Chapter VIII
General Observation and Conclusion

The concept health and disease vary from culture to culture. Every culture, irrespective of simplicity and complexity has its own beliefs and practices and laid customs concerning with health and disease. No culture works in a meaningless fashion in its treatment of diseases. Every culture evolves its own system of medicine in order to treat diseases in its own way. Inspite of the fact that traditional system of medicine is disappearing or has disappeared in many societies, a large number of people in tribal and rural areas were still depending on the traditional system of medicine.

In the present study an attempt has been made to examine the various issues of health and forest with reference to the tribal people. In this context concept of health and disease, medical system, related religious practices and nature of treatment have been studied. Along with this, to understand the relationship of forest with tribes, the cause of deforestation and its consequential bearing on the tribals as well as the effects of the afforestation programmes on them have been examined. Forest development and people's participation in forest management have been the other important issues for discussion under the present study. The study also emphasised on the changing relationship between the forest and the tribals. The present study was conducted on the Ho tribe which is one of the major Scheduled Tribes of Jharkhand State and distributed mainly in the districts of West Singhbhum, Seraikella-Kharsawan, and East Singhbhum covering urban, rural and forest areas. The study was carried out at selected tribal villages of Chaibasa and Khuntpani Block in the District West Singhbhum, Jharkhand, India. The area was chosen as it was a tribal dominated area with a rich forest resource.

Three types of villages were selected on the basis of scope and objective of the present work. The categorization was done on different criteria like distance from the town and forest, access to modern health facilities and communication. Accordingly Rangamati and Petapeti villages were selected representing Type-I category, which was far from the town with limited health facilities and inside the forest area. Again, village Guira was selected representing Type-II category not far from town and forest area and village
Dumbisai was selected representing Type-III area which was located far from forest area and very close to urban area having modern health facilities.

The present study deals with the health situation and treatment of different diseases among the tribal people of selected villages in different situations. Data were collected on different types of conception about disease, healing practice and traditional medicine among the Ho community along with different magico-religious practices prevalent among them. Role and activities of the traditional medicine man, doctors and quacks were also studied. One of the issues of the present study was to know the implementation of different preventive and promotive health care services followed by the governmental organisations like Integrated Child Development Services.

The health situation of the population of a country like India can be improved with the amelioration of the health status of the exploited section of the population. In India these can be achieved through the improvement of health scenario of tribal people residing in different parts of the country. It has been observed that the individual's health is strongly influenced by their environmental conditions and lifestyle and that these factors produce marked inequalities of health. To know the over all health situation of a population it is very crucial to observe their day-to-day health practices and knowledge about health and hygiene. Special attention was given on the availability of drinking water and nature of sanitation facilities.

The overall health status of the poor and socially excluded population over large parts of Jharkhand is very poor. The reasons for the poor health status of millions of people of Jharkhand are not hard to find. Major factor hindering access to quality health services are lack of or non existing inter-sectoral linkages between different stake holders. Government of India has launched the National Rural Health Mission to carry out necessary correction in the basic health care delivery system. Jharkhand is still struggling to capture the opportunity for expansion of health services to the last person and meeting the missions, goal and objective such as reduction in IMR and MMR, access to public health services, prevention and control of communicable and non-communicable diseases, access to primary health care, population stabilisation, gender and demographic balance, revitalisation of local health tradition and mainstreaming AYUSH and promotion of better healthy life style. The mission was committed to provide quality health care at
the grassroots but there are lot of implementation challenges in achieving the mission’s goal and providing health care services to rural population.

Forest is an important part of the environment. India has been confronting an environmental crisis as a result of rapid environmental degradation. According to State Forest Report (SFR) 2005, the total forest cover of the country is 677,088 km² and this constitutes 20.60 percent of the geographical area of the country which is very low for a country like India.

