# ECONOMIC ANALYSIS OF HEALTH SEEKING BEHAVIOUR OF SCHEDULED TRIBES IN ANANTNAG DISTRICT, JAMMU AND KASHMIR

**Tanveer Ahmad Dar***

**Dr. R.Saravanan****

**ABSTRACT**

The purpose of this paper is to study the health seeking behaviour of the scheduled tribes in Anantnag district, Jammu and Kashmir. The sample of the study consists of 300 respondents, which were selected by Multistage Random Sampling Method. The major objectives of the study are:- 1. To examine the disease wise treatment seeking behaviour of the sample respondents. 2. To find out the cost of the health care services for different system of medicine. The health problems of the scheduled tribes need special attention because the tribal people have distinctive health problem. The major insight of scheduled tribe population on health, health need and health care services are lack of infrastructures, inaccessibility to health institutions, ill-treated by government hospitals staff, acceptability and affordability are some of the main problems contributing to their poor health status. The inaccessibility to health care and reluctance to seek help for health issues remain a significant problem in scheduled tribe areas. In considering priorities for health, greater effort and resources are required to increase their awareness and change attitudes towards health issues. It was observed that scheduled tribe people generally do not pay much attention to the general health problems like fever, cough and cold, but for the treatment of the Acute and Chronic diseases, they mostly prefer to go to public hospitals. In the case of children's problems, they are mostly treated by giving some indigenous treatment, and in case the problem should persist after a certain period, the help of a medical practitioner is sought, who may or may not be qualified. It is only in very advanced stages of the problem that the help of a qualified medical person is sought.

**Keywords:** Scheduled tribes, Health status, Health seeking behaviour, Health facilities.

* Ph.D Research Scholar, Department of Economics, Annamalai University

** Assistant Professor, Department of Economics, Annamalai University

## INTRODUCTION

India's tribal population, the largest in the world, constituting 8.6% of the total population of the country, belongs to around 698 communities (Census 2011). The state of Jammu and Kashmir is the only state having its own constitution. The constitution of J&K has notified twelve communities as the scheduled tribes vide two (Scheduled Tribes) order (Amendment) Act. Eight communities--- Balti, Beda, Bot, Brookpa, Changpa, Garra, Mon and Purigpa, among them were given this status in 1989; And Bakerwals, Gujjars, Gaddis and Sippis were notified as the scheduled tribes vide the constitution (Scheduled Tribes) order (Amendment) Act, 1991. The Jammu and Kashmir State's most populous Scheduled tribes contain the population of 14, 93,299 which account for 11.9 percent of the total population of the State (Census 2011). Out of the 12 scheduled tribes, the Gujjar and Bakkarwal tribes form 69.1 percent of the total ST population. Out of the total nomadic Gujjar and Bakkarwal population, 66 percent in the state of Jammu and Kashmir are living below poverty line. Most of these tribes are found in Ladakh region of the state. The Anantnag district has 1,01,377 population of schedule tribes which constitute 31.85 percent of the total population of the schedule tribes of Kashmir division.

Health is the basic human right. Health implies a sound mind in sound environment. Health is not an easy concept to desire positive health seen to be an easy concept as love, beauty and happiness. The Health is one of the most important endowments of life to which man has a birth right. According to World Health Organization, health is a state of complete physical, mental and social wellbeing and not merely an absence of disease or infirmity. This is very broad definition and the characteristics of health suggested by it are not easy to pin point and measure. In simple language the health of a nation refers to the physical and mental state of the population. Healthy people refer to those who are physically, mentally and intellectually healthy. A healthy mind and proper intellectual development will help proper usage of manpower that is suitable for economic development. Health is the major component of human resources, which contributes to economic development and permits people to lead economically productivity and socially satisfying lives. Proper nutrition and reduction of sickness increase work productivity and life expectancy and promote economic development. A good health is to increase productivity, per capita income and standard of living. Economic development is the process of making the output of an economy with the help of physical and human capital. For long time physical, capital has

been argued for promoting economic growth and development. But in recent years human capital is said to have greater contribution to national output and increase the per capita income. The purpose of development is to permit people to lead economically productive and socially satisfying lives. The social and economic improvements that increase purchasing power can bring to them and their children better nutrition and health status.

