Researching Evidences on Prevalence of HIV/AIDS among Tribal People in India

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Introduction

The National AIDS Control Programme (NACP) in India has made commendable efforts to formulate its strategies based on continuous research and evidences generated through Behavioural Surveillance Surveys among general population and high-risk-groups viz. sex workers, men having sex with men (MSM), intravenous drug users (IVDUs) etc. While there is focus on extensive awareness creation among the masses, for effective prevention, the NACP has initiated targeted interventions among the high-risk populations. Now NACP aims at going beyond the high-risk-groups and extend the interventions to populations that are vulnerable to HIV such as the tribal people and those socially disadvantaged in both rural and urban areas.

The tribal population in the country has poor health generally due to, among other factors, their poverty and social vulnerability. Tribal people are known to have sexual practices that differ from those of mainstream cultures, and a high prevalence of sexually transmitted infections. Less or nothing is known about the prevalence of STI/HIV/AIDS among tribal people in India, except perhaps in some of the tribal states of the North-East of India as these have high prevalence of drug use. The tribal population in the country is high and their sheer number makes it imperative for the Government to bring them in the fold of the national programme. To be able to do so, it is essential to understand the behaviours, practices that drive the vulnerability and risk among the tribal people. This would help guiding evidence-based design of HIV/AIDS prevention, diagnosis, treatment and care programmes oriented towards tribal population.

In view of the above, the present paper tries to review the available literature and study existing programmes which may provide sufficient base to understand the behaviors, practices that drive the vulnerability and risk among the tribal people. The paper also explores primary data generated by organizations and individuals working closely with tribal people so as to provide a meaningful context to the review.

Tribal Population in India

India has the second largest concentration of tribal population in the World. Indian tribes constitute around 8.2 percent of nation's total population, constituting nearly 84.3 million according to Census 2001. There are 635 tribes in India located in five major tribal belts across the country. There are in all 35 States and Union Territories (UTs) in India, of which in about 14, the proportion of scheduled tribe population to the total population is

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more than 10 percent. These states and UTs are Manipur, Arunachal Pradesh, Meghalaya, Mizoram, Nagaland, Sikkim, Tripura, Jharkhand, Bihar, Orissa, Chattisgarh, Madhya Pradesh, Gujarat, Rajasthan, Maharashtra, Andaman & Nicobar and Lakshadweep. The main concentration of tribal people in India is the central tribal belt and the north-eastern States. Barring a few states, they have their presence in all States and Union Territories of the country. Predominantly rural, they mainly stay in forests and hilly regions. The literacy level among Scheduled Tribe is 47.1%, much lower than the national average of 64.8% (Census, 2001). A comparison of the recent classification[2] of high-prevalence, moderate prevalence, highly vulnerable and vulnerable states by the National AIDS Control Organisation (NACO) with the predominantly tribal states shows that barring one state (Rajasthan) almost all the states either fall in high prevalence or HIV vulnerable states.

Special Attention under NACP-III for Tribal Population in India

The National AIDS Control Programme (NACP) in its third phase plans to go beyond the high risk behavior groups covered by Targeted Interventions. This entails extension of interventions to populations that are vulnerable to HIV such as the Tribal people and socially disadvantaged sections of the population in both rural and urban areas. This necessitated undertaking a rural risk/vulnerability assessment and a Social Assessment of HIV/AIDS among Tribal People in India.[3] The Social Assessment among Tribal People documented the prevalence and risk of HIV/AIDS among tribal people, their levels of knowledge, social and behavioural causes and consequences of HIV/AIDS (including stigma), and strategies used for prevention, diagnosis, treatment and care (PDTC) of HIV/AIDS in order to ensure appropriate programme design and implementation to reduce the spread of HIV/AIDS and improve its management. Primary data collection, review of existing literature and programmes, consultation with stakeholders and development of Tribal Action Plan was an integral part of the assessment. The primary data collection, qualitative in nature, was done amongst the tribal populations in six states of the country namely – Andhra Pradesh, Chattisgarh, Rajasthan, Maharashtra, Manipur and West Bengal. The present paper utilizes the findings of the review in the Social Assessment as well as the evidences from other national (NFHS-3) and state level studies regarding socio-cultural profile of the tribal populations, their general health seeking behaviour, awareness regarding HIV/AIDS, prevention, knowledge of STIs, causes of vulnerability to STIs and HIV and HIV prevalence in this paper.

