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"A Study On Health Awareness Among Tribal Women In North Coastal Districts Of Andhra Pradesh"

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Abstract:
Adivasis, often known as "original inhabitants" or "indigenous peoples," are the approximately 17 million Scheduled Tribe people of India. The term "Scheduled Tribes" refers to a legal designation. The United Nations considers the Scheduled Tribes indigenous, accounting for 08.20% of the Indian population. Most are underprivileged and suffer from poor literacy and health care, starvation, and malnutrition. According to Census-2011, the number of scheduled tribes in India is **10 42 81, 034**. It is 8.6% of the total population of India. This questionnaire consists of 36 items covered on emotional and reproductive health perception. For measuring the perceptions of women towards emotional and reproductive health, The researcher, selected four areas viz., 1) Emotional Symptoms, 2) Depression and Anxiety, and 3) General Health. 4) Physical illness. These four areas are divided into eight subcategories. a) Depressed mood, b) Somatic Symptoms, c) Anxiety/fear, d) vasomotor symptoms, e) Sleep Problems, f) Sexual Behavior, g) Menstrual Symptoms, and h) Memory and concentration. According to this research work, results are shown. The age of tribal women does not significantly affect their health awareness. The birth order of tribal women does not significantly affect their health awareness.

Key Words: indigenous peoples, Scheduled Tribes, Emotional Symptoms, Depression and Anxiety, General Health. Physical illness.

Introduction:

Adivasis, "original dwellers" or "indigenous peoples," refer to India's approximately 17 million Scheduled Tribe people. They are referred to as primitives or primitives, and they are at the beginning of humankind's development. The word "Scheduled Tribe" refers to an administrative designation. The Scheduled Tribes are considered indigenous peoples by the United Nations Organization (UNO), accounting for 08.20 per cent of the Indian population. It is the country with the world's largest indigenous population. Before British rule, tribals were self-governing people' in most sections of the country. They controlled themselves outside of the 'unknown frontiers' and the influence of a specific king in the different states where the rulership did not extend. However, the "Permanent Settlement' in 1793, which gave the British power over enormous expanses of land, including tribal territory, for revenue collection, began the coercive relations of tribals with outsiders. Tribal communities are among India's most backward. Most are impoverished and suffering from poverty, with conditions such as inadequate literacy and health care, hunger and malnutrition. More recent revisions to the Indian Constitution have been enacted to alleviate the miseries of tribal tribes and remove barriers to their growth.

Tribals are frequently referred to as Adivasi, Vanyajati, Vanavasi, Pahari, Adimajati, a constituent name. With the entrance of the British, the concept of tribe evolved in India. In independent India, the concept of reservation gradually arose, with it, the concept of scheduled tribes. In India, 427 ethnic groups are classified as "scheduled tribes." They account for around 8% of the Indian population (2001 census). According to Census-2011, the number of scheduled tribes in India is **10, 42, 81, 034**. It is 8.6% of the total population of India. These tribal tribes from various cultural, social, and economic backgrounds live in a massive territory with widely differing environmental and geo-climatic conditions in various locations around the country.

The ethnicity, language, religion, and culture of Scheduled Tribes varied widely. Despite their differences, the mutually diverse tribal communities share certain broad parallels. Broad commonalities may be found in their way of life, with each tribe living in a particular ecosystem, speaking a shared dialect, sharing cultural homogeneity, and having a cohesive social organisation. India's tribal population speaks 105 separate languages and 225 associated languages. The languages spoken by Indian tribes are divided into four major language families: Tibeto-Chinese, Austro-Asian, Indo-European, and Dravidian.

The sex ratio reflects the population's socio-cultural, maternity, and child health care programmes. The tribal population had 972 females for every thousand males, according to the 1991 census, while the overall population, including the tribal population, was 9273. Odisha has the most incredible sex ratio for Scheduled Tribes in various states (1002), while Goa has the lowest (889). However, according to the 2001 census, the tribal population's sex ratio was 1003, while the overall population, including the tribal population, was 9334. Scheduled Tribes vary in their social, cultural, and economic development. The cultural pattern differs according to tribe and place. Tribals' economic lives are distinct. Adivasis The tribes of India can be categorised into seven groups, each based on their manner of life.

