National Seminar on

Achieving Healthy Tribal Community in India

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Editors

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Foreword

It is a great pleasure for us to learn that MANT is publishing a compilation of a galaxy of papers presented in the National Seminar organized by it on ***Achieving Healthy Tribal Community in India*** on 25th and 26th September 2013 in Kolkata, West Bengal. The Seminar itself had been a great success with support coming from the Ministry of Health and Family Welfare, Govt. of India and USAID. Support also came from two State Govt. viz, Orissa and Assam. 400 tribal people from 12 States of India participated and were addressed by 25 number of Scholars and Social Activists hailing from different parts of the country. We consider it to be a great privilege of MANT to get the necessary permission from the speakers for publication of their papers presented in the Seminar. We hope and fervently believe that the compilation will be of great help to the activists working in the field of the tribal development and we will consider it worth the purpose for which it is printed.

We are thankful to the Editors Sri Nirmalya Mukherjee, Director, Planning, MANT and Dr. S. Nagarathinam Associate Professor & Head Dept. of Communication, School of Linguistics and Communication, Madurai Kamaraj University, Madurai, India for the taking the pains of readying the articles for print and our thanks are also due to the printers Excel Printers, New Delhi for printing the Volume.

Dr. Chandidas Mukherjee
Secretary, MANT

Papiya Sen
Executive Director, MANT

Contents

CHAPTER 1

Adivasi Health in India: An Introduction

Nirmalya Mukherjee and S. Nagarathinam

"*Poor places keep people poor. And poor places also kill.*"

—Voices of the Poor
Crying out for Change[1]

The above observations are not apparently true if we consider the situation of indigenous people of India. The adivasi people in India are living in mineral rich areas surrounded by forests. Many adivasi areas are flanked by industries and many are regarded as famous tourist spots. But still adivasi people are poor and living in distress. Available natural and human resources do not help them to have a decent life. However, this is a more recent phenomena essentially after independence. Paul.

R. Greenough found that during 1858 to 1918 not a single adivasi died of famine.[2] But during the last decade a number of adivasi people died of famine like situation in Amlasole of Paschim Medinipur, Kanthalguri (closed tea garden) in Jalpaiguri of West Bengal, KBK Region of Odisha and in many more areas infested by them. So now the question is why adivasi people are dying untimely? Though the question is simple but the answer is very complex.

THE ADIVASI PEOPLE IN INDIA

"We are not myths of the past, ruins in the jungle, or zoos.
We are people and we want to be respected, not to be victims of intolerance and racism."

—Rigoberta Menchú Thum
Indigenous Leader of Guatemala

Adivasi people constitute 8.6 percent of the total population of India as per the latest 2011 Census which means more than 100 million tribal people declared themselves as tribal.[3] Adivasi people are regarded as autochthonous people. And it is to be noted that about half of the autochthonous people of world live in India.[4] Adivasis in India are heterogeneous in nature. As per the 2011 Census there are 705 main scheduled tribes.[3] The draft National Tribal Policy introduced adivasis by saying that, "The STs have traditionally lived in about 15 % of the country's geographical areas, mainly forests, hills, undulating inaccessible terrain in plateau areas, rich in natural resources. They have lived as isolated entities for centuries, largely untouched by the society around them. This seclusion has been responsible for the slower growth, dissimilar pattern of their socio-economic and cultural development and inability to negotiate and cope with the consequences of their involuntary integration with the mainstream society and economy".[5]

As per 2011 census, 59 % adivasi people are effectively literate. However there is a 19.1 % gender gap in literacy rate which is regarded as quite high.[3] Report no. 543 of NSS 66th round, 2009–10 reveals that 63.1 % tribal people are literate as against 72.8 % of all India figure. Statistics of School Education 2010-11 highlighted the disparities in drop-out rates among tribals and non-tribals.

Table 1: Drop-out Rates among Tribals and Non-tribals

	Boys		Girls	
	ST	All Categories	ST	All Categories
Classes-I-V	37.2	28.7	33.9	25.1
Classes-I-VIII	54.7	40.3	55.4	41.0
Classes-I-X	70.6	50.4	71.3	47.9

More than 34 % tribal people regard themselves as cultivators while more than 44 % are agricultural labourers.[3] One study highlighted the income pattern of the tribal people which stated that out of 54.21 % of the income earned from agricultural wages 63.54 % was spent on food consumption.[6] The 2011 Census highlighted the following:

- Around 91 % of the tribal population lives in rural areas as against 72 % for the whole country.
- The average tribal household size is 5.2 while the national average is 5.3.
- 81.6 % of the total ST workers are employed in the primary sector which encompasses sectors like agriculture & forestry.

Adivasis are characterized by distinct language, religion, a profound bond linking the individual to the community and to nature, minimal dependence on money and markets, a tradition of community-level self governance system and an egalitarian culture that sans the social hierarchy as prevailed in Hindu Caste System.[7] In general adivasi people are distinctively different in terms of a distinctive culture, primitive traits, and socio-economic backwardness.[8]

As per 2011 Census the adivasi people are lagging far behind in terms of enjoyment of basic amenities:

Table 2: Comparison of Availability of Basic Amenities

Group	Good Houses	% Households Having Latrine Facility within the Premises	Open Defecation	Un-covered well, Spring, River/ Canal, Tank/ Pond/ Lake, Other Sources etc. as Main Source of Drinking Water of Households	Households Availing Banking Services	% of House-holds Having Separate Kitchen Inside
All Social Groups	53.1	46.9	49.8	12.92	58.7	61.3
ST	40.6	22.6	74.7	26.60	44.98	53.7

Source: Tribal Profile at a Glance: May 2013. Ministry of Tribal Affairs, GoI

Planning Commission, India enumerated percentage of population (social group wise) living below the poverty line (2004–2005).

Table 3: Percentage of Population (Social Group Wise) Living Below the Poverty Line (2004–05)

Social Groups	Rural	Urban
Scheduled Tribe	47.3	33.3
Scheduled Caste	36.8	39.9
Other Backward Classe	26.7	31.4
Others	16.1	16

Source: Tribal Profile at a Glance: May 2013. Ministry of Tribal Affairs, GoI

However by using Tendulkar Methodology Planning Commission found that 47.4 % tribal people living in rural areas and 30.4 % tribal people living in urban areas are placed below the poverty line.

From the above discussion it is quite clear that the situation of the Adivasi people in India is an embarrassment for world's largest democracy. The fruits of so called 'development' are not trickling down to the people living in margins.

THE ADIVASI PEOPLE'S HEALTH IN INDIA

"We cannot have equilibrium in this world with the current inequality and destruction of Mother Earth"

—Evo Morales

In continuation of the above it could be safely said that most of the Adivasi people are economically weak due lack of sustainable income generation and backward in education which is further aggravated by rampant nutritional deficiency and no or limited knowledge about sanitation and hygiene. Now these factors have huge impact on the overall health status of the adivasi people of India. The health statistics of the adivasi people is not proportionate to their non-adivasi counter-parts and they are far lagging behind in terms of key health indicators as it could be evident from the following Table 4.

Table 4: Comparison of Health Status among Tribals and Non-Tribals

Indicators	ST	Total
Infant Mortality	62.1	57
Neo-Natal Mortality	39.9	39
Post-natal Mortality	22.3	18
Child Mortality	35.8	18.4
Under-5 Mortality	95.7	74.3
ANC Check-UP	70.5	77.1
Percentage of Institutional Deliveries	17.7	38.7
Full Vaccination of Children	31.3	43.5
Percentage of Households covered by a Health Scheme/insurance	2.6	31.9
Prevalence of any anaemia (<12.0 g/dl) in Women	68.5	55.3

Source: National Family Health Survey–3, 2005–2006.

The situation analysis of health indices of the tribal population in states like West Bengal and Odisha is also worse than the State average.

Table 5: Health Indices of the Tribal Population in State of West Bengal

Parameters	West Bengal (%)	ST (%)
Any ANC Check-up	96.1	90.2
3 or more ANC Visits	66.9	55.1
Stage of Pregnancy at the time of First ANC	42.5	30.9
Full ANC	19.6	15.6
Institutional Delivery	48.9	30.5
PNC (within 2 weeks after delivery)	56.9	39.1
Knowledge of Diarrhoea Management	87.1	71.8
ORS Given	46.4	39.2
Women aware of Danger Signs of ARI	43	27.1
Ever used contraceptive method	87.7	74.9
Using any Modern FP method	69.5	56.1
Current Use of Contraceptive Method	72	60.5

Note: ** 15–44 age group have been considered.
Source: DLHS-3.

Table 6: Health Indices of the Tribal Population in State of Odisha

Parameters	Odisha (%)	ST (%)
No ANC Visits	16.9	26.4
Three or more	54.6	38.8
ANC during Ist Trimester	47.5	34.0
Women who have not received TT	17.6	27.3
Consumed IFA for at least 3 months	32.9	28.0
Full ANC	23.3	14.5
% age of women who had received insti-tutional delivery	44.3	20.8
% of women who had delivery at home	54.6	78.2
% of safe delivery	50.9	25.8

Table 6 (Contd.)...

...Table 6 (Contd.)

Parameters	Odisha (%)	ST (%)
Govt. Financial Assistance for delivery care (JSY)	31.9	23.2
PNC Within 2 weeks of delivery	30.6	16.6
Sought treatment for post-delivery com-plication	61.0	49.4
Knowledge of danger signs of ARI	22.1	15.6
Ever Use of Any Contraceptive Method	56.6	39.2
Ever use of Any Modern Contraceptive Method	46.4	31.3
Current Use of any Contraceptive Meth-od	47.0	33.0
Current Use of Any Modern Method	37.8	27.3
Ever discussed about family planning with anyone	20.4	12.9
%age of women aware of family life education	76.5	61.6
%age of women perceived family life education is important	82.4	65.7
Who have heard about RTI/STI	14.4	3.7

Note: ** 15–44 age group have been considered
Source: DLHS-3.

From the above table it is quite evident that health outcomes for adivasi people are poor compared to the general population in the state and this is also a natural phenomenon observed in other states. The health status of the primitive tribal people like Birhore, Bondas, Lodhas, Totos are worse than their counterparts like Santhals who are regarded as better off tribal species in India.

The sub-optimal health status of the adivasi people and the health inequalities between adivasi and non-adivasi populations reflect a fundamental failure to ensure the freedom of adivasi peoples to fully realize their human, socio-economic and political capabilities.[11] However, it is to be noted that the indigenous people are universally experiencing health and wealth disparities across the countries of the world.[12,13]

Extreme form of health deprivation faced by the indigenous people are being frequently reported by organizations like Survival International, Cultural Survival and like. Another critical issue is that of representation—indigenous people are not merely another population group with ill health. They are people who are systematically marginalised within their own nation states; they are rarely given the opportunity to represent their own perspectives and understandings of their health and their views on the actions to be taken to improve it.[12]

It is true that most adivasi women do not utilize reproductive and child health services provided at Government health services.[14,15] This is more true for primitive tribal people like Birhore and Lodhas. The utilization of the Govt. sponsored programs of antenatal, natal and postnatal services is very low among them. The frequently reported reasons for not availing antenatal services are lack of awareness, non-accessibility, higher service charges, etc.[14,16] During the child's illness or general health problems, the first line of treatment is the traditional healers. It is believed that traditional healers can treat certain diseases like small pox, measles and leprosy. Only when his/ her treatment doesn't work do they approach private doctors/health service providers. Primary health centres (PHC) are used only in very severe cases as the last option.[17,18] Traditional Healers are also exploiting adivasi people by charging higher consultancy charges and exorbitantly higher cost of medicines.

Adivasi people are suffering disproportionately from both communicable and non-communicable diseases. Adivasi people have much higher rates of infection than their non-adivasi counterparts, and these infections are likely to be more severe or more frequently fatal in adivasi groups.[13] Various research studies reveal that widespread poverty, illiteracy, malnutrition, absence of safe drinking water and sanitary living conditions, poor maternal and child health services are the possible contributing factors for dismal health conditions prevailing among adivasi people.[19] It is also worthwhile to note that despite great diversity of indigenous peoples, many similarities in their health and illness and their determinants exists.[13]

Skin infections are very common among the adivasi people in general and primitive tribal groups in particular. Skin problems like scabies is a major health problem amongst the primitive tribes because of overcrowding and unhygienic living conditions and also lack of health awareness.

In a study conducted by the RMRC, Bhubaneswar, 20.6 % of Bondo, 6.9 % of Didayi, 10.7 % of Juanga and 15 % of Kutia Kondha tribes were affected with scabies (both infective and non-infective), which is comparable with the findings in Birhor primitive tribe (7 %) of Madhya Pradesh.[20] The community based cross-sectional study, that was carried out in tribal PHC of Maharashtra found that Among individual morbidities, the prevalence of acute respiratory infections was the highest (25.5 %) followed by acute diarrhoeal diseases (5.8 %), conjunctivitis (1.5 %), and skin infections (1.2 %).[21] A study conducted in tribal infested Koraput District of Odisha revealed that 16.5 % tribal people were found positive for malaria parasites out of which Plasmodium Falciparum was the major malaria parasite species accounted for 89.1 % of the total positives; Plasmodium Vivax and Plasmodium Malariae accounted for 9.3% and 0.2 %, respectively.[22] The study also indicated a rising trend in transmission of malaria in Koraput district compared to the situation during 1986–87 and indicated the necessity for a focused and reinforced approach for the control of the disease by improving people's access to diagnosis and treatment and ensuring implementation of the intervention measures with adequate coverage and compliance.[22] Another study indicates, little knowledge, less awareness and inadequate practices of respondents on various aspects of malaria and its control which may be one of the important factors responsible for the persistence of malaria in tribal areas of Bihar and Jharkhand states.[23] TB prevalence in the general population ranged from 144 per 100,000 in Wardha district, Maharashtra, up to 1070 per 100,000 in Raichur district, Karnataka while TB prevalence among tribal populations, again, a wide variation of prevalence rates was reported, ranging from 133 per 100,000 amongst the tribal population in Wardha district, Maharashtra, to 1270 per 100,000 amongst the Saharias, a primitive tribe of MP.[24]

Now for non-communicable diseases Dr. Salil Basu in his paper pre-pared the following table on the basis of the NFHS-3, 2005–06 data to compare the reported incidence of diseases among Scheduled Caste and Scheduled tribe and observed that:

a. Scheduled Tribes (both female and male) showed relatively much lower occurrence of diabetes as compared to Scheduled Castes.

b. But asthma cases were reported in higher frequency both among female and male Schedule Tribes as com-pared to Scheduled Castes.

c. In the case of goitre, there is not much difference among female of Schedule Tribes and Scheduled Castes, whereas its incidence was observed much higher among male of Scheduled Tribes.[25]

Table 7: Non-Communicable Diseases in Men and Women

Background Characteristics Caste/tribe	Number of Women per 100,000				Number of Men per 100,000			
	Diabetes	Asthma	Goitre or other Thyroid Disorder	Number of Women	Diabetes	Asthma	Goitre or other Thyroid Disorder	Number of Men
Scheduled Caste	789	1494	754	23125	991	1688	348	13188
Scheduled Tribe	349	1749	753	10119	477	1973	567	5725
Other Backward Class	774	1498	819	48880	955	1276	328	27219
Other	1189	2035	1240	41207	1336	1919	424	23214
Don't Know	650	1219	1675	649	1307	3551	871	177

Source: NFHS-3 (2005–06) as mentioned by Basu, Salil (2012): The Social Dimension of Health and Development in Tribal Communi-ties of the North-Central Sub-region of India.

The non-communicable diseases are also very much prevalent among adivasi community as evident from the findings of the studies mentioned here. A study revealed that the overall magnitude of hypertension among tribal people was found to be 16.9 %.[26] Another study as referred by the last one conducted among primitive tribal groups of Orissa reported prevalence of hypertension among males and females as 31.8 % and 42.2 %, respectively.[26] Research study conducted in Karnataka cautioned by saying that Hypertension is emerging as a significant health problem among tribal people as there was an overall prevalence of hypertension (21.7 %) among Jenu Kuruba tribe.[27]

Now from the above discussions it could be safely said that there is an alarming health disadvantage for adivasi peoples. On the other hand the paucity of data is a major problem in developing appropriate strategies and programmes, assess effectiveness of those activities and modify them if necessary, compare health standards between different groups of Indigenous and non-Indigenous people, and study changes in Indigenous health over time.[13]

Time has come for the governments both at central and states to ac-knowledge the special rights of the adivasi people and need; regularly collect data about adivasi health and related factors; adequate resources to close the gaps in health, disease, disability, and mortality between adivasi and other peoples; and addressing socioeconomic inequities between adivasi and non-adivasi populations to overcome these discrepancies.[13]

VOICE, CHOICE AND IDENTITY

"Next to killing a man, the worst you can do is to displace him"

—Thayer Schudder

People's voice, choice and identity are considerably important in having a healthy society. Understanding the voices and choices of the adivasi people will lead to identification of what people really want to enable them to lead healthier lives. Generally, voice is considered in three parts–individual voice (complaints), collective voice (voting) and participation (collective action) while exercising choice is seen in terms of complete exit (not using health care), internal exit (choosing another public service provider) and private exit (using private health care).[28] The existing avenues to air their voices and choices as well as what should be a preferred mechanism relating to that should be given priority as they are in urgent need of a personalized development model in general and personalized health care in particular. To have a preferred development model one needs to understand the policies of the government vis-a-vis adivasi people's own understanding of their development as well as its responses towards adivasi movements against deprivation by persons and agencies given to siphoning of the money en route to the ground level.

It is also very true that adivasi people who have suffered colonisation, forced settlement, assimilation policies and other forms of marginalisation and removal from ancestral lands almost always experience a dramatic decline in health and wellbeing. Dislocation from their land is almost always coupled with rising illness.[29] 'In general, the most devastating contact situations seem to have been associated with dispossession from the land'.[30] UNICEF seconded this view as they reported that, "Violence against the child, child abuse and exploitation contribute to, and are evidence of, the severe social strain under which many indigenous communities live. This strain is often a direct consequence of environmental degradation, displacement, the loss of traditional livelihoods and, in some cases, active attempts by authorities to homogenize and assimilate indigenous cultures."[31]

Imposed development and loss of land have had disastrous effects on the health of Indigenous people everywhere. Paradoxically, Indigenous people endure not only the ill health associated with poverty but also the chronic diseases that come with the lifestyle in industrialised countries—a situation that is directly attributable to loss of land and traditions and the resultant move to poor urban environments.[32]

The Identity crisis is occasioned by forceful alienation of the tribal people from their ecology by imposition of restrictions in the use of the usufructs of the forests to which they were habituated from time im-memorial. For adivasi people land has a cultural and spiritual significance in their life and land cannot be sold or bought as it is beyond its material value. Hence loss of land by the adivasi people worked as a strong force for obliteration of their existence and their very being. [33, 34].

For Indian adivasis land, locally available food, minor forest products, living in harmony with nature and community and health are inseparable components for living well. They are belonging to their communities wherein community identity is much more important than individual identity which is losing its ground very fastly because of exposure to the outer world. It is also true that with the shortage of positive Indigenous representations and role models and authority figures, "it

is a challenge not only to reclaim Indigenous identity, but to facilitate the development of healthy identities based on cultural strengths, not on disadvantage, disease burden and discrimination."[34]

Language is crucial to identity, health, and relations. It is especially important as a link to spirituality, an essential component of Indigenous health. Throughout the world, Indigenous languages are being lost, and with them, an essential part of Indigenous identity. Language re-vitalisation can be seen, therefore, as a health promotion strategy.[34] In India there are no prominent media houses which are publishing newspapers in any tribal language, no radio stations and TV Channels to broadcast programmes in the same.

Lastly, "Autonomy is closely linked with self esteem and the earning of respect. Both are basic and linked. Low levels of autonomy and low self esteem are likely to be related to worse health. Health professionals need to be aware that interventions within the arena of indigenous health necessarily have political implications. involvement in this area of professional practice often Involves challenging government policy and community attitudes which have the potential to impact negatively on social, emotional, cultural and spiritual well-being."[34]

THE BOOK

According to Prof. (Dr.) Salil Basu, the overall health status of the tribal community is the outcome of the several interacting factors i.e. holistic views of all the socio-cultural dimensions that are related to the health and health related problems of a community, effects of environment in which the tribal people inhabit, behavioral pattern and life styles of the tribal people, genetic characteristics, health care delivery service in tribal areas and constraints in accepting modern health care. To him the health, nutrition and medico-genetic problems of diverse tribal groups inhabiting widely varying geo-climatic and ecological conditions have been found to be unique and present a formidable challenge for which appropriate solutions have to be found by planning and evolving relevant research studies which should be need-based and problem solving in nature. He found that Primitive tribal groups of India have special health problems and genetic abnormalities with many varieties. Researchers, as he believed, while studying in depth health status and health needs of different tribal population groups in various states of India, attempted to incorporate a complete and over-all approach embodied in the concept of health culture.

According to Felix Padel, health of an individual in tribal communities is connected to health of the community and natural environment, and psychological health. He further stated that when it comes to more long standing diseases, treatment of wounds, and care during child-birth, little-recognised confusions between tribal systems of healing and the mainstream allopathic system on offer in medical centers have major impacts on tribal health. Perhaps what is needed in tribal areas marked by a severe lack of doctors and health centers is not so much a huge increase in financial outlay to provide modern high-tech health services, as cadres of dedicated health workers in remote areas who are prepared to teach some of the basic techniques of modern medicines to complement traditional tribal medicines, he suggested. Again, he pointed out that communities displaced or invaded by dams, mines and factories face Cultural Genocide due to which their traditional social structure hampered enormously. In this situation, he recommended that it needs to be recognised that indigenous health systems, like other aspects of tribal culture, are far from primitive: in many ways they are highly developed and holistic, forming part of a system of values and knowledge that is radically different from university or hospital-based forms of knowledge. So, it is of course a low-budget system of local health workers trained in both systems is the ideal approach, complementing improved access to government health centers, he concluded.

Boddu Vijay Kumar & Dr. Bollineni Keerthi clearly mentioned the objectives of the health forums-i.e. to act as bridge in between services and tribal communities and formed with local private health care providers, NGOs/CBOs working in health, People representatives and representatives from community core group and affected persons. Such community based groups are formed in TAP (tuberculosis reduction program) with TB or HIV affected persons, their family members and other like-minded people to uphold the health rights of tribal people in six coastal districts of

Andhra Pradesh (Srikakulam, Vishakhapat-nam, East Godavari, Krishna, Prakasam and Nellore) targeting the fisher folk, tribal people, rural communities and urban slum dwellers, they mentioned. The expected outcomes of the project include increased awareness of TB and HIV, increased usage of free government health services; community structures in place that promote and support health rights and health seeking behavior, and a stigma free health centre environment with improved TB diagnostic and treatment services, they concluded.