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[2] *National AIDS Control Programme, Phase III (2007 – 2012), Strategy and Implementation Plan*

[3] *"Social Assessment of HIV/AIDS among Tribal People" carried out by ORG Centre for Social Research (A Division of ACNielsen ORG-MARG, India), was sponsored by NACP-III Planning Team/The World Bank/DFID, India*

Socio-Cultural Profile of Tribal People

Impressive details on the customs of the tribal people have been presented in the studies conducted in the past.[4] ,[5] These studies reveal that customs like the institution of marriage, age at marriage, separation, sexual practices, opportunities made available to youth to mix with opposite sexes such as fairs etc. vary from tribe to tribe. Tribal communities of India, though a very close knit society, cannot be clubbed together as one homogeneous group. They belong to different ethno-lingual groups, profess diverse faith and are at different levels of development- economically, educationally and culturally. Over the years, displacement and rapid acculturation of this population has led to changes in their socio-cultural and value systems.

The tribal communities covered in the six states under the Social Assessment also followed different and interesting customs. With regard to marriage, the customs varied from state to state. The age at marriage ranged from 15-18 for girls and 18-21 for boys. A micro-level study, which dealt with the age at marriage of individual tribes, also reported similar range. [6] In some states the customs were strict as in non-tribal communities like arranged marriage by parents (Rajasthan and Chattisgarh); and in some states the tribal communities reported live-in relationships/starting a family before marriage mainly due to economic compulsion (West Bengal and Maharashtra); marriages were performed by negotiations, capture, love, and even elopement (Andhra Pradesh); and in Manipur since all the tribal societies are Christian, both arranged and love marriages were common. Women had the choice of divorce and remarry and in many societies; bride price (called *Lagan* in Rajasthan, *Moganali* in Andhra Pradesh) had to be paid by the bridegroom. Interestingly, dowry system was reported to be on the decline and they practiced a form of monogamy in which they changed partners and remarried. In Maharashtra sexual relationships before marriage were also acceptable, but not outside marriage, thus practicing monogamy. Among tribal people, cross-cousin marriages were also preferred and practiced. Customs which espoused safety for the widowed women like marriage to husband's brother *(Natha pratha*) and re-marriage *(Ana Karna*) were prevalent in Rajasthan. Divorce was socially accepted and could be initiated from either side. A new tradition of group marriages with several couples marrying in one ceremony (S*amuhik Vivah)* was promoted by NGOs and voluntary workers in Maharashtra. Major focus of these gatherings was to legalize childbirth and provide a status to the women in the community.

Financial independence was considered to be of utmost importance in most of the tribal societies. A study reported that the timing of the marriage depended on the ability of the couple to institute an independent economic unit.[7]

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[4] *Patnaik, S.M. (2002): Community Norms of Sexual Behaviour – A Preliminary Study of Tribes of Jharkhand, Chhatisgarh and Uttaranchal*

[5] *Basu, S K (1993): Health Status of Tribal Women in India, NIHFW: 3 http://www.hsph.harvard.edu/grhf-asia/forums/Tribals/Tribals/M002.HTM*

[6] *Basu, S K (1993): Health Status of Tribal Women in India, NIHFW: 3, http://www.hsph.harvard.edu/grhf-asia/forums/Tribals/Tribals/M002.HTM*

[7] *Gandotra, M.M. et. al (2001), Population Research Centre, MS. University , Baroda: The Demography of tribal population in Western India; 7 http://www.iussp.org/Brazil2001/s40/S48_P08_Gandotra.pdf*

Melas/fairs/dances were an integral part of the tribal societies in most of the states (*Beneshwar mela, Leelapani mela, Shamlaji mela in Rajasthan; Chhau dance and Santhal in West Bengal; Dimsa dance in Andhra Pradesh)* and these were the places where they got attracted to each other or the relationships between girls and boys generally developed.

