked with healthcare-seeking behaviour, as participants from higher income levels turn to home remedies and traditional healers before seeking professional care. These accounts highlight the complexities of health-seeking behaviours prevailing in the study population, suggesting influences beyond typical demographic markers. It is essential to delve deeper into the study's specific context and composition of population to understand why the demographic factors do not exactly align with conventional patterns. Exploring the specific contextual situation marked by cultural influences, healthcare access, and community support systems is indeed necessary. MacKian (2001) noted the limitations of traditional health promotion programs, emphasizing that simply providing the information is not sufficient for behavioural change. Health-seeking behaviours are shaped by collective community dynamics alongside personal, social, cultural, and experiential elements interwoven with it (Uzma *et al.*, 1999). This complexity, often overlooked in the literature, underscores the need for a broader perspective (Rahman, 2000).

*Health problems in the last two years*

Participants were asked to recall their health problems in the last two years preceding the interview. They reported experiencing a wide range of health problems, which were headache, hypertension, physical weakness/fatigue, stomach pain, seasonal cold allergy, fever, joint pain, typhoid, hypotension, cramps, formation of stones to be removed from various body parts, toothaches, skin rashes, earaches, back pain, and gritty eyes as shown in the Table 1.

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**Table 1:** Reported health Problems in the last two years

Health Problems	No of Informants	Health Problems	No of Informants
Headache	19	High blood pressure	08
Physical weakness/Fatigue	17	Stomach pain	05
Seasonal cold allergy	16	Fever	05
Joint pain	15	Typhoid	04
Hypotension	12	Cramps	04
Stones removed from various body parts	10	Toothache	04
Skin rashes	08	Earache	04
Back pain	08	Gritty eyes	04

It should be noted that a single woman reported experiencing multiple health problems, which is why the total number of informants for each health problem exceeded the total number of women interviewed. A total of 143 responses were recorded for the various health problems reported by the women. While the National Family Health Survey – 5 (NFHS) highlights a rise in chronic diseases like cancer and cardiovascular diseases, none of the respondents reported these when asked about their recent health problems. This could, however, be due to multiple factors, such as a lack of awareness or diagnosis, differences in healthcare access, or reluctance to disclose more serious health issues (IIPS, 2021).

Like many other tribal cultures, health and illness here are not solely viewed through a biomedical lens. Cultural beliefs often play a significant role in the way women perceive and explain their health problems. It includes attributing certain ailments to supernatural causes like witchcraft or evil spirits, though villagers' faith in supernaturalism varies from disease to disease (Khare, 1963). While other health issues were explained through a naturalistic lens, illnesses such as 'headaches' and 'the removal of stones from various body parts', like the elbow or shoulder, were attributed to the influence of evil spirits. These afflictions were believed to be the result of some, often personified, invisible malevolent forces casting spells or hexes. Consequently, they sought treatment exclusively from traditional or spiritual healers.

### *Treatments sought*

Rather than limiting themselves to self-treatment, most societies have access to multiple treatment options beyond self-treatment, which are organised in a 'hierarchy of curative resort'

that individuals can try (Kleinman and Benson, 2006). In this regard, anthropologists have sorted out treatment options into three functional realms of practitioner – folk, professional, and popular. The folk healing sector refers to a system of healthcare rooted in traditional, cultural, and community-based practices, often passed down through generations. It operates outside of formal, biomedical systems and relies on the knowledge of local healers, shamans, herbalists, or spiritual/faith healers. Folk healers require training, talents, or experience beyond those popularly available (Chrisman and Kleinman, 1980). The professional sector consists of healthcare professionals and organisations that work out their practice sessions around established, complex medical systems. This sector includes biomedicine and traditional systems like Ayurvedic medicine in India and Sri Lanka, Chinese traditional medicine in China, and biomedicine, chiropractic, optometry, osteopathy, and naturopathy in the United States of America and Canada. Practitioners of biomedicine and traditional medicine, however, need formal training and certification (e.g., medical school and a medical license). The popular sector is the biggest part of any healthcare system, making up almost two-thirds of all the systems pursued. It includes what we do not usually apply to ourselves when we're sick, as well as the help we get from family, friends, and the community. Most of the healthcare and support takes place within this sector, and it is here that the bulk of healthcare spending occurs. It is the most common medical knowledge every adult person learns from the social environment and applies in caring for themselves and their family (Ibeneme, 2017). Likewise, the treatment sought by the women involves folk healers (FHs) along with health professionals, even when they give an impression of relying on self-care.

