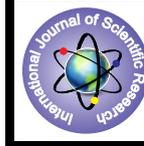


Health Status Among Tribes in Haliyal & Ganadal Village of Karnataka



Sociology

KEYWORDS :

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INTRODUCTION

Health is an important aspect of human Resource development. Good health care facilities and services are essential for creating healthy citizen and society that can effectively contribute to social and economic development. With increased urbanization, industrialization, are contribution of health resistance and the changing nature of health problems has become a great concern for world today. Therefore three of eight millennium development goes (1) Emphasize on health, they are two reduce child mortality improve mental health combat HIV/AIDS, Malaria and other diseases, (Registrar central of India, 2001 census).

The tribals, who live in forest areas and other remote place, have got their own culture, customs, practices and religion. They have not remained uninfluenced through the sources of change. The changes have taken place even among the tribal groups that who lived separate from non-tribal. The changes brought about by these forces have produced different results and the effects are positive in some cases and contrary in other cases. Therefore it is important to find out the type of changes that have taken place and the factors in effecting these changes and finally the pace and direction of changes that have taken place among them.

It is important to note that we can find several differences among the tribal communities in several spheres of social life. Therefore, the present study proposes to analyse the changes that have taken place among the Bedas in Haliyal & Ganadal village of Koppal district and the factors associated with these changes.

MEANING OF TRIBE

The tribals constitute nearly 7% of the population of India. The tribals live in forest areas, hilly regions, mountainous places and deep valleys. They are known by various names for example primitives, animists jungle people, adivasis and aboriginals.

Bardhan A.B.(1973) defines the tribe as a "course of a Socio-cultural entity at a definite historical stage of development. It is a single endogamous community with a cultural and psychological make-up going back into a distant historical past." In this definition the emphasis is on the cultural and psychological make-up.

George Jose and Shreekumar S.S.(1994:2) State that: "The tribe is a social group of a simple kind, the members of which speak a common dialect, have a single government, act together for common purposes and have a common name a contiguous territory. Relatively of common descent. Here the tribe is considered as a social group with common dialect, purpose, name and culture."

According to Gillian and Gillian: "A tribe is a group of local community which lives in a common area, speaks a common dialect and follows a common culture." "A tribe" according to Risely is a collection of families or groups of families bearing a common name which as a rule does not denote any specific occupation, generally claiming common descent from a mythical of a historical ancestor. Occasionally the name is derived from an animal only by the obligation of kinship, members speak the same language and occupy (of profess to occupy) a definite tract of country."(Shashi Birathi 1992:2).

Different scholars have used different terms to refer to tribes. Risely, Lanny, Elwin, Grigson, Shoobert, Sedyewick, Martin, Thakar A.V. and others have described them as "aborigines" of "aboriginals" Helton called them 'primitive tribes' G.S Ghurye

described them as 'So-called aborigines' or 'backward Hindus' and now they accept the designation.

'Scheduled tribes' as formulated in the constitution of the Indian Union. Some scholars and reformers have described them as 'adivasis' De. Das and others designated them as 'Submerged humanity'(Desai; 1977:17).

Many of the sociologists, social anthropologists and other social scientists have given a number of definitions. But no definition is universally accepted by all or found applicable to all the tribes who are living in different parts of the country.

Definition: Jawaharlal Nehru stated that: Health is a basic problem which forms the foundation of nation and if the foundation is weak it is likely to collapse.

May Baker Eddy: Health is not a condition of matter, but of mind or can the material sense bear reliable testimony or the subject of health.

Franklin defined: Health is a background feature of daily living & a person's displays to his essential normality health people are normal people are healthy.

Talcott parsons (1951) : Who describes health as a state of optimum capacity for the effective performance of value tasks.

Karnataka human development report 2005, Stated that "Good health is an invaluable asset for better economic productivity both at the individual and national level but above all it is valued by those who own it as prerequisite for better quality of life and better standard of living".

