



Health Seeking Behaviour among Tribes of India

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KEYWORDS Gaddis. Garo. Gond. Kattunayakan. Khasi. Konda Reddy

ABSTRACT Health seeking behaviour are those activities commenced by individuals in response to a symptom experience. Health seeking behaviour is a major concern in tribal health. In this review paper, the researchers presented evidence on health seeking behaviour and its barriers. A significant number of tribal people still use home remedies and approach traditional medicine practitioner /healers. If not cured, they approach private clinics. Barriers for health seeking behaviour identified among tribes of India when visiting hospitals were inaccessibility, lack of infrastructure, manpower and their behaviour, inconvenient visiting hours, disease condition. Also personal issues like fear of losing daily earning, cultural beliefs, affordability, illiteracy and unacceptability.

INTRODUCTION

Health seeking behaviour may be defined as those activities commenced by individuals in response to a symptom experience (Amuthavalluvan and Devarapalli 2011). Understanding the health seeking behavior can be helpful to prevent delay in diagnosis, improve patient compliance and promote health improvement strategies (Jayaprakash and Saravanan 2015). Studies on health seeking behaviour are more useful from a health care system development perspective (Jayaprakash and Saravanan 2015). Healthcare-seeking behaviour has emerged as a tool to tackle perceived ill health by taking remedial actions (Chandwani and Pandor 2015). Health seeking behaviour depends upon the severity of illness, the availability of health care facilities, the access to health care services and the economic condition of the individual/household and other such factors (Jayaprakash and Saravanan 2015). Health seeking behaviour is a major concern of tribal health apart from inaccessibility to health services (Jain et al. 2015) and an important issue in health management (Singh et al. 2016). It was observed that health seeking behaviour determine the morbidity and mortality (Basu and Kshatriya 1990). Hence, study on the health seeking behaviour and identi-

fication of its barriers among the tribes of India may lead to the improvement in the health status among tribal people of India.

Objective

To study the health seeking behaviour and to find out the barriers for health seeking behaviour among the tribes of India.

METHODOLOGY

Data for the present review paper were drawn from original articles available on 'Google'/'Google scholar' search engine using keywords such as "health seeking behaviour of tribes in India".

OBSERVATIONS AND DISCUSSION

The research results available on health seeking behavior is reviewed among the tribal populations of India reported from 1996-2017. In this report, studies on health seeking behavior on tribes spread in 14 states of India like Andhra Pradesh, Odisha, Rajasthan, Manipur, Kerala, Madhya Pradesh, Tamil Nadu, Gujarat, Karnataka, West Bengal, Jammu and Kashmir, Meghalaya and Himachal Pradesh were taken into consideration. These studies encompassed tribes such as Koyas, Konda Reddy (Rajamma et al.1996), Bhatara (Mahapatro and Kalla 2000), Gadoliya Lohars, Rabaris, Nayaks, Kanjars, Sansis, Nats, Kalbeliyas (Sachdev 2012), Bhils (Jain and Agrawal 2005), Paite (Guite and Acharya 2006), Kuruchiyas (Nelson 2011),

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Gonds (Rao et al. 2012; Singh et al. 2016), Paniyan (Vivek et al. 2012; Gandhi et al. 2017), Irula (Santosam and Samuel 2013), Kani (Nandha et al. 2014), Koraga (Shirisha et al. 2015), Garo, Khasi (Albert et al. 2015), Kinners, Lahules, Spitians, Pangwalas, Gaddis and Gujjars (Pathania and Katoch 2017), Kattunayakan and Bettakurumbas (Gandhi et al. 2017), unnamed tribal people belonging to Udaipur district of Rajasthan (Kumar et al. 2013), Gadchiroli district of Maharashtra (Sundarrajan et al. 2013), Narmada district of Gujarat (Chandwani and Pandor 2015), Villupuram district of Tamil Nadu (Jayaprakash and Saravanan 2015), Kalyani district of West Bengal (Ghosh et al. 2015), Anantnag district of Jammu and Kashmir (Ahmad and Saravanan 2015), Integrated Tribal Development Agency (ITDA) villages of 9 states (Laxmaiah et al. 2015) and Thiruvananthapuram district of Kerala (Babu et al. 2016).

