ISSN: 2348-4667
Anthropological Bulletin
8 (1), 56-61, 2017

Commentary

Status of Health Problems amongst Tribal Population in India

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The tribal population groups of India are known to be the autochthonous people of the land. Tribal are often referred to as Adivasi, Vanyajati, Vanvasi, Pahari, Adimjati and Anusuchit Jan Jati, the latter 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 the idea of scheduled tribe in independent India.

In India, 427 groups have been recognized as scheduled tribes. They form approximately 8 per cent of the total Indian population. These tribal groups inhabit widely varying ecological and geo-climatic conditions (hilly, forest, desert, etc.) in different concentration throughout the country with different cultural and socioeconomic backgrounds. Due to their remote and isolated living, tribal groups are difficult to reach.

There is bewildering variation in population size of the scheduled tribes, ranging from 31 Jarwas of Andaman and Nicobar Islands to more than 7 million Bhils of Rajasthan, Madhya Pradesh, Maharashtra and Gujarat (1981 Census). The highest number of tribes is represented by the State of Orissa (62) and the lowest of Sikkim (2). The largest tribal population around 15.4 million reside in Madhya Pradesh. Seventy four primitive tribal communities have been identified by the Government of India in 15 States/Union Territories for taking up special socioeconomic development programmes on the basis of (a) Pre-agricultural level of technology, following a hunting-gathering way of life, (b) Extremely low level of literacy, and (c) Small stagnant diminishing population (Report of the Working Group, 1989)4 The scheduled tribes differ considerably from one another in race, language, culture and beliefs. Notwithstanding so much diversity, there are certain broad similarities between the mutually divergent tribal groups. Striking similarities are noticed in their modes of living, each tribe lives in a definite area, has common dialect, cultural homogeneity and unifying social organization. The tribal population of India has been found to speak 105 different languages and 225 subsidiary languages indicating a great deal of variety (IGNOU, 1990). Languages spoken by Indian tribes can be classified into four major families of languages, namely; Austro-Asiatic family, Tibeto-Chinese family, Dravidian family and Indo-European family. On the basis of racial features, Guha, B.S. (1935) considers that the

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tribal population of India belongs to three races namely the Proto-Australoids, the Mongoloids and the Negritos. Literacy among the tribals is very low (25.9 per cent) and especially so among the tribal females (14.5 per cent) (NSSO, 1991). The level of education among the most of the scheduled tribes is upto primary level. The lowest level of literacy among females was found in Rajasthan (4.1 per cent). Sex-ratio (females per thousand males) reflects the status of socio-cultural, maternal and child health care programmes existing in the population. In the 1991 Census, the sex ratio of the tribal population was 972 females per thousand males against 927 for the total population. The highest sex ratio for scheduled tribes among various States has been reported from Orissa (1002) and the lowest from Goa (889). The scheduled tribes are at different stages of social, cultural and economic development.

The cultural pattern varies from tribe to tribe and region to region. The economic life of the tribals is specific in nature. Based on the manner in which the tribals primarily and distinctly make their living, the Indian tribals can be classified into seven groups:

(i) Food Gatherers and Hunters: For example Cholanaicken, Malapandaram and the Arahdan tribal groups of Kerala, Rajis of Uttar Pradesh, Birhor of Bihar, Hill Maria of Madhya Pradesh, Juangs of Orissa, Chenchus of Hyderabad, Kadars of Cochin, Jenu-Kuruba of Karnataka, the Onge, the Jarwa and the Andamanese of Andaman islands.

(ii) Shifting (Jhum) Cultivators: For example Khasis of Meghalaya, Nagas of Assam, Korwa of Bihar, Saora of Orissa, Muria and Maria of Madhya Pradesh.

(iii) Settled Agriculturists: For example major tribes like Santhal, Munda, Ho, Oraon, Gond, Bhil, Mina, etc.

(iv) Artisans: The number of tribes subsisting on crafts like basket making, tool making, spinning and weaving is small e.g. Kota of Nilgiri Hills, Birhor of Bihar.

(v) The Pastoralists and Cattle Herders: For example Todas of Nilgiris, Gujar, the Bakerwal and Gaddi in Himachal Pradesh.

(vi) The Folk Artists: For example Pradhans of Madhya Pradesh.

(vii) Wage Labourers: Large chunks of tribal territories have come under plantations, mining and industrial development. Tribals of Chhotanagpur have gone to North East India to work on tea plantations. The Santhals have been employed in coal mines of Bihar.