Theories of Health:

Parsonian functionalisation and 'the sick role' (1951): Although parsons were interested in a variety of issues concerned with the management of illness, It is for emphasis on the social importance of the sick roll that he is usually remembered parsons stresses that there is a significant issue of motivation involved in being sick and getting better in effect people have to decide that are sick and that they need treatment since being sick means choosing to withdraw from normal patterns of social behavior it amounts to a form of deviance; as such the functioning of social system depends on the management and control of those who have decided they are sick so that they can be restored to health to ensure they return to the performance of normal tasks and the renewed meeting of normal social obligations and responsibilities. In short the sick role requires a commitment on the part of those feeling unwell to try to return to normality as soon as possible.

Four features define the sick role.

- Sick people cannot make them selves better but need professional help.
- Sick people are obliged to want to get better being sick can only be toll rated if there is desire to return to health.
- Sick people are therefore expected to seek professional treatment.

Review of Literature

Banerji (1973) has observed that the structural constraints like poor image of primary health centre due to lack of medicines, overcrowding and long queues and the cultural and social gap between the health worker and the patient also limit utilization of health services.

Thimuss and rein (1968-69) have examined how socio-economic status can have a close relationship with health differentials and use of health services. The studies of Vaughan (1967) Richardson and Dingwall Fordyce (1968) and slower (1969) have focused on the access to health care facilities. A joint study of UNICEF/WHO (1975) suggested alternative approaches to meet basic health needs in developing countries.

Yesudin (1979) in his study of madras found that various health services were utilized more by the rich than the poor. The selection of health centre by the well to do person was on the bases of their personal knowledge of the doctor in the centre and at the same time they utilized the private health services also. The poor on the other hand depended entirely on public health services for all their health needs. Lack of resources and ignorance were the main causes for the poor being unable to properly utilize the health services.

According to Banerjee (1989) the Alma-Ata-Declaration of 1978 (WHO/UNICEF) was a shift to integrated health services, basic health services and to relating health services to the wider strategy for dealing with the socio-economic problems of the deprived sections of populations in different countries. More significantly it viewed social control our technology and health services development but on parts of their sectoral efforts to improve the health of the country population. Where as Ramlingswamy(1975) has examined the mature of health care services and their limited courage to a narrow section of upper and middle classes in improving the health status of the people.

Odin.W. Ananderson (1963) of served in his study in the united states that lower the income, the lower was the expenditure but higher was the percentage of income laid out in a year. Rodney M and Albert M (1965) also came to the same conclusion in their study of the utilization of community health services. They found that while upper classer spent more for health services the amount the spent represented a smaller proportion of their total income, while the lower classes spent a small amount for health services but this amount formed a larger portion of their total income. From the above mentioned various studies indicated that though the higher classes consume more health services and pay more from their pockets, it is not financial burden for them. On the other hand the lesser amount paid by the lower class takes a substantial for their small income, there by causing financial stringency in the house hold (yesudian 1988).

Thakur (1980) in his study of lepchas, a small tribe in Darjeeling district, observes that there is a slow change in their traditional activities although dress and food habits are gradually changing. There is a slow change in their outlook in their world view in their attitude to values and philosophy of life. The very ethos of traditional culture marked with homogeneity simplicity co-operation and leisure life has hardly been shaken. The live of aspirations and just for material comfort do not appear to be togetherness and co-operation for the traditional code of conduct and social customs and taboos are still strong among the lepchas. In his study on some aspects of urbanization in garo hills at Tura town in western Meghalaya, Majumdar (1980) said that the changes in economic sphere is limited to the urban population who have been indirectly affected by the urban economy of Tura and the changes in the social sphere will certainly have far-reaching consequences in the Garo society as a whole. Gori (1984) in his study on the changing phase of tribal areas of Manipur observes that growth of townships, literacy, transportation, implementation of plans and developmental work, democratization of system of administration, improved system of communication etc. brought about a process of radical change in tribal society. Aiyappan (1977) in his study of the tribes Irulas and kurumbas in Attapady valley in Kerala state observed that until very recently they had only minimal contacts with the people of the plains on the Malabar and Coimbatore sides as there were no roads to their valley.

