

# Covid 19 Effect on India's Indigenous Community

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**Abstract:** This paper describes the effect of covid 19 on the tribal people of India. Every tribe has their unique culture and indigenous knowledge which are protecting them from the covid pandemic. To understand the situation community leaders, young youths and woman were connected. As the homogeneous group of people irrespective of age, sex and economic classes the real situation came through different triangulations. This paper also describes towards very low spread and high recovery rate due to their traditional medicinal practices.

**Key Words:** —Covid, Community health, Tribal, Protection.

## I. INTRODUCTION

India has over 100 million people from various indigenous groups and they are locally known as “Adivasi,” meaning ancient inhabitants. They live in forests, drylands and islands away from the general public (Agoramoorthy & Hsu, 2020). Although India has enforced the lockdown from late March to the end of May 2020, little is known about its aftermath impacting the indigenous communities. A quick search of the word “COVID-19” in Web of Science database for 2020 has yielded 41 798 papers and when the phrase “COVID-19 indigenous people” was used, it yielded only 38 papers. When we have added “India” in the search, it did not yield anything, which shows the deficiency of data on the rarely discussed topic. This commentary provides the information on how the pandemic impacts India's vulnerable indigenous groups. The COVID-19 pandemic has already infected over 70 000 indigenous people with 2000 deaths (WHO, 2020). In Brazil alone, over 27 000 cases of COVID-19 infections and 806 deaths have been reported among the indigenous population till September 2020 (Charlier & Varison, 2020). Similarly, new infections were reported from one of the least approachable groups, the Nahua tribe in the Amazon region of Peru (WHO, 2020).

Manuscript revised September 17, 2022; accepted September 18, 2022. Date of publication September 19, 2022.

This paper available online at [www.ijprse.com](http://www.ijprse.com)

ISSN (Online): 2582-7898; SJIF: 5.59

In the United States, the pandemic has caused the death of one in 3600 white Americans compared to one in every 2300 Native Americans. The Navajo Nation alone has recorded many COVID-19 infections and deaths, exceeding New York and New Jersey. Historically, the Hindu scriptures have justified the untouchability narrative as a result of odious sins accumulated in previous births leading to rebirths of some individuals in lower social castes (Joshi, 1986). Although the caste prejudicial practice was outlawed in 1950, the discrimination nonetheless continues (Agoramoorthy & Hsu, 2020). India's indigenous communities represent 8% of the total population and 25% of them are listed as the most impoverished (Government of India, 2011). Similarly, a survey conducted in 2016 has showed that 46% of the indigenous groups had the least wealth compared to 27% of the scheduled caste, 18% of the backward castes, 8% of other castes, and 25% of cases unknown (NFHS-4, 2020).

## II. IMPACT OF COVID 19

India enforced the pandemic lockdown abruptly on March 24 that ended on May 31, 2020 and that certainly impacted the country's 1.35 billion inhabitants (Agoramoorthy, 2020). Among them, the disadvantaged migrant workers from various indigenous groups based in cities such as Delhi, Mumbai, and Kolkata were the most affected. Due to the lack of transport, many ended up walking for hundreds of miles to return home as they lost their jobs leading to sudden shortage of funds and food (Agoramoorthy & Hsu, 2020). Most of India's 550 indigenous groups are adapted to the lifestyle of the mainstream society with the exception of 75 highly vulnerable groups that continue to follow the hunter-gatherer way of life. They have minimal contact with outside leading

