INTERNATIONAL JOURNAL OF RESEARCH CULTURE SOCIETY ISSN: 2456-6683 Volume - 4, Issue - 9, Sept – 2020
Monthly, Peer-Reviewed, Refereed, Indexed Journal Scientific Journal Impact Factor: 5.743
Received on : 29/08/2020 Accepted on : 14/09/2020 Publication Date: 30/09/2020

Status of Tribal Health in Telangana: A Study on Working of Primary Health Centres

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Abstract: *The health is viewed differently by different people all over the world. The World Health Organization defined health as "a state of complete physical; mental, social and spiritual well-being and not merely an absence of disease or infirmity." Thus, good health is a synthesis of physical, mental, and social wellbeing. "Health" has found an important place in the constitutions of all States and the United Nation agencies. Of the 30 Articles of the Universal Declaration of Human Rights Act, 25 is particularly concerned with the right to health. Everyone has the right to a standard of living, adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary services and the right to security in the event of unemployment, sickness, disability; widowhood, old age or other lack of the livelihood.*

Key Words: *wellbeing. Health care services*

1. INTRODUCTION:

Health has been interpreted the World Health Organization (WHO), as a state of complete healthful in the terms of physical, mental, social and spiritual. United Nations (UNs) organizations and the Consitution of India has considered health as a fundamental right of a human being. According to the Charaka who is a renowned Ayurvedic Physician the health is a tool for the development of human in the context of ethical, artistic, material and spiritual. Good health will encourage to human productivity and development process. The development of a society depends on the health status of the human. Several factors influence human health development like education, social, economic and administration and the complex also effects sometimes unfavourably. The socio-economic factors cannot be related unilaterally sometimes. Hence, there is a need for a unified, integrated approach to public health care, to coordinate the public health services for improving the nutrition, control the communicable disease, caring of mother and child health, and family welfare. The health is classified into 3 categories viz., hereditary, environmental, and personal. These three categories play a crucial role in the caring health status of a human being. the administration of the Primary Health Care system. For a better understanding of the administration system of health care, the present chapter categorized into three parts. The first part deals with the administration system of the health care system from central to village level, the second part deals with the health care programs and policies implementing by the central and state governments. And part three explains the Administration of the Primary Health Centre (PHC) and health care services.

The present paper focus on the following aspects they are:

- To study the tribal health policies and programmes.
- To study the demographic profile of the sample villages.
- To examine the socio-economic status of the tribes in the study area.
- To study the status of the PHCs in the study area of ITDA Utnoor.
- To trace out the working of PHCs in the study area of ITDA Utnoor.
- To propose valid suggestions for improvement in the Health Care Administration in Tribal Sub Plan Area with special reference to ITDA Utnoor.

2. REVIEW OF LITERATURE:

Hati, A.K. (1986) in his article studied vector problems of malaria in West Bengal in certain pockets of the district like Birbhoom, Hoogly, and Burdwan. It was found that there was a reappearance of the malaria case in these areas. He opined that unless the vector problems are solved, malaria cannot be eradicated.

Kakar, D.N. (1988) in his work analyzed on therapeutic of traditional medical practitioners in community development. He also explains the role of medical practitioners playing in primary health. He also suggested that India as a vast country needs to integrate the medical resources to meet primary health to all the rural population.

Ram and Mohanty (1989) in their paper examined the nature and linkage between HRD and demographic parameters at the state level. Two indicators of HRD namely Human Development Index (HDI) and Capability Poverty Measure (CPM) have been constructed at the state level. It was found that there was a wide variation in human progress

and human deprivation across the country. The study found that greater investment in human resources with particular attention to poor states was essential for reducing poverty and population growth of our country. Human development brought together the production and distribution of commodities and the expansion and use of human capabilities.

Ram Kumar (1990) in his book deals with various aspects of women's health development and administration. He also acknowledges women as a key to the provision of health services in the family and society, as a central figure who provides child care, hygiene, nutrition, and even primary health care. He had studied meticulously and presented for the welfare and development of women.

Rao and Bhat (1991) in their article analyzed cross-section data on health indicators and health causes separately for the years 1971 and 1981. Empirical results the aforementioned algorithm has been used to estimate the CHSI of 15 states of India for which reliable and broad-based data was available for the years 1971 and 1981. Three indicators of health viz., the expectation of life at birth, estimated annual death rate, and infant mortality rate, and five cause variables viz., Ranjana Ray and Jayanata Benerjee (1993) in their paper examined the nutritional patterns of women in different tribes. The tribes who were lived in deep interiors were quite healthy even in the absence of modern health care facilities, residing probably because of their clean and undisturbed environment which also provides a cure to their diseases.

