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Socioeconomics of Tribals and Strategies of Their Health Problems: A Case Study of West Champaran District, Bihar

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ABSTRACT

Most tribal women do not utilize the maternal health services provided at government facilities. Social barriers may prevent the utilization of available nutrition supplementation programmers and services for women and children. The health seeking behavior is guided by superstitions and prevailing cultural practices.

The present paper is based on a prelimnary case study of socioeconomically seeking problems of West Champaran district Tribals and strategies of their health problems.

Keywords: ***Socioeconomics, West Champaran, Tribals, Health Problems.***

INTRODUCTION

India is the second populous country in the world as regards to tribal population. Women's status is often described in terms of their level of income, employment, education, health and fertility as well as the roles they play within the family, the community and society. A tribal woman occupies an important place in the socio-economic structure of her society. Literacy is considered to be an important tool for improving the status of women among the scheduled tribes. Education , language, childbearing and maternal mortality, Women's health, gyaenic problems such as menarche, menstrual problem, pregnancy, delivery, abortion, family planning practices, nutritional status, mothers health, etc. are responsible for overall general status of tribal women in India. These tools if properly used responsible for empowerment otherwise leads to hindrance and hurdles. Proper plan of action for developing the above parameters certainly enhance their day to day improvement and responsible for strong individual, then strong family and ultimately empowered tribal society[1-4].

METHODOLOGY

The study was conducted in West Champaran district of Bihar State. The main focus of this investigation was to study the effect of menstruation on the health of uneducated adolescent girls (a case study of West Champaran district). The survey tribal women of West Champaran has been utilized to select a representative sample of 200 respondents from four block namely Bettiah, Jagopatti, Madhubani, Narkatiaganj. The sample includes unmarried adolescent girls, women in reproductive age group, pregnant women, lactating mothers, health care workers and community stakeholders. The primary data have been gathered with the help of an interview schedule. Separate schedules were prepared for unmarried adolescent girls, women in reproductive age group, pregnant women and lactating mothers.

RESULTS AND DISCUSSION

200 respondents have been selected on the basis of sampling method. Adequate and representative same have been selected on the basis of stratified random sampling method. Descriptive research design has been considered for this study. The study is related to the women of urban areas. So according to the topic it is clear that all the respondents are women. During survey study age wise distribution (18-50 Years), educational level wise distribution, marital status wise distribution, family type distribution, type of house, monthly income, health is wealth, poverty line, health and economy, family traditional norms, early marriage, inherited and non-inherited diseases, sexually transmitted diseases, genetic disorder, health care awareness and jadoo-tona traditions were taken through questionairres. That can be clarified by study on the basis of health is wealth (Table 1).

Table 1
On the basis of know health is wealth

S.No	Age grp.	Yes (%)	No (%)	Total (%)
1	18-25	26(13.00)	04(02.00)	30(15.00)
2	26-34	30(15.00)	10(05.00)	40(20.00)
3	35-42	46(23.00)	14(07.00)	60(30.00)
4	43-50	50(25.00)	20(10.00)	70(35.00)
5	Total	152(76.00)	48(24.00)	200 (100.00)

All reveal on the basis of know health is co-related to economic condition. The question was asked to the respondent that- know health is co-related to economic condition? According to above table 55 per cent respondents know health is co-related to economic condition. But 45.00 per cent responses are in negative attitude. It also reveals on the basis of health status of tribal women is lower than other women. The question was asked to the respondent that- it is true health status of tribal women is lower than other women? 100 per cent respondents agreed it is true that health status of tribal women is lower than other women. Different food items are believed to be harmful and beneficial in the various Indian communities. Some beliefs are often associated with the concepts of ‘hot’ and ‘cold’ foods. In Indian communities food items perceived as ‘hot’ are often believed to be harmful for pregnant women and those perceived as ‘cold’ believed to be beneficial, although in a few communities effects are believed to vary in different stages of pregnancy and also on individual physical constitution. Some ‘hot’ food items are meat, egg, fish, onions, garlic, papaya, pineapple, mango, and black berry, suran and so on. The general concept of avoiding these food items was that they caused premature delivery, miscarriage, or abortion. Studies available on the dietary status and health of the Bihar and Maharashtra found deficiencies in calories as well as protein and essential amino acids in their diets though major signs of nutritional deficiencies were not observed. Surveys on the nutritional deficiencies among the tribals reported a high incidence of goitre, angular stomatitis among the Mompas of Assam and Vit. A deficiency among the Onges. A high incidence of malnutrition was observed in some primitive tribal groups in Phulbani, Koraput and Sundergarh districts of Orissa and also among Bhils and Garasia of Rajasthan, Padars, Rabris and Charans of Gujarat and Bondas of Orissa. Studies of tribal communities in Orissa conducted and found that an ecological imbalance caused by rapid deforestation had resulted not only in depleting food resources, but in prolonged droughts, adding to hunger and starvation.

CONCLUSION

The study has observed a gap among the ICDS and Health functionaries in communicating the accurate messages of different services to the tribal folks to bring out a behavioural change in their health care practices. It is, therefore, recommended to build the

capacities of ICDS and Health workers in terms of developing common messages in vernacular languages for social and behaviour change communication to facilitate in meeting out the objectives of different schemes.

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