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# Health of Tribal Population in India: A Glimpse of the Current Scenario

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## Abstract

Article 366(25) of the Indian constitution refers to indigenous people as “scheduled tribes,” which constitute 8.6% of the country’s population. For decades, the health of the tribal people had remained neglected and incorporated in rural health care because of incorrect assumptions of their similar health needs to that of the rural population. An expert committee coordinating with the Ministry of Health and Family Welfare and the Ministry of Tribal Affairs provided a detailed report on the current scenario and recommendations related to tribal health in India. They considered the health-care needs of the tribal population, highlighted their specific health problems, and gave a roadmap of best approaches. The tribal population has a unique and higher burden of health problems than the mainstream population, influenced by their health-seeking behavior, lack of awareness and education, sociocultural and magico-religious beliefs, customs, and practices. The current health-care system incorporates their health needs with approaches such as differing population norms in tribal areas, nonmonetary incentives to staff, mobile medical units, identification of high-priority districts, and the emergence of the “Swasthya” portal. However, tribal health is transitioning as with the rest of the population. Moreover, the present health-care services are unable to address this. Legal recognition of indigenous peoples’ rights to self-determination, their land, natural resources, and their knowledge is a need of the hour.

**Key words:** Health care, health system, indigenous population, tribal health

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## INTRODUCTION

The population of indigenous people is estimated at 476 million, spread across 90 countries.<sup>[1]</sup> China and India alone account for over two-thirds of the global indigenous population.<sup>[2]</sup> The diverse nature of indigenous people has compelled the United Nations (UN) not to define “indigenous” but to identify them.<sup>[3]</sup> The UN Permanent Forum on Indigenous Issues gave seven characteristic features to identify them.<sup>[3]</sup> Article 366 (25) of the Indian Constitution defined “scheduled tribes” as “*Such tribes or tribal communities or parts of or groups within such tribes or tribal communities as are deemed under Article 342 to be Scheduled Tribes for this constitution.*”<sup>[4]</sup> The Indian constitution enlisted 705 scheduled tribes (STs) with a contribution of 8.6% of the total population with an absolute number of 104 million.<sup>[5]</sup> Madhya Pradesh has the highest number of tribal people, and Meghalaya, Mizoram, and Nagaland have more than 75% STs of its total state population.<sup>[6]</sup> Seventy-five tribal groups have been identified as particularly vulnerable tribal groups who, among the tribal groups, are distinguished by their increased “vulnerability” (although the details of their susceptibility are unclear). With a population of <1000 persons in each, most of them reside in Odisha, Andhra Pradesh, and Telangana.

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## HEALTH PROBLEMS IN TRIBAL POPULATION

A multi-centric population-based study reported that indigenous people usually had poorer health outcomes than the benchmark population in the studied countries.<sup>[7]</sup> Life expectancy at birth of STs in India is 60.7 years versus 63.9 years in the benchmark population. The infant mortality rate in STs is 74.3% per 1000 live births versus 61.7% among the benchmark population.<sup>[7]</sup> It is known that the tribal population in India has poor health, but to address the same, their health needs remain subsumed in rural health care because of incorrect assumptions of their similar health needs as that of the rural population.<sup>[8]</sup> Geographical, socioeconomic, cultural, and political differences render them with health problems and health-care needs that are yet to be addressed.<sup>[8]</sup> Tribal populations often suffer from a “quadruple burden of disease,” i.e., communicable diseases, malnutrition, noncommunicable diseases (NCDs), and mental health illnesses, specifically addiction.<sup>[9]</sup> Health indicators related to all four domains of illness are poor among the ST population.<sup>[8,10]</sup> This epidemiological transition from communicable diseases and malnutrition to NCDs, mental health illness, and addiction has increased the disease burden in the tribal community.<sup>[9,10]</sup> While vector-borne diseases such as malaria and tuberculosis are also disproportionately high in tribal communities and are found in particular tribes.<sup>[11,12]</sup> A study in Andhra Pradesh shows that newly diagnosed NCD cases contribute to a higher proportion of the prevalence among the tribal population compared to old cases.<sup>[13]</sup> There are specific NCDs that are genetic and found to be more prevalent among tribals, like hemoglobinopathies, thalassemia syndrome, and glucose-6-phosphate dehydrogenase deficiency.<sup>[11,12]</sup> Common mental health disorders (CMD), such as depression, anxiety, stress, and suicide risk, are also common in tribal populations. CMDs might be underestimated as their sociocultural beliefs prohibit them from seeking health care from a formal health-care provider.<sup>[14]</sup> Substance use disorders and addictions are also pervasive, with opium being identified as a coping mechanism for crop failures in the tribal communities. Drinking alcohol among the elderly population, along with the younger population, is a widespread custom among the tribal community. A district sample survey by SEARCH (2015) in Gadchiroli, Maharashtra, showed that most of their income is spent on alcohol and tobacco use.<sup>[8,14]</sup>

The poor health-seeking among tribal individuals has complicated this quadruple disease.<sup>[15]</sup> Factors influencing tribal communities’ health-seeking behavior include a lack of awareness and education among tribal groups, their sociocultural and magico-religious beliefs, customs, and practices, and their health-care system selection based on socioeconomic and cultural factors.<sup>[16-18]</sup>

Sustainable development goal (SDG) 3, i.e., “ensure healthy lives and promote well-being for all at all ages” includes indigenous people as well.<sup>[19]</sup> The health of a tribal population is multifactorial; therefore, striving to attain an individual goal may not suffice and tribals must be a priority in all the other

