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Research Article

NGO Healthcare Services for the Garo Indigenous Community: A Study in Mymensingh District of Bangladesh

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ABSTRACT

People of Garo tribal community aren't aware of their basic health care. They are socially and culturally distinct from mainland Bengalis and lack modern healthcare facilities (no public or private hospitals) and that's why they have to rely on long-practised traditional healing methods to aid recovery from illness. The significant number of the respondents are housewives (36.8%) and day labour (24.1%) who have to work hard to earn their livelihood. According to the case of adolescents' health service, 5.8% are somewhat and 7.3% unsatisfied. Therefore, the government as well as NGOs need to undertake awareness programs to increase awareness among the Garo community about health problems and relevant treatments. Therefore, the study focuses on improving health care and performance. Contributes to maternal health-related interest which helps to bring more health care services in Dhobaura upazila. The findings of this study will be helpful in improving healthcare facilities and policy recommendations.

Keywords: Health care services, Traditional healing method, Indigenous community, G*aro*, NGOs

INTRODUCTION

Garo is a Mongoloid race. Millions of Garos live in Bangladesh. Most of them live in Haluaghat and Dhobaura of Mymensingh, Durgapur and Kalmakanda of Netrokona, Nalitabari and Madhupur upazila of Jhenaigati upazila and Tangail, Jamalpur, Sherpur,

Mymensingh, Netrokona, Sunamganj, Sylhet and Gazipur. In matriarchal Garo culture, mothers inherit property and rule their own households. Every husband or child's father acts as the manager of the family. The Garo is a distinct ethnic group with their own culture and language (Drong, 1994 and Banglapedia, n.d). Although the Garo ethnic group lives in Bangladesh, they are socially and culturally distinct from mainland Bengalis. Consequently, they have unique traditional medical systems and health management systems that are largely based on their culture and traditional beliefs (Playfair and Kar, 1975). Traditional healers are still very popular among the tribal population of Bangladesh. Family planning has progressed rapidly in Bangladesh. Contraceptive prevalence has increased from 8% to 53% over the past 20 years. In general, women in rural hilly and remote areas were not aware of family planning messages and half of the married participants in Chittagong Hill Tracts had no knowledge of contemporary family planning techniques. Others who are more sensitive to the 'weakening' effects of contraceptive technology shy away from family-planning techniques altogether because of the harmful associations inherent in religious dogmas and social norms (Rahman *et al.,* 2012).

Most Garo relies on long-practised traditional healing methods to aid recovery from illness. The hilly areas lack modern healthcare facilities and have no public or private hospitals. As a result, the Garos faced many problems that affected their physical, mental, economic and social well-being (Rahman, 2021). The Garos are in dire straits during the global pandemic. During the global pandemic, most Garo people lost their occupations as farmers and day labourers, leading to social isolation and loneliness, leading to psychological problems (Kabir *et al.,* 2023). Since time immemorial, indigenous peoples have primarily depended on forest resources to meet their food, nutritional and medical needs. One of the few matriarchal societies that still exist is the Garora. Ethnic Garos of Bangladesh are knowledgeable about medicinal plants (MP). Numerous common ailments including fever, cough, diarrhoea, skin conditions, constipation, catarrh, etc. can be treated using various plants. Six of the 10 diseases, including cancer, are the world's deadliest. Ethnic Garora used medicinal plants to cure conditions like cirrhosis, tuberculosis, diabetes, diarrheal diseases and bronchitis (Islam and Sarwar, 2020). In terms of plant parts, fruits of MPs are the most used, followed by leaves and bark. However, most of the plant parts used for medicinal purposes are roots, stems, leaves, fruits and seeds or a combination of different components including the whole plant (Islam, 2020).

The purpose of this paper seems to be to provide information and insight into various aspects of Garo health care in Bangladesh, including patterns of satisfaction with services received from NHCC and socio-economic status. It discusses issues such as satisfaction patterns in services received from the Garo NHCC, health care practices,

family planning, hygiene and their unique social structure (Mohiuddin, 2021). The text also highlights some of the challenges and issues facing the Garo people, including access to health care and their livelihoods. Overall, to highlight the type of services Garo communities receive from NHCC and their specific challenges and practices.

MATERIALS AND METHODS

The study was conducted by applying both quantitative and qualitative approaches to social research. Quantitative data and qualitative information were triangulated to get a comprehensive picture of health care-seeking behaviour including the health accessibility of the Garo indigenous community. The study was conducted in Dhobaura Upazila of Mymensingh division. The study population was the people of the Garo community, medical doctors, government officials, NGO workers, formal and informal leaders, and journalists, who have a clear understanding of healthcare-seeking behaviour including the health accessibility of the community.

