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RESEARCH ARTICLE

HEALTH SEEKING BEHAVIOR OF TRIBES – IDENTIFYING MULTIDIMENSIONAL CAUSES

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ABSTRACT

The tribal population in India constitutes 8.6% of the country's population (Census, 2011) and is considered as socially and economically backward and disadvantaged. Tribal poverty has come into sharp focus since their food sources from the forest have started dwindling. Also, widespread poverty, illiteracy, under nutrition, absence of safe drinking water and sanitary living conditions, poor maternal and child health services and ineffective coverage of national health and developmental services have been identified by several studies, as possible contributing factors to the dismal health conditions prevailing among the tribal population in India. In this article, the author focuses on certain interacting factors like the infant mortality rate, life expectancy, genetic disorders, sexually transmitted diseases, nutritional status, child health and health care practices which are generally responsible for determining the health status and health behavior of tribal communities.

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INTRODUCTION

Tamilnadu had 7, 94,697 tribal population[1] during 2011 census which constitutes 1.% of the total population. There are 36 tribes and sub tribes in Tamilnadu. Literacy rate: 27.9%. Most of the trials in Tamilnadu are cultivators, agriculture laborers or dependent on forests. There are six primitive tribes in Tamilnadu. They have contributed significantly in the management of the forests. Tamil Nadu was non-ASHA State till 2009. The State implemented Tribal Village Health Volunteer (VHVs) scheme since 2009 in12 districts with tribal population. 2650 VHVs (Accredited Social Health Activist-ASHA are designated as VHVs in Tamil Nadu) are placed in Tribal / Remote and inaccessible villages of Tamil Nadu. 1639 are trained and established and the remaining 1011 are undergoing training. Tribal leaders/ Members of VHWSC/ Supportive staff/ Local vaidyas etc., have been oriented through VHWSC meetings. In order to promote institutional delivery and for quality MCH care Services. Birth Waiting Rooms have been established in 17 foot hill PHCs under NRHM where the pregnant women stay one week prior to their EDD along with one attendant for each mother along with feeding charges. The remote tribal villages are covered by Mobile Medical Services through NGO in 12 places apart from Government run units.

Tribals and health

It is found that majority of these tribes believe the causes for ill health care (i) displeasure of supernatural entities, (ii) breach of taboos,(iii) non-fulfillment of obligations towards their gods, (iv) Influence of occultism and (v) Environmental and physical ones. Further, nutritional deficiencies are more in young tribal children and reproductive health care is also poor. Health of the tribes is prejudiced by a number of factors such as adequate food, housing, sanitation, healthy lifestyles, protection against-environmental hazards and communicable diseases. Experts have indentified variety of issues related to tribal health that is: (1) health and culture-including, (2) health, food habits and environment, (3) medicine, health and community-modern, (4) fertility and mortality, (5) interaction of traditional and modern systems of medicine at various levels and (6) reasons for non-adoption of modern practices (Naidu, 2008) (Naidu, 2008).

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Mortality

Studies on fertility and mortality trends among the tribal population of India have been found to be fragmentary and isolated. Limited studies are available on infant mortality and hardly any study is available on maternal mortality among the tribal population. Pandey (1990) observed high fertility and mortality in Mishmi tribal groups and attributed it to the low level of education and income lack of knowledge of family planning method and importance of small family size poor medical facilities, lack of proper sanitation and drinking water. Baryam (1982) studied 196 ever-pregnant women belonging to the Hajong tribe of West Garo hills district of Meghalaya. High infant mortality [18.2%] and pre natal mortality [3.1 %] were reported among them.

Table 1. Health Profile of Scheduled Tribes

Important Indicators	ST	Total
Infant Mortality	62.1	57
Neo-natal Mortality	39.9	39
Pre- natal Mortality	40.6	48.5
Child Mortality	35.8	18.4
Under five Mortality	95.7	74.3
ANC Checkup	70.5	77.1
Percentage Institutional Deliveries	17.7	38.7
Childhood vaccination (full immunization)	31.3	43.5
% households covered by a health scheme/ insurance	2.6	31.9
Prevalence of any anaemia (<12.0 g/dl) in women	68.5	55.3

Source: National Family Health Survey (NFHS) 2005-06

There has been a consistent decline in Infant Mortality Rate (IMR) and Under-Five Mortality Rate (U5MR) in India. The rate of decline in current decade is higher than in the previous. The rate of decline in current decade is higher than in the previous. The results from NFHS-4 in 15 States/Union Territories indicate that fewer children are dying in infancy and early childhood. After the last round of National Family Health Survey in 2005-06, infant mortality has declined in all first phase States/Union Territories for which trend data are available. All 15 States/Union Territories have rates below 51 deaths per 1,000 live births, although there is considerable variation among the States/Union Territories. Infant mortality rates range from a low of 10 in Andaman and Nicobar Islands to a high of 51 deaths per 1000 live births in Madhya Pradesh.

