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HEALTH CARE OF TRIBAL WOMEN A STUDY IN PRAKASAM DISTRICT OF ANDHRA PRADESH

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The majority of tribal populations are still dependent on their traditional medicinal plants and treatments through village priests/traditional practitioner. The distance to Health Centres is much longer and hence tribals have to travel a long distance to avail the medical facilities. The most serious problem is their lack of faith in the present medical treatment system. They still believe in getting treatment by traditional healers and local illiterate priest of their village. Majority of them still believe that the illness is caused by evil spirits. In this part, the available and utilization of the health care facilities in the nearby PHC's and district hospitals.

Method and material:

In Prakasam district there are 56 mandals in which only 4 mandals were occupied by the tribal population. The tribal population spread over in 52 habitations of 2362 families are living in these habitations with a total of population 8582 as per the 2011 census. Among those four mandals such as Dornala, Peddaravedu, Pullelacheruv and Yerrakonda Palem are the major concentration of tribal population. Thus, from all the four mandals, two mandals i.e. Dornal and Pullela Cheru has been chosen for the study. About 5 villages from each mandal are selected. From all the two mandals 10 tribal population villages are finalised. For the selection of sample out of 605 households in the ten villages, 300 household (49.58 percent) respondents covering the geographical area of tribal women household are selected from 10 villages by using systematic random sample method. The survey was conducted alternatively selected randomly every 2rd household in the sample villages. The data were collected in 10 tribal villages. In a total of 300 households were covered for the present study.

Objectives of the study

1. To analyse the perceptions and knowledge of the health care facilities in the study area.
2. To assess the socio-economic and psychological factors influencing health of the tribal women.
3. To ascertain the various health problems faced by the tribal women.

Hypotheses

1. Ho: There is no statistically significant difference on level of satisfaction with medical treatment by their place of residence.
2. Ho: There is no statistically significant difference on level of satisfaction on health programmes by their age.
3. Ho: There is no statistically significant difference on health facilities by their place of residence
4. Ho: There is no statistically significant difference on government services by their place of residence

Major Findings of the Study

Table-1: Health Sources of Information Vs. Age

Age	What is health sources of information			Total
	Health worker	Anganwadi teacher	TV	
< - 25	1	8	1	10
	.3%	2.7%	.3%	3.3%
26 - 35	23	40	7	70
	7.7%	13.3%	2.3%	23.3%
36 - 45	29	82	9	120
	9.7%	27.3%	3.0%	40.0%
46 - 55	10	44	6	60
	3.3%	14.7%	2.0%	20.0%
56 - >	7	30	3	40
	2.3%	10.0%	1.0%	13.3%
Total	70	204	26	300
	23.3%	68.0%	8.7%	100.0%

$\chi^2=7.750$, $df= 8$, $P <0.458$, Not Significant at 0.05 level

Health sources of information are one of the parameter to protect and take precautions for early detection of diseases. The table depicts that 23.3 per cent source of information is health worker, majority 68.0 per cent source of information is anganwadi teacher, 8.7 per cent are television.

In age the group of below 25 years of age, 0.3 per cent source of information is health worker, 2.7 per cent source of information is anganwadi teacher, 0.3 per cent are television.

In age the group of 26-35 years of age, 7.7 per cent source of information is health worker, 13.3 per cent source of information is anganwadi teacher, 2.3 per cent are television.

In age the group of 36-45 years of age, 9.7 per cent source of information is health worker, 27.3 per cent source of information is anganwadi teacher, 3.0 per cent are television.

In age the group of 46-55 years of age, 3.3 per cent source of information is health worker, 14.7 per cent source of information is anganwadi teacher, 2.0 per cent are television.

The study shows the results of the Chi-square test that there is no significant difference between age and Health Sources of Information ($P= 0.458$) at 0.01 levels. The results show that there is no statistically significant difference in Health Sources of Information by age wise categories.

