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Perspective

Health equity & tribal populations: Challenges & way forward

The world is a habitat of people with different characteristics – physical, social, cultural, economic, political and psychological. These very markers often become the axes of inequality consequent of differential access to resources, and historical deprivation. Differentials between indigenous and non-indigenous populations are fairly pronounced in all countries and regions[1,2]. Compared to non-indigenous, indigenous populations lag behind in development indicators marked with deprivation, marginalization and multidimensional poverty, which has serious effects on their health[2-4]. One third of the world's tribal and indigenous population, accounting for more than 104 million tribal people, live in India (8.6%), comprising 705 communities[3]. It is important to note that the scheduled tribes (STs) in India are demographically, culturally and economically heterogeneous, varying widely in terms of their population size, language and the nature of their interactions with the rest of the society[4]. The World Health Organization (2018)[5] states inequities as '*unjust differences in health between persons of different social groups, (which) can be linked to forms of disadvantage such as poverty, discrimination and lack of access to services or goods'*. In this context, health 'inequality', is different from health 'inequity'. The inequalities in health are related to differences between population groups due to innate and biological factors and are randomly distributed. Inequities, on the other hand, have asocial causation and a non-random pattern of distribution. Inequities that are reflected in specific social groups based on identity, influence access to resources of all kinds, including health. The conceptual underpinnings of inequities are in social justice and explain the differentials across administrative, social groups in India in terms of health attributes. The realm of social justice broadens the scope of understanding of the health of the tribal population to include the de-notified and nomadic and seminomadic tribes too.

The broad administrative groups identifying the social characteristics of the population as scheduled caste (SC), STs, other backward classes (OBCs) and others (including those who do not belong to any of the mentioned categories), are used for understanding the inequities in health[3,5]. The Constitution Drafting Committee took cognizance of the marginalization and exclusion of specific population groups from accessing the available benefits and opportunities. The Constitution of India, therefore, provides for safeguards for those marginalized and excluded[4,6]. The affirmative action policies formulated consequent of the constitutional safeguard for all, particularly the STs, have been instrumental in this change[5] and their influenced health. However, despite the affirmative action policies, the STs continue to be highly marginalized. Landlessness, poverty, mortality and drop-out from the education system are higher in this category as compared to others, including the marginalized groups[7-9], which influences health. The STs experience higher mortality, and undernutrition[10.], anaemia[11] and tuberculosis[12] . They are also exposed to food insecurity[11] and inadequate access to resources[13,14]. Often due to the processes of othering, they have remained excluded and unable to access opportunities available under the affirmative action policies[4]. Their lifestyle, marked by alcohol and substance use, is often viewed from 'outside', and is considered detrimental to their health and social wellbeing. Their local healing traditions are often negated and rendered unauthentic, while in effect, they contribute to the provisioning of care to underserved places and populations and are known to have developed healing and healthcare systems. This explains the lower neonatal mortality among them as compared to the other social groups[9].

Poverty, deprivation and access to health

The ST population account for more than one-fourth of the country's population below the poverty

line, and nearly half the country's STs population remains in poverty[8,9]. Thus, with social and income inequalities prevailing, it is presumptive to accept that health inequities across social groups have reduced. The progress achieved by the country since independence has continued to neglect the gap between tribal and non-tribal population. Historical deprivation has excluded them, often completely, from information dissemination and awareness regarding opportunities. Adding to the historical deprivation, is the shift towards the private health sector[4,5,13]. This has created unprecedented barriers to healthcare access among the poor and the marginalized tribal populations.

Given that the exclusion from social and economic opportunities varies in nature and magnitude, disparities in health outcomes between tribal groups are inevitable[13]. Yet most of the evidence on the health of STs is available either at the aggregated level, which does not reflect on the differentials among different ST groups[2,4,5,13]. Or alternatively, the focus is often on the health of a specific ST, making it difficult yet again, to understand the inequalities in relation to other groups.

The ST population have the poorest development indicators. Their access to land ownership[7] and healthcare[13,14] is poor. They lag behind in education from all other social groups[4]. While only 5.5 per cent STs are in the highest wealth quintile, 46 per cent are in the lowest quintile[8]. Although it has long been known that the tribal people have poor health and poorer access to resources, healthcare for tribal populations remained embedded in the larger frame of rural healthcare[1,2,10,11,14,15]. Their health needs and care-seeking behaviour was assumed to be similar to the rural and non-tribal population. Little cognizance was taken of their environment-physical, social, cultural; local healing and healthcare practices, in which their health-seeking behaviour would be embedded. Therefore, the health of the tribal populations remains an underserved and unsolved problem[15,16]. The Health and Development Committee (1946)[17], the first of its kind, remained *'averse to drawing any line of distinction between sections of the community'* which were differentially endowed in accessing care services. The tribal groups, however, remained excluded from this.

Beyond the STs

The official marking of the indigenous population of India, as STs has faltered in identifying and listing all of them[4]. Out of the total ST population, approximately 2.6 million (2.5%) belong to "Particularly Vulnerable Tribal Groups" (PVTGs), the most marginalized of all the ST communities[18,19]. Reaching out to them with an affirmative action plan is marred by barriers in access to information, and disparity in dissemination. Those identified as denotified and nomadic and semi-nomadic communities (DNCs) are not even recognized as citizens in the absence of any identity documents due to their mobility; and have little or no access to healthcare.

The Renke Commission[18,20] reported that there were about 1,500 nomadic and semi-nomadic tribes and 198 denotified tribes, comprising 150 million Indians without any claims to resources and citizenship status. About 50 per cent of DNTs lacked any kind of documents and 98 per cent were landless. Later in February 2014, the Idate Commission[19] recommendations lead to an increase in the Union budget for the DNTs in 2018-19 to ₹ 100 million from ₹ 60 million. Notably, the actual expenditure for each year has been below the budgetary allocation, reflecting on the strengthening dissemination of information, creating an enabling environment for availing funds and accessing resources meant for them.

Making the invisible visible

The ST is an administratively recognized category of population and has access to affirmative action, yet have the poorest health and other development indicators[3,5,20,21]. There are also issues of the same community being listed as SC and ST in different parts of the same State. The process of assimilation and acceptance, renders them without any legal or constitutional safeguards like other marginalized communities[22], affecting their access to healthcare, civic amenities and school enrolment.

Thus, consolidating evidence suggest that tribal populations have poor health status as compared to non-tribal, geographies are not a sufficient (although necessary) explanation for the difference in health and other development indicators *vis-à-vis* other groups[20,21]. Therefore, it becomes imperative to examine from the lens of inequity, rather than inequality; and understand the reasons through theorization of context with empirical validation. On the one hand, it is important to understand the differentials between the STs and other groups (SCs, OBCs, Others); it is equally important to not only understand the intergroup differentials but also provide for the groups who have remained excluded

and invisibilized. Only then the affirmative action will bear the fruits and the SDGs mission to leave no one behind in assuring health and wellbeing for all will be materialized.

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