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STATUS OF TRIBAL HEALTH IN INDIA – AN OVERVIEW



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Abstract: Over 104 million scheduled tribes (STs) live in India spread across 705 tribes and account for 8.6% of the country's population. Tribal people have remained marginal geographically, socio-economically, politically and therefore, health and healthcare in tribal areas remained unsolved problems. This paper attempted to focus on the tribal health states in India.

Keywords: Profile of Tribes, Burden of Disease, Healthcare Facilities, Administrative Response

Introduction

The Scheduled Tribe (ST) population is largely concentrated in 10 states and 8 northeast states. Nearly 90% of the tribal population lives in rural areas. The population of tribal males is 52.5 million and females are 52.0 million. The sex ratio in 2011 was 990, which is higher than the national average of 943. The child sex ratio of STs in 0-6 years age groups has declined from 972 in 2001 to 957 in 2011 census, but it is higher than the general population at 914 girls to 1000 boys.

As per the census 2001 & 2011, the literacy rate for STs in India has improved from 47.1% in 2001 to 59% in 2011. The male literacy rate has increased from 59.4 to 68.5% and the female literacy rate increased from 34.8% to 49.4% during the same period.

The life expectancy at birth for the ST population in India is 63.9 years, as against 67 years for the general population.

No recent estimates for maternal mortality among tribal women are available separately. The 68% rate of institutional delivery is much lower than the national

average of 78.9%, 71.5% of deliveries are conducted by skilled health personnel. Coverage of postnatal care remains poor. Only about 37% of tribal women reported receiving any post-natal care within 48 hours after home delivery.

As per National Family Health Survey – 4, the estimated infant mortality rate for the ST was 44.4; the 1-4 year child mortality rate was 13.4, under-five mortality rate 57.2, and the neonatal mortality rate 31.3 per 1000 live births. The time trend shows a major improvement in the mortality rates.

The immunization coverage of the tribal children remains lower than the total population as shown in table 1.

The percentage of stunting, wasting and underweight in tribal children was reduced but malnutrition is still higher than in all population children as shown in table 1.

Table 1
Comparison of Mother and Child Health Indicators in Scheduled Tribes (2015-16)

Sl.No	Indicator	Scheduled Tribe	All
1	Child Mortality Indicator per 1000		
	Infant Mortality Rate	44.4	40.7
	Neonatal mortality rate	31.3	23.2
	Post neonatal mortality rate	13.1	8.9
	Under 5 mortality rate	57.2	49.7
	Child mortality rate	13.4	6.6
2	Immunization services		
	Infants fully immunized (%)	55.8	62.0
	No vaccination	9.2	6.0
	Measles	77.4	82.8
	DPT 1	86.4	89.7
	DPT 3	73.5	80.5
	Polio 1	87.7	91.0
	Polio 3	66.3	73.9
	BCG	88.7	92.2
	Hep. B1	78.0	83.9
	Hep. B3	56.9	64.1
	Polio 0 dose	74.5	79.7
3	Nutritional Status		
	Under 5 Years children stunted	43.8	38.4
	Under 5 years children wasted	27.4	21.0
	Under 5 years children underweight	45.3	35.7
	Pregnant Women TT	79.0	85.5
4	Maternal Health		
	Institution delivery (%)	68.0	78.9
	Deliveries attended by skilled health personnel (%)	71.5	81.4
	Total fertility rate	2.48	1.93
	Couple using any contraceptive (%)	49.4	57.5

Source: Annual Report 2017-2018, Ministry of Health and Family Welfare, Government of India, New Delhi, 2018. & National Family Health Survey 4, Report, Ministry of Health and Family Welfare, Government of India, New Delhi, 2017.

The burden of Disease in Scheduled Tribes

Epidemiological transition is taking place in tribal areas also, as in the rest of the country. The health care needs of the tribal people are much more than Reproductive, Maternal, Newborn, Child Health and Adolescent (RMNCH+A). The ST population in the country faces a triple burden of diseases. While malnutrition and communicable diseases like malaria and tuberculosis (TB) continue to be rampant, rapid urbanization, environmental distress and changing lifestyles have resulted in a rise in the prevalence of non-communicable diseases like cancer, hypertension, diabetes, mental illnesses and addictions.