Saraswathi Swain (1994) in her study explored the health problems and perspectives of tribal people in Orissa and health status of the tribal population of the state and to suggest measures for improving their situation. Health status depended on food production and consumption, socio-economic factors including poverty, ignorance, and illiteracy. The relationship between food, nutrition, and health were highly related to the health of tribal than non- tribal population in the study area.

Sunita Kishor (1995) surveyed on gender differentials in child mortality to enable a comprehensive understanding of the nature of excess female mortality in India. The study suggested that excess female mortality can be decreased, either by increasing women's economic activity, especially where male-centred kinship arrangement predominates or by introducing female-centred kinship arrangements.

Krishnan, T.N. (1996) in his study revealed that household economic status in one of the major determinants of health status. In poverty-stricken households, fulfilling day-to-day food requirement itself is a through the task and considerable allocation for health is a distant dream as the health and poverty are closely related to the economy. The Indian health system is very regressive, where the distribution of the burden of treatment is unfavourable to poor and it contributes to the aggravation of poverty of especially in rural India.

Singh, A.K. (1997) revealed in his work that the tribes are the most affected community due to development in India in the area of economic, education, socio, and political. The author emphasised on the need for a new economic policy to improve the socio-economic status of tribes.

Laxmi Devi (1998) in her work stated that the productive health care in the context of primary health care should inter alia, includes; family planning counselling, information, education communication and services for prenatal care, safe delivery and postnatal, especially breastfeeding, infant and women health care prevention and appropriate treatment of infertility.

Upadhyan, V. (2004) made a study to check productivity and efficiency aspects of the PHCS and another factor- elastic tie of output by estimating the Cobb-Douglas type log-liner function. The results suggested that qualitative factors also privacy maintained while doing the medical examination, average time at the health centres, time spent by a staff with a client..

Thiagarajan, S. (2009) in his study examined women and child health care services by the PHC at Nagapattinam district of Tamilnadu state. The study analyzed infant and mortality registration, family planning and impact of working of PHC from the beneficiaries point of view.

Ravendra, K. Sharma (2010) in their study incontestable that the utilization of maternal and child health services is extremely poor among the tribes of central India. Clinically acceptable maternal and newborn care practices for delivery, cord-cutting and care, bathing of mother and newborn, and skin massage area unit uncommon. Therefore, newborns remained at high risk of physiological state, sepsis, and different infections. Prelacteals, supplementary feeding Practices, and delays in breastfeeding were quite common, although colostrum was less frequently discarded.

3. HEALTH CARE ADMINISTRATION AT CENTRAL LEVEL:

The Ministry of Health and Family Welfare (MoHFW) has been enjoying a significant role within the National efforts to modify the voters to guide a healthy and happy life. it's a theme of state and it brings awareness relating to social control and birth prevention, medical education, adulteration of foodstuffs and alternative merchandise, medication and poisons, the health profession, statistic together with registration of births and deaths and lunacy and moronity has been placed within the simultaneous List. All the key Schemes for up the standards of health ar sponsored and inspired by the Central Ministry. The Department of Health (MoHFW) is headed by a cupboard Minister, a Minister of State, and a Deputy Health Minister. There are four departments underneath the Ministry: 1. Department of Health, 2. Department of Family Welfare, 3. Department of Ayurveda, Yoga, and Naturopathy, Unani, Siddha, and Homoeopathy (AYUSH), and. 4. Department of Health Research.

3.1. THE DEPARTMENT OF HEALTH: The Department of Health works on completely different parameters relating to medical and public health matters, together with drug management and hindrance of food adulteration. the chief head of the health department was headed by a Secretary to the GoI; he has been aided by 5 Joint Secretaries, 5 Deputy Secretaries, one Director Administration, a Controller of Accounts, and huge body employees.

3.2. THE DEPARTMENT OF FAMILY WELFARE: The Department of Family Welfare has constitutional designing for family welfare, particularly in generative health, maternal health, pediatric medicine, info, instructional aid teams, and rural health services. The Secretary to the GoI within the MoHFW has been in overall charge of the Department of Family Welfare. He has been aided by a further Secretary and Commissioner, United Nations agency heads the Family Welfare structure, aided by one Joint Secretary.

