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Viewpoint

Tribal health issues: Need of tribal health policy

Tribal culture as distinct entity

It is proposed to discuss the tribal healthcare issues, as distinct variation from national healthcare policy and its governance. Are some ethnic groups, living in geographical isolation, in the forests and hills, referred as tribals by anthropologists, as Adivasi by Mahatma Gandhi, as scheduled tribes (STs) as per Article 342 of the Indian Constitution, different from the other ethnic groups and people, as citizens of India? Why have the distinct tribal States, districts and taluks been created after Independence in India? There is Tribal Development Ministry, at the Centre and in the States, and exclusive Tribal Sub-plan (TSP), administered by single-window tribal development departments, based on Nehru's Tribal 'Panchsheel'[1]. There are Tribal Research and Training Institutes in the States with sizeable tribal population. Why should there be a National Institute of Research in Tribal Health and Regional Medical Research Centre at Bhubaneshwar under the Indian Institute of Medical Research (ICMR), with field stations in tribal area?

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. However, despite proliferation of Christian faith, tribal communities in the north-eastern States continue to nurture tribal values and hardcore cultural practices, and are identified as ST as per the Constitution of India. After Independence from British Rule in 1947, more tribal states and districts were created for self-rule governance, under the 5th and 6th schedules of the Constitution, to facilitate focused development. However, the draft National Tribal Policy 2006, referred in official documents, continues to await formal statutory approval. As per the 73rd Constitution amendment, there is Panchayat Extension to Scheduled Areas (PESA) with a provision of five per cent TSP funds at the discretion of *Gram Sabha*, recommended to be enhanced to 10 per cent. In recognition of 60 per cent forest cover of the country in tribal areas, which has been the source of food for the tribals for centuries, the Forest Rights Act 2006[2] has been enacted to give ownership rights to the tribal community about minor forest produce. The regulatory forest department since British times treated tribal settlements as encroachments, while the forests were preserved by the tribal people through centuries[3].

What is distinctive about tribal culture?

Tribal communities have symbiotic relationship with nature, using it for basic daily needs, and not for greed of accumulation or creation of wealth[4]. There is more mutual co-operation than competition. Traditional economy is based on the principle of value-in-use, with barter of goods, as against our value-in exchange, with currency transaction. A traditional healer is compensated by payment in kind, such as grain. The deities and pilgrimage centres are local, not connected to regional- or national-level pilgrimage centres. Conventionally, tribals are known as collectors of food from the forest, not as producers of cultivated foods, like the caste peasantry.

Among the tribal communities, despite patriarchy, sex ratio is positive in favour of females, being 990 females per 1000 males, against 943 amongst others (2011 census)[5], probably due to custom of bride price. Obviously, there is no female feticide or infanticide. Desertion of women due to infertility or problems of widowhood are not the social issues. In case of infertility, some tribal women desert their husbands and marry another, since divorce process is easy and does not carry any social stigma. In the traditional labour intensive and cashless tribal economy, bride price is hypothesized as the consideration for loss of her labour to her parents, and for reproducing working hands to the family of procreation. As a result, a tribal

woman is more empowered and fearless, as compared to women in caste society. There is no molestation or rape in tribal society by tribal men.

Due to infrastructure development of roads and transport, social practices of discrimination and deprivation of the mainstream caste-peasantry, exploitative market mechanism has also reached tribal areas. This process has been summed up by Symington[6], I.C.S., a special inquiry officer, appointed by B.G. Kher as Chief Minister of Bombay Presidency, under the Government of India Act 1935[7] to study tribal indebtedness in the Khandesh area (current Nandurbar tribal district) in North Maharashtra.

According to Symington[6], *'Actually the problem of the aboriginal and hill tribes lies not in the isolation from but in their contacts with the main body of the community... in the places, where they are in constant contact with more educated people, they are degraded, timid and exploited... government appears to have ... usually assumed that whatever measures were suitable for the country at large were suitable also for the tribal areas.... in point of fact, the common law of the land is in many respects highly unsuitable for the tribal areas and produces serious oppression and exploitation'*. Such ideology seems to be the basis of Nehru's Panchsheel principles which has created single-window tribal development administration, currently in vogue.

