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HEALTH SEEKING BEHAVIOUR AND HEALTH NEEDS OF KORAGA TRIBE

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Abstract: *The tribal people are the oldest ethnological segment in the Indian population. The existence of these tribal's in India has been recorded long before the penetration of Aryan speaking people. They inhabit widely varying ecological and geo-climatic conditions in different concentrations throughout the country. India has the largest concentration of Schedule Tribes (synonymous with tribal/indigenous people) in the world except, besides Africa. There are approximately two hundred million tribal people in the entire globe, which constitute about 4 percent of the global population. There are 635 tribes in India located in five major tribal belts across the country. They account for 8.08 percent of the country's total population. The main concentration of tribal people is the central tribal belt in the middle parts of the India and in the north-eastern States. However, they have their presence in all States and Union Territories except the state of Haryana, Punjab, Delhi and Chandigarh. The predominant tribal populated States of the country with tribal population more than 50 percent of the total population are Arunachal Pradesh, Meghalaya, Mizoram, Nagaland and Union Territories of Dadra and Nagar Havelli and Lakshadweep. The present paper purports to examine the health seeking behavior among tribals in Karnataka.*

The tribe is a society having a clear linguistic boundary and generally a well defined political boundary. It is within the latter the regular determinate ways of acting are imposed on its members. The tribe also has a cultural boundary, much less well defined, and this is the general frame for the formal and informal interactions of these members. According to L.P. Vidyarthi, the tribe is a social group with definite territory, common name, common district, common culture, behaviour of an endogamous group, common taboos, and existence of distinctive social and political system, with full faith in their leaders and self-sufficiency in their distinct economy. Tribal settlements tend to be small and isolated and difficult to reach with facilities and services. However there are very few tribal people who are relatively well integrated into the communities and access and utilize services as other subgroups do. Some tribal groups are nomadic and undertake seasonal migration in response to the need for livelihood or employment. The erstwhile ecosystem tribes are now becoming eco refugees in search of an alternative but viable economic dependency. In addition, economic development is forcing out migration from traditionally tribal areas into cities and often to the margins of such agglomerations. In tribal areas there is a lack of infrastructure particularly related to the supply of drinking water, electricity and educational and health services. The tribal territory is rich in mineral, forest and water resources,

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but the poorest of the poor live here. The area has also an abundance of rare flora-fauna and rich in bio-diversity. Despite this, tribes have to migrate in search of their livelihood, have low access to health care and education and have higher morbidity and mortality.

The Scheduled Tribes are tribes notified under Article 342 of the Constitution, which makes special provision for 'tribes, tribal communities, or groups within which the President may so notify'. There is no definition of a tribe in the Constitution but one may distinguish some characteristics that are generally accepted: self-identification, language, distinctive social and cultural organization, economic underdevelopment, geographic location and isolation, which has been steadily and in some cases traumatically eroded. Many tribes still live in hilly and/or forested areas, somewhat remote from settlements. Many stereo types flourish about the tribal persona and tribal society. Many of the tribal people are undeniably economically under-developed and the process of their marginalization can be traced to the intrusion of British colonialism, which quickly detected in the forest that was home to tribals, great potential for appropriation of resources. Exploitation of forest-lands by both the British and the zamindars resulted in the clearing of huge tracts for commercial crops such as tea, coffee and rubber and allowing contractors to fell trees in the very heart of the forest. These actions deprived the tribal people of their livelihoods because many of them were hunters and gatherers of forest produce. The interaction with the outside world brought the tribal people face to face with problems they were not equipped to cope with, such as alcoholism and sexually transmitted diseases. Apart from the Scheduled Tribes, there are 75 indigenous groups in India known as 'Primitive Tribal Groups' (PTGs). The Tenth Plan of the Central Government observes that these vulnerable communities have experienced a 'decline in their sustenance base and the resultant food insecurity, malnutrition and ill-health has forced them to live in the most fragile living conditions and some of them are even under the threat of getting extinct'.

