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An Analysis upon Common Tribal Health Issues in Tribal Children in India

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Abstract – There is a heavy burden of communicable, no communicable and silent killer genetic diseases prevalent in tribal communities. Many of the infectious and parasitic diseases can be prevented with timely intervention, health awareness, and information, education and communication (IEC) skilled activities. In spite of the tremendous advancement in the field of preventive and curative medicine, the health care delivery services in tribal communities are still poor and need amelioration and strengthening with sustenance on the guidelines suggested to achieve the targeted goals of health for all in India. Unless locality specific, tribe specific and need-based health care delivery system is evolved which is appropriate, acceptable, accessible, and affordable, the goal of health for all would remain a Utopian dream! The perception of health and health seeking behaviour among the tribal children world over is intertwined with lots of factors – their traditional beliefs, practices, nature of interaction with physical environment and changing social, cultural and economic domain. Tribal population world over has been exposed to a rapidly changing world around them, the depleted natural resources on which they are dependent and alien culture of monetary economy.

Tribal children are mostly unable to cope with these new situations. Their social and cultural customs are in transition whereas in socio-economic front they are lagging far behind from others.

Globally, each year malnutrition is implicated in about 40% of the 11 million deaths of under-five children in developing countries. Under nutrition is still the major problem in our country especially in underserved areas such as urban slums and rural areas. So we undertook this study to assess the factors associated with malnutrition and risk of infections among malnourished children.

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INTRODUCTION

India is a home to more than half the world's tribal p population. Over 84 million people belonging to 698 communities are identified as members of Scheduled Tribes (ST) in India, constituting 8.2% of the total Indian population which is four times larger than that of the population of Australia. Scheduled Tribes are mainly the tribal population in India that the Government of India identifies as socially and economically backward and are in need of special protection from social injustice and exploitation. The Government of India identifies communities as scheduled tribes based on a community's 'primitive traits, distinctive culture, shyness with the public at large, geographical isolation and social and economic backwardness', with substantial variations in each of these dimensions with respect to different scheduled tribe communities, Through a constitutional mandate, formulated in 1950, scheduled tribes have been formally recognized as a distinct community in India, There exist clear government policies for affirmative action targeted at scheduled tribes, and their members are routinely enumerated in national surveys and censuses. The proportion of scheduled tribes in the total Indian population has increased from 5.3% in 1951 to 8.2% in 2001 since their formal recognition in 1950. The concentration of scheduled tribes varies substantially across the Indian states.

While there is a broad consensus that tribal are among the poorest social groups in the country, and figures about high levels of under nutrition among tribal adults and children are available, a concomitant concern about the illnesses they suffer from is not so obvious. There is little and scattered information on the actual burden and patterns of the illnesses that afflict them. The challenge of inaccessibility to health services and their health care seeking behaviour seem to dominate the discourse in tribal health. Further, it is still believed that tribal suffer mainly from infections and selected non-communicable diseases

such as hypertension while other illnesses like cancer, diabetes, mental illnesses, illnesses that require surgery and heart diseases are thought to be uncommon among them.

Proper diet or right Nutrition is the basic need for all the Human beings for the development and the growth. Nutrition constitutes the foundation for human development, by reducing susceptibility to infections, reducing related morbidity, disability and mortality, enhancing cumulative lifelong learning capacities, and adult productivity. It is critical to prevent under nutrition, as early as possible, across the life cycle, to avert irreversible cumulative growth and development deficits that compromise maternal and child health and survival, achievement of optimal learning outcomes in education and gender equality. When a person is deprived off proper nutrition, he / she may face multiple disabilities and his productivity reduces drastically.

Nutrition is also crucial for the fulfillment of human rights – especially those of the most vulnerable children, girls and women, locked in an intergenerational cycle of multiple deprivations.

Malnutrition or malnourishment is a condition that results from eating a diet in which nutrients are either not enough or are too much such that the diet causes health problems. It may involve calories, protein, carbohydrates, vitamins or minerals. Not having enough nutrients is called under nutrition while too much is called over nutrition. Malnutrition is often used specifically to refer to under nutrition where there are not enough calories, protein or micronutrients. If under nutrition occurs during either pregnancy or before the age of two years of age it may result in permanent problems with physical and mental development.

Extreme undernourishment, known as starvation, may have symptoms that include: a short height, thin body, very poor energy levels, and swollen legs and abdomen. People also often get infections and are frequently cold. The symptoms of micronutrient deficiencies also depend on the micronutrient that is lacking.

