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## **District Level Planning for Health and Family Welfare for Tribals**

### **Introduction**

THE purpose of planning is (a) to match the limited resources with many problems, (b) to eliminate wasteful expenditure or duplication of expenditure and (c) to develop the best course of action to accomplish a defined objective (Park and Park 1986). For efficient and effective planning, decentralisation of planning is often suggested (Ministry of Agriculture 1955). Health planning is also a part of national development planning and therefore, decentralisation of health planning may lead to better results than through the existing planning at the state level.

Among all the states of India, Madhya Pradesh has the largest population of tribals, accounting for about one-fourth tribal population of the country. These tribals, in general, constitute small, primitive, endogamous, group sharing common language and culture, living under varying but different climatic setting of hills and forests, far removed from modern conveniences of life. They are vulnerable from health and nutritional stand point. Because of their large dependence on primitive agricultural practice, like shifting cultivation, they often face uncertainty of food supply. Lack of proper health and educational facilities, faulty feeding habits, certain irrational belief systems and special tribal mores, that are likely to be prevalent among them, further aggravate the health and nutrition situation.

To achieve the goal of health for all by 2000, the National Health Policy in India proposed one PHC for every 30,000 in rural population and one PHC for every 20,000 population in hilly and tribal areas (Government of India

1985). Thus the Government is trying to reach the entire population with primary health care which has been defined as essential health care, universally accessible to individuals and families in the communities in an acceptable and affordable way with their full participation. But, as each tribe differs in its health seeking behaviour, customs, beliefs, social, economic and demographic characteristics, merely establishing a PHC for every 20,000 population in the tribal area will not be able to achieve the goal. There should be separate planning of health and family planning services at district level for the tribals, keeping in view their perceptions for health, health seeking behaviour and socio-demographic background. In this paper data on socio-demographic and health seeking behaviour of the tribals living in five districts with high concentration of tribals of Madhya Pradesh have been analysed to show the district-level health planning for the tribals is a necessity.

### Methodology and Data

The tribal population of Madhya Pradesh is not evenly distributed in all the 45 districts. The tribal population ranges from 0.1 per cent in Bhind to 83.5 per cent in Jhabua. Five districts which have at least 50 per cent of their population as tribals have been selected for this study. These districts are Jhabua (83.5 per cent), Bastar (67.8 per cent), Mandla (60.4 per cent), Sarguja (54.8 per cent) and Dhar (52.1 per cent). Among these Jhabua and Dhar are located in western, Sarguja in eastern, Bastar in southern, Mandla and Jabalpur in the central regions of the state. The details of the surveyed tribal districts are given in Table 1.

To study the population characteristics of tribals living in the tribal districts of Madhya Pradesh, the data on their age sex composition have been analysed. The data have been taken from the various studies conducted by the Regional Medical Research Centre (ICMR), Jabalpur (Pandey forthcoming) and by the National Institute of Nutrition (ICMR), Hyderabad (Rao *et al.* 1986). To make the analysis more comprehensive, data for one tribal population and one non-tribal population living in a non-tribal district have also been analysed. The data for various tribal districts relate to the years 1983-86. The details of the tribal population studied are given in Tables 2 and 3.

### Results

It is seen from Table 1, the tribal districts largely differ from non-tribal districts. Population density, per cent urban population, per cent literacy, per cent female literacy, growth rate and target achieved for MCH services are lower than that of non-tribal district. Also, in most indices, the tribal districts are far below the state average. It shows how backward these districts are. The