Tribal health dimension:

The tribal people live near forests and have long maintained and preserved the biodiversity of their territories. These tribals are protected from the forest and eat edible forest foods, both raw and prepared. The flowers and seeds have been fried. They make use of forest products such as lumber and fuel. These tribes have lived in the forests for centuries and have formed a bond with them. Their economic, social, religious, and cultural lives are so intertwined with the forest that they become a part of it. The tribals' relationship with the forest is known as symbiosis because the tribals are dependent on the mother of the kid, who is dependent on the forest.

India's diverse ethnic population and enormous riches contribute to its biodiversity. Approximately 45,000 wild plants have been discovered, with 9,500 important tribal medicinal species. Seven thousand five hundred are used medicinally in traditional health care techniques. The tribals consume approximately 3,900 plant species as food (145 species are rhizomes and tubers, 521 species are leaves and vegetables, 101 species are buds and flowers, and 647 species are fruits), 525 species are used to make fibres, 400 species are used as animal fodder, and 300 species are used in the manufacture of chemical substances. They are employed in extraction as bio-insecticides and bio-insecticides, and 300 species are utilised for resin, gum, perfume, and colour extraction (Arora 1977). Aside from this, several plants are employed as construction materials and lumber, and over 700 species are designated as culturally significant.

Local health traditions are mostly unrecorded and oral. They are almost certainly as old as humans. Because they are based on natural resources in various environments, these oral or

folk medicine traditions are incredibly diverse. It is estimated that over 7,500 medicinal plant species and over 200 animal and mineral resources are employed in India to treat ailments and solve health problems. These tribal health traditions are innovative, dynamic, and ever-changing, and they contain a wide range of health practices based on local knowledge and practical experience. They are not limited to any social or economic level, yet tribals are acknowledged as the keepers of these traditional practices. These customs have steadily declined during the last two centuries.

Along with recognised causes of cultural diversity reduction, such as the Western model of education, acceptance of development models that favour Western medical systems is a significant factor in the decline of these indigenous health practices. Physical, biological, and mental aspects are recognised as the causes and treatments of diseases in modern medicine. On the other hand, local health traditions believe that every living being has a spiritual part in addition to physical, biological, and emotional characteristics. As a result, many indigenous diagnostic and healing procedures contain spiritual rituals such as prayers, devotions, mantra recitation, and auspicious practice times. These strategies may be better appreciated in light of Ayurveda.

Ayurveda recognises that a human comprises three parts: body, mind, and soul. Because most disease situations combine biological, physical, and spiritual components, a whole-person approach is adopted, with the patient playing an active part. Only 30% of the Indian population is served by modern medicine in primary health care. Traditional healers, bonesetters, and midwives are available in the remaining areas. An examination of tribal and local health resources revealed that the keepers and carriers of tribal health traditions created approximately 50,000 herbal therapeutic compositions. In India, around 4,800 medicinal plants utilised in traditional medicine have approximately 50,000 local names. However, most of these natural resources are consumed locally as food, medicine, fodder, fuel, or dye. Many consider them possible variables for developing human resources and utilising their skills and knowledge.

The Indian subcontinent is home to 84 million tribal people divided into 427 tribal tribes and 225 language groups; They dwell in India's enormous mountains and jungles, which have various geographical and climatic zones. Their occupations ranged from gathering forest produce, hunting, sheep and cattle farming, cave habitation, nomadism, and permanent settlement in complete harmony with nature. Their preferred habitat is the forest. Their connection to the forest is symbolic. They use forest resources without disrupting the ecosystem's delicate equilibrium. Tribal communities remained essentially stable societies, undisturbed by the cultural, social, physical, and economic advances in so-called modern nations. However, in recent years, encroachment on indigenous habitations has disrupted this peaceful coexistence. Over time, traditional groups living near environments have developed specific knowledge regarding the use of living biological resources. Modernization of civilization, as opposed to industrialization and urbanization, has endangered indigenous societies' rich heritage of knowledge and ability. A recent investigation of the indigenous tribes' lives found that they possessed vital knowledge of the unique uses of a considerable variety of wild plant and animal origin agents, many of which were unknown to the outside world. Tribes are the genuine keepers of medicinal plants.