SITUATION OF TRIBALS IN KARNATAKA STATE

In Karnataka, Schedule Tribes (ST) account for 6.55 percent (3.46 million) of the total State population, this comprises 4.11 percent of the total tribal population of the country. Bellary district has the highest concentration of STs in Karnataka. Of the 50 major tribes with 109 sub-tribes in the State the Government of Karnataka has identified (*i*) Jenu Kuruba; and (*ii*) Koraga tribes as primitive groups (PTGs). Jenu Kuruba tribes are originally from Mysore, Chamarajanagar and Kodagu districts and Koraga tribes are from Udupi and Dakshina Kannada districts. PTGs constitute the most vulnerable among the all notified tribes. According to the surveys conducted by Department of Tribal Welfare, these tribes predominantly stay in districts where they originally belong to, however the possibility of tribal migration to neighboring districts for better employment opportunities cannot be denied. Whether the migrated tribes have been mainstreamed into the society or still continue to live as primitive groups, statistics are unavailable.

Koragas of Dakshina Kannada

The Koraga are a tribal community found mainly in the Dakshina Kannada district of Karnataka and the Kasaragod district of Kerala, South India. These two areas, along with Udupi district in Karnataka, are altogether often referred to as Tulu Nadu. Koragas are the aboriginal tribes of

Dakshina Kannada district who were notified as primitive tribes in 1986. Though the Koragas are tribals, they were regarded as ceremonially impure and unclean in the local Hindu society The Koragas are the most backward among the tribes of Karnataka State in every respect. A great majority of them lead a hard life and good proportion of them are engaged in their traditional occupations like basket weaving, coir making or working as 'paura karmikas' in village panchayaths, town municipalities and city corporations. District Gazetteer of South Canara reveals that 'Koragas are perhaps the poorest among the Scheduled Tribes. They were leading a nomadic life of hunting. Now they follow agriculture and do basket weaving etc'.

Koragas originally forest dwellers but now they have migrated from forest for different reasons. They take up Ajalu duties (a type of slavery system in which Koraga families made responsible to take up some assignments in a fixed geographic area) and their population is concentrated all over Dakshina Kannada and Udupi districts. A greater population of them lives in rural areas (76%), 17.8% in urban and 6.2% in forest areas. Elsewhere tribals are not untouchables and nowhere are they engaged in scavenging occupations. But in Dakshina Kannada and Udpi, it is mainly the Koragas who were engaged in scavenging work. According to 2001 census the total population of the Koragas in the district was 16,071. They are concentrated mainly in Udupi, Mangalore, Kundapur and Karkal, only 10% of them live in other taluks of district. Though the Koragas are among the earliest inhabitants of the district, their population has not increased much.

The Koragas are regarded as the lowest among the backward castes. Since the caste Hindus do not mix with them they were forced to have their own colonies on the outskirts of the villages. Even in the cities their colonies are segregated from that of others. In recent past the interaction of Koragas with the members of other castes and communities was restricted. The Koragas were once upon a time the ruling tribe of some parts of Dakshina Kannada district and Western Ghats region of the Karnataka state. It is also said that the Koragas were defeated by Mayura Sharma of the famous Kadamba dynasty and were enslaved around 6th century A.D., since then they were slave laborers and women were sent to forests. The District Gazetteer of Dakshina Kannada reveals that till the beginnings of the 20th century the Koragas were treated as slave laborers in weekly fairs and yearly jatras in the district.

What is more depressing and shameful is that in a district of Dakshina Kannada where there is 100% literacy and people are regarded as more cultured and disciplined, they have made the Koragas to eat the leftover food form the plantain leaves thrown during marriages and functions. It is significant to note that with the enactment of Ajalu Prohibition Act by the Karnataka Government this practice is fast disappearing from the district. The ethnic and anthropometrical features reveal that the Koragas are aboriginal Dravidian tribe. They are short to medium statured with curly hair and very distinct eyes and lips which would not allow them to be mistaken. The Koragas belong to matriarchal family system and worship all most all major Hindu deities. They perform simple ceremonies during death, puberty and marriage. Their god is called Koraga Thaniya who is their god, guide and mentor and they consider as their friend. In every Koraga colony we can find small stones, a few plants or trees representing different bhutas. Koragas are among the lowest rung of development in comparison with other tribal communities in Dakshina Kannada district in terms of employment, occupation, income, educational levels, housing, sanitation, living conditions and health status. The development

schemes have not helped them significantly to improve their socio economic status. Most of the programmes initiated for the development of the Koragas have been a failure due to inadequate knowledge about their problems, requirements and socio cultural values.