The reasons for health seeking behavior and for varied health problems reported among the tribal people were not uniform. Significant health problems include tuberculosis in Koya and Konda Reddy (Rajamma et al. 1996), sexually transmitted diseases in Gonds (Rao et al. 2012), dental problems in Paniya Paniyan (Vivek et al. 2012), institutional deliveries in tribes of Udaipur, Rajasthan (Kumar et al. 2013), malaria in tribes of Gadchiroli, Maharashtra (Sundarrajan et al. 2013) and tribes of Kalyani, West Bengal (Ghosh et al. 2015), leishmaniasis in Kani (Nandha et al. 2014), childhood diseases in tribes of Narmada district, Gujarat (Chandwani and Pandor 2015) and Gonds (Singh et al. 2016), diarrhea in Koraga (Shirisha et al. 2015), hypertension in tribes of ITDA villages of 9 states (Laxmaiah et al. 2015), gynecological morbidities in tribes of Thiruvananthapuram, Kerala (Babu et al. 2016), common ailments in Bhatara (Mahapatro and Kalla 2000), Gadoliya Lohars, Rabaris, Nayaks, Kanjars, Sansis, Nats and Kalbeliyas, (Sachdev 2012), Bhils (Jain and Agrawal 2005), Paite (Guite and Acharya 2006), Kuruchiyas (Nelson 2011), Irula (Santosam and Samuel 2013), tribes of Villupuram, Tamil Nadu (Jayaprakash and Saravanan 2015), tribes of Anantanag, Jammu and Kashmir (Ahmad and Saravanan 2015), Garo and Khasi (Albert et al. 2015), Kinners, Lahules, Spitians, Pangwalas, Gaddis and Gujjars (Pathania and Katoch

2017), Kattunayakan and Bettakurumbas (Gandhi et al. 2017).

Tribal people in India for their health problems take *home remedies* (Bhatara (49%) (Mahapatro and Kalla 2000); Irula (100%) (Santosam and Samuel 2013); Koraga (100%) (Shirisha et al. 2015); Garo, Khasi (79%) (Albert et al. 2015); *visit private hospitals* (Gadoliya Lohars, Rabaris, Nayaks, Kanjars, Sansis, Nats and Kalbeliyas (92%) (Sachdev 2012); tribes of Villupuram district, Tamil Nadu (9%) (Jayaprakash and Saravanan 2015); *follow indigenous medicine* (Koyas and Konda Reddy (6%) (Rajamma et al. 1996); Paite (10%) (Guite and Acharya 2006); tribes of Villupuram district, Tamil Nadu (28%) (Jayaprakash and Saravanan 2015); Kinners, Lahules, Spitians, Pangwalas, Gaddis and Gujjars (44%); *approach traditional healers* (Koyas and Konda Reddy (86%) (Rajamma et al. 1996); tribes of Gadchiroli, Maharashtra (100%) (Sundarrajan et al. 2013); Kani (100%) (Nandha et al. 2014); Garo, Khasi (10%) (Albert et al. 2015); Kinners, Lahules, Spitians, Pangwalas, Gaddis and Gujjars (37.2%) (Pathania and Katoch 2017) and *practice modern medicine/allopathy* (Koyas and Konda Reddy (86%) (Rajamma et al. 1996); Bhatara (6%) (Mahapatro and Kalla 2000); Gadoliya Lohars, Rabaris, Nayaks, Kanjars, Sansis, Nats and Kalbeliyas (28%) (Sachdev 2012); Paite (56%) (Guite and Acharya 2006); tribes of Udaipur, Rajasthan (48%) (Kumar et al. 2013); tribes of Villupuram district, Tamil Nadu (52%) (Jayaprakash and Saravanan 2015) tribes of Kalyani, West Bengal (40.63%), and Gond (68.4%) (Singh et al. 2016) in variable proportions.

