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IMPACT OF SOCIO-CULTURAL BEHAVIOUR ON HEALTH AND ILLNESS WITH REFERENCE TO MUTHUVAN TRIBES OF ANNAMALAIS IN THE WESTERN GHATS OF COIMBATORE, TAMIL NADU.

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Abstract:

Background: Every society has its own traditional beliefs and practices related to health care. Some practices are effective whereas others may be harmful or ineffective. These beliefs and practices are linked to culture, environment and education. Health workers must have concern for the community's cultural values and beliefs so that they can utilize the harmless practices for effective use as well as eliminate harmful practices. The study's objectives were to explore the Muthuvan tribals of Annamalais in the Western Ghats perception on health and illness, Identify the health care seeking behavior, and find the relationship between perceptions on health and illness with the study variables. **Method:** descriptive study was conducted among Muthuvan tribals of Annamalais in the Western Ghats. The study subjects (75) were interviewed through a questionnaire and selected by randomly. **Results:** Data shows that 57.3 per cent of the respondents stated that they have average level of perception on own health. Majority **(**70.0%) of the respondents are able to take decision themselves, nearly fifty (48.0%) of the respondents stated that during the illness they were treated themselves in nursing homes/clinics and majority (70.7%) of the respondents feeling that diseases are not severe enough. The data also showed that the people of Muthuvan tribals of Annamalais in the western Ghats perceived high health risk for the health and illness due to the using unsafe water & food, multiple sex partner, poor diet, overwork and immunity. Further, the result revealed that that there is a no significant association between perception on health and illness and selected variables because the p-values of all variables are more than 0.05. **Conclusion:** The study shows the impact of socio-cultural behavior on health and illness among Muthuvan tribals of Annamalais in the Western Ghats, either directly or indirectly.

Keywords: Health, Illness, Socio-cultural behaviour, Tribals

I. INTRODUCTION

Worldwide some section of humankind is being referred as Tribes, nomadic people, hunter- gatherers, primitive people, aborigines, forest dwellers, indigenous and adivasis. Tribal people are concentrated highly in the order as first in African continent, next in India., Australia and Northern America. Reviewing volumes of literature it is observed that albeit, these people are different in their attire, art and culture from region to region , they are very identical on some of their uniqueness such as living in clusters and are numerical, live in isolated places especially in deep forest and they are very strong in their family cohesion and cultural beliefs. India has the second largest tribal population of the world next to the African countries, as two hundred and fifty tribal groups live in isolated regions and constitute 8.2% percent of the country's total population. Tamil Nadu is about 1% and in Kerala 0.7% of the total population as per the 2001 census. The study area forest and wet lands, comprising of thick forest, dry deciduous forest, and flora and fauna. Muthuvan tribes are very much hesitant and relentlessly reluctant to mingle with other sub-groups of hill tribes and civilized people. Muthuvan tribes will not allow the hill Malapulayan tribes inside their houses and if hill Malapulan tribes inadvertently place their footsteps at the entrance of their hut, Muthuvan tribes immediately vacate the hut and erect another hut, thinking that they are superior to other tribes, which is still in vogue. Muthuvan and Hill Malapulayan tribes are two different dwindling tribes, live in isolation, forest dwellers, economically weak, disease prone, strong in socio-cultural belief, and practice. Government has taken various efforts to assimilate them into social mainstream but in vain.6 On the other hand, these marginalized people subjected to exploitation results in the aberration of their culture culminates in chronic alcoholism and drug abuse posing, threatening the total extinction of these marginalized hill tribes from the Indian History. The author, during his research field study has found out and developed an ― innovative‖ strategy for the Primary Prevention and Rehabilitation of alcoholism and substance abuse among these tribal youths , based on old Tamil proverb,

