



## HEALTH STATUS OF SCHEDULE TRIBES IN SELECT AREAS IN INDIA: A REVIEW

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### **Introduction:**

Tribal's are often referred as ADIVASI, VANAJATI, VANAVASI, ADIMJATI, PAHARI and ANUSUCHIT JANJATI, the later being the Constitutional name. The concept of Tribe emerged in India with the coming of the British, Gradually, the concept of reservation emerged and through that emerged idea of ST in Independent India.

In India, 461 principal tribes and 174 sub-tribes with a population of 10,42,81,034 Scheduled Tribes, these Tribal groups inhabit approximately 8.6 % of the total Indian population(Census of India 2011). These tribal groups inhabit widely varying ecological and geo-climatic conditions (Hilly, Forest, Desert etc) in different concentration throughout the country (except a few states) with different cultural and socio-economic back grounds. (Salil Basu, 1999).

### **Health and its correlations:**

Health is of critical concern determining the overall development of Schedule Tribe Population. Health indicators of Schedule Tribe's are generally poorer than those for the general population. According to the latest estimates of NFHS-3, ST Population in general and ST women and children in particular, faced worst in all parameters of health and nourishment such as Infant Mortality Rate, Child Mortality Rate, Poor Maternal Health, Child Sex Ratio, Malnourishment, high prevalence of anaemia, malaria etc., the adverse scores of these health parameters have a serious demographic and socio-economic consequences that needs immediate attention.

Health is a pre-requisite for human development and is essentially concerned with the well being of common man. The UNDP Human Development India (HDI) comprises three components (i.e Health, Education and Income Generating Capacity). Health is a function, not only of medical care but also of the overall integrated development of society like in Cultural, Economic, Educational, Social and Political. The health status of a society is intimately related to its value system. Good health and good society to together. This is possible only when supportive services such as nutrition and improvements in the environment and in education reach a



higher level (Ministry of Tribal Welfare) the culture of community determines the health behavior of the community in general and individual member in particular. The health behavior of the Individual is closely linked to the way he or she perceives various health problems.

The health problems need special attention in the context of tribal communities of India. Available Research studies point out that the Tribal population has distinctive health problems, which are mainly governed by their habitat, difficult terrains and ecologically variable niches. (Report of the High level committee on socio-economic, health, education status of the Tribal India, 2014)

The key areas that were studied by Swamy Vivekananda Youth Movement, Saragur to understand the Health Status and Health care delivery system and mechanisms were 1. Under Five Child health, 2. Maternal health, 3. Adult health, 4. other significant factors that impact the health status and 5. The status of Health facilities.

#### **General:**

STs constituting 8.6% of the total population of the country contribute to approximately 17.5 % of the rural poor. There is paucity of data pertaining to them and whatever is available is scanty. There seems to be no systematic mechanism to capture various disaggregates health related data for the ST population. All available studies and surveys leave one in no doubt that all the health indicators, especially related to health status, accessibility, reach and health delivery, are very much below the national average and in most instances lower than the rural figures.

#### **Under Five Child Health:**

The desk review shows that mortalities between 1 month to 5 years is 30 at the National level, 41 in the Rural areas and 64 in the ST areas per 1000 live births. The number of children dying in this age group in the ST areas is more than twice the national average. It is higher than the rural figures. The medical officers and other health providers interviewed during the field visit were found lacking in awareness of the extent of the mortality in different age groups of children in their area.

The health facilities like Sub Centre (SC), Primary Health Centre (PHC) and Community Health Centre (CHC)/First Referral Units (FRU) are inadequately equipped in terms of infrastructure, supplies, man power and skills to address illnesses which contribute to the morbidity and mortality in children. In addition to this, availability, accessibility and affordability issues come in the way of providing quality care to sick children. 4. The percentage of children who receive appropriate treatment for important childhood illnesses is low across the country as well as in the ST areas. In the ST, only 1 in 8 children gets appropriate treatment for Acute Respiratory Infections (13%) and Malaria (12%) and 1 in 3 for Diarrhoea (29%). Only 60% of ST women are aware of the importance of Oral Re hydration Solutions in diarrhoea.