Mohan Rao mentioned that 1978 was a significant year for health sector development as the countries of the world met at Alma Ata to declare a goal of Health for all by 2000 AD through Primary Health Care. After in the light of the submission of the HLEG report and the stakeholder consultations that followed heavily dominated by the corporate interests, along with a health chapter in the 12th Five Year Plan document which is seen to be tilting substantially towards insurance based schemes, and, a much larger involvement of the private sectors made one thing very clear that any future effort towards expansion of government-funded health care in India will have a major role for the private sector health care providers and various other profit seeking 'stakeholders' he observed. It in fact led to a reinforcement of state policy towards a selective and targeted approach; a decline in public investments especially in primary care; increasing use of private sector facilities for both in-patient and out-patient care; a fall in levels of efficiency and effectiveness in the public sector; indeed a further squeezing out of the poor from access to publicly funded health care, he penned. The private health care sector assumes greater significance in the context of the recommendations by the HLEG on Universal Health Coverage as well as the Steering Committee on Health for the Twelfth Five Year Plan favoring a national health package to be implemented by public and private providers as he cautioned.

While Adivasis form just 10 percent of India's population, they form around 70 percent of all those displaced due to mega government projects since 1947 as observed by Mr. Satya Sivaraman. And that is the first political and social reality that needs to be taken into serious consideration before analyzing the status of health of India's tribal populations, he opined. In other words before the Government of India does anything positive for Adivasis it should stop its discriminatory policies of displacement against them. To promise real cares for the health of the Adivasis, government must return what has been historically stolen from them he argued. A very important point for the Government of India to think about is involving the Adivasi populations in the control of resources being spent in their name or consulting them on what really needs to be done, he suggested. Another big problem, according to him, that affects the health of Adivasis in this country is the way funds allocated by the Government of India for their 'welfare' are either stolen by the bureaucracy, middlemen or diverted for other purposes. Thus, since Independence, it is precisely this attitude of Government of India that has been responsible for the deterioration of the health of India's adivasi population.

According to Dr. Pashupati Prasad Mahato, the roots of tribal sufferings lies in history. Due acute deforestation to in the whole of Jangal Mahal by the notorious Forest Act of 1796, the tribal species of Bengal-Jharkhand-Orissa suffered from many diseases unknown to them earlier and became sickly and feeble. It is also most interesting for that the indigenous and tribal people from Rarhbhum or present districts of Purulia, Bankura, Midnapore (East and West) and entire Jharkhand including Mayurbhanja, Keonjhar, Sukhinda of Cuttack and Sundargarh District of Orissa were forced to migrate as labour in indigo plantation semi slavery situations. Between the years of 1871 to 1921, nearly 9.7 lakh labours were forced to migrate because of drought, famine and forest cuttings of the entire regions of the tribal areas of West Bengal, Jharkhand, Orissa and Chhattisgarh. So, if we look back to the settlement pattern of the indigenous populations in and around the forest, we find very interesting environmental adjustment along with other ingredients of life with forest he opined.

Dr. Punyabrata Gun stated that due to various issues like landlessness, unemployment, scarcity of healthy habitat, marginalization, paucity of food and fodder, increasing rate of diseases and fatality, deprivation of enjoying natural resources and receiving various welfare services and above all violation of human rights has close-knitted relationship with displacement of the tribal people of India. While discussing about the prime grounds behind displacement of any population from their own land different categories and forms of human encroachment usually get evolved like erection

of industries, cities & towns; development of dams and highways, indiscriminate growth of power plants and mining works, he observed. Measures of development like dams, reservoirs, highways are compelling them to leave their own land! Displacement not only comes as a bolt from the blue in their life but also makes it miserable enough, coupled with abject poverty, economic fragility and thus destroying them socially, he successfully argued. So, to him, it is clear that in this situation tribal and indigenous people are not well. All that can be said that ensuring tribal rights to receive the quintessence of natural resources is more important than that of sending mobile medical van into tribal belts, he highlighted.

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CHAPTER 2

Culture Sensitive Tribal Health Care

Dr. Salil Basu

RATIONALE

Tribal people of India are considered to be socio-economically the most disadvantaged and exploited group. The overall health status of the tribal community is the outcome of the several interacting factors i.e. holistic views of all the socio-cultural dimensions that are related to the health and health problems of a community, effects of environment in which the tribals inhabit, behavioural pattern and life styles of the tribals, genetic characteristics, health care delivery service in tribal areas and constraints in accepting modern health care. The tribal population groups of India are known to be the autochthonous/ people of the land "ADIVASI", "VANYAJATI", "VANVASI", "PAHARI", "ADIMJATI", "ANUSUCHIT JANJATI", the latter being the constitutional name.

STUDY AREA

Basu, Salil and his team of researchers had carried out holistic comprehensive health related studies among different tribal and rural communities using both quantitative and qualitative approaches:

1. Muria, Maria, Bhattra, Halba tribal groups of Bastar district, Madhya Pradesh (1193 households). Basu and others, 1986, 1994.
2. Jaunsaris of Jaunsar–Bawar, Dehradun district, Uttar Pradesh (950 households) Basu Salil, 1993.
3. West Bengal, Santals, Bhumij, Savar (Purulia district).
4. Primitive Kutia Khonds of Phulbani district, Orissa (206 households) Basu *et al*, 1990, 1994.
5. Santals of Mayurbhanj district, Orissa (382 households) BasuSaliletal, 1993.
6. Dudh Kharias of Sundergarh district, Orissa (323 households) Basu, Saliletal. 1993, 1994.
7. Rathwas and Bhils from Baroda (Gujarat), Santals from Purulia (W.B.) Mundas and Oraons from Ranchi (Bihar), Gaddis from Chamba and Kinnauries from Kinnaur district (H.P district.) Beneficiary Social Assessment Study of the control of Tuberculosis was carried out in 1,000 tribal household from each tribal dominated ares. Health providers interviewed were 14 from Baroda, 15 from Purulia, 13 from Ranchi and 10 from Chamba & Kannaur (Basu, Salil 1995).
8. Jatapu and savara from Srikakulam (A.P.), Oraon and Munda from Gumla (Bihar), Damor and Bhil Meena from Dungarpur (Rajasthan), Pando and Khairwar from Surguja (M.P.), Santal from Mayurbhanj (Orissa), Patelia from Panchmahal (Gujarat), Raj Gond and Maria Gond from Gadchiroli (Maharashtra). (Indian J Soc Dev, Vol: 1, 2001, pp. 134–156).

Source: Basu, Salil and Mitra, Koumari, Indian Journal of Social Development, Vol: 1, No: 1, 2001, 134–156

CHARACTERISTICS OF PRIMITIVE TRIBAL GROUPS

The primitive tribals inhabit isolated and difficult terrain and their sustenance depends mainly on agricultural and forest produce. Their lack of contact with surrounding environment continues to envelop them into deep magico-religious beliefs and taboos. The poor health and health seeking behaviour of primitive tribes are mainly due to poor social and living conditions which force them to live on the margins. Tribal groups, in particular primitive tribal population, are well rooted in their cultural beliefs and they wish to live and survive in their own style. The cultural pattern varies from one primitive tribe to other. Some groups, like the Onge, the Jarawa of the Andamans, the Birhor of Bihar, the Mjapandaram and the Arandan of Kerala are practically in the food gathering and the hunting stages of economy; on the other hand, the communities like Lushi and Khasi of Assam are hardly distinguishable from their neighbouring population in relation to agricultural practices and other aspects.

The criteria generally followed (28th Report of the Commissioner of Scheduled Castes and Scheduled Tribes 1986-87), in the identification of primitive tribal groups are:

a. Pre-agricultural level of technology, following a hunting-gathering way of life.

b. Extremely low level of literacy.

c. Small, stagnant or diminishing population.

The word 'primitive' reflects the scale of our civilization. Most primitive communities are characteristically stable or very slowly growing and are trying to maintain a constant relationship with the environment (Author, 1990).

Table 1: Distribution of Primitive Tribal Groups (PTGs) in Different States of India (Report of Working Group, 1989)

States	Names of Tribal Groups		
Andhra Pradesh (n = 12)	• Bodo Gadaba • Bondo Poraja • Chenchu • Dongaria Khond	• Gutob Gadaba • Khond Paroja • Kolam • Kondareddt	• Kond Savaras • Paranjiperja • Thoti • Kuttia khonds
Bihar/ Jharkhand (n = 9)	• Asur • Birhor • Birjia	• Hill Kharia • Korwa • Mal Pharia	• Paharias • Sauria Pahariya • Savar
Gujarat (n = 5)	• Kathodi • Kotwalia • Padhar	• Siddi • Kolgha	
Karnataka (n = 2)	• Jenu Kuruba • Koraga		
Kerala (n = 5)	• Cholanaikayan • Kadar • Kattunayakan	• Kurumbas • Koraga	
Madhya Pradesh (n = 7)	• Abujh Maria • Baiga • Hill Korwa • Kamar	• • Sahariya • Birhor • Bharia	
Maharashtra (n = 3)	• Katkaria • Kolam • Maria Gond		
Manipur (n = 1)	• Maram naga		
Orissa (n = 13)	• Birhor • Bondo • Didayi • Dongria-Khond • Juang	• Kharia • Lanjiasaura • Lodha • Mankirdia	• Paudi Bhuyan • Saura • Chuktia bhunjia • Kuttia Khond

Table 1 (Contd.)...

...Table 1 (Contd.)

Rajasthan (n = 1)	• Saharias		
Tamil Nadu (n = 6)	• Kattu Naickans • Kotas • Kurumbas	• Irulas • Paniyans • Todas	
Tripura (n = 1)	• Reangs		
Uttar Pradesh (n = 2)	• Buxus • Rajis		
West Bengal (n = 3)	• Birhor • Lodhas • Totos		
Andaman & Nicobar Islands: (n = 5)	• Great • Andamanese • Jarawas • Onges	• Sentenelese • Shompens.	

From the above Table 1, it can be observed that the number of Primitive Tribes are highest (13) in Orissa and lowest (1) in Manipur, Tripura and Rajasthan.

HEALTH CULTURE

The culture of a community determines the health behaviour of the community and of its individual members. The cultural response of the community to the health problems it confronts, determines its health practices.

Health Culture = Cultural perception + meaning of health problems + health behaviour of individuals + available and accessible health institutions.

The complex whole embracing the cultural perception and meaning of health problems and the health behaviour of individuals within the context of the available and accessible health institutions is termed health culture (Banerjee. D, 1982).

Health culture becomes an integral component of the overall culture of a community. It is necessary to take a holistic view of all the cultural dimensions that are related to the health and health services of a community and to relate such a holistic perspective to the overall culture of the community.

The study of health culture of a particular community is important because (a) the health problems and the procedure to handle such problems and other health practices are influenced by the complex interplay of socio-cultural factors, and (b) implementation of health services (health centre, immunisation centre, or any kind of health programme) would be difficult without the knowledge of the community's traditional health culture (Basu. A, 1996).

The holistic concept of health culture provides a valuable framework for analysing work of anthropologists in health fields. However, a very few studies are available in this direction, specially among the tribal population. Basu, Salil with his team (1984–96) while studying in depth health status and health needs of different tribal population groups in various states of India attempted to incorporate holistic approach embodied in the concept of health culture. Sahu (1991) used the concept of health culture in his study 'Health Culture in Transition-A Case Study of Oraon Tribe in Rural' and explore how the health culture of a tribe undergoes change with change related to the concerned factors.

The UNDP Human Development Index (HDI) comprises of three components, i.e. health, education and employment. Health is a pre-requisite for human development and is essentially concerned with the well-being of the common man. Health is a function, not only of medical care, but of the overall integrated development of society-cultural, economic, educational, social and political. The health status of a society is intimately related to its value system, its philosophical and cultural traditions, and its social, economic and political organisation. Each of these aspects has a deep influence on health, which in turn influences all these aspects. Hence, it is not possible to raise the health status and quality of life of a people unless such efforts are integrated with the wider-effort to bring about the overall transformation of a society. The objectives of integrated development are to

eliminate poverty and inequality, to spread education (formal & non-formal) and to enable the poor and underprivileged to assert themselves. Health development can be integrated with the larger programme of overall development in such a manner that the two become mutually self-supporting. Such coordinated and simultaneous efforts to improve and change the entire social order generally yield better results because they are interdependent and mutually supportive (ICSSR-ICMR, 1981). Good health and good society go together. This is possible only when supportive services such as nutrition and improvements in the environment (Sanitation, hygiene, parasitic load, availability of safe drinking water) and education reach a higher level.

Table 2: Health Situation of Tribal Population in West Bengal

Parameters	West Bengal (%)	ST (%)
Any ANC Check-up	96.1	90.2
3 or more ANC Visits	66.9	55.1
Full ANC	19.6	15.6
Knowledge of Diarrhoea Management	87.1	71.8
ORS Given	46.4	39.2
Women aware of Danger Signs of ARI	43	27.1

Source: DLHS-3

From the above Table, it is evident that health outcomes for tribal people are poor as compared to the general population in the state Primitive tribal people like Birhore, Lodhas, Totos are worse than their counterparts like Santhals.

HEALTH PROBLEMS

The health problems and practices of any community are profoundly influenced by interplay of social, economic and political factors. It is necessary to take a holistic view of all the cultural dimensions of the health of the community and to relate such a holistic perspective to the overall culture of the concerned community.

Available research studies point out that the tribal populations have distinctive health problems which are mainly governed by their habitat, difficult terrain and ecologically variable niches. The health problems faced by the tribals are mostly regional health problems (Basu, Salil 1996). The health, nutrition and medico-genetic problems of diverse tribal groups inhabiting widely varying geo-climatic and ecological conditions have been found to be unique and present a formidable challenge for which appropriate solutions have to be found by planning and evolving relevant research studies which should be need-based and problem solving in nature. Primitive tribal groups of India have special health problems and genetic abnormalities like sickle cell anaemia, G-6-PD red cell, enzyme deficiency and sexually transmitted diseases were prevalent among some of them (Commissioner Report for ST & SC, 1986–87). In-sanitary conditions, lack of personal hygiene, health education and ignorance are the main factors responsible for their ill health.

Many primitive tribal communities are facing extinction like the Onges, Jarawas and Shompens in Andaman and Nicobar Islands. Possible reasons need to be explored although these may differ from population to population and are probably multiple (Verma, IC 1978). Some of the factors as indicated by investigations include (a) endemic diseases like malaria; disease introduced from outside like tuberculosis, influenza, dysentery, high infant mortality and malnutrition; (b) Venereal diseases, induced abortion, inbreeding, addiction to opium, custom of eating tubers of 'DIOSCERA' (may cause sterility as they contain substances used in oral contraception); (c) Declining sex ratio (FMR) leading to shortage of women.

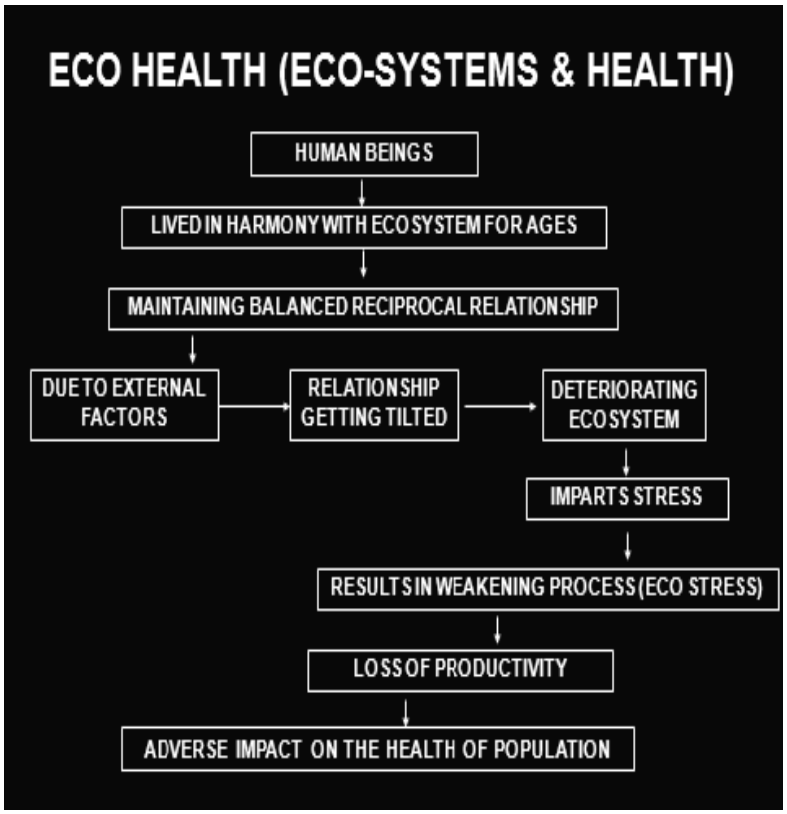
Urgent studies are, therefore, required on different primitive tribal groups of India which are small in size and are inhabiting inhospitable environment, to elicit their fertility, mortality, morbidity patterns, consanguinity status, food habits, physical growth trends, genetic environmental disorders and factors affecting them in order to delineate the high risk groups. These findings will ultimately help in formulating effective need-based health care strategies

among these vulnerable primitive tribal groups. It is crucial that the development programmes prepared for these communities are group-specific and specially tailored to meet the problems of each small primitive tribal community. (Source: Continuity and Change in Tribal Society, Edited by Mrinal Miri, 1993: Health Scenario and Health Problems of Tribal Population in India by Salil Basu pp. 259–284).

ECO-HEALTH (ECOSYSTEMS AND HEALTH)

Eco-health denotes ecosystems and health and it is a new arena for research of great potentiality. The negative impact of the deteriorating ecosystem may result in a weakening process, known as "eco-stress" and which eventually leads to a lack or loss of productivity with an adverse impact on the health of the population, specially women. The eco-stress experienced in most case of degrading eco-systems is due to some kind of human intervention, i.e., industrialisation, urbanisation, modernisation and the like.

This situation is prevalent in hunting and gathering stage (e.g. Cholanicken of Kerala; Birhor of Bihar; Hill Madia of Madhya Pradesh; Chenchus of Hyderabad; Kadars of Cochin) or slash-and-burn stage (JHUM) (e.g. Khasis of Meghalaya; Nagas of Assam; Muria, Maria of Madhya Pradesh; Saora of Orissa; Korwa of Bihar.



SOCIAL DEVELOPMENT OF TRIBAL HEALTH

Tribal groups of India have specific problems, some of these are built in problems of these communities and some are imposed upon them which jeopardize their overall development and progress inclusive of their health.

Social Impact Assessment

Social assessment is an important parameter which is generally undertaken at the start of any developmental work to ensure that the benefits of the proposed infrastructure development are distributed equitably and that no segment of the population is adversely affected.

Poverty Alleviation and Livelihood Development

To improve the quality of life of the disadvantaged marginal population, primitive tribes, marginal farmers etc. steps are to be taken for reduction of poverty through enhancement of livelihood system covering all production related activities as well as enabling measures i.e. land and water management/watershed development, community based forestry, small infrastructure, rural micro-finance (formation of Self Help Group [SHG]).

Non-Formal/ Formal Education

Adolescent (boys & girls) do not have proper knowledge on various aspects of sexuality, reproductive health care, family life education, HIV/AIDS. Both non-formal and formal education play significant role in promoting adolescent health, education and development among adolescent boys and girls.

TRAINING

- Organisation of short term orientation courses on tribal culture for health workers at district and sub-divisional headquarters.
- In tribal areas, 'haats' (weekly market centres) are the focal point of activity. Each 'haat' should be provided with a Primary Health Centre (PHQ/ Sub-centre in order augment the utilisation of health care services.
- Appropriate benefits from the government must reach the people in time, and government and non government staff should be readily available to understand and address the villager's problems with patience.
- Local community leaders, clan chiefs, Panchayat members and prominent caste leaders must be involved in the decision making process, in which women must also be included.

GENDER EQUITY & EMPOWERMENT OF WOMEN

These factors are important to ensure social security and to prevent violence against women. Skill development, capacity building, income generation activities empowering women and promoting gender equity in all spheres of activities, specially among disadvantaged population will raise the status of women and will eventually increase the role of women in decision making process of vital activities.

STRATEGIES FOR TRIBAL HEALTH DEVELOPMENT

Socio-Cultural and Environmental Awareness (Basu, Salil and Mitra, Koumari, Indian Journal of Social Development, Vol. 1, No: 1, 2001, 134–156).

- Formulation of realistic developmental holistic plans based on needs and culture of specific tribal group.
- Adequate understanding of socio-cultural background of different tribal groups, perception of diseases, their beliefs and taboos, study of health culture at micro level.
- Identification of indigenous herbs for medical use and their preservation and documentation.
- Efforts should be made towards developing proper sanitation, personal hygiene, and provision of safe drinking water and to dispel certain negative beliefs, taboos, and magico-religious thoughts and ideas.

NUTRITION

- Development of horticulture with emphasis on local fruits. Healthy nutrition should be encouraged through local produce and local recipes.

- Development of poultry and fisheries.
- It is necessary to evaluate the changing patterns of dependence on traditional food and dietary practices.

MATERNAL AND CHILD HEALTH

- Hundred per cent immunisation of mothers and children with special emphasis on measles vaccination.
- Distribution of Vitamin A.
- Attempts should be made to introduce oral rehydration therapy among different tribal population through their culturally accepted food habits.

GENETIC DISORDERS

Simple kits should be provided at PHC level and staff to be trained for genetic disorder tests like sickling/ G-6-PD enzyme deficiency etc.

- Screening of villages for sicklers and G-6-PD deficient individuals, identified persons to be given genetic advise/ genetic counselling.
- Distribution of leaflets and playing of audio and where possible, video cassettes, preferably in local dialects at weekly markets, ghotuls, schools, etc.
- Development of effective communication strategies on health education and health care among tribal groups in consonance with their socio-cultural characteristics.

GENDER INEQUALITY ISSUES AND WOMEN EMPOWERMENT

Promoting Gender Sensitive Strategies for Improving Women's Reproductive Health Care Services. (Salil Basu and Koumari Mitra) In India, gender inequality, limited access to healthcare facilities and economic resources are greatly facilitating the spread of reproductive tract infections and sexually transmitted diseases for populations living under impoverished conditions.

Sex and gender are both important determinants of health. Biological sex and socially constructed gender interact to produce differential risks and vulnerability to ill health, and differences in health-seeking behaviour and health outcomes for women and men. The basic source for empowerment of women in a society is to provide them with access to information, education, and skills. (WHO Report, 2008).

CASE STUDY APPROACH

A total of thirteen villages selected from Sitapur and eight from Shahjahanpur formed our basic sample. Both qualitative and quantitative data were collected.