"Mullai Mullal Edukkanum" i.e the illiterate tribal youths afflicted by the evil effect of alcoholism and substance abuse is to be weeded out with the help of the educated native youths – Primary prevention of alcohol and substance abuse and its follow-up is possible by – —Educated Native Youths (ENY) persistent interaction, intervention and cultural exchanges with Uneducated Tribal Youths (UTY) (i) through direct and social media networking and (ii) by undertaking, participating and promoting —Eco-Medical Tourism to the Tribal Settlement‖ with the help of various youth organizations such as —Nehru Yuvek Kendra‖ and NSS under direct supervision and advice of a medical doctor/ medical Psychiatrists, and this proposal, —Bicultural Skill Approach‖ could act as fulcrum for the prevention of alcoholism and substance abuse among hill tribes. The stimuli that induced the author to do this application oriented research was the high prevalence of alcoholism and substance abuse among the hill tribes predominantly seen among tribal youth. This review highlighted and brought to the limelight the common finding that the major issue related to the high prevalence of alcoholism and substance abuse among tribal youth in the study area is socio-cultural erosion and fast surfacing socio-cultural transformation among tribal youths. Most of the studies on the tribes are being carried out in the northeastern India and very few studies are being carried out in South India and especially the study on Muthuvan and Malapulayan tribes in the study area are only in single digit. However, very few studies on alcoholism and drug abuse among tribes were carried out in India that too only in North-eastern India. None of the previous research studies were concentrate on the prevalence, the trend, magnitude and disease burden of chronic alcoholism and substance abuse on the tribal community and its survival.

Literature reviewed for this study3 is partly ethnographic in content, though most except one4 are not informative on socio-economic details. Most ethnography accessed on the tribes in the Anamalais has been conducted during the early half of the previous century, excepting a few academic studies including genetics and the shifting cultivation system of the region conducted later. From the sources reviewed, the communities have been studied mostly during the first half of the 20th century, though in later years, attempts have been brief and inconclusive to change and transformations in livelihood ecology. This has resulted in a widening gap in ethnographic and sociological information after the 1970's on these communities both from an academic and administrative perspective. In this context, it is pertinent to mention that of the few latter-day accounts on the people of the Anamalais, some authors find it convenient to describe the tribes such as the Kadar or Malai Malasars as hunter-gatherers,5 simplistically dismissing economic realities and changes that have taken place over a century of acculturation. Contrary to what is seemingly meant in referring to them as hunter-gatherers with notions of primitiveness and complete dependence on natural resources, or poverty, closer inspection reveals these notions not wholly descriptive of these communities. With changed worldviews and living amidst new realities, their progress, stasis and development are not adequately represented. Beyond these notions, their aspirations toward betterment for their future in landscapes they live amidst and the issues they have to confront are not adequately represented. This report also has its failings in generalizing three ethnic identities and their livelihood from a perspective of understanding their current modes of existence vis-a-vis their past. In conserving natural heritage where people exist alongside fragile ecosystems, it is of paramount importance to comprehend and negotiate the needs of healthy natural habitats as well as rationale and choices of human livelihood given the many changes that have occurred in their systems of livelihood, the realities of the present and needs for the future.

Culture of the Tribes

The tribal people express their cultural identity and distinctiveness in their social organisation, language, rituals, festivals, dress, ornament, art, and craft. The tribes have retained their own way of managing internal affairs of the village mainly through two institutions namely, the village council and the youth dormitory. The dormitory is the core of tribal culture and it reinforces the age-old tradition. These aspects of their culture give meaning and depth to their lives and solidarity to their social structure. (www.orrisstourism.gov.org.). However, this author, during the base line survey, observes some common constant and conflicting issues from the commentaries given by the local tribal heads and tribal health healers that majority of tribal treasury vis'-a-vis their culture and livelihood resources have been engulfed on one hand by exploitation and invasion of outsiders under the pretext of development programs and on the other side by the imposition of various forest rules and regulations. Dilution of tribal customs and believes and the above fast socio-cultural transformation is the major issue related to the Alcoholism and Drug abuse among these poverty driven hill tribes, the author observes.

