TRIBAL HEALTH AND GOVERNMENT INTERVENTION IN TRIBAL HEALTH CARE: A CASE STUDY OF VITHURA GRAMAPANCHAYATH

S.R.Janaky

Assistant Professor

Department of Economics

Government College Nedumangad (University of Kerala)

1.1 INTRODUCTION

The Tribal population refers to a "social group usually with a definite area, dialect, cultural homogeneity and unifying social organisation." They constitute the aboriginal population of the land. The Constitution of India has notified them as the Scheduled Tribes under the provision of clause 1, article 342. They suffer from extreme social and economic backwardness and need special consideration for safeguarding their interest and for their development.

The welfare of the Scheduled Tribes has remained an imperative concern of the state since Independence. Several development programs have been designed and adopted by both the Central and the State governments with a view to enhance the welfare of the tribal population. Health is an indispensable pre-requisite for human development hence health care constitutes an important area where wide spread welfare measures have been initiated by the state.

Health is defined by the World Health Organization as a state of complete physical mental and social wellbeing and not merely absence of disease or infirmity. Health is a fundamental human right emphasized the Alma-Ata Declaration of 1978.Since the Alma-Ata conference on health which focused on equitable and cost effective primary health care, health has become an important rational concern in most countries, especially the developing countries.

The state of Kerala has significant tribal population. The scheduled tribe population in Kerala constitutes 1.45% (census 2011) of the total population. The term outlier (scheduled tribes) was introduced in the 1990's in the discussion of the Kerala model .The tribes are population groups who have been left out of the domain of public action and the capacity building process.

Kerala achieved a commendable health status in terms of mortality, fertility, life expectancy, comparable with many developing countries, but Kerala had the highest gap between the tribal populations and general population as far as health status was concerned. The health indices show the vulnerable position of tribes in Kerala. Various measures have

been adopted to improve health status of the Scheduled Tribes. Many of these efforts did not heed much result since the tribal settlements are situated in remote places far away from hospitals and health centres.

Tribal health and treatment are closely interrelated with the environment, particularly the forest ecology. Tribal populations, generally have poor health outcomes, because, often a healthcare delivery system does not cater to their needs. The mode of utilization of available natural resources often determines the long-term impact on health of tribals in India. Many tribal people die due to malnutrition, excessive consumption of tobacco and alcohol etc. They also face health problems such as the prevalence of sickle cell anaemia, premature birth and a low life expectancy. Recent studies says life style diseases such as hypertension, obesity, diabetics and stress generally considered as by-products of rapid urbanization are also found among tribal people.

Health care is major problem in far-flung isolated tribal areas. Lack of food security, sanitation, adequate hospital facility and high poverty levels aggravate the poor health status of tribals. The problem of malnutrition and lack of adequate health care facilities are multi dimensional and intergenerational in nature. There are wide variations among members of different tribal groups in health status and their willingness to access and utilize health services, depending on their culture, level of adaptation, interaction with general population etc.

Tribals remain deprived of the benefits of health care from modern medical facilities. In spite of meticulous planning by government authorities some areas of health care needs are not covered due to the limitations of the system. A big achievement in health care will be to create a new system to address how the tribals will be provided with overall health care coverage. Inequalities in health care between tribal and non-tribal areas have continued to increase. To ignore this problem is to invite problems in the future productivity and development of the country. This study tries to identify the factors responsible for the difficulties in healthcare delivery.

This study is an attempt to subject the tribal economy to systematic analysis to bring forth the present health status of tribal population of Vithura grama panchayath. The study also attempts to fathom the levels of progress made by the STs as a result of the Government intervention through welfare schemes especially with respect to health and to probe into the adequacy, critical gaps, issues and challenges involved in the delivery system of the health care to tribal population.

1.2 REVIEW OF LITERATURE

This section tries to review the different studies regarding health status of tribal population.

Salil Basu (2000) conducted a study related to health development and tribal development. He found that the provisions of potable drinking water should be very high on the list of priorities for delivery of health measures to the tribes. He suggested that we must also improve the education and literacy status of the tribes if there has to be durable improvement in the status of their health The Government must step up investments in education for the tribes and make health education an important part of it. He concluded that tribal medicine and medical traditions are valuable and hence are to be preserved.

Anand Kumar, (2003) have concluded in his study that the primitive tribals of Orissa and their health scenario presents a kaleidoscopic mosaic of various communicable and non-

communicable disease profile keeping in pace with their socio-economic development. Among these there are communities who still depend primarily on hunting and food gathering as primary source of livelihood. 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, have been found, as possible contributing factors of dismal health condition prevailing amongst the primitive tribal communities of the country. Many of the infectious and parasitic diseases can be prevented with timely intervention, health awareness and IEC activities. Some of the intervention programmes can be included in the national programme also. The non communicable diseases like diabetes and hypertension 36 are conspicuously absent indicating that the primitive tribal communities are still far away from the modern civilization and developments. In spite of the tremendous advancement in the field of preventive and curative medicine, the health care delivery services in these primitive tribal people are still poor and need to be strengthened in order to achieve the goal of health for all in the country.

Mehta (2000) reported that over two thirds of births in the world are delivered by local or traditional midwives or birth attendance in tribal areas. Traditional birth assistance is the only source of assistance available to tribals. This had led to increase in infant mortality and maternal mortality among tribal population.

Balgir (2005) conducted a study on the health status of the tribal population and found out that we should expect a socio economic gradient in health even within this marginalized population. The patterns of indigenous health derivation and heterogeneity are investigated in this study. The public health relevance of avoiding tobacco and alcohol use in India has been well documented in recent years.

A study on tribals in different parts of the country by the Ministry of Tribal Affairs (2007) suggests that there is no adequate reach of health care services in tribal areas. “The infant mortality, under-5 child mortality and percentage of children under-weight in respect of Tribes are higher than that of the overall population as well as of other disadvantaged socio economic groups.”

Rose Nambiakkim (2008) made a comprehensive study on the reproductive health awareness among the tribal woman in Churanchandpur district of Manipur. She examined the relationship between the socio-cultural factors and reproductive health among the tribal women. She also analyzed the education and health services rendered by the Missionaries. She observed that education is the best way to health awareness among tribal women. Now in Churanchandpur modern medical facilities are available and easily accessible to the people. She observed that if the young mothers are made aware of health, personal hygiene, nutrition and utilization of health services there will be considerable improvement in health status of Tribal population.