Tribal scene does not present a uniform canvas. The Dhebar Commission (1961) observed four different layers among the tribal population. On top is the acculturated layer whose scheduled tribe members have adopted more or less the way of life of non-tribal sections forming the upper crust of the society, e.g. Minas. They have travelled the farthest from original tribal habitat. The second are the settled scheduled tribes agriculturists e.g. Santal, Munda, Oraon, Gond, etc. in the fringe plains who have come quite some way from the tribal highlander, being no longer isolated and they are in the process of transformation. The third category is that of the highlanders who having hardly shifted from their habitat, have undergone little transformation and may still practice shifting cultivation e.g. Khasis, Muria and Maria. The last category, (at the base) a class of tribals, which is in an extremely underdeveloped stage, isolated backward groups, including the so-called "primitive groups", who, insisted in their original habitat, have been little exposed and, consequently, preserve original socioeconomic-cultural traits, e.g. Cholanaicken, Kadars, Onge, etc.

Health and Its Correlates

Health is a pre-requisite for human development and is essentially concerned with the well being of common man. The UNDP Human Development Index (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 - cultural,

economic, educational, social and political. The health status of a society is intimately related to its value system, philosophical and cultural traditions, and social, economic and political organization. Each of these aspects has a deep influence on health, which in turn influences all these aspects. Hence, it is not possible to raise the health status and quality of life of people unless such efforts are integrated with the wider effort to bring about overall transformation of a society. Health development can be integrated with the larger programme of overall development in such a manner that the two become mutually self-supporting. Good health and good society go together. This is possible only when supportive services such as nutrition and improvements in the environment and in education reach a higher level.

Health Culture

The culture of community determines the health behaviour of the community in general and individual members in particular. The health behaviour of the individual is closely linked to the way he or she perceives various health problems; what they actually mean to him or her, on the one hand, and on the other his or her access to various relevant institutions.7 The holistic concept of health culture provides a valuable framework for analyzing the work of anthropologists in health fields. However, a very few studies are available in this direction, especially among the tribal population. 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. 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 (Commissioner Report for Scheduled Tribe and Scheduled Caste, 1986-87). Insanitary conditions, ignorance, lack of personal hygiene and health education are the main factors responsible for their ill health. Some primitive tribal communities are facing extinction like the Onges, Jarwas and Shompens of Andaman and Nicobar Islands.11 Some of the problems as indicated by investigations include:

(a) Endemic diseases like malaria, introduced from outside or otherwise like tuberculosis, influenza, dysentery, high infant mortality and malnutrition,

(b) Venereal diseases, induced abortion, inbreeding, addiction to opium, custom of eating tubers of DIOSCERA (may cause sterility as they contain substances used in oral contraception), and

(c) Disturbed sex ratio leading to shortage of women.

Urgent studies are, therefore, required on different primitive tribal groups of India which are small in size. The health and nutrition problems of the vast tribal population of India are as varied as the tribal groups themselves who present a bewildering diversity and variety in their socio-economic, socio-cultural and ecological settings. Nutritional anemia is a major problem for women in India and more so in the rural and tribal belt. This is particularly serious in view of the fact that both rural and tribal women have heavy workload and anemia has profound effect on psychological and physical health. Anemia lowers resistance to fatigue, affects working capacity under conditions of stress and increases susceptibility to other diseases. Maternal malnutrition is quite common among the tribal women especially those who have many pregnancies too closely spaced. Tribal diets are generally grossly deficient in calcium, vitamin A, vitamin C, riboflavin and animal protein. Child bearing and Maternal Mortality Child bearing imposes additional health needs and

problems on women physically, psychologically and socially. Maternal mortality was reported to be high among various tribal groups but no exact data could be collected. The chief causes of maternal mortality were found to be unhygienic and primitive practices for parturition. For example, it was observed that among Kutia Khondhs the delivery was conducted by the mother herself in a half squatting position holding a rope tied down from the roof of the hut. This helped her in applying pressure to deliver the child. In complicated labour, obviously it might lead to maternal as well as child mortality. Similar crude birth practices were found to exist in other tribal groups like Kharias, Gonds, Santals, Kutia Khondhs of Orissa, Santals, Jaunsaris, Kharias, etc.). Expectant mothers to a large extent are not inoculated against tetanus. From the inception of pregnancy to its termination, no specific nutritious diet is consumed by women. On the other hand, some pregnant tribal women, (that is, Dudh Kharias, Santals) reduced their food intake because of simple fear of recurrent vomiting and also to ensure that the baby may remain small and the delivery may be easier. The consumption of iron, calcium and vitamins during pregnancy is poor. The habit of taking alcohol during pregnancy has been found to be usual in tribal women and almost all of them are observed to continue their regular activities including hard labour during advanced pregnancy. More than 90 per cent of deliveries are conducted at home attended by elderly ladies of the household. No specific precautions are observed at the time of conducting deliveries which resulted in an increased susceptibility to various infections. Services of paramedical staff are secured only in difficult labour cases. As far as child care is concerned, both rural and tribal illiterate mothers are observed to breast-feed their babies. But, most of them adopt harmful practices like discarding of colostrums, giving prelacteal feeds, delayed initiation of breast-feeding and delayed introduction of complementary feeds. Vaccination and immunization of Infants and children have been inadequate among tribal groups. In addition, extremes of magico-religious beliefs and taboos tend to aggravate the problems. The Infant Mortality Rate (IMR) The tribal population has much lower IMR as compared to the scheduled castes but moderately higher than the other population.