It is very important to assess different pre and post independence forest policies to understand the relationship of forest and tribe. Before the British came into power, the forest dwellers had full freedom to use forest resources. However, during that period there were certain traditional restrictions in the cutting of certain varieties of trees. After the British advent they realised the commercial value of the forest and as a result of this they tried to impose certain restrictions on its use. All these were done in the name of conservation of forests. A memorandum providing guidelines restricting the rights of the forest-dwellers to conserve the forests was issued in August 1855 and was later modified in 1894. In 1865 by virtue of the Forest Act, the Government was empowered to declare any land covered with trees, brushwood or jungle as government forest. The breach of the provisions of the Act and rules were laid down for confiscation of implements used in the offences and for the arrest of offenders. Thereafter, in 1878 in Indian Forest Act, the forests were divided into: (1) Reserved Forests; (2) Protected Forests, and (3) Village Forests. The National Forest Policy, 1894, Indian Forest Act, 1927 and Government Forest Act, 1935 were mainly framed for the purpose of ensuring the supply of timber and other resources to the British forest based industries. In fact, the British forest policies were mainly aimed at supplying of timber and other resources to British forest based industries and commercial exploitation of forests was encouraged at the cost of the tribals in the name of national interest.

After independence the new National Forest Policy was issued as a Government of India resolution in 1952. The policy emphasised ecological and social aspects of forestry and gave only secondary importance to the needs of commerce and industry as also the need for revenue. The National Forest Policy was an extension of the policy during the British rule and laid down that the claims of the communities living in and near forests should
not override national interest. Tribals living near forests were discouraged from using forest whenever possible. This was strictly because of the role of the Forest Department who blamed the tribals for the random destruction of forest. But in many studies it was clearly showed that the forest was better preserved by the forest dwellers. The National Commission on Agriculture (1976) advocated the commercialisation of agriculture at all costs and with disregard to the sustenance, tribals derived from the forest. According the Commission,

"Free supplies of forest produce to the rural population and their rights and privileges have brought destruction to the forests and so it is necessary to reverse the process. The rural people have not contributed much towards the maintenance or regeneration of the forests (1976:25)."

The Commission recommended that functionally all forest land should be classified into (i) Protected forest; (ii) Production forests, and (iii) Social forests. The Commission gives priority to the production forest and lower priority to the social forest. The emphasis of the Commission is on man made forests, also called production forests.

The provision of the Indian Forest Bill (1980) clearly shows pro-rich, pro-urban and anti rural-people bias. The Bill classifies forests into three categories: reserved forests, protected forests and village forests. The distinction was mainly based on the people’s rights over forest produce. The Bill emphasises forest protection not for the people, but from the people. The principal aim of the National Forest Policy (1988) is to “ensure environmental stability and maintenance of ecological balance including atmospheric stability, which is vital for sustenance of all life forms, human, animal and plant.” The National Forest Policy, 1988, has a separate section on ‘Tribal people and Forests’ which states that: “having regard to the symbiotic relationship between the tribal people and forests, a primary task of all agencies responsible for forest management, including the forest development corporations should be to associate the tribal people closely in the protection, regeneration and development of forests as well as to provide gainful employment to people living in and around the forest.” The degradation of the forest and the restrictions imposed by the Forest Department on the rights of the tribals in so far as the forest was concerned made an extensive change in their life system- their economic and socio-cultural systems.
To the Ho people, the term health means "the right functioning of the body." According to them the causes of illness are: natural causes, human agency and supernatural agency. Diseases due to natural causes are cured by their indigenous pharmacopoeia. The diagnosis of the disease was done by the deonwa. According to the traditional healer the examination of urine (dukida) is the common method of diagnosing the disease. The malignant Bongas are believed to cause diseases to persons and herds by direct interference. In the present study it was found that the concept of disease and the nature of treatment vary. It was noted that people in Type-I area observed their own knowledge of belief system behind disease and nature of treatment. The villagers of Type-II area have more or less the same belief regarding the concept of evil sprits behind the causation of disease. In the scenario of Type-III village the concept about the belief of evil eye behind the cause of disease was somehow changed and it may be due to the urban influence. Most of the educated persons did not support any relation between supernatural belief regarding health, disease and treatment, but it was conspicuously present among the older people and females.

