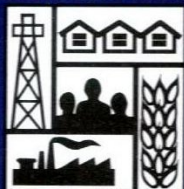


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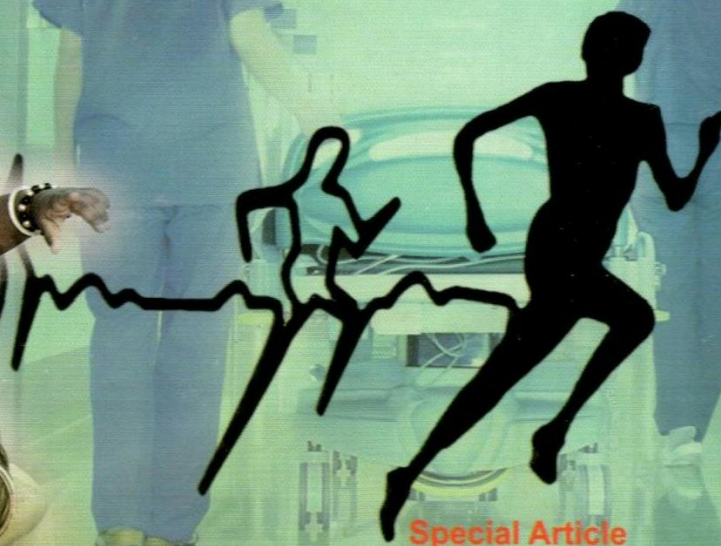
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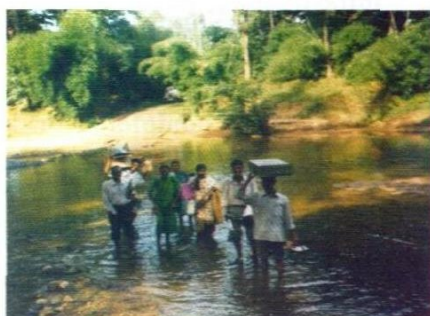
Special Article

Health In The Era of Sustainable Development

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Health Care in Tribal Areas : Present and the Future

Abhay Bang



Ministry of Health and Family Welfare and the Ministry of Tribal Affairs, Government of India, unsatisfied with the present state of tribal health and health care, have jointly constituted an Expert Committee on Tribal Health. The group is assigned with the responsibility of reviewing the present health status of the tribal people, the state of health care in tribal areas in the states, and to recommend the corrective solutions including designing a framework for a district health plan in tribal areas(5). The expert committee has reviewed the present situation, and is exploring the possible solutions

The Scheduled Tribes (ST) constituted 8.6 per cent of the total population of India in 2011, amounting to about 10 crore in absolute number⁽¹⁾.

Health of the ten crore marginalized and vulnerable people should become an important national concern. Their poor socio-economic and educational status is well known⁽²⁾. What is their health status?

The mortality indicators of ST population have certainly improved during the past decades. However, these are significantly worse than off the general population. A comparison on a few child mortality indicators is as follows⁽³⁾ –

		ST	Other	per cent diff.
1.	Infant Mortality Rate	62	49	27 per cent
2.	Under Five Year Child Mortality Rate	96	59	39 per cent

The infant and child mortality rates (most likely to be underestimates) in the STs are higher by about one-third than in the other population. Moreover, these show a huge variation between the states, and are particularly high in 7 states.

The nutritional status of ST children as well as of adults reveals a sad picture⁽⁴⁾.

- 53 per cent boys and 50 per cent girls in pre-school age were underweight, and 57 per cent boys and 52 per cent girls were stunted in height.
- 49.0 per cent of ST women had a Body Mass Index less than 18.5 indicating chronic energy deficiency.
- Dietary intake of tribal households showed large deficiencies in protein, energy, fats, iron, vitamin A and riboflavin.

The under-nutrition in children and adults have in ST population certainly decreased over time period (1985-87 to 2007-08), yet the present levels of deficient food intake and under-nutrition should be unacceptable.

The diseases prevalent in tribal areas can be broadly classified into following categories.

- The diseases of underdevelopment (malnutrition, communicable diseases, maternal and child health problems),
- Disease atypically common in ST population (Sickle cell disease, animal bites, accidents)
- Diseases of modernity (Hypertension, addiction, mental stress).