Access to Health Care and General Health Seeking Behaviour

Tribal people have poor access to health services and there is under utilization of health services owing to social, cultural and economic factors. Some of the problems of accessibility and poor utilization of health services unique to tribal areas are: difficult terrain and sparsely distributed tribal population in forests and hilly regions; locational disadvantage of sub-centers (SCs), Primary Health Centres (PHCs), Community Health Centres (CHCs); non availability of service providers due to vacant posts and lack of residential facilities; lack of suitable transport facility for quick referral of emergency cases; lack of appropriate policies to encourage/motivate the service providers to work in tribal areas; inadequate mobilization of NGOs; lack of integration with other health programmes and other development sectors; IEC activities not tuned to the tribal beliefs and practices; services not being client friendly in terms of timing, cultural barriers inhibiting utilization; non involvement of the local traditional faith healers and weak monitoring and supervision systems[8].

The primary data collected for the Social Assessment revealed that the health-seeking pattern varied from state to state. Traditional healers in Rajasthan, home remedies in West Bengal, Chhattisgarh and Maharashtra, self-medication in Manipur were the first measures taken at the onset of the disease. Health workers, especially ANMs were the key persons providing health care in some states. The health workers or the facilities were visited only in cases when the patients did not get cured. However, in Andhra Pradesh, accessibility of the government health facility was detrimental in availing the services. If the services were available within the village or close to it, these were availed at the very onset of the disease. Other options like traditional healers, home remedies etc were tried only either after this treatment could not cure the disease or health facility was inaccessible due to long distance or lack of transportation. However, the younger generation preferred to go to health facilities at the initial stage itself. Private treatment was preferred to government treatment due to easier accessibility. Faith in traditional healers/ home remedies was the prime reasons why people resorted to them at the onset of disease. Poor accessibility of government health facilities, presence of numerous quacks and unqualified private practitioners at accessible locations and faith in traditional healers were the main concerns to be addressed for improving primary health care services. There were reports of the faith healers referring the cases to hospitals (public or private). A study conducted in Madhya Pradesh revealed that around 71% of the tribal

[8] *Department of Family Welfare, MoHFW, GOI (2004): Project Implementation Plan for Vulnerable Groups Under RCH II: 11 http://mohfw.nic.in/*

people had faith in traditional healers, which they had inherited from their ancestors. They felt that traditional medicines are inexpensive and available at their doorsteps [9]

Awareness of HIV/AIDS, its Mode of Transmission and Prevention

The review reflects that the awareness and knowledge regarding Sexually Transmitted Infections (STIs) and HIV/AIDS was low among tribal people.

Only 38.6 percent of women belonging to scheduled tribe in the age group 15-49 years had heard about AIDS as compared to 55.3 percent of scheduled caste, 58.5 percent other backward castes and 72.7 percent of women from higher castes. The awareness among Scheduled Tribe men in the same age group though was higher (63.9%) than women, was substantially lower as compared to other caste groups (Scheduled Caste: 80.8%; Other Backward Caste: 84.1%; and Other castes: 89.6%). Television was reported to be the most common source of information about AIDS.[10]

Informing the population of ways in which HIV can be transmitted from a mother to her baby and that the risk of transmission can be reduced by using antiretroviral drugs are critical to reducing transmission of the virus from mothers to their babies. NFHS-3 revealed that among the major caste groups Scheduled Tribe women and men (27.6% and 44.5% respectively) were least likely to know about such transmission, followed by Scheduled Caste (40.5% and 59.7% respectively). The national level 46.7 percent of women and 63.3 percent of men knew about HIV transmission from a mother to her baby. Similarly, knowledge about prevention methods also revealed that Scheduled Tribe women and men were least aware of each of the three means of prevention: delaying sexual debut among young persons (abstinence), limiting the number of sex partners/staying faithful to one partner (being faithful), and use of condoms (the ABC approach).