All the parameters for under nutrition are higher in the ST than the National and the rural figures. 57% of ST children are Underweight (Rural – 50% and National – 39%), 55% stunted (Rural – 50% and National 45%), 29% wasted (Rural – 25% and National 19%) and 78% anaemic (Rural – 71% and National – 67%). The causes for the poor nutritional status are lack of access to appropriate quantity and quality of food due to poverty and reasons which go beyond the health sector which can only provide a necessary infrastructure and ensure its efficient functioning. In the nutritional interventions of the Anganwadi centres (AWC), the nutritional needs of the children in the crucial age bracket (6 months to 2 years) are not being addressed although the Integrated Child Development Scheme (ICDS) covers the age group 0 to 3 years also. Only for 13% of the children are all the three recommendations of Infant and Young Child Feeding practice (recommended by WHO) followed. 6. Among the ST children in the selected states, 32% (1 in 3) received full primary immunization (National – 48%, Rural – 43%) and 12% (1 in 8) no immunization (National – 5%, Rural – 7%) as per the data of 2005/06 National Family Health Survey 3. The ST figures are lower than the national and rural figures. There has been no appreciable improvement in trend between 1998/99 and 2005/06. The inadequate coverage of immunization is related to difficulties in availability, procurement, storage, maintenance of cold chain of vaccines and accessibility of the target population. The ST figures of immunization coverage are lower than the rural figures. Only 15% of the ST children received Vitamin A in the previous 6 months and this is less than in the rural and national figures.

### ***Maternal Health:***

1. Only 36% of the pregnant woman are registered for Ante Natal Care (ANC) in the I trimester, 41% receive mandatory 3 ANC and 28% do not have any ANC. 63% of the pregnant women receive IFA tablets but only 21% of them actually consume them for the mandatory 100 days. Among those registered for ANC, 40 to 64 % receive varying individual basic important components of the ANC. The percentage of women who receive all the basic components is not available from the reports. Only 32% of the pregnant women are told where to go if they experienced pregnancy related complications and 11 to 15 % of the pregnant women are given information on specific pregnancy complications. The important aspect of delivery preparedness and where to go if there are complications are not discussed with all the women.
2. Only 1 in 5 deliveries in ST is institutional delivery and 1 in 4 is assisted by health personnel in 2005 - 2006. In spite of the incentive schemes, there are difficulties in promotion of institutional deliveries. Although institutional deliveries in ST areas are reported to have increased considerably after the initiation of NRHM from the low level of 20%, the issue is still a matter of concern. The deliveries take place mainly in the Primary Health Centres or the First Referral Units and not in the Sub centres.
3. The infrastructural facilities, medical and paramedical human resources have not improved much. **SVYM expresses that just bringing the pregnant**



**women to the institution for delivery does not address the basic need for appropriate and optimal care during delivery as the facilities are lacking in resources. It seems that there is not much difference between home and hospital deliveries in terms of quality of care.**

4. On an average, 1 in 4 women gets Post Natal Care (PNC) within 48 hours of delivery. The health staffs are able to give PNC within 48 hours for only institutional deliveries and not for all home deliveries. In Orissa in the ST districts of Koraput and Mayurbanj, the DLHS 3 (2007/08) report states that the PNC within 48 hours of delivery is 100% and 95.7% respectively, though the percentage of institutional deliveries is only 11.6% and 40.3%. It is difficult to take the claim of 100% PNC. It is possible that the claim pertains to institutional deliveries only.
5. Figures for maternal mortality are not available in the reports of National Family Health Survey and District Level Household and Facility Survey(DLHS). The medical officers are of the opinion that maternal mortality has reduced and that they tend to occur in home deliveries. Sepsis, post partal hemorrhage and anemia continue to be the commonest delivery related complications. Yet, the Primary Health Centres and the First Referral Units are ill equipped to deal with such events. Only 40% of the FRU can manage the obstetric emergencies, 14% have blood storage facilities and 53% have facilities for Medical Termination of Pregnancy. Apart from mortality, the magnitude of the morbidity (so called near miss events) related to child birth is not known. The importance of maternal morbidity goes beyond the mother and affects the newborn as well. Status of unsafe abortions in the ST areas has not been recorded.
6. The other indicators like Total Fertility Rate (TFR), Birth order of >4, and Teenage pregnancy in ST are higher than the National average. TFR : ST – 3.14, National – 2.5, Rural – 2.77; Birth order >4: ST – 33.4, National – 22.2, Rural – 24.2; Teenage pregnancy : ST – 22.5, National – 19.9, Rural – 20.7. In Karnataka, the TFR in ST has increased from 2.38 to 2.53 and the birth order of >4 from 18 to 24, while the decadal growth rate for the ST in Dakshin Kannada has shown a negative growth of 2.9% This is a cause for concern and it needs to be studied further. Every 4th pregnancy in the ST areas is a teenage pregnancy, yet, neither the medical officer nor the Auxillary Nurse Midwife (ANM) were aware of the magnitude of teenage pregnancies in ST.
7. The total unmet need for Ffamily Planning in the ST is 25% for the selected states. It is 13% at the national level and 14%% for the rural population. Medical Termination of Pregnancy services were available in only 53% of the Community Health Centre's visited.