Sample Size and its Determination

The sample size was determined by using the following formula:

$$n = z2pq/d2$$

Where, n= desired sample size

z = 1.96 (95% confidence interval)

p = prevalence of health accessibility of Garo community = 0.50

q = 1-p

d = 5%=0.05

= (1.96) 2 (0.50) (0.50)/ (0.05) 2 [× design effect]

= 384

= 384+10% non-response= about 424.

A convenient sampling technique was used to reach the target sample. All the targeted respondents are covered as a sample (424 respondents) under the total questionnaire survey in face-to-face interviews. To get a comprehensive picture of healthcare-seeking behaviour as well as the health accessibility of the Garo indigenous community of Bangladesh. After checking and cross-checking the collected data, all the questionnaires were coded and entered into the SPSS database. An adequate number of professional data entry operators were recruited, who worked under the close supervision of the statistician and core research team.

STUDY FINDINGS

An ethnographically unique group, the Garos not only possess their own language and culture, but also maintain traditional medical systems and healthcare practices deeply rooted in their cultural and spiritual beliefs. Although living in Bangladesh, they are socially and culturally different from the main Bengali population. As a result, they are more dependent on NGO health care institutions for health care in addition to traditional healing practices like Anti-Natal Care (ANC), Postnatal care (PNC), Newborn baby care and family planning. Other NGO healthcare institutions like Christian Missionaries play a role in providing primary health care to the Garos.

Table 1: Demographic and Socio-Economic Status of the Respondent

Variables	N	Percentage
Age (years)		
21-30	153	36.1
31-40	118	27.8
41-50	86	20.3
51-60	42	9.9
61-70	16	3.8
71-80	9	2.1
Family members		
≥ 8	51	12
2-4	167	39.4
5-8	206	48.6
Family income (taka)		
1,000-10,000	118	27.8
10,001-20,000	203	47.9
20,001-30,000	82	19.4
30,001-40,000	15	3.5
40,001-50,000	6	1.4
Educational Qualification		
Illiterate	93	21.9
Primary	146	34.4
Secondary	103	24.3
Higher Secondary	53	12.5
Graduate	18	4.3
Postgraduate	11	2.6

Table 1, this study shows that (36.1%) of the respondents are in the age group of 21-30 years, whereas (27.8%) of them belong to 31-40 years age group. The rest of the age groups are 41-50 years (20.3%), 51-60 years (9.9%), 61-70 years (3.8%), and 71-80 years (2.1%). Besides, (48.6%) of the respondents have 5-8 family members, whereas 12% and 39.4% have more than 8 and 2-4 family members respectively. In the 'family income' section, (47.9%) of the respondents' family income is in the range of 10,001-20,000 taka. 27.8% and 19.4% of them are in the range of 1,001-10,000 taka and 20,001-30,000 takes. It is noteworthy that the portion of higher family income is too little (3.5% and 1.4% of the respondents' family income are in the range of 30,001-40,000 and 40,001-50,000 taka, respectively). It is disappointing that a fourth (21.9%) of the respondents are illiterate. A significant portion of them (71.2%) have some basic education, that is, primary (34.4%), secondary (24.3%), and higher secondary (12.5%) education. The number of students pursuing higher studies is little. Only, 4.3% of them completed their graduation, while the rest 2.6% have gone to post-graduation programs.

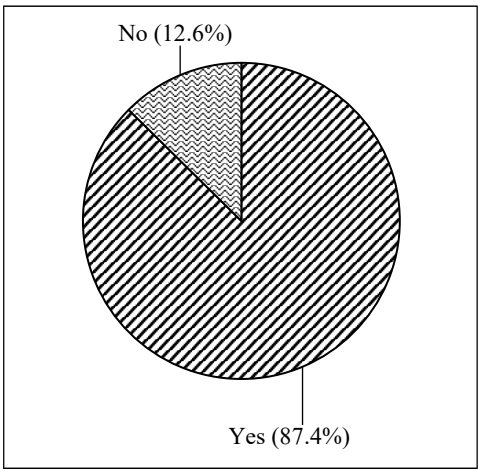

Figure 1: Knowledge about NGO healthcare centres

In Figure 1, it is seen that (86.4%) of the respondents have information about NGO health care centre (NHCC), whereas the rest of them (12.6%) have no idea about it.

Figure 2 shows that a significant portion of the respondents are satisfied to some extent with their healthcare services taken from the NGO Health Care Centre (65.1% are satisfied, while 23.1% are somewhat satisfied). Less than one-tenth (6.6%) of them possess neutral thoughts on the topic. The rest of them are either somewhat unsatisfied (3.1%) or unsatisfied (2.1%).

