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Health Status and Healthcare Care-seeking Behavior: A Study of Tribal Communities in Bijadandi Block in Mandla District

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ABSTRACT

Background: Despite significant advancements in the medical field, the health status of India's tribal population remains a concern, which was equally prevalent 25 years ago. Tribes still face numerous health issues, including malaria, infections, sickle-cell anemia, and nutritional deficiencies. Hence, this study tried to examine the morbidity status and treatment seeking behaviors of tribal communities.
Method and Material: A primary survey was conducted among 300 rural tribal households in Bijadandi block in the Mandla district of Madhya Pradesh. The purposive sampling was applied to select the household for collecting information on morbidity treatment history, place of treatment and reasons for not treating. For this study a structured interview schedule was used in the studied field. The primary survey was conducted from August to November 2019.
Result: The study found that nearly three-fifths had suffered from morbidities within the last 365 days prior to the survey which is higher experienced by 60 & above age groups, female, below primary schooling, farmer and housewife, and or widowed. Fever and cold cough prevalence were higher among tribes. Around 90 percent have received treatment during ill/sick. However, nearly two-fifths had received treatment from public healthcare centers while about three-fifth had received from private healthcare centers. Healthcare provider's behavior was found to be not suitable for the tribes, with discriminatory practices reported at public healthcare centers. This has led to a lack of desire for public healthcare services utilization, which is a significant obstacle affecting government healthcare services utilization in tribal areas. The study also highlighted the emergence of intermediate diseases, such as paralysis, resulting from smoking and alcohol consumption.
Conclusion: In general, the research indicates the importance of directing attention towards the health and socio-economic welfare, along with interpersonal interactions between healthcare service providers and tribal or vulnerable communities. Currently, tribes are expressing worries regarding their healthcare and medical care. Consequently, the central emphasis should align with the SDG (Sustainable Development Goals) principle of 'leaving no one behind,' placing a primary focus on enhancing the health and socio-economic well-being of both tribes and other susceptible groups.

Keywords: Tribes, Morbidity, Medical Care-seeking Behavior, Madhya Pradesh, Mandla

INTRODUCTION

The 2030 Agenda for Sustainable Development, comprising 17 Sustainable Development Goals (SDGs), was adopted by the General Assembly in September 2015. The new Agenda prioritizes a comprehensive approach towards attaining sustainable development for all, with a

focus on the principle of "leaving no one behind." However, health-related goals were also established to promote sustainable development in the healthcare sector, with a view to accomplishing these objectives. To align with the SDGs health goals, a new National Health Policy was introduced in 2017. Its implementation aims to fulfil the 2030 agenda for sustainable development in the healthcare sector in India.

As of the latest census in 2011, the population of tribes in the country currently stands at 104 million, which accounts for 8.6 percent of the total population. This is an increase from 8.2 percent recorded in 2001. Among the states in the central region, Madhya Pradesh has the largest tribal population, comprising 21.9 percent [1]. India has over 705 tribal ethnic groups with diverse cultural, traditional and cultural practices [2]. These communities mainly inhabit rural and remote areas and they are the most vulnerable and marginalized groups in society. They lag behind in various social, health, and developmental indicators [3]. Failure to address the concerns of such vulnerable populations will result in incomplete socio-economic transformation for India and it will not be feasible to achieve the U.N. Sustainable Development Goals by 2030 [4]. Due to poverty and social disadvantage, tribes are more likely to live under adverse conditions and poor socio-economic is affect their health [5-6].

As per Census of India, 2011, 104 million tribes constituted 8.6 per cent of the country's total population. In India, 705 different ethnic groups of tribes are scattered across 28 states and eight union territories with diverse cultural and life practices in India. Madhya Pradesh is the largest abode of tribes in India with 15 million tribes residing here. 14.4 per cent of the tribes of the country reside in Madhya Pradesh and they collectively constitute about 21 per cent of the state's population. These communities are mainly concentrated in remotely located forest and rural areas. Bijadandi block of Mandla district is a typical representative of a remotely located tribal area characterized by rural dwellings surrounded by forest and inaccessibility. Tribes in general and particularly in Bijadandi block are among the most vulnerable and marginalized social groups in the society. They lag behind in various indicators pertaining to socioeconomic development and health. Failure to address the concerns of tribes will result in inadequate socio-economic transformation in India and subsequently, the U.N. Sustainable Development Goals by 2030 may never be achieved.

