



## HEALTH STATUS OF TRIBAL COMMUNITIES IN TELANGANA STATE – A STUDY ON ITDA BADRACHALAM

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### ABSTRACT :

*About a half of the autochthonous people of the world with about 635 tribal groups and subgroups including 75 primitive tribes live in India. The newly state of Telangana occupies a unique position in the tribal map of India having 62 scheduled tribes including 4 primitive tribes with a population of over 9.15 million constituting 28.3% of the population of the state as per 2011 Census. There is a paucity of comprehensive health research among the tribal populations of India. Most of the studies are isolated and fragmentary in nature. There is an urgent need for initiating the area specific, tribe specific, action oriented health research in consonance with the felt needs of the tribal communities. Tribal communities in general and primitive tribal groups in particular are highly disease prone. Tribes are relatively isolated and autonomous groups. The existence of own cultural and medical system is one of the important features of a tribal society. The tribal social structure has its own structural and ethnic specificity and the diseases that inflict upon the tribal people are likewise specific to the attribute of their social structure. Also they do not have required access to basic health facilities. They are most exploited, neglected, and highly vulnerable to diseases with high degree of malnutrition, morbidity and mortality. The research should be mission oriented, having practical applications and directed towards improving the quality of life of tribal people. The health scenario of tribes of Telangana presents a kaleidoscopic mosaic of various communicable and non communicable diseases in consonance with socio-economic developments in the state. The wide spread poverty, illiteracy, malnutrition, absence of safe drinking water and sanitary conditions, poor maternal and child health services, ineffective coverage of national health and nutritional services, etc. are the major contributing factors for dismal health in tribal communities of Telangana State.*

**KEYWORDS :** Health Status, Health Care, Tribal Communities.

### INTRODUCTION

The Indian State must aim to ensure that all sections of society share in the economic and social prosperity of the country. It is widely acknowledged that a large section of the Indian population, especially the tribal communities, have not received the full benefits of development processes undertaken over the past six decades. Indeed, it is recognised that the tribal population has been adversely affected by the



developmental projects undertaken during this period. It is imperative that the causes, circumstances and consequences of this situation are studied and analysed in detail in order to design appropriate interventional measures to remedy the current state of affairs and uphold the progressive principles enshrined in the Constitution of India.

The tribal population in India, though a numerically small minority, represents an enormous diversity of groups. They vary among themselves in respect of language and linguistic traits, ecological settings in which they live, physical features, size of the population, the extent of acculturation, dominant modes of making a livelihood, level of development and social stratification. They are also spread over the length and breadth of the country though their geographical distribution is far from uniform. A majority of the Scheduled Tribe population is concentrated in the eastern, central and western belt covering the nine States of Odisha, Madhya Pradesh, Chhattisgarh, Jharkhand, Maharashtra, Gujarat, Rajasthan, Andhra Pradesh, Telangana and West Bengal. About 12 per cent inhabit the Northeastern region, about five per cent in the Southern region and about three per cent in the Northern States. Groups and communities identified and enumerated as tribes during British rule came to be re-classified as Scheduled Tribes after the Constitution was adopted in 1950. The Constitution, as per Article 342, provided for the listing of these groups in the Schedule so that certain administrative and political concessions could be extended to them. Thus, a distinction was drawn in the form of tribe as a social and cultural entity and tribe as a politico-administrative category. However, there were groups and communities who belonged linguistically, socially and culturally to the same community but found themselves listed in some States of the Indian Union but not in other, often neighbouring, States. Similarly within the State, the same community may have found itself listed in some regions but not in others.

Health and well-being is a matter of concern to all strata of the society. It is a tall order to envision society which is free from the perennial struggle against diseases. There have been a number of attempts to define public health. The best known definition of public or community health is that of Winslow who in 1920 described it as the science and the art of preventing disease, prolonging life, and promoting health and efficiency through organized community efforts, the development in the social machinery which will ensure to every individual a standard of living adequate for the maintenance of health. Health care delivery system for Scheduled Areas must keep as its guiding principle the Chinese axiom – How far can a mother walk on foot with a sick baby? Health care must be available within that distance. This, for the tribal communities living in forests, means health care must be available in their village/hamlet. Sixty years of failure should teach us that health care from outside is not a feasible solution. The design of health care in Scheduled Areas should be such that major share of health promotion and prevention and a sizable proportion of curative care is generated and provided within the village or hamlet.