Table-2: Particulars of times of conceived Vs. Age

Age	How many times conceived				Total
	1st Time	2nd Time	3rd Time	4th Time	
< - 25	0	10	0	0	10
	.0%	3.3%	.0%	.0%	3.3%
26 - 35	18	42	8	2	70
	6.0%	14.0%	2.7%	.7%	23.3%
36 - 45	41	57	17	5	120
	13.7%	19.0%	5.7%	1.7%	40.0%
46 - 55	26	24	8	2	60
	8.7%	8.0%	2.7%	.7%	20.0%
56 - >	28	1	5	6	40
	9.3%	.3%	1.7%	2.0%	13.3%
Total	113	134	38	15	300
	37.7%	44.7%	12.7%	5.0%	100.0%

$\chi^2=56.625$, $df= 12$, $P <0.000$, **Significant at 0.05 level**

The table 2 describe that how many times conceived of the respondents among 300 tribals women, 113 respondents constitute 37.7 per cent were conceived for the 1st time, 134 respondents (44.7 per cent) were conceived for the 2nd time, 38 respondents (12.7 per cent) were conceived for the 3rd time, 15 respondents (5.0 per cent) were conceived for 4th time.

In the category of below 25 years of age, 10 respondents (3.3 per cent) were conceived for the 2nd time.

In the category of 26 - 35 years of age, 18 respondents constitute 6.0 per cent were conceived for the 1st time, 42 respondents (14.0 per cent) were conceived for the 2nd time, 8 respondents (2.7 per cent) were conceived for the 3rd time, 2 respondents (0.7 per cent) were conceived for 4th time.

In the category of 36 - 45 years of age, 41 respondents constitute 13.7 per cent were conceived for the 1st time, 57 respondents (19.0 per cent) were conceived for the 2nd time, 17 respondents (5.7 per cent) were conceived for the 3rd time, 5 respondents (1.7 per cent) were conceived for 4th time.

In the category of 46 - 55 years of age, 26 respondents constitute 8.7 per cent were conceived for the 1st time, 24 respondents (8.0 per cent) were conceived for the 2nd time, 8 respondents (2.7 per cent) were conceived for the 3rd time, 2 respondents (0.7 per cent) were conceived for 4th time.

In the category of 56 and above years of age, 28 respondents constitute 9.3 per cent were conceived for the 1st time, 1 respondents (0.3 per cent) were conceived for the 2nd time, 5 respondents (1.7 per cent) were conceived for the 3rd time, 6 respondents (2.0 per cent) were conceived for 4th time.

The study shows the results of the Chi-square test that there is significant difference between age and times of conceived ($P= 0.000$) at 0.01 levels. The results show that there is statistically significant difference in times of conceived among age wise categories.

Table-3: Intake of Nutritive Food during Pregnancy Vs. Religion

Religion	Are you taken nutritive diet during pregnancy		Total
	Yes	No	
Hindu	48	197	245
	16.0%	65.7%	81.7%
Christian	8	47	55
	2.7%	15.7%	18.3%
Total	56	244	300
	18.7%	81.3%	100.0%

$\chi^2=0.753$, $df= 1$, $P <0.254$, **Not Significant at 0.05 level**

The table 3 depicts that respondents has taken nutritive diet during pregnancy. Among 300 tribal women, 56 constitute (18.7 per cent) taken nutritive diet during pregnancy, 244 constitute(81.3 per cent) not taken nutritive diet during pregnancy.

In Hindu respondents 48 constitute (16.0 per cent) taken nutritive diet during pregnancy, 197 constitute (65.7 per cent) not taken nutritive diet during pregnancy.

In Christian respondents 8 constitute (2.7 per cent) taken nutritive diet during pregnancy 47 constitute (15.7 per cent) not taken nutritive diet during pregnancy.

The study shows the results of the Chi-square test that there is no significant difference between religion and Intake of Nutritive Food during Pregnancy (P= 0.254) at 0.01 levels. The results show that there is no statistically significant difference in Intake of Nutritive Food during Pregnancy by religion wise categories among women.

Table-4: Health Check up during Pregnancy Vs. Caste

Caste	Did get health check up during pregnancy		Total
	Yes	No	
Chenchu	45	68	113
	15.0%	22.7%	37.7%
Yanadi	48	55	103
	16.0%	18.3%	34.3%
Sugali	22	45	67
	7.3%	15.0%	22.3%
Yerukala	10	7	17
	3.3%	2.3%	5.7%
Total	125	175	300
	41.7%	58.3%	100.0%

$\chi^2=5.399$, df= 3, P <0.145, Not Significant at 0.05 level

The table 4 depicts that respondents get health check up during pregnancy, among 300 tribal women, 125 constitute 41.7 per cent get health check up during pregnancy and 175 constitute 58.3 per cent didn't get health check up during pregnancy.