Tribal health

Amongst caste-peasantry and tribal communities, people traditionally managed their health and ailments through home remedies and with the help of experienced elders, herbalists such as *vaidu* and traditional birth attendants (*Dai*). Referrals such as traditionally trained *Vaidya* and *Hakim* were mainly available in urban centres. Princely States opened medical colleges in Ayurveda and Unani systems, while some allopathic colleges were established by the British government, in British Presidencies[8]. During British Rule, public health was mainly limited only to the management of epidemics.

Healthcare became a constitutional public responsibility only after Indian independence, leading it to becoming a Juridical Right. The Community Development Programme for rural-tribal transformation was initiated on October 2, 1952, which established Primary Health Centres (PHCs) with an allopathic doctor, and sub-centres (SCs) with an auxiliary nurse midwife (ANM), as per Bhore Committee recommendations (1946)[9]. Considering the terrain and low density of population, tribal PHC is expected to cover 20,000 population, against 30,000 population in other rural PHCs, and tribal SC for 2500, instead of 5000 in other cases[10]. There does not seem to be any other difference between tribal and non-tribal healthcare facilities in the public sector. Public health in India in rural and tribal areas is mainly implemented on the ground by women paramedics such as ANM, *Anganwadi* worker and a recent addition of Accredited Social Health Activist (ASHA). The doctors at PHC manage outpatient departments, function as referrals for SCs and monitor the data registers of paramedics and frontline workers. At PHCs in tribal areas, if allopathic doctor (MBBS) was not available, doctor from other Indian Systems of Medicine could be given charge of PHC.

Usually, in public debates, healthcare facilities are discussed in the context of allopathic medical education and availability of allopathic doctors in the public and private sectors. Health is a State subject under the Indian Constitution, permitting variability in dealing with healthcare in different States. There is a distinct Ministry of AYUSH, which covers Ayurveda, Naturopathy and Yoga, Unani, Siddha, Tibetan Medicine (Sowa-Rigpa) and Homeopathy. There are National Institutes in all these medical systems, including the North-Eastern Institute of Ayurved and Folk Medicine Research at Pasighat in Arunachal Pradesh, to facilitate the interface between traditional healers and scientific research process. There are hundreds of medical colleges in all these medical systems and export-oriented pharmaceutical industries. In States such as Himachal Pradesh, Madhya Pradesh, Chhattisgarh, Tamil Nadu and several other States, there are parallel systems of medicine, with separate Directorates, functioning in the public sector, having health centres in rural and urban areas. In Chhattisgarh with sizeable tribal population, Ayurved grams were developed, accepted as a replicable programme in the 12th Plan, titled as AYUSH Gram. Training material for traditional healthcare, for use by paramedics, has also been developed by the 'State Health Resource Centre' at Raipur[8]. The Department of Naturopathy in Tamil Nadu has developed similar training material for the paramedics. National Rural Health Mission tried to co-locate plural medical facilities, under one roof, with no appreciable success.

The High Level Committee appointed by the Prime Minister on Socio-Economic, Health and

Educational Status of Tribal Communities of India, Ministry of Tribal Affairs, Government of India (Xaxa Committee, 2014)[11], has made the following observations and recommendations about tribal health issues, after reviewing some health indicators, citing NFHS-3 (2005-2006) comparing tribal health with others. Total fertility rate (TFR) for ST being 3.1 against 2.4 for others; neonatal mortality rate (NMR), 39.9 *vs*. 34.5, infant mortality rate (IMR) 62.1 *vs*. 48.9, under five mortality rate (U5MR) 95.7 *vs*. 59.2. The percentage difference between ST and others for IMR is 27 per cent and for U5MR, 39 per cent[11]. Malnutrition, low birth weight (LBW) and diarrhoea are identified as major health issues. It is obvious that majority of the tribal people, who are poor, access local traditional healers, failing which, the public sector facilities, for healthcare.