#### **CONSTITUTIONAL SAFE GUARD FOR TRIBAL'S**

- Article 46 of the constitution, The state shall promote, with special care the educational and economic interest of the weaker sections of the people, and in particular of ST and SC, and shall protect them from social injustices and all forms of exploitation”.
- Article 15 prohibits discrimination on grounds of religion, race, sex and place of birth. free access to temple, hotels, schools and public places.
- Article 16 provide equal opportunities for employment and appointment in public sector and Government service.
- Article 16(4) provides reservation for jobs 7% for ST.
- Article 17 provides untouchability abolition

#### **Health System Reforms at primary health care level during Ninth Plan**

Faced with the problems of sub-optimal functioning and difficulties in providing adequate investments for improving health care facilities in the public sector, almost all state governments have initiated health system reforms with public sector institutions playing lead role. The structural reforms relate to reorganization and restructuring of all the elements of health care so that they function as integral components of the health system. The functional reforms are aimed at improving efficiency by creating a health system with well-defined hierarchy and functional referral linkages; the health personnel would work as a multi-professional team and perform duties according to their position, skills and level of care. The

community-based link worker who acts as a liaison between people and health care functionaries and ensures optimal utilization of available facilities should provide the last link. The PRIs should participate in planning programmes and assist in implementation and monitoring. Almost all the states have attempted introduction of user charges for diagnostic and therapeutic procedures in government hospitals from people above the poverty line and use the funds so generated to improve the quality of care in the respective institutions.

### REASONS FOR POOR HEALTH

Research has shown that 75 per cent of India's tribal population defecates in the open and 33 per cent does not have access to a clean source of drinking water. Insanitary conditions, ignorance, lack of health education and poor access to healthcare facilities are the main factors responsible for the poor health of tribals. Further, displacement from their traditional forest homes and natural source of food and lack of livelihoods makes them dependent on the public distribution system (PDS) and other government handouts for survival. Most tribal groups are traditionally hunter-gatherers and not accustomed to agriculture — their diets, therefore, are now severely limited in fruits and vegetables as well as good sources of protein (including fish and meat). Polished rice and cereals available through the PDS have replaced diverse dietary food baskets.

Although the government has provided for the establishment of Primary Health Centres (PHCs) in tribal areas for every 20,000 population and sub-centres for every 3,000 population, quality healthcare is not available to the majority of tribals. Posts of doctors and paramedicals are often vacant. Additionally, the non-availability of essential drugs and equipment, inadequate infrastructure, difficult terrain and constraints of distance and time (one Auxiliary Nurse Midwife is responsible for 15-20 scattered villages), and the lack of transport and communication facilities further hinder healthcare delivery. The geographical and infrastructural challenges to public health and the lack of health-related knowledge among tribals are exploited by quacks (unqualified medical practitioners), who are often available at the doorstep. Though some traditional practices and superstitions persist, acceptance of modern medicine has increased in recent years, but access to good care is the major issue. Levels of illiteracy are high, with 47 per cent in rural areas and 21.8 per cent in urban areas being unable to read and write. Better educated tribal communities will be better aware of their healthcare needs (and rights) as well as of better care-seeking practices.

### Marked lack of Health and Medical Services-

High degree of inbreeding and therefore high prevalence of genetically inherited diseases. Most of the tribes have high prevalence of goitre, among women of child bearing age groups, habitation in hilly area and lack of access to sea foods. Most of tribes studied by anthropologist and voluntary organisation appears to have a few common practices regarding maternal and child care; Expectant mothers are expected to restrict their diet and quantity as there is a common fear that if the baby is too large, delivery would be difficult and might lead to death of the mother. Among most of the tribes, gastrointestinal disorders, particularly dysentery and parasitic infection are very common leading to morbidity and malnutrition, diarrhoea, dysentery, skin diseases respiratory diseases.