In chenchu caste category, 45 respondents (15.0 per cent) get health checkup during pregnancy, 68 constitute 22.7 per cent didn't get health check up during pregnancy.

In yanadi caste category 48 respondents constitute 16.0 per cent get health check up during pregnancy, 55 constitute 18.3 per cent didn't get health check up during pregnancy.

In sugali caste category 22 respondents constitute 7.3 per cent get health check up during pregnancy, 45 constitute 15 per cent didn't get health check up during pregnancy.

In Yerukala caste category 10 respondents constitute 3.3per cent get health check up during pregnancy, 7constitute 2.3 per cent didn't get health check up during pregnancy.

The study shows the results of the Chi-square test that there is no significant difference between caste and Health Check up during Pregnancy (P= 0.145) at 0.01 levels. The results show that there is no statistically significant difference in Health Check up during Pregnancy among women in caste wise categories.

Table-5: Particulars of Place of Deliveries Vs. Marital Status

Marital Status	Place of Delivery				Total
	Govt. Hospital	Private Hospital	Home	Not applicable	
Married	108	50	83	0	241
	36.0%	16.7%	27.7%	.0%	80.3%
Unmarried	0	0	0	9	9
	.0%	.0%	.0%	3.0%	3.0%
Widow	27	4	6	0	37
	9.0%	1.3%	2.0%	.0%	12.3%
Divorced	5	3	5	0	13
	1.7%	1.0%	1.7%	.0%	4.3%
Total	140	57	94	9	300
	46.7%	19.0%	31.3%	3.0%	100.0%

$\chi^2=31.100$, $df= 9$, $P <0.000$, **Significant at 0.05 level**

The tribal women the majority reluctant to go hospitals for even deliveries also takes place at their homes. This is due illiteracy and ignorance. The table divulges among 300 women, 140 respondents (46.7 per cent) are placed delivery at government hospitals followed by 57 respondents (19.0 per cent) deliveries at private hospital and 94 respondents (31.3 per cent) deliveries are at home.

In married category, 108 respondents (36.0 per cent) are placed delivery at government hospitals followed by 50 respondents (16.7 per cent) deliveries at private hospital and 83 respondents (27.7 per cent) deliveries are at home.

In widow category, 27 respondents (9.0 per cent) are placed delivery at government hospitals followed by 4 respondents (1.3 per cent) deliveries at private hospital and 6 respondents (2.0 per cent) deliveries are at home.

In divorced category, 5 respondents (1.7 per cent) are placed delivery at government hospitals followed by 3 respondents (1.0 per cent) deliveries at private hospital and 5 respondents (1.7 per cent) deliveries are at home.

The study shows the results of the Chi-square test that there is significant difference between marital status and Particulars of Place of Deliveries ($P= 0.000$) at 0.01 levels. The results show that there is statistically significant difference in Particulars of Place of Deliveries among women by marital status.

Table-6: Morbidity during Child Birth Vs. Place of Residence

Place of Residence	Is there any morbidity during child birth			Total
	Yes	No	Unknow n	
Dornala	8	103	39	150
	2.7%	34.3%	13.0%	50.0%
PullelaCheruvu	8	105	37	150
	2.7%	35.0%	12.3%	50.0%
Total	16	208	76	300
	5.3%	69.3%	25.3%	100.0%

$\chi^2=0.72$, $df= 2$, $P <0.965$, **Not Significant at 0.05 level**

The major causes of neonatal morbidity (prematurity and birth defects) generally occur in pregnancies free of antecedent complications. Among 300 respondents, 5.3 per cent are only morbidity during the child birth and 69.3 per cent are not happened anything. About 25.3 per cent of the respondents are unknown the morbidity.

In dornala mandal 2.7 per cent are only morbidity during the child birth and 34.3 per cent are not happened anything. About 13.0 per cent of the respondents are unknown the morbidity.

In Pullela Cheruvu mandal 2.7 per cent are only morbidity during the child birth and 35.0 per cent are not happened anything. About 12.3 per cent of the respondents are unknown the morbidity.