In the studied areas traditional healer plays a very crucial role particularly in Type-I and Type-II areas, where people were much depended upon them. The reason was people easily access them whenever they needed any assistance. In Type-III area people go for modern a medical treatment which was easily accessible by them. It was noted that the studied villagers were willing to avail the traditional way of treatment considering the availability and efficiency of the healer. The other problem was the non-availability of medicinal herbs from the forest either due to deforestation or afforestation. Forest was inaccessible for many of the villagers and traditional healer due to different forest policies. But despite of the said constraints, it was found that in all the studied areas tribals were treated by traditional medicine man and they were also satisfied by the approach and attitude of the healer. In many cases it was found that by traditional healing treatment the patients were fully cured. It is true that the role of traditional healer in their society is closely associated with the norms and values as well as the same cultural background established a conspicuous advantageous position in the society. Furthermore the nominal charges in cash or kind created an easy accessibility which was another opportunity for the economically backward people. These facts state why the traditional healers have a strong hold and respectable position in tribal societies. The same cultural domain of healers and patients ensured a constructive framework in this regard.
In most of the diseases recognised specific indigenous medicines were commonly used. Most of them were quite effective. Hos have an extensive knowledge of herbal drugs which they gained from their forefathers. Their faith on indigenous medicines was probably strengthened as they were often cured after the application of the traditional medicine.

The frequency of diseases showed that intestinal disorders, arthropod diseases (malaria, unspecified fevers), diseases related with blood forming organs (anaemia), respiratory disorders, diseases of digestive system, skin diseases were fairly common. This is understandable because the disease pattern reflects the existing health care practices, environmental sanitation, food habits and lifestyle of the people.

It was noted that in Type-I area, villagers did not get the benefit of modern health facilities due to long distance and lack of communication facilities. Despite the said constraints sometimes the health workers visited the village during vaccine days of children. In PHC near to Type-I area patient had to treat by the health staff due to absent of doctor. Medicines were not supplied regularly. It was also noticed that villagers were getting expired medicines from the health workers as they did not have the stock of these medicines in their centre. Peoples from Type-II and Type-III areas could avail the facilities of hospital but they were not satisfied by the treatment and infrastructure of the hospital. They were not getting proper medical aid and they had to buy medicines from the outside medical stores. Poor villagers were also not able to bear the expenses of paying beds and purchasing of expensive medicines from the outside. Another point was that many of the said villagers visited the government doctors privately for better attention but it was not possible for the poor tribal family.

The barrier between the medical practitioners and the villagers was also because of psychological and cultural differences. The said persons were not concerned about the economic and cultural background of the patients. It was also reported by some of the tribal patients that they were not properly guided by the practitioners particularly the western doctors.

In the studied areas, three types of practitioners or healers were noted, the traditional medicine men, the quacks and the western doctors. Often it was noted that the tribals
consulted the quacks as they were easily available, less expensive than the western doctors and the medicines were provided by them.

Antenatal care was referred to pregnancy related health care provided by a doctor or health worker in a health centre or at home. In the present scenario it was found that in Type-I area the tribal people were unaware of this service but very few of them have the knowledge of it (who are educated). In the studied areas the ANC services were provided from the anganwadi centres.

Place of delivery is an important factor in the context of mother and child health. Home delivery is the common practice among the rural and tribal people of India. And it is very much intensive among the tribal people. Despite of government against campaigning the tribals of these studied areas were much accustomed with home-birth. They were also keeping touch with a traditional dai for the purpose. It was argued by them that it was their traditional custom and there was nothing wrong in this system of delivery. It has also been noted that educated tribal people visited hospital and nursing homes for delivery.

The status of immunization among the studied population (0-5 years) showed that though they were motivated for immunization but a higher percentage of people in Type-I areas showed their negligence towards child immunization. The areas in Type-I were not easily accessible by the government health officials and they did not regularly visit these areas. As a result, the villagers were not very much motivated. The result of immunization in Type-II and Type-III areas was quite good, as these places were easily accessible by the health officials and people had interest that their children were protected from serious diseases. Lack of awareness among the studied people was the main reason for not immunizing the children.

In the context of family planning programmes, it was noted that contraceptives were not supplied regularly and due to irregular operation programmes, villagers showed less awareness. The Type-I villagers were not aware about the right way to use of contraceptives. Although a confusing situation arise through the family planning campaigning, those people then started to avoid using the traditional methods and unavailability of herbal medicines was as added misfortune in this regard.
Government funded ICDS programmes were available in all the studied villages. But it was noted that necessary trainings were not given to the children by the ICDS worker. Only food was distributed but quality was not up to the mark sometimes it was unavailable also. They had not taken any conspicuous initiative to inform the parents about the activities of the *anganwadi* and also not communicated the idea. It was also found that pregnant mothers were not provided the nutritional feeding programmes; even many of them were not aware about such facilities.