Despite significant advancements in the medical field, the health status of India's tribal population remains a concern, which was equally prevalent 25 years ago [7]. Tribes still face numerous health issues, including malaria, infections, sickle-cell anemia, and nutritional deficiencies. Economic underdevelopment and inadequate access to modern education contribute to their poor health awareness. Dysentery, parasitic infection, Malaria, Tuberculosis, Hepatitis, Sexually Transmitted Diseases (STDs), Filariasis, Diarrhea, Jaundice, Viral and Fungal infections, Conjunctivitis, Yaws, Scabies, Measles, Leprosy, Cough and Cold and HIV/AIDS are common among tribes [8-9]. Unhygienic conditions and inadequate sanitation facilities are the leading causes of various illnesses. Poverty, malnutrition, poor environmental sanitation, lack of hygiene, and safe drinking water contribute to the prevalence of water and vector-borne infections [10-11]. In addition, low socio-economic status and inadequate education negatively impact healthcare utilization, whether it's private or government healthcare services [12-14] . Due to their geographical remoteness, tribal communities have limited access to healthcare infrastructure, resulting in their inadequate health facilities in the country [15]. Furthermore, their health deprivation is compounded by the inability to receive appropriate healthcare services for multiple diseases at the same time. The tribal population's poor health status can be

attributed to factors such as their living conditions in remote and hilly regions, limited access to modern healthcare, and their perceived backwardness and primitiveness. Additionally, inadequate health infrastructure, low ratio of healthcare service providers to population, poor connectivity, and limited political representation has resulted in compromised healthcare services. On the other hand, the high cost of private healthcare services and the unsatisfactory quality of public healthcare services make them vulnerable to poor health outcomes and limited access to healthcare facilities [16]. According to a study, over 50 per cent of the tribal population seeks treatment from private healthcare institutions, whereas nearly 40 per cent of them visit public healthcare institutions [17]. The tribal communities are disproportionately affected by the disparities in the availability and quality of health services [18] at public healthcare centers in rural areas. Additionally, some healthcare providers avoid physical contact during checkups and hand over medication without touching them [19] due to social taboos of untouchability in India. Other factors like transportation problems, distance from healthcare centres, and living in inaccessible hilly and forest areas also affect the utilization of healthcare services among tribal communities [20]. It may be worth considering why the tribal population is dissatisfied with government healthcare facilities, and previous research has identified certain factors that could shed light on this question.

The lack of proper healthcare infrastructure in tribal areas could be a significant contributing factor. A study conducted among tribes in Kerala revealed that despite healthcare services being provided free of cost, tribal people still hesitate to access them [21-22]. Moreover, research has revealed that discrimination against ethnic groups and Indigenous communities has severe implications for their health [23-24]. A study conducted in Assam found that the unavailability of doctors, scheduling difficulties, and long waiting times were major obstacles to healthcare utilization among tribes. Lack of money in hand is a barrier to access to healthcare utilization among tribal [25]. Tribes desire to access public healthcare services but are unable to do so due to insufficient healthcare facilities and transportation issues. A qualitative study has confirmed that a lack of transportation is one of the barriers to accessing healthcare among tribes. Furthermore, discrimination by healthcare providers has also led to tribes avoiding public healthcare centers. The ongoing study analyzed these factors in the context of the Bijadandi block of Mandla district of Madhya Pradesh. Moreover, this study also tried to examine the morbidity status and treatment seeking behaviors of tribal communities.

MATERIAL AND METHODS

Data Source

Between August to November 2019, primary data for the study was collected through a structured household questionnaire. The survey gathered information on self-reported morbidity and treatment-seeking behavior in the Bijadandi block. The study included households belonging to any tribal community in the study area. The morbidity data collected included specific diseases listed by the National Sample Survey Organization, with a reference period of the 365 days before the survey [26].

