

## Health Awareness Among Tribes of Rural India

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### Abstract

The tribal populations are recognised as socially and economically vulnerable. Their lifestyles and food habits are different from that of their rural neighbours. They depend on minor forest produce and manual labour for livelihood. They may not have adequate income. Their food consumption pattern is dependent on the vagaries of nature and varies from extreme deprivation (in the lean seasons) to high intakes (in the post-harvest period). About 21% of them are scheduled castes and 24% are tribes. Purulia suffers from very poor conditions in terms of hygiene, poverty, and lack of safe drinking water, resulting in major health problems such as diarrhoea, malaria, filarial, TB, anaemia, and others. Poor child birth and nutrition standards lead to high IMR and MMR. Open defecation, lack of sanitary latrines, poor educational standards for girl children, and poor awareness of HIV/AIDS also compound Purulia's health and development problems. Tribal people are known to have sexual practices that vary from those of mainstream cultures. Less or nothing is known about the prevalence of HIV and AIDS among tribal people in India, except perhaps in some of the tribal states of the North-East of India as these have high prevalence of drug use. HIV and AIDS has become the fourth largest killer worldwide, and in Asian counterpart which is scattering at an alarming rate. In developing countries, it was estimated that at least half of the non-pregnant and two thirds of the pregnant Women are anaemic. Maternal malnutrition which was quite common among the tribal women was also a serious health problem especially for those having numerous pregnancies too closely spaced and reflected the complex socio-economic factors that affected their overall condition.

**Keywords:** Diarrhoea; Malaria; Filarial; Anaemia

### Introduction

Socially backward and economically deprived tribal populations have their different life styles than other rural neighbours. They live from hand to mouth from manual labour and forest produce. They live with inadequate money. They consume daily food from vagaries of nature and suffer from debility due to minimum food consumption in the lean season.

About 21% of them are scheduled castes and 24% are tribes. Purulia suffers from very poor conditions in terms of hygiene, poverty, and lack of safe drinking water, resulting in major health problems such as diarrhoea, malaria, filarial, TB, anaemia, and others. Poor child birth and nutrition standards lead to high IMR (Infant mortality rate) and MMR (Maternal mortality rate). Open defecation, lack of sanitary latrines, poor educational standards for girl children, and poor awareness of HIV/AIDS also compound Purulia's health and development problems.

Only 1.0% people know about Oral Pills, 1.7%; people knew about IUD, Traditional methods were known to 3.7%, 56.3% Santals are know about family planning; 39.3% [1]. Lodha were aware about family planning through Primary Health centre and Aganwardi worker. Due to different kind of risk behaviour tribal of rural area are more susceptible to HIV/AIDS.

Tribal people's sex habit varies from mainstream cultures. There is no particular where about the HIV and AIDS infection. Among tribal population in India excluding some of tribal states of north east of India these have high common practice of drugs use [2].

HIV and AIDS has become the fourth largest killer worldwide, and in Asian counterpart it is scattering at an alarming rate. In other parts of Asia HIV and AIDS are alarmingly high. Nutritional deficiency is a major problem for tribal women in India and it is observed particularly in tribal affected areas.

In developing countries like India both pregnant and non-pregnant women suffer from anaemia. Among pregnant women about two

third of pregnant women suffer from blood deficiency and half of the common young women are anaemic. Nutritional anaemia was a major problem for women in India and it is more observed in the tribal belt.

In developing countries, it was estimated that at least half of the non-pregnant and two thirds of the pregnant Women are anaemic.

Maternal malnutrition which was quite common among the tribal women was also a serious health problem especially for those having numerous pregnancies too closely spaced and it reflected the complex socio-economic factors that affected their overall condition. Tribal diets are grossly deficient in Calcium, Vit A, Vit C, riboflavin, and animal protein [3]. Diets of South Indian tribes in general are grossly deficient even in respect of calories and total protein is deficient even in respect of calories and total protein. Tribal people have succumbed to poor access to health service; there is no such utilization of health services and there is no such utilization of health service, some social, cultural, and economic factors are responsible for these; some poor utilization of health services; are unique and some of the problems of accessibility are noticed in tribal areas; difficult terrain and sparsely distributed tribal population in forests and hilly regions suffer from these problems.