Venkat Rao (2001) showed that understaffing of primary health care centres is the main cause for the tribal to be deprived of the health care benefits. Most of the tribal population is desperately poor, backward, generally uneducated and lead a very hard and miserable life.

Vandana Panwar (1998) on the viability of a tribal health programme in Gujarat, cited understaffing of primary healthcare centres, exploitation of migrant labourers, and inadequate supplies of medicines as primary causes of underdevelopment and poor health outcomes. The widespread poverty, illiteracy, malnutrition, absence of safe drinking water and sanitary living conditions, poor maternal and child health services and ineffective coverage of national

health and nutritional services have been identified in several studies as possible contributing factors to dismal health conditions prevailing among the tribal population in India. In this article, the author focuses on certain factors like infant mortality rate, life expectancy, genetic disorders, sexually transmitted diseases, nutritional status, forest ecology, child health and health care practices which are generally responsible for determining the health status and health behaviour of tribal communities (Dimensions of Tribal Health 2000).

In a nutritional and demographic study (Prema et al. 1992) of Kannikar tribal women of Trivandrum district, Kerala, normal and physiological conditions like pregnancy and lactation were studied. Important sources of protein like pulses, milk and milk products and other animal foods were lacking in their diets. Average calorie consumption was found to be below the recommended level for normal, pregnant as well as lactating women. Detailed clinical examination of the Kannikar tribal women showed that anaemia (90 percent), vitamin A deficiency (30 percent) and niacin deficiency (10 percent) were prevalent among them. The morbidity status of the tribal women revealed the prevalence of pyrexia, respiratory complaints, gastro-intestinal diseases and rheumatic diseases. Among the adult women gynaecological complaints and deficiency diseases were common (Basu, 1993).

According to Verma et al (1999), tribal areas are inaccessible. High immunization rates among tribal children may be achieved through targeting illiterate mothers in inaccessible areas. These first-contact primary interventions, in turn, may also lessen the increasing rates of youth mortality seen among tribals.

Most of the tribal population is deprived of the benefits of modern health care system. A study done on health care among Kunabi Tribe of Karnataka revealed that traditional healers are present in certain villages and over 45 species of plants are still used in the area to treat a wide range of ailments such as fever, cough, skin diseases, rheumatism, snake-bite, jaundice and dysentery (Hebbar et al. 2002).

An epidemiological survey of tribal villages in southern Bihar revealed that there is no health care facility in tribal areas and noted that a lack of health awareness in the area remained the primary obstacle towards improved community health (Friedman et al. 2002).

Rao, (2010) states that a number of welfare schemes were introduced by the Government of Andhra Pradesh for the socio-economic upliftment of these marginalized people improving standards of tribals with emphasis on rehabilitation, settled cultivation, distribution of animals, improving educational standards, providing better health, and drinking water facilities. Houses and house sites were received by majority of respondents. Numbers of state departments, non-governmental organizations and social workers have been promoting self-help groups in these areas. The low infrastructure facilities created poor socioeconomic status of tribal people

1.3 RESEARCH GAP

Although several scholars have studied the tribal society within the state, not many studies have been conducted to understand the impact of public health policy on the development of tribes in Kerala at micro level. The major studies on the tribes included ethnographic surveys, socio- cultural analysis, socio-linguistic aspects of tribal life and anthropological studies. The segments of welfare and development were not given much importance. This resulted in economic planners formulating development as well as welfare schemes based on sociological and anthropological studies. Consequently, the programmes did not benefit the tribes as expected. Therefore, a research gap arises here which is to be

addressed. Thus, it is extremely important to subject the tribal economy to methodical study which can help in realising the levels of progress made by the Scheduled Tribes as a result of the Government welfare schemes which, in turn, can aid the Government in improving the quality of the already existent schemes and in launching new and innovative strategy for the advancements of Scheduled Tribes especially in the field of tribal health**.**

1.4 STATEMENT OF THE PROBLEM

Health is an important factor for the economic development of our country. It will also give assistance to the human capital formation. The tribal groups constitute an important part of our economy. There is a growing socio-economic inequality between tribal population and general population. Basic inequality in health care between tribals and non-tribals has increased over the years. Appalling poverty results in deprivation of even basic needs in general and health care in particular among the tribal society. Tribal development can be made possible only by ensuring adequate health facility.

Tribals constitute around 20% of the population of Vithura Gramapanchayath of Thiruvananthapuram district. Despite the concerted efforts of the government the effect of the welfare policies on tribal welfare and development has been marginal. Most of the tribes continue to remain under a state of deprivation. Hence it is essential to analyse the present status of health among the tribals, various health intervention schemes available for tribal population, its implementation, outreach and effectiveness in bringing about the development of the tribal economy.

The main issue faced by the tribals is the lack of health service which adversely affects their health. In spite of large numbers of government policies and schemes aimed at tribal welfare, they still face the problems of adequacy and accessibility of government health care facilities. Lack of education and limited awareness of different health facilities and government schemes available for them may have also led to poor health among them especially children and pregnant women. Many diseases prevalent among tribal population are not found among general population. This study intends to investigate the reasons for the same. The study is focused on analyzing the health issues faced by tribals and solutions for the problem.

1.5 OBJECTIVES

1) To analyze the socio-economic profile and the present health status of the tribal population of Vithura Gramapanchayath.
2) To evaluate the availability, adequacy and utilization of health services in the tribal areas and assess the level of awareness among tribals about the available health schemes.
3) To examine the role of schemes in the improving the health of tribals.

1.6 METHODOLOGY

The study was conducted in the Vithura panchayath of Thiruvananthapuram district. The study is based on both primary and secondary data. The main source of data is primary sample survey of households in the tribal settlements. Primary data was collected through direct interview method using questionnaire. Survey was made on the basis of simple random sampling method. It was supplemented with secondary data from panchayath. After the field work, the data collected were scrutinized and were processed in tabular forms. Both

quantitative and qualitative methods were employed to analyse the collected data. Suitable statistical tools were used for analysis.