Method and Methodology

From August to November 2019, a household interview schedule was administered in Mandla District. This schedule consisted of several sections that included questions on the morbidity status of household members, treatment-seeking behavior, the place of last treatment, and reasons for not seeking treatment. The survey was conducted with 300 tribal households, and all questions were closed-ended. Morbidity status was assessed for two reference periods, short-term (within

one year) and intermediate-term (within five years), and information was collected for both periods. The study used standard criteria to define short-term as within one year and intermediate-term as within five years [27]. It should be noted that individuals with any of the listed ailments in the 71st NSS survey conducted in 2014 were considered diseased or sick. The interview schedules were initially created in English and then translated into the local language (Hindi) for convenience during the field survey. Written consent was obtained from respondents prior to collecting any information.

Study Area: Mandla District

The Mandla district was chosen as it is the second-largest fifth schedule area after the Jhabua district in Madhya Pradesh. In addition, the district is categorized as least economically developed, falling under the 20 districts nationwide with the lowest economic index, according to the "District Development and Diversity Index Report for India and Major States" published in 2015. The report identified Mandla district as one of the economically disadvantaged districts in Madhya Pradesh [28]. The district has a total of nine blocks with 1,221 villages and 227,645 households. The population of the district is 953,894, with a majority residing in rural areas [1]. The Bijadandi block in Mandla district was selected for the final fieldwork as it has the highest concentration of tribal population, with more than 82 percent of the population belonging to tribal communities.

Selection of Villages

The survey villages were selected based the proximity of the village distance from a Community Health Centre (CHC) within a 15 km radius, as many villages in the area are located in remote forest hills, making them difficult to access. Based on this criteria, ten villages were chosen from the Bijadandi block for the survey

Selection of Households

The selection of households for the survey was based on their morbidity status during the year preceding the survey. Specifically, households were chosen only if at least one member had reported being sick or having fallen ill within the 365 days prior to the survey.

