

Between rivers, beliefs, and clinics: An anthropological study of health-seeking practices in the char areas of Gaibandha Sadar, Bangladesh

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ABSTRACT

Health-seeking practices in geographically isolated riverine islands (chars) of northern Bangladesh remain underexamined despite persistent climate vulnerability and infrastructural constraints. This qualitative study explores therapeutic decision-making among residents of Mollar Char and Kamarjani unions in Gaibandha Sadar. Drawing on 32 in-depth interviews, focus group discussions, key informant interviews, and field observations, the research examines how environmental instability, socio-economic precarity, and cultural belief systems shape patterns of medical pluralism.

Guided by the culture-centered approach (CCA) and the health belief model (HBM), the study analyzes how perceived barriers, risk perceptions, relational trust, and institutional accessibility influence healthcare trajectories. Findings indicate that traditional healers and informal providers constitute the primary entry point into care, while biomedical facilities are typically approached only when illness is perceived as severe. Maternal health vulnerabilities are shaped by the intersection of geographic isolation and gendered norms operating within limited-service availability.

The study highlights how therapeutic pluralism functions as both pragmatic adaptation and response to infrastructural constraints. Evidence-informed policy implications include strengthened referral linkages, mobile service integration, and context-sensitive health infrastructure planning for climate-vulnerable settings.

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1. INTRODUCTION

In the deltaic landscape of Bangladesh, the riverine islands known as "chars" represent a unique socio-ecological frontier where the boundaries between land and water are constantly in flux. The Gaibandha district, located in northern Bangladesh, is recognized as one of the most poverty-stricken and geographically vulnerable regions in the country (Hossain et al., 2020). Within this district, the sub-district of Gaibandha Sadar encompasses a vast network of chars formed by the siltation and hydro-morphological dynamics of the Brahmaputra and Jamuna rivers (Sabu, 2021). For the inhabitants of these islands specifically within marginalized unions such as Mollar Char and Kamarjani life is a precarious balancing act against the forces of nature, defined by annual monsoon flooding and rapid riverbank erosion (Hossain et al., 2023).

The health status of char dwellers is inextricably linked to this volatile environment. Physiographic and climate-change-induced hazards are primary drivers of health risks in Gaibandha, where recurring floods and droughts facilitate the spread of waterborne and airborne diseases (Hossain et al., 2020). In Gaibandha, reports indicate a high prevalence of digestive diseases, respiratory issues, and significant complications related to pregnancy (Hossain et al., 2020). Despite these acute needs, the char areas are characterized by a limited availability of formal medical infrastructure. Residents in unions like Kamarjani face a landscape

where community clinics are non-existent, and the few existing temporary sub-centers are frequently unstaffed or depleted of essential medicines and diagnostic tools (Share-Net Bangladesh, 2023).

This research approaches health-seeking behavior from an anthropological perspective, viewing it as a "sequence of remedial actions" taken by individuals to rectify perceived ill-health (Patil, 2016). In the isolated chars of Gaibandha, these actions are not merely clinical decisions but are deeply embedded in the "social suffering" caused by structural inequalities (Khan, 2018). The char population is often described as "subaltern," living at the material margins of mainstream Bangladeshi society and appearing in national discourse primarily as passive recipients of top-down policies (Jamil & Dutta, 2012). For these individuals, the journey to a mainland Upazila Health Complex is often described as "fighting a war," where the perils of crossing swollen rivers in the dark often result in patients dying before they reach professional care (Share-Net Bangladesh, 2023).

The landscape of healthcare in these regions is defined by "medical pluralism" the coexistence of multiple therapeutic systems within a single cultural setting (Halim & Mia, 2025). In the chars, this pluralism manifests in the overlapping roles of Kavirajes (folk herbalists), religious healers (Mollas and Fakirs), village doctors (Palli Chikitshaks), and the mobile services provided by NGOs (Ahmed et al., 2019; Hamida, 2024). Understanding why residents choose traditional healers over formal clinics requires an analysis of the "structural violence" that systematically denies them access to their fundamental right to health (Khan, 2018). Poverty, low literacy rates (reaching only 28.2% in Kamarjani), and geographical isolation act as "vulnerability factors" that dictate the "hierarchy of resort," often pushing residents toward informal providers who offer cultural proximity and "attentive nature of care" (Sabu, 2021; Hamida, 2024).