Nutritional problems are also a big issue in these tribe areas, vitamins A,C,B complex deficiencies, under-nutrition of mothers along with anaemia due to food taboos, protein energy under-nutrition and few cases of vitamin deficiencies in children due to general lack of awareness of child care and infant feeding practices. Though successive Five Year Plans have provided for the needs of tribal populations within different schemes, and a large amount of funds are allocated, little improvement has been noted on the ground. The poor health of tribal populations cannot be overcome by mere establishment of more PHCs and sub-centres. Scarcity of trained manpower for health is a major problem and an obstacle to the extension of health services to rural and tribal areas. Traditional healers, who are often the first point of care, can be sensitised and trained to deliver simple interventions like ORS for diarrhoea and anti-malarials as well as to refer patients to the PHC in a timely manner. Tribal boys and girls (who complete school but often have no

further opportunities) could be trained as community health workers or nurses and incentivised to stay and work in their own communities. Nutritional counselling and education, establishment of kitchen gardens and provision of a more diverse range of food items through the PDS would help in curtailing macro and micronutrient deficiencies. More research needs to be done on the traditional herbal medicines used by tribal people and their use encouraged, wherever beneficial.

### Health Status of Telangana State

The tribals are classified as a PTG (Primitive Tribal Group) and are one of the most backward tribal groups in the State inhabiting both banks of the Godavari river in the hilly and forest tracts of Badradri Kothagudem district. They live in the interior forest areas and are largely cut off from the mainstream. They were traditionally shifting cultivators and a few continue to practice this but in recent times they have gradually adopted settled agriculture and horticulture. The tribals who inhabit the fringe areas of the plains have become settled cultivators but those living in the vicinity of the hill areas are still resorting to shifting cultivation. Forest labour, collection of MFP and basket making are subsidiary sources of livelihood. Tribals constitute just 1.7% of the total tribal population of Telangana. They live in a very primitive stage of development in the hunter, food gatherer stage of human civilization. Telugu is their mother tongue. They speak chaste Telugu with an accent of their own. They are educationally very backward with only 2% of them are literate. Normally, their bodily constitution will be of little stout body, short legs, copper or chocolate colour. This group belongs to very primitive ADIVASI, the face will be just like a heart.

### Deterioration of health

Almost all the R&R colonies lack proper public health facilities, protected drinking water, marketing and transportation. Due to unhygienic conditions, health is a major problem of displaced tribal people, who are affected by various diseases such as malaria, typhoid, viral fevers, diarrhoea, cholera, skin diseases and jaundice. In mining projects, resettlement sites are situated close to mining operations, which result in respiratory diseases. Ill-health causes them to spend most of their earnings towards allopathic medical treatment, due to non-availability of herbal medicines.

### OBJECTIVES OF THE STUDY

1. To understand the availability of health care facilities and the awareness about health services in the study area;
2. To study the factors affecting health of tribals in the study area;
3. To find out the awareness of tribals regarding health problems and health care aspects; and
4. To suggest policy measures for effective and efficient administrative health problems and health awareness programme and living conditions among tribal communities.

### METHODOLOGY

The present study based on primary and secondary data. The study selected 50 Sample households from badrachalam ITDA by employing purposive random sampling. The data was collected with the help of a well structured schedule. Secondary data was collected from Research publications, Government periodicals, mandal office, village records, and office of Chief Planning Officer, Warangal and Khammam old districts. The information pertaining to various activities of Integrated Tribal Development Agency (ITDA) based on Annual action plan for the year 2014-15 were collected from the office of ITDA at Badrachalam.