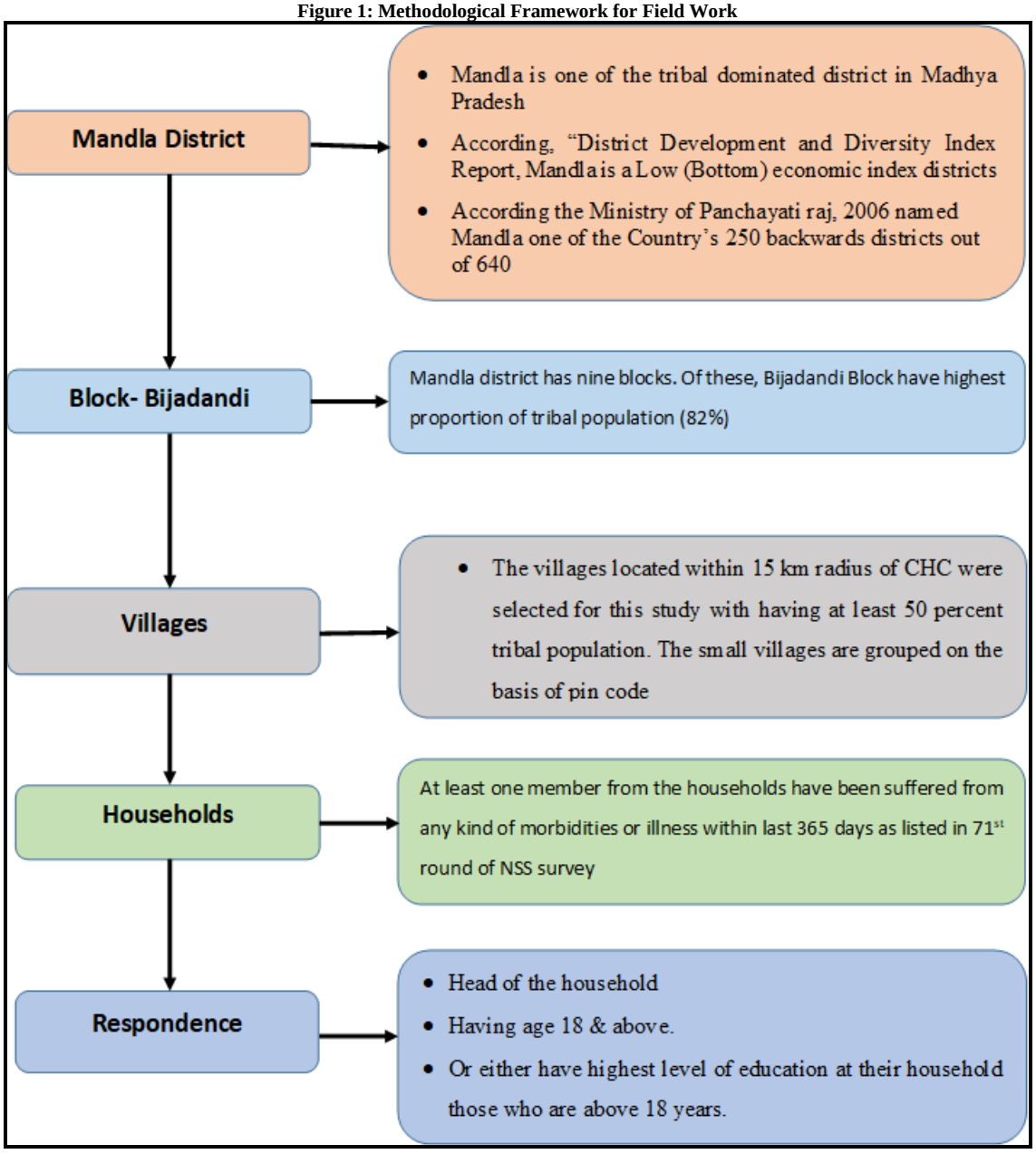
Selection of Respondents

To select the respondents, three criteria were established. Firstly, the head of the household was preferred for collecting information as per the study. Secondly, if the head of the household was absent, the most knowledgeable person in the household was selected, taking into consideration their level of education. Lastly, the member had to be aged 18 years or above.

Tools and Techniques for Primary Study

This survey employed a mixed-method approach and utilized a household interview schedule to collect data. The schedule consisted of specific sections that aimed to gather quantitative information on the morbidity status of household members, treatment-seeking behavior, healthcare facility preferences, and place of treatment. The original interview schedules were developed in English and later translated into Hindi, which was used during the field survey. Prior to commencing the interview, written consent was obtained from respondents. A pilot survey was conducted in tribal villages in a neighboring district to validate the household schedule's reliability and validity. Based on the findings from the pilot survey, modifications were made to the household schedule. After finalizing the household schedule, the final fieldwork survey was conducted in the selected area.

Figure 1: Methodological Framework for Field Work



RESULT

Names of Surveyed Tribal Communities

The purposive sampling method was used to interview 300 households belonging to tribal communities for this study. The study included a total of 149 male and 151 female participants who provided their written and verbal consent. The information on morbidity and treatment status was collected from 1223 members, including 616 males and 607 females, residing in these interviewed households. The morbidity information was self-reported by the household respondents and pertained to the 365 days preceding the survey.

The table 1 shows the number and percentage of households of different tribal groups interviewed in the study. The study interviewed a total of 300 households from the tribal population of Bijadandi block in Mandla district. The table shows that Maravi is the most dominant tribe in the area, with 44 households, accounting for 14.7 percent of the total households interviewed. Uikey is the second most represented tribe with 39 households, accounting for 13 percent of the total households interviewed. Markam, Parte, and Urreti are other significant tribes in the

study area, with 8.7, 7.3, and 6.7 percent of households interviewed, respectively.