TABLE 1— SOME CHARACTERISTICS OF THE TRIBAL DISTRICTS  
AND NON-TRIBAL DISTRICTS UNDER STUDY, 1981

<i>Characteristics</i>	<i>Tribal Districts</i>					<i>N.T.D.</i>	
	<i>Jhabu</i>	<i>Dhar</i>	<i>Sarguja</i>	<i>Bastar</i>	<i>Mandla</i>	<i>Jabalpur</i>	
Population density (km <sup>2</sup> )	117	130	73	47	78	216	118
Urban population (per cent)	8	13	9	6	7	45	20
Sex ratio (general) (Females/thousand males)	985	966	962	1002	1003	914	941
Sex ratio (tribal)	998	987	982	1002	1027	984	996
Literacy (per cent)	10.9	20.2	16.2	13.1	22.9	40.9	27.9
Female literacy (per cent)	6.4	10.3	7.6	7.3	11.2	28.2	15.5
Population engaged in agriculture (per cent)	90.0	86.5	84.8	88.7	89.2	52.3	76.2
Tribal population (per cent)	83.5	52.1	54.8	67.8	60.4	17.4	22.9
Growth rate (1971-81) (in per cent)	19.2	25.3	22.9	21.4	18.6	30.4	25.3
Family welfare (1981-82)							
(I.) Sterilisation (per cent target)	101.3	129.6	87.9	75.0	103.4	83.9	86.6
(ii) IUD (per cent) target	12.7	53.9	36.6	33.6	39.7	60.8	47.7
MCH (1981-82)							
(per cent target)	22.6	32.4	16.8	34.5	40.8	17.8	43.3
DPT							
TT	30.6	67.5	31.4	45.1	81.6	64.2	65.6
DT	41.7	42.2	40.5	68.9	64.2	40.7	67.9
VITA	11.5	66.9	30.9	68.4	85.2	144.7	61.0
Iron and Folic Acid tablets Women	74.7	83.5	76.5	40.2	78.6	145.7	74.4
Children	51.3	93.2	60.4	73.5	75.6	180.1	74.2

N.T.D.—Non-tribal district.

SOURCES: *Pocket Compendium of Madhya Pradesh, Statistics* (1982). Directorate of Economics Statistics, Bhopal.  
*Compendium of Scheduled Castes and Scheduled Tribes* (1984), Tribal Research Institute, Bhopal,  
*Fact Book on Family Welfare Programme in Madhya Pradesh*, Demographic and Evaluation Cell, State Family Welfare Bureau, Madhya Pradesh (1984).

TABLE 2—SOME CHARACTERISTICS OF SELECTED TRIBAL POPULATIONS UNDER THE STUDY

<i>Characteristics</i>	<i>Tribal Districts</i>					<i>Non-Tribal District Jabalpur</i>	
	<i>Jhabua</i>	<i>Dhar</i>	<i>Sarguja</i>	<i>Bastar</i>	<i>Mandla</i>	<i>Tribal population</i>	<i>Non-tribal population</i>
<i>Tribal Population</i>							
Region of M.P.	Western	Western	Eastern	South-ern	Central	Central	Central
Tribals studied	Bhil, Bhilala Patelia	Bhil, Bhilala	Gonds, Karn-war Khonis	Gonds, Helbas, Dorlas	Baigas	Gond, Baiga	
No. of villages	21	7	9	13	24	11	14
No. of households	1 099	809	1 131	1 276	966	1 297	915
Population covered	7 693	5 016	4 976	7 400	5 407	6 949	5 207
No. of persons per household	7.0	6.2	4.4	5.8	5.6	5.4	5.2
Sex ratio	968.0	918.9	938.0	1 001.0	991.6	1 000.3	889.3
Literacy level (in per cent)	11.2	6.5	25.0	7.8	5.6	26.4	41.8
Per cent sterilised eligible couples	9.5	8.2	14.4	3.1	9.2	37.6	38.9

tribal districts also differ between themselves in the socio-economic-health characteristics of their population.

Table 2 presents some characteristics of the tribal population which have emerged from the ICMR studies. It is seen from the table that the sex ratio in the tribal populations is higher than that of the non-tribal population. The acceptance of sterilisation is lower among tribals in the tribal district but higher in the non-tribal district. Though survey data on MCH acceptance are not available for comparison it is evident from Table 1 that the target of MCH services achieved for tribal districts is not very encouraging.