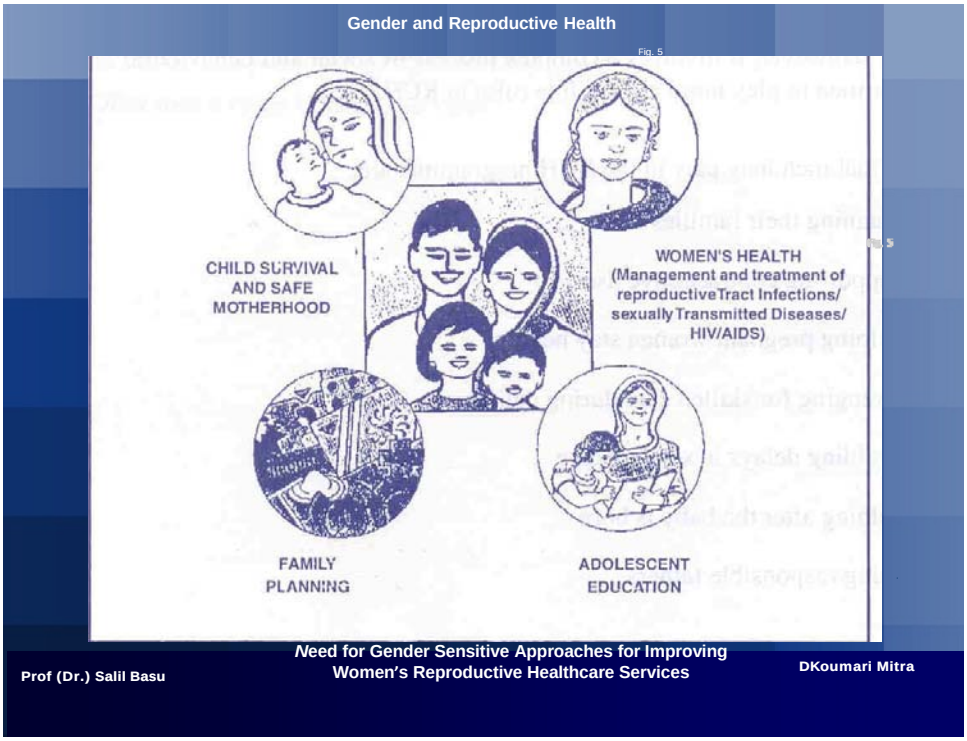
The survey revealed that not all villages were covered by the Anganwadi centres. Furthermore, public medical facilities, private medical practitioners and traditional birth attendants are not available in most villages more than half the population (55.29 percent) was illiterate; and Hindus dominated the area.

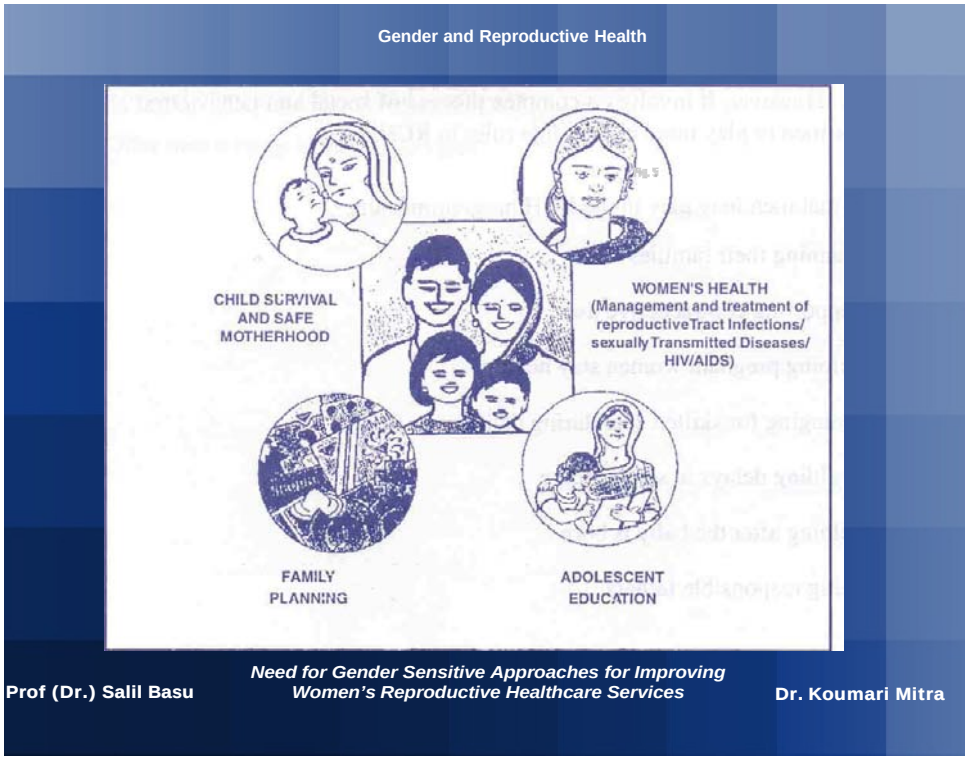
The qualitative data analyses revealed that both unmarried and married women (15–44 years) were less knowledgeable about male and female reproductive organs. But both groups recognized the physical changes that take place during adolescence.

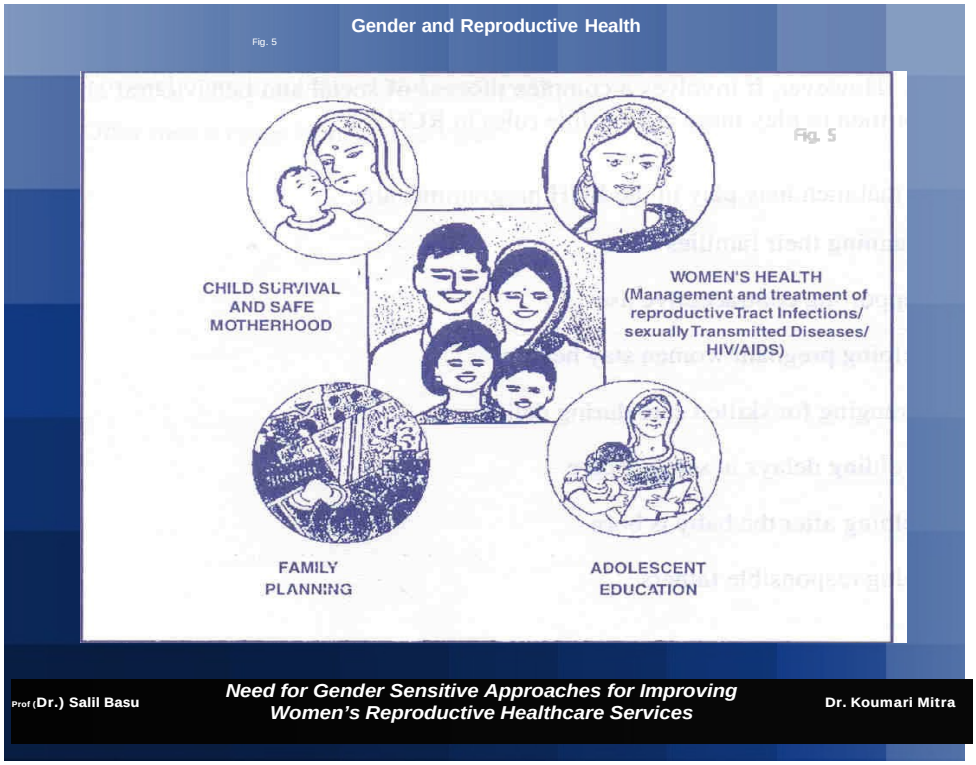
Women usually visit their private doctors or clinics for necessary treatment, however, knowledge regarding the necessity and benefit of the antenatal, natal and postnatal care was found to be very limited. Most deliveries were conducted at home and without the aid of trained healthcare workers. This study also found that knowledge with respect to RTI/STD, and its causes including preventive measures were quite low among married women and even lower among younger unmarried women.

Although the work of the anganwadi workers was described to be of advisory nature, many failed to perform these adequately due to their lack of counselling skills. As primary healthcare workers interact very closely with their respective communities, it would have been more beneficial to strengthen the capacities and train these healthcare workers for their improved functioning and better coordination with doctors and nurses at the village level.

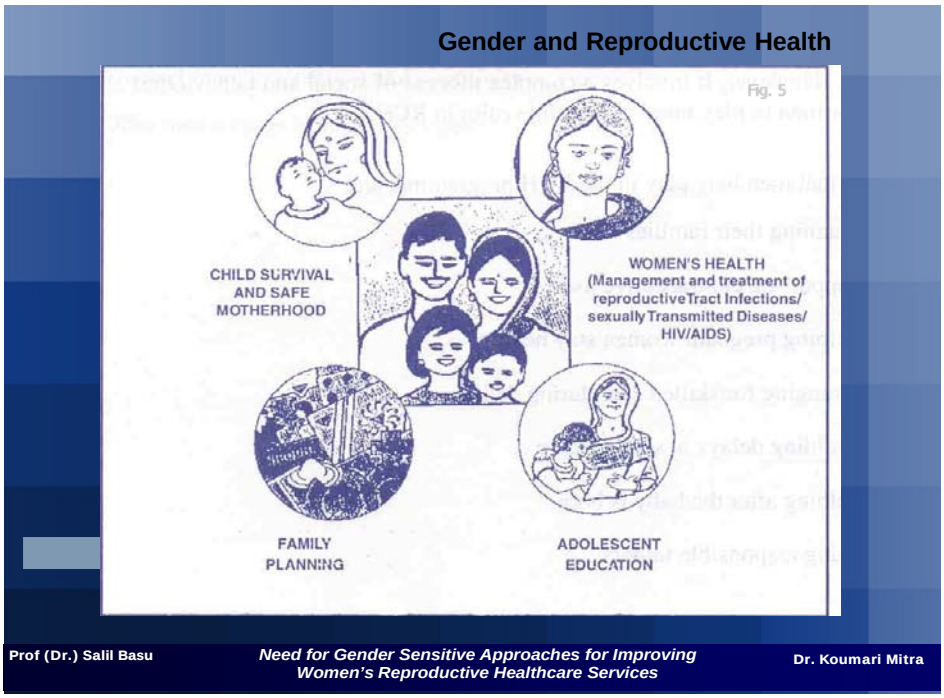
Empowerment, Women Health Needs, Reproductive Rights







Source: Training Module RCH, Population Foundation of India



WOMEN EMPOWERMENT

Empowerment is one of the main procedural concerns in addressing human rights and development. Four critical areas of women's health and physical wellbeing deserve special attention: (a) discrimination against girls resulting in higher mortality rates for females below age five, (b) poor nutrition; (c) poor reproductive health; and (d) lower use of medical services when sick. [Basu, Salil (1999)].

Empowerment includes the following or similar capabilities:

- The ability to make decisions about personal and collective circumstances.
- The ability to access information and resources for decision making.

SOCIAL DEVELOPMENT AND QUALITY OF LIFE

Social Development, Quality of life, Social uplift of underprivileged groups is absolutely necessary in the pursuit of human development activities to attain the optimal quality of life. Uttar Pradesh, West Bengal and Tamil Nadu also registered significant reduction in poverty (8–12 percentage points). However, Orissa and Madhya Pradesh show a rise in poverty levels between 1993–94 and 1999–2000.

SELF EMPLOYMENT PROGRAMMES

The SGSY programme is intended to provide benefits to SCs and STs, disabled and women-headed households that form the bulk of the rural poor. However, these sections would be excluded from the ambit of the programme if they are not listed in the below poverty line (BPL).

HEALTH SEEKING BEHAVIOUR

The conceptualization and measurement of health and quality of life are gaining increasing attention in the health services. One of the major issues in the health status measurement is the health seeking behaviour of a community which governs the morbidity and mortality pattern. Since the concept of health occupies different meaning in different social systems, the health seeking behaviour of a community cannot be studied in isolation from the social network of a community as it is deeply interwoven with every event of social, economical and biological aspects of a population. This assumes greater significance in the context of under privileged groups where the impact of state policies and contemporary modern developmental activities has minimum or no profound effects on health profile. Detailed studies in terms of socio-economic, nutrition, living conditions, sanitation, hygiene, parasitic load, fertility, mortality, morbidity, health seeking pattern were carried out among Muria, Madia, Haba, Bhattra tribal families inhabiting Jagdalpur and Konta tehsils of Bastar district (erstwhile M.P.), primitive Kutia Khonds of Belghara, Guma and Tumdibandha Panchayat areas of Tumdibandha block of Phulbani district, Orissa and among Kharias of Sundargarh district, Orissa. (Basu, Salil, Jindal Anil & Kshatriya, Gautam *et al.,* 1990, 1994)

These tribal population groups inhabit isolated and difficult terrain. The sustenance of these tribal groups depend mainly on agriculture and forest produce. Their main crops are rice, maize, kosra (cereals) and pulses. Methods of agriculture are primitive and production is oriented to subsistence requirements. They supplement their income by being occasional agriculture labour and contract labour or by bamboo cutting, fishing and basketry. The barter system of exchange of commodities still exists among these tribal populations. They spend large amounts of their income on social and religious ceremonies as a result of which they are most often financially hard pressed. Their low rate of literacy further adds to their ignorance and unawareness of surrounding environment which continues to envelop them into deep magico-religious beliefs and taboos. Consumption of milk is a taboo because of their superstition that a woman will not lactate if a calf is deprived of cow's milk. The availability of a high protein diet, therefore, is meagre among these tribal groups.

Sanitation and Hygiene

Sanitation and hygiene among the four tribal groups are found to be very poor. The houses are built of mud walls with thatched roof devoid of proper ventilations. The enclosures for animals are made within the household compounds which lead to poor environmental sanitation. These tribal groups depend on ponds, ditches, wells and rivulets for drinking water which considerably increases the chances of water borne fungal and bacterial infections.

Maternal-Child Health Care

Maternal-child care is an important aspect of health seeking behaviour, which is largely neglected among these tribal population groups. Expectant mothers to a large extent are not inoculated against tetanus. From the inception of pregnancy to its termination, no specific nutritious diet is consumed by a woman. The consumption of iron, calcium and vitamins during pregnancy is poor. More than 90 percent of deliveries are conducted at home attended by elderly ladies of the household. No specific precautions are observed at the time of conducting deliveries which results in an increased susceptibility to various infections. Services of paramedical staff are secured only in difficult labour cases. It has been observed that a specially prepared concoction from various kinds of herbs known as "Kasa Pani" is provided to mother on the third day after delivery. "Kasa Pani" is a herbal medicine which gives soothing effect, helps in recovering the energy lost and also acts as antibiotic. Nevertheless, maternal mortality directly related to pregnancy and child birth has been found to be appreciably high among the tribal populations of Bastar district. In addition, a lot of females suffer from ill health due to pregnancy and child birth in the absence of well defined concept of health consciousness.

As far as child care is concerned, a Breast fed infant in the first year does not get any supplementary diet. Vaccination and immunization of infants and children have been inadequate among these tribal groups. Since the personal hygiene is very poor, the under 5 children are the worst sufferers and most vulnerable to infections. In addition, extremes of magico-religious beliefs and taboos tend to aggravate the problems.

FOREST ECOLOGY AND WOMEN'S HEALTH

Because of extensive felling of trees by vested interests, the distances between the villages and the forest areas had increased, forcing the tribal women to walk longer distances in search of minor forest produce and firewood. In this rapidly changing milieu, tribal women were confronted with an extraordinary work load. A study of the Kondhs revealed (Dasgupta, 1988) that women put in an average of 14 working hours per day as compared to 9 hours put in by men. Given this additional workload, even women in advanced stages of pregnancy were required to work in the agricultural fields or walk great distances to collect fuel and minor forest produce. The over strain on tribal women however, was not adequately compensated due to the non-availability of minor forest produce and decrease in food grain production. A study among the Pauri Bhuniyas of Orissa showed (Ali, 1980) that 52 women as against 17 men in a sample of 268 persons suffered from diseases related to malnutrition. As a result of deforestation, additional distance and less fertile soil, the availability of food for the tribal family was reduced.

A study has shown that over 55 percent of Kondhs consumed less than 2000 calories per day (Patel, 1985) and most of them consumed as little as 1700 calories (Sharma, 1979) compared to the ICMR stipulated requirement of 2400 calories.

To add to the malnutrition and additional workload, there is destruction of traditional herbs through deforestation and the lack of access of the tribals to modern medicine. This, combined with the increasing ecological imbalance, has resulted in diseases such as TB, stomach disorders and malaria (Menon, 1987).

HEALTH STATUS AND HEALTH BEHAVIOUR–OUTCOME OF SEVERAL INTERACTING FACTORS

The overall health status of the tribal community is the outcome of the several interacting factors i.e. holistic views of all the socio-cultural dimensions that are related to the health and health problems of a community, effects of environment in which the tribals inhabit, behavioural pattern and life styles of the tribals, genetic characteristics, health care delivery service in tribal areas and constraints in accepting modern health care. The widely prevalent health practices, use of

indigenous herbal drugs, taboos and superstitions are also responsible for determining the health behaviour and health status of the tribal groups.

SANITATION, HYGIENE, PARASITIC LOAD AND SAFE DRINKING WATER

These are very important parameters which affect ultimate health and development of population. Tribal communities because of their living in difficult terrain, forest areas, in-sanitary conditions (sizable population of tribes share their living rooms with cattle and other domesticated animals), harbour and perpetuate malaria and various other infectious diseases. There is no proper sanitation and hygiene, no safe drinking water, coupled with primitive health practices, a number of diseases breed leading to higher mortality and morbidity rates.

GENETIC COUNSELING

Genetic counseling is the prediction of recurrence of a hereditary disease in offspring of parents who had an affected child and its communication within the framework of medical, emotional and social factors. (Basu, Salil, 1994, Shree Kala Prakashan, Delhi).

The purpose of the genetic counseling is to prevent the misery imposed on the individual as well as his family through the birth of defective children. Such counseling also has eugenic effects since it helps to reduce the number of genetically affected in families, and thus, in the population at large.

Pre-requisites for Genetic Counseling (Prospective counseling and retrospective counseling).

The following are the various steps which are pre-requisites for any form of genetic counseling.

Step I: Establishing the risk of recurrence:

a. Accurate diagnosis.

b. Detailed family history.

c. Knowledge about the disorder.

Step II: Interpretation and communication of the recurrence risk.

Step III: Formulation of a rational approach.

Step IV: Follow-up.

Genetic counsellingare carried out in Consanguineous Marriages, Blood Group Incompatibilities, Chromosomal Disorders, Pre-natal Diagnosis.

DISEASES AMONG TRIBAL COMMUNITIES

As we all know, tribal population groups of India inhabit widely varying geo-climatic conditions and are exposed differently to the various climatic and environmental stresses and strains. All diseases manifest themselves in interaction with the environment. Delineation of the causative factors behind disease requires in-depth investigations into the socio-cultural, socio-biological milieu of the population groups. It may include diverse factors such as the sanitation, hygiene, parasitic load, mating-pattern, preferential marital alliances, nutritional pattern, health seeking behaviour, genetic markers etc. Various factors affecting health and diseases in a particular population group may vary from one group to another.

The principal causes of morbidity are: (a) Infective and parasitic diseases (communicable diseases); (b) Nutritional Deficiencies; (c) Non-communicable diseases; (d) Diseases associated with Genetic Disorder.

Communicable Diseases

From the available studies and reports (Roy Burman, 1986; Basu (1987, 1995, 1996, ICMR, 1995–96 (RMCT); Mukherjee *et al*, 1986; Rao *et al.*, 1986; Swain *et al.*, 1990; Reports of Commissioner for SC & ST, 1986-87; ICMR Bulletin–2003, 2004; Regional Medical Research for Tribals. (ICMR), Jabalpur, 2003, 2004, 2005, 2006; NFHS, 1998, 1999; PIP, MoHFW, 2004) the following communicable diseases have been found to be prevalent in high frequency in different tribal areas of India.

Yaws

Yaws is a chronic non-venereal disease caused by Treponema Pertenue. The disease is mostly confined to the tribals who live in the Agency areas of Orissa and Andhra Pradesh (Roy Burman, 1986). It has also been reported from Tripura and Madhya Pradesh (Saxena, Darbar and Jain, 1978). The infectious cases for Yaws both late and early [Fig. 1] accompanied with necrotising ulcers and bone pains etc. were observed among tribes of Jagdalpur and some other districts of erstwhile Madhya Pradesh in 1977 by a team of specialists from Pt. J.N.M. Medical College, Raipur (Saxena, Dabar, Jain-1978).

Tuberculosis

It is reported that originally in tribal areas, there was no trace of this disease or it existed only in a small degree. But later on, however, as a result of the contacts with non-Adivasis this disease has increased in different tribal areas (i.e. Madhya Pradesh, Gujarat, Maharashtra, Bihar, Rajasthan, Himachal Pradesh, West Bengal, Tripura). Malnutrition has also been found to be one of the contributing factors. All tribes referred to tuberculosis as TB & none had any extensive knowledge about tuberculosis indicating it's relatively recent origin in tribal communities. A social Assessment Study was carried out in districts of Gujarat, Bihar, Himachal Pradesh, West Bengal (Basu, Salil, 1995, World Bank supported).

Leprosy

The incidence of leprosy is high among Mikir Hills of Assam, Scheduled tribes of Bihar, Madhya Pradesh, Orissa, Uttar Pradesh, Tripura, Laccadive and Minicoy Islands.

Malaria

As most of the tribal areas abound in forests and get heavy rainfall, malaria is widespread in these areas. 40 % of malaria cases are reported from the tribal areas. Out of all malaria from tribal areas, 60 % are reported to be due to Plasmodium Falciparum (NICD, 1993).

A Social Assessment study was carried out in Tribal dominated malaria prone hard core 7 districts (i.e. Srikakulum (AP), Dungarpur (Rajasthan), Panchmahal (Gujarat), Gadchiroli (Maharashtra), Gumla (Bihar), Surguja (MP) (now in Chattisgarh) and Mayurbhanj (Orissa) (Basu, Salil, 1996 World Bank supported).

Eco-Epidemiological Study of Drug Resistance to Anti-malarial in Plasmodium Falciparum (Pf) tribal infected areas–Mandla and Durg districts of Madhya Pradesh (Basu, Salil, 1998, supported by Pfizer Limited and DGHS, Govt. of India).

Drug resistance to anti-malarials is becoming one of the major problems in malaria control. Drug resistance with higher percentage of Pf is largely confined to hard core, hilly and forested areas in tribal dominated 100 districts of 7 states. About 60 % of the total deaths due to malaria are reported from these tribal areas. Orissa and Madhya Pradesh are at the top of the list with respect to incidence rate and Pf percentage.

ILLUSTRATION OF FEW TRIBAL DISEASES

Fig. 1: An Abujhmaria Yaws Patient

Fig. 2: A Saharia Child Patient

Fig. 3: Bharia Goitre Patient of Marasmus

Fig. 4: Genuvalgum Patients

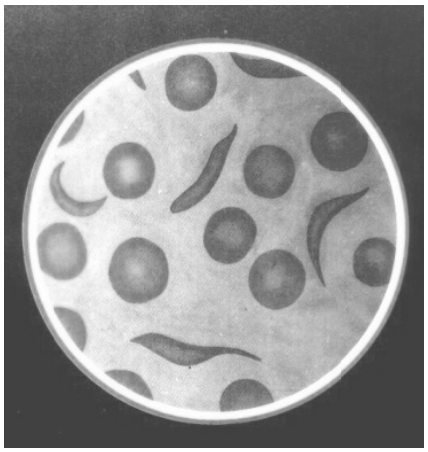


Fig. 5: Cells Showing Sickling

Fig. 6: Case of Sickle Cell Anaemia

TRIBAL SEXUALITY

Early researches on tribal sexuality of India conducted by Verrier Elwin (1964) makes it evident that there was considerably more sexual freedom and less male dominance in sexual and marital relationships amongst tribal communities. It was also made evident that tribal groups had varied sexual practices. Elwin discussed about "Village dormitories" or "Ghotul"(among Muria tribes) in which youth lived and slept together(Verma *et al.*, 2004). Muria had a simple, innocent and natural attitude to sex. In the "Ghotul", this was strengthened by the absence of any sense of guilt and the general freedom from external interference.