Table 1: Surveyed Tribal Groups in the Studied Area

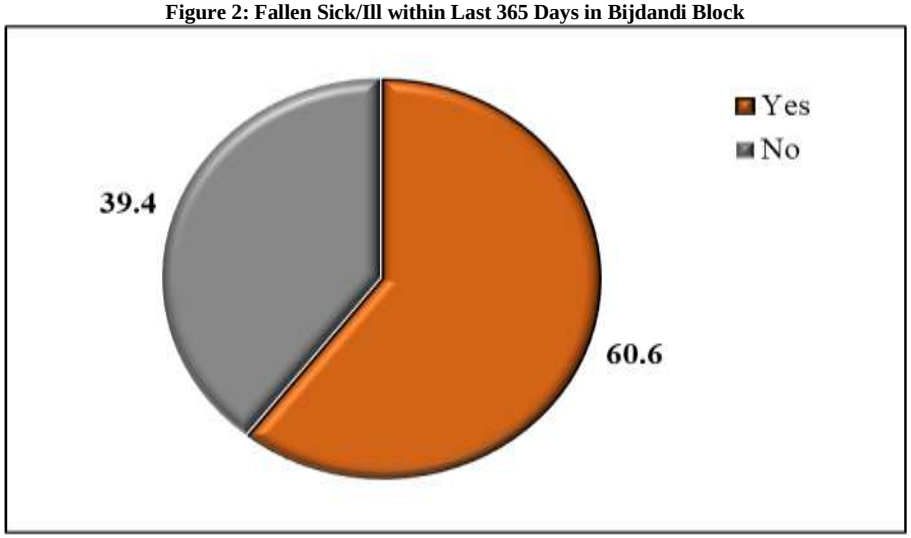
Name of Tribes	No. of H.H. s	Percent
Maravi	44	14.7
Uikey	39	13.0
Markam	26	8.7
Parte	22	7.3
Urreti	20	6.7
Baiga	15	5.0
Marko	14	4.7
Narreti	11	3.7
Vadkade	11	3.7
Other Tribes	98	32.7
Total	**300**	**100.0**

Source: Personal Field Survey, Aug-Nov., 2019

Morbidity Status among Tribes in Studied Area

During the field survey, a total of 1223 individuals were recorded from 300 households that were studied. Among these individuals, 741 (61%) reported having fallen ill or experienced morbidity/disease within the past 365 days as depicted in figure 2.

Figure 2: Fallen Sick/Ill within Last 365 Days in Bijdandi Block



Source: Personal Field Survey, Aug-Nov., 2019

Morbidity Status among Tribal Household

Table 2 illustrates that the age group of 60 years and above (74%) had the highest prevalence of morbidity or illness within the past 365 days, followed by the age group of 15-29 years (52%). Conversely, in the study area, females (63.8%) had a higher incidence of diseases or illnesses than males (57.5%). The prevalence of morbidity is notably greater among individuals with no formal education (66%) or those with only a primary-level education (66%). Nevertheless, the probability of experiencing morbidity or falling ill decreases among tribes as the level of education increases. Moreover, health status varied based on occupational status, with individuals engaged in farming (68%) being more susceptible to falling ill, sick, or diseased compared to those employed in government jobs (44%). Similarly, those who were widowed (69%) had a higher incidence of falling ill within the past 365 days compared to those who were unmarried (53%). Additionally, individuals who consumed water from wells (65%), tube wells (63%), and hand pumps (61%) reported the highest incidence of illness.

Table 2: Illness Reported By Tribes Based on Their Background Characteristics

Characteristics	No. of Ill Person	Percent	Total Recorded Population
Age Group			
0-14	117	57.6	203
15-29	223	51.5	433
30-44	170	67.7	251
45-59	148	66.1	224
60 & above	83	74.1	112
Sex			
Male	354	57.5	616
Female	387	63.8	607
Level of Education			
No Education	317	66.0	480
Primary	145	66.2	219
Secondary	158	51.8	305
Higher Secondary	74	56.1	132
Graduation & above	47	54.0	87
Occupational Status			
No Occupation	96	49.2	195
Self-Employed	4	50.0	8
Farmer	158	67.8	233
Labor Worker	126	61.5	205
Govt. Job	12	44.4	27
Private Job	5	55.6	9
Students	139	56.0	248
House Wife	197	68.6	287
Other	4	36.4	11
Marital Status			
Single	243	52.6	462
Married	439	65.2	673
widowed	58	69.0	84
Divorced/separated	1	25.0	4
Total	**741**	**60.6**	**1223**

Source: Personal Field Survey, Aug-Nov., 2019

Type of Ailments Reported by Tribes

Information regarding specific diseases was collected to determine the prevalence of morbidity. It was found that almost three-fifths (60.6%) of the tribes had experienced illness within the 365 days preceding the survey. Among the listed diseases, fever (60%) and cold cough (36%) were the most commonly reported, followed by body pain (14%) and other ailments (10.3%). The incidence of malaria (3%) was relatively low among the tribes in the surveyed villages, as shown in Table 3.

