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Self-Reported-Health (SRH) Status of Tribal Female: A Comparative Study in Paschim Medinipur, West Bengal

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Abstract Self-rating of health is among the most frequently measured health observations. Tribes are confined to economic and social backwardness and it is one of the important problems which directly or indirectly related with health. The aim of this study is to compare into two different tribal communities' on the basis of self-rated health (SRH) with respect to differences in age group. Therefore, the authors treat self-rating health status as the primary indicators for measuring of the health status on different age group among tribal adult female of Oraon and Munda community under Midanpore Sadar Block of Paschim Medinipur District, West Bengal. However, Self-rating health status had been evaluated which refers to both a single question such as "in general, would you say about your health is excellent, very good, good, fair, or poor?" Data have been collected by interview technique and observation method with the help of structured questionnaire schedules. The study demonstrate that, on average, the Munda female under study rated healthier status of their health compared to the Oraon female counterparts under area. Moreover, the present study may be raising the issues on tribal health status and concern about health for further anthropological study to the future researches.

Keywords: *tribes, economic and social backwardness, self-rated health, tribal female*

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1. Introduction

Health status refers quality of life and health care that indicates health is closely linked to essentials of living of a human individual. Single item self-assessments of health are the most widely used measures of health status [4]. Self-rated health also called Self-reported health which has been shown to be related to a number of important medical endpoints, such as health risk behaviors, disease states, disability, and mortality [4,6,9]. Self-rated health commonly used outcome measure in social studies, where it has been found to be inversely associated with various aspects of social position, such as level of education, ethnicity and socioeconomic group [1].

Dictionary of Anthropology [2] defines "a tribe as a social group usually with a social area, dialect, cultural homogeneity and unifying social organization. It may include several sub-groups such as Sibs or villages. The tribe ordinarily has a leader and may have a common ancestor, as well as a patron deity. The families or small communities making up the tribe are linked through economic, social, religious, family or blood ties."

According to Majumdar 1961 [8], "A tribes as a collection of families on group of families bearing a common name members of which occupy the same territory, speak the same language and observe certain taboos regarding marriage, profession or occupation and have developed a well assigned system of reciprocity and mutuality of obligation".

India has the second largest concentration of tribal communities in the world next to Africa. According to 2011 census, in India there are 104,281,034 persons of Scheduled Tribes which comprises of 8.6% of total population [12]. Tries described as the poorest among the poor who living in forests and depending on forests for livelihood and therefore, they confined to economic and social backwardness. Tribal female are deprived of equal access to education, health care and others. The main concentration of tribal population is in central India and in north-eastern states. However, in India, tribes are present into all the states and Union Territories except Haryana, Punjab, Delhi, Pondicherry and Chandigarh. The states of Madhya Pradesh, Maharashtra, Gujarat, Rajasthan, Orissa, Bihar, West Bengal and Andhra Pradesh account for around 83% of the total tribal population of India.

Gol 1998, stated that the health status of the tribal population is very poor to poorest especially the primitive

tribes because of their isolation, remoteness and being largely unaffected by the development process going on in the country [11]. On the other hand, the attention on tribal health has not been satisfactory, because of the three reasons such as (i) there was a general belief that living close to nature they enjoyed an environment which is conducive to good health, (ii) the tribals have been regarded as not very amenable to western system of medicine as they still depend very much on supernatural causes and (iii) the difficult terrain where it is difficult to reach health service adequately (Sachchidananda 1994) [10]. L. K. Mahapatra 1994 [7], conducted a study on the Concept of Health among the tribal population Groups of India and its Socio-economic and Socio-cultural Correlates, whereas intellectualizing the term 'health' he mentions two components of tribal health.

However, several theories have been supported to describe Self-rated health (SRH) may reflect symptoms of ill health which not bio-medically measurable [15]. Therefore, SRH simply reflects lifestyle, or psychosocial and socio-demographic conditions known to have adverse effects on health. Therefore, authors of the article treated self-rated health as the indicators of the health status among the female of different age groups into two tribal communities living under Kankabati Gram Panchayat of Medinipur Sadar Block in the district of Paschim Medinipur, West Bengal.

2. Objectives

Following the aforesaid background the main aim of the present study is to measure the prevalence of Self-rated health (SRH) status among the female on different age groups into two tribal communities living under the Kankabati Gram Panchayat of Medinipur Sadar Block in the district of Paschim Medinipur, West Bengal. Additionally aims to find out the frequency of knowledge of Concern about Health.

3. Materials and Method

The present study was conducted among the female of different age groups into two tribal communities belong from the Kankabati Gram Panchayat of Medinipur Sadar Block in the district of Paschim Medinipur, West Bengal. Using the purposive sampling method 180 female (equally distributed into two tribal communities) aged 14 years and above, from two tribal communities named Oraon and Munda were selected.

Data on self-rated health status and knowledge and attributes regarding health concerns was collected through pretested questionnaire. Data on self-rated health and knowledge regarding health concerns status has been evaluated by using some questions and its expected parameter like “How would you rate your general health status”? With reply alternatives: Very good, Quite good, Neither good nor poor, Quite poor, and Poor. And “How do you concern your health”? With reply alternatives: Very poor, Poor, Could not be better, Neither good nor poor, Slightly better, Good and Excellent [13,14].