The situation is very much confusing for the studied tribal people, as they were not sure, what type of treatment should be adopted for a specific illness. They have the knowledge of both forms of medical treatment traditional and western. Sometimes it was also noticed that they got both the treatments in various cases if not satisfied with any of the approaches and due to non-availability and not getting the proper medicine and treatment due to lack of infrastructure. Due to the changing situation (modernisation, deforestation and afforestation) they were losing gradually their traditional resources and treatment regarding health and disease but on the other hand they were also not getting proper modern health facilities due to poor economic condition, ill communication system and insufficient infrastructure at health institutions.

Public health policy is a system which improves condition under which people live, secure, safe, adequate and sustainable livelihood, life styles and environment, including housing, education, nutrition, reproductive health, child care and personal and social health services. Health policy may be adequacy measured by its impact on population health. Policy and strategy of government regarding health services are mainly favouring vertical approach which is difficult to sustain. There were shortages of manpower to provide health services and other resources at all the levels. Health department has worked without adequate involvement of other system of medicine, which is very well accepted in the community. Health policy and infrastructure have failed to address the needs of the majority, particularly in the context of rural poor and tribal people. The present western medical facilities which is supported by public funding has proved beyond doubt and are not inclined to and capable of meeting the needs of the majority of the people (rural and tribal people) it is not where their services are most required.
It is a matter of concern that tribal people who live close to nature, in and around natural environment apparently appeared to be normally healthy person but majority of them need health care of one kind or the other on account of abject poverty, malnutrition, lack of safe drinking water, poor sanitation and hygienic condition. Lack of awareness and social cultural barriers and apathy to prefer available health services in whatever form and extent these are also causes adversely on the health status of the tribal people. The National Health Policy accorded a high priority to provision of health services to those residing in tribal and backwards areas but the net result is below par.

Concept of hygiene was present among the studied tribal population but those were not sufficient to keep their belongings in proper hygienic conditions. Due to poor economic conditions they were not able to purchase many things like soaps, oil etc, which were also necessary for the said purpose. Less sufficient space of the houses forced them to live with their live stocks although they knew that it could cause many diseases. They cooked their food in open spaces often in rather unhygienic conditions.

The studied tribals were devoid of getting pure and safe drinking water. This problem was faced by every tribal people in the studied areas. Total sanitation programme was not implemented in the studied villages due to lack of awareness of the tribals and less initiatives by the government officials. An intensive lack of campaigning about those issues was not noticed in the studied villages. In Type-II and Type-III areas few families had proper latrine facilities in their houses but in Type-I villages there was no toilet facilities in their houses and all were using open spaces. Although a very few villagers realised the importance of proper sanitation in their house but due to economic and cultural constraints they were not able do so.

The nature of collection of forest material in the studied areas showed variations according to the availability and accessibility of the forest. It is noted that the collection of fuel wood in the Type- II and III areas was a very tough job whereas in the Type-I area people were using fuel wood from the forest and also sold it in the near by markets. But due to the destruction of forest, the time taken for the collection of fuel has been increased at present as compared to the immediate past. In the present studied areas male, female and the minor of both the groups were involved in the collection of fuel. In case of fuel management in Type-I area all of the families primarily depend on collection of fuel
from the forest. Situations were different in Type-II and Type-III areas where families depended on collection as well as on purchase of firewood from nearby localities. But in the past the scenario was totally different in these areas when they had a quick access over forest at that time and they did not have to purchase firewood for consumption.

The forest based food items collected by the tribals mainly supplemented their main food. In the present study it was found that people living near the vicinity of forest (Type-I) showed their great dependence on forest. Even though rice was their staple food, it was found that they consumed roots and tubers with it. Beside, they collected a large number of wild herbs, berries, roots and fruits from the forest. In Type-II and III areas the collection of food items from the forest was becoming difficult and the people depended on the local market. It is not only the vegetation that provided them food, hunting of small animals and birds which could provide them protein was also a regular practice in the past and now totally absent.

The collection of the fodder was an easy task for the people who lived near the natural forest. But for them who lived in the areas far from forest, scarcity of fodder was acute. In many cases it was found that they had to depend on purchased cow feed to feed their cattle.