#### *Folk healers*

Individuals often exercise their choice of remedies and practitioners based on their spiritual and cultural beliefs when seeking treatment, as illness understanding and perception are closely intertwined with these factors. This belief is further reinforced since traditional healers are always locally available, accessible, and conforming to their religious beliefs (Graner *et al.*, 2013; Cáceres *et al.*, 2023). Hence, consulting a faith healer often becomes the first course of action for those who believe in evil forces causing their illness, when medical assistance from biomedical doctors is considered futile, as it would not address the underlying spiritual or supernatural cause, which, in the consideration of some, has a level of efficacy. Faith healers are believed to be in possession of a special power bestowed upon them by a supernatural force. This power enables them to communicate with the spiritual world and drive out the evil spirits that were

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believed to be responsible for causing various diseases. Traditional healers are seen as intermediaries between the spiritual and physical worlds, in conformity with the commonly-held belief that they could access divine power to bring about healing. In addition, faith healers are revered for their extensive knowledge of herbal remedies and appropriate rituals. Their profound understanding of medicinal plants and beliefs associated with deep religious faith enhances their effectiveness in healing physical and mental illnesses. For many women, faith healing is integral to their well-being, reflecting its widespread prevalence and significance. Reproduced below are a few selected cases highlighting the prevalence and significance of faith healing among the women interviewed.

Zulhulu, who was 50 years old, sought help from a faith healer when she suffered from a severe headache and photosensitivity. She narrated her experience:

"When I experienced a heavy sensation in my head and sensitivity to sunlight, I sought help from the FH. Initially, I thought it was just a common headache, but I became increasingly concerned about the possibility of poisoning as the problem persisted. The FH confirmed that I was indeed poisoned in my head and removed it, bringing immediate relief. It was necessary to keep the episode secret as there's a belief that revealing it could lead to re-poisoning. The poison was disposed of by burning it wrapped in a piece of paper. I strongly believe poisoning to be the work of an evil spirit."

Venelu, who was 48 years old, shared her experience of seeking help from a faith healer when she experienced a sharp pain that affected her hearing. Her experience is reproduced below:

"I visited the traditional healer (FH) due to severe, sharp pain affecting my hearing. Unsure if it was caused by an evil spirit (dophi), I sought help from the FH. My suspicion came true when a stone was found in my ear. In such cases, I prefer consulting the FH more than the hospital because hospital medication, I believe, will worsen my condition further."

Bonjoh, 34, visited a faith healer for severe pain in the wrist, palm, and feet. As reported by her, stones supposed to be caused by evil spirits were removed three times, and in this case, medical doctors were of little help. In this case of faith healing, 'stone' as a cause of illness seems to be more symbolic than real. There is a mental component involved with it. Similarly, a 50-year-old woman, who was not willing to be named, had severe pain in the shoulder and felt a 'warm feeling' like a 'burning pain' while massaging the part with oil. She approached the FH, who could remove the stones from her shoulder. According to her, the application of oil does not

work well against the evil spirit; it only helps to identify the source of it. Duzo, aged 61, sought treatment from a faith healer for muscle cramps, not directly related to evil spirits. She avoided going to the hospital because of her dislike of swallowing pills. As an alternative, she consulted a traditional healer who diagnosed bad blood accumulation in her heels or ankles as the cause of the pain. All these examples suggest how personal beliefs and cultural practices can influence treatment-seeking behaviour.