Health Seeking Behavior

Health is a prerequisite for human development and is an essential component for the well being of the mankind. The health problems of any community are influenced by interplay of various factors including social, economic and political ones. The common beliefs, customs, practices related to health and disease in turn influence the health seeking behaviour of the community. Utilization of health care services is very poor among tribals. This could be attributable to poverty, ignorance, socio cultural practices and lack of access. There is a consensus agreement that the health status of the tribal population is very poor and worst among the primitive tribes because of their isolation, remoteness and being largely unaffected by the developmental processes going on in the country. Health seeking behaviour is an important factor in health management, but this is often ignored while considering schemes for providing health facilities to people. As a result, new schemes for providing health care do not get the desired acceptance of the community, and are therefore rendered unsuccessful. The decision makers in the health sector are recognizing the need for understanding the health seeking behaviour of the community and its acceptance and usage of traditional and modern methods, as also the perception of the community regarding the service delivery. This becomes especially relevant among traditional and tribal societies. Many attempts have been made to document the health seeking behaviour of the tribals in India. Of late, some attempts have been made to study it among the tribals of Madhya Pradesh and Orissa (Sawain, 1994, Basu, 1994 and Singh, 1994). The cultural patterns and the life style of the tribes vary a lot, and so does their health seeking behaviour. In the present study, an attempt has been made to document the health seeking behavior and health needs of the Koraga Tribes inhabiting in the rural and urban areas of Mangalore Taluk of Karnataka State,India.

Objectives

1. To study the health seeking behaviour among Koragas.
2. To elucidate information on the health needs of Koragas.

Research Design

The research design in the study is exploratory. The study was restricted to Koraga families living in Mangalore Rural and Urban areas. Considering the nature of the study the scope of the study was limited to 106 families residing rural and urban areas of Mangalore Taluk, Dakshina Kannada. The size of the sample of the study was 106 chosen from 704 families residing in rural and urban areas of Mangalore Taluk. The families were stratified as Rural and Urban by simple random technique. The family was taken as the unit of study. Efforts were made to gather information from the head of the family in a majority of cases and in their absence other senior members were contacted: Interview method of data collection by using structured pre-tested schedule was used throughout the survey. The investigator personally visited the

families to collect information. The schedule contained information on demographic details (family structure, literacy status, occupation, income), living conditions of the family (housing, water supply and sanitation), health condition of family members at the time of survey, health seeking behavior followed by the families during the preceding one year and health needs of the families. Data collection was undertaken between September to December of 2010.

RESULTS AND DISCUSSION

The age-sex composition among Koraga families' points to the fact that by and large the children below 5 years constitute 12.02 percent of the total population and 28.8 were in the age group of 5-21 years which is the principal period for children to pursue education from primary to degree levels. 42.6 percent were in the age group of 21-44 years. Old age population constituted 3.96 percent. Out of 106 families studied males constitute 328 and females constitute 354. Again there was more number of females beyond 60 years. Overall literacy level among Koragas for both the sexes in Mangalore Taluk was 76.2 percent which is more than the state average (66.6percent). According to 2001 census the literacy level of tribal population in the state was only 48.3percent. In spite of the higher literacy level in the present study it was observed that 28.1 percent of the females were illiterate in comparison to males (19.1percent). However, only 5.5 percent of the Koraga population was educated beyond high school level. It was observed that illiteracy was more in rural area (28.10 percent) as compared to urban areas.By and large the per capita income was more among urban families and the percentage of low income group was found more among rural families (35.9percent).This clearly indicates that the earning potential is more in urban areas and in the rural areas people are engaged in occupations which do not fetch them more income. In the present study, it was observed that, a majority of Koragas are still working as unskilled workers and only 1.61 percent was in the government service. This could be due to the inadequate number of educated Koragas at the college level. It is sad to note that their traditional basket weaving occupation in the verge of extinction (8.95 percent) due to various factors and the elder population of the community seems to have facing hard situation to meet the basic needs of the family. As regards housing all most all families are living in pucca houses. However, only 5.66 percent are living in Kutcha houses. These drastic changes occurred could be due to the housing programmes implemented under Ashraya, Indira Awaaj and other programmes of the government.