1.7 LIMITATIONS OF THE STUDY

The subject and area of study posed a number of challenges in the smooth conduct of the study. The most important limitation faced during the study was reluctance on the part of people to provide information. The study was limited to the area of a single grama panchayath and was conducted within a span of limited time. Hence, there was both space and time constraint.

1.8 ANALYSIS OF HEALTH STATUS AND HEALTH INTERVENTION AMONG TRIBAL POPULATION OF VITHURA

This section provides the result of analysis of data obtained through interview method during the field survey. The analysis of the variables helps to highlight i) The socio-economic characteristics of the sample unit ii) work details iii)health issues iv) expenses incurred.

- **Socio-economic characteristics**

Socio-economic characteristics were analyzed by considering:

i) Gender ii) Age iii) Religion iv) Education v) Number of family members vi) Income category vii) Average family annual income

i) GENDER

Table: 1.8.1 represent the gender of the respondents

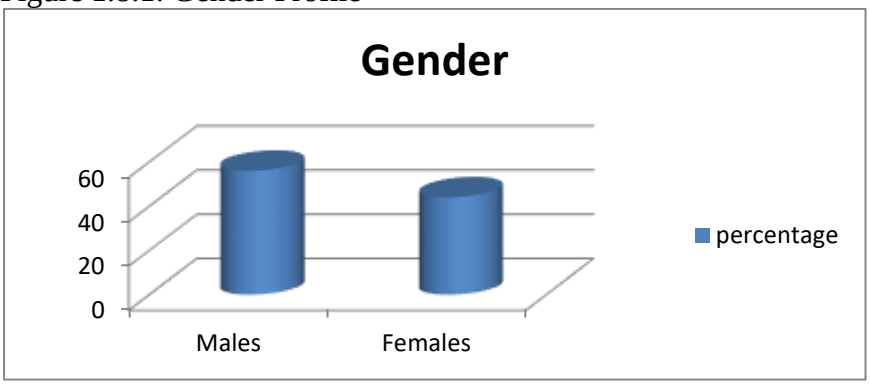
Table: 1.8.1 Gender Profile of the Respondents

Gender	**Percentage**
Male	56
Female	44
Total	100

Source: primary survey 2020

The above table shows that out of the 50 households surveyed majority of the respondents are males. 56% of the total respondents are males and 44% are females.

Figure 1.8.1: Gender Profile



Source: primary survey 2020

ii) AGE

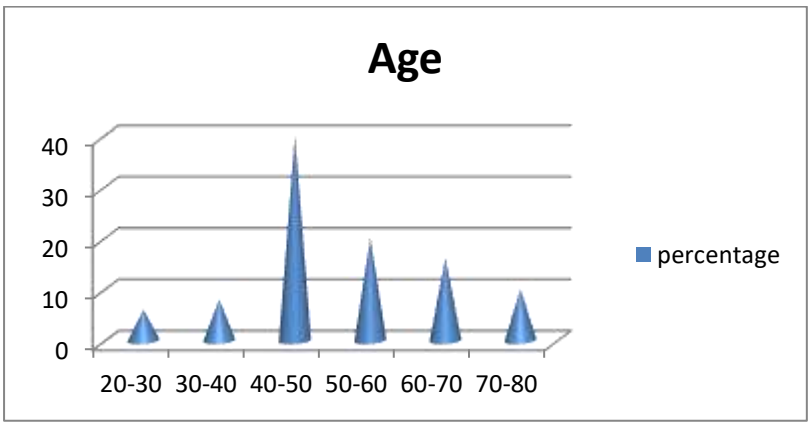
Table 1.8.2 Age profile of the respondents

Age	**Percentage**
20-30	6
30-40	8
40-50	40
50-60	20
60-70	16
70-80	10
Total	100

Source primary survey 2020

The above table shows that 6% of the respondents belong to the age group 20-30. 8% of the respondents belong to the age group 30-40. 40% of the respondents fall under the age group 40-50. 20% of the respondents belong to the age group 50-60. 16% of the respondent belong to the age group 60-70.10% of the respondents belong to the age group 70-80. This is represented in the following figure:

Figure 1.8.2 Age profile of the respondents



Source: primary survey 2020

iii)
iv)

v) RELIGION

Table: 1.8.3 represent the religion of the respondent

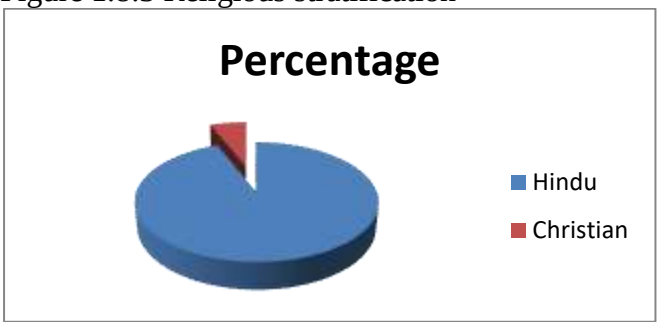
Table1.8 .3 Religious Stratification

Religion	Percentage
Hindu	94
Christian	6
Total	100

Source: primary survey 2020

The above table shows that the majority of the respondents belong to Hindu community followed by Christians. Around 94% of the respondents were Hindus and 6 % were Christians.

