Indian Journal of Health Care, Medical & Pharmacy Practice Vol 5; Issue 1, Jan-Jun 2024, ISSN 2583-2069

Research Article

A Study on Health Profile of 3 ITDA Spots of Kurnool District, Andhra Pradesh, India

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DOI: https://doi.org/10.59551/IJHMP/25832069/2024.5.1.30

Received: 11 March, 2024, Decision for Acceptance: 5 April, 2024

Abstract

Introduction: The Adivasi, often referred to as Indigenous people or original inhabitants, constitute approximately 17 million prospective tribes in India. The term "designated Tribe" holds a legal designation. According to the 2011 census, the number of planned tribes in India is 104,281,034, which equals 8.6% of India's total population. This paper aims to examine the health profile of Tribals in 3 ITDA spots of Kurnool District, Andhra Pradesh. Objectives: The main aim of the study was to assess the health profile and shed light on the top 10 diseases prevalent in the 3 selected ITDA spots of Kurnool district, as well as to promote the Unani system through mobile medical camps under the Tribal Sub Plan (TSP). Additionally, it aims to analyse the health profile and determinants of tribes in the study area. Methodology: This study focuses on the health profile of the 3 ITDA spots based on OPD data, including the distribution of patients by sex and age groups, and identifying the top 10 common diseases in these areas. Results: A total of 2583 individuals attended the OPD of the 3 ITDA spots in the year 2022-2023. Among them, the top 10 diseases were identified, and their distribution by sex and age group was analysed. Conclusion: The present study revealed that most of the tribals in the study area suffered from Sual o surfa (Cough), Sardi wa Zukam (Common cold & coryza), and Humma (Fever), which are common in the 3 ITDA spots, followed by Warm I Halaq (Pharyngitis), Suda (Headache), and Polyarthritis.

Keywords: Adivasi, Health Profile, 3 ITDA Spots, Top 10 diseases, Unani, Tribal Sub Plan (TSP), Mobile Medical Camps.

1. Introduction

Andhra Pradesh, the 10th largest state in India, boasts a population of 49.4 million, accounting for 4.8% of India's total population. The tribal population of the state stands at 2.739 million, constituting 5.53% of the total state population[1], with tribes dispersed across various regions. Kurnool District, with a total population of 4,053,463, has a Scheduled Tribe (ST) population of 8,283, comprising 2.04% of the total population, with males numbering 42,052 (1.04%) and females 40,779 (1.01%)[2].

While there is considerable knowledge about the health and health practices of the general population, information regarding the health status and practices among tribal populations is limited. Given the prevailing poverty[3], understanding the health status

and practices among tribals becomes particularly crucial. The health issues faced by tribal people in Andhra Pradesh are not significantly different from those encountered by other tribal populations in the country[4].

According to the World Health Organization (WHO), health is defined as a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity[5]. However, poor quality food intake due to low literacy rates, lack of awareness, food shortages, and nutrient inadequacies contribute to the ill-health of tribal populations[6].

This study was conducted in three Integrated Tribal Development Agency (ITDA) spots: Gummitham Thanda, Gudembai Thanda, and Panyam Chenchu Colony, situated in Kurnool District, Andhra Pradesh, under the Tribal Sub Plan (TSP). Among the 427 identified tribal communities in India, 33 tribal groups, representing various stages of socio-economic development, reside in Andhra Pradesh. Of these, eight tribal groups have been designated as primitive tribal groups by the Government of India[7]. The present study focuses on the Chenchu and Sugali communities.

2.1 The Sugalis

The Sugalis are a nomadic tribe found across India, inhabiting plains with a distinctive culture and shared characteristics, including physical features, language, habitats, cultural homogeneity, unified social organization, and habits. The literacy rate among the Sugalis stands at 49%[4].