A few officers of the forest department range visitors of the revenue department and the representatives of the land lords who owned a great part of the forests were the only outsiders whom they dealt with. As several miles of good roads were constructed

during recent years and with the exploitation of the forest and the clearing of forest land for co-cultivation, the tribes men were exposed to the fuel blast of the forces of change peer (1992) in his work. Tribal Development programmes: A case study of Karnataka observes that on account of contact with mainland people access to modern transport and communication, protective legislation and education, many changes have taken place in their socio-cultural life. Further he states that he gradual expansion of roads and others forms of communication have also led to the tribal exploitation accidentally since they opened the avenue for interaction between tribals and mainland population.

Haimendor & (1977) in his study says that the improvement of communication, particularly the construction of roads, as well as the intensified intervention of government agencies in more and more aspects of citizens activities, have combined to undermine the independence of tribal society. Further he says that most changes in the economic conditions and life style of tribal people have been caused by contacts with materially more advanced and politically more powerful population.

Objectives of the Study:

- To find out Bedas health problems.
- To study their socio-economic and political status.
- To find out the impact on health and economic condition of the family.
- To examine the health service as available in the community.
- To point out the prevailing health status among the people.
- To find out the problems like Agricultural, sanitary, Alcoholic, smoking problems faced by Bedas.
- To find out the recent change that is occurring among bedas

Importance of the Study:

The study of tribal society is an important area of inquiry for the sociologist. Many studies have the various aspects of social life. In contemporary Indian society various studies focused our attention to the changes taking place among the tribals in their social economic, religious and historical life. Due to the heterogeneity among tribal groups it has not been possible to derive uniform conclusions regarding the social political economical life as well as society.

Introduction of Adult franchise in India and periodical elections that take place to elect representatives to parliament and state legislatures and village panchayat have create awareness among the tribal people. Moreover they are aware of their political rights, power alignments and functional politics of the leaders. The supporters of politicians approach the tribals living in distant places for votes and promise them to improve their living condition. A result of this awareness about the non-tribal world is slowly emerging among the tribals. The special political privileges granted to the tribals by the Indian constitution have also contributed to the emergence of awakening regarding the political and social situation of the country.

Today political leaders of the tribes are more concerned with improvement in living conditions than with the question of ritual and social status. Hence above all aspects to understand the specific issue in tribal transition, it would be more appropriate to adapt micro method of investigation by selecting to specific tribal living in a specific geographical area. Such studies invariably tend to be empirical in nature and would be useful for making policy decisions to protect tribal and promote their total upliftment. Therefore, welfare of the tribal people is also welfare of the nation. Hence the study is essential.

Methodology:

Universe of the study

According to the 2001 census of Karnataka tribal population has been increased more than 8.8% of the total population in our study region Haliyal & Ganadal village of Koppal district Bedas constitute approximately 90% of the total population of the village.

Sample:

There respondent have been selected from Ganadal village and

Haliyal area. The data was collected from 100 respondents (head of the household) more over for the collecting data of the past the elders opinion, on the leaders & other knowledgeable person's in the community also interviewed.

Tools Techniques:

The study is based on both primary and secondary data. The primary data was collected with the help of an interview schedule. The interview schedule contained both pre-coded and open-ended questions. On an average each interview took about half an hour to one hour. The unit of the study was the head of the household and interviews were conducted during the day time.

After the completion of the data collection each interview schedule was carefully edited to check the completeness, accuracy and validity of the data. Besides respondents, the men and other family members also participated in the discussion.

**Table No.1.1
Education wise classification.**

Sl No	Education	Total	Percentage
1	Illiterate	45	64.28
2	Primary	20	28.57
3	Middle School	05	7.14
	Total	70	100.00

The above table 1.1 indicates the educational qualification of the respondents. The respondents interviewed are both men & women. Among the total respondents 45 (64.28%) are illiterate. 20 (28.57%) respondents studied up to primary school. 05 (7.14%) respondents have studied up to middle school. Therefore it is clear from data people are more negligent in education as well as in health condition.