Public Health Service to ST population is one of the weakest links. It suffers from several handicaps.

The author is the Founder Director of SEARCH, a well known non-government organization. He is currently Chairman of the Expert Committee on Tribal Health, Government of India. His work on childhood pneumonia and home-based newborn care (HBNC) have shaped global policies. He was a member of Government of India's High Level Expert Group on Universal Health Coverage (2011), of the High Level Committee on Tribal People (2014). He has extensively written and published in the national and international journals including the Lancet. He and his organization have received more than sixty awards, including the 'Global Health Hero' of the TIME magazine.

- i) It is often inappropriate for the scheduled areas, being a rubber stamp version of the national model primarily designed for the non-tribal areas. It does not take into account the different belief systems, different disease burden and health care needs as well as the difficulties in delivering health care in a geographically scattered, culturally different population surrounded by forests and other natural forces. It is surprising that no serious thought was earlier given to design a separate public health care plan for scheduled areas.
- ii) The other major difficulty in delivering public health care to tribal population is the lack of health care human resource willing, trained and equipped to work in scheduled areas. There is a shortage – vacancy, absenteeism or half heartedness – of doctors, nurses, technicians and managers in public health care system in scheduled areas.
- iii) Though buildings are built and health care institutions created in the form of health sub-centres, PHCs and CHCs – they often remain dysfunctional resulting in poor delivery of health care. This is further compounded by inadequate monitoring, poor quality of reporting, and accountability.
- iv) Unfriendly behaviour of the staff, language barrier, large distances, poor transport, low literacy and low health care seeking, - all lead to lower utilization of the existing health care institutions in scheduled areas.
- v) Access to hospital care for serious cases remains very low in tribal areas.

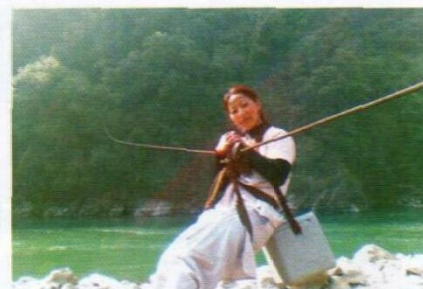
Thus, the public health care system in scheduled areas is characterized by low output, low quality and low outcome delivery system often targeting wrong priorities. Restructuring and strengthening it should be one of the highest priorities for the Ministries of Health and FW in states and at the centre.

One reason for the inappropriately designed and poorly managed health care in scheduled areas is the near complete absence of participation of ST people or their representatives in shaping policies, making plans or implementing services in the health sector. This is true from the village level to the national level.

In addition to the various handicaps listed above, there is a common perception and complaint that funds for health care in tribal areas are underutilized, diverted to other areas, or utilized inefficiently, and worst, siphoned off through corruption.

How to Redesign ?

1. The first principle of any policy or program for tribal people is the 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.
2. In view of the enormous diversity among nearly 700 tribes in India, the second principle to be followed, is of the area specific and tribe sensitive local planning. The PESA provides an institutional basis for this. Local tribal health assemblies, district level tribal health councils and, at the state level, Tribes Advisory Councils can be the institutional mechanisms which when created and made operational will allow local planning.
3. **Social determinants of health** – literacy, income, water, sanitation, fuel, food security and dietary diversity, gender sensitivity, transport and connectivity – play a 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.



ANM nurse crossing the river Lohit for vaccination (Picture courtesy: Karuna Trust)

Some specific suggestions for improving health are –

- i) The construction of drainage system, village sanitation infrastructure, personal toilets and the environmental measures to control mosquito breeding can be included in the MG-NREGA scheme and completed on a priority basis in scheduled areas.
- ii) To reduce the household use of unclean fuels and biomass burning, the solar energy, especially the solar cooker, water heaters and lights can be promoted in scheduled areas. This will also help to save trees.
- iii) Improving nutrition of children, adolescents, pregnant and lactating women is critical for the ST population. The nutrition awareness and feeding programs in the scheduled areas can be better implemented in collaboration with the National Rural Livelihood Mission and the Women's saving groups in the villages.
- iv) Health and income available for family will show improvement by controlling alcohol and tobacco.
- 4) Empowerment of the ST population is another cardinal principle. Building their capabilities to care for their health is the long term solution for superior to a perpetual dependence. This however, does not mean that the government or the rest of the society can abdicate their responsibility towards tribal people. But this responsibility can be better served in the long run by building local capacity. In other words, instead of 'giving' health care, the policy should be to build 'capacity to care for health'. This principle should guide in planning



A hut where the mother is kept for delivery and later the newborn joins her Picture (Courtesy: SEARCH, Gadchiroli)

health care – especially in the choice of who will provide health care, where, when and how.