3.3. AYUSH: AYUSH was established in March 1995 because of the Department of Indian Systems of Medicines and medical aid (ISM&H). The department has been charged with upholding instructional standards within the Indian Systems of Medicines and medical aid schools, strengthening analysis, promoting the cultivation of medicative plants used, and dealing on assemblage standards. Department of Health analysis was created as a separate department inside the MoHFW by associate degree modification to the GoI (Allocation of Business) Rules, 1961 on seventeenth September 2007.

3.4. HEALTH CARE ADMINISTRATION AT STATE LEVEL: According to the constitution, health may be a state subject and it provides health services with the help of native health organizations for instance companies, Municipalities, Panchayati Raj, Adhoc statutory bodies just like the Mines Board of Health, Employees, and State Insurance Corporation, etc.

3.5. HEALTH, MEDICAL AND FAMILY WELFARE: The Department of Health, Medical, and Family Welfare provide the health care facilities for people of Telangana State. It is responsible for the implementation of various health policies and programmes in the state and management of health care facilities.

3.6. COMMISSIONER OF HEALTH AND FAMILY WELFARE: The Commissioner of Health & Family Welfare plays a very important role within the implementation of Maternal and Child Health Care and Family Welfare services within the State viz. birth control, antepartum care, postpartum care as well as protection services. the main target is especially on encouraging and preventive care. Family Welfare Program may be a Centrally Sponsored Programme. The National Health Mission is additionally enforced by Commissionerate. The TSMSIDC created in 2014, to build and maintenance of infrastructure for PHCs, Hospitals, Dispensaries, Clinics, etc. Further, TSMSIDC plays a crucial role as a nodal agency for the acquisition of medicines, instrumentation and to distribute a similar to Government Hospitals, etc.

3.7. RAJIV AAROGYA SRI INSURANCE SCHEME: Rajiv Aarogya sri insurance theme is that the flagship theme of the Telangana Government that is implementing from 2007 (in undivided Andhra Pradesh) meaning to give quality health care to the poor. The Rajiv Aarogyasri Insurance scheme aims to attain "Health for All" in the state and to bring awareness among the agricultural plenty concerning the diseases they suffer from and to produce free medical recommendation and medicines for the common ailments.

3.8. DIRECTORATE OF HEALTH IN TELANGANA: The Directorate is answerable for implementing Health Care Services to make sure patients of accidents receive attention at PHCs and district hospitals, provision equipment to hospitals, medicines and health centres; give rehabilitative services for patients and provides the health awareness among the public by providing health education and conducting the health campaigns.

3.9. TELANGANA VAIDYA VIDHANA PARISHAD (TGVVP): The TGVVP is one of the divisions of the Health and Family Welfare Department of Telangana Government it deals with the mid-level hospitals of bed strengths starting from 30 to 350. The posting of the Doctors and other staff in these hospitals are carried through the TGVVP. There are 103 Area Hospitals, 8 district-level hospitals, 233 Ayurvedic, and 260 Unani hospitals are working under the TGVVP.

3.10. TELANGANA STATE AIDS CONTROL SOCIETY (TSAC) The TSAC is a non-profit organization and making efforts to prevent and spreading of AIDS. The TSAC also awareness about AIDS among the Tribes in the Telangana State.

3.11. DISTRICT LEVEL HEALTH CARE: The principal unit of administration in Telangana beneath a region Medical and Health Officer. There are 33 districts in Telangana. Inside every district once more, there square measure 3 types of administrative areas:

District Hospitals: The District Hospital has been an essential component of the district level health care system and function as a secondary level of health care, which provides curative, preventive and promotive health care services at the district level. The District Hospital has been only the secondary referral level in the district.it has been headed by Chief Medical Officer and assisted by Deputy Medical Officer, District TB Officer, District Immunization Officers, District Malaria Officer, Senior Medical Officer, Medical Officer and other supported staff.

4. HEALTH CARE PROGRAMMES IN TELANGANA STATE:

The Telangana State Government has implemented the following health care programmes.

AROGYA LAXMI: The Arogya Laxmi scheme was launched in the year 2013 in ICDS with most adverse health and nutrition indicators. Aarogya Lakshmi scheme is a nutritional program to support pregnant and lactating women by the Government of Telangana.

BALAMRUTHAM: This programme launched in 2019 to provide supplementary nutrition to children between seven months to three years.

SUPPLEMENTARY NUTRITION PROGRAMME (SNP): The SNP is provided to kids below six yrs elderly, pregnant and nursing mothers and adolescent women of a low financial gain cluster to enhance health and biological process standing and enforcing through the Anganwadi centres.