SDG goals with their active involvement. “Transforming Our World: The 2030 Agenda for Sustainable Development” indicates toward tribal population’s health three times, two in the target 2.3 and target 4.5 and one in the follow-up and review section where it calls for their participation.<sup>[20]</sup> SDG two is “zero hunger” where target three is to double the agricultural productivity and incomes of small-scale producers, indigenous peoples are one such group, whereas SDG target four is “quality education,” where target five is to eliminate all discrimination in education that includes discrimination against the tribal population as well and SDG indicators 2.3.2 and 4.5.1, respectively, depicts their status. Other indicators are there that indirectly depict indigenous people’s status; national and regional indicators are being developed.<sup>[20]</sup>

## HEALTH-CARE SYSTEM RESPONSE TO IMPROVE TRIBAL HEALTH

The Ministry of Tribal Affairs was established in 1999 to oversee tribal affairs and their welfare, including their health. In 2018, an expert committee was formed to address tribal health in India, focusing on identifying the present status of health and health care in tribal areas and providing a road map for improving the health of tribals by identifying existing gaps. The committee gave 10 diagnoses of tribal health, which can be summed as “prevalent communicable diseases, maternal and child health problems, rising NCD, especially mental health issues, accidents and violence, geographical disadvantage, poor socioeconomic determinants, inadequate health-care services, scarcity of human resource and unwilling workforce to serve in tribal areas, lack of financial share and its improper use, lack of data, and political disempowerment.”

The expert committee gave a roadmap for the future of tribal health in India.<sup>[8]</sup> Only some of their recommendations have been adopted by the current health-care system. For example, population norms in vulnerable areas (remote, tribal, desert, and hard-to-reach areas) are 3,000, 20,000, and 80,000 for the sub-health center, primary health center, and community health center, respectively.<sup>[21]</sup> Services like mobile medical units and ambulances under the National Health Mission (NHM) have been deployed in these areas where states can choose population norms or as per their requirement.<sup>[21]</sup>

Tribal majority districts with a composite health index lower than the state average have been classified as high-priority districts with more significant resources provided per capita under the NHM than the rest of the districts in the state.<sup>[22]</sup> A composite health index computes six indices for health status and health infrastructure, which focuses on the relative position of each district in a state in terms of health outcomes and health-care services.<sup>[23,24]</sup> Unique health challenges in these districts must be conquered with higher per capita funding, innovative approaches, enhanced monitoring, and supportive supervision.<sup>[21]</sup> Approaches such as “contracting in” and “contracting out” for specialist posts have been opted for, and nonmonetary incentive advantages for staff

servicing in vulnerable areas are preferential admission in postgraduate courses.<sup>[21]</sup> Recruitment of Accredited Social Health Activists (ASHAs) at the habitation level in tribal areas with a norm of one ASHA per 1000 population.<sup>[21]</sup> Swasthya, a knowledge portal curating information from different sources about tribal health and nutrition, envisages it will provide insights to all stakeholders working with India's tribal community to bring about evidence-based policymaking.<sup>[5]</sup> Furthermore, in the financial year 2022–2023, out of 90109 Health and Wellness Centers, 15,041 were operated in 177 tribal districts. There was a 12.32% increment in the budget outlay of Rs. 8451 crore allotted for the Ministry of Tribal Affairs.<sup>[22,25]</sup>

## PROBLEM STATEMENT AND THE WAY FORWARD

A literature review reveals that tribals' health status is miserable and needs systematic policies and interventions to improve.<sup>[26]</sup> Studies done among tribals in India show that the burden of various diseases is higher in them than in the general population and that tribal health is transitioning. There needs to be more knowledge about the modern health-care system's means and techniques, making it even more vulnerable to change. Therefore, it is propounded to enhance health literacy among the tribal population and to bring about comprehensive health-care policy for them at all levels of a health-care system that would promote modern medicine and imbibe their indigenous medical knowledge and practices.<sup>[26,27]</sup> Determinants of indigenous health differ from those of the mainstream population. Legal recognition of indigenous peoples' rights to self-determination, land, natural resources, and knowledge is needed. Health services can be culturally sensitive, considering language barriers, cross-cultural misunderstandings, and racial discrimination. There are more prominent "causes of causes," or distal determinants, of unhealthy life conditions as depicted by Michael Marmot's statement: "*The inequity is systematic, produced by social norms, policies and practices that tolerate or promote the unfair distribution of and access to power, wealth and another necessary social resource (s).*"<sup>[28]</sup>

Despite commendable efforts, obstacles exist that hinder the successful delivery of health-care services among tribal populations. Challenges such as geographical isolation, poor infrastructure, language and cultural differences, lack of health-care providers, socioeconomic disparities, and traditional healing practices can be conquered by joint efforts of the government, medical professionals, and tribals themselves.<sup>[29]</sup> Organization of service delivery for tribals given by the expert committee under "Bridging the gap and roadmap for the future" had gained recognition, despite which implementation is a challenge.<sup>[8,15]</sup>

## CONCLUSION

Tribal health in India is in a phase of transition, as is the rest of the world. The rise in NCDs alongside preexisting MCH

and communicable diseases depicts a huge burden. The status of tribal health is far more substandard than the rest of the population, where multiple determinants such as their sociogeographical, behavioral, economic, and lack of data on tribal health, are responsible for their poorer performance. The current health-care system in India has little to offer them for their health and well-being, which poses a challenge. Tribal health may be ingrained in the existing primary health-care system in the country, indifferent from the rest of the population rather, it can be approached differently keeping in consideration their unique needs.

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