The analyses had been performed separately for female in different age groups (15–24, 25–59, ≥60 years) $_{A}$ into two tribal communities. Comparisons between the SRH assessments were studied with respect to response distributions, in different age groups with Oraon and Munda community.

Simple bi-variate analysis had been carried out and results shown in percentages for different age group into two different tribal communities. To compared the self-reported-health status of Oraon female with Munda female a disadvantage ratio (DR) $_{B}$ had been computed for key indicators by dividing the indicators of Oraon female to Munda female. Though, DR of more than 1 represents poorer status of one tribal female than other tribal female. Thus, DR of less than 1 represents better or healthier status of one tribal female than other tribal female.

4. Results and Discussion

Table 1. Shows the Distribution of Self-Rated General Health Status:

Age Group	Very Good Health Status		
	Munda (%)	Oraon (%)	DR (%)
15-24	3.33	2.22	1.5
25-59	5.56	3.33	1.67
60 and above	2.22	1.11	2
Total	11.11	6.66	-
Quite Good Health Status			
15-24	5.56	6.67	0.83
25-59	7.78	5.56	1.4
60 and above	3.33	1.11	3
Total	16.67	13.34	-
Neither Good Nor Poor Health Status			
15-24	6.67	7.78	0.86
25-59	14.44	16.67	0.87
60 and above	5.56	3.33	1.67
Total	26.67	27.78	-
Quite Poor Health Status			
15-24	7.78	6.67	1.17
25-59	12.22	13.33	0.92
60 and above	3.33	5.56	0.6
Total	23.33	25.56	-
Poor Health Status			
15-24	7.78	10.00	0.8
25-59	11.11	12.22	0.91
60 and above	3.33	4.44	0.8
Total	22.22	26.66	-

The Table 1 shows the distribution of female study participants of oraon and munda community according to their Self rated health status. On the basis of total population higher percentage of Munda (26.67) and oraon (27.78) individuals rated their health as neither good nor poor health status, in which maximum percentage of peoples belong to the age group 25-59 (14.44 among munda, 16.67 among oraon) separately. And high prevalence of rating of self-health as quite poor health status (23.33 among munda 25.56 among oraon) is found among the both community respectively. Good percentages (22.22 among munda and 26.66 among oraon) of study participants are belong to the category of poor health status. And the DR of the study population represent that

munda females are live with better health status conditions than oraon females individuals respectively.

Table 2. Shows the Distribution of Concern about Knowledge of Health:

Age Group	Very poor knowledge about Health Concern		
	Munda (%)	Oraon (%)	DR (%)
15-24	6.67	7.78	0.86
25-59	10.00	12.22	0.82
60 and above	3.33	4.44	0.75
Total	20	24.44	-
Poor Knowledge about Health Concern			
15-24	4.44	7.78	0.57
25-59	7.78	11.11	0.7
60 and above	2.22	3.33	0.67
Total	14.44	22.22	-
Could not be better about Health Concern			
15-24	5.56	6.67	0.84
25-59	10.00	12.22	0.82
60 and above	3.33	2.22	1.5
Total	18.89	21.11	-
Neither good nor poor knowledge about Health Concern			
15-24	7.78	5.56	1.4
25-59	8.89	7.78	1.6
60 and above	3.33	1.11	3
Total	20	14.45	-
Slightly have better knowledge about Health Concern			
15-24	10.00	6.67	1.5
25-59	12.22	8.89	1.4
60 and above	4.44	2.22	2
Total	26.66	17.78	-

Table 2 shows the distribution of female study participants of oraon and munda community according to their health concern on the basis of knowledge about their health. Higher percentage of study participants of munda community (26.66%) slightly has better knowledge but among oraon community maximum percentage (24.44%) has very poor knowledge about their health. DR of the community indicate that oraon have very poorer knowledge about health than munda. This table shows discrimination of percentage of various categories among the both community. Lower percentages of munda participants (14.44%) belong to the category of poor knowledge where lower percentages of Oraon participants (14.45%) belong to the category of neither good nor poor knowledge. DR shows that prevalence of knowledge going higher towards poor knowledge among Oraon than Munda. However, the question health concern has seven different categories but the study population not very much concern on their health. Thus, the last two categories such as good and excellent is completely absent due to unavoidable of data into aforesaid categories.

5. Conclusion

In brief, findings of the present study suggest that there are maximum people rated their health as neither good not poor in which oraon are belongs comparatively frequent than munda. Additionally the present study also revealed that both the tribal community are belongs to the poor health conditions according to their self-rating of health. And the study also concluded that people of oraon community are less concern about health related knowledge than munda so from the study it can demonstrate that munda female are healthier than oraon female.

Moreover, the remarkable evident is that among the two tribal communities have no respondents who had the good concern about his or her as similarly in the category of excellent. Therefore, the study required to more study for overcome the health concern issues on tribal community.

Note:

A In Age Distribution age division basis on years, the category of the age group to follow the "POPULATION BY MAJOR AGE GROUP AND PERCENTAGE DISTRIBUTION BY AGE GROUP FOR THE WORLD" page - 37 Source: World Population Prospects: the 2004 Revision, Datasets in Excel and PDF Formats, Extended Dataset, United Nations, 2005.

B Disadvantageous Ratio or Difference Ratio (DR) calculated followed on the studied of Disadvantageous situation of tribal women and children of Orissa, India: a special reference to their health and nutritional status by Sutapa Agrawal, Centre for Control of Chronic Conditions.

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