- 5) To bridge the scientific knowledge gap of centuries, health care for scheduled areas should give paramount importance to spreading 'health literacy' by way of mass educational methods, folk media, modern media and school curriculum. Enormous scope exists for communication in local dialects and for the use of technology.
- 6) A large number of ST children and youth – more than one crore – are currently in schools. This provides a great opportunity – both for improving their health and for imparting health related knowledge and practices. Schools, including the primary schools, middle schools, high schools, ashram shalas and also the Anganwadis, should become the Primary Health Knowledge Centres.
- 7) 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 the health care must be explored.
- 8) Apart from the physical distance, a huge cultural distance separates the tribal population from others. Health care delivery to ST population should be culture sensitive and in the local language to overcome this distance.
- 9) Health care delivery system for scheduled areas must keep as its guiding principle the Chinese axiom – How far a mother on foot can walk 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 in the village or hamlet itself.

- 10) Addiction is a big drain on the ST population. It not only affects health but also affects productivity, family economy, social harmony and ultimately development. Hence i) The Excise Policy for Scheduled Areas, approved by the Ministry of Home Affairs, Govt. of India in 1976 and accepted by the states should be implemented effectively. ii) Moreover, the availability and consumption of tobacco and drugs should be severely controlled. These efforts should become a critical part of the Tribal Sub Plan. iii) The availability and use of alcohol and tobacco products in ST population, and the implementation of control policies by the states should be monitored on selected indicators.
- 11) The Tribal Sub Plan (TSP) budget, in proportion to the ST population, should be an additional input and not a substitute to the regular budget for the routine activities of the health department in the scheduled areas. At least fifteen per cent of the total TSP budget should be committed to the health sector, the Tribal Health Plan, in the scheduled areas, in addition to the regular health budget for these areas.
- 12) Data on ST population is a basic ingredient for planning, monitoring and evaluating health programmes in the scheduled areas. All national data systems – the Census, SRS, NFHS, NSSO, DLHS can be asked to plan for and generate ST specific estimates on specific health indicators at the district level and above. One per cent of the total budget for ST population (TSP) be allocated to generating reliable,

timely, relevant segregated data on ST population at the local to national level. This will provide the crucial instrument like the facts necessary to guide the program managers, policy makers and the ST populations.

The Way Forward

Ministry of Health and Family Welfare and the Ministry of Tribal Affairs, Government of India, unsatisfied with the present state of tribal health and health care, have jointly constituted an Expert Committee on Tribal Health. The group is assigned with the responsibility of reviewing the present health status of the tribal people, the state of health care in tribal areas in the states, and to recommend the corrective solutions including designing a framework for a district health plan in tribal areas⁽⁵⁾. The expert committee has reviewed the present situation, and is exploring the possible solutions. A national workshop on Best Practices in Tribal Health Care was organized recently in SEARCH, Gadchiroli, probably for the first time in the country. 23 best practices were presented and discussed.

We should look forward to the report of this expert group. Hopefully, it will show us the way forward.

Readings

1. Census of India (2011)
2. Report of the High Level Committee on the Socio-economic status of the Tribal People, Ministry of Tribal Affairs, Government of India. (2014)
3. Census (2001 & 2011)
4. National Nutrition Monitoring Bureau, Technical Report 25, National Institute of Nutrition, Hyderabad.
5. Ministry of Health and Family Welfare, Govt. of India, Constitution of the Expert Committee on Tribal Health (2013)

[The author gratefully acknowledges that this article heavily draws from the chapter on Health he wrote for the Report of the High Level Committee on Tribal People, Ministry of Tribal Affairs, Government of India (2014)]

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