The variation in MCH and family planning acceptance rate may be due to (a) differences in socio-cultural norms and values regarding the health-seeking behaviour among the tribals and (b) inaccessibility of these services to the tribal people. Some observations on their health-seeking behaviour are presented in

TABLE 3— OBSERVATIONS ON HEALTH-SEEKING BEHAVIOUR OF VARIOUS TRIBES IN THE TRIBAL DISTRICTS UNDER STUDY

<i>Health seeking Behaviour</i>	<i>Jhabua</i> ( <i>Bhil, Bhiiala Patella</i> )	<i>Dhar</i> ( <i>.Bhil, Bhiiala</i> )	<i>Sarguja</i> ( <i>Gonds, Kanwar, Khondt</i> )	<i>Bastar</i> ( <i>Gonds, Halbas, Dorias</i> )
(1)	(2)	(3)	(4)	(5)
Perception of sickness	N.A.	Sick person is neither physically fit nor has ability to work <sup>2</sup>	N.A.	A person is sick when he is unable to do his routine work and when he does ml behave normally <sup>3</sup>
Reasons of diseases	N.A.	Dakin (evil soul) <sup>2</sup> makes sick, measles, chicken pox, occur due to vengenance of Goddess	N.A.	1. Due to effect of an evil eye <sup>3</sup> 2. Due to Grab <sup>3</sup>
Remedy	1. First try seeds, roots, tree barks, etc. 2. Then they consult folk medicine man called Badwa. 3. Then local Ayurvedic and Allopathic Practitioners.	1. Firstly they wait to get an illness cured and provide indigenous homemade medicine <sup>2</sup> 2. Secondly they go to Badwa-traditional healers <sup>2</sup> 3. The local Ayurvedic doctor <sup>2</sup>	1. Firstly they try seeds, roots, tree barki etc. 2. Then they consult folk medicine man 3. Then local Ayurvedic and allopathic doctor	1. First consult other remedies according to suggestion of Sirha 3. Most of the patients reach PHC at very late stage

Use of PHC/ sub-centre	About two-third respondents have used PHC/S/C services (1)		About half of the respondents had used PHC S/c services	Only 8% people reported to have visited the PHC/ sub-centre for treatment 2. More rush on weekly market day
Treatment availed for (type of diseases)	Usually serious infective diseases <sup>1</sup>	N.A.	Usually serious infective diseases <sup>1</sup>	1. Most of patients reach PHC in serious condition <sup>3</sup> 2. Certain diseases "Oopari Bimar!" can not be cured by a modern doctor
Reasons of under utilisation	1 Non-availability of medicines <sup>1</sup> 2. Frequent absence of health person <sup>1</sup> 3. Not easily accessible	1. Wastage of time 2. Not easily accessible 3. In case of patient referred to Dist. Hospital non- availability of Money <sup>2</sup>	1. Non-availability of medicine <sup>1</sup> 2. Frequent absence of health personnel <sup>1</sup> 3. Not easily accessible <sup>1</sup>	1. Inadequate staff 2. (Some times) money <sup>2</sup> is asked for medicines
MCH and Family Welfare	1. Majority of deliveries at home <sup>1</sup>	1. Not familiar with the services available	1. Majority of delivery at home <sup>1</sup>	1. Delivery at hut separa- ted from main dwelling <sup>1</sup>

Table 3 (contd. on page 222)

(Table3 contd.from page 221)

(1)	(2)	(3)	(4)	(5)
	2. Delivery by elderly female of the community <sup>1</sup>	at PHC <sup>2</sup>	2. Delivery by elderly female of community <sup>1</sup>	2. 97 percent non acceptors <sup>1</sup>
	3. 90% are not acceptors of F.P. <sup>1</sup>	2. Delivery by elderly female at home <sup>8</sup>	3. Three-fourth respondents non-acceptors <sup>1</sup>	3. Most of the women do not take MCH services
	4. Folk medicine man supply certain herbs for contraception <sup>1</sup>	3. Lack of faith in modern medicine <sup>2</sup>	4. Lack of knowledge of P.P. methods <sup>1</sup>	4. No need of care during pregnancy <sup>3</sup> .
		4. Misconception regarding birth, sex of child, P.P. exists <sup>2</sup>		5. Most people are aware of modern F.P. methods but favour indigenous medicine for FP given by Sinha <sup>3</sup>
Operational	1. Difficult terrain, lack of transport and communication facilities, widely scattered distribution of population in small clusters.			
	2. Inadequate number of health personnel and their frequent absence from the hospitals.			
	3. Lack of awareness of the services available at the Centre.			