Table 3: Nature of Ailments Experienced by Tribes within Last 365 Days

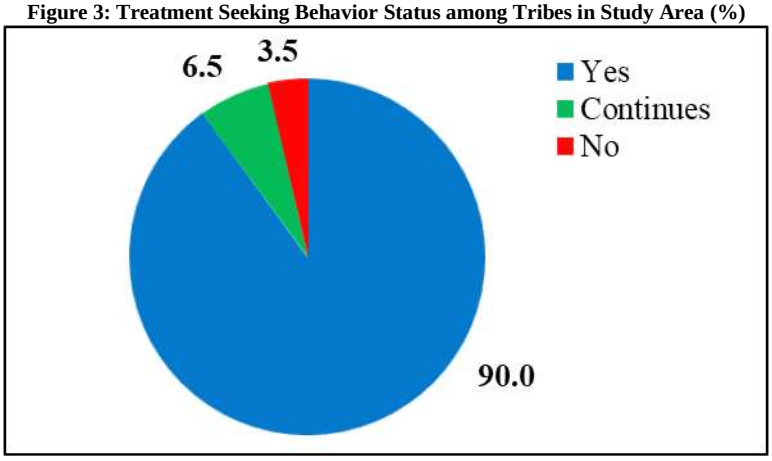
Nature of Ailments	Number (N=741)	Percent
Cold Cough	268	36.2
Fever	446	60.2
Malaria	21	2.8
Jaundice	4	0.5
Diarrheas	20	2.7
Dysentery	14	1.9
Headache	22	3.0
Weakness	37	5.0
Eyes Problem	9	1.2
Small Pox	3	0.4
Ears Problem	2	0.3
Stomach Pain	54	7.3
Mouth Ulcers	3	0.4
Body Itching	8	1.1
Pain (body, waist, leg & Chest)	107	14.4
Loo	3	0.4
Paralysis	2	0.3
Epilepsy	3	0.4
TB	3	0.4
Diabetes	1	0.1
Any Other	76	10.3

Source: Personal Field Survey, Aug-Nov., 2019

Treatment Status among Tribes

Treatment-seeking behaviors among the tribes are depicted in Figure 3. It was found that almost 90 percent of the tribes sought treatment during periods of illness, morbidity, or sickness within the preceding 365 days, while nearly 7 percent were undergoing treatment at the time of the survey. Approximately 4 percent of the tribes did not receive any treatment for their illnesses due to specific reasons, as further elaborated in this study.

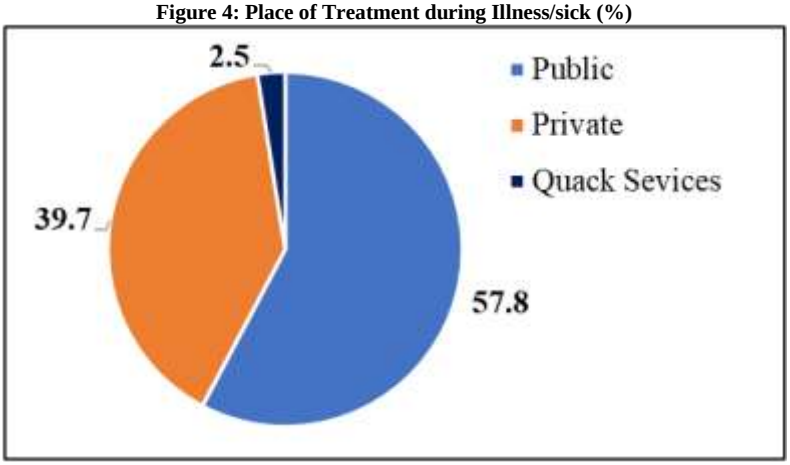
Figure 3: Treatment Seeking Behavior Status among Tribes in Study Area (%)