Figure 1.8.3 Religious stratification



Source : primary survey 2020

vi) EDUCATION

Table: 1.8.4 represent the education of the Respondents

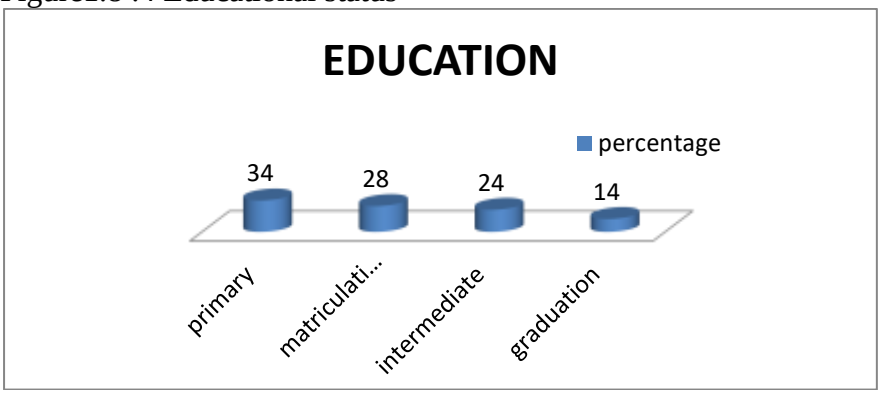
Table 1.8.4 Educational Status

Education	Percentage
Primary	34
Matriculation	28
Intermediate	24
Graduation	14

Source: primary survey 2020

The above table shows that 34% have primary education. Then 28% of the population has completed matriculation, 24% have completed intermediate, 14% have completed graduation. The following figure shows the educational status of the respondents.

Figure1.8 .4 Educational status



Source: primary survey 2020

vii) FAMILY MEMBERS/ SIZE OF THE FAMILY

Table 1.8.5 represents the number of family members in each household

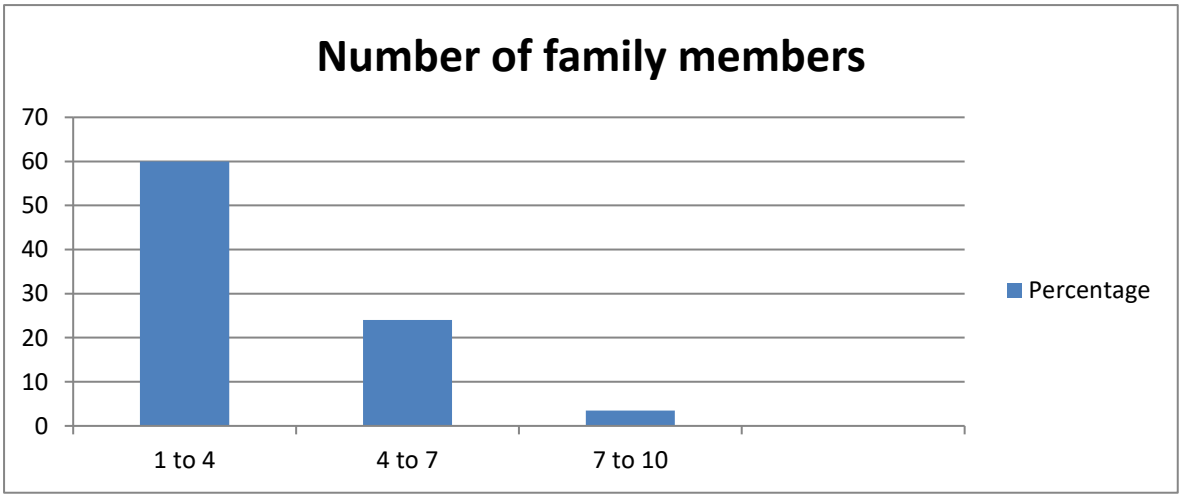
Table: 1.8.5 Family members

Number of Family members	**Percentage**
1-4	60
4-7	24
7-10	16
Total	100

Source: primary survey 2020

The above table shows that 60% of the households surveyed have number of family members between 1-4, 24% of the families surveyed have 4-7 members and 16% of the families have 7-10 members .

Figure 1.8.5 Number of family members



Source: primary survey 2020

viii) INCOME CATEGORY

Table: 1.8.6 represent income category of the respondents

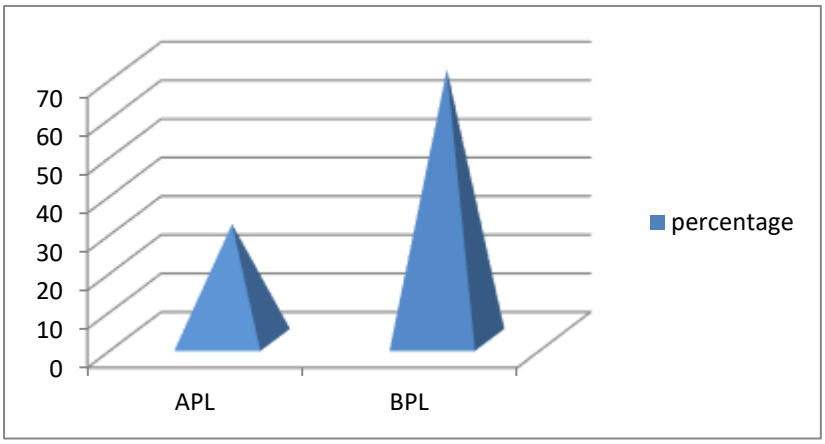
Table : 1.8.6 Income classification

Income category	Percentage
A.P.L	30
B.P.L	70
Total	100

Source :primary survey 2020

The above table shows that 30% of the households surveyed belong to A.P.L and 70% of respondents belong to B.P.L category.

Figure 1.8.6 Income classification



Source :primary survey 2020

ix) AVERAGE ANNUAL FAMILY INCOME

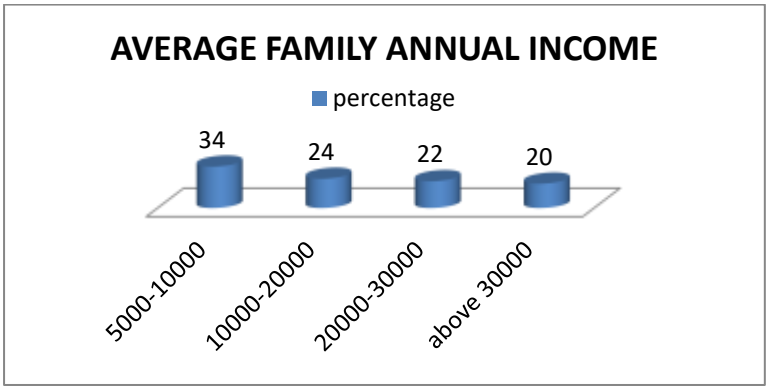
Table: 1.8.7 Average Annual Family Income

Average family annual income	Percentage
5000-10000	34
10000-20000	24
20000-30000	22
Above 30000	20
Total	100

Source: primary survey 2020

The above table and figure show that 34% of the respondents have average annual income between Rs 5000-10000, 24% of the respondents have income levels between Rs 10000-20000, 22% have income levels of 20000-30000, and 20% belongs to the income group above 30000.