It was observed that nearly 81.1 percent of the families get drinking water either from bore well or through the pipes and whereas the remaining families (18.8percent) use the water from the wells nearby. Nearly 60 percent of the families dispose of sullage water in a satisfactory way. Even though 94 percent of families live in pucca houses, 42.4 percent of the families have not made any arrangement for disposal of sullage water. As far as type of excreta disposal is concerned, it is far from satisfactory in rural areas (37.5 percent) even though there are government sponsored schemes for installation of sanitary latrines. The rural community appears to be deprived of the facilities under the scheme. None of the families make use of public bins for the disposal of refuse. However, nearly 88 percent of them dispose of satisfactorily. There is a need to educate 12.2 percent of the families in both the rural and urban areas to avoid indiscriminate throwing of refuse which are sources of fly breeding and cause for spread of diseases. Nearly

55 percent of the family members suffered from one condition or the other due to communicable diseases (mainly malaria, diarrheal diseases) and conditions pertaining to respiratory system. While the incidence of morbidity conditions due to respiratory system was more among females (56.1 percent), the incidence of communicable diseases was more among the male members (mainly Malaria). There is a significant decline in the number of Tuberculosis patients in both sexes in comparison to survey findings of Peer Mohammed (1994). Substance abuse among Koraga community was a common feature in both rural and urban areas. Majority of them are pan with tobacco chewers (29 percent), followed by alcohol (22 percent), gutkha consumption (20 percent), and tobacco chewing (18 percent) and smoking (7 percent). Tobacco and pan chewing was more common among females where as alcohol and smoking was more common among males. The expenditure incurred for the substance abuse was not available, but the respondents were of the opinion that for the health and welfare of the communities the substance abuse prevalence is a major hindrance. Ability to recall the illnesses in the past one year for all the family members was a major constraint. However they were able to recall the morbidity conditions which they suffered more and also long standing diseases. Some of them had more than one episode of illness in the past one year. It was noticed that more or less equal number of persons suffered from infectious diseases and respiratory illness both in rural and urban areas. Communicable diseases in particular Malaria and Tuberculosis were more rampant in the urban communities (32.9) whereas other diseases conditions showed more or less same pattern in both the areas.

Among the history elicited Anaemia was another common condition in both the areas which depends on the nutritional status. Further nutritional status depends partly on income and also on awareness of the nutritional content of food. Adequate attention will have to be paid to the diet of children and expectant matters that form the vulnerable segment of the population. Contrary to the belief that the tribes depend on traditional healing system compared to modern medicine was not observed in this study. A majority of them (82.3 percent) were in favour of modern medicine for their ailment and only 12.9 percent resorted to home remedies even though the literacy and availability of government health services in both the areas at a satisfactory level. Immunization programme is implemented by the central and state governments to reduce infant mortality rate. Vaccination against Diphtheria, Polio, Tetanus, measles is being conducted at regular intervals through a well net work of Public Health Centers and Sub Centers. Out of 106 families 61.3 percent got their children immunized against various diseases of childhood and amongst them it was found that 53.2 percent of the families in the rural areas got their children immunized which is a better response in comparison to urban families (73.8 percent). The observed difference in the immunization practices between the rural and urban areas was found to be statistically significant. Among the rural families 71.4 percent of the literate families got their children immunized against childhood diseases and among the illiterate families only 28.5 percent availed the immunization services. The difference in immunization practices between literate and illiterate families in rural area was found to be not statistically significant.

Health seeking behavior of expectant and nursing mothers among Koraga women is far from satisfactory. The National Family Health Survey (NFHS) data indicates that there was a marginal increase in institutional deliveries among the Scheduled tribes in Karnataka during

the period from 1992-93 to 1998-99 (Karnataka Human Development Report 2005). Such a trend could not be observed in the present study for want of data. However, there were more than 62.2 percent respondents who were totally ignorant of the immunization, IFA tablets (66.03 percent) consumption and nearly 80 percent of them regarding supplementary nutrition. As regards utilization of ANC and PNC services in both urban and rural areas on the whole only 44.3 percent availed the ANC and PNC services in both the urban and rural areas. The observed difference in seeking the antenatal and post natal health services between urban and rural areas was found to be not statistically significant. Literacy level did not appear to have any influence in the health seeking behaviour of the families (not statistically significant). 43.4 percent of the families availed the antenatal and post natal care services. Amongst them (46 families) nearly 74 percent were from literate families and 26 percent were from illiterate families. Maternity and child welfare services provided by the government have not been utilized by nearly 56.6 percent of the families irrespective of their literacy level.