Health seeking behaviour among different populations, particularly in the scheduled tribes, is a complex outcome of many factors operating at individual, family and community level. It depends upon the severity of illness, the availability of health care facility, the access to health care services and the economic conditions of the individual / household and other such factors. Health, like education, is among the basic capabilities that gives value to human life says the Nobel laureate Amartya Sen .The right to health extends not only to timely and appropriate healthcare, but it is essential to address the importance of its underlying determinants. The scheduled tribes are socially, economically and educationally disadvantaged and lack their own financial resources and in fulfilling their basic needs. In addition to the poor socio–economic status, low literacy levels and lack of awareness does play a major role in prioritizing health and the utilization of healthcare services among this community. Health information seeking behaviour is an important factor in health management, but this is often ignored while considering schemes for providing health facilities to people. As a result, new schemes for providing health care information do not get the desired acceptance of the community and therefore rendered unsuccessful. The decision makers in the health sector are recognizing the need for understanding the health seeking behaviour of the community and its acceptance and usage of traditional and modern methods, such as perception of the community regarding the service delivery. This becomes especially relevant among traditional tribal society. In this regard, the researcher identifies the health seeking behaviour and its determining factors among the Scheduled tribes in Anantnag District, Jammu and Kashmir.

## REVIEW OF LITERATURE

**Anal Dash (2013)** conducted a study on "Relates on Tribal Education and Health: evidence from rural India". In this study the author says that education and health are two major dimensions of the economic development. Improvement of good education of the mother as women plays an important role at home. Access failure of health and education services is affecting more to the

marginalised section. The number of the dropouts is still very high and community pressures have by and large remained unresponsive in challenging the perceptions of the patents. Poverty, illiteracy and safe drinking water deficiency is the main cause which affects the tribal health in other way. Till now untouchable system is in rural remote villages for that tribes are separating from the general communities. The study concludes that 95 percent for ST/SC households borrowed for health care expenditure and in datedness stage in case of providing collateral due to illiteracy and lost their cultivated land so debt positions among these deprive ST, s category not only because of poverty but also illiteracy. Parental education adversely affect to the child health care. In case of household health education, who are educated they must conscious about their own health and also their children and family planning.

**Base et, al., (1994)** conducted a study on "The State of Art: Tribal health in India" In this study the authors said that the health status measurement is the health seeking behaviour of a community which grows the morbidity and mortality pattern. The morbidity pattern is lower, infant and under five mortality rate are much higher among ST's as compared to the general population in AP. The infant mortality rate is 85.4 among ST's as against 68 in others. The poverty is the prime cause for ill health, persistent morbidity and early death. Lack of access to right food iron, protein and micronutrients such as to iodine and vitamins, causes a very high incidence of nutritional deficiency diseases, anaemia, diarrhoea and night blindness.

**Dhingra (2011)** conducted a study on "The Health Status of Tribal (Gujjar) Adolescent tribal Girls of Jammu and Kashmir". The results of the study revealed that adolescent Gujjar tribal girls enjoy a balanced emotional status along with capacity for strenuous physical activity. The data of the study showed that the body mass index (BMI) of the majority (88.1%) of the subjects was low indicating the highest prevalence of malnourishment among girls of 13 yrs of age. 96(48%) subjects had systolic blood pressure below 100. The observations for the signs and symptoms of anaemia and malnutrition indicated that 90 percent of the subjects had pale cold skin, 89.5 percent had general weakness and 86.5 percent had yellow conjunctiva. Majority (90.5%) of the respondents showed clear cut presence of anaemia having haemoglobin less to introduce health programmes in order to improve the health of adolescent girls in particular.

**Park. K (2000)** conducted a study on "Preventive and Social Medicine"**.** In this study the author says that health care awareness is necessary but not sufficient for good health. For practising health care awareness everybody should join in mediation, yoga, physical activity, diet control

and go for normal health check-up. Good health of the girls would contribute towards improvement in educational achievements. An increase in the health care and awareness of the girls shall go a long way for improvement in health status, reduction in infant mortality rate (IMR) and the maternal mortality rate (MMR) because these very girls shall marry and have their own family. Improved health status of the girls would also lead to decreasing trend in the MMR which is 540 in 2003 against the target of 100 by 2010 as per the national population policy 2000 and the MMR at up is 707 in 1997. It may be argued that reduction in IMR and MMR would lead to an increase in the population and which is contrary to the policy of controlling population growth.