Figure: 1.8.7 Average Annual Family Income



Source: primary survey 2020

x) EXPENDITURE ON HEALTH

Table : 1.8.8 represent the expenditure on health of the respondent

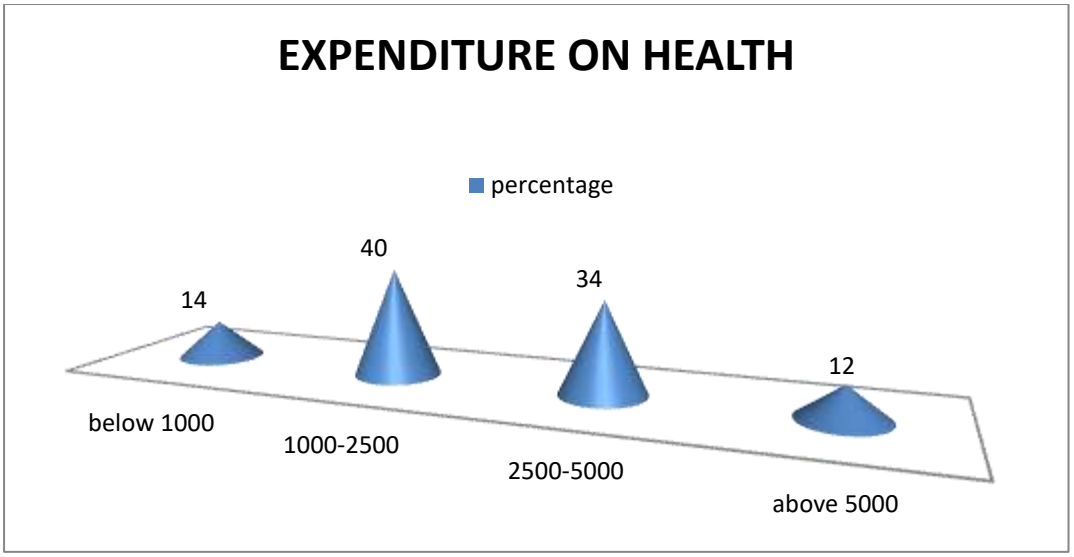
Table : 1.8.8 Expenditure on health

Expenditure on health	**Percentage**
Below 1000	14
1000- 2500	40
2500- 5000	34
Above 5000	12
Total	100

Source: primary survey 2020

The above table shows that 14% have expenditure on health below Rs. 1000.Then 40% of the respondents have expenditure on health between Rs 1000-2500, 34% of respondent spent an amount between Rs 2500-5000 on health.While 12% have an expenditure above 5000.

Figure: 1.8.8 Expenditure on health



Source: primary survey 2020

IX) TYPE OF WORK

Table: 1.8.9 represents the work type of the respondent

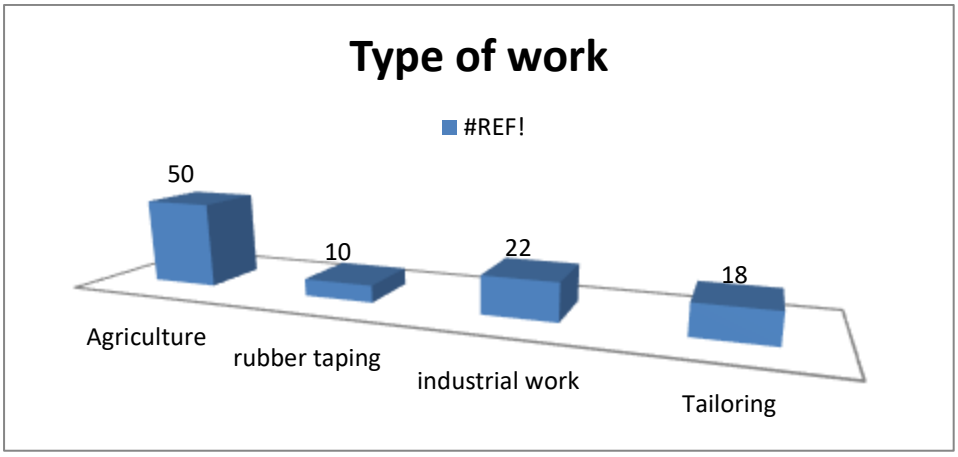
Table: 1.8.9 Type of Work

Type of work	**Percentage**
Agriculture	50
Rubber tapping	10
Industrial work	22
Tailoring	18
Total	100

Source: primary survey 2020

The above table and figure show that 50% of the respondents are engaged in agriculture activity, 10% are engaged in rubber tapping,22% are engaged in industrial work and 18% are engaged in tailoring.