The Xaxa Committee[11] has made the following observations and recommendations:

(*i*) *'A reason for the inappropriately designed and poorly managed healthcare in Scheduled Areas is the near complete absence of participation of Scheduled Tribes people or their representatives in shaping policies, making plans or implementing services in the health sector. This is true from the village level to the national level. Even though the PESA gives Gram Sabhas the right and the role of influencing social sector schemes, which include health, there are no mechanisms in place for such participation or oversight at the village level. Similar situation is observed at the ITDP, district and the state levels. At the Central level, the Ministry of Health and Family Welfare has no separate body to shape policies or monitor programs in Scheduled Areas. This is in complete disregard to the promise of the Constitution and the Panchsheel guidelines'*.

(*ii*) *'Traditional healers and Dais play an important role in the indigenous health care. Instead of alienating or rejecting them, a sensitive way of including them or getting their cooperation in health care, must be explored. Traditional herbal medicines should be protected through community ownership. The ownership and intellectual property rights of tribal community over their own herbal medicines and practices should be ensured'*.

(*iii*) *'...Due to the physical isolation of tribal communities, compounded by lack of doctors, it will be pragmatic to train, equip and empower the three 'As' – ASHA workers, Anganwadi workers and ANMs – in tribal areas to a higher level'*.

(*iv*) *'It is hoped that these observations and recommendation would be translated in health action plans. A distinct tribal health policy is the need of the day'*.

Perspective

The National Health Policy 2017[12] has facilitated some loud thinking about certification of local tribal healers to incorporate them as personnel of public health team. They have been providing preventive, promotive and curative services to the people since ancient times. Their indigenous knowledge which is branded as 'local traditions' in anthropology and labelled as ethnomedicine, has formed the basis of evolution of textual 'great traditions'[13], like classic texts by *Charak*, *Sushruta* and *Vagbhata* in Ayurveda, and such texts in other Indian systems of medicine. There is no reason why the practitioners of local health traditions could not be upgraded or further oriented to link with the textual knowledge system and formally incorporate them as a part of our public health human resource. We have 50 per cent reservation for women members of statutory *Panchayat Raj Institutions* (PRIs). How are we using them in functioning of our health system? Can we not orient them? Why have we discontinued *Dai* training? Why cannot we have a permanent agenda item and reporting about health issues in the tribal PRIs and *gram sabha* meetings?

In the media, there is constant reporting about judiciary seeking information about the prevalence and incidence of tribal malnutrition, as 'suomoto' injunction or under 'public interest litigation' (PIL). One such 'suomoto' injunction in Bombay High Court about tribal malnutrition resulted in the Government of Maharashtra bestowing an intervention project jointly to two voluntary organizations, 'Maharashtra Association of Anthropological Sciences', Pune, and 'Comprehensive Rural Health Project', Jamkhed, to develop a sustainable model to handle tribal malnutrition and LBW, in 250 tribal villages in seven districts across Maharashtra. This has led to the government scheme to feed tribal women during pregnancy, called as '*Bharat Ratna* Abdul Kalam *Amrut Ahar Yojana'*. The project was administered as a partnership programme of the government and voluntary organisations, regularly reporting to the High Court. On the ground, 250 female and 250 male

volunteers from these 250 villages were ensuring community participation and empowerment[3].

It is therefore necessary to have a National Tribal Policy and a distinct Tribal Health Policy. Women PRI members and community-based organizations like *Mahila Mandals* and self-help groups (SHGs) could be trained to administer the government schemes. There is significant quantitative growth amongst tribals, in primary and secondary education, due to Ashram Schools in the public and voluntary sectors. The indigenous health knowledge and practices of traditional healers and *dai*s need to be highly respected, upgraded and incorporated in our public health programmes, for promoting culture-friendly tribal healthcare.

The recent establishment of 'WHO Global Centre for Traditional Medicine' at Jamnagar, Gujarat, India, will deliberate on all the issues of traditional healthcare in Asia, Africa and Latin America.

Conflicts of Interest: None.

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