

**Study to understand the
Health Status and Healthcare Systems
In selected tribal areas of India**



Abridged Report



Swami Vivekananda Youth Movement

Saragur

**In collaboration with the Ministry of Health & Family Welfare &
WHO Country Office for India**

Disclaimer: *This document is not a formal publication of the World Health Organization (WHO) and the Ministry of Health and Family Welfare (MOHFW), Government of India. The study was supported under the WHO/GOI biennium workplan, however, the views expressed are solely of the authors and do not necessarily in any way reflect the opinion or views of WHO and GOI. The document may, however, be freely reviewed, abstracted, reproduced or translated, in part or whole, with due acknowledgement, but is not for sale or for use in conjunction with commercial purposes.*

Contents

Acknowledgements	3
Research Team of SVYM for this study	3
1. Introduction:.....	4
2. Goal:.....	5
3. Objectives:	5
4. Findings:.....	5
4.1. General:	5
4.2. Under Five Child Health:	6
4.3. Maternal Health:	7
4.4. Adult Health:	8
4.5. Other factors that contribute to the Health status:	9
4.6. Health facilities:	10
4.6.1. Primary Health Centres (PHC):.....	10
4.6.2. Subcentres (SC):	11
4.6.3. Anganwadi centres (AWC):	11
4.6.4. Community Health Centres (CHC) Or First Referral Unit (FRU):.....	12
5. Key Recommendations:	13
5.1. Disaggregate ST Data collection:	13
5.2. Under Five Child Health:	13
5.3. Maternal Health:	13
5.4. Adult Health:	14
5.5. Other factors that contribute to the Health status:	15
5.6. Health facilities:	15
5.7. Other recommendations to strengthen certain aspects of NRHM:.....	16
6. Conclusion:	17

Acknowledgements

This study would not have been possible but for the support of the World Health Organization and the Government of India. We thank Mr. Sunil Nandaraj, Ms. Anagha Khot, Ms. Ganga Murthy and all the Government functionaries of the states visited. We thank the field level government functionaries and the Non governmental organizations that helped us during the field visit. We thank the Schedule Tribe Community which whole heartedly interacted with us during the field survey. We thank the members of the Technical Resource Group and the Project Oversight Team for their valuable inputs. We thank Mr. Chamanlal for his suggestions for the final report. We are thankful for the support of the entire Health and Development Support team of SVYM and all the members of the Field study Team.

Research Team of SVYM for this study

Principal Investigator – Dr. V.S. Sridharan

Co-investigator – Dr. C. Anil

Support Team:

Dr. R. Balasubramaniam

Dr. M.A.Balasubramanya

Dr. M.R. Seetharaman

Dr. Sridevi Seetharaman

Dr. Bindu Balasubramaniam

Dr. Padmaja

Dr. Rajendra Prasad

Dr. Rekha Shanmukha

1. Introduction

India is home to 84.33 million people classified as Scheduled Tribes (ST), corresponding to 8.2% of the total population. There are 461 groups of tribes who are spread over 26 states and Union Territories. Included in these categories are 74 tribes who have been identified as “Primitive Tribal Groups” (PTG, now called particularly vulnerable Group) characterized by pre agricultural level of technology, extremely low level of literacy and extreme poverty. In general, the Scheduled tribes (ST) live in isolated, scattered and difficult to reach terrain generally near hills and shrinking forests on which they depend for their livelihood.

Despite rapid strides in the field of diagnostics and therapeutics, adequate health care has not been reaching them even after the completion of the tenth five year plan. There is a consensus among various governmental programs to pay special attention to the marginalized Scheduled tribe population, though, the actual state of health and health care in ST areas has not been adequately documented. Though there is data available for rural and urban areas, **data for ST areas is very scanty**. This study was born out of this urgent and felt need in the health sector to study comprehensively and systematically the health situation of the scheduled tribes in the country so that recommendations to strengthen the programmes of NRHM and improve the situation could be formulated. It was conducted by **Swami Vivekananda Youth Movement (SVYM)** a development organization founded in the year 1984, engaged in building a new civil society in India through its grassroots action in Health, Education and Community development sectors. Over the past two decades it has been addressing the various developmental issues of the marginalized scheduled tribe and rural population of H.D.Kote Taluk, one of the most backward ST dominated taluks of Mysore District, Karnataka.