The study shows the results of the Chi-square test that there is no significant difference between place of residence and Morbidity during Child Birth ($P= 0.965$) at 0.01 levels. The results show that there is no statistically significant difference in Morbidity during Child Birth of women.

Table-7: Maternal Mortality in the Family Vs. Religion

Religion	Is there any maternal mortality in your family			Total
	Yes	No	Unknow n	
Hindu	14	175	56	245
	4.7%	58.3%	18.7%	81.7%
Christian	1	37	17	55
	.3%	12.3%	5.7%	18.3%
Total	15	212	73	300
	5.0%	70.7%	24.3%	100.0%

$\chi^2=2.670$, $df= 2$, $P <0.263$, Not Significant at 0.05 level

The major causes for maternal mortality are severe bleeding, infections, high blood pressure and sometimes leads to death. In the study area only some rare cases was happened. The table presents the maternal mortality in their family. Among 300 respondents, very negligible 5.0 per cent are effected to maternal mortality and the large majority 70.7 per cent not happened anything. About 24.3 per cent are unknown anything.

In Hindu religion, 4.7 per cent are effected to maternal mortality and the majority 58.3 per cent not happened anything. About 18.7 per cent are unknown anything.

In Christian religion, 0.3 per cent are effected to maternal mortality and the majority 12.3 per cent not happened anything. About 5.7 per cent are unknown anything.

The study shows the results of the Chi-square test that there is no significant difference between religion and Maternal Mortality in the Family ($P= 0.263$) at 0.01 levels. The results show that there is no statistically significant difference in Maternal Mortality in the Family among women.

Table-8: Morbidity of Children Vs. Religion

Religion	Is there any morbidity of your children			Total
	Yes	No	Unknow n	
Hindu	9	182	54	245
	3.0%	60.7%	18.0%	81.7%
Christian	3	35	17	55
	1.0%	11.7%	5.7%	18.3%
Total	12	217	71	300
	4.0%	72.3%	23.7%	100.0%

$\chi^2=2.553$, $df= 2$, $P <0.279$, Not Significant at 0.05 level

It refers to the state of illness in a child, which may be due to lack or poor pre/postnatal care, a congenital condition. In tribal area, it is more widespread due to lack medical facilities if there is any problem they approach the traditional healers. The table depicted that 4.0 per cent of their children fell under the morbidity, 72.3 per cent of their children are not fell any morbidity and 23.7 per cent are unknown of the morbidity.

In Hindu religion, 3.0 per cent of their children fell under the morbidity, 60.7 per cent of their children are not fell any morbidity and 18.0 per cent are unknown of the morbidity.

In Christian religion, 1.0 per cent of their children fell under the morbidity, 11.7 per cent of their children are not fell any morbidity and 5.7 per cent are unknown of the morbidity.

The study shows the results of the Chi-square test that there is no significant difference between religion and Morbidity of Children ($P=0.279$) at 0.01 levels. The results show that there is no statistically significant difference in Morbidity of Children among women.

Table-9: Anemic of the Respondents Vs. Caste

Caste	Are you anaemic		Total
	Yes	No	
Chenchu	27	86	113
	9.0%	28.7%	37.7%
Yanadi	39	64	103
	13.0%	21.3%	34.3%
Sugali	20	47	67
	6.7%	15.7%	22.3%
Yerukala	3	14	17
	1.0%	4.7%	5.7%
Total	89	211	300
	29.7%	70.3%	100.0%

$\chi^2=6.300$, $df=3$, $P<0.098$, Not Significant at 0.05 level

In the tribal area women are more vulnerable and they unable to take nutritious food due to poverty, rearing of children, poor intake of food etc. All these factors are contributing to malnutrition of the tribal women. The table shows that 29.7 per cent of the women are anemic and majority 70.3 per cent are not anemic.

In Chenchu caste category, 9.0 per cent of the women are anemic and 28.7 per cent are not anemic.

In Yanadi caste category, 13.0 per cent of the women are anemic and 21.3 per cent are not anemic.

In Sugali caste category, 6.7 per cent of the women are anemic and 15.7 per cent are not anemic.

In Yerukala caste category, 1.0 per cent of the women are anemic and 4.7 per cent are not anemic.

The study shows the results of the Chi-square test that there is no significant difference between caste and Morbidity of Children ($P=0.098$) at 0.01 levels. The results show that there is no statistically significant difference in Morbidity of Children among women.