Almost all the women's experiences, particularly the elder ones, reveal a strong reliance on faith healing for addressing health issues believed to be caused by supernatural forces. Many turned to faith/spiritual healers for relief from persistent ailments, which they attributed to spiritual causes like evil spirits. These healers were considered more effective than providers of modern medical care in such cases as removing perceived supernatural afflictions like stones that caused the pain. In Ngaka Modiri Molema, a rural area in South Africa's North West Province, indigenous healthcare practitioners provide holistic care through spiritual guidance. They address health issues such as infertility and offer accessible, ongoing support for physical, emotional, and spiritual concerns (Baakeleng *et al.*, 2022). Among the Karbi tribe of Assam, the Kondha, and the Mayurbhanj tribals of Odisha, many physical ailments are believed to stem from supernatural causes, leading to the widespread use of magico-religious practices for healing. The Karbi people attribute illnesses to forces like the evil eye, evil wind, and charming arrows, while the Kondha view supernatural agencies as primarily affecting mental health, which later manifests physically. In both communities, magico-religious practitioners play a key role in healing, with the Kondha particularly favouring women healers, believing they have direct contact with supernatural beings (Bharati, 2013; Behera, 2014; Bhattacharjee, 2016). The Kamar, Hill Korwa, and Baiga communities of central India strongly believe that many illnesses are caused by the anger of deities or evil spirits. To appease these supernatural forces, they perform sacrifices of various animals and birds (Khatua, 2022). Faith/spiritual healing is seen as a powerful tool that enables individuals to connect with a higher source of power and receive divine intervention and healing (Sharma *et al.*, 2020). Moreover, these responses suggest that faith healing practices are deeply ingrained in their cultural and religious traditions. Prayer, meditation, and other spiritual practices are an essential part of their daily lives, which are used to seek guidance, support, and healing from a higher power. It speaks of the widespread prevalence and significance of faith-healing practices, emphasizing the role of faith and spirituality in enhancing the physical, emotional, and mental state of health.

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### *Professional healers*

On the other hand, women are quick to consult an allopathic doctor when they are convinced that the ailment is caused by a natural or biological agent. They follow a locally perceived selection process. However, it is not exactly known how they could come to the conclusion that certain diseases are biologically caused and some are supernaturally caused. Probably, these involve their perceptions, subjective understanding, and knowledge gained and passed down through generations. Largely intuitive, the methods they follow largely depend on their cultural belief system, personal experiences, and the way they identify the natural and spiritual causative factors. It does not mean that modern medicine holds little attraction for them. As a matter of fact, some cases clearly show an increasing dependence on modern medicine. With regard to health problems such as low or high blood pressure, joint and back pain, typhoid, toothache, and skin rashes, biomedical doctors from the village Primary Health Centre and doctors from Kohima, the state capital, were also approached. The following cases suggest that, in many cases, women, though not averse to traditional modes of treatment, showed increasing reliance on modern treatment.

Veuro, 50, regularly checked her blood pressure at the PHC whenever she felt fatigued and was unable to walk. She used to take rest, but did not seek treatment from traditional healers for this issue, as their advice was not quite in agreement with her personal knowledge. The doctor at the PHC once prescribed her medication to bring her blood pressure under control, and she followed it. Swuro, 61, initially treated her fever with home-made remedies, but when it persisted, her family urged her to seek medical care at a hospital. She was diagnosed with typhoid and treated with biomedicine for three months, leading to her recovery. A woman in her 50s, unwilling to be named, had almost similar type of experience. To quote her:

“I first went to an FH for my back pain, but the massages didn't work, and the pain returned. So, on my family's suggestion, I went to a hospital in Kohima, where I got X-rayed and was prescribed medicine by the doctor, along with advice to avoid lifting heavy things or sitting for too long. I am feeling better now.”

The experience of 50-year-old Muza may also be suggestive:

“I tried bathing with herbs. But when my condition did not improve, I went to the PHC for a check-up, and it turned out that I had vitamin A deficiency. The doctors prescribed me some medicines, which I am taking.”

Several women's experiences highlight their mixed approach to healthcare, blending cultural beliefs with practical needs. For conditions like high blood pressure, typhoid, back pain, and vitamin deficiencies, they turned to biomedical doctors after traditional remedies failed. One regularly checked her blood pressure at the health centre, while another, after trying home remedies, recovered from typhoid with biomedicine. A woman with persistent back pain sought hospital care after traditional massages didn't help, and another was diagnosed with Vitamin A deficiency after herbal baths failed. However, it is important to recognise that the actual scientific origin of a disease, whether biological or social, is less significant in this context. Instead, it is their beliefs, experiences, and perceived causes of their health issues that are responsible for creating a type of medical justification passed down from their ancestors, which often determines whether they view disease as biological or cultural, or a combination of the two.