Tribes in Andhra Pradesh:

For the study, only four tribes are taken from 34 tribes in Andhra Pradesh. These are:
The Konda Doras are primarily found in Andhra Pradesh's East and West Godavari districts, Srikakulam, Vizianagaram, and Visakhapatnam scheduled areas. According to

the 2011 census, they have a population of 210509 (male: 103977, female: 106532), and their overall literacy rate is 40.31. In their native dialect, known as "Kubi," they refer to themselves as "Kubing" or "Kondargi." The Konda Doras of East Godavari, Srikakulam, and Vizianagaram have forgotten their tongue and adopted Telugu. Konda Doras speaks Adivasi, Oriya, and Telugu in Visakhapatnam.

In the hilly and forested East and West Godavari districts of Andhra Pradesh, Konda Reddis live on the banks of the Godavari River on each side. Ninety thousand nine hundred thirty-seven people were living there as of the 2011 Census (Male: 44736, Female:46201). According to the 2011 census, Konda Reddi had a 46.78 per cent overall literacy rate. Telugu is their native language.

The Valmikis are exclusively recognised as Scheduled Tribes in Andhra Pradesh's Agency areas. They can be found in the East Godavari and Visakhapatnam agency areas. They assert that they are offspring of the revered sage Valmiki, who wrote the Ramayana. The 2011 Census indicates that their population is 7 0 5 1 3. (Male: 3 4 0 6 0 , Female: 36453). According to the 2011 census, Valmiki had a 59.86 per cent overall literacy rate.

The Koyas are primarily found in the hilly regions of Andhra Pradesh's West Godavari and East Godavari districts. According to the 2011 Census, 104348 Koya people were living in Andhra Pradesh (Males: 50482, Females: 53866), and the overall literacy rate was 52.94.

Tribal Welfare in Andhra Pradesh:

Through creating policies, programmes, and the proper carrying out of constitutional safeguards, the Tribal Welfare Department is dedicated to the general socio-economic development of scheduled tribes in the State. In Andhra Pradesh, there are 27.39 lakh tribal people, or 5.53 per cent of the State's total population, according to the 2011 census. The scheduled areas cover 14,132.56 sq km, or around 8.82 per cent of the State's total land, and include 5,318 villages spread over the districts of Srikakulam, Visakhapatnam, East Godavari, and West Godavari. The State is home to 34 ST communities. 27.39 lakh out of the tribal population, 10.54 lakh are found in the above five districts.

48.83 per cent of STs are literate (Female 39.40 per cent, Male 58.37 per cent). The government gave the development of tribes significant emphasis. In tribal regions, there is a strong emphasis on the development of social infrastructure, including road connectivity and the provision of potable water.

In order to promote the welfare and development of Scheduled Tribes, the department primarily supports ST children's educational advancement. Gives ST families financial assistance so they can engage in different income-generating activities, builds basic infrastructure to help STs engage in various economic activities, and purchases Minor Forest Produce (MFP) from ST families who depend on the forest so that they can implement a public distribution system in the real world. To formulate and implement TSP/STC, collaborate with the line departments of the State Government, and study, safeguard, maintain, and disseminate information on tribal culture through TCR&TI (TCR & TM).

Need and Significance of the study:

In the context of tribal groups in India, health issues deserve special consideration. According to available data, tribal communities have specific health problems mainly influenced by their environments, harsh terrains, and ecologically distinct niches. Different tribal groups' health, nutrition, and medico-genetic concerns are recognised as unique and appropriate remedies must be identified by creating and developing relevant research projects. In India, primitive tribal people have specific health issues and genetic anomalies such as sickle cell anemia, G-6-PD red cell

enzyme deficiency, and sexually transmitted diseases.' (Commissioner for Scheduled Tribes and Scheduled Castes Report, 1986-87). Their illness is primarily caused by paranoid conditions, ignorance, a lack of personal hygiene, and a lack of health education. Some of the issues raised by the researchers are (a) endemic diseases such as malaria. Tuberculosis, influenza, diarrhoea, high infant mortality and malnutrition, (b) venereal illnesses, induced abortion, fertility, opium addiction, and consuming Dioscera tubers (which may cause sterility because they contain chemicals utilised in the mouth).