This study was conducted between 15th August 2008 and 15th September 2009 in selected ST dominated areas across 5 states (Jharkhand, Madhya Pradesh, Orissa, Maharashtra and Karnataka) which are home for 47% of the Schedule Tribes of the country. Among the states selected for this study, 3 belong to the high focus non-NE group (Jharkhand, Madhya Pradesh & Orissa), while two fall under the non high-focus large group (Maharashtra & Karnataka). It was supported by Government of India and World Health Organisation.

2. Goal

To improve the health status of the 84.33 million Schedule tribe population in India and bring it on a par with the national average, by suggesting ways to improve the health care delivery through National Rural Health Mission (NRHM) programs.

3. Objectives

1. To study the health status of representative samples of schedule tribe population living across the country.
2. To study the existing health care delivery system and mechanism in the chosen ST areas by evolving appropriate survey instruments.
3. To identify both the positive aspects and the lacunae in the health care.
4. To give recommendations to strengthen the health care mechanism of the NRHM strategy in ST areas.

The study has two main components, namely, a desk review of the relevant national level documents and a field review based on interviews with both the providers of health care and the beneficiaries to understand the data obtained from the desk review.

4. Findings

The key areas that were studied to understand the Health Status and Health care delivery system and mechanism were 1. Under Five Child health, 2. Maternal health, 3. Adult health, 4. other significant factors that impact the health status and 5. The status of Health facilities.

4.1. General:

STs constituting 8.2% of the total population of the country contribute to 17.5 % of the rural poor. There is paucity of data pertaining to them and whatever is available is scanty. There seems to be no systematic mechanism to capture various disaggregates health related data for the ST population. All available studies and surveys leave one in no doubt that all the health indicators, especially related to health status, accessibility, reach and health delivery, are very much below the national average and in most instances lower than the rural figures.

4.2. Under Five Child Health:

1. The Crude Birth Rates in the ST are not available from the desk review materials.
2. The desk review shows that mortalities between 1 month to 5 years is 30 at the National level, 41 in the Rural areas and 64 in the ST areas per 1000 live births. The number of children dying in this age group in the ST areas is more than twice the national average. It is higher than the rural figures. The medical officers and other health providers interviewed during the field visit were found lacking in awareness of the extent of the mortality in different age groups of children in their area.
3. The health facilities like Sub Centre (SC), Primary Health Centre (PHC) and Community Health Centre (CHC)/First Referral Units (FRU) are inadequately equipped in terms of infrastructure, supplies, man power and skills to address illnesses which contribute to the morbidity and mortality in children. In addition to this, availability, accessibility and affordability issues come in the way of providing quality care to sick children.
4. The percentage of children who receive appropriate treatment for important childhood illnesses is low across the country as well as in the ST areas. In the ST, only 1 in 8 children gets appropriate treatment for Acute Respiratory Infections (13%) and Malaria (12%) and 1 in 3 for Diarrhoea (29%). Only 60% of ST women are aware of the importance of Oral Re hydration Solutions in diarrhoea.
5. All the parameters for under nutrition are higher in the ST than the National and the rural figures. 57% of ST children are Underweight (Rural - 50% and National - 39%), 55% stunted (Rural - 50% and National 45%), 29% wasted (Rural - 25% and National 19%) and 78% anaemic (Rural - 71% and National - 67%). The causes for the poor nutritional status are lack of access to appropriate quantity and quality of food due to poverty and reasons which go beyond the health sector which can only provide a necessary infrastructure and ensure its efficient functioning. In the nutritional interventions of the Anganwadi centres (AWC), the nutritional needs of the children in the crucial age bracket (6 months to 2 years) are not being addressed although the Integrated Child Development Scheme (ICDS) covers the age group 0 to 3 years also. Only for 13% of the children are all the three recommendations of Infant and Young Child Feeding practice (recommended by WHO) followed.
6. Among the ST children in the selected states, 32% (1 in 3) received full primary immunization (National - 48%, Rural - 43%) and 12% (1 in 8) no immunization (National - 5%, Rural - 7%) as per the data of 2005/06 National Family Health Survey-

3. The ST figures are lower than the national and rural figures. There has been no appreciable improvement in trend between 1998/99 and 2005/06. The inadequate coverage of immunization is related to difficulties in availability, procurement, storage, maintenance of cold chain of vaccines and accessibility of the target population. The ST figures of immunization coverage are lower than the rural figures. Only 15% of the ST children received Vitamin A in the previous 6 months and this is less than in the rural and national figures.

