The International Journal's
Research Journal of Social Science & Management
ISSN:2251-1571

Availability and accessibility of the basic facilities including health care by a Primitive Tribal Group of South India - An exploratory study

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Introduction:

Basic facilities such as food, water, shelter, sanitation, health and employment are the fundamental elements required for survival of human beings. Although national and state governments incur 85 per cent of the expenditure on these services, 2010 data from the United Nations Development Programme (UNDP) estimated that 37.2% of Indians live below the country's national poverty line. Poverty is an undesirable state which deprives part of the human population their ability to fulfill basic needs. Through poverty alleviation policies and programmes every nation strives to improve the quality of life of the poor and the marginalized in the society. In this context, to determine the effect of poverty alleviation interventions, accessibility and utilization of these facilities by these sections become significant.

Tribal communities constitute a significant segment of Indian society and civilization. The tribal population constitutes 8.2 percent of the total population of India in 2001 census. 258 communities have been listed as belonging to the scheduled tribes in India. Studies have shown that they were more exploited, isolated, deprived and remained below the subsistence level of economy and faced the threats and challenges of survival. They are highly vulnerable to diseases with high degree of malnutrition, morbidity and mortality. They do not have access to the basic essential health facilities (Balgir, 2004). Poverty, illiteracy, lack of safe drinking water, poor sanitation, ignorance of causes of diseases and superstitions are considered to be some factors for their poor state of affairs. Soon after Independence and launching of five-year plans for national development, welfare and development of tribal communities were given a new direction.

In Karnataka, Scheduled Tribes (ST) account for 6.55 percent (3.46 million) of the total State population; this comprises 4.11 percent of the total tribal population of the country. Apart from the Scheduled Tribes, there are 75 indigenous groups in India known as 'Primitive Tribal Groups' (PTGs). The Tenth Plan of the Central Government observes that these vulnerable communities have experienced a 'decline in their sustenance base and the resultant food insecurity, malnutrition and ill-health has forced them to live in the most fragile living conditions and some of them are even under the threat of getting extinct'. Government of Karnataka has identified (i) Jenu Kuruba; and (ii) Koraga tribes as Primitive Tribal Groups (PTGs). Jenu Kuruba tribes are originally from Mysore, Chamarajanagar and Kodagu districts and Koraga tribes are from Udupi and Dakshina Kannada districts.

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The Koraga are a tribal community found mainly in the Dakshina Kannada & Udupi districts of Karnataka and the Kasargod district of Kerala, South India. They are the aboriginal tribes of Dakshina Kannada district notified as primitive tribes in 1986. Their existence is believed to be prior to 6th Century A.D. Though Koragas are tribals, they are regarded as the lowest rung in the caste system and as untouchables were not allowed in side temples and upper caste households in the local conservative Hindu society. Koragas are engaged in their traditional occupations like basketry, coir making or working as Safai Karamacharis (manual sweeping, collection and disposal of municipal solid waste, commonly referred as 'Paura Karmikas') in village panchayaths, town municipalities and city corporations.

Koragas are among the lowest rung of development in comparison with other tribal communities in Dakshina Kannada (Peer Mohammed.1994). Poverty, illiteracy, untouchability, 'Ajalu' system (a form of slavery perpetrated by the upper caste local conservative Hindu society), malnutrition, prevalence of widespread diseases, poor housing and sanitation, lack of access to clean drinking water, lack of awareness on facilities, health and nutrition, poor health seeking habits are believed to have had significant impact on the social, economic and educational conditions of Koragas. According to the Community Based Organizations of the Koraga tribes which advocate the tribal rights many of the programmes/schemes initiated for the development of the Koragas have not made expected impact perhaps due to the insensitivity to their problems, requirements and socio cultural values.