Another important forest based economy of the tribals was the collection of different types of non-timber forest produces like mohua, sal, kendu etc. Out of these products sal plates were made in particular for their own use and sometime for selling purpose in less quantity. People sold as well as kept these collected items for domestic consumption. The NTFP that were collected by the tribals were mostly from the better preserved forest areas. In such places it is a supplemented form of tribal economy for the poor tribal people. The women in the studied areas prepared country liquor from Mahua and sold it in the market as an alternative source of income. But the main problem was that they were ill paid and market was practically controlled by the businessmen.

It is not that the tribals depend on forest resources only for their survival; their socio cultural life is also intricately interwoven with forest and forest resources. The importance of forest in tribal socio-cultural life would become evident from the fact that majority of the tribal communities believed that they were derived from different objects available in
nature particularly in the forest. They identified their origin from many such living or nonliving objects mostly available in nature. Their festival and religious life were often interwoven with different elements in nature. Thus degradation had influenced or minimised their socio-cultural traditions on which mainly their cultural identity was built up. It may not be out of context to mention that forest collection which was very common in the better preserved forest situations, had interesting social relevance or implications. It has been noted that forest collection was not limited to mere economic utility, but had immense social functions in strengthening or reinforcing the value of social relationship and social bond. The tribal people were conscious about environment. They followed some restrictions in their life which ultimately helped the nature to maintain the balance. Thus many of the species in nature were protected from random exploitation as the tribals traditionally protected them.

Deforestation or afforestation was one of the causes for not getting proper treatment through the traditional healer. Study showed that the major causes of rapid degradation of forest in the studied areas were illegal felling by mafias and revenue earning attributes of the Forest Department. Again, the forest was inaccessible for many of the villagers and traditional healers. Forest happened to be the main source of getting medicinal plants and animals. In reality the Forest Acts, deforestation and even certain types of afforestation programmes with commercially useful mono-plant forest have adversely affected the health and treatment of the tribals. In this study it was observed how the tribal medicine men were facing difficulties in getting medicinal plants. The said persons often reported their helpless as they were not getting the required medicinal plants whenever it was needed. The non-availability of medicinal herbs and hardships involved in the collection of medicinal herbs have been making the traditional knowledge of herbal medicine a vanishing entity. Daily use of herbal products was also decreasing due to above said causes and impositions of forest laws restricting the exploitation of forest resources.

Deforestation mainly affected the economy and livelihoods of the tribals and changed their constructive and symbiotic relationship with the forest. During the last two centuries the forest of Jharkhand came under the pressure of extensive agro-economic movement and suffered wide spread trespass of disintegration as a result of which except in the remote and inaccessible areas the natural form of forest have been greatly altered by a successive events of human history. In the past century when the scientific forestry was
introduced, conservation was the keyword in forest management because with the advancement of agriculture and settlements at the expense of forests and the residual vegetation began to degenerate due to intense exploitation and encroachment. From the present study it was revealed that illegal felling of trees by villagers, contractors as also the revenue earning attitude of the Forest Department were the major causes responsible for the rapid and excessive degradation of the forest.

Again, in the name of afforestation programme, a much greater attention was paid to develop trees having great commercial values, since the importance of forests as revenue-earner has been increasingly emphasized. It has been noted however, that most of the trees having great commercial value, planted under the various afforestation programmes, were of little use to the forest-dwellers or tribals. In fact, only such variety of trees planted which were often required for industries, mostly located far off from the forests. Thus, this type of development of forest could not really help the tribals and forest dwellers neither in the context of using forest produces nor in the generation of new employment opportunities locally. The problem has become more acute and critical where new plants were systematically planted replacing the earlier varieties, which were utilised by the tribals including the forest dwellers in a number of ways to meet their various demands. Thus, the new afforestation programmes not only affected and disturbed the existing tribal economy; it did not even provide an alternative. This type of forest policy in the context of afforestation programmes has already witnessed a number of tribal unrests and conflicts in different parts of India, particularly in the Jharkhand region. There were many instances where the tribals, in a group, have uprooted the new commercial trees planted by the Forest Department. It has been noted that the tribals were so intimately connected with the forest that they were quite aware of the utility of various trees, which should be planted under afforestation programmes. Sometimes, this developed due to their close association with forest and keen observation of the forest ecology. But unfortunately, this traditional knowledge was never utilised at the time of afforestation programmes.