*Self or Popular Treatment*

For those health problems that they thought were not so severe and were manageable or fell in the category of minor illnesses and pain, these women often relied on self-treatment by using home remedies and over-the-counter medications. Knowledge about these remedies was often passed down and acquired through generations based on traditional beliefs and practices, coupled with experiences gathered from friends, family, and their larger social surroundings. Such remedies include herbal teas, poultices, ointments, over-the-counter medications like pain relievers, antihistamines, and cough and cold remedies. Self-treatment has been a valuable method for treating pain, illnesses, and injuries for many people, particularly those living in rural areas. Despite its effectiveness, this method has not received the recognition and importance it deserves. Some of the health problems treated in this way were general physical weakness, joint pain, fever, cold, allergy/body rashes, back pain, common cold, diarrhea, headache, gastritis, injuries/cuts, snake bites, cat/dog bites, cough, stomach pain, toothache, flatulence, etc. The following are some selected verbatim from the participants.

Thuku (widow), aged 56, treated her joint pain at home and took painkillers her son bought from a drugstore 20 km from the village. To quote her:

"For my joint pain, I didn't seek any treatment from external sources. I took care of it at home, and when it became unbearable, I took a painkiller. My son bought the painkiller from the drugstore located some 20 km away from the village."

Shove, aged 40, said, "When my fever did not subside after treatments at home, I took a

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paracetamol tablet given to me by my friend/ neighbour." An unnamed woman in her 50s said that the allergy she had was caused by skin reactions to the pollen of the grains called 'sheh' during the cultivation period (*tüiso-rüü*). She had never been to the hospital for a check-up and instead used herbal paste all over her body. To her, because the occurrence of allergy was only during cultivation (June-November), she preferred home treatment. Her explanation may draw our attention:

"Allergy from pollen grains, known as 'sheh,' occurs annually during cultivation (*tüiso-rüü*) season. I manage it at home without hospital visits by applying the herbal paste on my body, as bathing with soap alone isn't effective. The allergy is seasonal, happening from June to November."

Sukhring, aged 65, said, "Whenever I have back pain from overworking, I just take a break and let it heal. But I've not sought help from BD or TH." Shijoh, 45, said that when she could not eat well because of weakness, her husband cooked wild animals from the jungle, which helped her feel better. She took care of herself at home with home-made remedies and did not feel the need to visit the hospital or FH. Kolo, who was 46 years old, was not in favour of either visiting the hospital or FH for minor complaints like weakness, which, according to her, would subside with a proper diet and sufficient rest. Tolu, 26, managed low blood pressure by taking a break from work, eating properly, and not resuming work until she could feel better. The women often rely on self-treatment for manageable health issues using home remedies and over-the-counter medications. Some manage joint pain with painkillers, while others use paracetamol for fever and herbal paste for seasonal allergies. Many prefer rest and proper nutrition for back pain and low blood pressure, viewing hospital visits as unnecessary. These accounts indicate the common practice of self-treatment among women, relying on traditional remedies and basic medications for minor health issues. Their approach reflects a preference for home-based care, often rooted in cultural knowledge and practical convenience, with medical intervention seen as unnecessary for conditions that are considered otherwise manageable.

Likewise, these women embrace a multifaceted healthcare approach, blending traditional and modern methods to address their health needs, underlining the prevalence of medical pluralism. While this underscores the importance of respecting local health beliefs, it deviates from some previous studies. Unlike findings indicating cost-effectiveness, geographical, quality, availability and accessibility, sociodemographic, and economic condition (Brahma and Mudgal, 2019; Reddy *et al.*, 2020; Pengpid and Peltzer, 2021) as primary drivers for seeking traditional healers, these women prioritize their understanding of the causes and

severity of their illnesses, that somehow aligns with the findings suggested by Novins *et al.* (2004), Fortney *et al.* (2012), and Boruah (2012), which indicate that the utilisation of biomedical and traditional healthcare services varies depending on the nature of the health problems. Let us delve deeper into the results by analysing them through popular theoretical frameworks in the field of health-seeking behaviour.

The Health Belief Model (HBM), developed in the 1950s, is a widely recognized cognitive framework used to comprehend the lack of participation in Public Health Service programs, responses to experienced symptoms, and medical compliance. It posits that decision-making regarding health behaviours is influenced by several key factors, including perceived susceptibility to illness, perceived severity of the illness, perceived benefits of preventive actions, and barriers to engaging in such behaviours, alongside sociodemographic factors (Rosenstock *et al.*, 1974; Thompson *et al.*, 2012; Scrimshaw and Lane, 2018). Despite its utility, the model overlooks a crucial dimension: the perceived causes of illness. In the context of this study, the health-seeking behaviours of the women are profoundly influenced by deeply ingrained sociocultural beliefs and practices, which often attribute illness to supernatural or natural causes. These beliefs, transmitted across generations, shape individuals' perceptions of health threats and their responses to them. Therefore, the absence of explicit consideration of perceived causes of illness in the HBM may limit its applicability in populations where such beliefs strongly influence health-seeking behaviours. Integrating these cultural and contextual factors into the model is essential for a more comprehensive understanding of health behaviours in diverse communities.