### ***Adult Health:***

1. 41% of ST men (National – 34%; Rural – 38%) and 47% of ST women (National – 36%; Rural – 41%) are undernourished with the Body Mass Index



(BMI) of <18.5. 40% of ST men (National – 25%; Rural – 28%) and 69% of ST women (National – 55%; Rural 57%) are anemic. The nutrition of adolescent girls, pregnant and lactating women bears a direct relationship with the nutrition of the child. The Anganwadi centre does not adequately address this section.

2. Disaggregate figures for the prevalence of tuberculosis for the state are not available. The awareness about tuberculosis and Directly Observed Treatment Schort course (DOTS) in ST is 70% and 60% respectively. Though cumulative figures for the ST districts across the nation show that the targets for Revised National Tuberculosis Control Programme (RNTCP) have been reached as per the annual report for 2008, during the field visit, it was learnt the health functionaries faced challenges in case detection and case holding. With these problems, it is difficult to understand how the targets for RNTCP have been reached in the ST districts. Disaggregate figures for the ST in the areas of Leprosy, Kala Azar and Malaria are not available.
3. Prevalence of Human Immune deficiency Virus (HIV) infection in the ST is not available. Awareness indicators for the ST show that 8% of women and 20% of men have comprehensive knowledge about HIV. Specific measures to address this problem have not been implemented at the state levels except in Maharashtra and Karnataka. Though HIV screening in pregnant women is recommended in the country there are no facilities for screening in three of the states visited. Integrated Counseling and Treatment Centre (ICTC) facilities are not easily available in the PHCs or FRUs and people need to go the District hospitals for these services.
4. There is low awareness amongst the PHC Medical Officers about the prevalence of genetic diseases in ST. At the PHC level the resources are inadequate to address the non communicable diseases and hence the patients have to go to the FRU or the district hospital for diagnosis and treatment.

***Other factors that contribute to the Health status:***

1. Only for 40% of the rural and lowest two wealth index categories, to which most of the ST population belongs, Government facilities are the source of health care. The remaining 60% seek private providers. The main reasons given for not seeking care in the government health facilities are poor quality of care (51%), lack of a nearby facility (45%), and long waiting times (32%).
2. 26% of women and 71% of Men use tobacco in some form or the other and 14% of women and 50% of men use alcohol in ST. 46% of ST women experience some form of spousal violence (Physical, emotional or sexual). These figures are higher than the national and rural figures. During the field visit, svym found that the PHC Medical Officers and the health workers are lacking in awareness of the magnitude of these problems. No specific focus on these issues is being given in general.



3. Only 2.6% of the ST families have any type of health related insurance.

### *Health facilities:*

#### **Primary Health Centres (PHC):**

1. Each PHC caters to a population of 17,000 to 65,000, the average being 40,000 spread over 59 villages and the average distance of the farthest village from the PHC is 24 km. The distance between the PHC and the nearest referral centre is 28 km. Nearly 18 percent of the villages do not have proper roads and 11 percent are not accessible during certain periods of the year. In terms of population coverage and accessibility, the PHCs in these ST areas are overburdened and not easily accessible by all the villages under their care.
2. Only in 43% of the PHCs were the medical officers staying on the campus. There is no back up support when the medical officers are on leave in PHCs with single Medical Officer. On an average 20 % of the posts of paramedical staff excluding Accredited Social Health Activist (ASHA) are vacant.
3. Only 72% of the PHCs were in good condition. Some of the PHCs are still in the process of transition or up gradation from PHC to CHC and hence there was confusion even among the medical officers as to the status of their own institution and their own job description. The up gradation process was not complete even 4 years after the implementation of NRHM.
4. Piped water supply was available in 45% and functional toilets in 58% of the PHCs 51% of the PHCs had regular electricity and 27% had generator back up. 44% of the PHCs had connectivity through land line phones. Some of the interior ST areas are not reachable even by mobile phone facilities. 76% of the PHCs had Ice Lined Refrigerator (ILR) and Deep freezer for vaccine storage yet only in 36% of them were they functional. 57% of the PHCs had more than 75% of the essential medicines including Anti snake venom. Minor Operation theatre is available in 28% of the PHCs and functional ambulance facilities in 34%. 5. Though clinical laboratory facilities are available in 69% of the PHCs, they had limitations in terms of range of basic investigations (one or more of the following tests are available – Haemoglobin estimation, Urine albumin, sugar estimation, Urine pregnancy test, smear for AFB and Malarial parasite) and availability of full time laboratory technician.
5. 75% of the PHCs have labour rooms where labour is being conducted. However, only 17% have adequate facilities for conducting normal labour and 19% for newborn care.
6. The general cleanliness of the PHC was good only in 5% of the PHCs. The waste disposal mechanisms in the PHCs are either burning or burial. None of the PHCs visited had the recommended waste segregation and disposal mechanisms in place.