The opinions of the respondents as to what they consider as serious health problems are in consistence with the observation made regarding the morbidity conditions identified at the time of survey. It is satisfactory to find them telling the actual names of the communicable and non communicable diseases which are a major problem in the community while the communicable diseases (Tuberculosis, Malaria, filarial) are regarded as major communicable diseases in the urban area, the non communicable diseases are considered as problem in the rural areas. Anemia and Malnutrition were other health problems in both the areas. This is, in spite of the fact that the government programmes including ICDS program for (Integrated Child Development Services) children, expectant and nursing mothers and also the public distribution system (PDS) to the poor. Koragas are associated with consuming alcohol, substance abuse and poverty as the major causes (95 percent) for poor state of health among them. Others (15 percent) attributed it to lack of health awareness, prevailing superstitions and unsatisfactory services at PHC. These findings demand for the department of Health, Social Welfare and ITDP to specifically address the needs of the Koraga community in this region. Only 24.5 percent of the families expressed their satisfaction over the quality of health services whereas 45 percent were not happy for one reason or the other. The Koragas have responded and identified many areas as their felt needs for the improvement of health. All these suggestions are complementary for the overall improvement of not only the health but also the living conditions and social status of Koragas. They have given priority for the provision of nutritious food to the families. Other areas where they feel intervention is needed on a priority basis are development and welfare activities including education and employment. They have also urged for the improvement in the quality of health services through the PHC's and Sub Centers. Substance abuse by the members was one of the major concern and respondents suggested that measures be undertaken on a priority basis to discourage alcoholism.

CONCLUSION

The present study was conducted mainly to gain knowledge and information on the health seeking behavior and health needs of the Koraga families in Mangalore rural and urban areas. An attempt was made to explore the existing situation in health seeking practices, literacy,

economic status and community participation in rural and urban areas among Koraga community. The study findings were significant in throwing light on the improvements needed for the health conditions of the Koraga families. In the light of the above observations, the following suggestions were made keeping in view the available resources.

1. There is a growing need to conduct a detailed study of the health status of the Koraga community and prepare region-specific health plans.
2. The Staff of the Primary Health Centers (PHCs) and Sub Centers should be motivated and directed to ensure 100 percent antenatal coverage and immunization of women and children. Provide secondary and tertiary care, transport facilities for emergency services and obstetric care.
3. Select educated Koraga girls for training as ANMs (Health worker) and post them to sub centers located close to the Koraga colonies or settlements. They could also be trained in traditional medicine and health practices, thus encouraging and integrating traditional healing system in to modern medicine.
4. Communicable diseases, anemia, respiratory illness and malnutrition are found to be major health problems among Koraga families covered under study. Families are not familiar with the special health schemes by the government (mobile clinic, annual check up, medical benefit, insurance etc ;). Efforts be made to popularize them for better community participation so that there will be better immunization coverage, antenatal and postnatal care and supplementary nutrition of the vulnerable group.
5. Substance abuse is becoming a major health concern and therefore counselling and de-addiction measures be initiated with active participation of Koraga community organizations and the NGO's on priority basis.
6. Organizing periodical free health check up camps for screening health problems and providing appropriate treatment to patients. Possibility of health insurance coverage for the entire population may be looked into.
7. Ensure adequate and proper nutrition to children, expectant and nursing mothers through Anganwadi centers with support from Koraga SHGs or Sanghas.
8. Encourage need based economic activities that use locally available raw materials and assist in marketing of finished goods. Skill diversification trainings would prove beneficial to Koragas especially for the younger population. Formation of self help groups would enable them to undertake the above activities with the guidance from the government and non-governmental organizations (NGOs).

There has been an encouraging trend in the educational advancement of Koraga families because of intensive efforts by the departments concerned for Koraga welfare, Koraga community organizations and NGOs. The Koragas are facing tough challenges in the rapidly progressing society. Social stigma, educational backwardness, marginalization in the society, lack of control over resources and lack of professional skills prevent them from attaining socio-economic advancement in the society. Good health being one of the human development indicators it is important to develop a comprehensive policy on Koraga development, which derives inputs from people at the grassroots level to ensure sustainable development that is ecologically sound, community oriented, decentralized and culturally acceptable.