Communicable Diseases

The ST population bears a disproportionate burden of communicable diseases (CDs). These include TB, Malaria, Leprosy, Sexually transmitted diseases (STDs), AIDS/HIV, Skin infections, Diarrhoeal diseases and Hepatitis etc.

Tuberculosis: The estimated prevalence of pulmonary TB in STs is significantly higher than the total population, i.e., 703 against 256 per 100000 population. Revised National Tuberculosis Control Programme (RNTCP) provides free diagnosis and treatment to all the patients. The program has been initiated to improve the case detection rate in hard-to-reach areas. Around 40000 tribal patients have been diagnosed and treated under RNTCP since 2015. To improve access to tribal and other marginalized groups, there is provision for:

1. Additional TB Units and Designated Microscopy Centres (DMC) in tribal/difficult areas
2. Compensation for transportation of patient and attendant in tribal areas
3. Higher rate of salary to contractual staff posted in tribal areas
4. Enhanced vehicle maintenance and travel allowance in tribal area, and
5. Provision of TB Health Visitors (TBHVs) for urban areas

The program would intensify its case finding activities through systematic active TB screening among clinically and socially vulnerable populations in campaign mode. Here the tribal districts of the state are mapped among vulnerable populations and door to door-case finding efforts are carried out. Phase 1 of the campaign was executed in January 2017 and 2nd Phase was implemented in July-August 2017. During this campaign, the program screened more than 72000 targets tribal population across the country and diagnosed 27 additional TB cases. The most significant aspect of the project is the development of the Mobile TB Diagnostic Van (MTDV) equipped with X-ray facilities and Sputum Microscopy facilities which offer diagnostic services for TB at the doorstep of the patient's home in difficult to reach areas of the STs. This project has been initially undertaken in 5 State viz., Madhya Pradesh, Gujarat, Chhattisgarh, Rajasthan and Jharkhand and in 17 districts. Nearly 35 MTDVs have been fabricated

for this purpose. The project covers a total population of approximately 17.65 million. This intervention is expected to improve the Standard of Care among the extremely deprived populations. The efforts are expected to improve early seeking of care, reduction in out-of-pocket expenditure of individual patients and curbing of individual patients being directed to multiple providers for treatment which results in a huge economic burden to patients and their families.

Leprosy: Under the National Leprosy Eradication Programme, state-wise disaggregated data of the ST population is collected every month. During the year 2016-17, out of 135485 new leprosy cases detected, 25474 (18.90%) were STs and 25449 (18.78%) were scheduled castes. Leprosy services are uniformly available to all including SCs and STs population irrespective of caste and religion. Under the program, funds are allotted to NGOs, to work in tribal areas for providing services like IEC, prevention of deformity and follow-up of cases. Intensified IEC activities have been taken up through various media including the rural media under which the population residing in remote, inaccessible and tribal areas is being covered.

Malaria and other Vector-Borne Diseases: Although STs constitute only about 8% of the total population, they account for about 30% of all cases of Malaria, more than 60% of *P. falciparum*, and as much as 50% of the mortality associated with Malaria. Under National Vector Borne Disease Control Programme, services for prevention and control of Malaria, Kala-azar, Filariasis, Japanese Encephalitis, Dengue/Dengue Haemorrhagic Fever (DHF) and Chikungunya are provided to all section of the population without any discrimination. However, since Vector-Borne Diseases are more prevalent in low socio-economic groups, focused attention is given to areas dominated by the tribal population in the Northern Eastern States and parts of Andhra Pradesh, Chhattisgarh, Gujarat, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra and Odisha. Additional inputs under externally assisted projects from Global Fund to North Eastern states and from World Bank to other states, especially for control of Malaria are provided. For Kala-azar elimination in the states of Bihar, Jharkhand and West Bengal, World Bank support is also being provided. In addition, Northeastern states are being provided 100% central assistance for the implementation of the program.