AAROGYASRI SCHEME: Aarogyasri (Rajiv Aarogyasri) was a flagship aid program, introduced in 2007, before the AP Re-organisation. once split of state in 2014, into Telangana and state, Aarogyasri became flagship aid theme of Government of Telangana and is run by Aarogyasri Health Care Trust. the most recent Government of state renamed the theme in 2019 to Dr.YSR Aarogyasri. It covers families who have up to Rs.2.50.

108 AMBULANCE SERVICES: The 108 Ambulance Service launched in 2005, to achieve public health goals of safe transportation in types of emergencies implementing by the GVK-EMRI. 104 SEVA KENDRA: The 104 Seva Kendra was launched in the year 2006-07 to provide non-emergency health advice and guidance related to medical & health care services and implementing as a PPP model. KCR KIT: A spread of interventions has been taken by the govt of Telangana with targeted attention on the welfare of pregnant ladies. This includes payment of wage compensation to pregnant ladies within the variety of KCR Kit. Telangana government has set to atone for the wages gone by pregnant ladies. The KCR Kit programme serves 3 objectives viz., to eliminate excess caesarean surgeries; to reimburse the wage loss throughout physiological condition, and to scale back babe further as maternal mortality. And mother and kid can get the advantages till the baby turns to a few months, and the help of 12000/- are given to pregnant ladies. the primary instalment 4000/- is given to pregnant ladies in associate degree instalment of Rs. 4000/- at equal intervals. The items list beneath KCR Kit scheme.

5. HEALTH CARE ADMINISTRATION IN TRIBAL AREA:

ITDA is an administrative model adopted by several States for delivery of programs and services to tribal individuals, households, and habitations. The ITDPs are generally contiguous areas of the size of a Tehsil or Block or more in which the ST population is 50% or more of the total. So far 194 ITDPs/ITDAs have been delineated in the country in the states of Telangana, Andhra Pradesh, Assam, Bihar, Gujarat, Himachal Pradesh, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Manipur, Odisha, Rajasthan, Sikkim, Tamil Nadu, Tripura, Uttar Pradesh, West Bengal and Union Territories of Andaman & Nicobar Island and Daman & Diu.

The building of Health Institutions in Telangana

Sl. No	Type of Institutions	SCs	PHCs	CHCs
1	Total number of Institutions	4863	668	114
2	Government Building	2425	638	104
3	Rented Building	2438	30	10
5	Buildings under construction	255	40	0

Source: D. Shyjan & T.D. Simon, Health Status in Telangana, Telangana Social Development Report 2017, Council for Social Development, Southern Regional Centre, Hyderabad.

The ITDP/ITDAs are undertaken planning and implementation of various programmes and projects of the State Governments as well as of the GoI in their respective areas. They are responsible for infrastructural development, income generation activities, health, and education-related service.

Table:1.1. Relaxed norms for health facilities

SL	Centres	Population Norms	
		Plain Areas	Tribal/Desert Area
1	SC	5000	3000
2	Primary Health Centre	30000	20000
3	Community Health Centre	120000	80000

Source: Annual Report, 2018-19, Dept. of H&FW, MoHFW, GoI, p. 397.

A new norm of "time to care" has also been adopted for setting up sub-health centres in tribal areas under which an SC can be set up within 30 minutes of walk from habitation. In terms of infrastructure development, thrust has been given to reduce the gap in the availability of facilities, particularly in tribal areas. There is a significant increase in the

number of SCs is 1,56,231 on 31st March 2017 in the State of Rajasthan (3894), Gujarat (1808), Chattisgarh (1368), Karnataka (1238), Jammu & Kashmir (1088), Odisha (761), Tripura (448), Madhya Pradesh (318) and Kerala (286).

6. PRIMARY HEALTH CENTRE (PHC): There were 25,650 PHCs functioning in the country as on 31st March 2017. At the national level, there is an increase of 2414 PHCs by 2017 as compared to that existed in 2005. The significant increase is observed in the number of PHCs in the States of Karnataka (678), Assam (404), Rajasthan (366), Jammu & Kashmir (303) and Chhattisgarh (268) and Bihar (251). The percentage of PHCs functioning in government buildings has increased significantly from 78% in 2005 to 90.9% in 2017. This is mainly due to an increase in the government buildings in the States of Uttar Pradesh (1681), Karnataka (841), Gujarat (450), Assam (403), Madhya Pradesh (410), Maharashtra (232) and Chhattisgarh (336). The number of allopathic doctors at PHCs has increased from 20308 in 2005 to 27124 in 2017, which is about 33.6% increase. The shortfall of allopathic doctors in PHCs was 11.8% of the total requirement for existing infrastructure.