Also known as Lambada or Banjaras, the Sugalis are a prominent tribe in Andhra Pradesh. They are described as intelligent, good-looking, well-built, and sturdy people who have endured numerous challenges over time. The Lambada community typically resides in regular Thandas, which are often located away from villages and preferably on elevated grounds[8].

2.2 The Chenchus

The Chenchus are typically of short stature, barely reaching 5 feet in height, although exceptions exist. They have small, curly faces, with jet-black hair trained to curl at the forehead. The name "Chenchu" is believed to be derived from "Chunchu," meaning 'Curl of Hair.' The malnutrition prevalent among these people is deeply concerning[8].

The Chenchu tribe was officially recognized as one of the primitive tribal groups by the Government of India in 1975 (GOI, 1985-90). References to the Chenchus can be found in Manusmrithi (Chapter X-48). An ecological interpretation of the word "Chenchu" suggests it means "a person who lives under a Chettu (tree)" (Ayyappan, 1948)[9]. The Chenchus are among the original tribes of Andhra Pradesh.

Perhaps no people in India possess fewer material possessions than the jungle-dwelling Chenchus; their belongings typically consist of bows and arrows, a knife, an axe, a digging stick, some pots and baskets, and a few tattered rags. The Chenchus are characterized by a strong sense of independence and personal freedom. They do not feel tied to any particular locality, and the ability to move between groups allows both men and women to choose their companions with whom they wish to share their daily lives[8].

2.3 Transformation of Chenchu Recreation

There has been a noticeable evolution in the recreational pursuits of the Chenchus. Once immersed in folk traditions for entertainment, they are now gradually transitioning to modern forms of amusement. Moreover, there has been a significant shift in their dressing style. No longer exclusively clad in loin cloths, they have adopted attire similar to that worn by villagers and urban residents[7].

Objectives

The primary objective of the current study is to organize free OPDs through Mobile Medical Camps. Additionally, it aims to analyze the health profile and determinants of tribes in the study area, as well as to understand the underlying reasons for health problems in the region.

Methodology

The data was collected from the OPD records of three ITDA spots: Gummitham Thanda, Gudembai Thanda, and Panyam Chenchu Colony in Kurnool district, Andhra Pradesh, India. The data collection period spanned from June 2022 to April 2023. A total of 2,583 patients attended the OPDs across the three spots collectively, with 584 from Gummitham Thanda, 952 from Gudembai Thanda, and a maximum of 1,047 patients from Panyam Chenchu Colony. Patients were categorized into groups based on gender (males, females, male children, and female children), and their distribution was recorded according to the affected disease. From each spot, the top 10 diseases were selected, and their distribution was analyzed by sex and age group. Mobile medical camps were conducted thrice a week.

A. GummithamThanda: A total of 584 patients attended the OPD. Among them, 282 (48.28%) were males, 291 (49.82%) were females, 4 were male children, and 7 were female children. The top 10 diseases were identified among the total patients and categorized by sex and age group. The top 10 diseases observed in Gummitham Thanda were as follows:

- Sual o Surfa (Cough/Bronchitis)
- Warm i Halaq (Pharyngitis)
- Husr/Ihtibas (Constipation)
- Suda (Headache)
- Reddish yellow colored urine (Bawl Ashqar)
- Irq al Nasa (Sciatica)
- Tahajjur wa Salaba al Mafasil (Ankylosing arthritis)
- Humma (Fever)
- Waja al mida (Gastralgia)
- Sayalan al Rahem (Leucorrhoea)

These diseases were further analysed based on gender and age groups within the Gummitham Thanda community.

Table 2 indicates that out of the total 246 patients, the majority were females, comprising 130 individuals, accounting for 52.84% of the total. Males constituted 107 patients, representing 43.49% of the total, while male children accounted for 5 patients, equivalent to 1.09%. Female children formed the smallest group, with only 4 patients, making up 1.52% of the total. It is noteworthy that females were significantly more affected than males, and the number of children attending the OPD was notably low.