Sexually Transmitted Diseases in Tribal Areas

Infections of the female genital tract are numerous and widespread. They constitute a large part of low grade morbidity among women, contributing to a continuous and physically draining fatigue (UN, NY, 1984). These infections are closely related to sexually transmitted diseases which are most prevalent in various tribal groups i.e. Andamanese, Todas of Nilgiri hills. Khasas of Jaunsar Bawar (U.P.) Kondhas of Orissa, tribal groups of Madhya Pradesh, Rajasthan, Mysore, Laccadive and Minicoy Islands. Generally the disease is transmitted due to contacts of tribals with non-tribals. Besides these, other common communicable diseases which are found in high frequency among various tribal groups from different tribal areas are upper respiratory infections, skin infection, gastro-enteritis, hellimenthiasis, trachoma, fevers of unknown aetiology.

Non-Communicable Diseases

Very little information is available about the prevalence of non-communicable diseases in tribal population. Studies carried out by NIN (Rao *et al*., 1986) among the tribals of Sarguja, Jhabua and Bastar districts of Madhya Pradesh showed high incidence (53.9 per cent) of Goitre (Enlarged thyroid gland) in tribals of Sarguja district [Fig. 3]. Eye condition like cataract, corneal opacity etc. were found to be in high frequencies (20.3 per cent) in Bastar district. Cases of dental caries (5.1 per cent) were noted in Jhabua. A few instances of cardiovascular diseases like hypertension, valvular heart diseases were clinically found in Jhabua, Sarguja and Bastar.

Non-Communicable Diseases as Reported from NFHS-3 Data, 2005–2006

Number of women and men of 15t49 age per 100,000 reported that they have diabetes, asthma, or goitre or any other thyroid disorders by background characteristics, (India, (NFHS-3) 2005–06). While comparing the reported incidence of diseases among Schedule Caste and Schedule Tribe, it has been observed that:

a. Tribes (both female and male) showed relatively much lower frequencies of diabetes as compared to Scheduled castes.

b. But Asthma cases were reported in higher frequency both among female and male schedule tribes as compared to schedule castes.

c. In the case of Goitre incidence, there is not much difference among female ST & SC whereas much higher frequency was observed among male STs.

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CHAPTER 3

Health and Identity in Tribal India

Felix Padel

Tribal people in India face enormous health problems. Many of these follow from the level of exploitation and dispossession which they face. Around 50 per cent of the Scheduled Tribe population is living on the edge of starvation, in conditions that meet the criteria of famine, as Binayak Sen has emphasized (NNMB 2006, *The Hindu* 2012). As privatisation pressures mount, healthcare is increasingly perceived as a commodity. Instead of increasing health expenditure beyond the present 1.2 per cent of GDP, present government plans envisage encouraging public-private partnerships, even though there is no evidence that this will increase the outreach of healthcare to Adivasis and rural populations who cannot afford the private sector. As a result, marginalised groups remain marginalised in the health system, and discriminatory practices remain common (Gill 2012, Dreze and Sen 2013, John 2013).

Other papers in this Volume, and the MANT organisation itself, are focusing on ways of counteracting processes of exclusion from the mainstream health system. Besides many other challenges are two main problems that receive far too little attention, which I shall therefore focus on here: the vast extent of little-acknowledged industrial diseases, and mainstream ignorance and frequent prejudice concerning indigenous systems of medicine and healing. Although National Rural Health Mission policy documents aim to encourage tribal medicine, for example by training tribal girls in nursing techniques, implementation remains poor, and prejudice remains rife (Gill 2012).

Proper figures have not been kept, but it is estimated that approximately 50 million people have been displaced by 'development' projects since Independence, of whom 40-50 per cent are tribal people (Fernandes 2006, Padel and Das 2008). This means that as much as a quarter of India's Scheduled Tribe population has already been dispossessed. Most of the rest face a system of endemic exploitation that prevents adequate nutrition except for the lucky few still living in and around areas of intact forest, which can be relied on to provide a varied diet (Padel and Das 2010).Where Adivasi movements aim to prevent displacement, this is because the desperate situation of displaced communities is already known about. When serious ill health afflicts communities displaced by the Upper Indravati dams in Odisha, 'we wait here to die' in the angry words of one man. Doctors never visit remote communities there, and unless people can collect money to go to visit a medical centre in a distant town, no medical help is forthcoming (Sahu 2010).

This is the context in which a vast number of Adivasi workers are afflicted by several major 'industrial diseases', including silicosis and asbestosis, which they pick up working in mines and factories where there are inordinate amounts of dust and fumes. Workers of the lower grades are regularly exposed to highly polluting conditions, on a daily basis, without proper safety equipment. Doctors in industrialised or mining areas are under pressure not to diagnose these conditions– which are anyway hard to diagnose and treat–and tend to give a more general diagnosis of lung disease instead, such as TB. As a consequence, thousands of Adivasi patients compound their debilitating lung diseases by taking inappropriate medicines.

Particularly notorious examples are the stone quarries and stone crushing units in Birbhum district of West Bengal, and neighbouring areas of Jharkhand; numerous mines and factories in Madhya Pradesh, Gujarat and Rajasthan, including stone quarries and marble mines (P.C.

Sharma 2012); the Jaduguda uranium mines in Jharkhand, where workers and their families are regularly exposed to high levels of radiation, with childhood deformities, premature deaths and cancers extremely common (Mahapatra 2004; Pallavi 2008; Vishnu 2010; Padel, Dandekar and Unni 2013: 95); and countless coal mines, power stations, and factories. For example, aluminium factories regularly expose workers to fluorosis as well as asbestosis. In an interview with workers in Balco's refinery-smelter complex at Korba, they first said they received prescribed health check-ups several times a year; when pressed they confided that if they revealed their real health situation, they would lose their jobs. Factories also frequently pollute water sources that villages depend on. For example, in villages neighbouring Nalco's aluminium smelter in Angul, Odisha, people have visible signs of skeletal fluorosis, as do their few surviving cattle. The ash pond for this factory's power station has frequently overflowed killing livestock and polluting huge areas of farmland (Padel and Das 2010).

Compensation for Adivasis who have contracted industrial diseases due to inadequate safety equipment is notoriously difficult to obtain, due to problems with diagnosis and legal questions of proof and responsibility. Two cases in which a few Adivasi workers were awarded compensation for silicosis–one in West Bengal, the other in Rajasthan –after enormous effort, exemplify this set of problem. In Midnapur district of West Bengal, out of tens of thousands of workers afflicted with silicosis from working in stone crushing units, a case was pursued up to the Supreme Court by Nagarik Manch during the 1990s, leading to compensation for a small number of workers, though this took some years even after the SC ruled that they should be compensated (Mukul Sharma 1997). In Rajasthan in 2013 it was considered a victory when 19 workers with silicosis were compensated with Rs.100,000 each, out of over 1,000 diagnosed with the disease in Jodhpur and Karauli districts, out of tens of thousands known to have it; with tens of thousands known to have died from it (Environics 2013). Only long and costly legal cases could achieve these results, compounded by years of delay; while hundreds of thousands of Adivasis who have spent the best part of their working lives labouring in dangerous conditions in mines and factories throughout India are known to be suffering from silicosis, their lungs filled with dust that is choking them to death, without compensation or treatment. In Gujarat, 238 deaths from silicosis among Adivasi migrant workers from MP have not been compensated despite an order from the Supreme Court (Yadav 2011).

The Madhya Pradesh government has also been accused of indifference towards silicosis victims (Gupta 2012a, b and c, *Hindustan Times* 2012):

'Reports received from non-government organisations paint a sordid picture of the prevalence of this disease, which is sadly in contrast to the almost near denial of the existence of this killer by Government authorities. Regional review meetings taken by the National Human Rights Commission have revealed an utter lack of concern of the state for victims of the disease.

[I] Naction despite the awareness among the professionals and the bureaucrats that silicosis is a widespread and after a certain stage incurable lung disease caused by inhaling dust containing free crystalline silca, is most deplorable. What is appalling is their lack of sensitivity to this serious health hazard. Often wrongly diagnosed by medical practitioners as tuberculosis, it remains undetected and untreated till it becomes too late for the disease to be cured. Very often the symptoms of silicosis and tuberculosis are similar and the treatment that is invariably prescribed is the one that is usually given to tuberculosis patients.' (P.C. Sharma 2012).

In other words, workers in large numbers are effectively being worked to death, with their employers making maximum use of their labour, while trying to avoid the costs of preventive measures as well as the medical expenses and compensation that is the workers' due. The Rajasthan and Tamil Nadu governments have recently taken steps to prioritise diagnosis of silicosis victims, though the rate of diagnosis and treatment remains extremely low (*The Times of India* 2013, Sairam 2012).

'Industrial diseases' affect Adivasis who work in mines and factories because they have been displaced or forced to migrate for work, or because their traditional economy has been disrupted

and the fertility of their land has been compromised by mines and factories invading their locality, as in Birbhum district or Jaduguda. Another level involves the pollution of water sources in particular, as well as air and earth, by factories, power stations and mines. All around sponge iron factories and steel plants, coal-fired as well as nuclear power stations, alumina refineries (red mud) and aluminium smelters (fluoride)–among many other factories- various forms of pollution are endemic, affecting countless families who now lack safe drinking water and are exposed to pollutants all around. Pollution operates on more levels than is usually realised. For example, asbestos roofing sheets have been distributed almost free to hundreds of remote tribal villages, and are standard use in resettlement colonies, when asbestos roofing was banned in 'developed countries' many years ago, since the inhalation of asbestos particles over years is a prime source of asbestosis.

Among hundreds of abandoned mines whose polluting effects are still active, afflicting countless communities with dangerous diseases, are some closed mines of Hyderabad Industries Ltd. in the Roro Hills of Chaibasa district in Jharkhand, where un-rehabilitated asbestos and chromite tailings have caused chronic, largely undiagnosed ill-health among hundreds of Adivasi families (Dutta *et al.,* 2003).

Fluorosis is another disease whose incidence in tribal villages has greatly increased in recent years. Partly this is due to pollution from smelters that use fluoride compounds in processing metals. The main reason though is that the ground water table, due to over-exploitation ('water mining') has dropped to a level where naturally occurring fluoride contaminates the main water sources. In large areas of Rajasthan, Gujarat, Madhya Pradesh, Andhra Pradesh and other states, fluorosis is a major problem, and remote villages show extensive cases of severe skeletal fluorosis. Dr Tapas Chakma's study of this phenomenon in Madhya Pradesh casts light on this grim subject, and his proposed interventions involving daily intake of locally available leafy vegetables rich in vitamins C and D3, calcium and iron–which are shown to have reversed skeletal and dental fluorosis-and closing affected pumps, offer viable solutions to a problem affecting hundreds of villages. In other places, especially in parts of West Bengal, it is naturally occurring arsenic that contaminates the groundwater and causes severe health problems. These challenges stem from the rapid escalation of 'water mining' using electric pumps since the green Revolution in the 1960s: where groundwater was available 30 feet below the surface in the 1960s, it is now often necessary to go down 500 feet or more to get water.

Diseases coming from industrial pollution and pollution or over-exploitation of water sources are a relatively recent phenomenon. When it comes to more longstanding diseases, treatment of wounds, and care during child-birth, little-recognised tensions between tribal systems of healing and the mainstream allopathic system on offer in medical centres have major impacts on tribal health. Often, mainstream medical practitioners barely acknowledge that indigenous tribal systems of medical treatment even exist. Prejudice is rife, expressed in terms such as 'quacks' and 'witch doctors'. As a result, the old system– which anyway relies partly on access to hundreds of forest plant species which are disappearing as the forest gets cut down–is in severe decline in many places, while the new system of allopathic medicine is coming in a very barstardised form, in ways that tend to create dependency.

Traditional healing takes many forms. Best known is the use of hundreds of plants: a form of herbal medicine that is by definition completely un-systematised. While some plant medicines are commonly known, others are known to particular practitioners, and this knowledge is often kept secret. Most tribal communities have access to several kinds of practitioners, which include specialised bonesetters skilled in mending broken bones or resetting dislocated joints, midwives, priests, diviners, shamans and gunias. Shamans offer healing through contact with the spirit world, through spirit possession, healing songs –some of the most beautiful music I have ever heard, charaterised by an extraordinary healing power-as well as a wide variety of rituals and physical contact.

When a family becomes Christian they tend to come under pressure not to consult these practitioners. In a way this is ironic, since Jesus did not heal people by giving pills and injections, but by the laying on of hands. The New Testament is full of stories of Jesus healing people through hand contact–what is also referred to as 'faith healing', which is close to forms of healing widespread in Adivasi culture.

Among the main sources of fresh knowledge in Adivasi culture, in addition to herbal uses and ritual practices tried and tested over generations, are dreams and shamanic possession. Dreams are considered an authentic source of knowledge–just as they are in Freudian or Jungian psychoanalysis, but with a more practical orientation-and practitioners report learning about the use of particular plants etc through dreams. Spirits possessing a shaman will often prescribe certain herbs or rituals. Mainstream medicine tends to dismiss such sources of knowledge mainly because they fall completely outside the forms of 'scientific' knowledge that medical practitioners are trained in. The ways that tribal cultures construct knowledge and reality is radically different from the 'social construction of reality' prevalent in modern society (Berger and Luckmann 1966), which is why the western system of medicine tends to dismiss and displace rival systems that have a completely different epistemological basis.

A more sensitive approach allows different systems to co-exist. Perhaps what is needed in tribal areas marked by a severe lack of doctors and health centres is not so much a huge increase in financial outlay to provide modern high-tech health services, as cadres of dedicated health workers in remote areas who are prepared to teach some of the basic techniques of modern medicine–such as rehydration of patients (especially babies) suffering from diarrhea using salts and glucose in water–to complement traditional tribal medicine.

The clash between different approaches to health is particularly marked with regard to child-birth. Government health schemes aim to attract many more tribal women to come and give birth in health centres, since most Adivasi women still prefer to give birth at home. When one understands the contrast, the reasons for this become starkly clear. The custom in a majority of tribal cultures is for a women to give birth in a squatting position, using gravity; in many cultures she hangs onto a rope suspended from the roof of the house, which gives leverage that is helpful for pushing the baby out. In the mainstream medical system that grew up in the West, the custom is to make the woman lie down, where the midwife can access the birth canal more easily. As a result, when a woman goes into a health centre, she is often forced to assume what is to her an unfamiliar, unnatural position for giving birth, with none of the familiar people and props on hand to comfort and aid her, including drinks, chants, resin-based incense and much more, instead of the impersonal atmosphere and medical smells characteristic of hospitals (John 2013).

In the West nowadays, a reverse process is observable that encourages families to personalise their birth process in terms of who is present, position of giving birth and much more. A similar openness to other ways of facilitating birth is much needed in health centres in tribal areas. The first step is simply to recognise that other ways of doing things, and other forms of knowledge, exist. When the tendency is to look down on tribal customs as 'backward' or 'superstitious' this reinforces a lack of self-confidence among patients and their communities. Basically it amounts to a form of racism–what can be referred to as cultural racism.

Some doctors go beyond these attitudes of arrogance and ignorance prevalent in the medical profession. For example, I once met Dr. Madson, the Lutheran missionary who started Bissamcuttack's Christian Hospital in Rayagada district of Orissa, who told me that Kond patients would often come in with wounds smeared with cowdung, which she recognised was usually a good initial treatment, since cowdung has strong antiseptic qualities.

At a time when hundreds of thousands of Adivasis have been displaced by big dams and industry, and hundreds of thousands more are resisting takeovers of their land, what is under threat is not just people's standard of living and their food and water security, and therefore also their physical well-being, but also the cohesion and survival of communities and cultures. Communities displaced or invaded by mines and factories face Cultural Genocide–the undermining of every

aspect of the traditional social structure, from a material culture in which people inherit sophisticated skills of making their own houses and most items of use from natural sources, to the kinship system, economic self-sufficiency, a highly egalitarian political and legal structure, value systems and systems of knowledge (Padel 1998, Padel and Das 2008, 2010, Padel and Krysinska-Kaluzna 2012). When the mainstream health system discounts traditional knowledge of healing by looking down on it or dismissing it out of hand, this compounds the cultural genocide.

Adivasis often point out that 'development projects' displacing them contribute little or nothing to their own development. In this sense 'development-induced displacement' is a misnomer. 'We're being flooded out by money' and 'We can't eat money' are frequent statements, questioning the mainstream paradigm that financial investment automatically enhances the development of a tribal area. Since financial investment invariably funds displacing projects, 'Investment-Induced Displacement' better characterizes the process of dispossession (Padel, Dandekar and Unni 2013: 30–46). Dams, mines and factories also damage the local ecosystems which tribal cultures have maintained in a system of symbiosis, in which there tends to be an equation between the health of an ecosystem and the physical health of people living in and around it. Congruent with cultural genocide, mining areas also show evidence of ecocide– the annihilation of species and water regimes that have sustained over centuries (Higgins 2010).

In this situation, it needs to be recognised that indigenous health systems, like other aspects of tribal culture, are far from primitive: in many ways they are highly developed and holistic, forming part of a system of values and knowledge that is radically different from university or hospital-based forms of knowledge.

Finally, in areas affected by the Maoist conflict, there is an extra need for medical outreach. The banning of Medicins Sans Frontiers from Chhattisgarh is profoundly unhelpful, since atrocities are perpetrated by both sides, and among the worst rapes and atrocities are those perpetrated by members of the security forces (Iqbal 2010, Dungdung 2013, Padel 2013). Rape as a weapon of war needs treatment at psychological and legal levels, as well as medically.

To summarise: a first set of challenges involves the extreme levels of exploitation, dispossession and corruption experienced by Adivasi communities, combined with a rapid privatisation of health services in India through 'Public-Private Partnerships'. In a situation where countless thousands of tribal people are inducted into low-level labouring jobs in mines, construction projects and factories, often with highly inadequate protection, industrial diseases are rife, as is pollution of water sources by effluents. There is a need to be far more vigilant and outspoken about these industrial and pollution-borne diseases, which extends to speaking out about asbestos roofing, among many other topics.

A different set of problems arises from the tendency of modern western-derived health systems to displace highly developed indigenous systems, whose efficacy operates at a more holistic level not just tribal communities' huge knowledge of plant-and animal-based medicines, but also, for example, the far-reaching healing properties of shamanic trance, which often brings a community together and affects a patient's motivational level very deeply.

This is not to dispute the need for greatly improved access to mainstream medicine in child-birth, treatment of children's diseases and emergencies, but to argue that this access should be managed in a spirit of sensitive co-operation with traditional skills, in a context where many mainstream health practitioners still show prejudice towards traditional techniques, dismissing them as 'superstition' etc.

Health of an individual in tribal communities is connected to health of the community and natural environment, and psychological health. A low-budget system of local health workers trained in both systems is the ideal approach, complementing improved access to government health centres.

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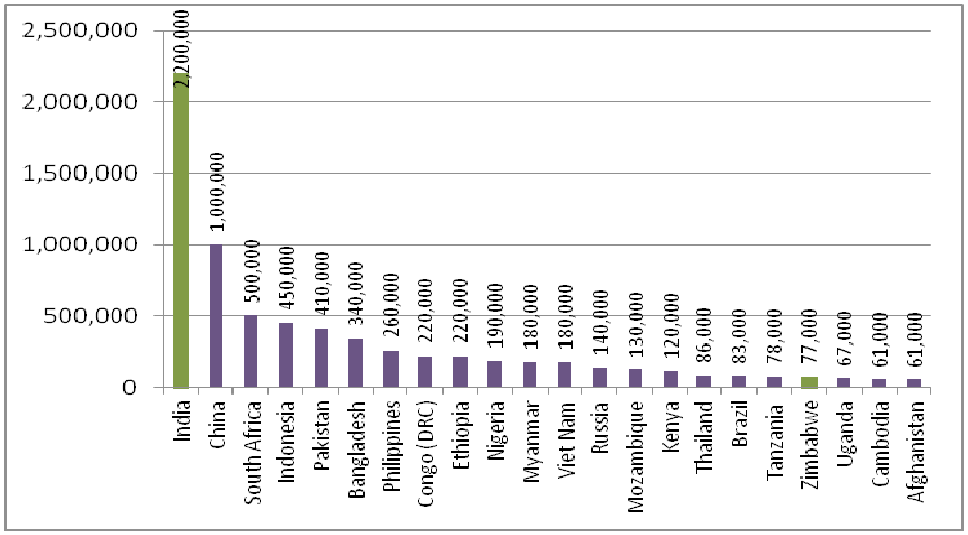
CHAPTER 4

Community Driven Tuberculosis and HIV Reduction by Tribal People for Upholding their Health Rights in Andhra Pradesh, India

Boddu Vijay Kumar and Dr. Bollineni Keerthi

BACKGROUND

India has the highest TB burden in the world, and contributes to approximately 20 % of the global incidence of TB annually (see table below of 22 high burden countries).



Since 1997, the Revised National TB Control Programme (RNTCP) has been implementing the Directly Observed Treatment Short Course (DOTS) strategy recommended by World Health Organisation (WHO) with the objective of curing at least 85 % of new sputum positive TB patients and detecting at least 70 % of such patients. The RNTCP is now in the 11th year of its implementation. Andhra Pradesh has only 7 % of India's population and yet 20 % of all HIV cases and 13 % of all TB cases are found in the state. The TB incidence in India is estimated at 203 (per 100,000 people). However, Vishakhapatnam and East Godavari have a very low case notification rate of 132 and 146 respectively, which means that 71 and 57 cases per one lakh population were undetected in Vishakhapatnam and East Godavari respectively (statistics from Health department, government of AP, 2011). According to the WHO, one TB patient that remains undiagnosed will transmit the disease to between 10 and 15 people.

In the two tribal regions, knowledge levels are very poor as noted in a baseline study with 260 community people with 20 members from each Mandal.

Only 11 % (29) mentioned persistent cough for more than two months as a symptom of TB. 57% believe that one can get TB while talking to TB infected persons 50 % mentioned that sharing of dishes with a TB infected person will transmit TB.

Only 57 % knew that treatment is available at government hospitals 43 % thought that Faith based organisations and non-governmental organisation were the treatment centres 32 % of the respondents knew about DOTS services. 68 % had heard of DOTS but didn't know that the services were available TAP programme has conducted baseline study with data collected from both service providers and beneficiaries along with the key stakeholders in each district to assess the knowledge levels of people in communities and gaps were identified. Stigma in health care settings still appears to be an issue of concern when community members walk in with HIV-TB co-infection. Very few people knew about tuberculosis symptoms, treatment and prevention methods. All 260 respondents were not aware of the nine health rights, but they knew that there is a right to health.