Tribal Households

About half of the population of Andhra Pradesh, Madhya Pradesh, Bihar and Orissa enter their dwelling units by bending or crawling only. In Gujarat, Rajasthan and Maharashtra about a quarter of the population has such dwelling units. Most of these houses lack adequate ventilation or natural lighting. A sizable population of tribes shares the living rooms with cattle, Bihar (40%), Madhya Pradesh (36%), Rajasthan (44%) and in Andhra Pradesh, it is very low (7%). Life Expectancy The expectation of life is the average number of years remaining to be lived by those surviving to that age. Basu and Kshatriya (1989) while studying the Bastar tribal groups of Madhya Pradesh found the average life expectancy at birth based on q5 values for Muria (males 37.56 years and females 40.07 years), Maria (males 40.26 years and females 41 years), Bhattra (males 43.68 years and females 45.30 years), and Halba (males 38.6 years and females 41.46 years) and 41.1 years for all the four tribal groups combined. Although these figures are comparable to the rural non-tribal population of Madhya Pradesh, they are far below the average life expectancy at birth of 58.6 years for the Indian population.

Genetic Disorders

Genetic disorders especially sickle cell disease and G-6-PD has been found to occur in high frequency among various tribal groups and scheduled caste population. The sickle cell disease has been found in 72 districts of Central, Western and Southern India. About 13 lakh G-6-P D deficients are present in tribal population. The prevalence is specially high among the tribes and scheduled castes of Madhya Pradesh, Maharashtra, Tamil Nadu, Orissa, Assam (more than 15 per cent) specially in hyper-endemic malarial zones (DST,

Report 1990). Prevalence rate upto 40 per cent of sickle cell trait has been reported in some tribes i.e. Adiyan, Irula, Paniyan, Gonds.

Sexually Transmitted Diseases (STDs)

Sexually transmitted diseases (STDs) are most prevalent disease in the tribal areas. VDRL was found to be positive in 17.12 per cent cases (reactive in dilution of 1:8 or more) of polyandrous Jaunsaris of Chakrata, Dehradun. Out of 17 per cent, 9.92 per cent was found among males and 7.19 per cent among females. Among the Santals of Mayurbhanj district, Orissa, 8.90 per cent cases (reactive in dilution of 1:8 or more) of VDRL were observed, out of which 4.99 per cent were females and 3.91 per cent were males.

Forest Ecology and Women's Health

The forest based, tribal economy in most parts of the world was women-centered. Women made provisions for the basic necessities like food, fuel, medicine, housing material, etc. from the forest produce. Food was obtained from shifting cultivation and from minor forest produces (MFP) like flowers and fruits collected from the forest. Extraction from herbs, roots and animals were used for medicine. All these efforts incurred an excessive workload on women. Because of extensive cutting of trees by vested interests, the distances between the villages and the forest areas had increased, forcing the tribal women to walk longer distances in search of minor forest produce and firewood. In this rapidly changing milieu, tribal women were confronted with an extraordinary workload. A study on the Kondhs revealed that women put in an average of 14 working hours per day as compared to 9 hours put in by men. Given this additional workload, even women in advanced stages of pregnancy were required to work in the agricultural fields or walk great distances to collect fuel and minor forest produce. The over strain on tribal women however, was not adequately compensated due to the non-availability of minor forest produce and decrease in food grain production. To add to the malnutrition and additional workload, there was destruction of traditional herbs through deforestation and the lack of access of the tribal to modern medicine. This along with the increasing ecological imbalance resulted in diseases such as TB, stomach disorders and malaria.

CONCLUSION

The scheduled tribes are at different stages of social, cultural and economic development. The cultural pattern varies from tribe to tribe and region to region. The economic life of the tribals is specific in nature. Based on the manner in which the tribals primarily and distinctly make their living, the Indian tribals can be classified into seven groups.

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