Malnourishment or in particular Undernourishment is becoming one of the major concern for India and all the developing countries. Under nutrition severely hammers child survival, growth and development, and it even slows down the national growth in the long run. It is a salient killer, which is mostly invisible. It is widespread among children and women, and is on verge of becoming acute and even alarming. In recent time it has become one of the most serious concerns. As per a Global Survey Report released by Save the Children on 19th July 2012, India is ranked at 112 among the 141 nations as regards to child development index (CDI). The recent Global Study referred to earlier also says that 42% children in India are underweight and 58% of children are stunted by two years of age. In another study conducted by UNICEF it says that about one third of under-five mortality is attributable to Malnourishment. Hunger and Malnourishment have a distinct gender dimension and are mostly widespread among the children and women/mothers. Malnutrition is caused by complex mechanisms and is traversing throughout the social, political and economic arenas.

Food security, feeding and health seeking practices, improved health status of women, and availability of better health care facilities are only some of the factors that determine the nutritional status. Malnourishment effects the entire life cycle of a human being, a low weight baby girl grows into a malnourished mother who further delivers a low birth weight baby. In one of the report it says that every second woman in India is anemic. Actually, anemia affects 75% children below 5 years, 51% women of 15-59 years and 87% pregnant women. More than 70% women and kids have serious nutritional deficiencies. So it is but natural for IMR and MMR to be high.

There is consensus that the early years are the most vulnerable period - when there are the greatest risks to survival, healthy growth, development and vulnerability to a vicious cycle of malnutrition and disease/infections. The prenatal first three years are critical for preventing under nutrition, especially in India where levels of under nutrition remain persistently high, 40 % of children under 3 years are undernourished and 79 % are anaemic - undermining their survival, development potential and active learning capacity. These early years are also the most crucial years – because their impact lasts a lifetime. More than 80 % of brain development is already complete by the first three years of life and the quality of nurturing impacts upon this significantly. These years are a time of rapid growth and development – an opportunity, in which even small investments can bring cumulative lifelong benefits, across the life cycle, especially for the most deprived. These are the years when the foundation is laid for physical, cognitive, emotional, social and linguistic development – for cumulative lifelong learning and human development. Early childhood interventions emerge as the natural entry point for more inclusive growth and as an effective way of breaking an intergenerational cycle of multiple deprivations -of under nutrition, poverty, exclusion and gender discrimination. Since malnourishment covers both over nutrition and under nutrition, in this research, the term malnourishment is applied to under nutrition which includes both macronutrient and micronutrient malnutrition leading to overall under nutrition in terms of low weight-for-age, low height-for-age and low weight-for-height of children as compared with the reference standards i.e. WHO Child Growth and Development Standards, 2006.

TRIBAL HEALTH IN INDIA

Studies reveal that tribal health maintenance system is attached with a lot of complexity intertwined with socio-

cultural beliefs and practices. It has been observed that the universal index of a threat to health is expressed through withdrawal from work. Mahapatra (1994), therefore, sees health among tribal groups as a functional and not clinical concept. Sachchida-nanda (1994) sees the field of tribal health aspects as a cultural concept as well as a part of social structure and organization which is continuously changing and adapting itself to changes in the wider society.

Prevalence of traditional health-care practices and nature and extent of acceptance of modern health-care practices among the tribal people in India has been mentioned by various scholars in recent years. Guite and Acharya (2006) have shown that the acceptance of a particular health care system among the tribal people mostly depends on its availability and accessibility. It is interesting to note that while the tribal groups following traditional religion use traditional medicines putting religious or supernatural value on it, the converted Christian tribes use the same medicine excluding its religious tune. The study reveals that education has been able to heal the traditional inhibition of tribal people to attend PHCs without ignoring the importance of traditional healing practices. Pramukh and Palkumar's (2006) study shows that the tribal groups namely, the Savaras, Bogatha, Konda Dora, Valmiki, Koya, Kond Reddi etc. believe in the power of prayers and rituals that enables some herbs to act as medicines to heal diseases among them. They attribute diseases to certain deviant acts of self and others towards elders, nature, and divine rules. Thus, their first priority is to get spiritual cure in a traditional way. Jain and Agrawal's (2005) study shows that the Bhills in Udaipur, Rajasthan, attribute disease to the act of deities and spirits of various kind and by appeasing them, they believe, disease may be healed. They depend on *Bhopa* (traditional healers), herbalist and *Dais* for cure of disease.

Bhasin's (2004) study among the Ladakhis shows a blend of healthcare involvement. She finds that in case of serious illness people tend to attend modern health-care facilities. But in many cases accessibility of such facilities do not confirm people's acceptance of modern health-care system. People invariably believe in spirit and other supernatural beings as causes of disease and priority of treatment inclined mostly towards traditional healers.