**Table No.1.2
Type of House**

Sl No	Type of house	Total	Percentage
1	Mud house	30	42.85
2	Thatched	25	35.71
3	Tiled house	09	12.85
4	R.C.C.	06	8.5
	Total	70	100.00

The above table 1.2 indicates the type of houses of the respondents. Majority of the respondents i.e. 30 (42.85) interviewed living in mud house. Then 25 (35.71%) living in thatched houses, 09 (12.85%) of respondents living in tiled houses and only 6 (8.5%) of the total respondents living in R.C.C. This is clear that the respondents are agriculturists and coolies are living in old mud houses. Because they were less aware of the sanitation condition of the house and their economic condition was poor.

**Table No.1.3
Occupation among respondents**

Sl No	Occupation	Total	Percentage
1	Hunting	05	7.14
2	Agriculture	50	71.42
3	Agriculture Labour	10	14.28
4	Coolie	05	7.14
	Total	70	100.00

The above table 1.3 indicates respondents occupation. 05 (7.14) respondents were engaged in hunting, 50(71.42) respondents were engaged in Agriculture. Further less number of respondents engaged in Agriculture Labour, they are 10(14.28) and remaining 5(7.14) were engaged in coolie.

**Table 1.4
Source of water supply**

Sl No	Source of water supply	Total	percentage
1	Private Tap in the house	09	12.85%

2	Public stand point in the Street	36	51.42
3	Public hand pump	20	28.57%
4	Public well	05	7.14%
	Total	70	100.00

The above Table 1.4 indicates the Source of water supply for the people of Haliyal and Ganadal village of Koppal Taluk. Out of 70 respondents 9 (12.85) respondents have replied that they get the water supply from private tap in the house. 36(51.42%) respondents have said that they were happy with the public water supply in the street and 5(7.14) use to get water from public well and 20(28.57) getting water from public hand pump. It is observed that due to the bad drinking water the various diseases spread in the villages.

**Table 1.4
Latrine facility-wise classification of the respondents**

Sl No	Latrines	Total	percentage
1	Latrine attached to the house	35	50.00
2	Open space at the road side	15	21.42
3	Community Latrine provided by the gram panchayat	04	5.71
4	Field defecation	16	22.85
	Total	30	100.00

The above table 1.5 indicates that out of 70 respondents 35(50.00%) have the Latrine facilities in the house but respondents said that it was not well maintained only in few occasion they are using Latrine at home. 15(21.42%) respondents said that they go to latrine at open space at the road side. 04 (5.71%) of respondents told that they use community latrine provided by the gram panchayat. 16 (22.85%) of respondents told that they go for field defecation and most of them go alone if they want to go for field defecation

It is necessary to analyse why people are not making use of latrine available in their homes. Researcher identified the various reasons they are

- 1) The villagers feel unhygienic and uncomfortable to have the latrine inside their house. According to them, going to the field early in the morning has an additional advantage that one enjoys morning walk and fresh air which city dwellers do not get easily.
- 2) Apart from the feeling uncomfortable inside the latrine and other things they pointed out to the fact that their houses are small and if latrine is provided inside the house, foul smell will become a characteristic feature of the house: and the villagers do not wish to use latrine for an another reason was given by an old man of 85 years age explained that no Hindu will tolerate about the cooking, eating and defecating at the same place under one roof.
- 3) There is no drainage system in the field region.

However, in its broader concept of health has been emerging in many countries as that of improving the overall 'quality of life' which, has been defined as conditions of life resulting from the combination of effects of the complete range of factors. Such as those determining health happiness including comfort in the physical environment and a satisfying occupation, education, social and intellectual attainments freedom of action, justice and freedom from oppression (WHO, 1977).