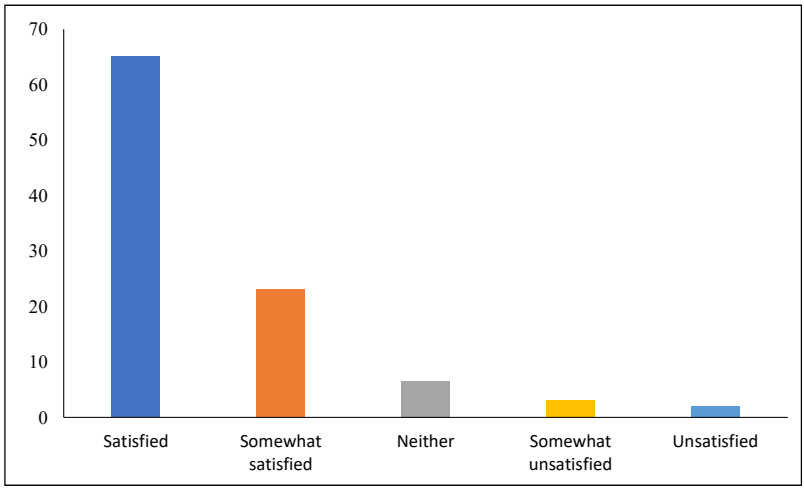

Figure 2: Satisfaction about the treatment of NGO Health Care Centre

Table 2: Satisfactory level of Anti-Natal Care (ANC), Delivery Care (DC) and Post-Natal Care (PNC) services from NGO Health Care Centre (NHCC)

Variables	N	Percentage
Anti-Natal Care (ANC)		
Satisfied	231	54.5
Somewhat satisfied	106	25
Neither	25	5.9
Somewhat unsatisfied	35	8.3
Unsatisfied	27	6.3
Delivery care (DC)		
Satisfied	198	46.7
Somewhat satisfied	72	16.9
Neither	87	20.5
Somewhat unsatisfied	48	11.4
Unsatisfied	19	4.5
Postnatal care (PNC)		
Satisfied	246	58
Somewhat satisfied	127	29.9
Neither	27	6.4
Somewhat unsatisfied	16	3.8
Unsatisfied	8	1.9

Table 2, in the case of ANC service, a significant portion, (79.5%) of the respondents are either satisfied (54.5%) or somewhat satisfied (25%). A good portion, (5.9%) of them remain neutral. The rest are either somewhat unsatisfied (8.3%) or unsatisfied (6.3%). According to the delivery healthcare service in NGO healthcare centres, it is seen that (63.6%) of the respondents are either satisfied (46.7%) or somewhat satisfied (16.9%). A good portion, (20.5%) of them remain neutral. The rest are either somewhat unsatisfied (11.4%) or unsatisfied (4.5%). A similar scenario can be seen in the cases of PNC service, (87.9%) of the respondents are either satisfied (58%) or somewhat satisfied (29.9%). Besides, (6.4%) of them remain neutral. The rest are either somewhat unsatisfied (3.8%) or unsatisfied (1.9%).

Table 3: Satisfactory level of family planning, adolescents' health, general health services, and health care service providers from NHCC

Variables	N	Percentage
Family planning service		
Satisfied	202	47.7
Somewhat satisfied	160	37.8
Neither	35	8.2
Somewhat unsatisfied	18	4.2
Unsatisfied	9	2.1
Adolescents' health service		
Satisfied	101	23.9
Somewhat satisfied	163	38.6
Neither	104	24.5
Somewhat unsatisfied	25	5.8
Unsatisfied	31	7.3
General health service		
Satisfied	221	52.1
Somewhat satisfied	147	34.7
Neither	16	3.8
Somewhat unsatisfied	21	5
Unsatisfied	19	4.4
Presence of healthcare service providers		
Satisfied	273	64.4
Somewhat satisfied	98	23.1
Neither	24	5.7
Somewhat unsatisfied	18	4.2
Unsatisfied	11	2.6

Table 3, in the case of family planning, a good portion, (85.5%) of the respondents are either satisfied (47.7%) or somewhat satisfied (37.8%). A significant portion, (8.2%) of them remain neutral. The rest are either somewhat unsatisfied (4.2%) or unsatisfied (2.1%). According to the case of adolescents' health services, it is seen that 62.5% of the respondents are either satisfied (23.9%) or somewhat satisfied (38.6%). A significant portion, 24.5% of them remain neutral. The rest are either somewhat unsatisfied (5.8%) or unsatisfied (7.3%). A similar scenario can be seen in the cases of other 2 variables (general health service, and presence of health care service providers), that is, (3.8%, 5.7%, each) of the respondents stay neutral. A good portion of them is either satisfied (52.1%, 64.4%) or somewhat satisfied (34.7%, 23.1%), and the rest are either unsatisfied (5%, 4.2%) or somewhat unsatisfied (4.4%, 2.6%).