Health and Culture of the Tribes

Tribal health has also to be understood from cultural contexts and a part of social structure and organization that is changing continuously and adapting itself to changes in a wider society. Health culture

of a community is referred to as the _cultural factors influencing the health of a community, cultural meaning of health problems, diffusion of health practices from outside, cultural innovations by the current generations to deal more effectively with health problems and the overall health-related behaviour of the community'. In some tribes, there is very little social control over behavior. In others, behavior is highly prescribed and there is little room for deviation. The tribes in the latter' group show lower levels of social problems whereas the less-integrated tribes, both currently and historically, have higher levels of homicide, suicide, and alcoholism. Establishing the prevalence and other epidemiological characteristics of fetal alcohol syndrome (FAS), alcohol-related birth defects (ARBD), and alcohol-related neuro-developmental disorder (ARND). Female substance dependents had major problem with privacy (87.5%), fear to treatment (75%) and absence of problem (75%). The World Health Organization (WHO) estimated that there are about two billion consumers of alcoholic beverages and 76.3 million people with diagnosable alcohol-use disorders worldwide. In addition to chronic diseases, such as cancer of the mouth, esophagus and larynx, liver cirrhosis, and pancreatitis, social consequences, such as road-traffic accidents, workplace-related problems, family and domestic problems, and interpersonal violence, have been receiving more public or research attention in recent years and stressed the need for planning, implementation, and evaluation of appropriate programs for the elimination of this social evil. Awareness among the population and necessary rehabilitation and self-help programs will help in bringing down the prevalence of alcoholism. The prevalence of current alcohol use ranged from a low of 7% in the western state of Gujarat (officially under Prohibition) to 75% in the North-eastern state of Arunachal Pradesh. There is also an extreme gender difference. Prevalence among women has consistently been estimated at less than 5% but is much higher in the North-eastern states. Significantly higher use has been recorded among tribal, rural and lower socio-economic urban sections. Unfortunately, the official response remains focused on the visible tip of the alcohol problem—people with alcohol dependence (around 4% of the adult male population)—instead of on the emerging crisis due to hazardous drinking in more than 20% of the adult population. This is reflected in the approach to alcohol control policies at federal and state levels. The focus is exclusively on supply reduction and tertiary prevention.

Statement of the Problem

An explorative study to assess the socio-cultural perspectives on health and illness among the people of Muthuvan Tribes of Annamalais in the western Ghats of Coimbatore, Tamil Nadu.

Objectives of the Study

1. To study the socio-economic profile of the respondents of Muthuvan Tribes of Annamalais
2. To analysis the impact of socio cultural behaviours on health and illness among Muthuvan Tribes of Annamalais.

II. VARIABLES

Key variables: Perception on health and illness, health care seeking behavior, perceived health risks.
Selected variables: Age, gender, type of family, education, occupation, monthly family income.

Sampling Procedure

The Western Ghats hill range of India, recognised as a global biodiversity hotspot, also contains impressive cultural diversity, including many tribal communities. This study uses past records and primary field research to describe aspects of socioeconomic characteristics of the respondents. The respondents were selected from three tribal communities in Muthuvan of the Anamalai hills along the Western Ghats of Coimbatore, Tamil Nadu, India. The data was collected by field survey. Kadar, Muthuvar, and Malai Malasar communities across 190 households in 8 settlements located adjacent to rainforests in the Indira Gandhi Wildlife Sanctuary. Among them; 25 households from all three communities were selected randomly. So the total selected population is 75.

Research Design

This study has adopted a descriptive research design. The descriptive method is simple and easily applicable to various social problems, particularly in developing nations. Burns and Grove (2003) said that "descriptive research is designed to provide a picture of a situation as it naturally happens". It may be used to justify the recent practice and make a judgment and to develop theories.

Descriptive research may be characterised as simply an attempt to understand, describe or identify what is.