In spite of some positive changes taking place in the social, economic and educational spheres of Koragas during the last decade, lack of basic facilities, substance abuse, malnutrition, communicable and non communicable diseases are found to be causing concern among Koraga Sanghas, Government departments and NGOs. In the year 2000, when Millennium Development Goals (MDGs) were formulated there was huge excitement and positivity about the realization of the goals. Now barely three years left to complete these goals it is high time to examine the progress in providing and utilizing the basic facilities by the Koraga Tribes of Dakshina Kannada district in order to understand the extent of the target achieved.

Objective:

- To study the availability and accessibility of basic facilities by the Koraga Tribes in Dakshina Kannada district of Karnataka State, South India.
- To determine the utilization of health care facilities by the Koraga Tribes.

Materials and Methods:

An exploratory study was conducted amongst 300 Koraga families residing in five taluks of Dakshina Kannada district. Proportionate stratified sampling method was used. Family was the unit of the study and information was collected mainly from the head of families irrespective of gender. Structured interview schedule, pilot tested and validated was used. This pre-designed, pre-tested and structured questionnaire included topics relating to demographic variables, basic facilities and maternal health. A total of 300 respondents were interviewed after taking informed consent between February-December 2012. Data was analyzed statistically by simple proportions.

Results:

The study comprised 300 households. 76% of the families from rural and 24% from urban areas were covered. 54.3% of the respondents were men and 45.7% women. Mean age of the respondents was 48.27yrs. 66.6% were nuclear families, 29.7% joint families and whereas 4.0% were single families. Nuclear families were more in rural areas (66.1%). Among the respondents 32% were

daily wage earners, 30% basket weavers (more in rural), 9.7% Safai Karmacharis and beedi rollers (5.7%). Only 4% were found in government and private jobs. The mean per capita income per month was Rs 1334.63. 300 families consisted of 1589 members of which 49.8% were males and 50.2 were females. Education wise 25.5% were educated up to upper primary, 20.9% lower primary, 17.0% high school and 7.1% studied beyond high school level of which 4.7% studied post graduation, degree, teacher training, nursing and diploma courses. 25.4% were illiterates.

55.6% families did not have pucca houses to live in and nearly 91% families were landless and possessed an average of 3 cents (0.03 acre) of house sites. 24% of families did not get latrine facility and 72% families did not have bathing room facility. They bathed either in make shift sheds or in the open.

Table.1

Availability of Basic facilities in Koraga Tribe families/clusters (n=300)

Facilities	Rural		Urban	
	Yes	No	Yes	No
Landholding	19 (6.3%)	205 (68.4%)	6 (2%)	70 (23.3%)
Pucca housing	85 (28.3%)	142 (47.4%)	48 (16%)	25 (8.3%)
Piped drinking water	217 (72.4%)	10 (3.3%)	73 (24.3%)	0
Latrine	160 (53.3%)	67 (22.3%)	68 (22.7%)	5 (1.7%)
Bathing room	53 (17.7%)	174 (58%)	31 (10.3%)	42 14%)
Public transport	74 (24.7%)	153 (51%)	43 (14.3%)	30 (10%)
Link Road	210 (70%)	17 (5.7%)	67 (22.3%)	6 (2%)
Electricity	143 (47.7%)	84 (28%)	66 (22%)	7 (2.3%)
Fair price shop (median distance =1kms)	96 (32%)	131 (43.7%)	37 (12.3%)	36 (12%)
Anganwady(Pre- school for 3-6yr children) (median distance=1kms)	132 (44%)	95 (31.7%)	63 (21%)	10 (3.3%)
Primary school (median distance=2kms)	89 (29.6%)	138 (46%)	56 (18.7)	17 (5.7%)
PHC (median distance= 3kms)	40 (13.3%)	187 (62.4%)	27 (9%)	46 (15.3%)
Mode of cooking-LPG	11 (3.7%)	216 (72%)	10 (3.3%)	63 (21%)

61% Koraga families lack public transport facility. They either go on foot or by auto rickshaw to market places or for jobs. 30% lack electricity facility. More than half of the families had to walk 2kms (median distance) to the fair price shops. In 48.3% families children (6 yrs and above) had to walk nearly 2kms to primary schools and in more than half(65%) of the families children between 3-6yrs walk 1km to attend Anganwady centers (Pre School for children between 3-6yrs) from their clusters.