Sub centres, primary health centre (PHC) community health centre are not; located in proper places, causing disadvantages to tribal women, there is lack of infrastructure; there are less number of doctors and nurses, paramedical staffs, transport facility is poor in time of emergency and other developments, Appropriate policies should be

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made to encourage or motivate the service provided to start work in tribal areas; inadequate mobilization of NGO lack of integration of other health program reach culmination, IFC (Iron folic acid supplement programmes) activities are not tuned to tribal beliefs and practices; Services are not patient- friendly in terms of training, cultural barriers; inhibit utilization, local traditional faith healers are not involved; weak monitoring and supervision system are not entangled.

Among schedule tribes in age group of 15-49 years only 38.6 percentage of women had heard or knew about AIDS while 55.3% of scheduled caste women do not have any knowledge of AIDs other backward caste do have knowledge of AIDS [4]; altogether 58.55% among higher caste 72.7% know about AIDS; schedule tribes men are very much aware of this that is 63.9% higher than women. It was substantially higher as compared to other lower caste groups (schedule caste 80.8%, other backward category 84.1% and other castes (89.06%). Television enlightens common sources of information about AIDS through different programmes.

Onges in the Andaman have very little awareness or access to either nutrition or health care. Differential area-specific need assessment, strategies and programmes to improve access, and utilisation of nutrition services have to be developed for each of tribal areas. The demographic status of the primitive tribes has shown a declining or static trend. The demographic data of Juanga primitive tribe of Orissa revealed a marital fertility rate of about 6 and life expectancy at birth was 35.9 years. A study carried out recently by RMRC, Bhubaneswar amongst four primitive tribes of Orissa, revealed an infant mortality rate (per 1000 live birth) of 139.5 in Bondo, 131.6 in Didayi, 132.4 in Juanga and 128.7 in Kondha (Kutia); a maternal mortality rate (per 1000 female population) is of 12 in Bondo, 10.9 in Didayi, 11.4 in Juanga and 11.2 in Kondha tribe; the life expectancy of 48.7 years in Bondo, 57.1 years in Didayi, 49.6 years in Juanga and 50.7 years in Kondha; the crude birth rate (per 1000 population) is of 18.31 in Bondo Kondha population Intestinal protozoan and helminthic infestations are the major public health problems and were observed in 44.6% in Bondo, 44.9% in Didayi, 31.9% in Juanga and 41.1% in Kondha primitive tribes of Orissa. Amongst helminthic infestation hookworm was most common (21% in Bondo, 18.7% in Didayi, 14% in Juanga and 18.2% in Kondha.

As per nutritional status there are wide variations and access to and utilization of nutrition and health services also vary from women to women, literacy level is high among tribal people in north east states; they avail access facilities, comparing with the national average of nutritional and the health status of women and children In that states they are better, on other hand, Onges of Andamans belong to primitive tribes and are not aware of access to either nutrition or health care; different areas have specific assessment strategies and programs are to improve access and nutritional services have been utilized for development of tribal areas. The demographic states of the primitive tribes have declining trend or it is static. The demographic data of Tuanga primitive tribes of Orissa show a material fertility rate about 6% and life span at birth is around 35.9 years. A deep attention has been drawn in recent time by RMRC, Bhubaneswar among four primitive tribes of Orissa. It discloses an infant mortality of 13.4 in Juanga and 128.7 in Kondha (kutia). A maternal rate (per 1000 female population) of 12 bondo, 10.9 in didayi, 11.4 in Juanga and 11.2 in mortality rate Konda tribes shows that the life expectancy is 48.7 years in Bondo 57.1 years Diyadi, 49.6 years in Juange. The birth rate which is 18.31 as per thousand in Bondo among Kondo major health problem is intestinal protozoa and helminthic infestation. They were noticed in 44.6%, 14%

in Juanga ,18.7 in Didayi it is common helminthic infestation hook worm. IV-1-positive patient was cured after the transplantation of CCR5 Δ32/Δ32 stem cells [5]. This isolated case illustrates the potential of translational genetic research to combat HIV/AIDS.

### Sources of Data Collection

Data collection is done by direct interview method where respondents directly response questionnaire; the interview schedule is composed. with open- ended questions for this out of 200 people among them hundred people response complete aim to complete present study. A qualitative study is done from August 2009 to October 2009. Adolescents are required to complete questionnaire; which have included a signed consent and specific question on age and ethnicity. Questionnaires give clear indication about their socio-economic condition, ethnicity, religion, and their general awareness of health status. This study is done among men and women from 15 years to 45 years of age.