### TRIBAL HEALTH

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. The health, nutrition and medico-genetic problems of diverse tribal groups have been found to be unique and present a formidable

challenge for which appropriate solutions have to be found out by planning and evolving relevant research studies. Primitive tribal groups of India have special health problems and genetic abnormalities like sickle cell anemia, G-6-PD red cell enzyme deficiency and' sexually transmitted diseases. Insanitary conditions, ignorance, lack of personal hygiene and health education are the main factors responsible for their ill health. The first principle of any policy or program for tribal people is participation. Tribal people as a population segment are not politically very vocal. However, they have different geographical, social, economic and cultural environments, different kind of health cultures and health care needs. Hence their views and priorities must get due place in any health care program, meant for them.

### AREA HOSPITAL BADRACHALAM

An Area Hospital in Bhadrachalam is set up to improve the quality of health services. The Area hospital in Bhadrachalam serves the people from interior villages of tribal area, where the medical facilities are not available either in Government or Private Sector.

The hospital caters to the requirement of people from other states as well. The hospital treats around 300 -400 per day as outpatients and around 300 pregnant deliveries are performed per month.

In Badrachalam Agency Area, there are 33 PHCs and 195 sub centers institutionalized to deal with the health issues. Seasonal analysis of health shows that T.B., Viral Hepatitis, Acute Respiratory infections and Typhoid are being endemic. Health services are operational under the primary health care system. In tribal area, the health services are executed by the Additional District Medical & Health Officer and malaria by District Malaria Officer and monitored by ITDA. The PHCs are functioning at Mandal level and health service is rendered grossly operational at village level through MPHA (M) & (F). Health service is rendered in the face of in - adequate staff and geographic spread of agency necessitated development of a comprehensive, systematized and collaborative health intervention to reduce the seasonal morbidity and mortality in coordination with all departments working under the umbrella of ITDA. The health services offered, impact created and people's opinion/satisfaction is discussed in the subsequent paragraphs.

### National Vector Borne Disease Control Programme (Nvbdcpc) / ABOUT THE PROGRAMME

NVBDCP is a central nodal agency for prevention and control of vector borne diseases such as Malaria, Dengue, Lymphatic Filariasis, Kala-azar, Japanese Encephalitis and Chikungunya.

Under the scheme awareness generation camps are organised to prevent the diseases. In ITDA, Bhadrachalam office of the Additional District Medical and Health Officer spearheads the efforts under the scheme.

**Table 1.1 Distribution of Sample Respondents By The Family Size**

Family Size	Number of House holds	Percentage of Households
2-4	21	42%
4-6	20	40%
6-8	6	12%
Above 8	3	6%
Total	50	100%

Source: Primary Data

The table 1.1 shows that 42 percentages of the sample respondents have a small family size with two or three children. 40 percentages have family size up to six. Only 6 percentages of Badrachalam Agency Area have big family size. It is observed that most of the respondents don't have knowledge regarding the family planning measures.

### Health (Common Diseases)

Health is an important determinant of community's living status. Health determines the mortality rate of different groups. Generally the tribals are not much concerned about their health in the initial stages of diseases. They seek medical treatment only in the last stages. . Health among the sample respondents are analyzed by considering 3 variables: diseases, depending institutions, and vaccination. The common diseases among the tribes are fever, cold and infectious diseases. Apart from these a minor percentage is affected by some other diseases. The following table shows other diseases generally affecting the tribes.

**Table 1.2 Distribution of the Sample Respondents on the basis of common diseases**

Family Size	Number of House holds	Percentage of Households
Asthama	5	10%
Allergic	15	30%
Cancer	10	20%
Tuberculosis	5	10%
Skin Diseases	15	30%
Total	50	100%

**Source: Primary Data**

From the table it is clear that only a few percentages of the sample respondents are affected by the diseases like asthma, allergic, cancer and tuberculosis. This is mainly due to their life style. The active intervention of the Primary Health Care centers among the tribes is also help in controlling these kinds of diseases. Among the sample respondents there are only 10 Cancer patients. Skin diseases are common among the tribes. 20% of the sample respondents are suffering from skin diseases.

