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HEALTH CARE SERVICES IN TRIBAL TEHSILS OF NASHIK DISTRICT

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Abstract-

With 8.6% of the tribal population, India considers it impossible to cross the health-care divide between the tribal and non-tribal communities. The tribal community faces a lot of problems due to its vulnerability and deprived status, with numerous aspects in which health is one of the important issues that makes them more vulnerable and deprived. Tribal wellbeing over a span of time is in a state of on-going dialogue and deliberation. A more commonly recognised reality is the tribal and their cultural context of disease and wellbeing. Tribal health problems, disease burden and ameliorative challenges in tribal area in specific, tribal societies in overall and primeval tribal groups are particularly vulnerable to disease. They still may not have the requisite access to basic health services. Secondary data is collected on various aspects health care services are collected from Socio-economic abstract of Nashik district, from 1981 to 2019. Tribal, irrespective of their regions or sects, obey those cultural norms related to their well-being and disease throughout the length and breadth of India. The current paper aims to illustrate the different aspects of the tribal health and health care services available in the study areas.

Key Words-Tribal, Health, Health care, Health services, Patients

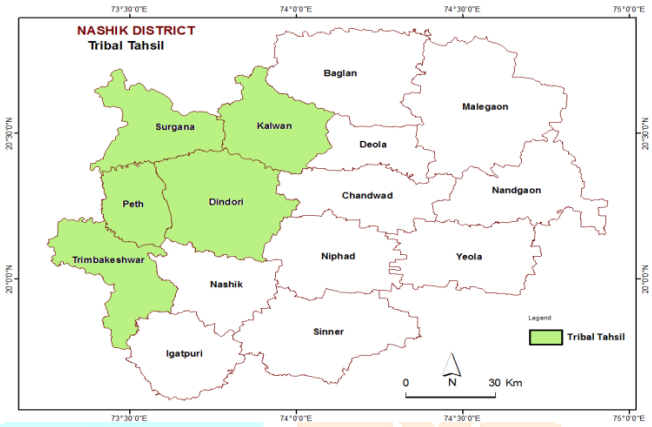
I. Introduction-

Health system in India- opportunities and challenges for improvements, the Indian health system is at a crucial stage, the felt. They emphasised the need to develop healthcare facilities, especially for the vulnerable, which are sensitive to community needs **(Ramani and Mavlankar 2005)**. Orthodox, conservative and under-privileged persons are Indian tribal. They are socially and culturally poorer and also living in an agricultural economy and generalised backwardness under abject poverty. This is due to their poor health, and is a source of suffering and a result of it. Inequality of the health system and the radical insecurity of the masses are the main barriers to good health. Illness decreases the potential to learn, decreases productivity, revenue and investment, leading to low quality life and thereby continuing poverty. The congregation has no basic care services and a greater number of tribal residents living below the poverty line. For their safety, there's an immediate need to work on them. Given the budgetary provision of public money ratings for their schooling and well-being, inability to wipe out the race due to perpetually polluted and harmful diseases existing in the whole tribal areas due to inaccessibility of timely medicinal assistance and government funded health care programmes.

II. Study Region:

Nashik district consist of 15 tehsils, namely Malegoan, Nandgaon,Nashik, Niphad, Peint, Baglan, Sinnar, Surgana, Trimbakeshwar, Chandwad, Devala, Dindori, Igatpuri, Kalwan, and Yevla. The main Sahyadrian range runs across north to south on the western portion of this district.Selbari range approximately forms the boundary between Nashik and Dhule districts. Nashik is located at an altitude of 600 meter above mean sea level. The study mainly emphasises to focus on tribal tehsils of Kalwan (20º29'25" N latitude and 74º01'35" E longitude),Dindori (20º12'00" N latitude and 73º49'59" E longitude), Peint (20º15'30" N latitude and 73º30'11" E longitudes), Surgana (20º34'12" N latitude and 73º37'12" E longitude) and Trimbakeshwar (19º55'56" N latitude and 73º31'51" E longitudes) in Nashik district.