Non-Communicable Diseases

The evidence of an early epidemiologic transition in tribal areas and the associated increase in the incidence of non-communicable diseases (NCD) is being observed

Hypertension: One in every four ST adults suffers from hypertension. Further, the prevalence of hypertension increased significantly with age, consumption of tobacco, alcohol and a sedentary lifestyle. Yet two out of three ST adult men and women did not know the signs and symptoms of the ailment. Only 5% of men and 9% of women suffering from hypertension knew their hypertensive status.

Blindness and Visual Impairment: The National Programme for Control of Blindness and Visual Impairment (NPCB&VI) is a centrally sponsored scheme (60:40

in all states and 90:10 in North-East states) to reduce the prevalence of blindness to 0.3% by 2020. The benefits of the scheme are meant for all including the SC&ST population as per the need. The following initiatives have been implemented under NPCB&VI, keeping in view the needs of North-East states including Sikkim, which are tribal predominant.

1. Assistance for construction of dedicated eye units in the North-Eastern States including Sikkim and other hilly states.
2. Appointment of contractual ophthalmic manpower (ophthalmic surgeons, ophthalmic assistants and eye donation counselors) to meet the shortage of ophthalmic manpower in states.
3. Assistance for setting up of multipurpose district mobile ophthalmic units for diagnosis and medical management of eye diseases for coverage in a difficult area.
4. Besides cataract, assistance for treatment and management of other eye diseases viz., diabetic retinopathy, glaucoma, refractive errors corneal transplantation, vitreoretinal surgery and childhood blindness, is provided.

Genetic Disorders

The prevalence of sickle cell disease (anemia and trait together) and thalassemia-another genetic disorder – varies between 1-40% in different STs. However, most of the prevalence is due to the heterozygous form of the disease. Sickle cell anemia, the more serious form, is prevalent in 1 in 86 births among STs in central India. Another genetic disease prevalent in many tribal groups in India is G6PD deficiency. Among the 14 Primitive Tribes from four different states showing a high frequency of sickle gene, the prevalence of G6PD deficiency varied from 0.7 to 15.6%.

Mental Health and Addictions

Almost 72% of the ST men in 15-54 years are group use tobacco as compared to 56% non-tribal men and about 50% tribal men consume some form of alcohol. Tobacco and alcohol, both are risk factors for NCDs and cause serious diseases, and increases mortality. They reduce productivity and increase poverty, disrupt family harmony and generate law and order problems.

Animal Attacks and Violence in Conflict Area

As tribal areas are often surrounded by forests, animal bites from snakes, dogs and scorpions are common.

Health Care Infrastructure and Tribal Development: Tribal Development has been a challenge to the government since independence. This is mainly on account of their traditional lifestyles, remoteness of habitation, dispersed population and displacement. Tribal Sub Plan (TSP) strategy now known as Scheduled Tribal Component (STC), was adopted in the 5th Five Year Plan for accelerated development of STs. Ministry of Tribal Affairs (MoTA) and Ministry of Health and Family Welfare

(MoHFW) are making efforts through tailored educational, infrastructural and livelihood schemes for the improvement in terms of various indicators relating to literacy, health and socio-economic status etc. however, there is still a significant gap in human development indicators between STs and other communities.

Health Care Facilities under National Health Mission

Health Care Infrastructure: As per the present norms, tribal and hilly areas should have one sub-center (SC) per 3000 population, one Primary Health Center (PHC) per 20000 population, and Community Health Centre (CHC) per 80000 population. In-country, there are 18 states which consist of the highly ST population, among them 7 states show no shortfall in the number of SCs against the required number was observed. In the remaining 11 states, a shortfall of 4996 SCs i.e., 27% of the required numbers in these states was noted. Refer to PHCs; no shortfall existed in 11 states and the remaining seven states a shortfall was noted of 1023 PHCs which was 40% of the required number in these states. Regarding CHCs, in 8 states, there was no shortfall, and in the remaining 10 states, a shortfall of 209 was observed. The shortfall accounted for 31ST of the required number of CHCs in these states. While in Union Territories an 8% shortfall in SCs and of 1 CHC (against the requirement of 1) was reported from Dadra and Nagar Haveli. No other shortfall was found at any level. Thus in about half of the states, the health institutions in tribal areas were deficient in number by 27 to 40% as compared to the present norms.