Table 3 illustrates the distribution of the top 10 diseases by age groups. Among these diseases, the highest occurrence, totaling 121 cases (49.18%), was observed in the age group of 21-40 years. This was followed by 85 cases (34.55%) in the age group of 41-60 years, 25 cases (10.16%) in the age group of 61-80 years, and a minimal 15 cases (5.70%) in the age group below 20 years.

Table 1: Distribution of Patients According to Top 10 Diseases

S. No.	Top 10 Diseases	No. of Patients
1	Sual o Surfa (Cough/Bronchitis)	35
2	Warm i Halaq (Pharyngitis)	31
3	Husr/Ihtibas (Constipation)	30
4	Suda (Headache)	27
5	Bawl ashqar (Reddish yellow coloured Urine)	23
6	Irq al Nasa (Sciatica)	22
7	Tahajjur wa Salaba al Mafasil (Ankylosing arthritis)	21
8	Humma (Fever)	21
9	Waja al Mida (Gastralgia)	19
10	Sayalan al Rahem (Leucorrhoea)	17
Total		**246**

Table 2: Gender wise Distribution of patients

S. No.	Name of the Disease	Male	Female	Male Child	Female Child	Total
1	Sual o Surfa (Cough/Bronchitis)	17	13	01	04	**35**
2	Warm i Halaq (Pharyngitis)	14	17	00	00	**31**
3	Husr/Ihtibas (Constipation)	16	13	01	00	**30**
4	Suda (Headache)	12	14	01	00	**27**
5	Bawl ashqar (Reddish yellow coloured Urine)	07	16	00	00	**23**
6	Irq al Nasa (Sciatica)	09	13	00	00	**22**
7	Tahajjur wa Salaba al Mafasil (Ankylosing arthritis)	16	05	00	00	**21**
8	Humma (Fever)	08	11	02	00	**21**
9	Waja al Mida (Gastralgia)	08	11	00	00	**19**
10	Sayalan al Rahem (Leucorrhoea)	00	17	00	00	**17**
Total		**107**	**130**	**05**	**04**	**246**
Percentages		**43.49%**	**52.84%**	**1.90%**	**1.52%**	**100%**

Table 3: Age wise distribution of patients

S. No.	Name of the Disease	Below 20 yrs.	21-40 yrs.	41-60 yrs.	61-80 yrs.	Total
1	Sual-o-Surfa (Cough/Bronchitis)	05	16	10	04	**35**
2	Warm I Halaq (Pharyngitis)	01	10	17	03	**31**
3	Husr/Ihtibas (Constipation)	02	18	10	00	**30**
4	Suda (Headache)	03	10	12	02	**27**
5	Bawl ashqar (Reddish yellow coloured Urine)	00	10	08	05	**23**
6	Irq al Nasa (Sciatica)	00	11	09	02	**22**
7	TahajjurwaSalaba al Mafasil (Ankylosing arthritis)	00	11	05	05	**21**
8	Humma (Fever)	02	11	08	00	**21**
9	Waja al Mida (Gastralgia)	01	10	04	04	**19**
10	Sayalan al Rahem (Leucorrhoea)	01	14	02	00	**17**
Total		**15**	**121**	**85**	**25**	**246**
Percentages		**5.70%**	**49.18%**	**34.55%**	**10.16%**	**100%**

B. Gudembai Thanda

A total of 952 patients attended the OPD of Gudembai Thanda. Among them, 437 were males, 480 were females, 21 were male children, and a minimum of 14 were female children who attended the OPD. Among the total OPD attendees, the top 10 diseases were identified and categorized by sex and age group. The top 10 diseases observed were as follows:

- Sual o Surfa (Cough/Bronchitis)
- Nazla o Zukam (Common Cold & Coryza)
- Warm i Halaq (Pharyngitis)
- Suda (Headache)
- Humma (Fever)
- Husr or Ihtibas (Constipation)
- Bawl Ashqar (Reddish yellow colored Urine)
- Nabd Qawi (Strong Pulse)
- Zof e Ishtiha (Anorexia)
- Waja al Mida (Gastralgia)