Location Map



III. Objectives:

1) Find out the availability and adequacy of healthcare services in study areas.
2) To search cause analysis of healthcare services in tribal.
3) To develop and improve the framework of healthcare service for tribal population.

IV. Methodology& Data Analysis:

The Tehsil is taken as a unit to determine the level of healthcare facilities in the field of research. Tehsil has a Schedule Tribe (ST) population known as a tribal tehsil for more than 50% of its total population. This criterion derived from the direction given by Government of India, in 1975-76 the villages where more than 50 Percent of the population is tribal, were constituted into Integrated Tribal Development Projects (ITPT). The current research is based on a secondary data source. Secondary data is collected from the Nasik district socio-economic abstract **(1981, 1991, 2001, 2011 and 2019)**, Handbook of Nashik District Census, District Gazetteers, numerous internet sources. Data has been analysed on the basis of population norms and make tabulation with graph and diagrams of tribal health services availability with in their areas are also examined.

V. Discussion

Health care services in Tribal Areas of Andhra Pradesh, in this research lack of shelter, inadequate infrastructure, large-scale absences and shortages, poorly educated and unskilled staff are the reasons for poor health services, which in turn contribute to poor tribal health in the region**. (Rao K. Sujata, 1998)**. There is a consensus that tribal people's welfare problems are rather abysmal. This state of health is further exacerbated by the remoteness of the regions which is further aggravated and nuanced by inaccessibility. Much of India's tribes live in hilly terrain where it is difficult to access health care centres or systems and it is automatically impossible for health care staff and systems to reach them. The wellbeing of any group can be recognised from the accessibility of the health care system and services within the limits of its coverage.

Health Services:

The tribal health care system operates heavily in the magical-religious health care system. It is apparent from the multiple surveys that the health care system is heavily dependent on the conventional health care system in the tribal regions. Tribal people have their own medicine and health care system based on their own understanding of herbs and shrubs and the conventional system of diagnosis and treatment, such as shamans (traditional medicine man), if the same is the same. Health care system in India, the health care system in tribal areas was also investigated **(Murthy 2011)**. It is noted that the overall health services for the tribal

villagers are vital for vector-prone and water-prone diseases to be tested and eradicated. In the tribal areas, services can be built in order to draw 100% of hospital deliveries.

Table No. 01: Government Health Services in the Tribal Area

Decade	Hospitals	Dispensaries	Maternity Home	Primary Health Centres	Sub-Primary Health Centres	Doctors	Nurses	Beds
1981	04	12	2	8	17	43	95	85
1991	9	13	24	26	31	66	108	616
2001	11	17	44	39	45	90	294	1055
2011	9	1	85	38	67	139	377	624
2019	9	0	0	39	217	145	467	947

Source: Socio-economic abstract of Nashik District, from 1981 to 2019.

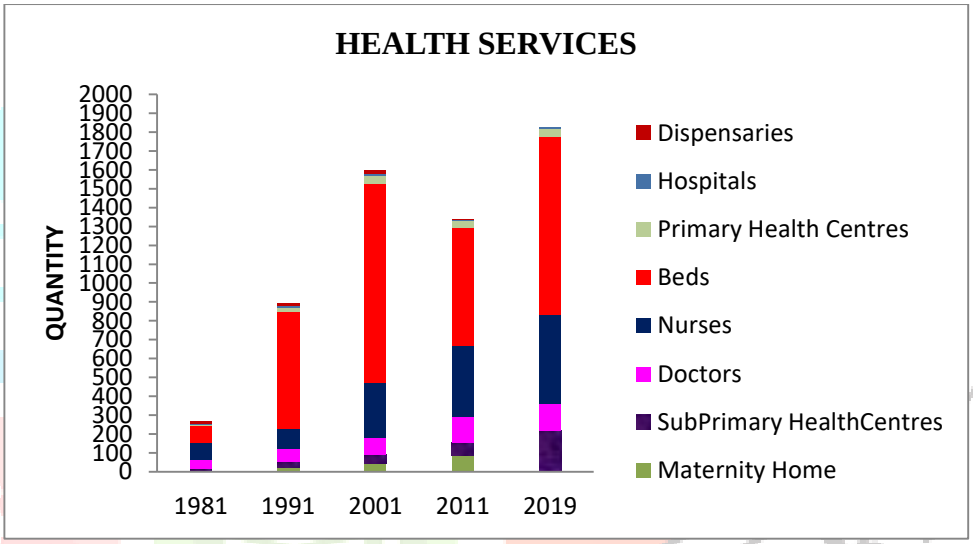


Fig. No. 1 Government Health Services in the Tribal Area (1981-2019)