Better care for women during pregnancy and childbirth contributes to reduction of maternal deaths and improved child survival. Almost all mothers have received antenatal care for their most recent pregnancy and increasing numbers of women are receiving the recommended four or more visits by the service providers. More and more women now give birth in health care facilities and rates have more than doubled in some States in the last decade. More than nine in ten recent births took place in health care facilities in Andaman and Nicobar Islands, Andhra Pradesh, Goa, Karnataka, Puducherry, Sikkim, Tamil Nadu, and Telangana, providing safer environments for mothers and newborns. Among the socio-economic factors, in India studies have shown that a child born to a Scheduled Tribe family has 19 per cent higher risk of dying in the neonatal period and 45 per cent risk of dying in the post-neonatal period compared with other social classes[6] Though similar trends in child mortality have been observed for infant and neonates in both tribal and non tribal populations, there is a disproportionate increase in death among children aged 1-4 yr belonging to the Scheduled Tribes compared with the non-Scheduled Tribes (Das et al., 2010). These differences may be related to the increased social and health related vulnerabilities of the tribal population. Further examination of the infant mortality among the Scheduled Tribes by place of residence shows the highly disadvantaged position of the children born to mothers belonging to Scheduled Tribes in rural areas compared to urban areas (Das et al., 2010). In general, there is an increased likelihood of deaths of infants in rural as compared to urban areas; however, with regard to the Scheduled Caste/Tribes population, the risk is exacerbated (Dwivedi et al., 2013).

Genetic disorders

Genetic disorders namely sickle cell anemia and Glucose- 6-Phosphate enzyme deficiency (G-6-PD) are most common among the tribal community. Sickle cell anemia are found to occur in rather high frequencies in tribes, both male and female are equally affected in the populations whereas males are more affected than females in G-6-PD deficiency cases. Prevalence rate up to 40 percent of heterozygous form (sickle cell trait) was reported in some tribes i.e. Adiyan of Kerala, Irula, Paniyan, Mulukurumbha of Nilgiri hills and Gonds of Rajpur[9]. G-6-PD is an important enzyme of the red blood cell and its deficiency are inherited as an X-linked recessive trait. Males are strongly affected but expression in females varied greatly. This enzyme deficiency caused frequent hemolytic episodes by intake of commonly used drugs such as anti-malarials, antibiotics; analgesics etc, About 13 lakhs G-6-PD deficients are present in tribal population (Report of a DST Expert Committee, 1990). The prevalence was especially high among the tribes of Madhya Pradesh, Maharashtra, Tamil Nadu, Orissa and Assam states.

It is commonly found among people of tropical countries and transmitted as autosomal recessive character. It is the most common single genetic mutation in man and reported from a large part of the world i.e. Africa, Mediterranean countries, Middle East and parts of South American countries, India and others parts of the globe where people originating from these countries have settled. If a person receives only one gene responsible for sickle hemoglobin from either of parent, the condition is called carrier or trait. If one inherits two defective genes, one from each parent, the condition is called sickle cell disease. As the carrier state is stated to provide protection against mortality against malaria, it has attained high frequency in many parts of the tropical world (Serjeant and Serjeant, 2001).

Sexually transmitted diseases

Sexually transmitted infections (STIs) are perhaps as old as human civilization itself. Medical descriptions of STIs date back to the fifteenth century when syphilis and gonorrhoea were primarily responsible for the abandonment of public baths in Europe. After World War II, new diagnostic techniques and clinical and epidemiological studies established that many 'non-traditional' microbes could also produce infections when

transmitted sexually. In the USA, of the top 11 reportable diseases in 1996, 5 were transmitted sexually (gonorrhoea, chlamydial infection, syphilis, hepatitis B and acquired immune deficiency syndrome [AIDS]). STIs are also among the 5 leading causes of health problems in developing countries. The World Health Organization (WHO) estimated that in 1999, 340 million new cases of curable STIs occurred globally, of which 150 million cases were reported from South and Southeast Asia including 50 million from India. The term STD denotes more than 25 infectious organisms that are transmitted through sexual activity, along with dozens of clinical syndromes that they cause. Some of the very common STDs are Gonorrhea, Syphilis, Chancroid, Lympho Granuloma Venerum (LGV), Donovanosis Chlamydis infections. Genital Herpes, Hepatitis B, Genital Warts and Pelvic inflammatory diseases. AIDS is the latest addition in the list.