The study aims at examining the resultant consequences of socio-cultural perspectives on health and illness among the people of Muthuvan Tribes of Annamalais in the western Ghats of Coimbatore, Tamil

Nadu. The researcher has developed a structured interview schedule to gather specific data from the study participants. This is a part of the formalised schedule for data collection in the study. The type of interview schedule for interviews is mostly determined by the type of survey method implored. It can be used to realise how a respondent feels about a specific topic before using a second method (such as in-depth interviewing or observation) to gather information from them.

Statistical Tools

The data was collected after obtaining the written consent from the eligible participants. The data was analyzed using descriptive (frequency and percentage) and inferential statistics. The analysis was done based on objectives by using SPSS package version 16.

III. ANALYSIS

Table 1: Socio-economic Characteristics of the Respondents:

SI. No	Category	Frequency	Percentage
1	**Age in years**		
	25-40	52	69.3
	41-60	22	29.3
	Above 60	1	1.3
	Total	75	100.0
2	**Gender**		
	Male	25	33.3
	Female	50	66.7
	Total	75	100.0
3	**Educational status**		
	Illiterate	22	29.3
	Primary	17	22.7
	Secondary	36	48.0
	Total	75	100.0
	Type of family		
4	Nuclear	42	32.7
	Joint	32	56.0
	Extended	1	1.3
	Total	75	100.0
5	**Occupational status**		
	Agriculturist/tailoring	52	69.3
	House wife/coolie	23	30.7
	Total	75	100.0
6	**Month Income**		
	Below 2500	46	61.3
	2501 to 5000	29	38.7
	Total	75	100.0

With regard to age groups, the above table shows that 69.3 per cent of the respondents belong to the age group of 25 to 40 years, 29.3 per cent belong to 41 to 60 years and remaining 1.3 per cent belong to Above 60 years. Based on gender, 66.7 per cent were females and 33.3 were male selected. Regarding education of the respondents, nearly fifty (48.0%) per cent of the respondents studied up to secondary level, 29.3 per cent of the respondents are illiterate and the rest 22.7 per cent of the respondents studied up to primary level.

As far as family type of the respondents, majority of the respondents (56.0%) belong to joint family, 32.7 per cent of the respondents belong to nuclear family and the remaining 1.3 per cent respondents belong to extended family.

With respect to occupation, majority of the respondents (69.3%) are agriculturists/tailoring, 30.7 per cent of the respondents working as house wife or coolies. While as, more than sixty (61.3%) of the respondents whose monthly family income is Rs. below 2500 and 38.7 per cent of the respondents whose monthly family income is 2501 to 5000.

Table 2: Respondents opinion about Health seeking behavior:

SI. No	Area	Frequency	Percentage
1	**Perception of own health**		
	Good	30	40.0
	Average	43	57.3
	Poor	02	2.7
2	**Decision taking to seek medical help**		
	Life partner	17	23.6
	Self	53	70.0
	Siblings	05	6.4
3	**During illness where do you take treatment**		
	Public centres/hospitals	7	9.3
	Private hospitals	27	36.0
	Nursing homes/clinics	36	48.0
	Home remedies	5	6.7
4	**Reason for not seeking health care**		
	Feeling that diseases are not severe enough	53	70.7
	Unable to pay medical expenses	47	62.7
	Unreasonable charges in medical institution	24	32.0
	Knowing how to deal with disease themselves	28	37.3
	Having no free time	26	34.7
	Long distance from medical institution	13	17.3
	Complicated medical procedures	25	33.3
	Long queuing and waiting time	32	42.7
	Poor services	3	4.0

As far as Perception of own health, 57.3 per cent of the respondents stated that they have average level of perception, 40.0 per cent opined that they have good and 2.7 per cent of the respondents have poor perception about their own health.