1. Rao, D H. *et al*, 1986, Health and Nutritional Status of Tribals in Madhya Pradesh, National Institute of Nutrition (ICMR) Hyderabad, (mimeo)
2. Mishra, O.K. *et al*. 1986, An Anthropological study of Health seeking Behaviour among the Tribals of Madhya Pradesh : A Case Study of Bhil and Bhilalas of Dhar, Regional Medical Research Centre, (ICMR) Jabalpur (mimeo).
3. Mawar.N., *etal.*, 1986, An Anthropological Study of Health Seeking Behaviour among the Tribals of Madhya Pradesh : A Case Study of Muria Gonds of Bastar, Regional Medical Research Centre (ICMR), Jabalpur (mimeo.).

Table 3. It is seen from the table that the perceptions of sickness and the reasons for it are different among the tribals from those of the non-tribal population. Their priority of treatment for different systems of medicine also differs. They go to PHC only for chronic/infectious diseases or accidents. They do not believe in ante-natal, post-natal care. Maoy couples are not reasonably aware of family planning methods. They have misconceptions regarding pregnancy, sex of the child (that it depends on date of conception), sterility etc. The under-utilisation of PHC is also due to (a) non-availability of medicine, (b) frequent absence of health personnel, (c) inadequate PHC staff, (d) non-accessibility of PHC (distance factor), and (e) (sometimes) the demand for medicine. These reasons vary from tribe to tribe and from one tribal district to another. The difference in health seeking behaviour of various tribes in different regions is one reason why district-level planning of health and family welfare programme for the tribals should be there. There is a need to orient the health and family welfare services, keeping in view the perceptions, the socio-economic status and other local health requirements of the tribals at the district level.

In the absence of migration, the age composition of a population depends on its past levels of fertility and mortality. Age structure with large proportion of population at older ages reflects higher levels of fertility and mortality in the past. It is evident from Table 4 that the proportion aged 60+ among the

TABLE 4—PERCENTAGE AGE DISTRIBUTION OF THE TRIBAL POPULATION UNDER STUDY

Age	Tribal District					Non-Tribal District Jabalpur	M.P. 1981	All-India 1981	
	Jhabua	Dhar	Sarguja	Bastar	Mandla	Tribal pop.	Non-tribal pop.		
0-9	32.4	29.7	26.7	27.0	35.6	24.6	26.2	28.2	26.6
10-19	21.4	23.5	20.7	25.8	21.0	22.9	23.4	22.3	22.5
20-29	16.8	17.1	17.1	15.6	14.8	17.5	17.4	15.5	16.3
30-39	11.9	11.2	12.8	13.7	11.9	12.1	10.9	11.9	12.2
40-49	8.6	8.1	10.8	10.3	8.5	8.1	7.1	9.4	9.5
50-59	6.2	6.1	6.7	4.8	4.7	8.9	7.3	6.1	6.3
60+	2.7	4.3	5.2	2.8	3.5	5.8	7.7	7.6	6.6
Total	7693	5016	4976	7400	5407	6949	5207	52	685
								milli-	milli-
Mean	22.2	23.0	25.1	24.8	21.5	25.6	24.3	24.7	25.1
Median	18.2	18.6	21.7	18.9	16.9	21.4	20.2	19.8	20.6

tribals is lower than among the non-tribal population, indicating lower longevity among the tribals. The proportion of 60+ population among the different tribes living in different regions also varies from 2.7 per cent in Jhabua to 5.8 per cent in Jabalpur. The median ages of the populations also vary considerably, from 18.2 for the tribals of Jhabua to 21.7 for Sarguja. The tribals of Mandla, Jhabua and Dhar are 'young' relative to the non-tribal population and the population of the state (Table 5). Some tribal populations however, have higher median age than the non-tribal population (Table 5).