Sexually transmitted diseases are epidemics of tremendous health consequences spread all over the world. There are four serious health consequences of sexually transmitted diseases. These are a) blockage of the fallopian tubes which can lead to infertility and ectopic pregnancy, b) pregnancy loss and increased newborn deaths caused by transmission of the infection to the infant during pregnancy and childbirth, c) genital cancers for males and females, and d) enhanced transmission of HIV/AIDS. Besides, the psychological impact of having a sexually transmitted disease can be severe. Some persons become depressed or anxious. They fear recurrent outbreaks, transmission to sex partners, and encounter difficulties in developing new relationships. Globally, more than 340 million new cases are being reported every year related to STD. Of these, over 80 percent are believed to occur in the developing countries[12]. According to the national estimates for 1996, more than 15 million new STD cases occur each year in United States[13]. However, the annual STD incidence among young Americans is not known, even though 15- 24 year olds represent 25 percent of the sexually experienced population aged 15-44 (Sonenstein, 1998). The active sexual life of the youth of primitive tribal groups begins at an early age and lasts for a longer period with multiple sexual partners. The chance of getting sexually transmitted diseases increases with the lack of knowledge about condom and its use.

Nutritional status

The health and nutrition problems of the vast tribal population of India were as varied as the tribal groups themselves, who presented a bewildering diversity and variety in their socio-economic, socio- cultural and ecological settings. The nutritional problems of different tribal communities located at various stages of development were full of obscurities and very little scientific information on dietary habits and nutrition status was available due to lack of systematic and comprehensive research investigations (Studies in Methods, U.N., 1984). Deficiency of essential components in diet leading to malnutrition, protein calorie malnutrition and micronutrient deficiencies (vit A, iron and iodine) are common. Goiter of various grades is also endemic in some of the tribal areas. Water borne and communicable diseases: Gastrointestinal disorders, particularly dysentery and parasitic infections are very common, leading to marked morbidity and malnutrition. Malaria and tuberculosis still remain a problem in many tribal areas, while the spectrum of viral and venereal diseases has not been studied in-depth. High prevalence of genetic disorders mostly involving red blood cells: Genetically transmitted disorders like sickle cell anaemia, glucose phosphate dehydrogenise deficiency and different forms of thalassaemia are also common. All these defects lead to the early destruction of red blood cells and add to the overall anaemia. As for the nutritional status of children, which is a determining factor for child health, about 57 percent of children are underweight. Only 59 percent of mothers received at least one antenatal care in the last three years period, while 18 percent of pregnant women delivered their babies in some kind of institution (NFHS-III, 2005-06). A study using the National Family Health Survey (NFHS-2) (Mishra, 2005) found that in almost all the states of India, tribal households had a higher incidence of childhood stunting (52.3%) than non-tribal households (42.8%). Using the same dataset, Nagda 2004 reported an anemia prevalence of more than 80% among tribal children. Several studies have also reported deficient intake of calories and protein among tribal populations relative to the Indian RDA, which may be an explanation for the high rates of stunting among this group. Iron deficiency is recognized as the major cause of anemia in tribal communities, Reddy et al., 1995; Vyas and Choudhry, 2005 and several studies have reported that deficiencies of micronutrients such as iron and zinc often occur together. Hence the high rates of anemia among tribal populations provide additional evidence of the possibility of marginal zinc deficiency in tribal areas. This is further supported by the high prevalence of stunting and the highly deficient dietary energy intakes in the tribal populations since intake of both zinc and iron are known to be highly correlated with dietary energy intake.

Tribal populations still largely depend on agriculture and forest products for their livelihood and they follow a relatively homogenous lifestyle with their food habits, dietary practices and general pattern of living. Most tribes still rely on their indigenous foods, which usually consist of wild unconventional forest products although some cultivate grains and other farm products for subsistence. The most frequently used cereals are maize, millet or rice and these form part of a major meal at least once daily.

Child health

Studies among tribal populations in India have shown poor indicators relating to immunization coverage and initiation of breastfeeding. Infant mortality and prevalence of under-nutrition also remain high. Poverty and poor infrastructural development in tribal dominant areas have been the main reasons contributing to inability of the MCH programmes from reaching out to tribal populations. Behavioral and socio-cultural conditions, environmental and socio-economic conditions are important determinants of health. The use of medicinal herbs is still a tradition adopted by ethnic communities in central India

Morbidity and mortality in childhood

The common morbidities among children reported in these tribes included symptoms suggestive of upper and lower

respiratory infection, diarrhea, febrile illnesses, malnutrition, jaundice, malaria, kala azar, reddish discoloration of skin on entire body. Of special concern to these tribal people was the non-union of the skull fontanel's of infants.

