Chapter II

Survey of Literature
II.1 Introduction

Aspects of health among the tribals have been appearing in the literature mainly done by
the anthropologists. It has also been done by the sociologists and medical personnel. The
literature reviewed are of the period beginning from the early 60s to date. The health of
the tribes has hardly appeared by the geographers. Though there are some works in the
field of health by Mishra (1970) and Akhtar (1982). Akhtar has traced back the origin
and development of the ‘medical geography’ or ‘geography of Health’. The work gives
an extensive account on the bibliography on this particular subject. The survey of
literature on the various aspects of tribal health, therefore, includes the works done by
scholars from all disciplines. It also includes the relevant literature not directly related to
the tribes but some common issues. All the literature have been classified on the basis of
following themes: i) concept of health disease, and remedy in tribal Chotanagpur, ii)
morbidity, iii) nutrition, iv) health care utilisation, v) socio-economic development and
health condition, vi) socio-economic development and its interlinkages with health, vii)
methodological issues, viii) government intervention, ix) health expenditure and critique
of the government health services, x) liberalisation and health, xi) tribal sub-plan and
health, and xii) research gaps.

II. 2 Concept of Health, Disease, and Remedy in tribal Chotanagpur

In every society there are certain myths, beliefs and practices in some health and well­
being aspects. This is not a feature of the Scheduled Tribes only. The difference is that
people from other communities have better access to modern health care services, which
make them use these side by side. Jailly (1999) says that illness and health care have very
specific psychological and cultural resonance all over the world for each human group.
The individual and collective attitudes to health care are strongly influenced by concepts
and perceptions, which are deeply rooted in the culture that have been inherited from the
past and often much earlier generations. Sahu (1991) is of the same opinion.

The interpretation of the concept of health, diseases, and remedy are till recently used to
be done as early literature on the subject. For example Pal, Bhattacharya and Guha
(1968), Gupta (1986), Mahaptra (1994), etc. say that the concept of diseases among the
tribal people is related to the supernatural agencies, human agencies and some natural causes. These supernatural agencies include soul loss, spirit intrusion, spirit sickness and breach of taboo. Human agencies include evil eye, evil touch, evil mouth and sorcery. The natural causes include those factors, which are also explained by the modern medicines. Choubey (1998) explores the reasons of the poor health of tribal people as the immense faith in conventional health care system. He concludes that they believe in folk medicine, because it fits with their culture and way of thinking. They have their own specialists who serve them well and in whom they have complete faith and confidence.

In most of the literature on tribal health, many things like cultural, economic, and traditional aspects seem to be duplicated. However, Mann and Mann (1992) examines that rural people are blamed for not using the modern systems but wherever there is an option of these systems, they have opted for the modern one only. He raises a question that whether the villagers really not interested in accepting modern medical facilities or are the modern facilities non-existent in the area.

II.3 Morbidity

There are very limited studies on morbidity pertaining to tribes. Anthropologist like Singh and others (1987) have attempted to study the morbidity in the tribal Chotanagpur taking 991 samples, where 29 percent of the families had some illness or disability. About 10 percent had suffered some kind of defect related to the eye.

NFHS (1992-93 and 1998-99) gives some account on morbidity related to the women and children at state level and social group-wise break-ups. This information is limited to certain diseases fever, ARI and diseases related to digestive systems. The NFHS-2 results show that the Scheduled Tribe Children below 3 years of age have more prevalence of cough accompanied by ARI fast breathing and fever were found to be higher than all other social groups (SCs, OBCs and Others). However, Diarrhoea is found to be lower than the SCs and Others.

NSSO 52nd Round (1998) gives information pertaining to short and long Morbidity of

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morbidity at state level, where there is social-group wise rural-urban break-up. The result shows that the proportion of ailing population (PAP, which has been taken as prevalence rates too\(^2\)) with any ailment among the Scheduled Tribes of rural Bihar is 64 per thousand population with a reference period of 15 days.