According to World Health Organization (1976), traditional healer is a person who is recognized by the community in which he lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background, as well as on the knowledge, attributes and beliefs that are prevalent in the community regarding physical, mental and social well-being and the causation of disease and disability (Bhasin 2007). Traditional healers are known by different names among tribal populations. Traditional healer is called 'Dasari' in Bhatara (Mahapatro and Kalla 2000) and 'Bhopa' in Bhils (Jain and Agrawal 2005). It

has been observed that tribal, for health care, depend on the traditional medicine and use about 8,000 plant species and 25,000 folk medicine based formulations (Sharma et al. 2016). It was observed the major reasons for approaching traditional healer were cultural beliefs such as anger of Gods, inability to disclose certain problems to modern medical practitioner, side effects and incurability of certain diseases by modern medicine, to appease supernatural forces and belief that diseases were the repercussion of their sins and medicine works if their deities permit them to work (Nelson 2011; Nandha et al. 2014; Pathania and Katoch 2017). In all the tribal populations reviewed in this paper used mixed approaches as ill-health remedies.

Tribal people dependence on modern medicine is increasing due to literacy and awareness, destruction of forests leading to non-availability of herbal and medicinal plants, effectiveness, availability and affordability of health care service provision, and good behaviour of the service providers (Singh 2008; Islary 2014). Appreciation on modern medicine was found to be higher in young and educated tribal people (Nelson 2011; Albert et al. 2015). Income and occupation was also observed to influence the type of approach for their ailments among tribal people. People with low education opted for government hospitals, whereas higher educated preferred private clinics. Agriculture labourers and farmers chose government hospitals, whereas government employees and non-farm workers opted private clinics. Indian system of medicine (Ayurveda and Siddha) was more popular among agriculture labourers and farmers. High-income people gave preference to private clinics and low-income people opted government hospitals (Jayaprakash and Saravanan 2015).

The following factors were identified as barriers for health seeking behavior among tribal populations in India: lack of awareness and infrastructures, inaccessibility of health care institutions, inconvenient out-patient timings, non-availability of doctor, lack of time for waiting the doctor, ill-treatment by government hospitals staff, fear of losing daily earnings by the accompanying person, less time spending of doctor with patient, high price and ineffectiveness of allopathic medicine, need to travel long distances, absence or inconvenient transport facilities, firmly fixed cultural be-

liefs, male-dominated society, more concern for the well-being of the male child, final word of the head of the family, dissatisfaction with the healthcare services, lack of accountability among health care personnel, religious misinterpretations, socioeconomic constraints, women's restricted movements, larger family size, illiteracy and shyness in case of sexually transmitted diseases and gynecological problems (Kumar et al. 2013; Chandwani and Pandor 2015; Laxmaiah et al. 2015; Mahapatro and Kalla 2000; Sachdev 2012; Vivek et al. 2012; Santhosam and Samuel 2013; Gandhi et al. 2017; Rao et al. 2012; Babu et al. 2016).

Rural Health Statistics (RHS) also reveals huge gaps in the health infrastructure and resources in tribal areas due to serious geographical and socioeconomic challenges. Access to health services becomes difficult as the roads are poor or restricted. Poor availability of health personnel, lack of adequate equipment, language and social barriers, waiting time at health centers and poverty also add to problems (Tribal Health in India 2013).

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (World Health Organization 1948). Health was recognized as fundamental human right in universal declaration of human right in the year 1948. Health is also considered as an important component of development, vital to nation's economic growth and internal stability. Health plays an important role in reducing poverty. Health is influenced by intrinsic factors like genetics, behavior, culture, habits, life style and external factors such as economic, social, environmental and technological (Web Page of World Health Organization 2007). Health is a component of human development index, which measures the average achievement in key dimensions of human development. It has been observed that meanings, perceptions, illness and health seeking behavior differ across cultures (Mishra et al. 2013). Among tribal people, health is seen as a functional rather than a clinical concept (Mahapatra 1994). The meaning of health changes and adapts according to the needs of the society. To understand the concept of health and illness it is advised to include the causes of illness, the treatment seeking behavior and the utilization level of health care services (Mishra et al. 2013).