Table-10: Reasons for Malnutrition

Sl. No	Reasons	Yes	No	Total N=300
1	Poor intake	18.7	81.3	100.0
2	Menstruation	20.7	79.3	100.0
3	Poverty	70.0	30.0	100.0
4	Lack of nutrition education	75.7	24.3	100.0
An overall total percentage		46.3	53.7	100.0

The table 10 reveals that nature of malnutrition in the tribal area among tribal women is prevalent due to various reasons. Among the respondents the table shows that 18.7 per cent of respondents said that due to poor intake, 20.7 per cent are due to menstruation, 70.0 per cent are due to poverty and 75.7 per cent are due to lack of nutrition. An average total percentage about 46.3 per cent of the respondents revealed that there is poverty, poor intake and lack of nutrition food etc. and 53.7 per cent said that there is no malnutrition.

Table-11: Vaccination to the Children

Sl. No	Vaccine	Yes	No	Total N=300
1	D.P.T	70.7	29.3	100.0
2	B.C.G	85.3	14.7	100.0
3	Measles	81.7	18.3	100.0
4	Polio	91.0	9.0	100.0
An overall total percentage		82.2	17.8	100.0

The above table 11 shows that mostly 70.7 per cent of the tribal women said that their children have taken vaccination for Diphtheria Pertussis Tetanus (DPT), 85.3 per cent tribal women of the children's got Bacille Calmette Guerin (BCG) vaccination, 81.7 per cent got Measles vaccination, 291.0 per cent of the tribal women said that their children have taken vaccination for Polio done by the health workers.

An overall total percentage that 82.2 per cent of the respondents revealed that their children had vaccination and only 17.8 per cent of the respondents revealed that their children had no vaccination. It is good tendency that the tribal households getting vaccination against the killer diseases.

Table-12: Adoption of Family Planning Contraceptives

Sl. No	FP Device	Yes	No	Total N=300
1	Tubectomy	22.7	77.3	100.0
2	Vasectomy	22.3	77.7	100.0
3	Loop/Cop -T	5.7	94.3	100.0
4	Oral pills	10.7	89.3	100.0
An overall total percentage		15.3	84.7	100.0

The family planning methods are adopted for spacing the children as well as control the births. The table divulges that Adoption of Family Planning Contraceptives for spacing children and control of births. Tubectomy is a major surgical procedure in which the fallopian tubes are cut open and clipped or tied up to block the passage of the egg into the uterus. About 22.7 per cent of the respondents are adopted this method. Vasectomy for men, Vasectomy is a form of male birth control that cuts the supply of sperm to semen. It is also birth control method. The majority 66.7 per cent of their husbands are gone through this small operation, Loop/Cop -T can be useful for temporary method of birth control and it is meant for women. It is about 5.7 per cent only gets and used this method and 10.7 per cent are used oral pills.

An overall the majority 84.7 per cent of respondents are undergone the family planning methods. It is learning that the change has been adopted in the terms of utilization of medical facilities.

Table-13: Frequency of Visit the Medical Clinics Vs. Place of Residence

Place of Residence	How often do you visit the medical clinics				Total
	Regularly	Periodically	Occasionally	Rarely	
Dornala	35	17	31	67	150
	11.7%	5.7%	10.3%	22.3%	50.0%
Pullela Cheruvu	34	18	32	66	150
	11.3%	6.0%	10.7%	22.0%	50.0%
Total	69	35	63	133	300
	23.0%	11.7%	21.0%	44.3%	100.0%

$\chi^2=0.066$, $df= 3$, $P <0.996$, **Not Significant at 0.05 level**

The table 13 displays that frequency of visit the medical clinic by respondents. Among 300 respondents, 23.0 per cent are visits the clinics regularly, 11.7 per cent are visits periodically, 21.0 per cent visits occasionally and 44.3 per cent are visits rarely.

In Dornala mandal, 11.7 per cent are visits the clinics regularly, 5.7 per cent are visits periodically, 10.3 per cent visits occasionally and 22.3 per cent are visits rarely.

In Pullela Cheruvu mandal, 11.3 per cent are visits the clinics regularly, 6.0 per cent are visits periodically, 10.7 per cent visits occasionally and 22.0 per cent are visits rarely. Therefore, the half of the respondents visits the medical clinics and taking treatment.