Thirteen DMCs exist in two tribal regions but only three centres (two in Vishakhapatnam and one in East Godavari) have X-ray facilities. East Godavari has x-ray testing facility offered at subsidised rates and services are provided only on Sundays at Rampachodavaram. In Vishakhapatnam 175 medical officers are in place against a sanctioned strength of 204. Among them, 156 were provided training on TB, TB-HIV. All 57 Lab technicians have also been provided training. All the centres have microscopes for testing. There are 908 (745 Aganwadi Worker, 125 Axillary Nurse Midwife and 29 Registered Medical Practitioner) DOTS providers and only 10 ANMs were provided training in East Godavari. None of the DOTS providers in Vishakhapatnam were trained on DOTS. The attitude of the personnel at the health facility is also one of the reasons for low levels of testing at the centres. The client follow up on treatment is very limited, which has resulted in dropout from treatment after completion of intensive phase of treatment. As a result, the same patients are reaching the centres with TB symptoms again.

The study recommended increase of DMC in east Godavari, availability of mobile DMC to reach the unreached, provision of DOTS through AWWs through advocacy with the government. For this purpose, training to all grassroots level functionaries on TB screening and DOTS provision was highly recommended. TAP also realised that there was a need to advocate for double nutrition to TB affected children during treatment through the ICDS programme of WCD at par with HIV affected children.

In the two tribal areas mentioned in this paper, buses ply occasionally and the most common mode of transport in hilly areas are jeeps overloaded with passengers sitting on the roof. On sandy days (A market place arranged at one place weekly once), three wheeler auto rickshaws with persons hanging on both the sides with materials purchased are available. The most convenient mode of transport in the mountainous area is the two wheeler motor bikes for male on which more than three persons travelling is the norm. In short, transport facilities are very limited for patients.

PROJECT INTERVENTIONS TO ADDRESS THE ISSUES

Government statistics, feedback from tribal families through focus group discussions and key informant interviews with service providers and civil society about TB burden among tribal people revealed that the number of undiagnosed TB cases is very high among tribal people than people in plain areas. VMM initiated TAP–tuberculosis reduction programme in Andhra Pradesh with the technical support of TB Alert funded by DFID for 43 months (from September 2011 to March 2015) in six coastal districts (Srikakulam, Vishakhapatnam, East Godavari, Krishna, Prakasam and Nellore) targeting fisher folk, tribal people, rural communities and urban slum dwellers. TAP reached 231 tribal villages in thirteen mandals (regions) of two districts. The project aims to reduce levels of TB and TB/HIV co-infection and increase access to effective health services through empowered communities and local advocacy. The expected outcomes of the project include: Increased awareness of TB and HIV; Increased usage of free government health services; community structures in place that promote and support health rights and health seeking behaviour, and; A stigma free health centre environment with improved TB diagnostic and treatment services.

The interventions are planned strategically to improve the quality of life among the tribal population with a focus on tuberculosis and HIV co-infection from a rights based perspective.

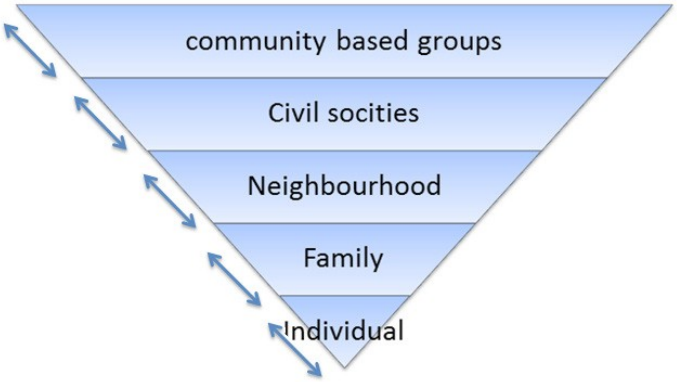
The strategies are: education and knowledge building advocacy, service delivery, monitoring and evaluation.

Table 1

TB and HIV Community Based Care	Administrative
Education of families and communities on symptoms, testing, treatment and follow up of TB care.	Follow up and patient tracking.
Follow on cross referrals between TB and HIV and vis a vis.	
Awareness and education of communities.	A network of referrals and linkages with community based groups and service providers Monitoring and evaluation systems.
Formation and strengthening of community structures: support groups with adults and children, community core groups, health forums and inclusion in the women self-help groups' agenda.	
Psychosocial and economic support Counselling for stigma reduction.	Care and treatment at Service provider.
Treatment adherence and follow up, family counselling.	Sensitisation of service providers for reduction of stigma and to maintain sensitivity with patients.
Psychosocial support for TB and HIV–TB co-infection patients, care givers and their immediate family.	Counselling by facility level personnel.
Counselling of parents and teachers for continuation of children's education.	Reduced cost for x rays for diagnosis.
Travel support to needy patients.	Enabling environment through policy changes.
Nutrition support through local resource mobilisation.	

Education and Capacity Building

Education and capacity building are key strategies. Improved knowledge is being provided to all stakeholders on health rights, TB symptoms, services, treatment and follow up and services at community level through awareness meetings, mass events, cultural shows and use of information, education and communication (IEC) material. At the same time, civil society, health care workers, private health care providers and village level health functionaries are being trained to provide quality services. This knowledge and capacity building is provided at 5 levels.



The community outreach workers, Volunteers and community group members are from tribal communities hence the messages provided to them reach other tribal people. They are better able to deal with the challenges of stigma and discrimination towards TB and HIV patients, delayed identification of symptoms, discontinuation of treatment and follow up as they are members of the same community. The outreach worker spent time with tribal families to help them understand their health rights. The messages are provided to the tribals through pictorial IEC material and games for children and adults. Snakes and ladders, a popular traditional board game was adapted with messages for TB reduction and is being used by tribal groups who find it interesting and easy to use. In tribal areas, the marketing of consumer products either food, clothing or utensils etc., are only on shandy days hence the messages were provided for TB reduction in health camp mode through float boards in which six pictorial boards are hung from two trees or poles and explained in the tribal language. Tribal people who require the services of the outreach worker take the phone numbers or contact details and those who had TB like symptoms were referred to the nearest health facility.

Awareness meetings, organized with small groups of 25–30 people and mass meetings with groups of 100–150 people, have disseminated messages and resulted in 34115 tribal seeking health services. In tribal population with low levels of literacy, tribal youths were trained on culture specific folk performances for conveying the message on tribal health rights specific to Tuberculosis and HIV.

Table 2: Number of Referrals and TB Cases Identified Through Awareness Activities

Activity	Number of Activities	Number Participated		Persons Referred for Testing		Persons Tested		Persons Found Positive	
		Male	Female	Male	Female	Male	Female	Male	Female
Awareness camps	1869	16168	17947	1952	1345	1709	1188	268	121
Mass events	42	1331	2388	98	76	93	70	17	6
Cultural Shows	20	1834	1839	51	50	48	46	9	11
Total	1931	19333	22174	2101	1471	1850	1304	294	138

TAP Project identified self-help groups formed under a government flag-ship programme. TAP programme linked with 77 such self-help groups with 1096 women and included information on TB in their agenda. VMM field staff also attended 125 village organisers' monthly meetings, mandala samakhya meetings and group meetings at village level. The programme has developed an exit strategy built into the plan and hence, TB and HIV reduction work is mainstreamed into the self- help groups. As some of the women SHG members had themselves been affected with TB or HIV, they were able to empathise with the project activities. One SHG member says, "Now I am aware how to identify symptoms and access government health services. When my husband suffered with symptoms, we could not access services at early stage and used local medication and when we went at the last stage to the DMC, he died even before the treatment could be initiated. Now I am committed to becoming an ambassador for TB reduction as I know the pain of losing a family member". Community based groups are formed in TAP programme with TB or HIV affected persons, their family members and the likeminded to work for upholding the health rights of tribal people. Different types of groups that were formed included:

Adult support groups with focus on adults are led by people affected by TB-HIV. This group provides support for adults that are concerned about TB-HIV, including referrals to government clinics.

Community core groups are led by community leaders–including teachers, faith based leaders, and women self-help group leaders–and people affected by TB–HIV. Group members discuss issues around TB and HIV, including cultural perceptions of the two diseases, and how these may be overcome.

Health forums are formed to act as bridge in between services and tribal communities and formed with Local private health care providers, NGOs/CBOs working in health, People representatives, 3 representatives from Community core group, one HIV affected person, one TB affected person.

Children support groups with young adults are groups for children, some of whom are infected or affected by TB and/or HIV. The group provides play-based support and life-skills training to help children grieve and to support their sense of belonging with their peers.

Grannies clubs with aged care givers is a forum to provide advice and support for grandparents whose children have been affected by TB–HIV, many of whom are raising children orphaned by AIDS and TB. 21 adult support groups were formed with 343 members, 5 community core groups with 79 members, 2 health forums with 29 members, 2 grannies clubs with 49 members and 15 children support groups with 239 members, all of them from tribal communities. Their active participation in TAP has led to improved services for tuberculosis and HIV.

Observance days are another tool to bring awareness among the communities about prevalence and consequences of tuberculosis. Rallies are organised and focus is given on Involving the

participants such as school going tribal youth, teachers, women self-help groups, community leaders and influential people.

To improve referrals and linkages, all groups have been provided with a District level resource Directory developed under the TAP programme. Groups have been trained on utilisation of the directory and each group has a directory so that they are able to contact the appropriate service provider to resolve their problems. This is one of the good practices that will be sustained after the end of the programme. For example, the communities used the resource directory to approach ITDA (Integrated Tribal Development Agency) for travel support to approach health facility and to access nutrition support.

Capacity Building

TAP project has trained 2 Project Managers, 18 outreach workers and 42 Volunteers in various aspects of the project as quality of programming and outcomes depend on training received. Training included topics such as community mobilization, stigma reduction, health rights, documentation, monitoring and evaluation and skill building on advocacy and theatre arts. TAP project field workers trained traditional healers, local medical practitioners, community health workers, anganwadi teachers and school teachers by organising regular interactive meetings with them, participating during their monthly meetings.

Service Delivery

The interaction with private health care providers focused on reducing the cost of x-ray for the extra pulmonary and sputum negative cases. The project entered into a Memorandum of Understanding (MOU) with local medical doctors. In East Godavari, the project developed linkages with the Ramakrishna Mission which conducts a medical camp every week (on Sunday) in the tribal regions of the district and charge INR 50 per x-ray. In Visakhapatnam tribal regions there is only one private practitioner who operate x ray unit hence the local NGO partner entered into an MOU with local medical practitioner to supplement the two x ray units available in the government hospital. That helped the project in getting 97 people tested for TB and 13 were put on treatment. As x-ray facility is scarce in tribal regions, the linkage with private health care providers helped in diagnosis of cases that would otherwise be missed through sputum testing.

Sensitization of community leaders plays a vital role as they are influential in the tribal communities. Community leaders include faith based leaders, local political leaders, tribal community leaders that have gained knowledge during sensitization meetings.

Tribal patients suffer with cough but do not approach the health facility owing to lack of transport to reach the health centre; Reasons: inability to pay for travel and inability to commute due to sickness. The project addressed these by paying one way transport charges and in poverty cases, two-way travel is paid to come for testing and treatment centres. Where the patient is unable to commute due to sickness or due to lack of transport, the outreach workers collects sputum at their door step (two samples or collects one sample and accompanies them to health facility to give second sputum sample), so that the patients gets diagnosed and treated as required.

VMM has conducted socio-medical study in one tribal village with 34 households with 120 population. Among 100 members who participated in the medical study, 12 persons were diagnosed with TB and were on treatment or just completed the course for TB. The villagers expressed that many died before TAP intervention with severe cough and sputum and weight loss and neither approached any health facility nor a doctor. In the village many of them are graduates but they were unaware of the disease and their rights. A 35 year old tribal man expressed that 'in his life time in the village, it was the first time he had seen a doctor coming to their village.'

Monitoring Evaluation

For accountability, the project introduced referral slips in triplicate: one with patient to deliver and filed at health facility, second copy with either community groups or Volunteers in the

programme and a third copy with outreach worker to use for data entry. The mechanism works effectively and tracks the patient from referral stage to treatment completion through the Management Information System (MIS) developed exclusively for this programme based on the RNTCP indicator i.e., number of people diagnosed with TB. Project specific indicators include:

At Outcome Level

Knowledge of TB amongst community in project area.

At Output Level

Knowledge of health rights and HIV amongst community in project area. Number of PMPs and SHGs sensitised on TB and health rights Level of stigma and discrimination amongst community members towards people with HIV and TB. Existing community structures integrate HIV and TB into their agenda Adult support groups endorsing and supporting the project's health advocacy and community-based activities.

ADVOCACY INITIATIVES OUTPUT LEVEL INDICATORS

RNTCP initiates Sputum Collection Centres in intervention area Provision of DOTS is included in the official job chart of AWW Nutritional support provided to 12 months for children under 6, diagnosed with TB The referral slips capture the basic information of the patient including name, address, sex, age, symptoms for referral, to which facility referred, on what date, how the patient approached the outreach worker, and which outreach worker dealt with that case. The back of the slip contains the information on results, the tracking number at the facility based on clients' willingness. As many patients do not preserve their records carefully, the information with VMM and its partners is crucial. Secondly the data is used as evidence to showcase the contribution of the programme for TB reduction.

Communities participated in the project in project design, implementation and review stages. Participatory community reviews were conducted annually by Involving tribal TB patients, other stakeholders in the community and health facility including the government health functionaries. Participatory tools like voting, ranking, venn diagram and research methodologies such as case studies, focused group discussions and observations were made and conducted for a period of 10-15 days at the village level.

Advocacy

Based on baseline study and recommendations made, VMM developed advocacy plan for getting double ration GO for children on INH and DOTS. A series of discussions with government departments of health and women and child development finally convinced the government to pass an order supporting double ration to be made available for children on INH and DOTS. VMM disseminated the GO to implementing partners at both the districts. The partners met with district officials and grassroots workers for implementation of the GO. One of the Anganwadi workers at Sanyasampalem village of Hukumpeta mandal has provided information about the scheme and requested support of double ration for one child on INH. Before the provision of double ration the child was malnourished and well below the normal weight but after 2 months of nutrition support, the child has gained 250 grams in weight. Another recommendation of the study was inclusion of DOTS in the anganwadi workers job chart. The project successfully advocated with the Women and Child Development Department which passed an order that all AWWs will work of TB reduction by creating awareness, following up on symptomatic clients and promoting testing and treatment of their target group i.e women and children.

Project Results

The greatest strength of the programme is the commitment of tribal community people to uphold the health rights of their own people. This has resulted in the early identification of the tuberculosis

and HIV symptomatic patients. Even after phase out of the TAP programme, empowered communities will continue the work that has been initiated:

Table 3

	DMC						ICTC					
	Referred		Tested		Positive		Referred		Tested		Positive	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
ASG	72	39	61	35	12	5	36	58	35	55	1	3
CSG	6	7	5	7	1	0	0	1	0	1	0	0
CCG	15	15	13	15	1	3	7	6	7	5	0	0
HF	2	3	2	3	0	0	0	0	0	0	0	0
GC	0	1	0	1	0	0	0	0	0	0	0	0
Total	95	65	81	61	14	8	43	65	42	61	1	3

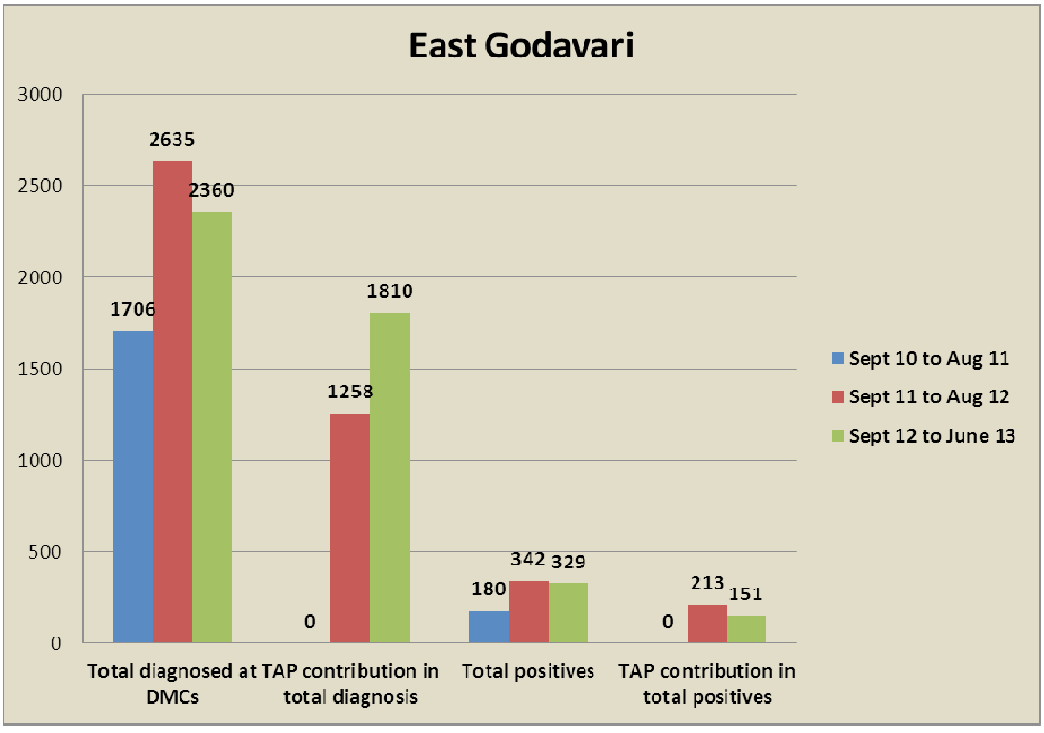
In Dumriguda mandal of Visakhapatnam the community core group has done local advocacy by representing to the district that the vacancy of the Lab technician is causing problems to the tribal communities for early diagnosis.

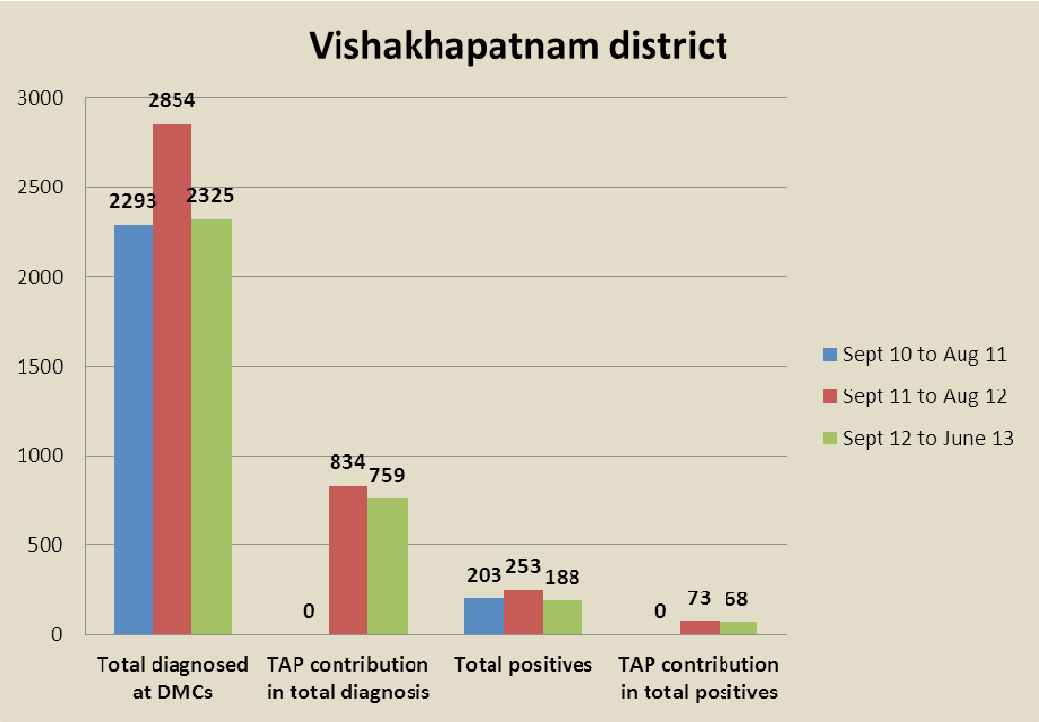
The Involvement of self-help groups resulted in improved referrals to health facility (designated microscopic centre or DMC). 135 patients were referred for TB testing and among them 8 (7 %) were TB positive. 48 patients were referred for HIV testing and among them none positive.

The internal linkages among the various programmes of the NGO partners has led to better coordinated effort for addressing HIV-TB co-infection and early diagnosis. Example: In East Godavari the NGO has developed internal linkage with their Prevention Parent to Child Transmission Programme where the TB knowledge is spread to the HIV affected patients and their family members.

Developing association with educational institutions has two fold effects: NGOs benefit through local resource mobilization and the students will get practical experience which will add value to educational institutions for accreditation. In Visakhapatnam district the NGO has entered into a MOU with local university.

TAP project has contributed towards TB reduction by identifying new cases which is evident from the improved case notification, an increase from 132 to 151 in Vishakhapatnam and from 146 to 157 in East Godavari within a period of 12 months (2011 to 2012)[1].





http://www.tbcindia.nic.in/pdfs/TB%20India%202013.pdf

CHAPTER 5

India's Retreat from Alma Ata—A Note

Mohan Rao

1978 was a significant year for health sector development as the countries of the world met at Alma Ata to declare a goal of health for all by 2000 AD through Primary Health Care. PHC promised something new, indeed something revolutionary, challenging the might of the medical-industrial complex and hence was not to be, as the world embarked upon the second wave of globalization soon after.

The post-oil price hike tremors in the financial markets were the immediate provocation for the launch of the global neo-liberal project. Economists hesitated to use the word "depression" to describe this phenomenon, the new global recession, since it brought back painful memories of the 1930s, a period that had plunged the world into the horrors of fascism and the Second World War, but the "recession" of the 1980s was similarly widespread and deep, with equally profound social consequences. These changes took place together with the collapse of the Soviet Union and the state controlled economies of the socialist world, as the Berlin wall crumbled and the world turned upside down. They also led to a reshaping of the capitalist world, not in the direction of the new international economic order envisaged by the Third World but in a diametrically opposite direction. The new world order that was actually created led to a complex of changes known as globalisation, privatisation and liberalization.