to low education, less socioeconomic progress and more susceptible toward diseases (Giri, 2020). For example, the Odisha state has over 60 indigenous groups and 13 of them have been listed as the most vulnerable. They have a combined population of 250 000, distributed across 1500 villages. Six from two vulnerable groups (Bonda and Didayi) were tested positive for COVID-19 (Mohanty, 2020). The first case was recorded from Malkangiri district, home to 12 000 people. The source of the infection remains unclear, so it has become an epidemiological nightmare for officials. Likewise in March 2020, the Chhattisgarh state government reported only six COVID-19 cases (Raju, 2020). But, the cases have exploded to 198 000 including 2400 deaths by November 2020. Also, the viral spread has reached the remote indigenous region of Bastar by infecting five from the Abujh Maria community. The infected patients traveled outside recently that might have triggered the viral exposure (Sharma, 2020). The isolated indigenous populations located in the Andaman and Nicobar Islands have a long history of death by diseases. The historical record showed that contagious diseases namely pneumonia, measles, mumps, and influenza were introduced by outsiders and they played a major role to wipe out nearly half of the indigenous population in the 1800s (Krishnakumar, 2008). When the British officials arrived in 1858, the Great Andamanese community had a population of 5000. But many died by defending territories and also by diseases namely measles and influenza introduced by soldiers. In 1999, about 90 people from the Jarawa tribe were impacted by an outbreak of measles (Pandya & Mazumdar, 2012).

### III. PROTECTING THE TRIBAL GROUPS

India's indigenous populations live in remote areas with poor healthcare facilities. They also lack timely awareness to efficiently deal the COVID-19 outbreak. To make matters worse, no baseline data are available for over 50% of the vulnerable indigenous groups. Therefore, the indigenous communities are under immense threat from COVID-19 than other communities. By early March 2021, India had recorded over 11.4 million infected cases of COVID-19 with 159 000 deaths. People from the indigenous groups have not exposed to novel outside pathogens as they have minimal contact with the outside (Pandya & Mazumdar, 2012). Hence, they are more vulnerable toward various viral diseases. Also, the lack of access to adequate health care facilities and the scarcity of access to clean water, sanitation, and personal protective equipment have made the indigenous populations more vulnerable toward the pandemic (Kasi & Saha, 2021).

Moreover, the indigenous population is the most marginalized socio-economically and therefore less scientific studies are done to understand the actual infectious disease burden faced by them. So, we call for more studies and the government have to allocate special research grants to boost systematic disease surveillance in the least studied tribal region. The indigenous areas of Chhattisgarh and Odisha states are the epicenters of the Naxalite–Maoist insurgency where attacks on officials, soldiers, and indigenous people lead to deaths (Ahuja & Ganguly, 2007). Sociologists have argued that the indigenous groups are deprived of economic opportunities when compared to others as they are inept to express their outcries through the electoral process and thus, they have become more fearful of the systemic violence committed against them historically. The poverty and predicament have further pushed them to distrust the government (Guha, 2007). According to the UNICEF (2020), the nutritional services for the indigenous children and their mothers have plunged by 68% in April 2020 when India's lockdown came into effect that indicated how the government continued to ignore their agony. When the COVID-19 news reached the indigenous communities, many have turned to forest deities for natural protection from the pandemic. The Hallaki group in Karnataka has a pandemic goddess named “Mari” and people believe that it would cut the head of the pandemic demon. Similarly, in the Bastar region of Chhattisgarh, people seek protection from a deity named “Sheetla.” Scientists have recognized that religious faith-induced perceptions have shown more tolerance to psychological and physical stress leading to the fine handling of threatening diseases (Le et al., 2019). Besides, the indigenous people use numerous medicinal plants to control ailments that affect them and their livestock (Adhikari et al., 2018). They also use the traditional medicine for COVID-19 (Basu, 2020). Unfortunately, the knowledge of forest medicinal remedies is under threat due to deforestation. Therefore, scientists have called for the documentation of indigenous knowledge to sustainably manage medicinal plants across the region before it gets worse (Kanaujia Sukula, 2006).