Shariff (1999) mentions the short and long duration (chronic and acute diseases). However, the results of these studies are not comparable with the present study due to technical considerations. Some rough adjustments can be done with the NSS 52\(^{\text{nd}}\) round. The RGI (1997) provides some information on the diseases in rural areas. However, these are reported diseases causing deaths and there is no social break-up. There is some literature such as Sekhar (1997), which have used the data of either NSS or NFHS but there is no collection of primary data.

**II.4 Nutritional Status**

There are numerous studies on nutritional status of tribal population compared to the studies on morbidity patterns. Narayan (1985) finds that a good number of children born in tribal areas die within a year of their birth, many are expected to die during the preschool year or are found to suffer from physical disability due to lack of inadequate nutrition. Singh and others (1987) found that two-third children under the age 5 were malnourished, 44 percent having severe malnutrition.

NFHS-2 (2002) reveals that there are regional variations in nutritional intake, height and weight. The women belonging to the tribal communities found to be more vulnerable than the women belonging to the general populations in Jharkhand (Chotanagpur). The percentage of height of women below 145 cm is about equal to the OBC women, much lower than the Scheduled Castes women. The BMI is found equal to the Scheduled Castes and OBC women; and the percentage of women with BMI less than 18.5 (undernourished) is Scheduled Castes and OBC women. The percentages of women with any kind of anaemia and also the severe anaemia are found highest with significant difference among the tribal women only. Moreover, the more underweight and stunted

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Yadav et al. (1999) also finds that half of the tribal children are malnourished with marginal male-female difference. The higher level of nutritional deficiency is found among the tribals than the non-tribals children. Now the studies (NNMB, 1991; Tandon, 1994, IIPS, 2001; IIPS, 2002; NNMB, 2001) show the improvement in the nutritional status of the Indian children including tribal children, yet the present situation is grim. Moreover, the NNMB Repeat Survey (2001) finds that there is male female disparity in nutritional status even in the tribal areas, which indirectly pointed out that the negligence towards health problems of females in remote villages where disparity in food consumption is less conspicuous.

### II.5 Health Care Utilisation

The literature on health care utilisation has been mainly done in the anthropological, and sociological perspectives. There are hardly any statistics on health care utilisation by the Scheduled Tribe population of the study area.

Singh and others (1987) found that only less than 8 percent tribal children were immunised in Chotanagpur. Choudhuri (1992) has examined the influence of cultural factors on both the medicines- traditional and modern in tribal and non-tribal set-up differently with a case study in Bengal. He finds that the major factor is their traditional belief systems not the poverty in the tribal villages, which restricts them to the traditional medicine. And the modern medicine co-exists side-by-side in the multi caste village. In the tribal village the last resort is modern medicine and if not treated for some reason their disbelief on modern medicine and belief and reliability on the traditional interpretations and medicine further gets stronger. In the multi caste non-tribal village the people interpret diseases in non-scientific but some value based positive way like they indicate that dishonesty, disrespect to elders, dirtiness, unrestricted movements of females bring some harm by the influence of ghosts and deities. The author finally suggests that the problem of rural health needs not only medical personnel but also the
social scientists in order to understand the non-medical problems for prevention and cure. Bowling (1991) is also of the same opinion, who emphasises non-biological factors for disease and treatment.

In most of the literature on tribal health, cultural factors/constraints have been replicated, but Mann and Mann (1992) says that rural people are blamed for not using the modern systems of medicine. But wherever there is an option of modern medicines, they have opted for the modern system of medicine. Chaudhury, B. (1986) and Swain, S. (1994) have also got the same findings. They add that the tribes are accused of not to use the modern facility, but in many areas the facility is inadequate or non-existent supplemented by the improper treatment due to the inadequate facilities and negligent behaviour by the health workers. Health institutions, more often remain unmanned for indefinite periods, unsympathetic treatment by the health workers, expensive services, extreme difference of medicine and treatment from their own indigenous system and drugs and equipments are always in short supply and so on. The entire system seems to be negligent towards the tribal health. Mahapatra (1994) is of the view that “when one goes deeper and analyse the real situation in tribal world, one is apt to be impressed with the numerous hurdles, constraints and afflictions, which compel them to seek whatever remedies, redress and confidence they may muster.” They have been compelled to confine themselves to a limited world mostly due to their economic backwardness.