Significant progress has been achieved (96.6%) upon acceptance of the Peer Mohammed Study Recommendations by the Dakshina Kannda Jilla Panchayath in 1994 in providing drinking water facility, piped and supply through storage tanks, near the dwellings of the Koraga families in Dakshina Kannada. 92.3% Koraga families had kutcha link road facility to their clusters from the nearby main roads. 93% families were using firewood for cooking (Table -1).

Table.2

Utilization of Maternal Health Facilities by the Koraga Families (n=113)

Services	Rural		Urban	
	Yes	No	Yes	No
Supplementary Nutrition	70 (61.9%)	13 (11.6%)	19 (16.8%)	11 (9.7%)
TT	73 (64.7%)	10 (8.8%)	21 (18.6%)	9 (7.9%)
IFA	73 (64.7%)	10 (8.8%)	16 (14.2%)	14 (12.3%)
Health check up(Regular)	69 (61.0%)	14 (12.4%)	20 (17.8%)	10 (8.8%)
Immunization of children under 5yrs	77 (68.1%)	6 (5.3%)	30 (26.6%)	0 (0%)

As regards health care facility, 77.6% families lack PHCs near their clusters and had to walk nearly 2 kms for their health care needs. Ante Natal and Post Natal Care programme was found to be utilized well by the 113 families (Table.1). Nearly 78% of the expectant and post natal mothers received supplementary nutrition, 83% Injection Tetanus Toxoid (TT), 79% Iron & Folic Acid (IFA) tablets and 79% regular health check up services. 94.7% of the Koraga children under 5 were immunized.

Table.3

Diet during ANC & PNC Period (n=113)

Period	Rural		Urban	
	Yes	No	Yes	No
Ante Natal Care(ANC)	32 (28.3%)	51 (45.2%)	22 (19.5%)	8 (7.0%)
Post Natal Care(PNC)	30 (26.5%)	53 (46.9%)	13 (11.6%)	17 (15.0%)

52.2% of the expectant mothers and nearly 62% post natal mothers did not have any special diet during pregnancy (Table.3).They had Rice Ganji (boiled rice with water commonly used by economically poor families in the district) with salt and pepper. Only 47.8% antenatal and 38.1% post natal mothers consumed egg, meat and fish occasionally as special diet. In 63.7% cases breastfeeding was initiated immediate after deliveries and exclusive breastfeeding for 6 months period was reported in 39.8% families (Table.4).

Table.4
Breastfeeding practices (N=113)

Feeding Practice	Rural		Urban	
	Yes	No	Yes	No
Initiation of breastfeeding immediate after delivery	57 (50.4%)	26 (23.0%)	15 (13.3%)	15 (13.3%)
Exclusive breastfeeding for 6 months	32 (28.3%)	51 (45.2%)	13 (11.5%)	17 (15.0%)

Despite encouragement to improve institutional deliveries 17.7% of home deliveries were still reported. 10 infant deaths were reported during the last 5 years preceding the study. Of the 300 families 113 had history of pregnancy, no one reported maternal deaths during the last 5 years.

Discussion:

In the present study overall literacy level among Koragas for both the sexes was found to be 70.5% which was higher than the state level literacy rate for STs (57.4percent-National Sample Survey 2007-8). In recent years NGOs, private-public partnership and government programmes like Sarva Shiksha Abhiyan have made considerable impact on increase in elementary school education among the underprivileged in Karnataka (Karnataka Development Report.2002 & Vishnu.M Shinde. 2012). 7.1% of the Koraga population was educated beyond high school level that may be the reason that a dominant percentage of Koragas were still working as unskilled workers (40.1%) and only 2.3% % were in government service.