The total tribal population in India is 104.28 millions. There are 705 tribal groups in the country.

Seventy-five tribal groups are named as primitive based on pre-agricultural level of technology, extremely low level of literacy; and small, stagnant or diminishing population (Government of India Report on Tribes 2013). Tribal population constitutes 8.6 percent of Indian population. Tribal population represents 2.8 percent and 11.3 percent of urban and rural population. Fifty percent of tribal population inhabit in the states of Dadra Nagar Haveli, Arunachal Pradesh, Meghalaya, Nagaland, Mizoram and Lakshadweep. The sex ratio, among tribal populations in urban and rural areas, is 980 and 991 females per 1000 men. The literacy rate among tribal populations is 58.96 percent. The proportion of tribal population living below poverty line in urban and rural areas is 30.4 and 47.4 respectively. The main occupation of tribal population is agriculture and agriculture labour (Census of India 2011; Thomas et al. 2015).

Various health indicators observed among tribal population are of the following proportions: infant mortality (62.1%); neo-natal mortality (39.9%); post-natal mortality (22.3%); child mortality (35.8%); ANC check-up (70.5%); percent of institutional deliveries (17.7%); child vaccination (full immunization) (31.3%); percent of households covered by a health scheme/insurance (2.6%) and prevalence of anemia in women (68.5%) (Tribal Profile at a Glance 2014). The identified common health problems among tribal population include infant and maternal mortality, malnutrition, anaemia, and malaria (Foundation of Healthcare Technologies Society 2013). Among primitive tribe groups, the reported significant health problems are sickle cell anemia, G6PD deficiency, venereal diseases, malnutrition, protein-calorie malnutrition, vitamin and micronutrient deficiency, goiter, dysentery and parasitic infections, upper respiratory infections, anemia, diarrhea, cholera, scabies, tuberculosis, leprosy and yaw (Islary 2014). The risk factors for health problems in Indian tribes are high rates of poverty, illiteracy, smoking, and alcohol use, as well as harsh and isolated living environments and poor access to healthcare (Thomas et al. 2015).

Socio-cultural factors, geophysical environment, personal predisposition, perceived morbidity, degree of autonomy on making decisions, magico-religious beliefs and practices influence the health seeking behaviour in tribal community, thus making them to seek either traditional or modern systems of medicine and sometimes even use self-

treatment for illnesses (Islary 2014). Health seeking behaviour among tribes explains the role of social capital and reflective communities (Gandhi et al. 2017).

Studies on health seeking behavior among tribes of India need to be conducted on all tribes to evolve a holistic view. Very few studies have focused on the health seeking behavior of primitive tribes. It is not known whether same or different health seeking behavior exists among common or primitive tribes. Available evidence is heterogeneous and make difficult to facilitate comparisons between the tribes. Development of uniform questionnaire and objectives may help in comparison of health seeking behavior between tribes. Health seeking behavior among tribes was observed for different health problems. Comparison of health seeking behavior in tribes between diseases can bring into light whether homo or heterogenous health seeking behavior exists among them. Qualitative or mixed than quantitative approaches can bring into focus the factors or barriers responsible for low health seeking behavior among the tribes. Anthropologists in contrast to other biomedical researchers are better equipped in highlighting the cultural dimension of health seeking behavior by non participation observational tool. Efforts are needed from biomedical researchers to evolve methodology and tools for better characterization and comparison on health seeking behavior among tribes of India. Since time immemorial, different type of medical systems are existing among general as well as tribal populations. Education on the rationality and limitations of each system of medicine as well integration of available medical systems can change landscape of health seeking behavior and health status of the tribal people.