4.3. Maternal Health:

1. Only 36% of the pregnant woman are registered for Ante Natal Care (ANC) in the I trimester, 41% receive mandatory 3 ANC and 28% do not have any ANC. 63% of the pregnant women receive IFA tablets but only 21% of them actually consume them for the mandatory 100 days. Among those registered for ANC, 40 to 64 % receive varying individual basic important components of the ANC. The percentage of women who receive all the basic components is not available from the reports. Only 32% of the pregnant women are told where to go if they experienced pregnancy related complications and 11 to 15 % of the pregnant women are given information on specific pregnancy complications. The important aspect of delivery preparedness and where to go if there are complications are not discussed with all the women.

2. Only 1 in 5 deliveries in ST is institutional delivery and 1 in 4 is assisted by health personnel in 2005 - 2006. In spite of the incentive schemes, there are difficulties in promotion of institutional deliveries. Although institutional deliveries in ST areas are reported to have increased considerably after the initiation of NRHM from the low level of 20%, the issue is still a matter of concern. The deliveries take place mainly in the Primary Health Centres or the First Referral Units and not in the Sub centres.

3. The infrastructural facilities, medical and paramedical human resources have not improved much. **We feel that just bringing the pregnant women to the institution for delivery does not address the basic need for appropriate and optimal care during delivery as the facilities are lacking in resources. It seems that there is not much difference between home and hospital deliveries in terms of quality of care.**

4. On an average, 1 in 4 women gets Post Natal Care (PNC) within 48 hours of delivery. The health staffs are able to give PNC within 48 hours for only institutional deliveries and not for all home deliveries. In Orissa in the ST districts of Koraput and Mayurbanj, the DLHS 3 (2007/08) report states that the PNC within 48 hours of delivery is 100% and 95.7% respectively, though the percentage of institutional deliveries is only 11.6% and 40.3%. It is difficult to take the claim of 100% PNC. It is

possible that the claim pertains to institutional deliveries only.

5. Figures for maternal mortality are not available in the reports of National Family Health Survey and District Level Household and Facility Survey (DLHS). The medical officers are of the opinion that maternal mortality has reduced and that they tend to occur in home deliveries. Sepsis, post partal hemorrhage and anemia continue to be the commonest delivery related complications. Yet, the Primary Health Centres and the First Referral Units are ill equipped to deal with such events. Only 40% of the FRU can manage the obstetric emergencies, 14% have blood storage facilities and 53% have facilities for Medical Termination of Pregnancy. Apart from mortality, the magnitude of the morbidity (so called near miss events) related to child birth is not known. The importance of maternal morbidity goes beyond the mother and affects the newborn as well. Status of unsafe abortions in the ST areas has not been recorded.

6. The other indicators like Total Fertility Rate (TFR), Birth order of >4, and Teenage pregnancy in ST are higher than the National average. TFR : ST - 3.14, National - 2.5, Rural - 2.77; Birth order >4: ST - 33.4, National - 22.2, Rural - 24.2: Teenage pregnancy : ST - 22.5, National - 19.9, Rural - 20.7. In Karnataka, the TFR in ST has increased from 2.38 to 2.53 and the birth order of >4 from 18 to 24, while the decadal growth rate for the ST in Dakshin Kannada has shown a negative growth of 2.9% This is a cause for concern and it needs to be studied further. Every 4th pregnancy in the ST areas is a teenage pregnancy, yet, neither the medical officer nor the Auxillary Nurse Midwife (ANM) were aware of the magnitude of teenage pregnancies in ST.

7. The total unmet need for Ffamily Planning in the ST is 25% for the selected states. It is 13% at the national level and 14% % for the rural population. Medical Termination of Pregnancy services were available in only 53% of the Community Health Centres visited.