Furthermore, maternal health remains a critical site of struggle. While Bangladesh has made strides in reducing national maternal mortality, the disparity in remote chars remains acute, with nearly 79.4% of women still giving birth at home with untrained attendants (Islam et al., 2024). The lack of 24/7 emergency obstetric care means that every pregnancy in the chars carries a "deadly condition" risk (Share-Net Bangladesh, 2023). Innovative interventions, such as the floating hospital ships operated by the NGO Friendship, have begun to address this "fragmentation of service," yet they operate in a context where the state's presence remains minimal (Ahmed et al., 2019; Islam et al., 2024).

This study aims to investigate these health-seeking practices in detail, analyzing the transition between traditional beliefs and clinical interventions. By employing the Culture-Centered Approach (CCA) and the Health Belief Model (HBM), the research seeks to amplify the voices of the char dwellers of Gaibandha Sadar, providing a comprehensive view of the challenges and potential solutions for healthcare in one of the world's most climate-vulnerable regions (Halim & Mia, 2025; Jamil & Dutta, 2012).

The Health Belief Model structured exploration of behavioral determinants. Interview probes examined perceived susceptibility (e.g., flood-related illness risks), perceived severity (e.g., thresholds for seeking formal care), perceived barriers (e.g., transport cost, loss of wages), perceived benefits (e.g., trust in Kavirajes), and cues to action (e.g., advice from kin networks). During analysis, inductively generated codes were subsequently clustered under these HBM constructs, ensuring systematic linkage between belief structures and therapeutic trajectories.

Through this combined approach, CCA centered subaltern voice and agency, while HBM provided analytic structure for interpreting decision-making processes under structural constraint.

2. METHODS

2.1. Study Design

This study adopts a qualitative study design to examine the health-seeking practices and cultural health beliefs of the riverine island communities in Gaibandha Sadar, Bangladesh. The qualitative approach was selected to obtain a deep understanding of medical pluralism, traditional healing rituals, and the "subaltern" perspectives of marginalized char dwellers (Halim & Mia, 2025; Uddin, 2015). The research is theoretically grounded in the Culture-Centered Approach (CCA), which prioritizes the voices of marginalized communities in defining their own health narratives (Jamil & Dutta, 2012). Additionally, the Health Belief Model (HBM) is applied to explain health-related behaviors through the lens of perceived barriers, such as geographical isolation and "structural violence" (Halim & Mia, 2025; Khan, 2018).

2.2. Sampling Strategy

Purposive and snowball sampling techniques were used to select participants who could provide deep, relevant information regarding health practices in the chars (Halim & Mia, 2025; Uddin, 2015). A total of 32 participants were involved in the qualitative phase, including community elders, traditional healers, mothers, and NGO frontline workers. Purposive sampling ensured that key community decision-makers and vulnerable groups were represented, while snowball sampling was used to identify traditional Kavirajes and spiritual healers who often operate outside formal recognition (Hamida, 2024; Uddin, 2015).

Table 1 summarizes the socio-demographic diversity of participants, demonstrating representation across community elders, traditional healers, mothers, and local institutional actors.

Table 1. Categories and characteristics of the respondents (n = 32).