Source: Personal Field Survey, Aug-Nov., 2019

In addition, Figure 4 illustrates the locations where tribes sought or continued their treatment. These locations were categorized as either public healthcare facilities (such as SHCs, PHCs, CHCs, and other public healthcare centers) or private healthcare services. The study found that approximately 40 percent of the tribes sought treatment from public healthcare centers, while around 58 percent of tribes utilized private clinics or hospitals. This suggests that public healthcare services are underutilized by both tribal and non-tribal populations.

Figure 4: Place of Treatment during Illness/sick (%)

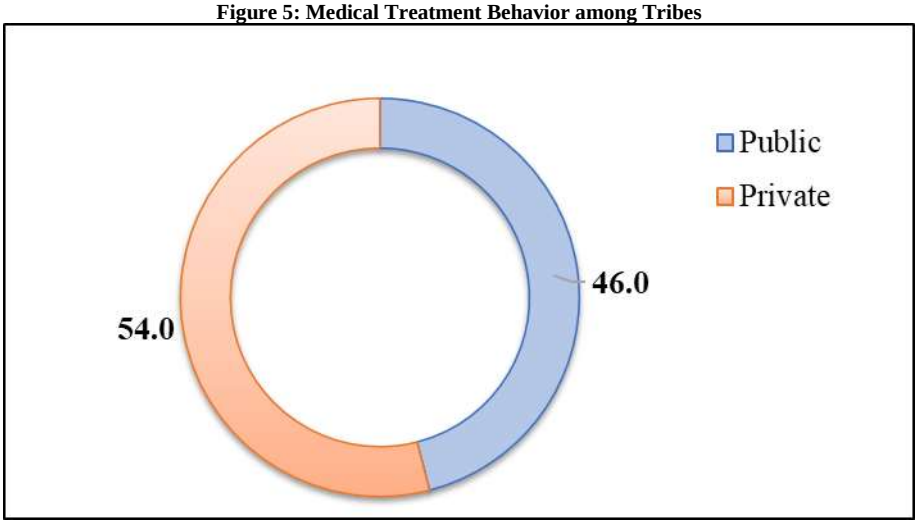


Source: Personal Field Survey, Aug-Nov., 2019

Place of Treatment Preferences among the Tribal Communities

Over half of the tribal population prefer private healthcare (54%) centers over public healthcare centers (46%) for treatment, as shown in Figure 5. The reasons for not preferring public healthcare services are provided in the figure.

Figure 5: Medical Treatment Behavior among Tribes



Source: Personal Field Survey, Aug-Nov., 2019

Reason for not Preferring Public Healthcare Services

According to the study, the majority of tribal households (54%) opt for healthcare services from private clinics and hospitals, which is a higher percentage compared to those who avail of government healthcare services (46%) as shown in figure 6. The study also presents reasons for not utilizing public healthcare services. The reasons for this are listed in table 4. During the study, tribes cited ten significant reasons for not utilizing public healthcare services. Among these reasons, the two most common ones were that the "quality of services" was not satisfactory (61%) and that public healthcare centers did not offer "effective relief" (65%). In addition to these, tribes reported other reasons such as lack of belief in public healthcare services (27%), unavailability of required medicine at public centers (20%), distance and transport problems (23%) and unavailability of services nearby (18%). The study also revealed some behavioral practice-related reasons between service providers and beneficiaries (10%). Tribes reported that some service providers did not conduct check-ups before treatment and only gave tablets (8%). Additionally, some healthcare services providers practiced untouchability practices at centers (7%), which discouraged tribes from seeking treatment at public healthcare centers.