The study shows the results of the Chi-square test that there is no significant difference between place of residence and Frequency of Visit the Medical Clinics ($P= 0.996$) at 0.01 levels. The results show that there is no statistically significant difference in Frequency of Visit the Medical Clinics.

Table-14: Level of Satisfaction with the Medical Treatment Vs. Place of Residence

Ho: There is no statistically significant difference on level of satisfaction with medical treatment by their place of residence.

Place of Residence	Are you satisfied with the medical treatment		Total
	Yes	No	
Dornala	83	67	150
	27.7%	22.3%	50.0%
Pullela Cheruvu	79	71	150
	26.3%	23.7%	50.0%
Total	162	138	300
	54.0%	46.0%	100.0%

$\chi^2=0.215$, $df= 1$, $P < 0.364$, Not Significant at 0.05 level

The level of satisfaction of the respondents when taking medical treatment in government hospitals. The table shows that 54.0 per cent of the respondents are satisfied with taking medical treatment in government hospitals. Whereas, 46.0 per cent are not satisfied with taking medical treatment.

In Dornala mandal 27.7 per cent of the respondents are satisfied with taking medical treatment in government hospitals. Whereas, 22.3 per cent are not satisfied with taking medical treatment.

In Pullela Cheru mandal 26.3 per cent of the respondents are satisfied with taking medical treatment in government hospitals. Whereas, 23.7 per cent are not satisfied with taking medical treatment.

The study shows the results of the Chi-square test that there is no significant difference between place of residence and Level of Satisfaction with the Medical Treatment ($P= 0.364$) at 0.01 levels. The results show that there is no statistically significant difference in Level of Satisfaction with the Medical Treatment among tribal women by area wise.

Hence, the null hypothesis has been accepted and the research hypothesis has been rejected.

Table-15: Most Preferred Treatment of Disease in the Family Vs. Age

Age	Which is the most preferred treatment of disease in the family				Total
	Self treatment	Herbal & Ayurvedic	PHC & CHC	Private hospital	
< - 25	1	5	4	0	10
	.3%	1.7%	1.3%	.0%	3.3%
26 - 35	3	32	31	4	70
	1.0%	10.7%	10.3%	1.3%	23.3%
36 - 45	11	50	53	6	120
	3.7%	16.7%	17.7%	2.0%	40.0%
46 - 55	1	26	29	4	60
	.3%	8.7%	9.7%	1.3%	20.0%
56 - >	2	21	16	1	40
	.7%	7.0%	5.3%	.3%	13.3%
Total	18	134	133	15	300
	6.0%	44.7%	44.3%	5.0%	100.0%

$\chi^2=7.289$, $df= 12$, $P < 0.838$, Not Significant at 0.05 level

Tribal's are reside in remote locations and there is no proper transport facilities due to that they preferred village traditional practitioner. The table portrays that 44.7 per cent of the respondents are approached the traditional practitioners in the village, 44.3 per cent are approached the government doctors in PHC/CHCs followed by 6.0 per cent are self treated and 5.0 per cent are approached the private doctors.

In below 25 years of age group 1.7 per cent of the respondents are approached the traditional practitioners in the village, 1.3 per cent are approached the government doctors in PHC/CHCs.

In 26-35 years of age group 10.7 per cent of the respondents are approached the traditional practitioners in the village, 10.3 per cent are approached the government doctors in PHC/CHCs.

In 36 – 45 years of age group 16.7 per cent of the respondents are approached the traditional practitioners in the village, 17.7 per cent are approached the government doctors in PHC/CHCs.

In 46 – 55 years of age group 8.7 per cent of the respondents are approached the traditional practitioners in the village, 9.7 per cent are approached the government doctors in PHC/CHCs.

The study shows the results of the Chi-square test that there is no significant difference between age and Most Preferred Treatment of Disease in the Family ($P= 0.838$) at 0.01 levels. The results show that there is no statistically significant difference in Most Preferred Treatment of Disease in the Family among women by age wise categories.