CATEGORY	SEX (M/F)	AGE RANGE	OCCUPATION/ROLE EXAMPLES	INTERVIEW TYPE	n
Community Elders	4M / 4F	55–75	Knowledge holders, village elders	IDI	8
Traditional Healers	5M / 1F	40–70	<i>Kaviraj, Molla, Fakir</i>	IDI	6
Mothers & WRA	0M / 10F	18–45	Primary maternal health negotiators	FGD / IDI	10
Local Leaders / NGO Staff	6M / 2F	30–60	UP chair, Friendship/SKS staff	KII	8

2.3. Research Instrument

The primary research instruments for this study consisted of semi-structured interview guides and focus group discussion (FGD) protocols developed by the lead researcher, aligned with the culture-centered approach (CCA) and the health belief model (HBM). The guides were initially drafted in English and subsequently translated into the local Bengali dialect to ensure linguistic and cultural equivalence. The in-depth interview (IDI) guide was organized into four thematic modules covering socio-demographic and environmental history, illness perception and etiology, the “hierarchy of resort” (therapeutic sequencing), and structural barriers to formal care. Prior to full implementation, the instruments underwent pilot testing with two residents from a neighboring char to refine the wording of sensitive questions, particularly those related to maternal health and spiritual beliefs. In addition, a standardized field observation checklist was employed to systematically document environmental conditions, transport availability, and the physical condition of local health sub-centers.

2.4. Data Collection Procedure

In-depth interviews (IDIs), key informant interviews (KIIs), and focus group discussions (FGDs) were the primary tools used for data collection.

IDIs and KIIs: Explored the “hierarchy of resort” and the structural barriers to accessing formal hospitals (Uddin, 2015; Ahmed et al., 2019).

FGDs: Captured collective perceptions of illness etiology, such as the role of the “evil eye” in childhood ailments (Uddin, 2015).

Field Observations: Supplemented interviews by documenting the physical landscape, including the state of transport boats and the distance to the nearest mainland clinic (Halim & Mia, 2025; Hossain et al., 2023).

Fieldwork was conducted in the Mollar Char and Kamarjani unions between October 2022 and February 2023 (Halim & Mia, 2025). Interviews were carried out in the local Bengali dialect to maintain cultural nuance and ensure participant comfort (Uddin, 2015). All sessions were audio-recorded with the consent of participants and accompanied by elaborate field notes. Each session lasted between 60 and 90 minutes (Uddin, 2015).

2.5. Ethical Considerations

The rights and dignity of all study participants were the central concern of the research process. Participation was entirely voluntary, and all respondents were informed of their right to withdraw at any stage without penalty. Given the high illiteracy rates in the chars, verbal informed consent was prioritized and recorded after a full explanation of the study goals in the local dialect (Sabu, 2021; Halim & Mia, 2025). To protect participant identities, pseudonyms were assigned, and any identifying contextual details were removed (Hossen et al., 2023; Uddin, 2015). Additionally, the research team remained sensitive to Purdah norms, ensuring that female participants were interviewed by female researchers in private settings to respect cultural and gender-based boundaries (Hamida, 2024).

2.6. Data Analysis

All interviews were transcribed verbatim and translated into English while retaining analytically significant vernacular expressions. Thematic analysis was conducted in three stages.

First, open coding identified recurring patterns related to therapeutic sequencing, maternal practices, environmental risk perception, and institutional access. Codes were generated inductively from the data while remaining sensitized to HBM constructs.

Second, focused coding clustered related codes into broader thematic categories. NVivo software facilitated code organization, retrieval, and cross-comparison across participant groups.

Third, analytic memoing was employed to document emerging interpretations and reflexive considerations. Coding was conducted primarily by the lead researcher. To enhance analytic consistency, transcripts were revisited iteratively, and emerging interpretations were cross-checked against raw data to ensure fidelity to participant voice. To enhance analytic reliability, 20% of transcripts were independently reviewed by a second researcher trained in qualitative coding. Coding discrepancies were discussed collaboratively until consensus was reached, ensuring consistency in theme development and interpretive accuracy.

Data collection continued until thematic saturation was reached, defined as the point at which no substantively new codes emerged across three consecutive interviews.

Secondary quantitative statistics cited in this manuscript are used solely for contextual framing and are not part of the analytic dataset.

