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# Tribal Health Status and Challenges in India

**Date: January 09, 2021**

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Dr. Vinay Tripathi has received his academic training in the discipline of Anthropology and obtained Masters, M.Phil. and Ph.D from University of Hyderabad. Before joining IHMR-Delhi, he was working with IHMR-Bangalore and was involved in teaching courses on Demography, Research Methodology, Health Survey and MIS in Healthcare. With more than five years of rich experience in the field of research and development, he has coordinated and evaluated different projects related to health, water and sanitation, education and rural development domain. With sound understanding of both qualitative and quantitative research methods, he has been instrumental in developing various research grants and proposals. He has presented papers in national conferences and published paper in a book of international repute.

# Tribal Health Status and Challenges in India

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## Outline of presentation

- An overview of the tribal
- Tribal health
- Tribal health status
- Challenges

- Tribe vs. Scheduled Tribe
- Tribe has a socio-cultural connotation
- Scheduled tribe has a administrative and political connotation
- Social group with territorial boundary, distinctive dialect, strong kinship bonds, egalitarian and **cultural homogeneity**.
- Schedule tribes - tribes or tribal communities or parts of or groups within tribal communities which President of India may specify by public notification (under Article 342 of the Constitution)

- Example:

  Banjaras, a tribal group, are considered as Scheduled Tribe in Andhra Pradesh, Odisha and Bihar. However, in Karnataka, Delhi and Rajasthan they are considered as Scheduled Caste. In UP, they are considered under OBC category and interestingly in Maharashtra and Tamil Nadu as a de-notified tribe.

- **De-notified**, nomadic, semi-nomadic tribes, and **PVTGs**
- About 150-200 tribes were branded as Criminal Tribes under the Criminal Tribes Act (1871, 1911). These tribes were viewed as hereditary criminals [Nats, Khanjars, Banjaras, etc.].
- Act was removed in 1952 and these 'Criminal Tribes' since than are called as 'De-notified Tribes' instead.

- Example:

  Kaikadis, a de-notified tribes, considered as STs in Maharashtra except for Vidharba region (where they are considered as SCs).

- **PVTGs** - a group among the tribals who are considered as most vulnerable [Sentinelese and Jarawas from Andaman Islands; Bondos from Odisha; Cholanaickans from Kerala; Abujh Marias from Chhattisgarh and Birhors from Jharkhand]
- Exmple: Paudi Bhuiyan, a PVTGs of Odisha, are still not listed under Scheduled Tribes
- 75 PVTGs in India (Census, 2001)
- Extremely declining population

# PVTGs with less than 1000 populations

| | |
|---|---|
| Birjia (Bihar) | 17 |
| Sentinelese | 39 |
| Great Andamanese | 43 |
| Birhor (Madhya Pradesh) | 143 |
| Asur (Bihar) | 181 |
| Mankidias (Odisha) | 205 |
| Jarawa | 240 |
| Cholanaicken (**Kerala**) | 326 |
| Shompen | 398 |
| Birhor (Bihar) | 406 |
| Savar (Bihar) | 420 |
| Raji (Uttarakhand) | 517 |
| Sauria Paharia (Bihar) | 585 |
| Birhor (Odisha) | 702 |
| Korwa (Bihar) | 703 |
| Todas (**Tamil Nadu**) | 875 |
| Kota (**Tamil Nadu**) | 925 |
| Raji (**Uttar Pradesh**) | 998 |

So when we say tribal health are we referring to tribal groups with socio-cultural ascription or tribal groups with administrative or political ascription?

**Scheduled Tribes**

- 705 groups which are listed as STs constitutes 8.6 percent of the total population - about 10.5crores (census 2011)
- The population size of these groups varies from lakhs to three digit numbers
- Populous tribes like Gonds, Bhils, Santhals, Oraons, Minas, Mundas, etc. ranges from 10 lakhs to 70 lakhs, while PVTGs are in three digits numbers
- Northeast states and central-east Indian region, consisting of Andhra Pradesh, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Odisha and West Bengal, has the largest proportion of STs (around 68 percent of the schedule tribes.