Table-16: Implementation of the Health Care Programmes

Sl. No	Programme	Yes	No	Total N=300
1	Cash Assistance for Institution Delivery	63.3	36.7	100.0
2	Free medicines	66.7	33.3	100.0
3	Free diagnostics	93.3	6.7	100.0
4	Free diet during a stay in the health institutions	76.7	23.3	100.0
5	Free provision of blood	10.0	90.0	100.0
6	Free medical camps	31.7	68.3	100.0
An overall total percentage		56.9	43.1	100.0

Health provisions in the primary health centre/district hospital to be implemented for patients admitted in the hospitals. The table 5.44 depicted that cash assistance for institution delivery 63.3 per cent of the respondent families' benefitted and 36.7 per cent of the families not benefitted any such kind of programme. The ANM's motivates the pregnant women for safe delivery at government hospital so that tribal women also moves towards government hospital for safe delivery.

As regards to free medicines that 66.7 per cent are received from government hospitals whereas 33.3 per cent of the tribal families not received any free medicines.

Free diagnostics facilities, about 93.3 per cent of the respondent's families gets free diagnostics facilities and 6.7 per cent of the respondent families not gets any free diagnostics facilities.

Free diet during a stay in the health institutions, 76.7 per cent only gets free diet during the stay in the hospital and 23.3 per cent of the respondent families are not gets free diet supply programme.

Free provision of blood that 10.0 per cent of the respondents families receive the programme and large majority (90.0 per cent) are not received the free blood provision.

It is very clear that the government doctors who appointed in the PHC's should conduct health camps fortnightly in the major villages. The table revealed that 31.7 per cent of the respondents family are benefitted from health camps and remaining 68.3 per cent are not benefitted any health camp.

An average total percentage about 56.9 per cent of the respondents revealed that implementation of health care programmes are benefitted by respondents and 43.1 per cent said that there is no benefit of the programmes.

Table-17: Level of Satisfaction on Health Programmes Vs. Age

Ho: There is no statistically significant difference on level of satisfaction on health programmes by their age.

Correlations							
Health Programme		Maternal Health services	Child health services	ICDS Nutrition Programme	Family planning services	AIDS/RTI/STI services	Age
Maternal Health services	Pearson Correlation	1	.150**	.194**	.082	.147*	.261**
	Sig. (2-tailed)		.009	.001	.158	.011	.000
	N	300	300	300	300	300	300
Child health services	Pearson Correlation	.150**	1	.222**	.068	.228**	-.048
	Sig. (2-tailed)	.009		.000	.238	.000	.403
	N	300	300	300	300	300	300
ICDS Nutrition Programme	Pearson Correlation	.194**	.222**	1	.197**	.716**	.145*
	Sig. (2-tailed)	.001	.000		.001	.000	.012
	N	300	300	300	300	300	300
Family planning services	Pearson Correlation	.082	.068	.197**	1	.253**	.160**
	Sig. (2-tailed)	.158	.238	.001		.000	.005
	N	300	300	300	300	300	300
AIDS/RTI/STI services	Pearson Correlation	.147*	.228**	.716**	.253**	1	.176**
	Sig. (2-tailed)	.011	.000	.000	.000		.002
	N	300	300	300	300	300	300
**. Correlation is significant at the 0.01 level (2-tailed).							
*. Correlation is significant at the 0.05 level (2-tailed).							

The table 17 displays that correlation between levels of satisfaction on health programmes implemented by government by their age.

As regards to Maternal Health services the correlation r value is 0.261 and P value is 0.000 at 0.01 level. Thus, there is very high positive correlation and level of satisfaction is very high by age wise categories among the respondents on maternal health services. Hence, the null hypothesis has been rejected and the research hypothesis has been accepted.

The Child health services the correlation r value is -0.048 and P value is 0.403 at 0.01 level. Thus, there is no correlation and level of satisfaction is no difference by age wise categories among the respondents on child health services. Hence, the null hypothesis has been accepted and the research hypothesis has been rejected.

The ICDS Nutrition Programme the correlation r value is 0.145 and P value is 0.012 at 0.05 level. Thus, there is moderate positive correlation and level of satisfaction is moderate by age wise categories among the respondents on ICDS Nutrition Programme. Hence, the null hypothesis has been rejected and the research hypothesis has been accepted.

Family planning services the correlation r value is 0.160 and P value is 0.005 at 0.01 level. Thus, there is high positive correlation and level of satisfaction is high by age wise categories among the respondents on Family planning services. Hence, the null hypothesis has been rejected and the research hypothesis has been accepted.