**Sinha (2006)** conducted a study on "Health Status and Health Care among Tribals: The Case of Jharkhand". In this study the author explains that lower morbidity among tribals does not necessarily indicate better health because the former is determined by many factors like socio-economic development, poverty, availability of health care services and facilities and their willingness to acknowledge their ill health. "it has generally been observed that the morbidity rates are positively associated with economic status and level of development. In other words the better off segment or the area is likely to report higher level of morbidity than then the not so well off".

**Usha Shri Garikipati et al. (2003**) conducted study on "A study of Infant Deaths in Tribal area of Andra Pradesh, India" The study shows that there is a huge burden of neo-natal ill health in tribal areas. High prevalence of home deliveries and inaccessibility of neo-natal care in tribal area indicate a need to develop and promote home based neo-natal care practices. The ASHA/TBA is the anchor workers at village level. By improving the skills of these health workers at community level, lot of improvement can be achieved in reducing IMR and NMR. There should be separate programmes for plan of implementing programmes for tribal and non-tribal areas. The review of maternal and child health (MCH) services should not be based on over all condition of the district but should be specific to the regions.

## OBJECTIVES

1. To analyse the health system wise treatment seeking behaviour of sample respondents in the study area.

2. To examine disease wise treatment seeking behaviour of the sample respondents in the study area.
3. To find out the cost of the health care services for different system of medicine.

## METHODOLOGY

The researcher has selected the Anantnag district from the 10 districts of the Kashmir valley. This district has relatively large number of scheduled tribe population. The total number of Scheduled tribe households of the given area as per census 2011 was 1,01,377. The sampling of the study is said to be *Multi-Stage Random Sampling Method*. District Anantnag has 7 blocks namely Dachnipoa, Khoviripora, Breng, Shangas, Qazigund, Shahabad and Achabal. Out of these 7 blocks, two blocks namely Dachnipora and Khoviripora blocks were selected on the basis of high concentration of scheduled tribe population. Awoora, Khiram and Lehandajan were selected from Dachnipora block and Nagbal, Hapatnad and Ganiegund were selected from Khoviripora block and 50 sample respondents were selected randomly from the 6 selected villages of the two blocks and a total of 300 sample respondents were selected for the present study.

## ANALYSIS AND DISCUSSIONS

**Table-1 Education and Gender wise classification of the sample respondents.**

| Education | Male | Female | Total |
|---|---|---|---|
| **Illiterate** | 110 (52.3) | 47 (52.2) | 157 (52.3) |
| **Primary** | 26 (12.1) | 15 (16.7) | 41 (13.7) |
| **Secondary** | 27 (13) | 11 (22.2) | 38 (12.7) |
| **Higher Secondary** | 23 (11) | 8 (9) | 31 (10.3) |
| **Graduation** | 16 (7.6) | 5 (5.5) | 21 (7) |
| **Post Graduation** | 8 (4) | 4 (4.4) | 12 (4) |
| **Total** | **210 (100)** | **90 (100)** | **300 (100)** |

**Source:** Computed
**Note:** Figures in the parentheses denotes percentages to the column total.

Table-1 shows the education-wise classification of the sample respondents. Out of the 300 respondents, (52.3%) of them were illiterate. (13.7%) of the sample respondents had completed their primary education followed by (12.7%) respondents who had completed their

secondary education. (10.3%) respondents had completed their higher secondary education. (7%) respondents had completed their graduation and (4%) respondents were post graduates in the study area. It was also found that out of the 300 sample respondents (70%) respondents were males and (30%) respondents were females in the study area.