Table 1: Distribution Of Patients According to Top 10 Diseases

S. No.	Top 10 Diseases	No. of Patients
1	Sual o Surfa (Cough/Bronchitis)	**71**
2	Sardi wa Zukam (Common cold/Coryza)	**61**
3	Warm i Halaq (Pharyngitis)	**48**
4	Suda (headache)	**43**
5	Humma (Fever)	**42**
6	Husr/ Ihtibas (Constipation)	**37**
7	Waja al Mida (Gastralgia)	**35**
8	Bawl Ashqar (Reddish yellow coloured Urine)	**33**
9	Nabd Qawi (Strong Pulse)	**32**
10	Zof e Ishtiha	**31**
Total		**433**

Table 2: Gender wise Distribution of patients

S.No	Name of the Disease	Male	Female	Male Child	Female Child	Total
1	Sual o Surfa (Cough/Bronchitis)	26	33	04	08	**71**
2	Sardi wa Zukam (Common cold/Coryza)	26	27	06	02	**61**
3	Warm i Halaq (Pharyngitis)	28	20	00	00	**48**
4	Suda (headache)	21	19	03	00	**43**
5	Humma (Fever)	15	22	04	01	**42**
6	Husr/ Ihtibas (Constipation)	23	12	02	00	**37**
7	Waja al Mida (Gastralgia)	23	12	00	00	**35**
8	Bawl Ashqar (Reddish yellow coloured Urine)	19	14	00	00	**33**
9	Nabd Qawi (Strong Pulse)	14	18	00	00	**32**
10	Zof e Ishtiha	14	16	01	00	**31**
Total		**209**	**193**	**20**	**11**	**433**
Percentages		**48.26%**	**44.57%**	**4.6%**	**2.5%**	**100%**

Table 3: Age wise distribution of patients

S. No.	Name of the Disease	Below 20 yrs.	21-40 yrs.	41-60 yrs.	61-80 yrs.	Total
1	Sual o Surfa (Cough/Bronchitis)	13	30	24	4	**71**
2	Sardi wa Zukam (Common cold/ Coryza)	10	23	26	2	**61**
3	Warm i Halaq (Pharyngitis)	01	27	16	4	**48**
4	Suda (headache)	03	14	19	7	**43**
5	Humma (Fever)	06	21	13	2	**42**
6	Husr/ Ihtibas (Constipation)	02	18	15	2	**37**
7	Waja al Mida (Gastralgia)	02	18	14	1	**35**
8	Bawl Ashqar (Reddish yellow coloured Urine)	00	17	14	2	**33**
9	Nabd Qawi (Strong Pulse)	01	16	14	1	**32**
10	Zof e Ishtiha	01	18	11	1	**31**
Total		**39**	**202**	**166**	**26**	**433**
Percentages		**8.8%**	**46.65%**	**38.33%**	**6%**	**100%**

These diseases were further analysed based on gender and age groups within the Gudembai Thanda community.

From the above table, it is evident that out of the total patients, 209 individuals, accounting for 48.26%, were males, while 193 individuals, representing 44.57%, were females. A minimum of 2.5% were female children, and 4.6% were male children. Males outnumbered females in attendance. Additionally, it is notable that the number of children attending the OPD was very low.

The distribution of the top 10 diseases was analyzed by age group. The above table reveals that these top 10 diseases were more prevalent, accounting for 46.65%, in the age group of 21-40 years. This was followed by 38.33% in the age group of 41-60 years, 8.8% in the age group below 20 years, and a minimum of 6% in the age group of 61-80 years.