## Tribal Health

- Cultural context of health and well-being – becomes very important aspect – when we talk about tribal health
- Every culture has its native concepts or perceptions of health, the explanation of diseases or illness and the subsequent ways of curing them, which in turn guides the health and treatment seeking behaviour and practices
- Example from Konda Reddis (first hand experience)
- In tribal culture explanation of diseases or illness are either naturalistic and personalistic in nature
- A particular health behaviour considered awkward in a particular culture can be regarded as a completely normal in another culture
- Example from Baiga (first hand experience)

- Cultural construct of being healthy

  Example from Garos of being healthy (first hand experience)

- Culture and Food

  Example from Konda Reddis : consumption of 'tadi' (first hand experience)

- Plurality in treatment and health seeking behaviour

- Current ongoing ICMR study

(Healthcare seeking behavior for Malaria – An ethnographic study of health service seekers and healthcare providers in a tribal dominated district of Chhattisgarh)

## Health status of Tribal

- Disaggregated data on the health status of and health care to tribal population are not easily available

*"There is a near complete absence of data on the health situation of different tribal communities. In the absence of a comprehensive picture of tribal health in the country, policy measures and government programs are often ad-hoc"*

*Expert Committee on Tribal Health*

- Sex ratio - 990 females per 1000 males (country average of 933)
- IMR among tribals have been showing a declining trend ( 91/1000 live births in 1988 to 44/1000 live birth in 2014) others = 32
- Similarly, U5MR also declining (from 135/1000 live births in 1988 to 57 in 2014) Others = 39

- Following seven states where IMR and U5MR was highest among STs (NFHS 3)

| States | IMR (among STs) | U5MR (among STs) |
|---|---|---|
| Jharkhand | 93.0 | 138.5 |
| Odisha | 78.7 | 136.3 |
| Chhattisgarh | 90.6 | 128.5 |
| Madhya Pradesh | 95.6 | 140.7 |
| Gujarat | 86.0 | 115.8 |
| Rajasthan | 73.2 | 113.8 |
| AP | 94.1 | 112.0 |

- A child born to a ST family in India has 19% higher risk of dying in the neonatal period and 45% greater risk of dying in the post-neonatal period compared with other social classes (Anderson et. al., 2016)

- About 40% of under five tribal children are stunted, and 16% of them are severely stunted (against 9% among non-tribal children) reflecting on chronic undernutrition (Comprehensive National Nutrition Survey 2016-18)

- Tribal children (aged 6-59 months) are more anaemic in comparison to children from other category (77% vs 64%, NFHS 4]

- Tribal women (15-49 years) are more anaemic in comparison to women from other category (65% vs. 47%, NFHS 3]

- The burden of communicable diseases like malaria, TB, leprosy, etc. is comparatively higher among tribals
- Districts with 30% or more tribal population accounted for 70% of total Pf malaria cases and 47% total malarial deaths in the country between 2008-2012 (Sharma, et. al., 2015)
- Prevalence of tuberculosis (TB) is significantly higher among tribal populations (703 per lakh compared to the national average of 256 per 100,000) [Thomas, et. al., 2015]

- Rise in NCDs - one out of every four tribal adults suffer from hypertension (Tribal Health Report, 2017)
- High consumption of alcohol and tobacco (72% of tribal men in age group of 15-54 years use tobacco against 56% of non-tribal men)
- Hereditary diseases like sickle cell anemia (which is more prevalent in central India (one out of 86 births among tribal carry sickle cell trait)
- Animal attacks and violence in conflict areas

To summarize, the tribal population in the country suffers from

- diseases of underdevelopment (malnutrition, communicable diseases, maternal and child health problems)
- diseases, particularly common among tribal population (Sickle cell disease, animal bites, accidents)
- diseases of modernity (hypertension, high consumption of alcohol and tobacco, stress)

**Healthcare seeking, health infrastructure and human resources**

- Heavy reliance on public health facilities for outpatient care as well as inpatient care (Tribal Health Report, 2017). Also, reliance on traditional healer (mainly in central and eastern regions).
- Huge gap in health infrastructure and human resources
- Against the norms, the deficiency in terms of availability of healthcare facilities (mainly SCs, PHCs, and CHCs) are in the range of 27 to 40 percent (THR, 2017)
- High vacant positions of doctors and specialists in tribal regions and shortage of nursing staff

## Challenges

- Addressing the pluralistic healthcare seeking behaviour as well as health practices of tribal people
- Addressing the shortfalls in terms of healthcare infrastructure and human resources
- Addressing the need of having disaggregated data at sub-district, district and national level
- Addressing the need of inculcating knowledge about 'cultural dimensions of health and well-being' across the health system when dealing with tribal health

# THANK YOU