**Table-2 Income wise treatment seeking behaviour of the sample respondents.**

| Income (in Rs) | PHC | Govt. Hospital | Private Hospital | Ayurvedic | Some other source | Total |
|---|---|---|---|---|---|---|
| **Below-30000** | 37 (46) | 45 (40) | 12 (21) | 8 (26.7) | 9 (42.8) | 111 (37) |
| **30001-40000** | 24 (30) | 33 (29) | 14 (25) | 9 (30) | 5 (23.8) | 85 (28.3) |
| **40001-50000** | 13 (16) | 23 (20) | 14 (25) | 8 (26.7) | 5 (23.8) | 63 (21) |
| **Above-50000** | 6 (8) | 12 (11) | 16 (29) | 5 (16.6) | 2 (9.6) | 41 (13.7) |
| **Total** | **80 (100)** | **113 (100)** | **56 (100)** | **30 (100)** | **21 (100)** | **300 (100)** |

**Source:** Computed
**Note:** Figures in the parentheses denotes percentages to the column total.

Household income is one of the proxy indicators in assessing the levels of development of the households. Table–2 shows the income wise treatment seeking behaviour of the sample respondents. The sources of household annual income come from various sources of the study area. The income has been grouped into four major sub classes below Rs 30,000, Rs 30,001 to Rs 40,000, Rs 40,001 to Rs 50,000 and above Rs 50,000.the table also shows that the majority of the respondents are in the category of below Rs 30,000 (37%) followed by Rs 30,001 to Rs 40,000 (28.3%) and Rs 40,001 to Rs 50,000 (21%) and only (13.7%) of them are in the class of above Rs 50000. It was observed that the respondents with low income groups visit primary health centres and adopt some other sources for their treatment. It was also revealed that the respondents having higher incomes get the treatment for their diseases from the private hospitals.

**Table-3 Awareness about health among the female respondents**

| S.No. | Health variables | Yes | No |
|---|---|---|---|
| **1** | Know the importance of IFA tablets | 7(7.8) | 83(92.2) |
| **2** | Information from health personal during Pregnancy time | 36(40) | 54(60) |
| **3** | Availed the service from ASHA | 41(45.6) | 49(54.4) |
| **4** | Awareness about family planning from ASHA | 38 (42.2) | 52(57.8) |

**Source:** Computed
**Note:** Figures in the parentheses denotes percentages.

Table-3 shows the awareness about health problems among the female respondents. It is revealed from the table that (92.2%) of the Scheduled tribe women did not know the importance of IFA tablets. It was also found that (60%) of the female respondents did not visit the doctor during their pregnancy. It was also found that only (45.5%) of the female respondents availed the service from ASHA. It was also found that (57.8%) female respondents did not get the awareness about the family planning from ASHA.

**Table-4 Health care availability in the study area.**

| S.No. | Distance from health centre | Total |
|---|---|---|
| 1. | Below-5km | 23 (7.7) |
| 2. | 6-10km | 72 (24) |
| 3. | Above-10 | 205 (68.3) |
| **Total** | | **300 (100)** |

Source: Computed
Note: Figures in the parentheses denotes percentages to column total.

Availability of health care facilities is important for human development. In this context, the health care service in the study area is studied. Table-4 reveals that (68.3%) percent of the sample respondents were living above 10 km from the primary health centre, (24%) percent of them were living 6-10 km from the primary health centre and (7.7%) were living below-5 km from the primary health care centre.

**Table-5 Health care practices of scheduled tribe women in the study area.**

| Practices of health care | PHC | Govt. Hospital | Private Hospital | Some other source | Total |
|---|---|---|---|---|---|
| **Care of Pregnancy** | 65 (72.2) | 17 (19) | 5 (5.5) | 3 (3.3) | 90 (100) |
| **Delivery** | - | 51 (56.7) | 1 (1.1) | 38 (42.2) | 90 (100) |
| **Care of New Born** | 2 (2.2) | 62 (69) | 14 (15.5) | 12 (13.3) | 90 (100) |
| **Care of Common Disease** | 11 (12.2) | 14 (15.5) | 35 (39) | 30 (33.3) | 90 (100) |

**Source:** Computed
**Note:** Figures in the parentheses denotes percentages.

Table-5 shows the different practices of health care practices and different sources of treatment among the scheduled tribe women in the study area. It was observed that majority of the female respondents (72.2%) get the treatment for pregnancy from Primary health centres. It was also observed that majority of the female respondents deliveries (56.7%) occur in the

government hospital. It was also observed that majority of the female respondents (69%) take the care for new born babies in primary health centre. It was also observed that majority of the female respondents (39%) visit the private hospitals for the treatment of common diseases.