7. Only 58% of the MOs had any kind of skill development training in the previous two years.

**In general, during the field visit of SVYM found that the PHCs are not fully equipped to address the health needs in the tribal areas.**

#### **Subcentres (SC):**

1. On an average each PHC has 11 subcenters ranging from 5 to 18 per PHC each having a population of about 4000 spread over about 7 scattered hamlets. As per NRHM, the Sub-Centres are currently provided on the population norm of 1 per 5000 population in general areas and 1 per 3000 population in tribal areas.
2. 28% of the subcentres have no vehicular access, 18% have no proper access road and 11% have no all weather access. 6% had no ANM and 65% have no male health worker. 49% of the ANMs claimed that they live in the subcentre village. Though 11% of the subcentres had designated rooms for conducting normal labor, they were not conducive for it. None of the subcentres had facilities for newborn resuscitation. Basic drugs were available in only 60% of them.

#### **Anganwadi centres (AWC):**

1. Though the percentage of utilization of the AWCs in ST is higher than the rural figures, in absolute terms only 50% of children are registered and 38% among them are weighed regularly for monitoring of their nutritional status. 48% of the mothers whose children are weighed receive some form of nutrition related counseling. Thus the benefit of growth monitoring goes only to a very small fraction of ST children.
2. The overall hygiene of the centres and the children was very poor in the centres visited. In some states there were no buildings for the centre and the worker managed by cooking in her home. None of the AWCs had a toilet. The quality of the food grains that were stocked was poor. Many of the centres had no weighing scale. In areas prone for terrorist / Maoist attacks,(Jharkhand) we were told that 1/3rd of the budget of the centre goes to the Maoist supervisor – Mapahadia people.
3. The challenges facing Anganwadi workers include too much of documentation work, people not having faith in anganwadi services, poor infrastructure at anganwadi, irregular supply of provisions to the centres, difficulty in transporting the provision to the centres as they are not paid separately for this. The present function of the Anganwadi worker (AWW) as a part time honorary worker is a hindrance to their full involvement with the program. Their salary/honorarium is poor and its disbursements are irregular. They are also given periodically certain non health related jobs. These difficulties decrease their morale and enthusiasm in the work.



4. The Anganwadi is more a feeding center and the component of preschool education of the children is often lacking.
5. The ST community (in Jharkhand, Madhya Pradesh and Maharashtra) feels that food must be provided twice a day.

#### **Community Health Centres (CHC) Or First Referral Unit (FRU):**

1. Each CHC serves a population of 1,34,250, spread over 100 villages and is a referral centre for 5 PHCs. The CHCs are currently provided on the population norm of 1 per 1,20,000 population in general areas and 1 per 80,000 population in tribal / desert areas.
2. Only 72% of the CMC buildings were maintained well and functional toilets were available only in 58% of them. Some of the crucial facilities which contribute to adequate health care during emergencies were found to be wanting. Obstetricians, Surgeons and Anaesthetists were available only in 44%, 30% and 20% of them respectively. 44% of the CHCs had facilities for Medical Termination of Pregnancy and 14% had blood storage facilities. Only around 40% of the CHCs were equipped to address the Obstetric and infant related emergencies and 22% Surgical emergencies due both to poor infrastructure and non availability of skilled human resource.
3. X-ray facilities were available in 66% and functional Ambulance facilities in 85% of the CHCs.

#### **Conclusions:**

It is revealed from the above studies that the Medical facilities provided by the Government to the Tribal area is inadequate. Government has to initiate steps to re-structure the existing system of First Referral Unit (FRU), Community Health Centres (CHC) and Primary Health Centres (PHC) as there are the first and foremost referral units for treating the patients and before referring the patients to District Hospitals or referral hospitals. Para medical staff and ASHA should visit the each and every house hold once in a fort-night or frequency of visiting may be increased to educate the Tribal people on health and health related issues.

The studies conducted by swami Vivekananda youth movement shows that the facilities available to scheduled tribe is very insufficient to meet their health requirement. Through this paper, it would be fair to disseminate the work carried out by them on Tribal people, which will enable concerned authorities to make alternate arrangements to meet the necessary medical services to them. It evident from their studies that the Scheduled Tribe people are far from the general masses with regard to medical facilities provided by Government. The status of scheduled Tribe is more or less same in everywhere, that needs to be improved by provide advanced medical equipments in primary health centers so that the modern diagnostic techniques and treatments facilities will reach and available at primary health centers itself and sufficient skilled staff may be provided to operate the modern medical equipments



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