Regarding decision taking to seek medical help, 70.0 percent of the respondents are able to take decision themselves, 23.6 per cent of the respondents life partners talking decision regarding medical help and 6.4 per cent opined that siblings talking decisions for their medical help.

The above analysis revealed that 48.0 per cent of the respondents stated that during the illness they were treated themselves in nursing homes/clinics, 36.0 per cent of the respondents visited to private hospitals during illness, 9.3 per cent of the respondents visited public centres/hospitals for treatment and 6.7 per cent of the respondents doing home remedies during illness.

Based on reason for not seeking health care, the above data illustrated that, majority (70.7%) of the respondents feeling that diseases are not severe enough, 62.7 per cents stated that they are unable to pay medical expenses, 42.7 per cent opined long queuing and waiting time, 37.7 per cent of the respondents know how to deal with disease themselves, 34.7 per cent informed due to lack of time, 33.3 per cent of the respondents informed that medical procedures is complicated, 32 per cent opined that they are unreasonable charges in medical institution, 17.3 per cent opined that due to long distance from medical institution and 4 per cent of the respondents not seeking health care because of poor services.

Table 3: Perceived health risk

SI No	Risks	Low risk	Moderate risk	High risk
		(%)	(%)	(%)
1	High tension/stress	10.7	52.0	37.3
2	Using unsafe water & food	0	22.7	76.0
3	Open electric wire	37.3	32.0	30.7
4	Multiple sex partner	5.3	36.0	58.7
5	Obesity	17.3	44.0	37.3
6	Improper personal hygiene	12.0	45.3	42.7
7	Noise	42.7	52.0	5.3

8	Poor diet	20.0	16.0	64.0
9	Emotional status	14.7	70.7	14.7
10	Over work	2.7	61.3	36.0
11	Ageing	8	49.3	41.3
12	Immunity	10.7	33 44	44.0
13	Family problem	13.3	52	33.3
14	Hereditary	28.0	46.7	25.0

The table 3 showed that the Muthuvan tribals of Annamalais in the western perceived high health risk for the health and illness due to the using unsafe water & food, multiple sex partner, poor diet, over work and immunity.

Table 4: Perception on health and illness:

SA: Strongly Agree (4), A: Agree (3) D: Disagree (2), SD: Strongly Disagree (1).

Statements	**SA**	**A**	**D**	**SD**
Perception on Health:	**%**	**%**	**%**	**%**
Health is a complete state of physical, mental and social wellbeing	81.3	18.7		
Health is promoting a positive attitude	33.3	35	18.7	1.3
Health is actively seeking out things that make me happy	49.3	44	6.7	
Health is taking charge of and responsibility for, my own life	29.3	56	12	2.7
I believe health is finding ways to resolve any inner conflicts	26.7	54.7	16	2.7
Health is thinking positively and seeing the illness as challenge	28	40	30.7	1.3
I believe health means looking after myself and taking things easy	32	50.7	16	1.3
I believe health means giving up unhealthy habits	45.3	34.7	17.3	2.7
I believe home prepared foods are good for health	81.3	9.3	9.3	
I believe yoga/meditation is good for health	88	10.7	1.3	
I believe exercises reduces the health risk	66	32	1.3	
Perception on illness:	%	%	%	%
Illness/diseases are caused by wrath of the god/goddess	16	45.3	29.3	9.3
Venereal diseases are caused due to illicit sexual intercourse	10.7	36	38.7	14.7
HIV/AIDS caused among poor socio economic people	49.3	30.7	14.7	5.3
Leprosy and tuberculosis caused due to their past sins	29.3	26.7	36	8
Children are most susceptible to the effect of 'evil eye'	20	34.7	36	9.3
Childhood diseases are attributed to the anger of god.	40	36	22.7	1.3
Hysteria or epilepsy (fits) are due to ghost intrusion	40	48	10.7	1.3
Illness can be traced by enemies	38.7	36	22.7	2.7
Illness can be prevented by eating certain types of foods.	14.7	45.3	30.7	9.3
Foods such as meat, egg, fish are considered to generate heat	14.7	20	37.3	28
Foods such as curds, milk, vegetables are believed to cool the body.	8	20	21.3	50.7
Fasting leads to nutritional deficiency disorder	17.3	28	33.3	21.3
Alcohol intake causes illness	62.7	29.3	2.7	5.3
Passive smokers more prone to get certain diseases	28	53.3	13.3	5.3
Poor ventilated houses cause diseases.	41.3	40	14.7	4
Some diseases are caused by my 'karma'.	32	30.7	25.3	12
Some diseases are inherited	22.7	52	14.7	10.7
Illness has serious financial consequences	70.7	18.7	9.3	1.3
Some illness strongly affects the way the patient sees himself as a person.	14.7	61.3	21.3	2.7
Illness makes me feel afraid and angry	62.7	29.3	1.3	6.7