As the long boom of the post-War golden age of capitalism grounded to a crisis, this period was marked by the rise of right-wing monetarist regimes in the USA and the UK, along with the domination in the belief in what Hobsbawm describes as "ultra-liberal economic theologians", whereby "the ideological zeal of the old champions of individualism was now reinforced by the apparent failure of conventional economic policies" (Hobsbawm 1994: 409).[1] Neo-liberal economic policies, described variously as Reaganomics, Thatcherism, Corporate Globalisation or Monetarism, reflected an ideological commitment to unbridled market principles, ignoring the remarkable role that the state had played even in the advanced capitalist countries. One of the significant lessons of post-War economic growth had been the singular role that the state could play, and indeed needed to play, in capitalist countries to avoid recurrent periods of crisis due to falling demand. For instance, state involvement in public health had been considered critical, not simply because health is a merit good, but also because state provision of such goods was at the heart of the strategy to stabilise the economy and to increase productivity. In the new environment of the 80s, these Keynesian policies increasingly came under fierce attack. The new consensus shared a profoundly cynical view of the state, especially in developing countries, although neo-liberal free-market rhetoric often contrasted sharply with the actual practices of the Reagan and Thatcher governments in their own countries where the state was increasingly subsidising the rich (Gershman and Irwin 2000).[2] Indeed, neo-liberal globalisation has also been described as a

[1] Hobsbawm, E.J. (1994), Age of Extremes, Viking, Delhi.

[2] Gershman, John and Irwin, Alec (2000), "Getting a Grip on the Global Economy" in Jim Yong Kim, Joyce V.Millen, Alec Irwin and John German (Eds), Dying for Growth: Global Inequality and the Health of the Poor, Common Courage Press, Maine.

global project to restore upper class privileges to the levels that prevailed in the early twentieth century, in a profound trickle up of wealth and resources (Harvey 2005).[3] Reducing the role of the state and increasing that of the market, irrespective of their social and indeed long-term economic costs, was thus at the center of this model of therapy. Economic growth, it was maintained despite extensive evidence to the contrary, would trickle down to the less fortunate and thus result in overall development.

What also occurred was a profound change in the idea of a nation state, of a welfare state and of health itself. With the weakening of labour unions, and the loss of communitarian ideals, the post-Second World War consensus of citizen's rights and entitlements was broken. The state itself was now an instrument of corporate and finance capital. Areas of the social sector– such as education and health, considered sacrosanct public goods were now marketisedor privatized. It was global finance, insurance and multi-national pharmaceuticals increasingly concentrated through mergers and acquisitions–that were setting the agenda in health globally. Thus the effort to privatise the world's first National Health System in the UK (Pollock 2004).[4] While this has been resisted, without great success, populations across the globe have been disempowered by macro-economic changes, by job losses, squeeze on wages, cutbacks in welfare and so on.

The driving force behind this phase of imperialist globalisation is speculative finance capital, not related to manufacturing or trade, or indeed to the metropolitan nation state, but instead opening up the world in a quest for rentier profits (Patnaik 2003)[5]. Together these policies and processes increased indebtedness of Third World countries that they were supposed to reduce, increased the rate of exploitation of wage-workers across the globe, and shifted wealth from productive to speculative sectors. The policies also led to the increase of casual, poorly paid and insecure forms of employment. Fund cuts in education and health also meant that already weak and under-funded systems of health, education and food security collapsed. It is thus not accidental that these policies increased levels of poverty in already poor countries even as a small section of the population became richer.

Thus it is that these decades have often been described as lost decades. Structural adjustment programmes, then, did not reduce debts, cut levels of poverty or return countries to a path of growth. The external debt stock of developing countries increased from 616 billion in 1980 to an estimated five trillion at the end of 2011. Yet at the same time, the flow of resources to rich countries actually increased, as indeed they were designed to. In 1960, the poorest 20 per cent of the global population received 2.3 percent of the global income. By 1991, their share had sunk to 1.4 per cent. A 141 country study in 2011 by UNICEF showed that the wealthiest 20 percent of the population enjoyed more than 81 percent of the world's income as of 2007, with the poorest 20 percent holding on to just over one percent (Ortiz and Cummins 2011).[6].At the same time, the ratio of income of the wealthiest 20 per cent of the people to that of the poorest 20 per cent was 30 to 1 in 1960. According to the UN, 1.2 billion poorest people account for only 1 per cent of world consumption while the billion richest consume 72 per cent.[7] In other words, while the world had grown incomparably richer, the wealth generated had been distributed remarkably unequally. We have in the early 21st century, global inequalities in wealth restored to what existed in the early 20th century. UN data indicates that assets of the world's three richest men exceed the combined Gross Domestic Products of the world's 48 poorest countries.[8]

This kind of income inequality also has health consequences in the form of preventable deaths and diseases in large parts of the world, and collapse of poor funded health systems. The

[3]Harvey, David (2005), A Brief History of Neoliberalism, OUP, New York.
[4]Pollock, Allyson (2004), NHS-PLC: The Privatisation of Our Health Care, Verso, London.
[5]Patnaik, Prabhat (2003), The Retreat to Unfreedom: Essays on the Emerging World Order, Tulika, New Delhi.
[6]Isabel Ortiz and Matthew Cummins (2011), Global Inequality: Beyond The Bottom Billion, UNICEF, New York.
[7]UN (2013) A new global partnership: Eradicate poverty and transform economies through sustainable Development: The Report of the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda, United Nations, Geneva.
[8]http://www.un.org/cyberschoolbus/briefing/poverty/poverty.pdf

influence of global finance, insurance and pharmaceuticals have put in place an architecture for global trade known as the WTO which includes health as trade in services. This profoundly shapes what institutions and actors in countries like India can and cannot do.

At the same time today our country has the fifth lowest public health expenditure in the world. As the National Health Policy, 2002 (NHP) admitted, this is, at 0.9 per cent of the GDP, lower than the average in even Sub Saharan Africa (GOI 2002).[9] Along with decreasing state spending on health, policy measures have encouraged the growth of the private sector in health care so that today we have the largest, and least regulated, private health care industry in the world. Evidence from across the country indicates that access to health care has declined sharply over this period. The policy of levying of user fees has impacted negatively upon access to public health facilities, especially for poor and marginalised communities, and to women (GOI 2005).[10] With the sharp rise in health care costs, the medical expenditure has emerged as one of the leading causes of indebtedness. The Report of the Steering Committee on Health for the 12th Five Year Plan acknowledges the worrying trend of the growing reliance on private providers, which currently service 78 per cent of outpatients and 60 per cent of in-patients. According to the report, for those who cannot afford private services, illness translates into high out-of-pocket expenditure as a proportion of total household expenditure, often reaching catastrophic proportions, i.e. equal to or greater than 40 per cent of a household's non-subsistence income (GOI 2012).[11] State support for private health care grew with the initiation of private-public partnerships (PPP) that took a variety of forms. [12] This had now of course international imprimatur: Global PPPs emerged as the new mantra in a partnership between a tired, financially emasculated and visionless WHO and ruthlessly energetic new International NGOs, specifically for HIV/AIDs, tuberculosis and malaria (Missoni 2009).[13] These provided a new impetus to vertical programmes but with a difference: private funds made their entry through these partnerships. For instance, under the aegis of Global Alliance for Vaccines and Immunisation (GAVI) and the WHO, plans are underway in the Ministry of Health and Family Welfare to introduce a range of utterly unnecessary vaccines in a replay of let them eat cake (Chakravarty 2008).[14] It is truly remarkable that GAVI conditions for support include a guarantee for "reasonable prices", support for a credible and sustainable markets, and prohibitions on compulsory licensing. India has taken the support of GAVI for the introduction of hepatitis B vaccine in selected pilot projects. Thus, the creation of new markets along with the neglect of the determinants of diseases in populations (Puliyel and Madhavi 2008).[15] Parallel to this, the existing public-sector vaccine production units across India were closed down, apparently to harmonies with WTO regulations. For both BCG and DPT, after shutting down the vaccine production unit, it was admitted by the union health minister that the ministry is purchasing the same vaccine at more than double the cost from the private sector.[16] However, following a public outcry, the licenses were restored and some of the units restarted production in 2012. This was also in line with the recommendations of the Javid Chowdhury Committee report that described license suspension as "incorrect" and based on an "illegal procedure" and a "flawed appreciation" of the issues.[17] It is reported that with the PSUs

[9]Government of India (2002), Ministry of Health and Family Welfare, National Health Policy, New Delhi.
[10]Government of India, Ministry of Health and Family Welfare (2005), Report of the Commission on Macroeconomics and Health, New Delhi.
[11]Planning Commission (2012), Report of the Steering Committee, Health Division, Government of India, New Delhi.
[12]Two states, leading in PPPs, Andhra Pradesh and Gujarat, have entered into PPPs in the health sector with Satyam computers, at considerable cost to the state exchequer. Satyam has recently been revealed to be India's biggest corporate fraud, its CEO the Madoff of India. The PPPs however continue.
[13]Missoni, von Eduardo (2009), "A Long Way Back towards Alma Ata", Bulletin von Medicus Mundi Scheiwz, No.111, February.
[14]Chakravarthy, Indira (2008), "Role of the World Health Organisation", Economic and Political Weekly, Vol. XLIII, No.47, 22nd-28th November.
[15]http://articles.timesofindia.indiatimes.com/2011-02-23/india/28625904_1_dpt-vaccine-bcg-lab-bcg-vaccine
[16]http://www.thehindu.com/todays-paper/tp-national/tp-newdelhi/public-sector- vaccine-unit-restarts-production-supply/article2944655.ece
[17]JayatiGhosh (2013), PSUs need booster vaccine but govt puts Mylan on hold, Indian Express, Aug 7, New Delhi.

freezing/cutting their vaccine facilities, roughly half of India's budget on the national universal immunisation programme is now spent on procurement from the private sector against 25 per cent some five years ago (Ghosh 2013).[18] What these efforts to promote private manufacturers effectively do is undermine comprehensive public health care: routine immunisation rates have dropped in several states in the country. Thus the poetry of PPPs is another case of sucking up of resources, what the French call *actionecapillaire*.

Yet another scheme has been the provision of a range of incentives to the private sector in health through provision of land at throw-away prices, grant of customs duty exemptions for import of sophisticated medical technology, and loans from financial institutions at low interest rates. These incentives have been provided for both private[15] Puliyel, J.M. and Madhavi, Y. (2008), Vaccines: "Policy for Public Good or Private Profit?", Indian Journal of Medical Research, January. for-profit and not-for-profit institutions. The period thus witnessed the emergence of a corporate health sector, increasingly influential in policy setting. These facilities were however priced out of the reach of even the middle class, and suffered from excess capacities. The government again stepped in to create demand. Thus, for example, the Central Government Health Services (CGHS) scheme, which caters to a substantial population of government employees, was altered to permit the central government employees to avail of high-end private sector medical care. Soon the teachers of Delhi University followed suit. These twin factors–need for demand generation for corporate hospitals and skyrocketing medical care prices that keep even the middle class out of large specialty hospitals find expression in the strident calls for universal health insurance to cover such care in the Twelfth Plan.

A study indicated that these schemes had been utilised primarily by urban-based institutions that had not always provided free services to the poor as they were expected to as per the terms of the contractual agreement (Bhat 1998).[19] Further, there were no mechanisms to monitor these projects, with the government's limited institutional ability to do so. A Committee was set up by the Government to examine the violations, by private hospitals, of the terms of their agreements. This Committee found gross violations on every commitment made: in short the public had been diddled, with the government watching benignly on (Government of Delhi 2001).[20] The Qureshi Committee report of course gathers dust. Similarly, a committee set up by the Maharashtra state government to review the performance of charitable hospitals found that the court directive to treat poor patients was not being followed. The committee report said that on an average only four per cent of the earmarked beds-out of a mandated 20 per cent-were being used to treat the poor.[21].

Such arrangements have also led to the burgeoning of high-technology diagnostic centres in urban areas, with excess capacities. This growth in 'rapid strides' has continued over the past few decades, and as a recent CII report observes, diagnostic providers along with hospital chains have emerged as "stand-alone corporate entities". It also thankfully acknowledges that "collaboration between the government and private sector has emerged stronger, with some successes". Understandably, between 2000 and 2012, hospital and diagnostic centres saw the largest amount of FDI inflows within the healthcare sector, as evident from the Table 1.

Indira Chakravarthi's recent work has drawn attention to a significant and relatively new player, namely private equity funds (Chakravarthi 2013)[22], This is especially the case for the

[18]Bhat, R (1998), "Private Health Care Sector in India: Issues Arising out of its Growth and the Role of the State in Strengthening Public-Private Interaction", Unpublished, I.I.M., Ahmedabad.

[19]Government of Delhi (2001), "High Level Committee for Hospitals in Delhi: Enquiry Report", Justice A.S. Qureshi Committee, New Delhi.

[20]Daily News and Analysis (2012), "Hospitals Not Following Diktat to Admit Poor Patients: Report", 13 May, accessed at http://www.dnaindia.com/mumbai/ report_hospitals-not-following-diktat-to-admit-poor-patients-report_1688114, on 31 August 2012.

[21]Chakravarthi, Indira (2013), "The Emerging 'Health Care Industry'in India: A Public Health Perspective", Social Change, Vol.43, No.2, June.

[22]http://www.thehindu.com/news/national/government-paid-private-insurer-crores-in-premium-for-ghost-beneficiaries/article5083382.ece), 2nd September 2013

spread of corporate hospital chains in Tier II and Tier III cities. The International Finance Corporation (IFC) of the World Bank has invested about 200 million dollars in India with loans to Apollo, Max, Rockland, Artemis etc. ICICI Venture invested 36 million dollars in Sahayadri Hospital, Pune, 24 million dollars in Vikram Hospital, Mysore, and so on. ICICI has recently been indicted for large-scale swindling of public funds under the RSBY scheme (*The Hindu* 2013).[23]

Table 1: FDI Inflows in Healthcare Sector (April 2000 to December 2012)

Sector	Amount (US$ Million)
Hospital and diagnostic	1,542.35
Drugs and Pharmaceuticals	9,783
Medical and Surgical Appliances	584.14

Source: CII-Grant Thornton (2013), "Bridging the Divide-for a Healthy India"

In such a situation, not warranted by public health considerations, there has occurred the irrational and overuse of such technologies, with Say's Law coming into play: supply in the health sector, it is over-determined, creates demand. The oversupply of doctors in the private sector has also led to unnecessary or over-medication of healthy people (Nandraj 1994).[24] Given differential emoluments, it also sucks out personnel from the public health system, with significant internal migration. Policy-led development of health tourism has contributed to this.[25] Ironically, this weakening of the health system from within watched over by the bureaucrats is paralleled by the decision of the government to reimburse the bureaucrats and their dependent family members for their travel costs and complex medical treatment abroad using tax money (Baru 2013).[26]

While India produces more than enough doctors–but not enough nurses–for her public health system, she is in fact facing an acute crisis in human health resources for the public health system (Rao *et al* 2011).[27] Over the same period there has been a burgeoning of medical colleges in the private sector, charging astonishing capitation fees. This has not surprisingly led to appalling standards of medical care, but also to high dowry rates (Srinivas 1993).[28]

Suffering a huge crisis of human resources in the public health sector, despite the overproduction of doctors, India has also emerged as a major exporter of health human resources.[29] Initiatives like the Global Commission on Macroeconomics and Health, presided over by Prof. Jeffrey Sachs, architect of Russia's disastrous shock therapy that saw unprecedented mortality rise, spawned similar committees in countries like India that have

[23]Nandraj, S. (1994), "Beyond the Law and the Lord: Quality of Private Health Care", Economic and Political Weekly, Vol. XXIX, No.27.

[24]There if a flourishing trade, a black market of body parts, in the private sector in India, including reproductive ones. Newspapers frequently report kidney removal scandals. There is also a burgeoning industry in assisted reproduction, including commercial surrogacy.

[25]Rama V Baru (2013), An official vote of no confidence, The Hindu, Chennai, Sept 16.

[26]Rao, Mohan, Shiva Kumar, A.K. Chatterjee, Mirai, Sundararaman, K. and Rao, Krishna D. (2011), India's Health Resource Crises: Too Many and Yet Too Few, Lancet, Vol.377, Feb.

[27]Srinivas, M.N. (1993), "Changing Values in India Today", Economic and Political Weekly, Vol.28, No.19, pp. 933-38.

[28]There is indeed a great deal of anecdotal evidence about unemployment among doctors in India, concentrated in urban areas, and fiercely competing for practice with little attention to medical norms or rational prescription practices. Reflecting this, it appears that doctors are the second largest category of applicants to the Indian Administrative Services exams. But, of course, we have no firm data. If data from the government sector in India is unreliable, there is in fact little data on the private sector which is even averse to academic enquiries.

[29]If institutions that were now selling the idea of governance, applied it to themselves, the WHO's Commission on Macroeconomics and Health should never have come into being, or Sachs appointed its head, after the health disaster his recommendations precipitated in Russia. But then issues of accountability and governance are always selectively raised. UtsaPatnaik has written angrily that AmartyaSen, who wrote about the Chinese famine deaths, vastly exaggerating the mortality, has not written about the deaths that Sach's measures imposed in Russia. See "Economic and Demographic Collapse in Russia", in The Republic of Hunger, Three Essays, Gurgaon, 2007.

repeated these shibboleths(Patnaik 2007). [30] These have been pungently, and indeed accurately, described as "neither public health nor macroeconomics"

There is an utterly tiresome uniformity here, a mantra albeit edged with schizophrenia. We therefore have an analysis of the problem that bears no relation at all to the solutions proposed. Thus while state institutions have been criticised for their failure to deliver there is simply no explanation as to why this has occurred, or indeed why the private sector is supposed to work better. There is an assumption that India is characterised by widespread state presence in all sectors of the economy and polity. In the case of the health sector, this is simply not the case. Along with a weak state sector, an unregulated and powerful private health care sector raises several issues of universal care, of comprehensive care and above all, of equity. Failing this, efforts at tinkering through projects carries the risk of consolidating the dual health care system that the country now possesses: one weak and under-funded for the vast majority of the population with no access to primary health care, and the other largely urban-based curative high technology health care for a minority of the population whose public health needs are taken care of. Larger macro-economic changes that have increased regional, rural-urban and class inequalities have compounded the problem. It is thus not surprising to note that despite the fact that economic growth over the nineties has been described as shining, India's position on the Human Development Index (HDI) globally, never shining to begin with, has fallen further into areas of darkness, from 127 to 132 (Rao 2007) [31].

That the public health system in India is dysfunctional, or inefficient is not the question; the question is did we ever seek to create a public system that was different– our budgetary allocations do not seem to indicate that. Yet these very features of the public health system created by public policy-have been utilised in the age of globalised governance to further weaken the public health sector, introducing incommensurable principles of the market into it, for the private sector to squeeze out further profits.

India was earlier characterised by relatively low costs of drugs and pharmaceuticals, along with a significant indigenous production of drugs It is now witnessed, with India signing on to the WTO, a greater concentration of drug production, a larger role for multinationals, a higher proportion of imported drugs and unbelievably steep rises in the costs of drugs (Sengupta 1996).[32] The following table provides clear evidence of the substantial growth of private pharmaceutical business in India as well as its rapid expansion, globally. With the growth of exports being much higher than domestic consumption, drug prices within the country are under pressure. A huge increase in the prices of essential drugs is visible even as its availability declines in the country. A discussion paper prepared by the Department of Industrial Policy and Promotion (DIPP) of GoI in 2010 maintained that this is despite the fact that India itself has a large unmet domestic demand for critical medicines(GOI 2010).[33] Around 65 per cent of the Indian population still lacks access to essential medicines. The share of drugs in OPD expenses were estimated at 63 per cent by NSSO 60th Round (January 2004). NSSO, in their report on the 61st Round indicated that this expenditure had increased to 82 per cent, though by the 66th round in 2010, a slight decline to 77 percent was seen(NSSO 2011). [34] As per the National Health Accounts, medicines accounted for 38–62 per cent of inpatient expenditure in rural and urban areas.

[30]Rao, Mohan (2007), "Health in the Age of Globalised Governance" in Kameshwar Chaudhri (Ed), Globalisation, Governance and Reforms in India, Sage, New Delhi.
[31]Sengupta, Amit (1996), "Economic Reforms, Health and Pharmaceuticals", Economic and Political Weekly, Vol. XXXI, No 48.
[32]GoI (2010) Discussion Paper on Compulsory Licensing, DIPP, New Delhi. 34 NSSO 2011: Key Indicators of Household Consumer Expenditure 66th Round 2009-10, NSSO, New Delhi.
[33]GOI, Ministry of Health and Family Welfare (2007), Select Health Parameters: A Comparative Analysis across the National Sample Survey Organisation, New Delhi.
[34]Baru, Rama, Acharya Arnab, Acharya, Sanghamitra, Shiva Kumar, A.K. and Nagaraj K. (2010), "Inequities in Access to Health Services in India : Caste, Class and Region", EPW, Vol. xlv, No.38, 18th Sep.

Table 2: Growth of Indian Pharmaceutical Companies

	1996–97	2008–09
Ranbaxy Laboratories	1146	4755.76
Glaxo Smithkline Pharmaceuticals	699.63	1668.08
Cipla	451.88	4807.67
Aventis Pharma	382.69	-
Piramal Healthcare	319.28	1665.42
Alembic	282.38	-
Torrent Pharmaceuticals	258.85	-
Cadila Healthcare	255.48	1765.40
Ipca Laboratories	251.15	-
Dr. Reddy's Laboratories	244.99	4394.90
Lupin	-	2934.25
Sun Pharma	-	2830.86
Aurobindo Pharma	-	2730.75
Wockhardt		1448.87

Since public health infrastructure in the country is limited and grossly inadequate to meet the health care demand, private health care has taken a dominant position—often with active state support especially with regard to treatment of routine illnesses. Private general practice is presently the most commonly used health care service by patients in both rural and urban areas. When India became independent in 1947, the private health sector provided only 5–10 per cent of total patient care. In the next few decades however, things changed drastically and by 2004 a large proportion of total ailments were treated from private sources—78 per cent in the rural areas and 81 per cent in the urban areas (GOI 2007).[35]

When it comes to utilisation of facilities, private institutions dominate in 2004, about 58 and 62 per cent of the hospitalised cases in the rural and urban areas, respectively, were treated by the private institutions. The proportion of government and private institutions in the provision of care has shown a stark reversal between 1986–87 to 2004, from a situation where about 60 per cent of the hospitalised cases were treated by the government institutions. A steady decline in the use of government sources and a corresponding increase in the use of private sources over the last three NSS rounds can be observed. The changes were, however, sharper during the period between 1986–87 and 1995–96 rather than between 1995–96 and 2004. Between 1986-87 and 1995–96, rural hospitalisation cases accessing private facilities increased from 40.3 per cent to 56.2 per cent—an increase of 15.9 percentile points—but between 1995–96 and 2004, the increase was only by another 2.1 percentile points. A similar deceleration occurred in urban areas too (GOI2007, *ibid*)) However, this need not be indicative of a trend as lately the government policy shows a marked tilt towards increased private sector participation in provisioning.