Knowledge of STIs

The Social Assessment revealed that the knowledge of tribal people regarding STIs was low in all the states except for Manipur and to some extent in Maharashtra and Andhra Pradesh. The awareness in Manipur, Maharashtra and Andhra Pradesh was mainly attributed to information, education and communication efforts made by the Government programmes and NGOs. The review further substantiated these findings. A study conducted in southern part of the country among tribal people revealed that most of the respondents had not heard of STIs, and of those who had, only 1 percent was aware of associated symptoms[11]. The awareness varied from state to state as one study in

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[9] *Mathiyazhagan, T. (2004) :A Pilot Study on Communication Strategy for Reaching the Unreached Tribal Population in Mandla district of Madhya Pradesh : 3*

[10] *National Family Health Survey-3 (2005-06), International Institute of Population Sciences*

[11] *Naik et. Al (2005) Rural Indian tribal communities: an emerging high-risk group for HIV/AIDS in : 3 http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=554109*

Maharashtra showed that 49 percent of men and 59 percent of women were aware of STIs.[12]

Causes of Vulnerability to STIs and HIV

Several causes of vulnerability to STIs and HIV were reported during the Social Assessment and in other studies. Across all the states it was revealed by NGOs, academicians and Government officials that migrants, mobile sex workers and clients of mobile sex workers, those with multiple sex partners are more vulnerable to STI. The medical practitioners interviewed added that the youth are more susceptible to STI due to lack awareness of safe sex practices. In Manipur, the NGO workers, Government officials as well as tribal people mentioned that persons, who take injectable drugs, visit sex workers and maintain multiple partner relationships are more vulnerable to STIs. A mention of army personnel being vulnerable to STIs was also made. In Chhattisgarh the health providers were of the opinion that,

"*The tribals on their own never catch STI, it is only when the outsiders such as contractors (Thekedar) visit their areas, they leave behind such problems*"

In Andhra Pradesh, discussions with Government officials and NGO outreach workers revealed that the tribal girls participating in fairs/dances (e.g. *Dimsa Dance)* are made easy prey to commercial sex by the tourists with the help of local brokers. Stakeholders like NGOs, academicians and private practitioner mentioned that vulnerability of young increases because of lack of information on safe sex.

It was also found that tribal people got greatly influenced by outsiders. This interaction happens during *melas*/fairs and also as a result of exploring employment opportunities due to acute poverty. Although generalizations can not be made due to scant literature, based on the available information it can be said that to some extent these interactions have created space for HIV vulnerability among tribal youth.

A study listed several causes for the vulnerability of tribals to STIs. It found that in the prevalent institution of bride price if the boys from the communities are unable to pay the bride price, then girls are offered in marriage to non-tribals like truckers, contractors, forest contractors etc. While the unsuspecting tribals considered this union as marriage, those marrying the girls considered this as fun and often left the girl after the sexual union. Further exploratory studies are needed to this effect, based on which measures can be initiated to generate awareness.

The research conducted during earlier times on sexuality has indicated considerable sexual freedom among tribal people. These studies described the 'village dormitories', or

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[12] *World Vision (1997) An Exploratory Study of Sexual Networking Patterns of Tribals, Navapur, Maharashtra: 13*

'*ghotul*' in which the youths of both sexes stayed together.[13] However, one of the studies, which carefully researched the dormitory system in several tribal communities (*Ghotul of Muria Gonds, Gitoria of Munda, Ho and Birhors, Basaghar of Parajas, Rang Bang of Bhotias, Dhumkurias or Jonkerpa among Oraons)* observed that though these practices are continuing there has been an influx of outsiders which has disturbed their cultural system for instance '*Dhumkurias*' have taken shape of brothels where trade of tribal women as sex workers has started. Hence, sexual assault and the after math lead to them to contracting venereal diseases which in turn make them susceptible to the HIV infections and other diseases as well.[14] As regards the extramarital relationships, the review of literature indicated that extramarital relationships are widely practiced by men especially when women are pregnant or nursing or during period of travel for work. The data indicated that tribal women are particularly vulnerable to HIV/AIDS since they commence sexual activity at an early age and also get married early. In India there are a number of ethnic groups in which sex work has a special traditional cultural status. In these groups some young girls are designated to take on the permanent status of 'unmarried' and to engage in forms of entertainment including the provision of sexual services. The '*Nat*' ethnic groups in Rajasthan, and several groups in Madhya Pradesh, including the *Banchhara*, *Bedia* and *Sansia* people, are among those mentioned in recent studies.[15]