### Method

The study was conducted on 200 adolescents; the current billion strong generation of 10-19-year-old will be the largest generation inhibitory to make transition from childhood to adulthood. Though reproductive health of adolescent girls they have been neglected for long past, but for last 10-12 years an emphasis has been given to raise their awareness level by introduction of lifestyle in school education and this should be performed in friendly environment [6]. Present study reveals that mainly Adolescents girls feel awkward and shy to get knowledge about contraceptives before their marriage. Somewhere they have guilty feeling. Due to some initiative of government to aware about adolescent reproductive health their attitude towards it is not so helpful for those programs (Anwasha Clinic, Weekly Iron Folic Acid tablet supplement, Rastriya Bal Sakti karjakarm, Kisori shakti yoyaja). Parents are not even interested to aware their adolescents girls about reproductive health; they even think about knowing all about family planning they experience premarital sex, but this thinking made adverse effect on adolescent, due to lack of knowledge of contraceptive Adolescents go through unsafe abortion which leads to infertility for life or life risk [7]. It was found that due to poor knowledge about family planning; early marriage causes sexual disharmony.

### Results

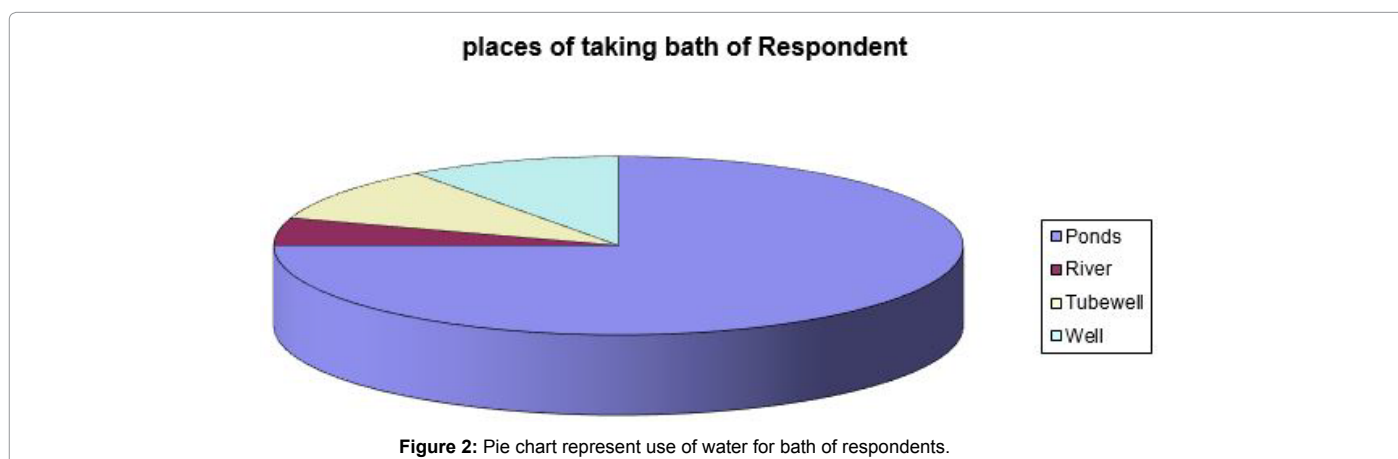
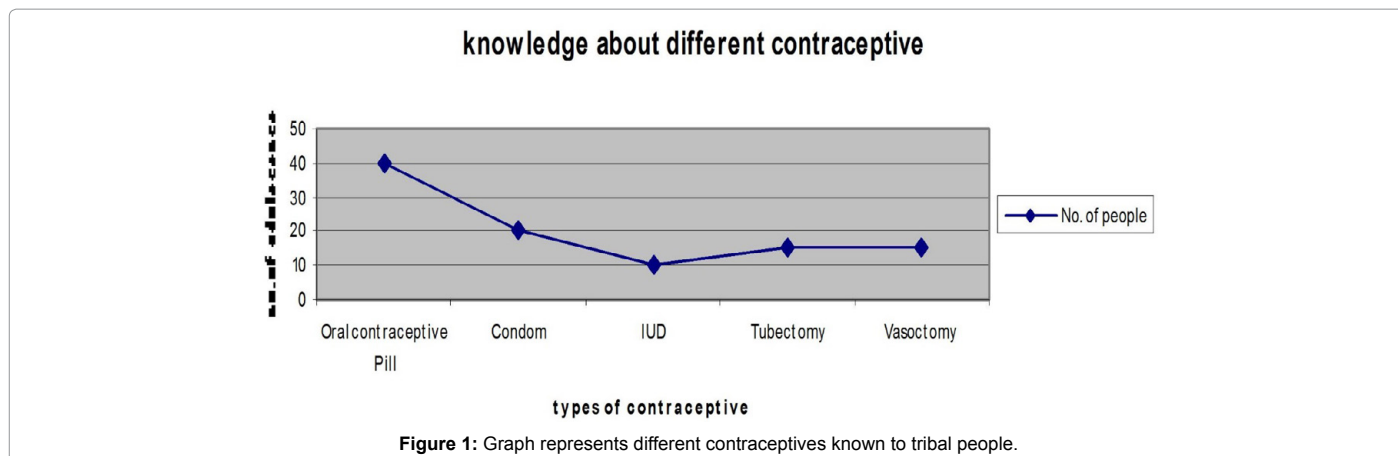
Table 1 represents 65.4% girls came to know about HIV/AIDS from friend, in rural area tribal people get treatment from quak 35.8% (Table 2). In respect of contraceptive pills method. tribal married