### IV. CRISES AND INEQUALITY AMONG TRIBAL YOUTH DURING COVID-19

According to the 2011 Census, the tribal population constitutes 8.6% of the total population in India. The majority of this population resides in rural areas, where healthcare facilities are usually poor and are even poorer in the regions scheduled for tribal people. The tribal population residing in

rural areas has increased from 10.4% to 11.3%, while that residing in urban areas increased from 2.4% to only 2.8%. It is also interesting to note that the majority of tribal people are located in small states like Mizoram, Meghalaya, Tripura, Nagaland, and so forth, which are mostly devoid of infrastructural development. Mizoram has the highest proportion of tribal population counting to 94.43. A report by the Government of India (GOI) on the growth rates (GRs) of all the states cited the 2011 census, which showed that the GR of Mizoram was  $-2.55$ . On average, the GR of the state has varied from 7.15 in 2012–2013 to 4.82 in 2017–2018 as against 7.0, which is the national GR average (GOI, 2020). There is a big debate on whether or not GR can be considered as the marker of development. The conditions of tribal youth in bigger states like Rajasthan and Madhya Pradesh are not very positive. Data on the infrastructural facilities available in tribal regions and the shortfall from the main target given in the following sections demonstrate that tribal population in India has always faced inequality in several ways.

#### V. THE CRISIS IN EDUCATIONAL FACILITIES

The literacy rate of the tribal population has improved from 47.1% in 2001 to 59% in 2011. However, the national average is 73%. Youth literacy rate in the rural areas for tribal youth has increased by 12 percentage points for the male youth, and Scheduled Tribes (ST) female youth literacy rate has increased by 21 percentage points. However, they are still below the Scheduled Caste (SC) youth literacy rates. There is a shortfall of 14% in the literacy rate of the STs than the national average (MoTA, 2017: 24–25). Similarly, the employment rates are not very high among the tribal population. The majority of the tribal population is still dependent on farm-based occupations, although there is a recent trend of a shift to other occupations as well. However, this shift is liable to preferable economic conditions and availability of employment in non-farm activities. Especially during COVID-19, there has been a major setback for those who are employed in the informal sector and in non-farm activities without any permanent status of employment. With a declining trend in Gross Enrollment Ratio (GER) of tribal youth in secondary (IX–X grades, 14–15 years), senior secondary (X–XII grades, 16–17 years), and higher education (above XII grade, 18–23 years), it is difficult to find tribal youth employed in the formal sector with a high salary.

#### VI. INEQUALITY IN ECONOMIC CONDITIONS

All the above facts speak vehemently toward the impending inequality that tribal youth face in India, and this inequality has further increased during the pandemic. According to the 2011 Census, 45.3% of the STs in rural areas and 24.1% in urban areas fall in the Below Poverty Line (BPL) category. Further, 44.82% of Other Backward Classes (OBCs), 20.06% of SCs, and only 11.89% of ST household's own land. Approximately, 90% of the ST households do not own land as an economic asset, which makes them work on others' lands as agricultural laborers or other works of cultivation and the informal sector as well. The Unemployment Survey of 2013–2014 (cited in MoTA, 2017: 34–35) (Table 1) shows that only 48.2% of the ST youth have been employed for a period of 12 months and 47.4% of the ST youth have been employed for 6–11 months. This indicates that more than half of the ST youth also remain unemployed for a maximum time of the year. The pandemic has grossly hit the employment of youth in India and should also have a gross impact on tribal youth. The unemployment rate during COVID-19 spiked to 29.2% in the urban areas as against 26.7% in the rural areas (The Hindu, 2020). The national average unemployment rate spiked to 27.11% in May from only 7% during the start of the pandemic in mid-March, in 2020. A dismal picture shows that 35.65% of the ST households do not own land and derive their income from manual casual labor, only 4.36% of the ST households have a salaried job in the government, 86.53% of the ST households have a monthly household income of less than 5000 rupees, 57.39% of the households are without any phone, 1.48% of the households have a salaried job in the private sector, and 0.58% of the households have salaried jobs in the public sector (GOI, 2017: 31). Such a loss of jobs can have an impact on the women in the tribal households. In India, more than 75% of male tribal youth are engaged as main workers. Most of this work is in the form of wage labor or casual labor, which was at the highest risk during the pandemic. More than 50% of ST female youth are engaged as marginal workers. As a result of the loss of jobs, there are higher incidences of domestic violence over tribal female youth.