C. Panyam Chenchu Colony: A total of 1047 patients attended the OPD. Among them, 469 individuals, accounting for 44.79%, were males, while 524 individuals, representing 50.04%, were females. The ratio of male to female children was equal, with 27 children (2.57%) of each gender attending the OPD. Among the total patients, the top 10 diseases were identified and categorized by sex and age groups. The top 10 diseases observed in Panyam Chenchu Colony were as follows:

- Sual o Surfa (Cough/Bronchitis)
- Nazla wa Zukam (Common cold & Coryza)
- Humma (Fever)
- Warm i Halaq (Pharyngitis)
- Husr/Ihtibas (Constipation)
- Bawasir (Piles/Hemorrhoids)
- Ishal (Diarrhea)
- Waja al Mida (Gastralgia)
- Duf al Ishtiha (Anorexia)
- Nafkh al Mida (Flatulence or gases)

These diseases were further analyzed based on gender and age groups within the Panyam Chenchu Colony community.

Table 2 indicates that the distribution of diseases among males and females was equal, with 198 patients (44.79%) being affected in each gender category. Additionally, a minimum of 21 patients (4.75%) were male children, while 25 patients (5.65%) were female children.

Table 3 displays the distribution of the top 10 diseases by age group. The highest number of patients, comprising 44.34% (196 individuals), fell within the age group of 21-40 years. This was followed by 37.55% (166 individuals) in the age group of 41-60 years, 10.85% (48 individuals) in the age group below 20 years, and a minimum of 7.23% (32 individuals) in the age group of 61-80 years.

Table 1: Distribution of Patients According to Top 10 Diseases

S. No.	Top 10 Diseases	No of Patients
1	Sual o Surfa (Cough/Bronchitis)	**64**
2	Nazla wa Zukam (Common Cold &Coryza)	**61**
3	Humma (Fever)	**59**
4	Warm I Halaq (Pharyngitis)	**55**
5	Husr/ Ihtibas (Constipation)	**38**
6	Bawasir (Pile/Haemorrhoids)	**37**
7	Ishal (Diarrhoea)	**33**
8	Waja al Mida (Gastralgia)	**33**
9	Duf al Ishtiha (Anorexia)	**32**
10	Nafkh al Mida (Flatulence/Gases)	**30**
Total		**442**

Table 2: Gender wise Distribution of patients

S. No.	Name of the Disease	Male	Female	Male Child	Female Child	Total
1	Sual o Surfa (Cough/Bronchitis)	25	23	05	11	**64**
2	Nazla wa Zukam (Common Cold & Coryza)	30	23	06	02	**61**
3	Humma (Fever)	22	15	10	12	**59**
4	Warm iHalaq (Pharyngitis)	23	32	00	00	**55**
5	Husr/ Ihtibas (Constipation)	14	24	00	00	**38**
6	Bawasir (Pile/Haemorrhoids)	19	18	00	00	**37**
7	Ishal (Diarrhoea)	18	15	00	00	**33**
8	Waja al Mida (Gastralgia)	20	13	00	00	**33**
9	Duf al Ishtiha (Anorexia)	14	18	00	00	**32**
10	Nafkh al Mida (Flatulence/Gases)	13	17	00	00	**30**
Total		198	198	21	25	**442**
Percentages		**44.79%**	**44.79%**	**4.75%**	**5.65%**	**100%**

Table 3: Age wise distribution of patients

S. No.	Name of the Disease	Below 20 yrs.	21-40 yrs.	41-60 yrs.	61-80 yrs.	Total
1	Sual o Surfa (Cough/Bronchitis)	16	21	24	03	**64**
2	Nazla wa Zukam (Common Cold &Coryza)	10	29	18	04	**61**
3	Humma (Fever)	22	14	20	03	**59**
4	Warm i Halaq (Pharyngitis)	00	22	27	06	**55**
5	Husr/ Ihtibas (Constipation)	00	21	14	03	**38**
6	Bawasir (Pile/Haemorrhoids)	00	16	18	03	**37**
7	Ishal (Diarrhoea)	00	19	11	03	**33**
8	Waja al Mida (Gastralgia)	00	20	10	03	**33**
9	Duf al Ishtiha (Anorexia)	00	18	12	02	**32**
10	Nafkh al Mida (Flatulence/Gases)	00	16	12	02	**30**
Total		**48**	**196**	**166**	**32**	**442**
Percentages		**10.85%**	**44.34%**	**37.55%**	**7.23%**	**100%**