A comparison of the average medical expenditure incurred per hospitalised case for rural and urban areas for all the three NSS rounds show an increase in the overall expenditure over the three rounds. The increase has been steeper in the private sector even after adjusting for the general price rise. Another comparison of the hospitalisation expenditure of the two recent NSSO rounds, after adjusting price rise by CPI, shows a rise in relative expenditure by nine percentage points in rural private hospitals in a period of nine years as compared to rural government hospitals where it, more or less, remained the same. In urban areas, the government hospitalisation cost was 12 per cent more as compared to the earlier period of 1995–96 in 2004. Correspondingly, a steep 37 per cent relative increase in urban private sector cost for hospitalisation was seen (GOI 2007, *ibid*).

[35]See Neil Pearce (1996), "Traditional Epidemiology, Modern Epidemiology and Public Health", The American Journal of Public Health, Vol.86, No.5, pp.678-683; Ann V. Diez Roux, (1998) "Bringing Context Back into Epidemiology: Variables and Fallacies in Multilevel Analysis", American Journal of Public Health, Vol.88, No.2, pp.1027-32, M. Susser (1998), "Does Risk Factor Epidemiology put Epidemiology at Risk?" Journal of Epidemiology and Community Health, 52, pp.418-426, N. Kieger (1999), "Questioning Epidemiology: Objectivity, Advocacy and Socially Responsible Science", American Journal of Epidemiology, Vol.89, No.8, pp. 1151-53.

Comparative analysis of different NSS rounds compiled by WHO and the Health Ministry reveal that about 47 per cent of the total rural hospitalisation cases in the country were financed by the sale of assets or loans. This proportion ranges from 37 to 63 per cent across different income class of households. The high expenditure for hospitalised treatment in the private sector is a major reason for this. This was aggravated by the decline in the proportion of hospitalisation in the comparatively cheaper public sector. In urban India, about 31 per cent of the hospitalisation cases were financed by loans and sale of assets, with the proportion ranging from 13 to 55 per cent for different class of households. Both rural and urban areas show a steep rise in the financial burden of inpatient treatment. Alarmingly, the number of untreated ailments due to financial reasons has risen steadily. In 1986-87, the financial reason cited for not accessing health care by 15 per cent and 10 per cent in rural and urban areas respectively rose sharply to 28 per cent in rural and 20 per cent in urban areas in 2004 (GOI 2007, *ibid)*. It is not just the poor, but even the middle classes-the upper echelons of whom welcomed globalisation-are finding it increasingly difficult to meet medical care costs (Baru *et al.,* 2010).[36]

Health sector reforms in India, then, did not meet the goals it set out with. What it has in fact led to is a reinforcement of state policy towards a selective and targeted approach; a decline in public investments especially in primary care; increasing use of private sector facilities for both in-patient and out-patient care; a fall in levels of efficiency and effectiveness in the public sector; indeed a further squeezing out of the poor from access to publicly funded health care.

The characteristic feature of the World Bank-like approach to health–and not just in India–is the tendency to deal with disease and health merely at the individual level, to conceive of populations merely as aggregates of individuals, thus disregarding the social and economic context of diseases, has provoked a rich and heated debate in public health.[37] But central to this was the ideology of introducing market principles into hitherto sacrosanct areas of public goods, converting health care into a market-driven, profit-maximising enterprise. To do so it required a philosophical commitment to methodological individualism in public health, an oxymoron, but nevertheless achieved globally through the same institutions as the World Bank and the WHO, and new ones such as the Commissions on Macroeconomics and Health. This also meant a focus on proximate causes, leading to what has been described as individualising and psychologising health (Yadavendu 2003).[38] Thus, the dominance of the behavioural approach to public health, which has always characterised the major schools of public health in the US. This is not only hubris, but also profoundly cynical: the US has the world's most dysfunctional health care system.

In its influential 1987 document *Financing Health Services in Developing Countries: An Agenda for Reform*, the World Bank stated, "the approach to health care in developing countries has been to treat it a right of citizenry and to attempt to provide free services for everyone. This approach does not work" (cited in Gershman and Irwin 2000: 30).[39] The role of the state, then, was to be confined to regulation–and hence the salience of the phrase governance–while the private sector was to be encouraged, often through state subsidy, to take on the role of provisioning of health services, with the exception of a minimum clinical package, that ironically included family planning. Over this period, of course, the role of the World Bank in health sector development had increased enormously, while that of the WHO had shrivelled; indeed World Bank loans for one programme, malaria, exceeds the entire budget of the WHO (Rao and Lowenson 2000). The Bank is today "the largest single source of health care finance in developing countries with an unparalleled degree of policy-making authority"(Kim *et al* 2000:143). New players, INGOs, were

[36]Yadavendu, V.K. (2003), "Changing Perspectives in Public Health: From Population to an Individual", Economic and Political Weekly, Vol. XXXVI, No.49, pp.5180–88.
[37]Gershman and Irwin (2000), op cit.
[38]Qadeer, Imrana (2013), "Universal Health Care: The Trojan Horse of Neoliberal Policies", Social Change, Volume 43, Number 2, June.
[39]Planning Commission (2012) Report of the Steering Committee on Health for the Twelfth Five Year Plan, New Delhi.

now doing to public health what had been earlier done with population control–divorcing it from its determinants and building a market for technologies. At the same time, the health sector itself emerged as a leading source of multi-national profits as the health sector in developing countries was prised open for investment in a range of areas from high-level technologies to insurance and indeed low-level ones such as routine immunisations under the new WTO regimes.

HLEG AND UHC

A High Level Expert Group was set up by the Planning Commission in preparation for the Twelfth Five-Year Plan. The HLEG Report on UHC observes that compartmentalised initiatives of the government to regulate may have led to further fragmentation of an already segmented industry. It accepts that these were efforts to define standards for healthcare facilities. However, the problem according to HLEG lies in not having a single, unified system. Such a system is needed to establish standards applicable to both the public and the private sector and to monitor the functioning of health facilities and compliance with established standards, while ensuring complete accountability. The HLEG report recommended the establishment of a National Health and Medical Facilities Accreditation Unit (HLEG 2011).

The HLEG report defines Universal Health Coverage as "ensuring equitable access for all Indian citizens, resident in any part of the country, regardless of income level, social status, gender, caste or religion, to affordable, accountable, appropriate health services of assured quality (promotive, preventive, curative and rehabilitative) as well as public health services addressing the wider determinants of health delivered to individuals and populations, with the government being the guarantor and enabler, although not necessarily the only provider, of health and related services" (HLEG Report 2012). It visualizes making a choice between public sector facilities and contracted-in private providers available to patients.

The private health care sector assumes greater significance in the context of the recommendations by the HLEG on Universal Health Coverage as well as the Steering Committee on Health for the Twelfth Five Year Plan favouring a national health package to be implemented by public and private providers. It is getting increasingly clear with the publication of the 12th Five Year Plan document that any effort by the government towards universalisation will be through mechanisms similar to RSBY, running across the country. Looking at the RSBY's functioning over the last few years shows the pitfalls of tying up with private providers. In the absence of adequate regulations and enforcement machinery in place such a tie-up has had adverse impacts on the scheme. If Universal Health Coverage means such contracting with private providers on an even larger scale without reining them in, it would inevitably result in cost-escalation, large scale corruption, and eventual failure. There have been valid criticisms of health care being replaced by 'medical' care in such initiatives and HLEG report's silence on social monitoring mechanisms (Qadeer2013).[40] In line with the HLEG's recommendation of utilising private sector capacities via a "contracting-in" mechanism, albeit within a strict regulatory framework, the Steering Committee on Health for the Twelfth Five-Year-Plan too recommends leveraging the strengths of the private sector, subject to strict checks and balances. It also states that in a system of cashless access to an "essential" package, public health care facilities should be provided financial and operational autonomy to enable them to compete with private and non-governmental organisation (NGO) providers (Planning Commission 2012).[41] It has not, however, made clear how a historically-starved public sector will be able to "compete" with private and NGO providers. Obviously, a level playing field does not exist, as of now.

In the light of the submission of the HLEG report and the stakeholder consultations that followed heavily dominated by the corporate interests, and a health chapter in the 12th Five Year

[40]The 12th Plan Document clearly states that opposing insurance 'per se' is not 'realistic'

[41]Sengupta, Amit (2013), Universal Health Care in India Making it Public, Making it a Reality, Monograph, Alternatives to Privatisation Project.

Plan document which is seen to be tilting substantially towards insurance based schemes[42] and a much larger involvement of the private sector, one thing is clear: any future effort towards expansion of government-funded health care in India will have a major role for the private sector health care providers and various other profit seeking 'stakeholders'. The advocacy zeal in the 12th Plan Document in handing over public funds to the private health sector using the insurance mechanism is however uninformed by evidence. The overall managed care model that is being promoted heavily is known to promote profit maximisation at the cost of health. However, as Sengupta puts it, Universal Health Care today means very different things to different people. The dominant neoliberal argument equates care with 'coverage' through minimal, insurance-based packages. In contrast, a broader public health approach would require that health systems be publicly provisioned and publicly financed, as well as comprehensive, integrated and accountable to the needs of communities (Sengupta 2013).[43] Clearly, there are powerful forces at play trying to paint the UHC debate in India in totally different colours, equating criticisms to the current private sector dominant model proposed to right-wing critiques to Obamacare, terming every dissenting voice as "irrational protests" (*The Lancet* 2012).[44]

International evidence suggests that an insurance based system can be effective if-and only if-there is an extremely muscular role of the government in regulating *as well as provisioning*. Countries, like Thailand and Costa Rica, which have strong public systems have been more successful in ensuring universal coverage of government health insurance at reasonable cost.[45] In India, government provisioning is weak. In order to have a successful insurance model we need to build a public health system that provides good quality care first. In India although the private sector dominates service provisioning, it is extremely heterogeneous, largely under developed and completely unregulated. We do not even have basic statistics about the private sector, its spread and distribution, the quality of care or indeed its "efficiencies". Given the nature of private sector, market failures would be rampant and moral hazard problems are likely to prevail, as anecdotal evidence from Kerala suggests. This would further drive up costs and lead to use of unnecessary and unregulated technologies. Global experience suggests that the cost of administration and regulation, in private sector dominated insurance systems, is around a third of the total insurance cost. If that be the case, administrative costs alone would be more than what is being spent by the government currently on health.[46] We cannot clearly adopt such expensive models. Furthermore, the likelihood of an insurance based model being successful in India is rather low given extremely high levels of income poverty, a huge proportion of the population in the informal sector with varying daily levels of wages and high levels of under and un employment.[47]

Another glaring lacuna of the insurance based model is that it does not generally cover out-patient illness.[48] A study in 2006 showed that while per capita income grew at 3.76 per cent per annum, private health expenditure grew at the rate of 10.88 per cent per annum.[49] A substantive section of OOP expenses are for out-patient illnesses and a major of the expenses are in the form of drugs, tests and doctor consultation. We have recently had evidence of large scale fraud in

[42]The Lancet (2012), Editorial: The struggle for universal health coverage, Vol. 380 September 8,

[43]Indranil (2011): "Universal Health Coverage: Maximising Corporate Profit to Minimize People's Pain?",Budget Track, Vol. 8, track 2, Centre for Budget and

[44]Generally the experience has been that universal insurance based systems can be ensured at 3.5-5 per cent of GDP. If we assume that India would be able to mobilize these resources, and if a third of it goes towards regulation, as is the case in the USA, we would end up spending more than 1 per cent of GDP on regulating the private sector (Pollock, Allyson M (2004) NHS plc: The Privatisation of our Health Care, Verso, London.) Instead, this could be used to strengthen public systems of provisioning, drawing back people who have fled due to poor quality of services, among other reasons.

[45]Shiva Kumar *et al*, op cit.

[46]Kurian, Oommen C (2011), "From Right to Health to Right to Health Insurance",

[47]Info Change India; accessed online:http://infochangeindia.org/health/analysis/ from-%E2%80%98right-to-health%E2%80%99-to-%E2%80%98right-to-health-insurance%E2%80%99.html on 13.09.2011.

[48]Bhat, Ramesh and Jain, Nishant (2006), Analysis of Public and Private Healthcare Expenditures, Economic and Political Weekly, Vol. 41, No.1, 7th Jan.

the operations of the insurance schemes, with massive financial losses to the government as a result of "fixing" of the system by private insurance companies (*The Hindu* 2013, *op cit*).[49]

The sabotage of Alma Ata was neither accidental nor innocent. It emerged out of a new political economy both within India, and globally. The political class in India does not now even require the imprimatur of the West and its institutions: they were confident they had arrived at a muscular new India on the global stage.

[49]http://www.thehindu.com/news/national/government-paid-private-insurer-crores-in-premium-for-ghost-beneficiaries/article5083382.ece), 2nd September 2013

CHAPTER 6

Health in Tribal Areas in India

Satya Sivaraman

While it is quite laudable that the Government of India is seeking to adopt measures to improve the health situation of tribal populations in India there is more than a fair bit of irony in all this too. This is simply because, since Independence, it is precisely the Government of India that has been responsible for the deterioration of the health of India's adivasi populations.

Before I go into the reasons why this is so let me also add that the pauperisation of tribal populations on the Indian subcontinent started much before modern India was born. It probably began with the waves of migrations from particularly central and west Asia that have taken place over the last several millennia pushing the indigenous people of India away from the fertile river basins and plains areas into the forests, up the hills and towards the coast in search of safety and survival.

India is indeed a land of many ethnic groups, races, religions and communities but at the bottom of this melange are the indigenous people, who are the original inhabitants of this land but reduced to being an endangered species–like the tiger but without the international attention that the king of the jungle gets.

The serious exploitation of tribal areas in the modern period of course began with British colonialism, first under the East India Company and then the Raj. While the feudal and predominantly agricultural economies of the pre-British era had no use for the timber and minerals available in tribal occupied territories the British brought in the techniques to extract these resources. It is not a coincidence that the first great revolts against British colonialism were in the tribal areas where deforestation and mining had created great devastation and discontent.

Successive Indian governments have carried on the legacy of the British colonial regime and even more rapaciously than their predecessors. While the Partition of the subcontinent in 1947 is estimated to have displaced 20 million people and is acknowledged as a mini holocaust not many people know that more than three times the number of people–i.e., more than 60 million–have been displaced over the last six decades–all in the name of development projects.

The share of the Adivasis among the displaced is extremely high compared to their share in the population. While Adivasis form just 10 percent of India's population they form around 70 per cent of all those displaced due to mega government projects since 1947.

Such displacement has a devastating impact on the lives and health of tribal people particularly through deprivation of proper nutrition. The WHO says that any community with more than 40 % of its members with a BMI below 18.5 may be regarded as being in a state of famine. By this criterion there are various subsets of the population of India 0–the Scheduled Tribes, scheduled castes–which may be regarded as being permanently in a state of famine. According to Dr. BinayakSen, the well-known public health and human rights activist, this is nothing short of a genocide being carried out through deliberate state neglect of the Adivasi and Dalit populations.

The composition of the displaced thus reflects the social power different groups enjoy and different degrees of their hold over the state machinery. And that is the first political and social

reality that needs to be taken into consideration before analysing the status of health of India's tribal populations.

In other words before the Government of India does anything positive for Adivasis it should stop its discriminatory policies of displacement against the Adivasis of India. The first principle in medicine is 'do no harm' and that is the principle that the Indian government should adopt while dealing with the Adivasis of our country.

The next big problem that affects the health of Adivasis in this country is the way funds allocated by the Government of India for their 'welfare' are either stolen by the bureaucracy, middlemen or diverted for other purposes.

Take the case of SCP for Scheduled Castes and TSP for Scheduled Tribes that were instituted in the year 1978–79. These are the two plans which form an integral part of the SC/STs and Tribal welfare fund, where the government had decided that out of every 100 rupees spent by the government, Rs.16/-will be spent for Dalits and Rs.8/-spent for Adivasis every year; and that the funds would be used for such schemes that will directly benefit SC/ST individuals/households or SC/ST bastis/ tolas/ localities.

The government has instead, very conveniently, diverted a large share of this money for general schemes, hardly benefitting the Dalits and the Adivasis. One of the recent such examples being diversion and misappropriation of funds, which happened during the Commonwealth Games where a large sum of money was spent on building the stadia and other such infrastructure. This act on the government's part is utterly shameful. It demeans the importance of government budgetary planning and sense of justice.

In the union budget of 2012–13, a shortfall of Rs. 27526.78 crore to SCP and Rs. 11008.90 crore to TSP in violation of the SCP and TSP guidelines has been noticed. Even in the amounts that have been allocated, there is a 'notional' allocation (other than intended) of Rs. 6,229.96 cr. in SCP and Rs. 2267.05 cr. in TSP. In the XIth plan period alone Rs. 96,236.70 cr. was denied to Dalits and Rs 46,628.50 cr. to Adivasis, making a total of Rs.1,42,865.20 cr. for SCP/TSP by the Union Government alone. If the Union and state denials in this manner were to be aggregated, the amount denied would be double of what it is now at the Union level.

The problem unfortunately does not stop at the level of allocation of budgets meant for tribal development. Once the money has been allocated only a small portion of it finally gets used for the purpose it has been allocated with a bulk of it eaten up on way to its destination. This is a reality in all the tribal areas of India that very little of the money already sanctioned for welfare or infrastructure activities actually gets utilised. This has to stop immediately, though we all know that it will take nothing short of a miracle to achieve an end to such corruption on a Voluntary basis by those who benefit from such scams.

The issue of health is not just a matter of building new hospitals, supplying medicine or creating posts for doctors and nurses. It is well understood in medical science today that the social and economic determinants play a critical role in the prevention of diseases.

These determinants include provision of affordable food, clean drinking water, safe environments, sanitation, cheap energy, literacy and transportation facilities. If one goes through the data on all these factors available from tribal areas in the country one finds that they are the worst off sections of the entire national population.

Just to give some figures from Census data in 2011:

- 1.87 crore Adivasi households do not have the main source of drinking water within their premises.
- Out of these, more than 78 lakhs household will have to go a significant distance to fetch drinking water.

- Only about 24 lakhs Adivasi household–just below 10% of all Adivasi households–get tap water supply within their household premises; even outof these, 6.5 lakhs household get tap water supply from untreated sources.

A very important point for the Government of India to think about indeed is whether it is really capable of delivering anything good–whether in the sector of health or any other for that matter-without involving the Adivasi populations in the control of resources being spent in their name or consulting them on what really needs to be done. Here my suggestion is quite straightforward, that the Government first stop pretending that the Adivasis have no brains, no community organisation, no history of self-rule and no ability to look after their own interests.

In other words the Government and policy makers need to give Adivasi populations greater and greater autonomy over their own resources and the federal powers to decide their own futures. This need not be only at the state level, as with the formation of so called 'tribal states' like Jharkhand and Chhattisgarh but at the district and even block levels wherever Adivasi communities live in significant numbers.

It is only with such political autonomy and the exercise of sovereignty over their own land, forest and other resources that Adivasis can reverse the decline of their communities and achieve true welfare for themselves. What the Government of India needs to do, if it really cares for the health of the Adivasis, is to return what has been historically stolen from them (at least what was stolen since Independence), give them full political autonomy and even better go and learn some of the wisdom that has enabled the Adivasis to be the most environment, gender and child friendly people on the planet. It is time for Gabbar Singh to stop pretending that he is interested in the welfare of Basanti!

CHAPTER 7

Forest, Environment & Tribal Health

Dr. Pashupati Prasad Mahato

Most of the indigenous and tribal population in India are living in and around the forest and hilly terrains in Indian geographical situations. This environmental situation for centuries the indigenous or tribal/ scheduled castes and other economically backward classes explored and enjoyed along with their economy and love for the forest. There are many communities in West Bengal especially Birhor, Kheria, Bhumij, Kudmi-Mahatos, Santhals, Oraons, Munda, Ho, Bagal, Bedia, Rabha, Rajbanshi, Toto, etc are now forest and agriculture based communities. But for the last three hundred years we observed a very interesting human migration to Sunderban Regions and North Bengal including present Bangladesh. The destruction of forest for Indigo Plantation, exploitations of the East India Company and the Zamindars forced the indigenous/tribal population to revolt against the destruction of the forest.

The Revolt was organised by Kesu Aari, Kharia Sabar leader along with Raghunath Mahato in Salboni region in the then Jangal Mahal now in the District of South Midnapur. In a mass meeting of Lodha-Sabars at Keshiyari in 2011, organised by Prabhu Bhokta, the women participants while dancing sung a song:

"Keshu Aarir fansi hailo Raghunath Mahato bandai gelo Bansbone dom hoila
kana Rage jalchche Jangal Mahal thana."

(Keshu Aari was hanged, Raghunath Mahato was arrested, the whole Jangal Mahal region was burning and the oppressors failed to find another rebel liked Dom failing to recognize a good bamboo in the bamboo forest).

The people's memory is flowing from generations to generations. The indigenous or tribal people revolted against the East India Company or British authorities in 1767 to 1800 against their forest policies and indiscriminate forest cuttings and sending it to London via Tamralipta Port, which was known as Chuar rebellion. The British Authorities uttered the word 'Rascal' against them and in Bengali translation it became 'Chuar' Revolt. It is also most interesting for the plantation of indigo the indigenous and tribal people from Rarhbhum or present districts of Purulia, Bankura, Midnapore (East and West) and entire Jharkhand including Mayurbhanja, Keonjhar, Sukhinda of Cuttack and Sundargarh District of Orissa were forced to migrate as labour in semi slavery situation. I have collected a song, which is nothing but continuations of the people's memory:

"Nil lota kyte kyte, hath gelo phyte he Babur bap, Bapu bap, deno tuku kancha halud baite."

While cutting indigo plants, my hand became cracked, oh my son's father please prepares a turmeric paste).

After fifty years when the tea plantation started in Assam, these tribal people were forced to migrate to Assam teagardens. Between 1871 to 1921 nearly 9 lakh 70 thousand labours were forced to migrate because of drought, famine and forest cuttings of the entire regions of the tribal areas of West Bengal, Jharkhand, Orissa and Chattisgarh.

"Chal Mini Assam jabo, dese baro dukh re Assam dese re Mini Cha-bagan hariyal, Sardar bale kam kam babu bale dhari an Saheb bale libo pither cham."

Mini, (my small daughter), let us go to Assam, our region is poverty stricken. In the Assam area Teagardens are green, Sardar demands only work and work, the Babus (Clerk) demand our presence and the Sahib (White Man) will peel our skin from the back.

If we look back to the settlement pattern of the indigenous populations in and around the forest, we find very interesting environmental adjustment along with other ingredients of life with forest. Though food scarcity was there they could maintain good health. Forest provides them:

1. Food
2. Fodder
3. Fuel
4. Fertilizer
5. Farm implements
6. Family usable woods
7. Family medicine
8. Fresh air
9. Fresh water
10. Fresh and open area of traditional forest deities
11. Fresh area of love

This eleven "F" became major significant factors for their good health for generations after generations. While I was doing field work in "Birhore Dera" at Bhupati Palli village in Baghmundi Police Station in the District of Purulia in 1994-1995 and also in Murguma Dam area under Jhalda (Bekumkodar) Police Station. I find, the Birhor woman carrying the heap of wood on their head and traversing to 10-12 miles to local market of Kalimali, Dava-Torang, Bekumkodar etc. On the other hand the male Birhors are doing the same thing while carrying the woods from Baghmundi forest and hills. It is also observed that 'Lal-pimpra' or red-ant is a very tasty food, as we observed in Amlasole of West Midnapur villagers. They eat along with 'Mar-bhat' during the famine and scarcity of food. During my childhood when I visited Dava- Torang village of Baghmundi along with my mother to my 'Mamaghar', the house of Late Rajkishore Mahato and Late Kanka Mahato, who was the first choreographer of Manbhum School of Chhou Dance, I still remember the Jhumur song, sung by the villagers:

"Baghmuris pahare, lahar boro chetire Lohar doulate dader eri saman dhutire Hathe bhangi narkol, paye bhangi belre Mochrai bhangi je sarsha, gaye makhi telre."