Health Human Resource: A huge gap in Health Human Resources (HRH) in health centers in tribal areas is attributed to reasons such as limited scope for professional interaction or growth for the staff, a feeling of social and professional isolation, weak human resource policies, poor working conditions and environment in the government health institutions, limited social infrastructure, etc. Various states have tried different measures to overcome this shortage of doctors, but the problem persists. Several states have introduced a bond for compulsory rural service, but it is flouted by most of the doctors completing MBBS. The medical education and the health department seem unwilling or unable to enforce the execution of the bond. The MoHFW and MoTA, in October 2013 jointly constituted an Expert Committee on Tribal Health, under the chairmanship of Abhay Bang. The committee suggests the following measures to improve human resources for ST's health.

1. Feature of ST demand that the health care provider, as far as possible, should be local tribal. The present health workforce pattern is the opposite of this.
2. The only way of affecting a vibrant, responsive and accessible health workforce in the tribal areas in a sustained manner, is by ensuring that local ST people are trained and deployed in the health force.
3. It is important to place the center of gravity of the workforce not at the top, the specialist and doctors, but closer to the STs.

4. The Accredited Social Health Activist (ASHA) in tribal areas should have an expanded role. There are eight types of functions and a total of 4 hours of work per day is expected from tribal ASHAs.
5. Mid-level care providers should be created through bridge courses and placed at the SCs
6. To attract doctors to work in tribal areas, the total salary of Medical Officers needs to substantially increase.
7. To provide doctors dedicated to working in tribal areas, the committee recommended the creation of dedicated medical colleges in tribal districts, exclusively for ST students in the Scheduled Area.

Way Forward

The following steps are urgently needed to address the prevailing health situation of the STs:

First, the governments both at the Centre and States must recognize improvement in the health status of the ST as among the topmost priorities from a policy point of view and ensure adequate budget allocations made including under the National Tribal Plan. The Government of India should implement the recommendations of the Expert Committee on Tribal Health. Besides augmenting resource allocation, the common practice in the governments of diverting the scant resources meant for tribal development for other purposes, as indicated also by the CAG report must be stopped.

Second, the government at the Centre should consider establishing the National Institute for Tribal Health with field stations at different locations in tribal areas. By coordinating and networking with all existing institutions working on tribal health, this institute could facilitate information exchange and assist in conducting action research and in policy dialogue. Within the MoTW, a health section/department should be established to coordinate with other agencies.

Third, a tribal health policy and a joint coordinated action plan need to be framed and its speedy implementation is to be ensured. Special attention is to be paid to the tribal populations while planning and implementing national programs. The poor health infrastructure exemplified by the absence of doctors or specialists in the health facilities must be tackled on an emergency basis. The governments must make use of information technology such as telemedicine and mobile technology to improve efficiency and quality of health services by linking the district hospital staff with a specialist or a consultant based in a medical college or higher-level facility for expert advice and guidance in the management of difficult cases or critical care.

Fourth, prioritize and fast track on a priority basis collection and analysis of data about health situation and underlying factors. At present, the national data are scant thereby providing a fragmented picture of tribal health and obscuring tremendous

diversity among tribal groups scattered across the country. Disaggregated data by specific tribal groups and assessing the social, cultural and economic determinants of health is, therefore, urgently needed. Such research data will have a crucial role in designing and initiating evidence-based health policies, strategies and public health action suited to their unique social, cultural and geographic environments.

Fifth, it is also important to have experts belonging to STs in policy-making bodies including those dealing with health. The problem of non-representation has been highlighted by the special committee on tribal issues constituted by the Government of India, stating that one of the key reasons for poor health service in tribal areas, is 'near-complete absence of participation of people from the ST or their representatives in shaping policies, making plans, or implementing services in the health sector. Finally, it is imperative to focus on enhancing the overall development of tribes to try and bridge the prevailing inequalities and disparities in the country.

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