DISCUSSION

This narrative discusses various aspects of Garo community life, including Anti-natal care (ANC), Delivery Care (DC), Postnatal Care (PNC), Neonatal care, age-under children healthcare, EPI services available from NHCC. This study shows that a significant portion of Garo (71.2%) have some basic education, that is, primary (34.4%), secondary (24.3%), and higher secondary (12.5%) education. The number of students pursuing higher studies is little. 4.3% of them completed their graduation, while the rest 2.6% have gone to post-graduation programs. On the other hand, According to Rashid the socio-economic status of indigenous Garo women in Bangladesh is very poor as only 35% of them have completed primary school and 40% have graduated from secondary school while 64% of Garo women work as day labourers and 61% are in debt. Since both husband and wife play important roles in family formation and 80% of family decisions are taken jointly, the traditional role-female headship-has shifted irreversibly. A few similarities and contrasts can be observed between this research and other researches and then it can be said that the education rate among the Garo is still low compared to other ethnic groups. (Rashid *et al.,* 2022).

This study explains that in the case of ANC service, a significant portion, nearly half (54.5%) of the respondents are either satisfied or somewhat satisfied (25%). A good portion, more than three-tenth (5.9%) of them remain neutral. The rest are either somewhat unsatisfied (8.3%) or unsatisfied (6.3%). In another study, Rahman et al. illustrated his study in Bangladesh, maternal healthcare usage is low and continuously declining from the antenatal to postnatal period. Prenatal care, skilful delivery, and postnatal care for both mother and newborn climbed from 13% in 2012-13 to 25% in the 2019 study. Furthermore, the use of care in Bangladesh remains skewed in Favor of the wealthy (Rahman *et al.,* 2022). Similarly, Chowdhury showed that prenatal care

by Aboriginal women exhibits diversity and differs from other Aboriginal communities. As most women in Lengura Union have more experience with home-based care, biomedical care seems less relevant to them. Another group of women, especially from Nazirpur Union, usually rely on home remedies as their first line of defence, delaying biomedical treatments and underutilising their knowledge of biological antenatal care services. The conviction of their mothers/in-laws and male partners that pregnancy is a regular occurrence in every woman's life prevents Garo tribal women from using health care services. This study is similar to the above study (Chowdhury, 2023).

This study illustrated that a significant portion of the respondents are satisfied to some extent with their healthcare services taken from the NGO Health Care Centre (65.1% are satisfied, while 23.1% are somewhat satisfied) and (6.6%) of them possess neutral thoughts on the topic. The rest of them are either somewhat unsatisfied (3.1%) or unsatisfied (2.1%). In another study, Islam indicated his study regardless of community service provider, (30.7%) of women visited MCHS. UHC treated women (55.1%) locally, followed by FWC (28.3%). Women visited SC (4.3%) and village/local doctors (4.0%). Some similarities and differences can be observed between this study and other studies and then it can be said that the Garo population shows more interest in adopting traditional medical methods than modern medical methods because they also use spiritual emotion in their treatment. According to religion, they are more interested in traditional treatment than modern treatment (Islam, 2017).

CONCLUSION

The study delves into various aspects of the Garo community's healthcare utilisation, education, and employment status. It is evident that a significant portion of the Garo population has received some basic education, with primary, secondary, and higher secondary education being the most common levels of attainment. However, the number of individuals pursuing higher education remains relatively low. The employment landscape among the Garo community is diverse, with a significant proportion engaged in household responsibilities, daily labour, and various forms of manual labour for their livelihood. In terms of maternal and child healthcare services, the study reveals that while a substantial portion of respondents express satisfaction with Antenatal Care (ANC) services, there is room for improvement in addressing the needs and concerns of those who remain dissatisfied or neutral. Additionally, the Garo community generally shows satisfaction with the healthcare services provided by NGO Health Care Centres, although there are individuals who express varying degrees of dissatisfaction or neutrality.

RECOMMENDATIONS

Maternal and Child Healthcare: To address the varying levels of satisfaction with ANC services, healthcare providers should engage with the community to better understand their specific needs and concerns. Tailored ANC programs and increased awareness about the importance of maternal healthcare can improve outcomes.

Healthcare Centre Improvement: NGO Health Care Centres should continue to strive for quality improvement to meet the healthcare expectations of the Garo community. Regular feedback mechanisms and community engagement can help identify areas of improvement and ensure that services are aligned with community needs.

Community Outreach and Awareness: A concerted effort should be made to raise awareness within the Garo community about the importance of healthcare services, including vaccination (EPI services) and postnatal care (PNC). Community health workers and awareness campaigns can contribute to higher utilisation rates.

In conclusion, the study provides valuable insights into the Garo community's education, employment, and healthcare utilisation. By addressing the identified areas of concern and implementing the recommended measures, the overall well-being and healthcare outcomes of the Garo community can be significantly improved.

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