HIV Prevalence

NFHS-3 is the only survey which has assessed HIV prevalence in a representative sample at a national level and in high HIV prevalence states in India. The survey revealed that HIV prevalence rates are low for all the population groups. The analysis by caste groups revealed that though the differentials are small, prevalence of HIV is relatively high among Scheduled Caste Men (0.39%) as against the national average (0.36%). The HIV prevalence among Scheduled Caste women was only 0.12% as against the national average of 0.22%.

Tribal Action Plan (NACP-III)

Based on the comprehensive understanding gained from the Social Assessment and the stakeholder consultation[16], the National AIDS Control Organisation designed a Tribal Action Plan to improve the access of tribal people to information, prevention and comprehensive care and support under NACP-III. The action plan is tailored to three types of tribal situations. First, in the predominantly tribal northeastern region, the plan

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[13] *Verma et. al (2004): Sexuality in the Times of AIDS, Contemporary Perspectives from Communities in India: 346-347*

[14] *Patnaik, S.M. (2002): Community Norms of Sexual Behaviour – A Preliminary Study of Tribes of Jharkhand, Chhatisgarh and Uttaranchal, Chapter 5: 1-9*

[15] *Swarankar (2001), M.P. Human Rights Commission, 2001*

[16] *A Stakeholder Consultation was organized by NACP-III Planning team to discuss the findings of the Social Assessment. It was attended by the Government, International, National and local organizations/networks working with tribal people.*

envisages strengthening AIDS prevention and treatment services. Second, in states with designated tribal sub-plan areas which have concentrated tribal populations, it plans to map the vulnerable tribal groups and collaborate with officials of the Integrated Tribal Development Authorities (ITDAs) to improve prevention and treatment services. In both these sets of states, IEC materials will be translated in local dialect and local communication channels would be used to promote safe behavior, increase access to condoms, and provide referrals to ICTC and ART services. These services will be provided free of charge to poor tribal people. Patients and attendants who travel to health centers for diagnostic or treatment services will be compensated for travel and related expenses. Third, tribal people who are dispersed among non-tribal populations will be reached through mainstreaming efforts, particularly IEC, interventions for migrant workers, and other local initiatives. In all three situations, NGOs/CBOs (especially but not only those involved in tribal development activities, such as residential schools and producer cooperatives) will collaborate in prevention and referral activities, and those with hospitals and mobile dispensaries will also support treatment and care. Within all three situations, districts in the High and Moderate Prevalence categories will be given priority attention[17].

Research Gaps emerging from the Review and Suggestions for Bridging the Gaps

The evidence above though seem to be touching several facets of risks faced by tribal people with respect to vulnerability to STI/HIV, the available published information carried out among tribal populations is scarce and the evidence patchy. Therefore there is a need to carry out more behavioral studies using ethnographic approach in different tribal belts and systematizing knowledge management on HIV/AIDS for developing strategic interventions for tribal people. To strengthen the interventions among tribal people formative research is required to be carried out. Review and documentation of existing interventions and related research among vulnerable and tribal groups carried out at the ground level will also provide great insights to the programme managers.

Acknowledgements

The review presented was carried out under "Social Assessment of HIV/AIDS Among Tribal People in India" sponsored by National AIDS Control Programme –III Planning Team, NACO, GOI/The World Bank/DFID, India. The authors sincerely acknowledge the guidance received from Dr. Meera Chatterjee (World Bank) and Dr. M. Sudhakar and Dr. Manoj Kar (NACP-III Planning Team) during conducting the Social Assessment and thank them for their support. Special acknowledgement due to Mr. C.V.S Prasad (Senior Advisor, South Asia, ORG Centre for Social Research) for providing overall technical guidance on the Social Assessment .

[17] *National AIDS Control Program Phase III (2006-2011) Tribal Strategy and Implementation Plan*