Moreover, a scarcity of women, resulting in an imbalanced sex ratio. As a result, there is an urgent need for research on India's many primitive tribal groups, many of which are small in size. The health and nutrition concerns confronting India's enormous tribal population are as varied as the tribal communities, demonstrating tremendous variation in their socioeconomic, sociocultural, and environmental circumstances. Nutritional anemia is a big issue for women in India, especially in rural and tribal communities. This is especially acute for rural and indigenous women, as anemia negatively influences mental and physical health. Anemia impairs fatigue resistance and the capacity to perform under demanding conditions and increases vulnerability to other disorders. Maternal malnutrition is widespread among tribal women, particularly those who have many births within a short period.

The researcher intends to determine women perceptions of health in this study.

OBJECTIVES OF THE STUDY:-

1. To find out the Health awareness of the tribal women with respect to the following variables:

a. Age : 16 Years to 20 Years/ 21 to 25 Years/ 26 to 30 Years
b. Birth order : First/ Middle/ Last

Sample: total sample comprises of 50 tribal women from Vijayanagaram district, Andhra Pradesh.

Method used:

To investigate this issue, a descriptive survey method was used. The survey method was shown to be useful in gathering information regarding women perception towards emotional and reproductive health.

Construction of the tool:

This questionnaire consists of 36 items covered on emotional and reproductive health perception. For measuring the perceptions of women towards emotional and reproductive health. The researcher, selected 4 areas viz., 1) Emotional Symptoms, 2) Depression and Anxiety 3) General Health 4) Physical illness. These four areas divided into eight sub categories. a) Depressed mood, b) Somatic Symptoms, c) Anxiety/fear, d) vasomotor symptoms, e) Sleep Problems, f) Sexual Behavior, g) Menstrual Symptoms, h) Memory and concentration.

It is an instrument designed for self-rating of the women opinion of the degree to which they feel on the perceptions towards emotional and reproductive health. The statements were given in the questionnaire studied by the investigator against the criterion of its applicability on the women perceptions of towards emotional and reproductive health. Further, they were examined in terms of their suitability the questionnaire was given to experts a preliminary survey was conducted for suggestions, the suggestions given by the experts were taken in to consideration and modified the statements as suggested to measure the reliability of the test. The split-half reliability co-efficient for the women towards emotional and reproductive health scales as perceived by women was **0.906**.

Data Analysis:

1. To find out the Health awareness of the tribal women with respect to the following variables:

a. Age : 16 Years to 20 Years/ 21 to 25 Years/ 26 to 30 Years

b. Birth order: First/ Middle/ Last

The following hypotheses have been formulated and they are tested one by one.

1. Age of tribal women makes no significant difference in their health awareness.

Table No. 1 Health Awareness – Age – MEANs - SDs

Age	N	Mean	Std. Deviation
16 to 20 Years	28	114.17	11.04
21 to 25 Years	14	111.92	9.00
26 to 30 Years	8	106.12	15.88
Total	50	112.26	11.53

Interpretation:

The table 1 shows that 16 to 20 years age tribal women got the highest level of health awareness, its mean score is 114.17, 21 to 25 years aged tribal women had the second highest health awareness with mean score of 111.92 and 26 to 30 years aged tribal women obtained the lowest level with mean score of 106.12.

1 Bar diagram Information of Health awareness based on Age

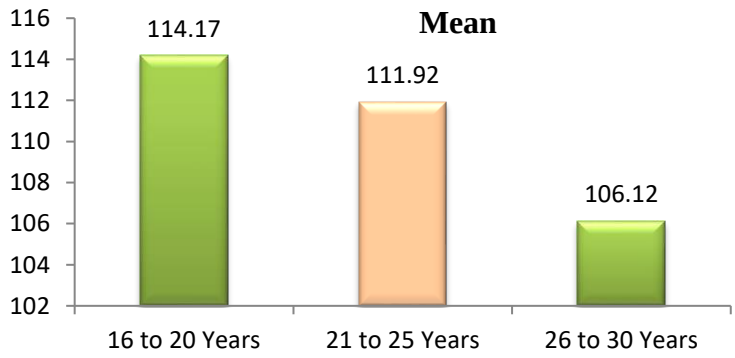

Table No. 2 Health Awareness – Age – ANOVA

	Sum of Squares	df	Mean Square	F
Between Groups	405.709	2	202.855	1.559*
Within Groups	6113.911	47	130.083	
Total	6519.620	49		

*Not significant at 0.05 level

Interpretation:

It is observed from the table 2 that the obtained F-value (1.559) for df = 2 and 47 is less than the table value of 3.01. Therefore, it is not significant at 0.05 level. Hence, the null hypothesis is retained. So it can be said that Age

of tribal women doesn't make a significant difference in their health awareness.