Table 1& graph applies to the various health facilities offered at various levels by the government. Tribal tehsil has been found to make remarkable improvement in many facilities. The proportion of PHC is higher in tribal areas. New tribal tehsil systems have been successfully introduced. The members of the Maharashtra Local Assembly of this region are very involved in providing continuous health and other facilities in this area. The growth in the number of doctors increases in each decade; number of nurse's increases in each decade and beds is also increase in tribal Tehsil. In the tribal area, the number of dispensaries declined after 2001 many dispensaries were turned into PHCs and hospitals. From this table, the rise and decreases in PHC can be clearly observed in 2011, there were 38 Primary health centres, according to the table, during the study period, the number of PHC, primary health sub centres, doctors, nurses, and the beds have been raising.

In overall health care services such as hospitals, dispensaries and maternity home are observed to be decreased in tribal areas where as a positive thing is that this share increases the number of P.H.C., number of SPHCs , Number of doctors, nurses and number of beds. For Doctors, beds, nurses and no P.H.C. and PHCs this rise is significant. It is apparent that the situation was very worst in 1981, so change is obviously defined. In the case of primary health centres, the tribal people requirements help to raise the volume of primary health centres in the tribal region. (1 P.H.C for per 20000 population in tribal region and 30000 in case of other population, mainly rural)

The positive improvement in the development process has been shown in Dindori tribal tehsil. Dindori Tehsil is situated close to Nashik Tehsil, making it easier to execute government schemes. In the growth of health care services in Dindori, the fringe influence of Nashik Urban Center is also having a positive impact. In its states, just 1 out of 5 Tribal Tehsil indicates progress (for study Peth, Surgana, Kalawan, Dindori and Trimbakeshwar) . After 40 years of attempts, the other four tribal tehsils remain in the

similar low development group. These four tehsils are away far from the Nashik Tahsil. The facilities for transportation and correspondence remained not as strong as those of Dindori. The hilly area is distinguished by Tribal Tehsil such as Peth, Surgana, Trambak and Kalwan. Political reasons largely affect the decisions on the creation of government healthcare facilities.

Patients:

Reproductive health behaviour of the Nocte women in Arunachal Pradesh,the tribal believe in conventional ways of healing the ailments, it said. First of all, traditional healers are consulted for therapy and then for other medical attention. He also concluded that while traditional customs, traditions, values, and behaviours, as well as disease diagnosis and care **(R.K Kar 1993)**.

Table No. 02 : The Number of Patients

Decade	Indoor Patient			Outdoor Patient		
	Male	Female	Child	Male	Female	Child
1981	392	468	780	7675	1741	1476
1991	212	396	114	3000	4500	3600
2001	7384	12350	6522	10956	10045	17462
2011	9580	7890	1683	24924	11990	22659
2019	20826	42239	16370	31092	46508	26615

Source: Socio-economic abstract of Nashik District, from 1981 to 2019.