Figure: 1.8.9 Type of Work



Source: primary survey 2020

X) HEALTH ISSUES

Table : 1.8.10 represents the health issues of the respondent

Table : 1.8.10 Health Issues

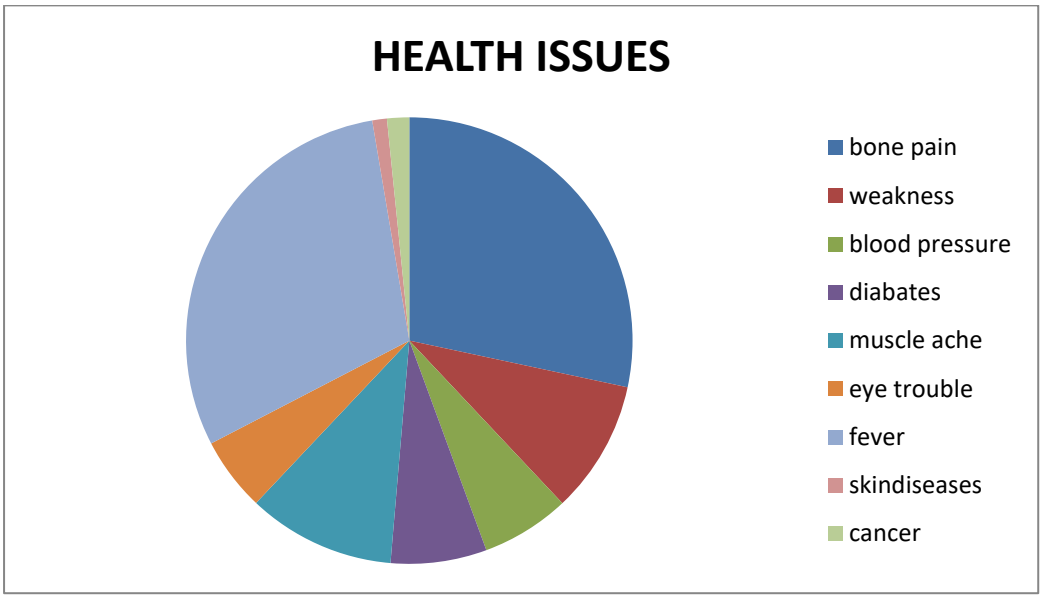
Health Issues	**Percentage**
Bone pain	28.34
Fever	29.94
Weakness	9.62
Blood pressure	6.41
Diabetes	6.95
Muscle ache	10.69

Eye trouble	5.34
Skin diseases	1.06
Cancer	1.60
Total	100

Source: primary survey 2020

The above table shows that 29.94% are affected by fever, 28.34 are affected by bone pain, 10.69% are affected by muscle ain, 9.62% are affected by weakness, 6.41% are affected by blood pressure, 6.95% are affected by diabetes, 5.34% are affected by eye trouble, 1.06% is affected by skin diseases and 1.60% is affected by cancer.

Figure: 1.8.10 Health Issues



Source: primary survey 2020

XII) DURATION IN THE OCCURANCE OF THE HEALTH ISSUES

Table: 1.8.11 represents duration of illness affected by the respondent

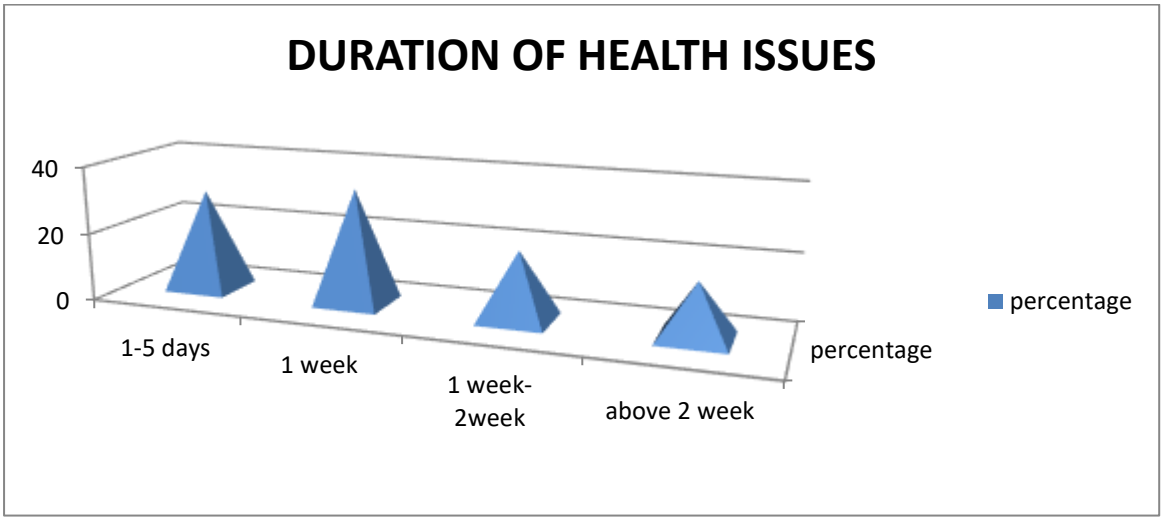
Table: 1.8.11 Duration of illness

Duration	**Percentage**
1 – 5 days	30
1 week	34
1 week to 2 week	20
Above 2 week	16
Total	100

Source: primary survey 2020

30% stated that they suffered from illness for a period of 1-5 days, 34% have duration of one week, 20% have duration of one week to two weeks and 16% have duration above two weeks.

Figure: 1.8.11 Duration of illness



Source: primary survey 2020

XII) NUMBER OF CHILDREN

Table: 1.8.12 represents no of children in a family

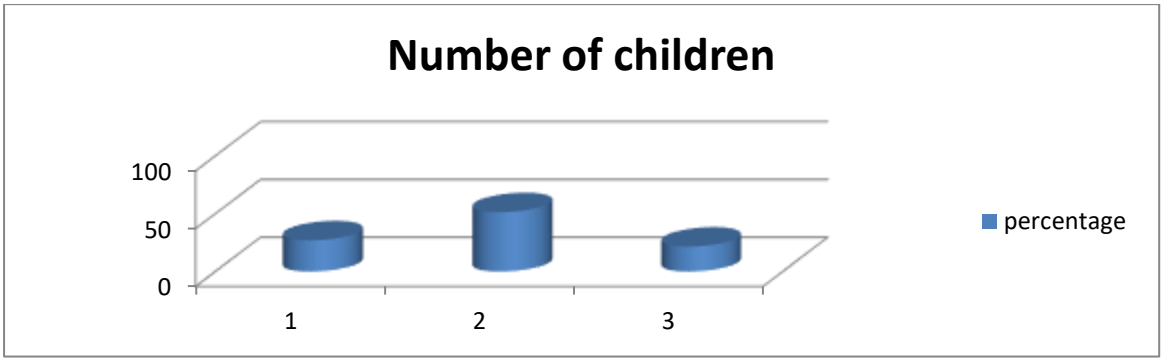
Table:1.8.12 Number of children

Number of children in a family	Percentage
1	32.5
2	47.5
3	20
Total	100

Source: primary survey 2020

The above table shows 32.5% of the families had only one child in a family, 47.5% families had 2 children and 20% had three children's in a family.