4.4. Adult Health:

1. 41% of ST men (National - 34%; Rural - 38%) and 47% of ST women (National - 36%; Rural - 41%) are undernourished with the Body Mass Index (BMI) of <18.5. 40% of ST men (National - 25%; Rural - 28%) and 69% of ST women (National - 55%; Rural 57%) are anemic. The nutrition of adolescent girls, pregnant and lactating women bears a direct relationship with the nutrition of the child. The Anganwadi centre does not adequately address this section.
2. Disaggregate figures for the prevalence of tuberculosis for the state are not available. The awareness about tuberculosis and Directly Observed Treatment Schort course

(DOTS) in ST is 70% and 60% respectively. Though cumulative figures for the ST districts across the nation show that the targets for Revised National Tuberculosis Control Programme (RNTCP) have been reached as per the annual report for 2008, during the field visit, it was learnt the health functionaries faced challenges in case detection and case holding. With these problems, it is difficult to understand how the targets for RNTCP have been reached in the ST districts. Disaggregate figures for the ST in the areas of Leprosy, Kala Azar and Malaria are not available.

3. Prevalence of Human Immune deficiency Virus (HIV) infection in the ST is not available. Awareness indicators for the ST show that 8% of women and 20% of men have comprehensive knowledge about HIV. Specific measures to address this problem have not been implemented at the state levels except in Maharashtra and Karnataka. Though HIV screening in pregnant women is recommended in the country there are no facilities for screening in three of the states visited. Integrated Counseling and Treatment Centre (ICTC) facilities are not easily available in the PHCs or FRUs and people need to go the District hospitals for these services.
4. There is low awareness amongst the PHC Medical Officers about the prevalence of genetic diseases in ST. At the PHC level the resources are inadequate to address the non communicable diseases and hence the patients have to go to the FRU or the district hospital for diagnosis and treatment.

4.5. Other factors that contribute to the Health status:

1. Only for 40% of the rural and lowest two wealth index categories, to which most of the ST population belongs, Government facilities are the source of health care. The remaining 60% seek private providers. The main reasons given for not seeking care in the government health facilities are poor quality of care (51%), lack of a nearby facility (45%), and long waiting times (32%).
2. 26% of women and 71% of Men use tobacco in some form or the other and 14% of women and 50% of men use alcohol in ST. 46% of ST women experience some form of spousal violence (Physical, emotional or sexual). These figures are higher than the national and rural figures. During the field visit, we found that the PHC Medical Officers and the health workers are lacking in awareness of the magnitude of these problems. No specific focus on these issues is being given in general.
3. Only 2.6% of the ST families have any type of health related insurance.

4.6. Health facilities:

4.6.1. Primary Health Centres (PHC):

1. Each PHC caters to a population of 17,000 to 65,000, the average being 40,000 spread over 59 villages and the average distance of the farthest village from the PHC is 24 km. The distance between the PHC and the nearest referral centre is 28 km. Nearly 18 percent of the villages do not have proper roads and 11 percent are not accessible during certain periods of the year. In terms of population coverage and accessibility, the PHCs in these ST areas are overburdened and not easily accessible by all the villages under their care.
2. Only in 43% of the PHCs were the medical officers staying on the campus. There is no back up support when the medical officers are on leave in PHCs with single Medical Officer. On an average 20 % of the posts of paramedical staff excluding Accredited Social Health Activist (ASHA) are vacant.
3. Only 72% of the PHCs were in good condition. Some of the PHCs are still in the process of transition or up gradation from PHC to CHC and hence there was confusion even among the medical officers as to the status of their own institution and their own job description. The up gradation process was not complete even 4 years after the implementation of NRHM.
4. Piped water supply was available in 45% and functional toilets in 58% of the PHCs. 51% of the PHCs had regular electricity and 27% had generator back up. 44% of the PHCs had connectivity through land line phones. Some of the interior ST areas are not reachable even by mobile phone facilities. 76% of the PHCs had Ice Lined Refrigerator (ILR) and Deep freezer for vaccine storage yet only in 36% of them were they functional. 57% of the PHCs had more than 75% of the essential medicines including Anti snake venom. Minor Operation theatre is available in 28% of the PHCs and functional ambulance facilities in 34%.
5. Though clinical laboratory facilities are available in 69% of the PHCs, they had limitations in terms of range of basic investigations (one or more of the following tests are available - Haemoglobin estimation, Urine albumin, sugar estimation, Urine pregnancy test, smear for AFB and Malarial parasite) and availability of full time laboratory technician.
6. 75% of the PHCs have labour rooms where labour is being conducted. However, only 17% have adequate facilities for conducting normal labour and 19% for newborn care.