#### VII. THE CRISIS IN HEALTH INFRASTRUCTURE IN TRIBAL AREAS

There is a grave requirement of healthcare facilities in tribal-dominated regions. The nutritional status and mortality rates among STs are much higher than the rest of the rural and urban

populations. The infant mortality rate among the STs is 62.1%, higher than the national average of 57%. The child mortality rate is 35.8%, which is more than the national average of 18.4%. The National Family Health Survey (NFHS) data of 2005–2006 (cited in MoTA, 2017: 28) show that 53.9% of ST children under 5 years were stunted, 54.4% of the children were underweight, and 24.9% of the children were severely underweight. It is evident that this proportion of ST children who will now be in the age group of 16–19 years are in the risk group with low immunity to fight the spread of infection of COVID-19. This large proportion of tribal youth is currently at stake and in need of healthcare facilities to survive the spread of infection. Along with high rates of maternal mortality and lack of care facility received from medical professionals in tribal areas, there is a significant problem with the levels of awareness. The statistical profile of tribal population published by the MoTA (GOI, 2013) reported that, among the surveyed tribal population, there is still a very low level of awareness over the occurrence and prevention of tuberculosis (TB): 13.7% of ST women and 17% of ST men do not want the status of TB patients to be revealed. Along with low levels of awareness, the incidence of diseases is also high among the STs. ST women and men in the age group of 15–49 years who are affected with asthma are also higher in number than the SC and OBC people.

### VIII. CRISIS IN HOUSEHOLD AMENITIES

Even basic amenities like clean drinking water are not available for tribal people. Given the high levels of poverty, it is difficult to expect that tribal people can afford to improve immunity level with good food, improved measures of cleanliness, and access doctors in the districts or town areas for treatment. As Singh (2020) mentioned, the tribal women in Deogarh district of Jharkhand were surviving only on millets and paddy during the initial phase of lockdown. In addition to maintaining these facilities, it is also not possible for tribal people to maintain the norms of social distancing. This is because bathing facilities, latrines, and drinking water facilities are not found in the majority of the cases in close proximity to the tribal households and are also not available on the premises of their households. Data show that 74.7% of the STs opt for open defecation, 77.4% households do not have latrine facilities, only 22.6% of ST households have latrine facility within their premises, 33.6% of the STs have to travel far to get drinking water, and only 19.7% households have sources of drinking water within their premises (MoTA,

2013: 68). Twenty-four percent of rural ST households and 16% of urban ST households did not receive safe drinking water, according to the National Sample Survey Organisation (NSSO) survey 2008–2009 (MoTA, 2013: 86). Given this lack of infrastructure, it is difficult to expect that tribal people will be able to maintain the norms of social distancing for COVID.

### IX. CONCLUSION

The Indian government needs to enforce public health policies in partnership with indigenous groups while respecting their traditional perspectives on diseases and their treatments. The government must respect their rights for self-governance prioritized by the UN Declaration on the Rights of Indigenous Peoples in 2007. Officials in general are reluctant to work in remote forest areas so young officers, educators, and health professionals need to be trained to sensitize the indigenous culture so that they can work exclusively to resolve their concerns. The state government of Tamil Nadu, for example, has offered additional merit points for each year of service in remote areas where indigenous communities live that attracted health professionals (Bruno Mascarenhas, 2012). Also, some doctors prefer to stay in remote forest areas to serve the indigenous communities as they often develop close relationships with people and thus get used to the rural lifestyle (Sheikh et al., 2012). In order to encourage such health workers, the state government of Chhattisgarh came out with an attractive scheme and offered higher salaries to health professional to serve the indigenous communities inhabiting the remote forest areas and thus establishing a successful model (Mavalankar, 2016). Given the lack of data on the vulnerable indigenous groups, a coordinated effort by various government and non-government agencies to monitor COVID-19 in the indigenous communities is highly recommended.

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