As F-value is not significant at 0.05 level, no further probing of obtaining differences in different age groups is attempted.

2. Birth order of tribal women makes no significant difference in their health awareness.

Table No. 3 Health Awareness – Birth order – MEANs - SDs

Birth Order	N	Mean	Std. Deviation
First	18	108.11	13.30
middle	21	114.57	9.58
Last	11	114.63	10.90
Total	50	112.26	11.53

Interpretation:

The table 3 shows that tribal women has last birth order got the highest level of health awareness, its mean score is 114.63, tribal women has middle birth order had the second highest health awareness with mean score of 114.57 and tribal women had first birth order obtained the lowest level with mean score of 108.11.

2 Bar diagram Information of Health awareness based on Birth order

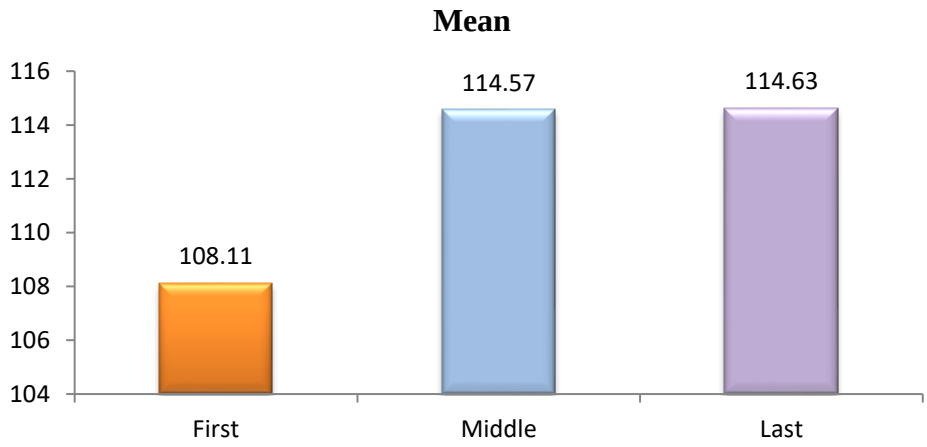

Table No. 4 Health Awareness – Age – ANOVA

	Sum of Squares	df	Mean Square	F
Between Groups	484.154	2	242.077	1.885*
Within Groups	6035.466	47	128.414	
Total	6519.620	49		

*Not significant at 0.05 level

Interpretation:

It is observed from the table 2 that the obtained F-value (1.885) for df = 2 and 47 is less than the table value of 3.01. Therefore, it is not significant at 0.05 level. Hence, the null hypothesis is retained. So it can be said that birth rder of tribal women doesn't make a significant difference in their health awareness.

As F-value is not significant at 0.05 level, no further probing of obtaining differences in different birth order groups is attempted.

Finding:

1. Age of tribal women doesn't make a significant difference in their health awareness.
2. Birth order of tribal women doesn't make a significant difference in their health awareness.

Conclusion:

As a result, research on India's many primitive tribal groups, many of which are small in size, is urgently needed. The health and nutrition issues affecting India's vast tribal population are as diverse as the tribal communities, reflecting a wide range of social, societal, and environmental factors. Nutritional anemia is a significant problem for women in India, particularly in rural and tribal areas. Anaemia significantly impacts mental and physical health, which is more acute for rural and indigenous women. Anemia reduces fatigue resistance and the ability to operate under stressful conditions and increases vulnerability to other illnesses. Maternal malnutrition is common among tribal women, especially those with many births. According to this research work, results are shown. The age of tribal women does not significantly affect their health awareness. The birth order of tribal women does not significantly affect their health awareness.

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