2.7. Researcher Positionality and Reflexivity

Given the study's emphasis on marginalized voices, reflexivity was incorporated throughout the research process. The research team was affiliated with a public university in Bangladesh and possessed fluency in the local dialect spoken in the char communities. Gender-sensitive interviewing practices were implemented, particularly for female participants observing Purdah norms, with female researchers conducting interviews in private settings.

The research team remained attentive to potential power asymmetries between academic investigators and participants. Interviews were conducted conversationally to minimize hierarchical distance. Reflexive memos documented how institutional affiliation and interpretive frameworks might shape analysis, particularly when examining themes of state absence and infrastructural exclusion.

3. RESULTS

3.1. Socio-Demographic Vulnerability and the Environment

The findings highlight a "reinforcing cycle between poverty, environmental instability, and health vulnerability" where geographical isolation serves as the primary driver of socio-economic and health hazards. In unions like Kamarjani, literacy rates are as low as 28.2%, and nearly 49.3% of the population is landless. Environmental instability is a constant, with islands often submerged annually between June and August, forcing frequent displacement and disrupting the social networks that underpin informal health support.

3.2. Health-Seeking Dynamics

Table 2 illustrates the layered structure of health-seeking behavior, highlighting the coexistence of pluralistic care practices alongside systemic barriers.

Table 2. Thematic categorization of health-seeking dynamics.

MAIN THEMES	SUB-THEMES
1. Pluralistic health seeking	1.1 Domestic remedies as the first resort 1.2 Trust in <i>Kaviraji</i> and spiritual healers 1.3 Role of the "village doctor"
2. Barriers to clinical care	2.1 Transport as a "war" 2.2 Financial prohibitiveness 2.3 Structural neglect by the state
3. Maternal health and rituals	3.1 Prevalence of home delivery 3.2 Taboos on pregnancy disclosure 3.3 Dependence on untrained attendants (<i>Dais</i>)
4. Disease and hazard perceptions	4.1 Perceived etiology (natural vs. supernatural) 4.2 Impact of seasonal floods on disease patterns.
5. NGO interventions	5.1 Success of floating hospitals 5.2 Community medic-aides (FCMs) as bridges.

3.2.1. Pluralistic Health Seeking

Most community members first approach traditional healers, only moving to modern treatment when these fail. *Kaviraj*es remain deeply trusted because they offer holistic care that considers the "dynamic equilibrium" of the body and spirit (Hamida, 2024). Specialized rituals for jaundice, such as "liver *khilano*" (feeding the liver) or wearing garlands made from *Bamanhati* plants, are common. Beliefs in "evil eyes" and supernatural causes for childhood ailments (reported by ~20% of residents) reinforce the reliance on spiritual practitioners like *Mollas* and *Fakirs*.

3.2.2. Barriers to Clinical Care

The recurring metaphor of “war” used by respondents to describe accessing treatment reflects more than physical hardship. While it captures the immediate dangers of night-time river crossings and financial strain, it also signals a normalized expectation that survival is experienced as contingent upon navigating institutional limitations. Framing treatment-seeking as “war” suggests an internalized recognition of systemic marginalization, where preventable mortality is experienced as embedded within geography rather than exceptional misfortune. Through a culture-centered lens, this language constitutes a form of subaltern political expression naming inequality without formal political discourse. Multiple participants described accessing formal healthcare as “fighting a war.” The phrase was used particularly in reference to night-time river crossings and emergency obstetric transport.

3.2.3. Maternal Health and Rituals

Maternal health is characterized by significant risk, with 79.4% of women delivering at home. Cultural norms, including the practice of Purdah and taboos surrounding early pregnancy disclosure, often delay seeking professional antenatal care until the late trimesters. The absence of community clinics in chars like Mollar Char means that emergency obstetric care is virtually non-existent.

3.2.4. Disease and Hazard Perceptions

The findings revealed that perceptions of disease in the char communities of Gaibandha Sadar were shaped by the coexistence of biomedical understanding and deeply rooted cultural beliefs. Participants commonly associated some illnesses with natural causes such as contaminated water, seasonal changes, and poor living conditions; however, certain persistent or unexplained conditions were interpreted as resulting from supernatural influences, including the “evil eye” or spiritual affliction.