Annexure

Table 1
Age And Sex Distribution Of The Members of the Families

Age group(in yrs)	*Male*	*Female*	*Total*
<5	39(11.90)	43(13.10)	82(12.02)
5 – 14	41(12.50)	51(15.65)	92(13.49)
14- 21	49(14.93)	56(17.05)	105(15.40)
21- 44	141(42.90)	150(45.73)	291(42.67)
44- 60	45(13.81)	40(12.20)	85(12.46)
60 and above	13 (3.96)	14 (4.27)	27 (3.96)
	328	354	682

Table 2
Distribution of Family Members According to Occupation in Rural and Urban Areas

	Male		*Female*		*Total*		
Occupation category	*Rural*	*Urban*	*Rural*	*Urban*	*RuralM+F*	*UrbanM+F*	*Total*
Unemployed	12	50	22	50	34(9.18)	100(32.05)	134(19.66)
Daily wage worker	77	13	25	13	102(27.58)	26(8.33)	128(18.77)
Basket weaving	18	08	27	8	45(12.18)	16(5.12)	61(08.95)
House wife	00	0	24	12	24(6.48)	12(3.84)	36(05.28)
Sanitary worker	04	16	02	16	06(1.63)	32(10.25)	38(05.57)
Beedi roller	00	10	15	10	15(4.05)	20(6.24)	35(05.13)
Govt. Servant	01	04	02	4	03(0.80)	08(2.56)	11(1.61)
Attender	10	0	01	0	11(2.97)	0	11(1.61)
Agriculture / Cultivation	02	0	01	0	03(0.80)	0	03(0.44)
Self employed	04	01	07	01	11(2.97)	02(0.64)	13(1.90)
At Home (children+	53	54	63	42	116(31.39)	96(30.78)	212(31.08)
old people)	181	156	189	156	370(54.25)	312(45.75)	682(100)

Table 3
Distribution of Families According to Per Capita Income

Per capita income	*Rural*	*Urban*	*Total*
< Rs.500	23(35.94)	07(16.67)	30(28.30)
501-1000	25(39.06)	18(42.86))	43(40.57)
1001-1500	11(17.19)	08(19.05)	19(17.92)
1501-2000	04(06.25)	04(09.52)	08(07.55)
2001+	01(01.56)	05(11.90)	06(05.66)
	64	42	106

$X^2 = 7.227$ df = 3 $P > 0.05$

Table 4
Distribution of the Families According to Type of Water Supply

Type of water supply	*Rural*	*Urban*	*Total*
Well water	14(21.80)	6(14.28)	20(18.87)
Piped water	45(70.31)	34(80.95)	79(74.53)
Bore well	5(7.81)	2(4.76)	07(06.60)
	64	42	106

Table 5
Distribution of Families According Disposal of Sullage

Type of disposal of Sullage	*Rural Number*	*Urban Number*	*Total Number*
Soakage pit	0	12(28.57)	12(11.33)
Used for Kitchen garden	13(20.31)	4(9.52)	17(16.04)
Used for coconut trees	23(35.93)	9(21.43)	32(30.18)
Allow to stagnate	28(43.76)	17(40.48)	45(42.45)
	64	42	106

Table 6
Distribution of Family Members According to Sex and Morbidity at the Time of Survey

Morbidity conditions	*Male*	*Female*	*Total*
Respiratory system	55(56.13)	40(34.78)	95(44.60)
Bones & joints	13(13.27)	26(22.61)	39(18.31)
Communicable diseases	09(09.18)	14(12.17)	23(10.79)
Eye infections	07(07.14)	14(12.17)	21(09.86)
Cardio-Vascular system	03(03.06)	06(05.23)	09(04.23)
Anemia	04(04.08)	05(04.34)	09(04.23)
Mental illness	06(06.12)	02(01.74)	08(03.76)
Diabetes	01(01.02)	04(03.48)	05(02.34)
Others (ill defined)	0	04(03.48)	04(01.88)
Total conditions	98(46.01)	115(53.99)	213(100)

Table 7
Distribution of Members According to Number of Substances Abused

Number of substances abused	*Male*	*Female*	*Total*
Two substances	40(85.11)	15(100)	55(88.71)
Three substances	06(12.77)	0	06(9.68)
Four substances	01(2.12)	0	01(1.61)
Total	47(75.81)	15(24.19)	62(100)