In the studied area State Forest Department in the recent past made concerted efforts to reach out to local communities in an initiative known as Joint Forest Management. This initiative involved the creation of village committees consisted of members from every village household and some Forest Department staff. In committee meetings, villagers
and foresters were supposed to decide collaboratively on forest regulations and management options. In this regard, during the year 2002 Forest Department formed Eco Vikas Samiti (EVS) (in Type-I area) by taking young and energetic people from the villages in regard to protect and carry out developmental programmes within the village. During the study it was noticed and has been informed of the intimidation by the urban based timber or forest mafia who occasionally were involved in illegal felling of trees for timber needs. There was a subdued tension between villagers and the urban based timber mafia. Outsiders bribed the forest staff for the collection of fuel wood and minor forest produce and forest officials often blamed these people for degradation. Despite of all these villagers and the members of Eco Vikas Samiti tried to resist the operation of timber lobby and villagers willing to protect the forest were threatened by the people involved in timber felling.

During the study it also emerged as a problem that deforestation and impoverishment often forced male members to work as a wage labour in other areas. From the British period to the era after India’s independence, different rules, regulations and restrictions imposed on the tribals/forest dwellers in the context of collection of forest resources on which their economy depended to an appreciable extent nearly put them at the clemency of the Forest Department.

The non-involvement of the tribals in the planning of programmes resulted in the failure of the whole process. Due to lack of proper control and management of the forest officials the degradation of the forest continued. Interviews with the forest officials and villagers revealed that the relationship of the local people and the forest officials was getting wider, each feeling other as impediment in his way.

The present study revealed that there was definite concept of health, disease and treatment among the studied tribal villagers. It was also found that both the systems (traditional and modern) have separate positions in these societies. It can be realised that how and why the tribal people used both the systems simultaneously.

To conclude, in order to achieve the much aspired health for all, ethnomedical understanding of various health cultures is needed. It is essential to study and document the beliefs and response patterns, treatment patterns, indigenous *materica medica,*
utilization of modern medical care and associated problems among the tribals as their perception of health and illness were quite distinct from those of the majority of the non-tribal population. Therefore, there is a resistance to the mainstream health programmes since some therapeutic practices are in direct conflict with the traditional beliefs and cultures. It is essential to understand the beliefs, practices and world view of the tribals in order to formulate the appropriate development policy. This is particularly emphasised as an existing body of knowledge is available in the context of health, disease and treatment. So, an understanding of such factors will be of great help in framing specific policies to encourage tribal participation in various community based national health programmes, in implementation of certain modern medical programmes and in disseminating health care to the poorest and marginalised section of the society particularly the tribals. Again, in the context of tribe and forest relation, the commercial aspects of forest should not be totally overlooked but this should not be done at the cost of tribals, their economy and livelihood as they largely depend on forest. The national interest should not be ignored, but not at the cost of the tribals. A harmony is to be made between the local and national interests.

Suggestions

- Traditional concept of health, disease and treatment should be preserved.
- Traditional medicine men using herbal medicines should be encouraged. For protection of medicinal plants Forest department should take necessary steps.
- Health institutions should be more equipped.
- Awareness camps should be organised properly in time it enhance the people's knowledge.
- Medical officials should care the feeling and should know socio-cultural background of the people.
- Population control programmes should be taken without affecting the faith and ideology of the tribals.
- Government should be very careful to plan health scheme considering the economic condition, education and cultural background of the tribals.
- More importance will be given on proper functioning of the Forest Protection Committee.
- Traditional knowledge and applied experience should be utilised in every aspects of forestry.
• Local people must be empowered to manage the forest resources.
• Promotion of more forest based works around the villages.
• Tribal co-operatives should take major role play for the encouragement of the villagers for the collections, processing and marketing of non-timber forest produces.
• Forest officials should change their attitude towards the local people.
• The commercial aspects of forests should not be totally overlooked at the cost of the tribals who are largely depends on forest for their subsistence.
• Serious efforts be undertaken to improve the socio-economic-education and health status of the community. Different approaches and combinations are considered making use of the local resources within the socio-cultural milieu of the community. It is the overall development of the people that is necessary.