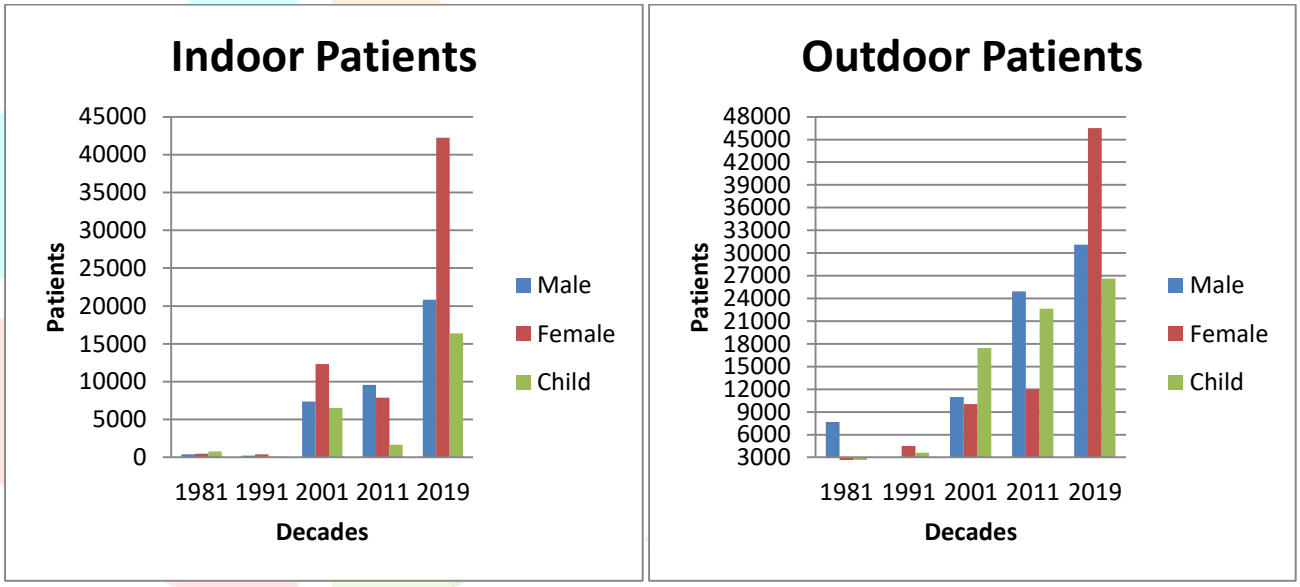


Fig. No. 2 The Number of Indoor and Outdoor Patients (1981-2019)

The number of patients who have benefited from medical services, such as indoor and outdoor patients, is shown in Table 4 during the study period. Compared to the outdoor patient services, the gain of internal facilities was much smaller. It is also known that the number of patients accessing medical services is continuously dropping due to individuals in private hospitals and the new facilities offered there.

VI. Conclusions:

The rise in public health care services have impressive, but unequal in the study duration. In the case of PHC, nurses and beds and even physicians, this growth is faster in tribal areas. There is a substantial decline in the number of clinics, maternity homes and pharmacies, as these have been moved to either PHC or hospitals. The number of PHCs in the tribal area is dramatically rising Dindori, tehsil has made tremendous strides in developing health care facilities are not retained in the field of research, but health facilities are according to standards in few situations. The number of patients who have benefited from medical services, such as indoor and outdoor patients compared to the outdoor patient services, the gain of internal facilities has much smaller. In its states, just 1 out of 5 tribal tehsil indicates progress (for study Peth, Surgana, Kalawan, Dindori and Trimbakeshwar). After 40 years of attempts, the other four tribal tehsil remain in the same low development group.

VII. Findings: From the above discussion following findings can be derived:

1) It is found that the health services in this tribal region have almost improved. The number of doctors, nurses, physicians and beds saw a rise.
2) Lack of budget for medicine, lack of physical facilities in PHC centres, low income of tribal citizens, poor level of pure nutrition, lack of cooperation, low level of income and education have been observed in the study area.
3) The number of patients who have benefited from medical services, such as indoor and outdoor patients Compared to the outdoor patient services, the gain of internal facilities was much smaller.

VIII. Policy Measures-

1) The demographic criteria proposed by the (Bhore Committee or the National Health Plan 1983) for delayed health care services should be enforced. According to 2011 census the population Dindori tehsil has 315709 lakh and the specifications; Dindori tehsil requires 16 Primary health centres. as per rules, but it now has only 10 primary health centres as, so in the near future, more PHC should be built in this tribal tehsil.
2) According to 2011 census the population of Kalwan tehsil has 208362 and the specifications, Kalwan tehsil requires 10 P.H.C., but it currently has only 7 PHC as per norms, so in the near future, more PHC should be built in this tribal tahsil.
3) There is a need to expand the number of community centres, primary and sub-primary health centres and hospitals and the timely delivery of medications and supplies in order to enhance the public health services within the block.
4) Creating a structural framework for health and overall growth change, penetrating to the lowest level of settlements and incorporating the recipient group-initiated plans and acts
5) Few rural health centres do not have a medical director, and few do not live-in health centre areas. This can impact health care delivery at the rural or tribal level. By offering more benefits and services, physicians should be encouraged to operate in tribal areas.