No. of respondent Get information about AIDS/HIV	
Source of information	Percentage
Parents	10.7
Teacher	10
Friend	65.4
Doctor	20.9
Counsellor	80

Table 1: Frequency percentage from sources of Information HIV-AIDS known to clients.

Distribution of different type of health facility utilization	
Treatment Center	No. of people (percentage)
Hospital	72.8
Sub centre clinic	60.9
Home remedy	30.5
Quak	35.8

Table 2: Different health services available to tribal people.



	Different kind of disease	Place of bath (pond)
Mean	36.66666667	28.33333333
Variance	58.33333333	25.33333333
Observations	3	3
df	2	2
F	2.302631579	-
P(F<=f) one-tail	0.302788845	-
F Critical one-tail	19	-

**Table 3:** Represents relation of different disease and place of bath.

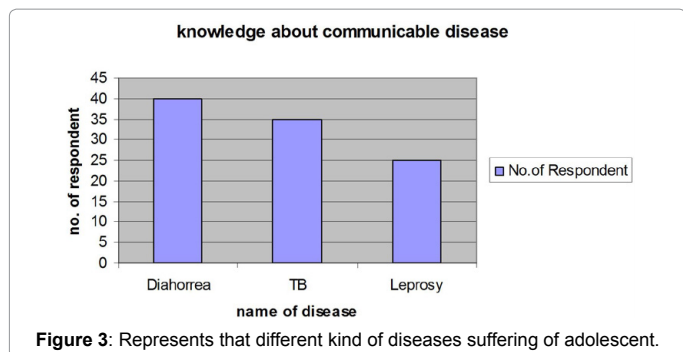
	Different disease	Place of taking bath (river)
Mean	36.66666667	19
Variance	58.33333333	9
Observations	3	3
df	2	2
F	6.481481481	-
P(F<=f) one-tail	0.133663366	-
F Critical one-tail	19	-

**Table 4:** Represents relation of different disease and place of bath.

adolescent have idea about contraceptives pill in comparison to other contraceptives, girls have habit to take bath in river and pond being unaware of proper hygiene they become susceptible to reproductive tract infection, white discharge etc. (Figures 1 and 2). Tables 3 and 4 represents that different types (RTI, skin disease) of statistical shown significant relation with their use of pond water, river which proves that due to unhygienic habit they become susceptible to those disease.

### Discussion and Conclusion

40% among responded have knowledge about Contraceptive pills irrespective of both sex (Figure 1). Majority of rural people are suffering from skin disease, sexually transmitted infection, and reproductive tract infection due to taking bath in pond water (75%) (Figure 2). when women, men reported about white discharge, irritation



Due to lack of knowledge about several diseases and main cause of occurrence of disease, they are frequently suffering from those kind of diseases, in cases of Tuberculosis patient sometimes failed to take medicine and it causes return of disease. In present study, it shows there are tendency to early marriage of girls in rural areas and tribal people, mean age of marriage is 15.8 years; 43% girls have their first child before age of 19 years, at time of this study a report shows that counsellor of adolescent centre has found 4 cases of unmarried pregnancy and one girl experiences to go through abortion, but she is not interested about any kind of abortion. Due to awareness of generation of about contraceptive they are to consume emergency contraceptive pill at time of emergency (Figure 3).

Early age marriage is main cause of birth of low birth weight child or intrauterine growth retardation; biologically girls do not mature physically to carry on their womb. In rural India women, still are neglected on nutrition, 50% are anemic; use of sanitary latrine are so poor and they use open field for defecation which cause worm infestation which leads anemia.

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