Table 8
Health Problems of the Members in the Past One Year

Broad diseases category	*Rural*	*Urban*	*Total*
I. Infectious diseases	44(38.60)	51(32.27)	95(34.92)
II. Respiratory diseses	18(15.79)	12(07.59)	30(11.02)
III. Communicable diseses			
Malaria	01	45	
Filaria	0	02	
Tuberculosis	04	05	
Leprosy	01	00	
6(5.26)	52(32.91)	58(21.32)	
IV. Non communicable dis.			
Cardio vascular	07	04	
Mental illness	04	06	
Diabetes	02	02	
Cancer	0	02	
13(11.40)	14(08.86)	27(09.93)	
V. Anemia/ weakness	12(10.53)	07(04.44)	19(06.99)
VI. Bones & joints	08(07.02)	06(03.79)	14(05.16)
VII. Others			
Gastro intestinal	04	0	
Genito urinary	03	01	
Eye conditions	05	02	
Vague complaints	01	13	
13(11.40)	16(10.14)	29(10.66)	
Total conditions	114(41.91)	158(58.09)	272(100)

Table: 9
Immunization Practices of Children

Immunization	*Rural*	*Urban*	*Total*
Yes	34(53.12)	31(73.81)	65(61.32)
No	30(46.88)	11(26.19)	41(38.68)
	64	42	106
	$X^2 = 4.53$	df =1	$P < 0.05$

Table: 10
Distribution of the Families According to the Sources of Health Service and Type of Health Services Received by Expectant and Nursing Mothers

Sources of Health services	*Immunization No.*	*IFA tablets No.*	*Supplementary nutrition*
Government (PHC and Sub Center)	38(35.84)	34(32.07)	0
Private clinic	2(1.88)	2(1.88)	0
Anganwady	0	0	22(20.76)
No response	66(62.26)	70(66.03)	84(79.24)
	106	106	106

Table 11
Distribution of Families According to Antenatal Care (ANC) and Postnatal Care (PNC) Services Received in Rural and Urban Areas

Response	*Rural*	*Urban*	*Total*
Yes	27(42.18)	20(47.61)	47(44.33)
N0	37(57.82)	22(52.38)	59(55.67)
	64	42	106
	$X^2 = 0.774$	df = 1	p > 0.05

Table 12
Distribution According to ANC/PNC Services Received in Total Families and Literacy

Literacy level	*Response*		*Total*
	Yes	*No*	
Illiterate	12(26.08)	20(33.33)	32
Literate	34(73.92)	40(66.67)	74
	46(43.40)	60(56.60)	106
	$X^2 = 0.648$	df = 1	p > 0.05

Table 13
Distribution According to ANC/PNC Services Received in Total Families and Literacy

Literacy level	*Response*		*Total*
	Yes	*No*	
Illiterate	10(32.43)	12(32.43)	22(34.38)
Literate	17(62.96)	25(67.57)	42(65.12)
	27(42.19)	37(57.81)	64
	$X^2 = 0.146$	df = 1	p > 0.05

Table 14
Urban Area

Literacy level	*Response*		*Total*
	Yes	*No*	
Illiterate	2(10.52)	8(34.78)	10(34.38)
Literate	17(89.48)	15(65.21)	32(76.20)
	19(45.24)	23(54.76)	42
	$X^2 = 3.374$	df =1	p > 0.05

Table: 15
Obstacles Identified by the Respondents for Poor Satisfactory State of Health of the Community

Obstacles Identified	*Rural*	*Urban*	*Total*
	Number	*Number*	*Number*
Alcohol Abuse	55(34.59)	34(38.20)	89(35.88)
Substance abuse	49(30.82)	29(32.58)	78(31.45)
Insufficient income	29(18.24)	13(14.60)	42(16.94)
Lack of Health awareness	14(08.80)	5(05.61)	19(07.66)
Superstitions	6(03.77)	7(07.86)	13(05.24)
Unsatisfactory services at PHC	5(03.14)	1 (01.12)	06(02.43)
Health centres far off	1(0.64)	0	01(0.40)
Total	159	89	248

Table: 16
Health Needs and Remedial Measures Suggested by the Respondents for the Improvement

Suggestions	*Number*
Nutritious food	4432.35
Development and welfare activities	3022.06
Discourage alcoholism	2719.85
Improve Health services	1813.24
Education facilities	1007.35
Employment opportunities	0705.15
Total suggestions	136

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