24.7% of the population was found engaged in daily wage work, 10% in basketry (in rural), 6.0% as Safai Karmacharis and 3.5% in beedi rolling. Only 2.3% were found in government jobs that too in menial jobs. Of the eligible employable persons, 12.6% were found to be still unemployed. There was significant association between education and occupation of Koragas ($p=0.003$) and this could be the reason being involved mainly in unskilled jobs. 81% were BPL category families. Per capita income of the family per month was rupees 1334.63. According to Government of India Economic Survey(2010–11) & India Human Development Report(2011), a quarter of the population still lives below the poverty line and more than half of the population belonging to SCs and STs is living below the poverty line. Nearly 90% of families lack agricultural lands despite government's decision to allot 2.5 acres to each Koraga families in Dakshina Kannada and Udupi districts. The improvement in housing was found to be not significant even after consideration of Peer Mohammed. Study recommendations (1994).

Dakshina Kannada, being awarded as the best achiever in total sanitation programme, yet 24% of the Koraga families lack latrine facility. Access to safe water and hygienic sanitation are fundamental to good health. According to Karnataka Human Development Report (2005) only 30 per cent of the SC and ST households have access to toilet facilities in the state, which is even lower than their respective national averages. Significant progress has been achieved (96.6%) since 1994 (Peer Mohammed.1994) to provide drinking water facility to Koraga families in Dakshina Kannada.

In maternal health front too there was great improvement. Of the 113 families a majority (78.0%) of the expectant and post natal mothers received supplementary nutrition from anganwady centers and T.T injection (83.0 %), IFA and regular check up from PHC/SCs (79.0%) respectively as against 56% in Peer Study.1994. In study of Antenatal Care among Tribals in Chhattisgarh and Jharkhand (2010) it was observed among STs, 38% women have received antenatal check-up from public health facility and 28% from other health sources.

Among Koraga families' poverty seems to be a problem. Majority of the families do not get sufficient nutritional support during ANC and PNC which was well reflected in the diet they followed. In 52.2% ANC and 62% PNC cases women had Rice Ganji (boiled rice with water) with salt and pepper. Only 47.8% ANC and 38.1% PNC women used egg, meat and fish occasionally in their diet. 94.6% achievement was found in immunization of Koraga children less than 5 years (74% in Peer Mohammed.1994). According to India Human Development Report (2011) the percentage of children receiving all vaccinations increased for STs in 2005–06 as compared to 1998–09.

Significant improvement in institutional deliveries (77%) among Koraga women was noticed. This is a great achievement as compared to home deliveries reported in case of STs 2005-6 was as high as 82% (India Human Development Report.2011). Also according to NFHS-3 (2005-06) only 17.7% institutional deliveries reported among scheduled tribe population. Higher rate of coverage could be attributed to the programmes of the health department, NRHM coverage into villages and increased demand from the CBOs for health facilities for Koragas. In 63.7% cases breastfeeding was initiated immediate after deliveries and it is obvious that these deliveries occurred in hospitals. In 35.3% cases pre lactal food such as boiled water, boiled water with sugar candy and honey was administered to infants. 35.3% post natal women exclusively breastfed their babies till 6 months (mean =4mnths). During the last five years 10 infant death cases and four miscarriages were reported. No maternal death was reported.

Conclusion:

Provision of basic facilities and access to these for the socio economically poorest sections in the society is a decisive factor in determining the development of the community. Basic facilities such as education, health, nutrition, sanitation, housing, transport will enhance wellbeing and are essential regardless of their effects on productivity. The study reveals that despite progress in providing certain basic facilities like drinking water supply, electricity, link roads, ANC and PNC care services to Koraga Tribes, efforts need to be scaled up to improve their housing, sanitation, literacy and employment conditions which ultimately contribute to improvement of quality of life. To further development outcome, a need based, participatory and collaborative approach is the need of the hour, which would go a long way to improve the quality of life of Koraga Tribes. To achieve eradication of poverty, improvement in maternal mortality, reduction in child mortality and ensure environmental sustainability, this study can also be viewed from the point of Millennium Development Goals 2015.

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