Discussion

Article 342 of the Indian Constitution defines "Scheduled Tribes" as "Tribes or Tribal communities or part of or groups within tribal communities" which the President of India may specify by public notification. Approximately 90% of the tribal population in the country resides in rural areas, primarily in hilly and forested regions, accounting for nearly 60% of the forest cover in the nation.

The issue of lower health status among tribal populations is not unique to India; it is a global concern. In India, tribal communities constitute a heterogeneous group with diverse health indicators, facing a greater burden of morbidity, mortality, and limited access to healthcare services[9].

Tribal populations in the country encounter a triple burden of diseases. While malnutrition and communicable diseases remain prevalent, rapid urbanization, environmental degradation, and changing lifestyles contribute to the rising incidence of non-communicable diseases. Additionally, mental illness, particularly addictions, pose a significant

challenge, with high rates of respiratory, mental, and musculoskeletal conditions reported among tribal populations.

The present study highlights the most common diseases affecting tribal communities, including Sual o Surfa (Cough/Bronchitis), Sardi wa Zukam (Common cold/Coryza), Humma (Fever), and Warm i Halaq (Pharyngitis), which are prevalent across all three ITDA spots investigated.

There is evidence of an early epidemiologic transition in tribal areas, with an associated increase in the incidence of non-communicable diseases[9].

Across the three ITDA spots collectively, females are more affected than males, with minimal impact observed on male and female children. The incidence of the top 10 diseases is highest among individuals aged 21-40 years across all three ITDA spots.

Tribal communities worldwide are susceptible to addictive substances such as smoking, tobacco, alcohol, and bhang[9]. These communities have traditionally lacked scientific knowledge about disease causes and prevention methods such as sanitation, personal hygiene, nutrition, and immunization. Consequently, their poor health habits make them more susceptible to conditions like cough, bronchitis, colds, fever, and pharyngitis. However, the study area appears to be less prone to chronic diseases.

Results & Conclusion

Tribal communities in India have been identified as distinct, since Ramayan and Mahabharat era and through historical times. British Rule in India excluded entry of others to the north-east, except to the missionaries[10].

In conclusion, it can be observed that tribal populations exhibit poor health status and face a triple burden of disease. Their unhealthy habits and susceptibility to addictive substances contribute to a high incidence of respiratory diseases. As a result, tribal communities are often affected by recurrent cough, bronchitis, pharyngitis, and fever due to compromised immunity. Efforts to address these health challenges among tribal populations should prioritize interventions aimed at improving hygiene practices, promoting healthy behaviors, and providing access to appropriate healthcare services. By addressing these factors, there is potential to alleviate the health disparities experienced by tribal communities and improve their overall well-being.

Acknowledgement

Authors would like to convey their deepest gratitude to the Ministry of AYUSH, Govt of India & Director General of CCRUM, New Delhi for under taking TSP & providing all necessary needs & funding for the completion of this project. Authors would also like to expand their special thanks to all the local Pradhan's and scheduled tribe people for their co-operation & support as well as entire staff of TSP at CRU, Kurnool for helping us in completion of the project.

Funding: Central Council for Research in Unani Medicine

Conflict of Interest: None

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Cite this article Shaista Tabassum S et al, A Study on Health Profile of 3 ITDA Spots of Kurnool District, Andhra Pradesh, India. Indian Journal of Health Care, Medical & Pharmacy Practice.2024; 5(1) 20-28.