3.2.5. NGO Interventions

Participants described NGO-led healthcare initiatives as transformative in addressing the geographical and environmental barriers that characterize life in the char areas of Gaibandha Sadar. Floating hospitals were perceived as highly effective in delivering essential medical services during periods of flooding and physical isolation, when conventional access to health facilities became difficult or impossible.

Table 3 presents participant narratives that substantiate key analytic themes, particularly trust in traditional healers and perceived transport risks.

Table 3. Relevant quotations from study participants.

THEME	SUB-THEME	COMMENTS FROM STUDY RESPONDENTS
Pluralistic health seeking	Trust in <i>Kaviraj</i>	“We don't go to the doctor unless it's really bad. For stomach pain or cold, the <i>Kaviraj</i> is our first hope.”
Barriers to clinical care	Transport as a “war”	“We couldn't find a boat in time for my sister-in-law. She passed away on the way to the mainland hospital.”
Maternal health and rituals	Prevalence of home delivery	“Delivery at home is our tradition. The hospital is too far, and crossing the river in the dark is a nightmare.”
Disease and hazard perceptions	Perceived etiology (natural vs. supernatural)	“Sometimes medicines from the shop don't work because the illness is from the 'evil eye'. Only a <i>Molla</i> can cure that.”
NGO interventions	Success of floating hospitals	“The hospital ship is a blessing. It comes to our doorstep when the roads are gone.”

4. DISCUSSION

4.1. Structural Violence and the Geography of Neglect

The health-seeking behaviors of char residents in Gaibandha Sadar are not merely individual choices but are profoundly shaped by “structural violence” the systemic ways in which political, economic, and geographical organizations prevent individuals from reaching their full potential (Khan, 2018). Limited state investment in permanent health infrastructure and flood-resilient transportation in unions like Kamarjani and Mollar Char constitutes a structural inequity in access to health services. (Khan, 2018; Share-Net Bangladesh, 2023). The “war” metaphor used by respondents to describe the journey to a hospital underscores a reality where physical isolation significantly increases mortality risk during emergencies for those with emergency complications (Share-Net Bangladesh, 2023). This subaltern positioning limits their incorporation into centralized planning frameworks to national health planning, which often utilizes urban-

centric models inapplicable to the shifting hydro-morphology of the riverine islands (Jamil & Dutta, 2012; Ahmed et al., 2019).

4.2. Medical Pluralism as Pragmatic Resilience

From an anthropological perspective, the heavy reliance on Kavirajes and religious healers is a form of "dynamic hybridity" a pragmatic adaptation to economic precarity and spatial marginalization (Hamida, 2024; Halim & Mia, 2025). Medical pluralism in the chars allows residents to navigate between systems that offer cultural proximity and those that offer pharmaceutical relief (Halim & Mia, 2025). Traditional healers act as "trusted advisors" who offer perceived interpersonal responsiveness contrasting with the often-unfriendly or discriminatory encounters reported in formal biomedical facilities (Hamida, 2024; Share-Net Bangladesh, 2023). The use of jaundice garlands or rituals for "evil eyes" provides a sense of agency and psychological comfort to a population that has little control over its physical environment (Hossain et al., 2020; Uddin, 2015).

4.3. Maternal Health: The Intersection of Gender and Geography

The critical state of maternal health in the chars represents the intersection of structural neglect and deeply rooted social norms (Islam et al., 2024; Hamida, 2024). The high home delivery rate (79.4%) is driven by the physical impossibility of reaching emergency care in the dark and the "cultural taboo to pregnancy disclosure" (Islam et al., 2024; Share-Net Bangladesh, 2023). Gender-equity theories suggest that women's empowerment is linked to access to services; however, in the chars, Purdah norms and the requirement for a guardian's permission often delay seeking care until it is too late (Hamida, 2024; Halim & Mia, 2025). The absence of community clinics transforms pregnancy into a high-risk condition within this infrastructural context (Share-Net Bangladesh, 2023).