MALNUTRITION AND CHILD HEALTH

Causes of Malnutrition-Malnutrition is a manifestation of multiple and interrelated determinants. The causes of malnutrition can be divided in to some categories as follows:

i) *Immediate Causes:* Inadequate dietary intake and illness are the two most significant immediate causes of malnutrition.

ii) *Underlying Causes:* Inadequate access to food in a household; insufficient health services and an unhealthful environment and inadequate care for children and women are identified as the three clusters of underlying causes lead to inadequate dietary intake and infectious disease.

Malnutrition is demarcated as a responsible factor in more than half of all child deaths worldwide. Millions of children survived from malnutrition are left crippled, chronically vulnerable to illness and it is believed to make children intellectually disabled. Despite these huge problems the worldwide crisis of malnutrition has created little public alarm. Malnutrition is a multifaceted phenomenon. It appears in various forms and many a time in combination contributing to each other. To mention a few: protein-energy malnutrition, iodine deficiency disorders and deficiencies of iron and vitamin A etc.

MALNUTRITION AND CHILD HEALTH ISSUE IN INDIA

In recent years there have been reports of death of tribal children in the country due to nutrition deficiency. The immediate cause of such extensive death is attributed to severe malnutrition though the social and physical environment of people play important role in health aspect.

The physiological synergism between malnutrition and infection has been recognized for some quite time but it did not find a place in health care strategy of several developing countries worldwide. A recent analysis of 28 epidemiological studies of the malnutrition-mortality relationship concluded that the relationship is consistent across diverse world populations; a significant effect exists of mild to moderate malnutrition (MMM), as well as of severe malnutrition; and the effect is not simply due to confounding by socioeconomic factors or inter-current illness. In addition, evidence supports the hypothesis that malnutrition and infection have multiplicative effects on child mortality, not the additive effects implicitly assumed. An empirically based model suggests that by potentiating infection, malnutrition accounts for 56% of child deaths, 83% of which are due to MMM. These estimates are far higher than conventional figures that do not take account of potentiation and MMM (FAO 1998).

The major nutritional problem in India is found to be that of PCM or *protein calorie malnutrition*, especially among most vulnerable groups like children, pregnant women, lower income groups and population living in tribal tracts.

For children 1-5 years of age, the prevalence of underweight ranged from 13% in the State

Meghalaya to 77% in Gujarat. The prevalence of stunting ranged from 20% in Goa to 83% in Gujarat. According to the WHO, a prevalence of underweight above 30% is considered a serious public health problem. The most badly affected States, with a prevalence of underweight above 60%, were Gujarat, Orissa, Karnataka, Maharashtra, Madhya Pradesh and Andhra Pradesh. As for underweight and stunting, wasting is a serious public health problem in most States. The distribution of wasting does not coincide with that of stunting and underweight except for the States of Madhya Pradesh and Arunachal Pradesh which show the worst nutritional situation of all States in India.

Children under five years are most susceptible to vitamin A deficiency (VAD). The consequences of VAD are tragic and include night blindness, irreversible blindness, growth retardation and increased susceptibility to infections. The National Nutrition Monitoring Bureau have shown the 9 states and UTs as most affected states, with a prevalence of vitamin A deficiency above 6%, namely - Assam, Bihar, Gujarat, Madhya Pradesh, Rajasthan, Tripura, Uttar Pradesh, West Bengal and the Andaman and Nicobar Islands. As a consequence of Iron Deficiency the prevalence of anaemia in pre-school children (haemoglobin level below 11g/dl) was very high ranging from 30% in Tamil Nadu to 95% in West Bengal. Out of the six cities studied between 1981and 1996, the prevalence of anaemia in school age children 6-14 years old (hemoglobin level below 12g/dl), was highest in Calcutta at 96%.

MALNUTRITION AND CHILD MORTALITY

Every year, 7.6 million children die before they reach the age of 5, most from preventable or treatable illnesses and almost all in developing countries. Malnutrition is an underlying cause of more than a third (35 percent) of these deaths. A malnourished child is up to 10 times as likely to die from an easily preventable or treatable disease as a well-nourished child. And a chronically malnourished child is more vulnerable to acute malnutrition during food shortages, economic crises and other emergencies. Unfortunately, many countries have not made addressing malnutrition and child survival a high-level priority. More importantly, young children bear a huge part of the burden of disease resulting from the lack of hygiene. India still loses between 0.4 to 0.5 million children under five years due to diarrhoea. Infant mortality and under five mortality rates have declined over the years for the country as a whole, in many states, these have stagnated in recent years. One of the reasons is the failure to make significant headway in improving personal and home hygienic condition.