**Table-6 Different types of diseases wise treatment seeking behaviour of the sample respondents.**

| S.No | Types of Diseases | Sources of Treatment | | | | | Total |
|---|---|---|---|---|---|---|---|
| | | PHC | Govt. Hospital | Private Hospital | Ayurvedic | Any other Source | |
| **A** | **Common Diseases** | **33** | **32** | **36** | **16** | **61** | **178** |
| | Viral fever | 7 | 9 | 13 | 7 | 20 | 56 |
| | Cough | 4 | 6 | 5 | 3 | 15 | 33 |
| | Cold | 6 | 7 | 7 | 2 | 19 | 41 |
| | Headache | 8 | 5 | 6 | 2 | 3 | 24 |
| | Stomach pain | 5 | 3 | 3 | 1 | 2 | 14 |
| | Skin disease | 3 | 2 | 2 | 1 | 2 | 10 |
| **B** | **Acute diseases** | **23** | **25** | **15** | **8** | **5** | **76** |
| | Diarrhoea | 11 | 9 | 7 | 3 | 2 | 32 |
| | Jaundice | 7 | 12 | 5 | 4 | 2 | 30 |
| | Cholera | 5 | 4 | 3 | 1 | 1 | 14 |
| **C** | **Chronic disease** | **13** | **14** | **13** | **6** | **-** | **46** |
| | Asthma | 3 | 3 | 3 | 2 | - | 11 |
| | Cancer | 3 | 2 | 2 | 1 | - | 8 |
| | Leprosy | 2 | 1 | 2 | - | - | 5 |
| | High BP | 2 | 3 | 3 | 1 | - | 9 |
| | Diabetic | 1 | 2 | 2 | - | - | 5 |
| | Sleeplessness | 1 | 3 | 1 | 2 | - | 7 |
| | Psychiatric treatment | 1 | - | - | - | - | 1 |
| | **Total (A+B+C)** | **69 (23)** | **71 (23.67)** | **64 (21.33)** | **30 (10)** | **66 (22)** | **300 (100)** |

**Source:** Computed
**Note:** Figures in the parentheses denotes percentages.

Table-5 shows the different types of diseases wise treatment seeking behaviour of the sample respondents. It is revealed that there are three types of diseases such as Common diseases, Acute diseases and Chronic diseases in the study area. It is observed from the table that (33.7%) of the sample respondents get the treatment for their common diseases from some other sources such as self medication local medical shop etc., (33%) sample respondents get their treatment for acute diseases from government hospitals and (30.4%) respondents get the treatment for their chronic diseases from government hospitals.

**Table-7 Number of days sample respondents stayed in Govt. and Private Hospitals for the last year.**

| No. of Days | Government Hospital | Private Hospital | Total |
|---|---|---|---|
| **1-3** | 141 | 34 | 175 |

| | | | |
|---|---|---|---|
| | (60.7) | (50) | (58.3) |
| **3-5** | 56<br>(24.3) | 23<br>(33.8) | 79<br>(26.4) |
| **Above-5** | 35<br>(15) | 11<br>(16.2) | 46<br>(15.3) |
| **Total** | **232**<br>(100) | **68**<br>(100) | **300**<br>(100) |

**Source:** Computed
**Note:** Figures in the parentheses denotes percentages to the column total.

Table-7 reveals the number of days the sample respondents stayed in both Govt. and private hospitals. Out of the 300 sample respondents the majority (77.3%) sample respondents get their treatment from Govt. hospitals and (22.7%) respondents get their treatment from private hospitals. It is also revealed that (58.3%) of the sample respondents stayed for 1-3 days, (26.4%) of the sample respondents stayed for 3-5 days and (15.3%) of the sample respondents stayed above 5 days.