Table 5: Association between perceived health & illness and selected variables

SI. No	Category	Average Perception	High Perception	x2	P value
1	**Age in years**				
	25-40	6	46		
	41-60	6	16	2.97	.22
	Above 60	0	1		
2	**Gender**				
	Male	4	21	1	.63
	Female	8	42		
3	**Educational status**				
	Illiterate	7	31		
	Primary	5	20	4.62	.099
	Secondary	0	12		
4.	**Type of family**				
	Nuclear	8	34		
	Joint	34	28	.739	.390
	Extended	0	1		
5	**Occupational status**				
	Agriculturist/tailoring	6	6	.763	.519
	House wife/coolie	40	23		
6	**Monthly Income**				
	Below 2500	7	42	.305	.742
	2501-5000	5	21		

The table 5 illustrated that Chi-square was computed to analyze the association between perceived health & illness and selected variables. The results showed that there is a no significant association between perception on health and illness and selected variables because the p-values of all variables are more than 0.05. Thus, the null hypothesis was accepted with regard to these variables and alternative hypothesis was rejected.

IV. FINDINGS

Findings based on Socio-economic characteristics of the respondents:

- With regard to age groups, majority (69.3%) of the respondents belong to the age group of 25 to 40 years.
- Based on gender, majority (66.7%) of the respondents were selected females.
- Regarding education of the respondents, nearly fifty (48.0%) per cent of the respondents studied up to secondary level.
- As far as family type of the respondents, majority of the respondents (56.0%) belong to joint family.
- With respect to occupation, majority of the respondents (69.3%) are agriculturists/tailoring. More than sixty (61.3%) of the respondents whose monthly family income is Rs. below 2500.

Findings based on Health seeking behavior:

- As far as Perception of own health, 57.3 per cent of the respondents stated that they have average level of perception.
- Regarding decision taking to seek medical help, majority **(**70.0%) of the respondents are able to take decision themselves.
- The above analysis revealed that nearly fifty (48.0%) of the respondents stated that during the illness they were treated themselves in nursing homes/clinics.
- Based on reason for not seeking health care, the above data illustrated that, majority (70.7%) of the respondents feeling that diseases are not severe enough.

Findings based on Perceived health risk:

- The people of Muthuvan tribals of Annamalais in the western region perceived high health risk for health and illness due to unsafe water & food, multiple sex partners, poor diet, over work, and immunity.

Findings based on Association between perceived health & illness and selected variables:

- The results showed that there is a no significant association between perception on health and illness and selected variables because the p-values of all variables are more than 0.05.

V. CONCLUSION

Every society has its own traditional beliefs and practices related to health care. Some practices are effective whereas others may be harmful or ineffective. These beliefs and practices are linked to culture, environment and education. So the study shows that the impact of socio-cultural behaviour on health and illness among Muthuvan tribals of Annamalais in the Western Ghats, either directly or indirectly. Therefore, the health workers must have concern for the community's cultural values and beliefs so that they can utilize the harmless practices for effective use as well as eliminate harmful practices.

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