Drinking water is one of the several routes for transmission of diseases. Others are poor hygiene behaviour, contaminated food and unclean toilets are equally important, yet receive far less attention. Hand washing practices are as important from a disease reduction perspective as are the use of toilets or drinking safe water or the use of hygienic toilets. Here is how unsafe water and lack of sanitation leads to ill health and other health related problems.

1 Unsafe water is cause of many diseases.

2 The lack of sanitation leads to contaminated and unsafe drinking water

3 In both villages and cities, the non-availability of safe drinking water facilities for all residents also leads to more diseases

4 Diarrhea, cholera, jaundice, typhoid spread due to unsafe drinking water

5 Malaria, dengue Filaria, encephalitis spread due to mosquitoes breeding in stagnant water.

Under nutrition in children can manifest itself in several ways, and it is most commonly assessed through the measurement of weight and height. A child can be too short for his or her age (stunted), have low weight for his or her height (wasted), or have low weight for his or her age (underweight). A child who is underweight can also be stunted or wasted or both. Each of these indicators captures a certain aspect of the problem. Weight is known to be a sensitive indicator of acute deficiencies, whereas height captures more chronic exposure to deficiencies and infections. Wasting is used as a way to identify severe acute malnutrition (UNICEF, 2009)

Maternal and Child Undernutrition Status in India and Tribal's: In India, 48% children (61 million) under the age of five years are stunted; 43% children (53 million) under five are underweight; and nearly 20% children (25 million) under five are wasted. Out of the 25 million wasted children, 8 million are severely wasted or suffer from severe acute malnutrition (SAM) (NFHS-3, 2006). India contributes to one-third of severely wasted children under five in the world. There are 104 million people from 705 distinct scheduled tribes. Within this population, 11.5 million are under the age of five years. More than half (54%), or 6.2 million of these tribal children are stunted in India. They are among the poorest and most deprived social groups in the country. In India, 60% of children with SAM fewer than five years live in 6 states: Uttar Pradesh, Madhya Pradesh, Bihar (Jharkhand), Rajasthan, Maharashtra and Tamil Nadu. The response to SAM in India is inadequate as less than 3% of children with SAM receive treatment. Most of the deaths caused by SAM can be averted.

Infant and Young Child Feeding practices remain sub optimal- early initiation of breastfeeding within 1 hour is 25 % (NFHS 3), 40.6 % as per DLHS 3. Only 46 percent of infants younger than Six months are exclusively breastfed, and at the completion of 6 months, only 28% are exclusively breastfed (NFHS 3 - 2005-06). There has been an increase in introduction

of complementary feeding in children 6-9 months from 33 % to 55 % between NFHS 2 and 3, which can be used to build further improvements in young child feeding. Anaemia in young children, adolescent girls and women across the life cycle, is also reflected in that three out of four young children are anaemic (79%) and anaemia prevalence in young children, under 3 years has increased from 74 % to 79% between NFHS 2-1998-99 & NFHS 3-2005-06.

CONCLUSION

Prevalence of malnutrition and consequent health hazards among tribal children has been universally accepted by now. But, till recently, malnutrition and related diseases were viewed separately ignoring the unavoidable cause-effect relationship among them. Media has played a vital role in bringing to forth the widespread cases of malnutrition in tribal dominated areas of the state.

It is also worth noting that welfare measures in the form of grants in cash and kind are pouring in, in the affected areas. Schemes like supply of supplementary nutritious food; cereals etc. have been distributed by different means. Financial assistance has been offered to the affected families as well as to the entire localities. But the problem recurs again and again. The most disturbing question thus springs up as to why these groups of people, who have their age-old experience of self-sufficiency and life-ways and independent social control system, have become dependent on non-traditional domain to save their children's life, and to push their life up? Why has the age-old traditional knowledge become a failure in their present situation? Who is to be blamed for such a condition?

It was found that in this region malnutrition death was not a phenomenon unknown to the tribal people before. But, as had been reported, such incidents were not known to be so widespread. Natural calamities followed by crop failure and loss of edible vegetation etc. preceded such incidents of child death due to malnutrition in the past.

Children of Relatively younger age, from rural areas and girls are the common victims of malnutrition. Respiratory tract infections and acute gastro-enteritis were the common co-morbid conditions found among malnourished children. Most of the children were in the early stages of malnutrition, a little extra attention and awareness of parents might definitely help to reduce this problem. Nutrition education has to be imparted to the people regarding consumption of cost effective nutritious diet (Emphasize it in Village health and Nutrition days-VHNs). Environmental sanitation has to be promoted in reducing infections and break the vicious cycle of infection leads to under nutrition. Acute respiratory Tract Infections and Acute Gastro-enteritis should be managed as early as possible, as these are the common disease lead to malnutrition.

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