**Table-8 Direct Cost distribution of the sample respondents.**

**Per Annum**

| **Details** | **Govt. Hospital N =232** | | **Private Hospital N = 68** | | **TOTAL (Govt. + Private) N=232+68=300** | | |
|---|---|---|---|---|---|---|---|
| | **Patient** | **Attendant** | **Patient** | **Attendant** | **Patient** | **Attendant** | **Total** |
| **Transport** | 27840<br>(120) | 83520<br>(360) | 9520<br>(140) | 28560<br>(420) | 37360<br>(1245) | 112080<br>(373) | 149440<br>(498) |
| **Medicine** | 197200<br>(850) | - | 71400<br>(1050) | - | 268600<br>(895) | - | 268600<br>(895) |
| **Hospitalization** | 41760<br>(180) | - | 10200<br>(150) | - | 51960<br>(173) | - | 51960<br>(173) |
| **Food** | 48720<br>(210) | 146160<br>(630) | 14280<br>(210) | 42840<br>(630) | 63000<br>(210) | 189000<br>(630) | 252000<br>(840) |
| **Lab fees** | 81200<br>(350) | - | 38080<br>(560) | - | 119280<br>(397) | - | 119280<br>(397) |
| **Others** | 34800<br>(150) | - | 19040<br>(280) | - | 53840<br>(179) | - | 53840<br>(179) |
| **Total** | **431520<br>(1860)** | **229680<br>(990)** | **162520<br>(2390)** | **71400<br>(1050)** | **594040<br>(1980)** | **301080<br>(1003)** | **895120<br>(2984)** |

**Source:** Computed
**Note:** Figures in the parentheses denotes the average.

Table-8 shows the direct cost distribution of the sample respondents for the treatment of their diseases. The direct cost includes different categories such as transport, medicine, hospitalization, food, lab fees and others for different types of diseases in the study area. It is revealed that on an average the cost of the sample respondent (patient + care taker) is Rs 2984 per year for the treatment.

**Table-9 Indirect Cost distribution of the sample respondents.**

**Per Annum**

| **Details** | **Govt. Hospital** | **Private Hospital** | **TOTAL (Govt. + Private) N=232+68=300** |
|---|---|---|---|

| | Patient | Attendant | Patient | Attendant | Patient | Attendant | Total |
|---|---|---|---|---|---|---|---|
| **Man-days lost** | 1160 (5) | 1856 (8) | 340 (5) | 544 (8) | 1500 (5) | 2400 (8) | 3900 (13) |
| **Income loss in Rs** | 482560 (2080) | 779520 (3360) | 141440 (2080) | 22848 (3360) | 624000 (2080) | 802368 (2675) | 1426368 (4754) |

**Source:** Computed
**Note:** Figures in the parentheses denotes the average.

Table-9 shows the indirect cost distribution of the sample respondents in the study area. The total potential man-days lost due to ill health of the patients are 3900 per year (patient + care taker) for the treatment and due to disability of diseases and the average man days lost are 13. It also reveals that the total income loss due to ill health of the patients is Rs1426368 and the average income lost due to ill health is Rs 4754.

**Table-10 Total Economic Cost (Direct + Indirect) distribution of the sample respondents Per Annum**

| Items | Patient | Attendant | Total |
|---|---|---|---|
| **Direct Cost** | 594040 (1980) | 301080 (1004) | 895120 (2984) |
| **Indirect Cost** | 624000 (2080) | 802368 (2675) | 1426368 (4754) |
| **Economic Cost (Direct +Indirect) Total** | **1218040 (4060)** | **1103448 (3678)** | **2321488 (7738)** |

**Source:** Computed
**Note:** Figures in the parentheses denotes the average.

Table-10 explains the total economic burden of the sample respondents in the study area. The total economic cost of the respondents is Rs 2321488 per year, which includes treatment and income loss of the respondents and the Average Economic Cost is Rs 7738 per person per year.

## FINDINGS

- It was also observed that majority of the sample respondents (52.3%) were illiterates in the study area.
- It was observed that majority of the sample respondents for the treatment of the common diseases (33.7%) did not visit any hospital, they use self medication only.
- It was also observed that majority of the female respondents (57.8%) did not get any awareness about family planning from ASHA.
- It was found that Government health sector is a major health care provider in the study area.

- It was also observed that majority of the sample respondents (68.3%) were living above 10 km distance from the primary health centre.
- On an average the direct cost distribution of the patients (patient + care taker) per year is Rs 2984.
- On an average man-days lost due to ill health of the patients (patient + care taker) per year are 13 and the average income lost due to ill health is Rs 4754.
- On an average the Economic cost which includes treatment cost and income loss of the respondents per year is Rs 7738.