AIDS/RTI/STI services the correlation r value is 0.176 and P value is 0.002 at 0.01 level. Thus, there is high positive correlation and level of satisfaction is high by age wise categories among the respondents on AIDS/RTI/STI services. Hence, the null hypothesis has been rejected and the research hypothesis has been accepted.

Table-18: Health Staff Visiting of the Village

Sl. No	Statement	Yes	No	Total N=300
1	ASHA worker	64.0	36.0	100.0
2	Male Health worker	32.3	67.7	100.0
3	ANM	79.0	21.0	100.0
4	Doctor	12.7	87.3	100.0
5	104 Health care unit	29.0	71.0	100.0
An overall total percentage		43.4	56.6	100.0

Health personnel available in the village to organise health education programmes, health check up and immunisation programmes. As regards to ASHA workers, 64.0 per cent of the respondents said that they are available in the village and 36.0 per cent said that there is no ASHA worker in the village.

Male health worker also available in the villages to serve the people in regards to health problems. About 32.3 per cent of the respondents said that male health assistant is available in the village and 67.7 per cent male health assistants are not available in the village.

ANM (Auxiliary Midwives Nurse) also deputed in the under health care programme. Whereas, 79.0 per cent of the respondents said that ANM are visited in the village frequently and 21.0 per cent did not visit any ANM in the village.

About 12.7 per cent of the respondents said that doctors are conducted health check up camps monthly once in the village and 87.3 per cent of the respondents said that there is no health check up camps.

As regards to 104 health care mobile van, 29.0 per cent of the respondents said that 104 mobile vehicle is coming to their villages and 71.0 per cent said that 104 mobile vehicle is not coming to their villages.

An average the total percentage about 43.4 per cent of respondents revealed that health staff available in the villages and 56.6 per cent was not available in the village.

Table-19: Perceptions of Respondents towards Health Facilities Vs. Place of Residence**Ho: There is no statistically significant difference on health facilities by their place of residence**

Correlations			
		Your overall opinion regarding Health Facilities in your area	Place
Your overall opinion regarding Health Facilities in your area	Pearson Correlation	1	.197**
	Sig. (2-tailed)		.001
	N	300	300
Place	Pearson Correlation	.197**	1
	Sig. (2-tailed)	.001	
	N	300	300

** . Correlation is significant at the 0.01 level (2-tailed).

Figure –1: Scatter plot graph correlation between Perception of health facilities by their Place of Residence



The correlation table and scatter graph shows that r value 0.197 and p value 0.001 which is overall opinion regarding Health Facilities existing in two mandals are different. The relationship among two mandals is high level of positive correlation increasing and dependent on each other at 0.01 level. Hence, the null hypothesis has been rejected and the research hypothesis has been accepted.

Table-20: Perception of Respondents towards Government Services Vs. Place of Residence

Ho: There is no statistically significant difference on government services by their place of residence

Correlations			
		Your overall opinion regarding Government Services in your area	Place
Your overall opinion regarding Government Services in your area	Pearson Correlation	1	.205**
	Sig. (2-tailed)		.000
	N	300	300
Place	Pearson Correlation	.205**	1
	Sig. (2-tailed)	.000	
	N	300	300
**. Correlation is significant at the 0.01 level (2-tailed).			

Figure –2: Scatter plot graph correlation between Perception of Government services by their Place of Residence



The correlation table and scatter graph shows that r value 0.205 and p value 0.000 which is overall opinion regarding Government services existing in two mandals are different. The relationship among two mandals is high of positive correlation increasing and dependent on each other at 0.01 level. Hence, the null hypothesis has been rejected and the research hypothesis has been accepted.

Conclusion

It is discusses the health care related activities and the determining factors. It reveals that hospital facilities, marriage age and nature of delivery have a greater influence on the health care of the tribals. The major reasons for low utilization of modern medicine were the distant location of health care facilities, rough and hilly difficult terrain, poor economic condition, character and illiteracy, non-availability of medicines even from the health care institution etc., besides inflicting loss in terms of valuable working time for the activities related to livelihood. Provided the appropriate medicine supplies, management and information about health, these are some of the needs that call for immediate attention in the tribal areas to improve the health conditions of the tribal women and reduce the level of morbidity and mortality.

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