4.5. Applying the Health Belief Model (HBM) to the Char Context

The Health Belief Model provides a useful framework for understanding how residents of the char areas evaluate illness severity and determine when to transition from informal to formal care. Participants' narratives reveal that perceived barriers constitute the most dominant determinant shaping therapeutic decision-making. Geographic isolation, unpredictable river transport, financial constraints, and loss of daily wages collectively shape the calculus of whether clinical care is feasible.

Perceived severity was frequently linked to functional impairment rather than biomedical diagnosis. Illness was often categorized as "serious" only when it disrupted daily labor capacity, which is central to household survival. This functional framing of severity influences the timing of care-seeking and contributes to delayed transitions to formal facilities.

Perceived benefits of traditional providers were associated with relational accessibility, flexible payment arrangements, and culturally embedded explanations of illness. Kavirajes and religious healers were viewed as immediate and socially proximate, reinforcing their position within the therapeutic hierarchy.

Cues to action typically emerged through informal kinship networks rather than institutional messaging. Advice from family members or neighbors often initiated the decision to consult a healer or seek biomedical care.

Importantly, these behavioral determinants operate within broader structural constraints. HBM helps illuminate how residents interpret risk and negotiate available options, while the surrounding infrastructural conditions delimit the practical range of those choices.

4.6. The Role of NGOs and Disaster-Resilient Health

The success of Friendship's 3-tier healthcare model demonstrates the effectiveness of "mobile and floating" infrastructure in unstable environments (Ahmed et al., 2019; Islam et al., 2024). This model of "integrative design" reflects a "context-responsive service-delivery model" that puts the community's unique needs first (Ahmed et al., 2019). However, the reliance on NGOs also highlights a "fragmentation of service" and a limited institutional integration within national systems (Ahmed et al., 2019; Khan, 2018). The study argues that for long-term sustainability, the government must integrate these mobile models into the national health framework as part of the National Health Infrastructure Revitalization Plan 2024-2025 (World Bank, 2024).

5. CONCLUSION

This study demonstrates that therapeutic hierarchies in Gaibandha's char communities are shaped by the interaction of environmental instability, perceived barriers, relational trust, and institutional accessibility. Traditional healers function as primary care entry points not solely due to cultural continuity but also because of geographic and financial constraints. Maternal health risks arise at the intersection of gender norms and

infrastructural absence. The metaphor of “war” encapsulates collective awareness of the struggle embedded in accessing formal healthcare.

Policy implications emerging from these findings include structured referral partnerships between informal providers and formal facilities, flood-resilient transport systems for emergency care, and integration of mobile or floating clinic models into national planning frameworks. Several traditional healers acknowledged their limitations in handling severe cases, indicating potential openness to referral collaboration. These recommendations are derived from participant narratives rather than aspirational positioning and underscore the need for context-responsive health infrastructure in climate-vulnerable regions.

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DECLARATION OF COMPETING INTEREST

The authors declare no competing interests.

DECLARATION OF GENERATIVE AI USE

During the preparation of this work, the authors used Gemini (Google AI) in order to refine the academic tone, improve the grammatical flow of the manuscript, and assist in the formatting of tables according to journal standards. After using this service, the authors reviewed and edited the content as needed and take full responsibility for the content of the published article, ensuring that all anthropological interpretations and field data remain authentic to the original research conducted.

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AUTHORS' CONTRIBUTIONS

Sheikh Mehzabin Chitra: Conceptualization, Methodology, Formal Analysis, Investigation, Data Curation, Fieldwork, Writing – Original Draft.

Sheikh Mehbuba Moitree: Methodology, Validation, Writing – Review & Editing, Legal and Policy Contextualization.

AVAILABILITY OF DATA AND MATERIALS

The data supporting the findings of this study are available upon reasonable request from the corresponding author. The data are not publicly available due to ethical restrictions related to the privacy and confidentiality of the participants in vulnerable riverine communities.

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