## CONCLUSION

The study concludes that the people of scheduled tribes are socially, economically, politically and legally ignored and excluded in Indian health society. The health status and utilization pattern of scheduled tribes give an indication of their social exclusion as well as an idea of their linkages between poverty and health. The scheduled tribe people have very poor awareness about their health and health care systems in and around to their communities and inhabitants. The main hindrance in the poor health status of Scheduled tribes is the nomad tribal environment and non acceptance of community towards professional doctors and their association with strong social networks identified as key determinants for common perception in all communities. However, the inaccessibility and unaffordability to health care and reluctance to seek help for health issues remain a significant problem in scheduled tribe areas. No doubt, the medical facilities are just rudimentary. But these people are not even willing themselves to go to hospitals for minor diseases like cold and cough as shown in the results of the present study. Above facts has been supported by the present study that they preferred to visit hospitals only in case of acute and chronic diseases. For common diseases they did not go to the hospitals for treatment but deal within their groups. Finally it can be said that the health status of scheduled tribes is very poor as compared to other sections of the population. In considering priorities for health, greater endeavour and resources are required to increase their awareness and change attitudes towards acceptance of now a day's health care services**.** The author suggested that a combination of inter personal communication and traditional media may be adopted to deliver health care messages to the tribes in Anantnag district, Jammu and Kashmir. This is in line with national Population Policy (2000) which also emphasis on communicating clear and focused health care message to the people in the remote areas of the country in local dialects through local artists, singers, folk-dance groups, comedians, actors, drummers, popular film stars etc.

## SUGGESTIONS

From the above findings, the researcher has given few policy suggestions to safeguard the scheduled tribes. The suggestions are as follows:-

- The patients who are staying and taking treatment in public hospitals should provide more nutrient food for early recovery from diseases.
- There are nearly percent of the sample respondents who are illiterate, so the government should encourage and strengthen school education in the study area.
- The primary health centre is not located in the study region and people spend more money for private health sources, so the Government should provide new hospital and medical facilities.
- Finally, the Government of India should repeatedly take steps to strengthen preventive health care services in addition to provision of easy treatment for delivery and emergency services.

## REFERENCES

A.K.Sen(1999), "Health in Development". Bulletin of world health organization 77(8), 619-623.

Ahmad Showkeen Bilal (2014), "Assessment and Understanding of Gujjar and Bakarwal Women Health in Jammu and Kashmir ", *journal of business and management and social science research* Vol.3,No.3, pp. 37-43.

Anal Dash (2013), Relates on tribal education and health: evidence from rural, India. International journal JR OF Social science 2 (11):11-16

Balwan Singh (2013), "Knowledge and Awareness as Determinants of Reproductive Health: A Rural–Urban Perspective." *American International Journal of Research in Humanities, Arts and Social Sciences*, 5(1):95-103

Base et, al., (1994) "The State of the Art: Tribal health in India". Manak Publications PVT Ltd. Delhi.

Chopra, K & Neelam M (2004), "Common Health Problems Encountered by the Tribal Community in Bastar District". *Health and Population-Perspectives and Issues*, 27 (1): 40-48

Dhingra, Rajni (2011), "Study on an Assessment of Health Status of Adolescent Gujjar Tribals Girls of Jammu district". *Kamla-Raj*. 9(2): 133-138 (2011). Retrieved from http:// www.krepublishers.com/.../St-T&T-09-2-133-11-196-Dhingra-RTS.pdf

Nagda, B.L. (2004), "Tribal Population and Health in Rajasthan" *Stud. Tribes* Tribals, *2(1): 1-8.*

Park K. (2000), "Preventive and Social Medicine". Simplex Printing Press, Jabalpur. 12-631.

Singh, B. (1994), "Factors Influencing Health of Tribal Population Groups: in Salil Base (Ed), Tribal Health in India". Delhi, Manak Publications Pvt Ltd.

Sinha (2006), "Health Status and Health Care among Tribals: The Case of Jharkhand". Institute for Human Development, New Delhi.

Usha Shri Garikipati et al., (2003), "A study of Infant Deaths in Tribal area of Andhra Pradesh, India", *global journal of medicine and public health.* Vol. 2, no. 4.

Verma, D.K, Omi, Verma (2014), "Reproductive Life of the Bhatra Women of Bastar Chhattisgarh", *International Journal of Humanities Social Sciences and Education*, 1(9):122-128.

www.census .co.in 2011.