7. COMMUNITY HEALTH CENTRES: As of 31st March 2017, there were 5,624 CHCs functioning in the country. The significant increase is observed in the number of CHCs in the States of Uttar Pradesh (436), Tamil Nadu (350), West Bengal (254), Rajasthan (253), Odisha (139), Jharkhand (141), Kerala (126), Gujarat (91) and Madhya Pradesh (80). The number of CHCs functioning in government buildings has also increased during the period 2005-2017. The percentage of CHCs in Government buildings has increased from 91.6% in 2005 to 96.7% in 2017.

8. HEALTH FACILITIES: In addition to 4156 Specialists, 14350 General Duty Medical Officers (GDMOs) are also available at CHCs as on 31st March 2017. There was a huge shortfall of Surgeons (86.5%), Obstetricians & Gynaecologists (74.1%), Physicians (84.6%), and Paediatricians (81%). Overall, there was a shortfall of 81.6% specialists at the CHCs vis-a-vis the requirement for existing CHCs.

Table1.2. Health facilities available in Tribal areas

SL	Health Facility	All India			Tribal Areas		
		RHS 2005	RHS 2017	% Increase	RHS 2005	RHS 2017	% Increase
1	SCS	3222	5624	74.55	643	1028	59.88
2	PHCs	23109	25650	11.00	2809	4024	43.25
3	CHCs	142655	156231	9.52	16748	28200	68.38
	Total	168986	187505	10.96	20200	33252	64.61

Source: Annual Report, 2018-19, Dept. of H&FW, MoHFW, GoI, p. 397.

States have been provided with the flexibility of relaxing the norm of one ASHA per 1000 population to one ASHA per habitation in Tribal/hilly and difficult areas. While other States had one Mobile Medical Unit per 10 lakh populations subject to the capping of 5 MMUs per district, for tribal and hilly States of MMU exceeds 60 patients per day in plain areas and 30 patients per day in tribal/hilly areas.

Table 1.3 Human Resources in PHCs and CHCs in Telangana

Sl	District	Required	Sanctioned	In Position	Vacant
1	MPHW at Sub-Centers and PHCs	5531	9141	7705	1436
2	Doctors at PHCs (Allopathy) one per PHC	668	1318	1024	294
3	Health Assistance (Female)/ LHV at PHCs	668	1111	944	167
4	Health Assistant (Male)at PHCs one per PHC and 7 per CHC	668	-	-	-
5	Surgeons at CHCs one per PHC	114	71	14	57
6	Obstetricians & Gynecologists at CHCs one per PHC	114	71	41	30
7	Physicians at CHCs one per PHC	114	71	28	43

8	Paediatricians at CHCs one per PHC	114	71	33	38
9	Radiographers at CHCs one per PHC	114	71	28	43
10	Pharmacists at PHCs & CHCs per PHC	782	928	691	237
11	Laboratory Technicians at PHCs & CHCs per PHC	782	765	566	199
12	Nursing Staff at PHCs & CHCs one per PHC	1466	1666	1453	213
13	Block Extension Educator at PHCs	-	633	544	89

Source: D. Shyjan& T.D. Simon, Health Status in Telangana, Telangana Social Development Report 2017, Council for Social Development, Southern Regional Centre, Hyderabad.

The government health care sector, it can find that a large number of SCs (2438 out of 4863) are functioning in rented buildings. Despite having a surplus of health workers (female), doctors and health assistants (female) at PHCs, there are severe shortages of health assistants (male in PHCs) specialists like surgeons, obstetricians and gynaecologists, physicians, paediatricians and radiologists (in CHCs); pharmacists, laboratory technicians, nursing staff (in PHCs and CHCs); and Block Extension Educator (in PHCs) in the state.

9. CONCLUSION:

The health problems need special attention in the context of tribal communities of Telangana Tribal population has distinctive health problems which are mainly governed by their habitat in different terrains and ecologically venerable niches, Therefore, measures for the healthy development of tribals and their delivery system cannot be the same as per the general population and there have to be variations even in inter and intra tribal situations depending upon the health status and consequent health needs of the various groups. In the case of tribes, the overall health status is linked to their socio-economic development Optimal health level among tribes cannot be achieved only through linear expansions of the existing system of health services It is observed that two methods of treatment (both traditional and modem) operate side by side in the same situation the inadequate nature of modem health facilities available in ITDA Utnoor is responsible for the lack of tribal faith in modern treatment. It is, therefore pertinent to understand and appreciate the tribal's preference to their indigenous system of tribal medicine. But, if want to improve the health status of tribals, there is a need to judiciously manage available natural resources.

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