Anderson's Behavioural Model offers a comprehensive framework for understanding health services utilisation by considering predisposing, enabling, and need factors. Predisposing factors encompass social and demographic characteristics that shape individuals' inclination toward seeking healthcare. Enabling factors encompass resource availability and access to services, which either facilitate or impede healthcare utilisation. Need factors encompass illness severity and perceived health needs, driving individuals to seek healthcare services when necessary (Kehrer, 1972; Andersen and Newman, 1973; Anderson, 1995; Alkhawaldeh *et al.*, 2023). However, the model also falls short in explaining the influence of perceived causes of disease on treatment choices. Therefore, while Anderson's model provides a valuable framework for understanding healthcare utilisation, it may need to be supplemented with considerations of perceived causes of disease to better capture the complexity of health-seeking behaviours in diverse contexts.

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The social cognitive theory, developed by Bandura (1977; 1998), explores the interplay between socio-structural and personal determinants of health behaviours. It employs a triadic reciprocal causation model, emphasizing the dynamic interaction between personal factors, environmental influences, and behaviour (Shamizadeh *et al.*, 2019; Jenkins *et al.*, 2018). In other words, it emphasizes the interaction of the social, environmental, and personal factors that influence individuals' health behaviours (Sebastian *et al.*, 2021). The finding of the present study that women base their treatment choices on the perceived cause and severity of the illness can be explained best through this perspective. Firstly, their sociocultural background plays a significant role in shaping their interpretation of disease, influenced by long-standing indigenous medical traditions passed down through generations. This cultural heritage, learned and built up within their social circles such as family and friends, shapes their understanding of health and illness and influences their treatment decisions. Secondly, environmental factors (geographical location, accessibility to healthcare services, cost, and the quality of medical care and personnel) might have influenced their treatment choices, but these were not directly reflected in their responses. Thirdly, personal factors, including individual interpretations of the severity of illness, contribute substantially to their treatment decisions. The perceived cause and severity of the illness are filtered through their personal experiences, beliefs, and perceptions, ultimately guiding their choice of treatment.

### *Limitations of the study*

The study encountered several limitations during fieldwork, including time constraints and a limited sample size, as interviews were conducted late in the evening when participants returned home. Additionally, reliance on self-reported information may introduce biases such as memory recall and social desirability biases, impacting objectivity. The research design also has limitations. The use of snowball sampling, while effective for specific populations, restricts the generalizability of the findings, as it relies on the social networks of initial participants. Consequently, the conclusions drawn are limited to the experiences of the women involved and cannot be automatically applied to a broader population. The inherent biases in snowball sampling may further influence its outcomes, as individuals referred to may share similar characteristics, potentially skewing the data. Therefore, while valuable insights could be gained, they must be interpreted cautiously, reflecting the specific context of the participants rather than providing a broad overview of health-seeking behaviours across diverse groups.

## CONCLUSION

Health-seeking behaviour is not a one-off, isolated event. Every community has inherited health beliefs, norms, values, and practices concerning various health issues, which influence the health-seeking behaviours and the health systems they indicate. Thus, responding to illness or seeking care might involve multiple steps with multicausal factors (MacKian, 2001; Das and Das, 2017). Illness causation falls into two main categories: natural and supernatural causes. Based on this classification and the perceived seriousness of the disease, in the present case, women's choice of treatment may be categorised into three types: folk healers (faith healers), professional healthcare (biomedicine), or popular self-treatment. Giving recognition to these beliefs-turned-convictions is crucial for holistic and culturally sensitive healthcare practices to be of some meaning. Disregarding or dismissing spiritual beliefs outright risks alienating the community healthcare workers' desire to assist with their side. For many, achieving complete health involves connecting with nature and the spiritual world (Antoniotto, 1983; Lidell *et al.*, 2005). Even when biomedical treatments are utilized, indigenous communities often include rituals acknowledging nature and spirits in recovery (Atkinson and Haran, 2005; Kahissay *et al.*, 2017). There is undoubtedly a mental component involved with it.

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