Health seeking behavior can be increased by addressing the barriers responsible for it. Illiteracy is majorly responsible for the lack of awareness on health seeking behavior. Increasing literacy and improving educational levels among tribal people can go hand in hand for improving the health seeking behavior. Interpersonal communication, the dominant mode of communication among the tribes followed by traditional media like radio and television can also be helpful to increase the level of awareness among tribals (Matiazhagan et al. 2007). Additionally, services of accredited social health activists (ASHA) can also be utilized for increasing the awareness on health seeking behavior and

removing the misconceptions on modern medicine. Responsibility of improving the infrastructure, timely availability of health personnel, attitude of health personnel towards the government and participation of non-governmental organizations is also crucial to make the tribal people understand about the significance of modern medicine. Physical barriers in health seeking behavior can be removed by conducting mobile health clinics and application of telemedicine in far remote areas and special clinics for mobile/nomad tribal people. Lastly, increasing the female health personnel in health care institutions may increase health seeking behavior in women for sexually transmitted and gynecological morbidities.

CONCLUSION

Response of the individual to the experience of symptom is known as health seeking behaviour. The present review focussed on health seeking behaviour of 29 specific tribes of India spread in 14 states. The reasons for health seeking behavior and for varied health problems among the tribal people were not uniform. These health problems include tuberculosis, sexually transmitted diseases, dental problems, birth deliveries, malaria, leishmaniasis, childhood diseases, hypertension, diarrhea, gynaecological morbidities and common ailments. Tribal people in India for their health problems take home remedies, visit private hospitals, follow indigenous medicine, approach traditional healers and practice modern medicine/allopathy. All the tribal populations reviewed in this paper used mixed approaches for their ill health remedies. The major reasons for approaching traditional healer were cultural beliefs such as wrath of Gods, inability to disclose certain problems to modern medical practitioner, side effects and incurability of certain diseases by modern medicine, to appropriate supernatural forces and belief that diseases were the repercussion of their sins and medicines work if their deities permit them to work.

Appreciation on modern medicine was found to be higher among young and educated tribal people. Income and occupation was also observed to influence the type of approach for their ailments among tribal people. The factors identified as barriers for health seeking behavior among tribal populations in India were lack of awareness and infrastructures, inaccessibility of health care institu-

tions, inconvenient out-patient timings, non-availability of doctor, lack of time for waiting the doctor, ill-treatment by government hospitals staff, fear of losing daily earnings by the accompanying person, less time spending of doctor with patient, high price and ineffectiveness of allopathic medicine, need to travel long distances, absence or inconvenient transport facilities, firmly fixed cultural beliefs, male-dominated society, more concern for the well-being of the male child, final word of the head of the family, dissatisfaction with the healthcare services, lack of accountability among health care personnel, religious misinterpretations, socioeconomic constraints, women's restricted movements, larger family size, illiteracy and shyness in case of sexually transmitted diseases and gynecological problems. Studies are needed to be carried on how to minimize the barriers and enhance the health seeking behaviour of tribal people.

RECOMMENDATIONS

Infrastructure in government run hospitals should be improved. Doctors should be made to stay nearby hospitals by providing facilities for their comfortable residence. Government doctors should be instructed to spend adequate time with the patients. Behaviour of the staff of the government hospitals can be modified by providing effective training and enforcing discipline. Evening clinics can be conducted by ESI hospital for the benefit of manual labourers to prevent the loss of daily earnings. In remote areas, frequent mobile health camps should be conducted. Medicines should be provided free of cost to the patients. Government sponsored generic drug medical stores should be opened in as many places as possible. Efforts should be made to cover more number of tribal people under the government health schemes. Illiteracy of people should be improved by adult education centres. Belief on modern medicine can be improved by health awareness/education programmes. Free transport facilities should be provided to the poor patients to reach hospitals by the charitable institutions and nongovernmental organizations.

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