(On the hills of Baghmundi, the shellac is full in the trees and through shellac; my elder brother is wearing the 'dhoti' upto the ankle. I break the coconut with my hand, marmelos with my leg. I twist the sorisha (mustard seed) and the oil of it is used by me in my body.)

The fruits of several trees in forest are very good for health. The fruits are mainly Aam, Jam, Kendu, Mahul, Bhurru, Piyal, Haritaki, Bhela etc. The forest trees also provided medicines along with the creepers. Inside the revier bed and shadow of tree, a very interesting food namely "Chatu" (mushroom) grows and mango-pickle, Jam, Bar-phol, Kendu, etc are used as food.

Mahua or Mahul tree provide the indigenous tribal people with the liquor, Haritoki and and Bhela trees are medicinal plants. Besides, various types of insects are palatable to them. Due to forest cutting in Baghmundi and Jhargram region, especially the whole of Jangal Mahal, by the notorious Forest Act of 1796, the Birhors of Purulia, and Kheria, Lodha-Sabars of Purulia and Midnapur are suffering from 'Pathophobia' and becoming sickly and feeble. On the other hand the

use of Kendu leaves; make the employment of not less than 5 lakhs of people as *Biri Sramik* in Purulia, Bankura, Murshidabad etc. The use of Sal leaves as Patri, Khala, etc also provided 2 lakhs employment in Jangal Mahal, Singbhum and Mayurbhanja, Keonjhore, Sundargarh regions of Orissa. The collection of Kendu, Palash and Sal leaves are becoming curse to them. The forest guards and Rangers including D.F.O: etc. consider themselves as Semi God to the indigenous people who are living in and around forest in "Rakab" region in Baghmundi region and "Matha" region, etc.

The villagers selling the dry woods in markets are very much afraid of the forest officials. The entire groups namely, Kurmi, Santhals, Bhumij,

Munda, Deswali, Majhi, Kheria, Sabar, Lodha, who are living in the forest regions are extremely feel terrorised of the forest officials. But the annual hunting festival or "Desh-Sikar" or "Disum-Sendra" on the day of Buddha Purnima has become very colourful in which thousands and thousands of tribal and indigenous people participated in Ajodhya Hill. In respect of tribal health, the various types of bush and bark of some medicinal trees namely, Arjun, Haritoki, Piyal, Kendu, etc are very important to the tribals. As of now, the Alopathic treatment especially the cost of medicines, fees of the doctors, medical tests including blood tests are becoming very costly. On the other hand, the plantation of Eucalyptus and Akashmoni trees, which grow rapidly in Purulia to Salboni–Jhargram forest regions became a profit earning trees in place of traditional costly and medicinal plants and trees. Thereby the health of the indigenous and tribal people is deteriorating very fast.

CHAPTER 8

Displacement & Health of the Tribal People

Dr. Punyabrata Gun

While discussing about the prime grounds behind displacement of any population from their own land different categories and forms of human encroachment usually get evolved like erection of industries, cities & towns; development of dams and highways, indiscriminate growth of power plants and mining works. In India, in between 1955–1990 almost 2 crore and 10 lakhs people had been evicted for the sake of development. In the year 2007, total 2crore and 13 lakhs population had been expelled from their soil, which can easily outnumber the population evicted between 1955–1990.

Within 2 crore and 13 lakhs displaced population, 1 crore and 64 lakhs people had been evicted for dam building purpose, 25 lakhs and 50 thousand for mining plant, 12 lakhs and 50 thousand for industrial development whereas creation of national parks & sanctuaries had forced 6 lakhs of people become land & property less.

It is been statistically revealed that 40 % of the total displaced population was tribal and indigenous people while 8.2 % of the entire Indian population constitutes of these ethnic people.

Offspring of soil, being evicted from their home land are living like refugees; dams, reservoirs, highways are compelling them to leave their own land! Displacement not only comes as a bolt from the blue in their life but also makes it miserable enough, coupled with abject poverty, economic fragility and thus destroys them socially.

Kaleidoscopic mosaic of various issues like landlessness, unemployment, scarcity of healthy habitat, marginalization, paucity of food and fodder, increasing rate of diseases and fatality, deprivation from enjoying natural resources and receipt of various welfare services and above all violation of human rights have close-knitted relationship with displacement as such.

Uprooted population often become the victims of social pressure and psychological hazards. After being rehabilitated in a new environment, evicted people often fall prey to various diseases especially parasite and insect borne maladies like malaria. Severe dearth of potable drinking water and sanitation system often leads to increasing risk of getting diarrhoea and outbreak of dysentery and other water borne diseases. In the midst of them elderly people and newborn are in high risk of contracting illnesses and sometimes death.

Coming to the topic, Health–according to WHO health is not only the absence of diseases or any disability but also the social, psychological and physical well being of an individual.

Let us count on the health of tribal and indigenous people of our country. We are not uttering these words on our own, but 10th Five Year Plan under Planning Commission of India describes the fact that–"tribal women and children are usually suffering from undernourishment which leads to physical weakness and poor immunity that further results in permanent impairment of brain. Most of the tribal women suffer from anaemia and they usually get tired, frequent childbirth hinders their working capacity as well as increases the risk of getting illnesses. Poor nutritional status of tribal women influences their reproductive health which is compelling them to give birth to the low weight newborn–longevity, growth & development of the newborn get hampered most of the time".

It has been seen that daily food list of tribal and indigenous people lacks Calcium, Vitamin–A & C, Riboflavin and animal protein.

Following table can provide us with clear picture of well being of tribal women and children.

Indicators	Tribal NFHS-II	Tribal NFHS-III	Non-Tribal NFHS-III
Average age at Marriage (%)	15.8	16.3	18.1
Awareness regarding Legal Age of Marriage (%)	7.5		22.0
Fertility Rate	3.06	3.12	2.68
Mean Age of giving birth to Ist Child (in years)	18.8	19.1	20.6
ANC received during Pregnancy (%)	43.1	37.8	22.8
Delivery at Home (%)	81.8	82.3	49
Child Mortality Rate	84.2	62.1	57
Breastfeeding Status (in months)	2.9	3.1	1.9
Full Immunization (%)	26.0	31.3	53.8
No-Immunization (%)		11.5	4.3

Source: NHFS-II and NFHS-III

Let us have a glance on Chhattisgarh for obtaining the unholy nexus between displacement and tribal health.

Emerging from the womb of Madhya Pradesh, Chhattisgarh as a distinct State has come into being from the year 2000. It is the part of Central India, which is impregnated with highest number of tribal population of our country. Tribal people constitutes 31.8 % of its total population and 11.6 % are counted as scheduled castes. 21 % of land is denoted as forest land in India where 44 % of the overall land in Chhattisgarh comes under wooded area. Tribal concentration is found mostly in forest villages. Chhattisgarh is very rich in mineral resources; iron-ore, bauxite and calcium stones are frequently available over here. This is the only state, which is rendering India with tin-ore. Latest excavation reveals that this area is also loaded with gold, diamond and corundum. However, mineral resources are accumulated by 'Mother Nature' in those forest lands, infested with tribal people. Mining excavation means deforestation and uprooting of ethnic people from their villages.

The largest industrial development in Chhattisgarh came under the aegis of Vilai Steel Company. But rapid industrial development in this area had started its journey from 1990s. At the present day, Government has proposed to initiate 60 Coal-Power Plants generating 50,000 MW electricity; even though the State is now in need of 5000 MW electricity. More than 40 Steel Plants will be erected soon; big cement factories are also in the offing. Raw materials of these plants are being supplied from forest areas; therefore tribals are forcibly displaced from their own land.

Let us see the scenario of well being of the tribals in Chhattisgarh.

We can't collect the data on health indicators of tribal people in Chhattisgarh in comparison with rest of India; similarly we can't gather comparative data on tribal and non-tribal segment of Chhattisgarh. However, we can show you the difference between tribals and non-tribals as one-third of the total population of Chhattisgarh is covered by tribals and indigenous people, which represent the one biggest share of total tribal population of India.

Table 1: Major Health Indicators

Health Indicators	Chhattisgarh	India
Birth Rate	25.2	25.0
Death Rate	8.5	8.1
Death Rate among Newborn	70	63
Life at Birth (1991)	61.4	57.3
MMR	498	406

Let us see the availability of essential or basic facilities for ensuring healthy life of Chhattisgarh population.

We can get the difference between rural and urban situation. Most of the tribal people are living in villages or rural areas.

Table 2

Basic Facilities Received	Overall	Rural	Urban
Electricity	31.8 %	25.4 %	61.2 %
Potable Drinking Water	51.2 %	45.1 %	79.6 %
Toilet	10.3 %	3.3 %	42.4 %
Above three	7.6 %	1.5 %	35.6 %
None of the above	36.1 %	41.9 %	9.6 %

Table 3: According to National Family Health Survey-II, 1998–99 and District Level Household Survey, RCH, 2002–2003

Indicators	Chhattisgarh	India
ANC Received (%)	41.7	73.4
Institutional Delivery (%)	20.2	40.5
Full Immunization (%)	21.8	42.0
Child Mortality Rate within One Year (%)	80.9	67.6
Child Mortality Rate within Five Years (%)	122.7	94.9

Above statistical data of Chhattisgarh are collected prior to "Operation Green Hunt". "Saloa Judum", the refugee camps of displaced tribal can leave a clear picture of "well-being of ethnic people after eviction"- but it is impossible to be intervened.

With this small report, a single message conveyed the tribal and indigenous people are not well. Each and every minute they are being ripped off from their own niche build over the years. It is asserted that ensuring tribal rights to receive the quintessence of natural resources is more important than that of sending mobile medical van into tribal belts.

CHAPTER 9

Recommendations National Seminar on Achieving Healthy Tribal Community in India

HEALTH

1. Encouraging tribal people to participate in the VHSNC for planning, implementation & monitoring of activities. There should be a mandatory list of priorities as identified by the tribal people to be considered in district-wise Plan of Action (PoA) for NRHM or area-specific health plans for the tribals to be prepared.
2. For every tribal habitation and hamlet, ASHA and Anganwadi Workers (from the same community), irrespective of the size of the population of the habitation or hamlet, are to be recruited. The seat reservation of tribal girls in recruitment of ASHA & AWW is to be given priority.
3. Keeping in view the mis-utilization of RSBY by the private sector, there is an urgent need for regulation of private sectors through effective enforcement mechanism by involving medical experts as well as tribal people and NGOs.
4. No coercive targets, incentives & disincentives are to be adopted in Family Planning Programme while contraception accessories are to be available in all CHCs, PHCs and Sub-centres as well as in the small multipurpose shops, in business in tribal areas. However, for the Primitive Tribal Groups (PTGs) who are on the verge of extinction should not be exposed and linked to the family planning much.
5. To make the CHCs, PHCs and Sub-centres as tribal friendly institutions, the existing staffs should be trained on tribal specific health care and needs, they should be fluent in language the tribal people use and the personnel to be recruited in future must preferably be from tribal community, if not, the people from the community is to be selected as the in-charge of public relations. To make Adivasis confident to come to the health centres there should be a bunch of health workers attached to the Govt. facilities who are non-racist in their attitude and are aware of the tribal culture and its system of medicine and healing. The top-down behaviour of the medical staffs should be strongly discouraged:
6. Traditional tribal healing system is to be promoted through training of the traditional healers under the supervision of AYUSH doctors, documentations of traditional practices, ethno botanical conservation, formation of district-wise platform of traditional healers to be effectively engaged in dialogue with the counterpart, Govt. officials, medical experts and like.
7. The NGOs can play a pivotal role in advocating the tribal issues and orientation of the leaders of the tribals and PRI counterparts at the local level.
8. A nationwide status report on the tribal with the special focus on health is to form an important step. However, there should be a check on the status of health of the tribal without any benefits reaching out to them. There is also a need of impact-assessment of various Tribal Development Programmes that have been implemented for years by the Government and NGOs. Most importantly the epidemiological studies are to be conducted in every tribal species to finalize the tribes' specific health service delivery.

Segregated data on tribal health should be made available through Annual Health Survey (AHS) for better need assessment and planning. The inter-state variations in terms of tribal development should also be looked upon.

9. PHCs are to be strengthened and be conveniently located for the tribal people as regular functioning of health centres for primary health is crucial. However, initiatives should be taken in strengthening of infrastructure in tribal areas not through ad hoc PPP projects, but through adequate state provision of quality health care so that people are not driven to the private sector. It is also to be noted that as Mobile Medical Clinics are not very effective in the tribal areas where low health care seeking behaviour among the tribal could be detected. In many a case it was found that MMC services are not accessible enough to remote communities; geographically, economically & culturally. The demand generation through pictorial, theatrical & audio-visual presentations, in local dialect and language and by the local tribal people should be given a priority. As the tribal hamlets or habitations are located in the difficult terrains without all weather road facilities, there is a need for outreach healthcare services by trained health workers preferably from tribal community for equitable distribution of health care service delivery. As the tribal people are used to function in their own area of existence hence their needs and requirements are to be respected and catered to in their own terms and not by compelling them to visit of places to receive the health care services that is alien to them. To give basic training in basic medicines to local people including the traditional healers or anyone who is motivated to help their community in this way with a hope that it could be complemented at minimum cost of training and this could lead in avoiding the dependency syndrome on the external help. In addition, services like VHND, Home Based Care for Pregnant Women & Newborn and availability of drugs at tribal village level for primary health care are to be strengthened.

10. There should be repository of tribal health and development related information, positive experiences, what works and what doesn't, the IEC materials in tribal languages and the orders of Govt. at various levels to be available free of cost and at one go.

11. Legislation on industrial diseases should be effectively enforced. A huge shift is needed to ensure the correct diagnosis and treatment and also to require correct safety measures and equipments in mines, factories, stone crushing units, etc. (especially to protect silicosis and the like) and to ensure proper compensations for sufferers of industrial diseases and their families.

12. The practice of distributing asbestos roofing to adivasi villages should be stopped without any delay. Similarly, use of traditional cooking pots has to be encouraged as these are good for health and cooking in aluminium utensils should be discouraged.

13. There should be synergy between NGOs, Govt., private players and PRIs in strengthening the inter-sectoral convergence for implementation, planning and monitoring of health and developmental activities in tribal are as. Incorporation of tribal health in various training plans and mainstreaming of tribal health strategy can go a long way in this regard.

14. There should be special awareness programmes on human anatomy, human reproduction along with reproductive rights among tribal women in general and tribal adolescents in particular.

15. The poor and limited health infrastructures are to be taken care of and renovated according to the need of local tribal people. The doctors and technical staffs working in the tribal area should be given special incentives. Nevertheless, HRH issues to be readdressed in the areas where tribal people dwell. The health facilities are to be widely publicized in tribal languages. In the same way the citizen charters and service availability should be circulated in tribal language. It would be helpful if cultural and linguistic competence related measures are integrated into Performance Improvement Programmes, Patient Satisfaction Assessment and Outcome-based Evaluations.

16. Inclusion of mental health and environment sanitation is to be given its due importance in tribal health policies and programmes.
17. Screening programme for non-communicable diseases particularly cancer (particularly oral cancer-since tobacco chewing will be high) can be done once in a month in CHC/PHC in the tribal areas
18. To make the referral system cost-effective, feasibility studies is to be carried out for establishing specialized hospitals at the vicinity of the tribal people.

CROSS-CUTTING ISSUES

1. Concept of promotion of herbal farms and horticulture farms, provision of cultivation of millets, cereals etc. in the tribal areas is to be promoted sincerely. The Public Distribution System should be universal in terms of access to it for the tribal people.
2. The block, district & state-level Tribal Development Agency consisting of tribal people and informal leaders is to be formed for the protection of entitlements of the tribal in respect of divestment of land and forest, access to schools and other educational institutions and water bodies, forceful eviction and displacement, etc. The challenges of promotion of healthy tribal community of India can't be resolved through compartmentalized interventions. Problems like violent land appropriation and displacement, plundering of their resources like jungle and water bodies, overt and covert discriminations as well as lack of recognition of their own institutions and self-imposed cultural silence complicated the scenario. Hence, involvement of Adivasi people in decision-making at all levels should be highlighted. Lastly, land and healthy environment are the two important indispensible parts in promotion of tribal people's health, rights, choice, voice and identity, which should be given utmost priority.
3. Organizations like NGOs,/CBOs can play a facilitative role in forming a platform for various tribal organizations and people to come together to raise their voices as well as choices.
4. Monitoring of mid- day meal programmes in schools located in adivasi areas (monitoring of quantity of food materials supplied and quality of food)
5. The Govt. officials at various levels should be sensitized regarding the rights and schemes for the tribal people.
6. Female literacy is to be given priority with seasonal and time flexibility and in this regard Family Centred and Community based Schools by educated tribal youths could prove helpful. However, tribal specific contextual educational curriculum with required flexibility and in tribal language should be given priority.
7. A focused approach in addressing inequalities in social and economic well-being within and between various tribal groups and non-tribal groups might result in reduction of inequalities.
8. The ICDS performance data should be desegregated to understand the real picture and thereby taking an informed policy decision.
9. Improve water and sanitation situation by effective engagement of tribal people. The public water bodies are to be handed over to the tribal community to manage their own water resources and in no case it should be taken away.
10. Effective integration of Forest, Education, Social Welfare and Women & Child Welfare Departments & PRIs is the need of the hour.
11. Provision of adequate housing & proper disposal of rubbish, sew-age, solid waste and draining of stagnant pool of water.

12. The ICDS workers, Gramsevak & Gramsevikas and other Govt. workers, NGOs, CBOs can be involved in encouraging tribal people to promote nutritional eating habits, non-smoking habit & alcohol intake would be helpful.
13. Poverty Alleviation Programmes such as Mahatma Gandhi National Rural Employment Guarantee Act and others to be effectively implemented and monitored and must be linked with existing health care programme (s).
14. Lastly, there is an urgent call for holistic vision of health and developmental interventions for the tribal people in India, which should be more integrated, more pluralistic and more upstream than that of the present that we have been experiencing.
15. Media advocacy, sensitization of media people for equitable coverage for the tribal should be given due importance. For this an advisory to be issued by the appropriate authorities. The best coverage on tribal issues also be recognized and rewarded duly.

Author Index

Contributors Profile

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Dr. Felix Padel is the great grandson of Charles Darwin and is living in a remote village of South-west Orissa for the last 17 years. Felix Padel is a freelance anthropologist trained at Oxford and Delhi Universities. His first book, The sacrifice of human being: British rule and the Konds of Orissa (Oxford University Press, 1995), analysed the imposition of colonial structures over a tribal society. His famous book Sacrificing People: Invasions of a Tribal Landscape has been published by Orient Blackswan in 2010. He is also a performing musician in Indian and Western traditions. He is now associated with IIHMR, Jaipur, Rajasthan

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Mohan Rao is a Professor at the Centre of Social Medicine and Community Health, School of Social Sciences, Jawaharlal Nehru University, New Delhi. He is a medical doctor, specialized in public health. He works on health and population policy, and the history and politics of health. His publications include From Population Control to Reproductive Health: Malthusian Arithmetic (2004), Disinvesting in Health: The World Bank's Health Prescription (edited, 1999), and The Unheard Scream: Reproductive Health and Women's Lives in India (edited, 2004).

(Networking & Media Operations): Satya Sivaraman is a print and broadcast journalist with over 25 years of experience in South and Southeast Asia. Having started his career with India's English language press, he moved to Thailand in 1992 where he was special correspondent for New Delhi Television and Senior Writer with Asia Times. He worked as audio-visual consultant for UN ESCAP in 1999-2000. He was then series producer for Young Out-look, featuring young social activists in 25 countries round the world. Currently he is working with ReAct on themes ranging from finding new ways of communicating the human-microbe relationship to mobilizing popular movements around Antibiotic Resistance issues.

Dr. Pashupati Prasad Mahato stood first class first in M.A. (Anthropology) in 1966 from Ranchi University. He was conferred and awarded with D. Litt for his outstanding research on "the Social mobility movement of the Kudmi Mahatos of Purulia and neighbouring areas of Bihar & Orissa" from Ranchi University in 1995. He is life member of the Asiatic Society and member of the Anthropology Sub-Committee and Institute of Historical Studies, Kolkata and life member of Indian Association. He was awarded "Jharkhand Ratna: in 1994 by the Jharkhand Buddijibi Manch and "Banga Ratna" in 2009 by the "Better World" and Indian Free Lance Journalist.

Dr. Punyabrata Gun, who had been associated with Shankar Guhaniyogi and Shaheed Hospital, now has been working in the Shramik-Krishak Moitri Swasthya Kendra in Chengail of Howrah district, this was established at the initiative of the Sangrami Shramik Union of Kanoria Jute Mill. He also a co-founder of Shrama jibi Swasthya Udyog. He strongly believes medical care and health system can be made accessible to everyone even in this economy where all prices are shooting up.

Dr. S. Nagarathinam is Head and Associate Professor of the Department of Communication, Madurai Kamaraj University, Madurai, India. He was a winner of EU-India Media Award and the UNFPA-Laadli Me-dia Awards. Previously, he was associated with Dinamalar Newspaper and the Times of India Group, Bangalore. He has 15 years of experience in writing, editing and researching topical interests. He also served in teaching and trained in FTII. He is committed for the cause of Media, Health, Environment etc., He was a fellow of Reuters Foundation, New York, USA and the Lilly MDR-TB Media Partnership. He won bursaries for traveling and writing research news articles from Thomson Foundation, UK and INTERNEWS Network, Chennai. He is a member of expert Commission on Education and Communication of International Union for Conservation of Nature-IUCN, Switzerland.

Mr. Nirmalya Mukherjee is having more than 15 years of experience in designing, managing, & evaluating health & development projects. His roles in NGOs allowed him to gain great insight into the mindset & living pattern of various tribal groups. He is a trained and professional social worker and pursued another master degree course in Public Health from Mahidol University, Bangkok, Thailand during 2009–2010. At present, as a technical head of MANT, an organization of repute, he is managing the Mobile Health Care delivery project in 4 districts (supported by NHM); Tobacco Control Initiative in 7 Districts & Communication for Development initiatives aimed at providing avenues for airing tribal people's voices and choices and thereby promoting the identity of them. Previously he was also In-charge of Tribal RCH Project to cover half-a-million of tribal people of hardest to reach areas of 6 Districts of West Bengal for 5 years. He is also involved in various public health researches, some of which published in reputed journals.