**Table 1.6
HABITS OF SMOKING**

Sl No	Particulars	Total	percentage
1	Bidi	16	22.85
2	Cigarette	11	15.71
3	Bidi+ cigarette	21	30.00
4	Ganja	10	14.28
5	Do not smoke	12	17.14
	Total	70	100.00

The above table 1.6 indicates that among 70 respondents 16 (22.85) respondents used to smoke Bidi and 11 (15.71) respondents used to smoke cigarette. 21 (30.00) respondents told that they smoke both bidi and cigarette. 10 (14.28) respondents used to smoke Ganja. Smoking bidi is more common than the use of cigarettes. Cigarette smoking cannot be afforded by a majority of the people. Hence the smoking of bidi is gradually increasing in the village. It is noticed that out of 70 respondents 12 (17.14%) do not have the habit of smoking.

ALCOHOL CONSUMPTION

According to Keller and Efron (1955:619-644), alcoholism is characterized by the repeated drinking of alcoholic beverages to an extent that exceeds customary use or compliance with the social customs of the community and that interferes with the drinkers health or his social or economic functioning. An alcoholic is different from an 'occasional drinker'. Any person who takes alcohol is 'drinker', while a 'compulsive drinker' who cannot live without taking alcohol is called an alcoholic. According to Clinebell (1956: 17) has defined an alcoholic as one whose drinking interferes frequently or continuously with any of his important life adjustment and interpersonal relationships.

The field work covered the habits of alcohol consumption in a community under study. As it was expected that the number of habitual drinkers were more among both illiterates and literates.

Table 1.7
HABITS OF SMOKING

Particulars	Respondents	Percentage
Yes	31	44.28
No	39	55.72
Total	70	100.00

The Table No.1.7 indicates that out of 70 respondents 39 (55.72%) of respondents do not have the habit of alcohol consumption. 31 (44.28%) of respondents out of 70 are found to be habitual drinkers. Thus the chronic and heavy drinking habit of alcohol is often responsible for liver damages, neuritis, and other similar complaints (Gangulee.Op.Cit). It is important to note that among the respondents who are habitual drinkers include men, women and grown up children.

Government of India now, has the monopoly of production and distribution of Excise arrack. This results in increasing habit of alcohol consumption among the younger generation as a matter of serious concern to the individual in particular and to the nation in general, as it creates many health problems eroding the productive capacity of the nation and the future growth. In developing countries like, ours, where majority of the people live in the vicious circle of poverty, a good part of their income is going to liquor which leads to the under-nourishment of the people and erosion of their health status. Thus from the health point of view, drinking affects directly the eating habits and life style of the people. As Walsh (1985) observed that many disabling and sometimes physical and mental conditions can be attributed either wholly or in part to excessive drinking. The chronic and heavy drinking habit of alcohol is often responsible for liver damages, neuritis, and other similar complaints. We do not have much information with regard to the incidents of these diseases except one who is suffering from liver and lungs damages due to the excessive consumption of alcohol.

COMMON DISEASES IN THE VILLAGE LOCALITY AND CAUSES OF SOME OF THESE DISEASES AS PERCEIVED BY THE VILLAGERS

The basic assumption of this study is that persons who are living in a particular geographical area are subjected to face their own specific health problems. Every society views health problems from the perspective of its own culture and responds to them according to the understanding, knowledge, values and beliefs of the people. Health is not only biophysical phenomena but also a cause of the social disorder in the life of the community. Here social disorder of the life of the community is viewed in terms of community environment and civic amenities which exists in the

community. The data shows that most of the respondents perform occupations like agriculture and coolie and most importantly are illiterates and the factors like housing pattern, latrine system, bathing habits and food habits, smoking and alcohol consumption etc. are leading to the following consequences of which it is associated with.