Figure: 1.8.12 Number of children



Source: primary survey 2020

XIII) TYPE OF HOSPITAL

Table: 1.8.13 represents the type of hospitals preferred by respondents

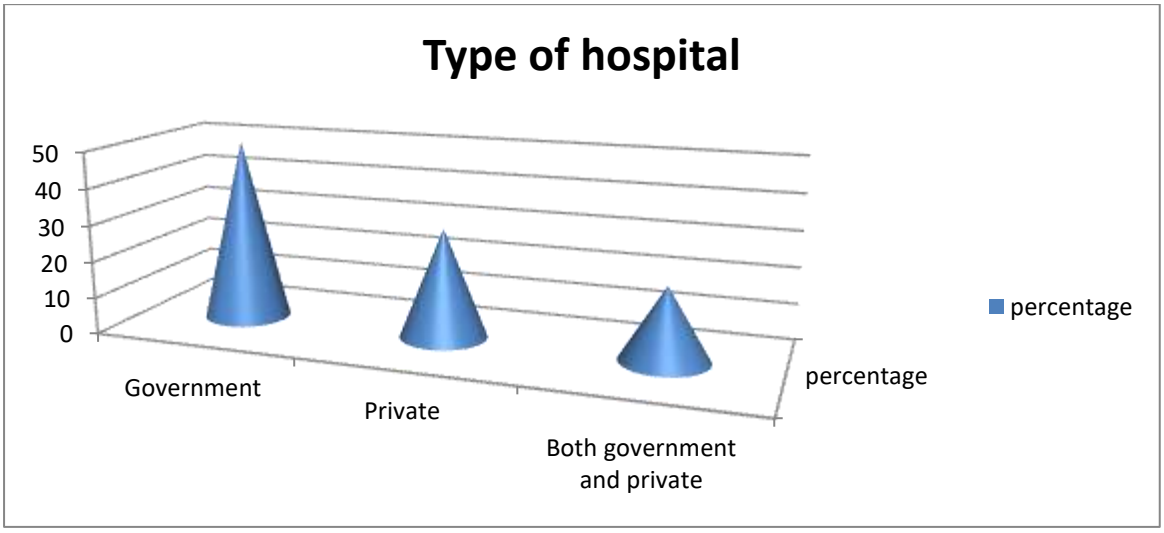
Table: 1.8.13 Type of hospitals

Type of hospital	Percentage
Government	50
Private	30
Both government & private	20
Total	100

Source: primary survey 2020

The above table shows 50% of respondents preferred government hospitals, 30% of respondents preferred private hospitals and 20% of respondents preferred both government and private hospitals alike.

Figure: 1.8.13 Type of hospitals



Source: primary survey 2020

XIV) Availability of Health Insurance Plan

Table 1.8.14 represents the availability of health insurance plan by government

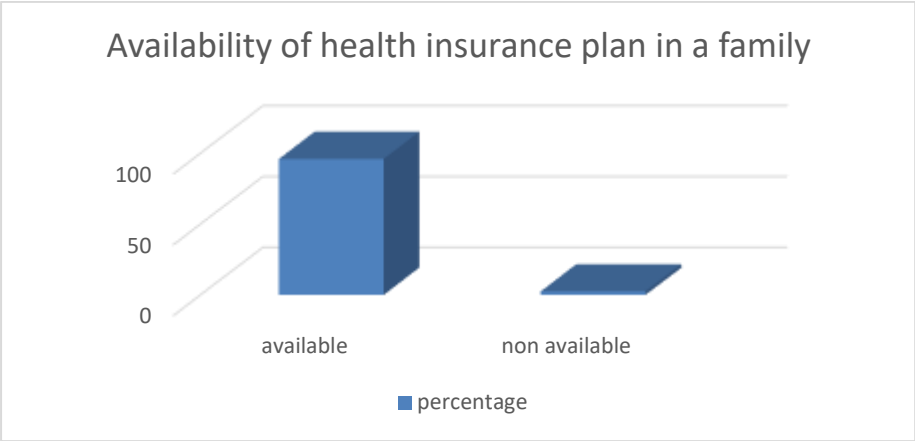
Table: 1.8.14 Availability of health insurance plan in a family

Category	Percentage
Available	96
Non available	4
Total	100

Source: primary survey 2020

The above table shows that 96% of families used health insurance scheme and 4% did not use the health insurance plan.

Figure: 1.8.14 Availability of health insurance plan in a family



Source: primary survey 2020

XV) Available tribal health care schemes in Vithura gramapanchyath

Table: 1.8.15 Represents tribal heath care schemes in Vithura Grama Panchayath

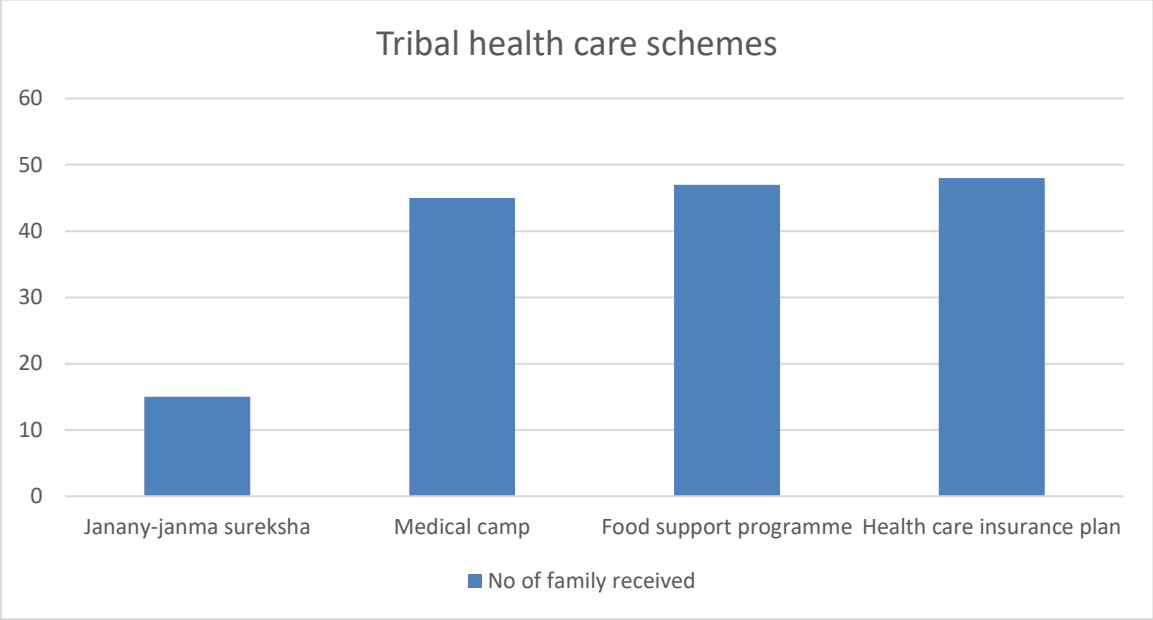
Table: 1.8.15 Tribal health care schemes