Reference:

1. Balgir, R.S (2007): Tribal Health Problems, Disease Burden and Ameliorative Challenges in Tribal Communities with Special Emphasis on Tribes of Orissa. Jabalpur Regional Medical Research Centre for Tribal (ICMR), page No.161-176
2. Boro B, Saikia N (2020): A qualitative study of the barriers to utilizing healthcare services among the tribal population in Assamhttps://doi.org/10.1371/journal.pone.0240096
3. Borse, N. & Surywanshi D. S. (2017). Comparison of Development of Government Healthcare Facilities In Tribal And Non Tribal Region Of Nashik District (Maharashtra) India. International Journal in Management and Social Science, V(VII), 392–398.
4. Dandub Palzor Negi1, Dr. Monica Munjial Singh (2019): Tribal Health in India: A Need Fora Comprehensive Health Policy, International Journal of Health Sciences & Research (www.ijhsr.org), Vol.9; Issue: 3; March2019. (P. 301, 302)
5. Harshal T PandveTukaram K Pandve (2014): Primary healthcare system in India: Evolution and challenges, Year : 2013 | Volume: 1 | Issue Number: 3 | Page: 125-128
6. http://mahatribal.gov.in/htmldocs/tsparea.html
7. Kar, R.K: Reproductive Health Behavior of the Nocte Women in Arunachal Pradesh. Social Change. December l993. 23(4). p.40-52.
8. Kumar M M, Pathak VK, Ruikar M. (2020): Tribal population in India: A public health challenge and road to future. J Family Med Prim Care. 2020;9(2):508-512. Published 2020 Feb 28. doi: 10.4103/jfmpc.jfmpc_992_19
9. Lal B. Suresh, (2011): Economic Analysis of Healthcare Services: A Study in Tribal Areas of Andhra Pradesh – India, International Journal of Health Management and Information (IJHMI) Volume 2, Number 2, pp. 119-131, ISSN: 2229-3108,
10. Murthy (2011): Health Care System in Tribal Areas – An Insight with Reference to Andhra Pradesh State, India January 24, 2011). Available at SSRN: https://ssrn.com/abstract=1747341
11. Powell-Jackson, T., Acharya, A., & Mills, A. (2013). An assessment of the quality of primary health care in India. Economic and Political Weekly, 48(19), 53–61.

12. Ramani KV, Mavalankar D. Health system in India: opportunities and challenges for improvements. J Health Organ Manag. 2006;20(6):560-72. doi: 10.1108/14777260610702307. PMID: 17168107.
13. Rao, K Sujata (1998): Health care services in Tribal Areas of Andhra Pradesh: A public policy perspective, Economic and political weekly, 33(9), Feb 28-Mar. 6,
14. Salil Basu, (2000): Dimensions of Tribal Health in India, Health and Population, prospective and issues 23(2)
15. Satpathy, Maheswar, and Jagannatha Acharya. "Tribal Health and Wellbeing in Odisha-A Health Systems Communication Perspective." Mediascape in 21st Century-Emerging Perspectives, Rabindranath, M. Sharma, M. Mishra, R. Singh, N.K. Goswami, M.P., Murthy, K. and Tirkey, A.A (Eds.), Kanishka Publishing: New Delhi I (2018): 259–65.
16. Socio-Economic abstract of Nashik from 1981 to 2019.
17. Tukaram Vaijanathrao Powale (2015): A study of health care services in tribal area, www.epitomejournals.com, Vol. I, Issue V, September 2015, ISSN:2395-6968 (P. 3,11)