Table 1.8
Common health problems and diseases of the respondents

Sl No	Particulars	Total	percentage
1	Headache	11	15.71
2	Back pain	17	24.28
3	Body pain	09	12.85
4	Chest pain	13	18.57
5	Cough and cold	06	8.57
6	Stomach ache	06	8.57
7	Dysentery	08	11.42
	Total	70	100.00

The above table 1.8 clearly shows the common health problems faced the respondents in the daily living in the village under study. It is noticed that there is relationship between the personal hygiene, food habits, occupation and incidence of health problems and diseases. Out of 70 respondents 11 (15.71%) said that they have regular headache problems. 17 (24.28%) of respondents said that they have back pain and 09 (12.85%) respondents said that they have body pain problem. 13 (18.57%) of the respondents replied that they have chest pain. 06 (8.57%) said they get cough and cold regularly. 06 (8.57%) respondents said that they have regular stomach ache (gastric) problems. 08 (11.42%) the respondents told that they have frequent dysentery problem.

AWARENESS ABOUT HEALTH SERVICES

The people of Haliyal and Ganadal village of Koppal district make use of the health services provided by the Primary health Care Centres. 80% of the respondents have made use of the available utilization of the government hospital for their health condition. The reason that respondents gave for attending the government hospital were treatment is good, free medicine is supplied and faith in government hospital and doctor.

The rest of the 18 percent of respondents said that they do not have faith in the modern medicine and government hospital and tend to go to a private practitioner for the treatment. Because they said that the treatment is good and doctor is known to them. However near about 02 respondents use traditional type of medicine which is prepared at home.

In general it is accepted that tribal people have a poor health profile. The government of India and Karnataka government has made special provisions to provide better health care in general. But the far fung areas where most of the tribal habitations are the population coverage norms for delivery of primary health care have been relaxed to 01 primary health centre (PHC) for every 20,000 population and one Sub-centre for every 3,000 population in tribal areas as compared to one PHC for 30,000 and one sub-centre for 5000 population in general non-tribal rural areas.

According to the Annual Report, Ministry of Health and Family Welfare, 1993-94, By 1994, 3,400 PHCs, 360 community Health Centres, 20,000 Sub-centres, 1,100 Allopathic Dispensaries, 120 Allopathic Hospitals, over 1000 Ayurvedic Dispensaries, about 40 Unani and 4 Siddha dispensaries in addition to Homeopathic Hospitals (28) and dispensaries (25) have been established in tribal areas. In spite of this impressive expansion of health care facilities, the health status of the tribal population has not improved along the described lines.

But Karnataka Government has not made any efforts to look after the tribal health care who are thickly populated in the study area. Therefore, certain policies should be implemented for up-

liftment and to take proper care about the beda tribes in the study region.

CONCLUSION AND FINDINGS:

The main objective of the study was to understand the nature status and health problems among the bedas of Haliyal and Gandal villages in Koppal Taluka. the findings of this study are based on the data collected from 100 respondent. Lets us present the major findings of the study

1. The data shows that bedas in the past were living in the forest and mountain regions they were depending upon the forest products for their livelihood but the present data shows that 70% of the respondents were engaged in Agriculture and most of the them were leading settled life
2. It is seen that housing condition in the village is very bad nearly 78.56% of the respondents live in the mud houses and thached houses where each of the houses are attached to each other and giving no room for fresh air and sun light to enter the house
3. The respondents have shown their discomfort towards the drainage system, village sanitary condition is worst and polluted environment this is causing diseases and directly affecting their health system
4. Regarding smoking habit is concerned nearly 44.28% of the men and children smoke bidi+cigrate and about 55.72% of the people are not smoking.
5. But in general, investigator observed that 70% of the villagers have a habit chewing and splitting betel nut and betel tobacco the chewing of sweet pan, masala pan and gutaka are also found in younger generation
6. Investigator observed that (Haliyal and Gandal- Koppal Taluk) few respondents were affected by HIV, mental stressed, and lung cancers etc.
7. The data proved that among the respondents 24.28% have the back pain, 12.85% respondents have body pain. 18.57% respondents have the chest pain. The reason for this is that most of the respondents are below the poverty line and engaged in different physical work like agriculture labour work, coolies etc.

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