7. The general cleanliness of the PHC was good only in 5% of the PHCs. The waste disposal mechanisms in the PHCs are either burning or burial. None of the PHCs visited had the recommended waste segregation and disposal mechanisms in place.
8. Only 58% of the MOs had any kind of skill development training in the previous two years.

In general, during the field visit we found that the PHCs are not fully equipped to address the health needs in the tribal areas.

4.6.2. Subcentres (SC):

1. On an average each PHC has 11 subcenters ranging from 5 to 18 per PHC each having a population of about 4000 spread over about 7 scattered hamlets. As per NRHM, the Sub-Centres are currently provided on the population norm of 1 per 5000 population in general areas and 1 per 3000 population in tribal areas.
2. 28% of the subcentres have no vehicular access, 18% have no proper access road and 11% have no all weather access. 6% had no ANM and 65% have no male health worker. 49% of the ANMs claimed that they live in the subcentre village. Though 11% of the subcentres had designated rooms for conducting normal labor, they were not conducive for it. None of the subcentres had facilities for newborn resuscitation. Basic drugs were available in only 60% of them.

4.6.3. Anganwadi centres (AWC):

1. Though the percentage of utilization of the AWCs in ST is higher than the rural figures, in absolute terms only 50% of children are registered and 38% among them are weighed regularly for monitoring of their nutritional status. 48% of the mothers whose children are weighed receive some form of nutrition related counseling. Thus the benefit of growth monitoring goes only to a very small fraction of ST children.
2. The overall hygiene of the centres and the children was very poor in the centres visited. In some states there were no buildings for the centre and the worker managed by cooking in her home. None of the AWCs had a toilet. The quality of the food grains that were stocked was poor. Many of the centres had no weighing scale. In areas prone for terrorist / Maoist attacks,(Jharkjand) we were told that 1/3rd of the budget of the centre goes to the Maoist supervisor - Mapahadia people.
3. The challenges facing Anganwadi workers include too much of documentation work,

people not having faith in anganwadi services, poor infrastructure at anganwadi, irregular supply of provisions to the centres, difficulty in transporting the provision to the centres as they are not paid separately for this. The present function of the Anganwadi worker (AWW) as a part time honorary worker is a hindrance to their full involvement with the program. Their salary/honorarium is poor and its disbursements are irregular. They are also given periodically certain non health related jobs. These difficulties decrease their morale and enthusiasm in the work.

4. The Anganwadi is more a feeding center and the component of preschool education of the children is often lacking.
5. The ST community (in Jharkhand, Madhya Pradesh and Maharashtra) feels that food must be provided twice a day.

4.6.4. Community Health Centres (CHC) Or First Referral Unit (FRU):

1. Each CHC serves a population of 1,34,250, spread over 100 villages and is a referral centre for 5 PHCs. The CHCs are currently provided on the population norm of 1 per 1,20,000 population in general areas and 1 per 80,000 population in tribal / desert areas.
2. Only 72% of the CHC buildings were maintained well and functional toilets were available only in 58% of them. Some of the crucial facilities which contribute to adequate health care during emergencies were found to be wanting. Obstetricians, Surgeons and Anaesthetists were available only in 44%, 30% and 20% of them respectively. 44% of the CHCs had facilities for Medical Termination of Pregnancy and 14% had blood storage facilities. Only around 40% of the CHCs were equipped to address the Obstetric and infant related emergencies and 22% Surgical emergencies due both to poor infrastructure and non availability of skilled human resource.
Functional
3. X-ray facilities were available in 66% and functional Ambulance facilities in 85% of the CHCs.

5. Key Recommendations

5.1. Disaggregate ST Data collection:

Systems and mechanisms to collect disaggregate data pertaining to the health of the ST population at the village, block, district and the State levels on an ongoing basis need to be established to monitor the health related indicators prospectively.