### Early Detection and Prompt Treatment (EDPT):

The G.O.s, The Self Help Groups, Village Organizations of IKP and all Voluntary Organizations working in the agency area are joining hand to extend assistance to Health Department to respond quickly to the referral cases. As per the mandates of the Mandal Mahila Samakhya (MMS) who is acting as the platform to the respective mandals on the schedule day of MMS meeting, all departments are to participate and solve the issues of the community. Each department is getting a time slot for addressing the issues raised by SHGs. The current arrangement has enabled the health department to know the problem and provide quick response to the needy and most vulnerable and marginalized and in the community.

**Tribal Health Assembly:** From the Gram Sabhas at village level, up to the national level, Tribal Health Assemblies should be annually organized in which the people (at the level of village) or their representatives (at the higher levels) participate.

### TRIBAL HEALTH COUNCILS:

These should be constituted by including elected representatives, NGOs, experts and government officers for the purpose of planning and monitoring of programs. Such councils should be constituted at the block or ITDA level, district, state and national level. These should be empowered to shape the health plans and monitor implementation. These sub-committees of Panchayat level, district level and Zilla Parishad could function as Tribal Health Councils.

### SOCIAL DETERMINANTS OF HEALTH –

literacy, income, water, sanitation, fuel, food security and dietary diversity, gender sensitivity, transport and connectivity – play very important role in determining the health outcomes. Hence, intersectoral coordination for improvement in other sectors is as important, if not more, as health care

Traditional healers and Dais play an important role in the indigenous health care. Instead of alienating or rejecting them, a sensitive way of including them or getting their cooperation in health care, must be explored. Traditional herbal medicines should be protected through community ownership. The ownership and intellectual property rights of tribal community over their own herbal medicines and practices should be ensured.

### **Transparency and stakeholder participation**

One of the reasons for tribals not accessing the health facilities even if it was within reach was because of myths and misconception. Therefore one of the first steps the TNHSP undertook to develop the tribal health initiatives after analysing the gaps in access / non availability of health care services was to consult with several stakeholders in the tribal districts. The consultative meetings were conducted with the district level health administrators, representatives from the National Rural Health Mission, Department of Health and Family Welfare, tribal welfare department, district administration, NGOs working with the tribal population, and tribal leaders from all the tribal districts. This enabled the development of an action framework by all the departments concerned.

### **Bed grants in tribal areas through PPP initiative:**

Though the public health care facilities in the tribal areas have adequate infrastructure and manpower, the utilization in term of bed occupancy and OP utilization is very low. The tribal population is attracted by the services that are provided by the committed NGOs as they are nearer to them. Therefore to support / encourage the services provided by the NGOs the "Bed grant" was established as a pilot programme to reimburse all costs associated with inpatient care for tribal in two NGO operated tribal hospitals. More than half of the sampled patients have visited the hospital from a distance of 25 kms or more than that. This suggests that the bed grant facilities available in the hospital are in Significantly high demand and that patients have availed these facilities in spite of large distances. Around 17 percent of the selected patients were in the age group of 14 years or less than that, another 25 percent patients were reported in the age group of 15 - 25 years, around 55 percent patients were reported in the age group of 26 to 60 years. As per the assessment, 95 percent of the tribal population who access the hospital had a monthly income of less than Rs.5000. The initiative can be replicated in tribal areas where there are private providers by bearing the inpatient treatment cost. This will lead to an increase in uptake of in-patient service and decrease in morbidity and mortality. More so importantly it would help to reduce the out of pocket expenses of the poor tribal population.

### **CONCLUSION**

In light of these principles and in view of the common disease pattern and needs listed earlier in the conclusions section, we recommend that the Ministry of Health and Family Welfare should redesign the primary and secondary health care services in Scheduled Areas. The new pattern should not be enforced as a top-down, vertical, uniform national program, but should provide a framework for local planning with local participation. Thus, the 'Tribal Health Plan' will have three feature: one, a process framework about 'how' to prepare the local plan, which will be in the form of guidelines on mechanisms; second, a series of locally developed need-based contents of the plan and third, a design or structure of the health care system to deliver such services in all Scheduled Areas. This 'Tribal Health Plan' should become an essential feature of the National Health Mission and of the Tribal Sub Plan. The goals and monitoring indicators of this plan will be different than the regular MIS of the NHM.

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