Pre natal and immediate postnatal care

Most deliveries are conducted at home by untrained Traditional birth attendant – (TBA/ Dai), except among the Ho tribe, where sometimes the husband occasionally assists in the delivery and cuts the cord. The dai uses a new blade to cut the umbilical cord, by placing the cord on a one rupee coin. Soap is used to wash the hands after the delivery. The sixth day after birth is an occasion of community celebration (Chhatiyari), till such time the mother and child are kept separate from the family and the mother is exempted from household work.

Immunisation – Awareness, decision-making, practices and beliefs

Awareness regarding need for and availability of immunisation services for children varies among the different tribes and villages.

Treatment modalities

Indigenous and home remedies are used for several diseases among the tribal population. Diseases for which home remedies are used include: stiffness of limbs, reddish discoloration of skin (rangbad), diarrhoea, cold, cough, fever and body pain. Often, these remedies are used for symptomatic relief rather than cure. For instance, although the people are aware that puni (cerebral palsy) is not curable by herbal or modern medications, they still opt for oil massages to strengthen the stiff limbs. Herbal remedies and traditional medications are also used in case of kala azar, diarrhoea, dysentery and malaria. For fever and malaria, Calpol (paracetamol) and anti malarial drugs are procured from the AWC.

First preference for service provider

In villages that lack modern health facilities, the tribal people resort to traditional healers and indigenous medicine. This is often the first port of call. Moreover, there is a tendency to wait and watch for a day or two to see what course the illness takes, before seeking any medical help at all. With changing awareness levels and attitudes, more tribal people are seeking modern methods of treatment since these are gradually being perceived as more effective, compared to other methods.

Health care practices

Although the National Health Policy, 1983 accords high priority to extending organized services to those residing in the tribal, hilly and backward areas as well as to the detection and treatment of endemic diseases affecting tribals, yet they continue to be one of the fragile population, mainly due to their poor health and disease management. The different tribal communities in India, represents a heterogeneous group. There is considerable variation in the context of socio-economic life, custom and tradition, behaviour and practices. Variations are also there in the context of demographic features. There is one factor common among all tribal communities except North-east tribals, it is low literacy rate and poor health status and indigenous method of disease management. The tribal illiteracy has a close link between health and disease management. Health and disease management reflect the social solidarity of a community. In a tribal community, for example, illness and the consequent management of disease is not always an individual or familial affair, but sometimes the decision about the nature of treatment is taken at the community level. In the tribal areas, in case of some specific diseases, not only the diseased person or his/her family, but the total village community is affected. All the other families in the village are expected to observe certain taboos or norms and food habits. The non-observance of such practices often calls for action by the Village Council/ Caste Panchayat.

The common beliefs, customs, traditions, values and practices connected with their health and disease have been closely associated with the treatment of diseases. In most of the tribal communities, there are number of folklores related to health. Knowledge of folklore of different socio-cultural systems of tribals may have positive impact, which could provide the model for appropriate health and sanitary practices in a given eco-system. Tribal health system and medical knowledge over ages known as 'Traditional Health Care System' or 'Indigenous Health Practices' depend both on the herbal and the psychosomatic lines of treatment. While plants, flowers, seeds, animals and other naturally available substances formed the major basis of treatment, this practice always had a touch of mysticism, supernatural and magic, often resulting in specific magico-religious rites. Faith healing has always been a part of the traditional treatment in the Tribal Health Care System, which can be equated with rapport or confidence building in the modern treatment procedure. Certain practices are suggested to avoid illness or diseases, while some are prescribed to have better health. With the coming of the state in the tribal areas during pre and post-independence number of changes are taking place in both material and non-material culture of tribal masses.

Conclusion

Tribal communities are different from other communities because of their traditional cultural background. The health care problems of tribals are more because of illiteracy, widely spread communities, poor sanitation in some areas and their customs and traditions. A number of welfare measures are undertaken by Government of India to improve general welfare, including health, in tribal communities. Despite this, there is a general belief that tribals are still following traditional methods of dealing with their health problems. Some services are inappropriately used, whereas others, such as preventive health programmes, are under utilised Practical difficulties experienced by tribals may be another reasons for under-utilized. The inaccessibility and high cost to health care and reluctance to seek help for health issues remain a significant problem in tribal areas. In considering priorities for health, greater endeavor and resources are required to increase their awareness and change attitudes towards acceptance of the current health care services.

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Source: Office of RGI & Census commissioner of India, Ministry of Home Affairs

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