5.2. Under Five Child Health:

1. The mechanism for recording of birth and death of ST children at the PHC level needs to be strengthened by efficient utilization of the services of ASHA, AWW and ANM. The PHC medical officer needs to have a pro active mechanism to track and record these life events as and when they happen.
2. The PHCs and the CHCs must be adequately equipped in terms of infrastructure, human resource and equipments to address the illnesses in children. Accessibility, availability aspects of health care need to be strengthened.
3. The Medical Officers and the paramedical staff need to be sensitized about the extent of mortalities in children. They must undergo relevant initial skill development trainings before appointment to the facilities and periodic in service training thereafter.
4. There is a clear need for strengthening and ongoing monitoring of focused interventions in the areas of Immunization, Vitamin A supplementation and Anganwadi services in the ST areas. The possibility of introducing additional incentives to ANM, ASHA as well as the parents of children may be examined for strengthening these interventions.
5. Focus should be given in the ST areas on regular Health education activities specifically targeting the issues of nutrition, immunization, utilization of nutritional services and childhood illnesses.

5.3. Maternal Health:

1. Pro active promotion of early ANC registration, provision of all the components of ANC care and counseling regarding complications and delivery preparedness need to be ensured through ASHA and ANMs. This should be actively monitored by the medical officer on a monthly basis. As there is poor compliance to oral iron preparations, use of parenteral safe iron sucrose formulations need to be considered.

2. Effective communication mechanism must be established between the community, sub center ANM/ASHA, the PHC medical officer and the FRU especially with regard to delivery care. Proper delivery preparedness must be discussed with each and every pregnant mother. For people living in very remote areas, arrangements for living near the PHC around the time of delivery (transit accommodation) need to be established, especially in ST areas. Maharashtra is planning this model. (Maher scheme of giving transit accommodation to the pregnant woman in/near the PHC).
3. The Sub center, PHC and FRU need to be well equipped and adequately staffed to provide appropriate levels of obstetric care. Development of delivery facilities in the Sub center needs to be examined in the ST areas.
4. Information related to ANC, Institutional deliveries, temporary and permanent methods of family planning need to be regularly included in all health education activities in the community. All the misconceptions regarding the various methods of FP need to be addressed. Gaps in provision of care in the area of family planning need to be filled. Medical Termination of Pregnancy (MTP) services must be made available in all the FRUs.
5. Giving incentives even to the home deliveries needs to be reconsidered as it has a negative impact in promoting institutional deliveries

5.4. Adult Health:

1. Nutrition programs of AWC should proactively focus on the nutritional inputs of all intended beneficiaries, i.e., Pregnant women, Lactating women and the adolescent girls.
2. Disaggregate ST data must be collected at the PHC, Block and District levels for the communicable and non communicable diseases. As this involves additional human resource, adequate provisions must be made to address this important ongoing activity.
3. There is need for more District Microscopy Centre (DMC) in the ST areas. In view of the peculiarity of the scattered population, ST areas should be provided DMCs as per their actual requirement and not merely on the basis of the prescribed population norms. To strengthen the supervisory mechanism under DOTS in ST areas because of their scattered population, separate DOTS supervisors must be sanctioned for the ST areas. The PHC medical officer in the ST areas must be more actively involved in DOTS programme.

4. ICTC facilities need to be established in the FRU and must be available at least once a week at the PHCs.
5. Awareness programs need to be strengthened in the ST areas for HIV and Tuberculosis.
6. Medical officers need to be sensitized about the genetic disorders in the ST.
7. Facilities need to be provided at the PHCs for primary level treatment of non communicable diseases.

5.5. Other factors that contribute to the Health status:

1. Primary mental health care programme needs to be integrated at the PHC level.
2. Issues like Alcohol use, Tobacco or other substance use and spousal violence need to be addressed by multipronged approach of health education, counseling, rehabilitation etc. The health staff must be sensitized to the prevalence of these social problems.
3. Community based health insurance plans need to be popularized in the ST areas, linking them with the micro credit schemes.