Dependency ratio is an important indicator of the economic characteristics of a population. Children (0-14) and the old (60+ ) are mostly dependent upon the adult population (15 — 59). It is seen from Table 5 that Baigas of Mandla district have higher dependency ratio of 107.5, that is for each 100 persons in the productive population there are 107 dependants. The tribals of certain tribal districts have, however, dependency ratio lower than the state level.

The aged-child ratio takes into account both the numbers and the changes at both ends of age distribution simultaneously and is considered the best index of ageing (Hawley 1959). It is the percentage of the population 60 years and over to the number of children under age 15. Customarily, a population with an aged-child ratio with a value under 15 is described as young and that over value 30 as old. By this definition all the tribal populations of the tribal districts are young and the tribal population of Jabalpur (non-tribal district) is comparatively 'old'. The aged-child ratio varies widely between tribal populations as follows : Jhabua < Bastar < Mandla < Dhar < Sarguja < Jabalpur (tribal population) < Jabalpur (non-tribal population.)

This shows that high fertility and mortality prevail among the tribal populations. Certain tribal populations have population indices which are lower than what they were more than two decades earlier for the state population. Health and family welfare services for these populations need to be strengthened. For this, the health and family planning services have to be modified keeping in view their health needs. District-level health and family welfare planning for the tribals can do this much better.

### **Summary and Conclusions**

From this study, the following points have emerged :

1. Socio-economic characteristics of populations, acceptance of health, MCH, and family welfare services vary between the populations of tribal districts and non-tribal districts.
2. Population characteristics of tribals living in different districts of the state also vary widely.
3. The various tribal groups living in different regions of Madhya Pradesh

TABLE 5—SOME AGE RELATED INDICES OF THE POPULATIONS  
MADHYA PRADESH AND INDIA

<i>Population Index</i>	<i>Tribal district (Tribal population)</i>					<i>Non-tribal Dist t. Jabalpur</i>		<i>M.P.</i>			<i>India</i>		
	<i>Jhabua</i>	<i>Dhar</i>	<i>Saguja</i>	<i>Bastar</i>	<i>Mandla</i>	<i>Tribal population</i>	<i>Non-triba population</i>	<i>1961</i>	<i>1971</i>	<i>1981</i>	<i>1961</i>	<i>1971</i>	<i>1981</i>
1. Percent 0-14	45.3	42.0	37.6	40.5	48.3	38.2	39.1	40.8	43.3	41.3	41.0	42.0	39.5
2. Per cent 15-59	53.0	53.7	57.2	56.7	53.7	56.0	53.2	54.0	50.5	52.8	53.4	52.0	54.0
3. Per cent 60+	2.7	4.3	5.2	2.8	3.5	5.8	7.7	5.2	6.2	6.4	5.6	6.0	6.5
4. Young dependency ratio (Pop(0-14) x 100 Pop. (15-59))	87.1	78.2	65.7	71.4	100.2	682	73.9	75.6	86.5	78.2	76.8	80.8	73.1
5. Old dependency ratio Pop- (60)+ x 100 Pop. (15-59))	5.2	8.0	9.1	4.9	7.3	10.3	14.5	9.6	10.5	12.5	10.6	11.5	12.0
6. Overall dependency ratio	92.3	76.2	74.8	76.3	107.5	78.5	88.3	85.1	96.9	90.3	87.4	92.3	85.1
7. Index of ageing Pop. (60) + x 100 Pop. (0-14))	5.9	10.2	13.8	6.9	7.2	15.2	19.6	12.6	13.2	15.4	13.7	14.2	16.5

differ in their perception of health and family welfare services and their need for these.

4. Some of the tribal populations of the state are lagging in their population characteristics more than two decades behind the population of the state.

Given these facts, district-level planning for health and family welfare services for the tribals of Madhya Pradesh would achieve better results. Instead of decentralising health and family welfare services for all districts, the planning process may be decentralised initially for the tribal districts, where it is more desired and then expanded to the rest of the districts.

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