Table 4: Reason for not Preferring Public Healthcare Services

Reasons	Percent	Total (N=162)
Not Satisfied with Govt. Healthcare Services	61.1	99
No Relief /effective Govt. Healthcare Services	64.8	105
Not Believe in Government Health services	26.5	43
Not available required medicine at Govt. Health centers	19.8	32
Transport Problem	22.8	37
Not Good Behavior of Services Provider	10.5	17
Not check-up before treatment & gives tablets only	8.0	13
Health Provider does not Touch for Check-up	6.8	11
Healthcare Provider not available at centers	9.9	16
Not available healthcare centers nearby place	17.9	29
Other	9.9	16

Source: Personal Field Survey, Aug-Nov., 2019

History of Prolong Diseases among Tribal Communities

According to table 5, which displays the morbidity status of tribes, the study examined the prolonged or intermediate-term disease status among tribes. This pertains to the morbidity status of individuals who have experienced diseases within the past five years, including former members and those currently residing with

the household members. The results indicate that approximately 26 percent of tribal households have experienced prolonged or chronic diseases in the past five years. Paralysis (26%) was the most common disease experienced by tribes, as shown in table 5.

Table 5: History of Chronic Disease among Tribal Communities

Intermediate-term (Long Term)	**Percent**	**Total No.**
Yes	26.0	78
No	74.0	222
Total	**100**	**300**
Name of Intermediate-term (Long Term)		
Charm Rog	9.0	7
Paralysis	20.5	16
Epilepsy	9.0	7
TB	7.7	6
Cancer	5.1	4
Diabetes	2.6	2
Others	46.2	36
Total	**100**	**78**

Source: Personal Field Survey, Aug-Nov., 2019

DISCUSSION

This study looked at the health and treatment-seeking behaviors of tribes in the Bijadandi block of Mandla district in Madhya Pradesh. It found that 60.1 percent of the tribes in the area were suffering from morbidities between August to November 2019, with around 90 percent of them receiving treatment, which is close to the national average [29]. The prevalence of illnesses was higher among females, uneducated individuals, and those in specific occupations. Fever and cold cough were the most commonly reported illnesses among tribes, while malaria was reported less frequently, while it was around 25 percent malaria prevalence was contributed by Mandla district during 2002 [30]. Water sources like paddy fields, open wells, and tube wells that lacked chlorine were significantly associated with illnesses like diarrhea and vomiting as some other studied demonstrate the same finding [31]. The study also found that around 21% of tribal households reported at least one case of paralysis within the last five years, and this was the most commonly reported prolonged illness. A healthcare provider at the PHC said that habits like drinking and smoking may be contributing factors to paralysis among tribes. Although, the reporting of paralysis is significantly higher among those who are drinking alcohol more than once a day and smoking more than once a day [32]. Tribal people were found to be utilizing private healthcare services more than public services due to factors like poor quality of care, exclusionary practices, and poverty. Tribes also reported discrimination from healthcare providers, which made them less likely to use public healthcare services as found in other study also [33]. In addition to these reasons, the study identified several others, including inadequate road infrastructure, a shortage of healthcare personnel, insufficient medical equipment, language barriers between healthcare providers and patients, social barriers, long wait times at healthcare facilities, and poverty [34]. Language barrier poses a significant challenge for tribes to understand the instructions given by healthcare providers. It also makes it challenging for healthcare providers to communicate effectively with tribes. Due to these language barriers, tribes often resort to traditional practices for treatment [35].

CONCLUSION

In general, the research indicates the importance of directing attention towards the health and socio-economic welfare, along with interpersonal interactions between healthcare service providers and tribal or vulnerable communities. Currently, tribes are expressing worries regarding their healthcare and medical care. Consequently, the central emphasis should align with the

SDG (Sustainable Development Goals) principle of 'leaving no one behind,' placing a primary focus on enhancing the health and socio-economic well-being of both tribes and other susceptible groups

Declaration by Authors

Ethical Approval: Ethical clearance prior to data collection was obtained from the Student Research Ethics Committee of the Institute. Written and verbal informed consent was obtained from the participants and assured confidentiality and informed that the survey data would be used for research purposes only.

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Conflict of Interest: It is certified that author do not have any conflict of interest with respect to the publication of this manuscript and approved the final manuscript.

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