Tribal health care schemes	**Beneficiary Families**
Janany- janmasureksha	15
Medical camp	45
Food support programme	47
Health insurance plan	48

Source: primary survey 2020

The above table shows that fifteen families received the benefits from janany- janmasureksha scheme, 45 families received the benefits from the medical camp, 47 families received the food support programme, and 48 families availed the health insurance plan.

Figure: 1.8.15 Tribal health care schemes



Source: primary survey 2020

1.9 FINDINGS, SUGGESTIONS AND CONCLUSIONS

This section summarizes the major highlights of the study.

Major Findings

*A significant percentage of the respondents belong to the age group 40-50, while rest belongs to the group 20-70. All respondents are married and they belong to either Christian or Hindu community. 94% of respondents are Hindus.

*Regarding education of the respondents, few of them had completed graduation. Majority of respondents have primary level education.

*The family average annual income of 34% varied between 5000-10000 while 24% belongs to income group of Rs 10000-20000, 22% belongs to income group between Rs 20000-30000 and 20% belongs to income group above 30000.

*With respect to type of work they are engaged in agriculture, rubber taping, industrial work and tailoring. 50% are engaged in agriculture activities.

*They faced some health issues such as bone pain weakness, fever, blood pressure, diabetes, skin trouble, eye trouble, muscle pain, cancer.

*Duration of health issues normally ranged between 1 to 7 days, 16% faced health issues for a period above two week.

*Regarding their expenditure on health majority spent1000-2500.only 16% of respondent spent above Rs 5000.

*Majority of respondents meet their medical expenditure through the use of insurance card.

*Majority of respondents preferred government hospitals, 20% of people preferred both government and private hospitals.

*Majority of families have two children.

Suggestions and Policy Implication

On the basis of the study follows measure are suggested for improving the health status on tribal population.

In order to meet the shortage of manpower in the critical areas of health care centres, district authorities in health care departments should be adequately authorized so that time is not lost in replacement of manpower and the work is effectively managed. Eligible candidates from nearby areas can be considered for employment to facilitate the uninterrupted service.

⇒ Continuous training of paramedical staff to increases the productivity must be considered. The training must include special interpersonal relations, awareness of tribal problems that can foster a sense of belongingness. Compensation for the mobility of health staff must be considered. This will take care of cost effectiveness and designed implementation monitored and evaluated.

⇒ It is suggested to formulate a committee under the aegis of the district medical officer (DMO) at district level to design, implement, monitor and evaluate the progress of tribal health programmes. This would facilitate faster response to the need in health care centres. This committee also should be empowered to check and maintain an inventory of laboratory chemicals, medicines and hospital disposables apart from manpower resources.

⇒ Motivated healthcare professionals have to be posted in the tribal belt. It is difficult to expect health care staff to serve continuously in tribal areas due to their personal reasons and the nature of geographical locations and climatic conditions. Therefore, job rotation of employees may be considered to motivate and develop commitment among the staff.

⇒ Special wages and incentives package need to be evolved with a focus on proper promotion, housing, skill based training for the health care professionals and paramedical to enhance their competency and involvement in the job

⇒ Working in rural area be made compulsory for fresh medical graduates and students. Government agencies, NGO's and private nursing school should unite and work jointly to deliver health care services in the tribal settlements.

⇒ Present rule of serving in rural hospital for medical students has to be further strengthened. Government agencies can collaborate with nursing training colleges for cost effective nursing services.

⇒ Providing treatment to cure diseases (therapeutic) is far more expensive than preventing (prophylaxis) them. Therefore a robust system must be in place for planning, organizing, developing and utilization of the resources to achieve the objective of health care for tribals.

⇒ Tribal family should be educated on importance of immunization to maintain good health; especially tribal mothers must be educated

*The government should give appropriate development policies for tribal health care.

*Provide medical investigation for removing the epidemic and other issues.

*Should provide health centres for tribal areas.

*Government should appointed permanent doctors and establishing night service for people.

*To ensure adequate medicines in health centres and other vaccinations, laboratories etc.

*Take more initiative to given health awareness programmes for improving tribal health.

CONCLUSION

The present study was an attempt to find out the health status of tribal population. The study showed that tribals had awareness about the government policies for tribal health care. They require better treatment, travelling facility, medicines etc. A number of factors are responsible for the tribals not being able to get the benefits of modern health care. The main reason is due to the geographical isolation and inaccessibility. Health care centres are far away from tribal areas and poor transportation makes it even more difficult for tribals to make use of the available medical facilities. In the tribal context, environment plays an important role in the framework and evaluation of health care systems. Therefore, policies and programmes should be evolved keeping in mind the ground realities. Poor socioeconomic condition forces the tribal children to give up their education. No doubt, existing heath care system is people centric but it is the fact that the benefits have not reached the tribals.

The plans and policy options of health care delivery system should be ambitious, at the same time, be guided by the realities. It is imperative to carry out locally relevant initiatives for better service delivery. There is a wide scope for studying the problems inherent to the tribal society. Developing a system that can ensure a close monitoring and evaluation of the implementation of delivery system to augment positive response from the tribals is the need of the hour. Though a number of national and international agencies have conducted studies to evolve schemes for upliftment of tribal population, there is a mismatch between the problems and solutions. If an effective machinery to supervise and execute the health care services of the tribals is developed with social and legal accountability tribal health can be improved. In order to achieve national integrity in this regard a time bound and comprehensive health programme needs to be developed tribal upliftment.

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