5.6. Health facilities:

1. As the population density in the country is not uniform especially in the ST areas, infrastructural provision and improvement as per norms of NRHM should be effected on priority basis in ST areas by setting up of more Anganwadis, Subcentres, PHCs and CHCs in just relation to the actual needs and accessibility of these areas. It would make eminent sense to link the number not to the population but to the case load and distance of the village / habitation.
2. The Infrastructure, Human resource availability, laboratory facilities, equipments, supplies, transport facilities of the PHCs and CHCs need improvement as per what is guaranteed by NRHM. Recruitment of adequate medical and nursing man power to the ST areas by offering more attractive benefits will need to be considered. Crucial facilities which contribute to adequate health care during emergencies, labour, infant and childhood illnesses need to be made available in PHCs and CHCs round the clock. Priority should be given to posting of an additional ANM to the Sub centres and additional medical officers to the PHCs in the ST areas. Providing local staff from among the ST for working in ST areas needs to be seriously considered. The health

staffs need to have periodic skill up gradation training.

3. Communication facilities between the community and the ANM and ambulance related facilities need to be improved.
4. All ST habitation falling within the revised population norm of 300 must be provided one AWC. The norm should be further relaxed to ensure that every ST habitation, irrespective of the population, has this basic facility related to nutrition security. Food and other materials for use in the AWC need to be supplied at its doorstep regularly. Efforts should be made to provide a ST woman as an AWW in ST areas. Her honorary status needs to be reconsidered and her remuneration needs to be paid regularly without undue delay. The nutritional needs of children in the crucial age bracket of 0 to 2 years need to be specifically addressed.
5. The quality of care can be improved by conducting regular mandatory specialist camps at the PHC level.
6. Strengthening of the monitoring mechanism in ST areas should receive special attention of the health authorities. Separate periodic monitoring of the activities of the Anganwadis, Sub centres, PHCs and CHCs need to be ensured. Desirability of involving civil society through eminent activist or a credible Non Governmental Organization may also be considered.

5.7. Other recommendations to strengthen certain aspects of NRHM:

1. Human resource:

Recruitment of adequate medical and nursing man power to the ST areas by offering more attractive benefits will need to be considered. The salary for contract workers must be on par with the regular service people. It is felt that many contract workers are not fully involved with the work. As many of the support staff are recruited on contract basis, they are not given residential quarters and this needs to be addressed.

As the clinical responsibilities of the medical officer have increased with increasing hospital deliveries and case loads, there is a felt need to have more human resource for clerical and supervision work related to building construction.

2. Fund flow:

The designated funds for NRHM for various levels need to be released in time to avoid last minute hurry to spend. The cheques should be accompanied by clear instructions as to

the purpose for which they are ear marked (Annual Maintenance Grant, Untied Fund, Rogi Kalyana Samiti) to avoid confusion and hesitation in using them. There needs to be more decentralization of fund management and the medical officer should be given independent money drawing power during emergencies. Transparency of fund utilization must be ensured by adequate external auditing.

The Tribal Welfare Directorate needs to be more actively involved in the policy decisions, project planning, implementation and monitoring of the activities of NRHM.

3. AYUSH:

The process of mainstreaming of AYUSH needs to go beyond posting of an AYUSH medical officer as an additional medical officer in the PHC. Documentation of the revitalization of the local health traditions in the ST areas must be done proactively.

6. Conclusion

This study was born out of an urgent and felt need in the health sector to study comprehensively and systematically the health situation of the scheduled tribes in the country so that recommendations to strengthen the programmes of NRHM and improve the situation could be formulated. It was conducted between 15th August 2008 and 15th September 2009 and it included two main components, namely, a desk review of relevant national level documents pertaining to the health status of the ST and a field review in selected ST dominated areas across 5 states (Jharkhand, Madhya Pradesh, Orissa, Maharashtra and Karnataka) which are home for 47% of the Schedule Tribes of the country. Among the states selected for this study, 3 belong to the high focus non-NE group (Jharkhand, Madhya Pradesh & Orissa), while two fall under the non high-focus large group (Maharashtra & Karnataka). The key areas that were studied to understand the Health Status and Health care delivery system and mechanism were 1. Under Five Child health, 2. Maternal health 3. Adult health, 4. Other significant factors that impact the health status and 5. The status of Health facilities. The study yielded valuable information and insight to the health status in the selected ST areas to identify the major concerns and formulate relevant recommendations for NRHM.