Sachidananda (1994) says that there is a requirement of a proper understanding of indigenous medical beliefs and practices to allow modern medicine to find its place by following the socio-cultural norms of the society. As the patient and the traditional healer share the same faith, belief and other cultural traits, which provides strong faith and easy acceptance of the indigenous system of medicine. The patient is not only treated for the disease, but is socio-psychological reinforcement that helps quick-recovery. Therefore, there is a need to analyse critically the reality, whether the tribals are really not interested to accept modern medicine or there are some other factors.

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Sometimes ignorance and other factors like unavailability and inaccessibility (where even unaffordability is not a factor) cost heavy to the tribal people. Some contradictions arise out of this in terms of health expenditure and the preference of the type of source of treatment. Sometimes the cost to traditional medicine crosses by huge amount. For example instead of just few tablets a patient spends heavy amount in cock, goat, liquor, etc. Choudhuri (1992) explains that in terms of number of patients, amount of expenditure and frequency of use, patronage of indigenous medicine surpasses that of western medicine one hundred fold.

NSS 52nd Round (1998) brings out an extensive account on treatment of ailments by types of care taken and expenditure on treatment. It is also disaggregated at state level only. NFHS (IIPS, 2001, NFHS, 2002) gives some aspects of preventive and curative health care utilisation for the women and children of different social groups. The RHS-RCH (IIPS, 2000) is the only source providing district level information on preventive cares (antenatal care, institutional deliveries, medical assistance at birth and child immunisation). However, there is no data for tribal population separately. The statistics reveals that the sample districts are poor in terms of these indicators except for child immunisation, which is slightly better in Gumla.

11.6 Socio-economic Development and Health Condition

Duggal, Nandraj and Vadair (1995) has found there is a big gap in infrastructure between rural and urban areas in India as well as in Bihar in public sector hospitals. Moreover, Kutty (1991) in his study found that hospital beds of the private sectors are evenly spread while it is highly urban biased.

Singh (1976) finds that the services of preventive and curative care and health education including family planning in tribal areas are handicapped due to the problems of accessibility. Srinivasan (1987) in his study of management of rural health care finds that the effectiveness of the PHCs had deteriorated due to large coverage. Voluntary Health Association in India (1997) in its report highlighted the role of media-print as well as the electronic audio-visuals in health care utilisation.
Singh and others (1987) has found among the tribal community of Chotanagpur that a large majority of the sample i.e. 71 percent used to take tobacco (khaini), 89 percent of them used to consume alcohol, mainly rice beer (handia). The personal and sanitary habits were found to be very poor. An average tribal woman married at the age of 15 and had 6 children. 2 of them dying during her lifetime. The room density was very high (3.5 persons per room). The extent of scientific information and attitude in relation to physical and mental health, diet and nutrition, family planning and childcare including breast feeding and hygienic health habits were almost negligible.

Mann and Mann (1992) explores that there is a new dimension of tribal health that its relationship with natural resources. The Forest Acts have affected the tribal health a lot. They have imposed restrictions on collections and gatherings of tribals affecting their economy, food, and even the herbal medicines. Even the deforestation has led to the negative consequences.

The prosperity and well-being has different correlates, especially in terms of food and nutrition. Basu (2001) says that there is a definite nexus between forests and nutrition. It has been noted by many that tribals living in remote areas have a better overall status and eat a more balanced diet than tribals living in less remote, forest free areas.

Sachidananda and Prasad (1994) finds that the main cause for the health problem in tribal Chotanagpur is mainly related to malnutrition, lack of proper sanitation, prevalence of infectious diseases, various water born diseases and unsanitary habits aggravated by illiteracy/low educational levels, ignorance and poverty.

Health care is predominantly urban-oriented. Moreover, increasing commercialisation, curative nature of health care, and poor availability and accessibility have also jeopardised the utilisation.

II.7 Socio-Economic Development: Its Interlinkages with Health

Health is directly or indirectly interrelated to the processes of socio-economic development (Dyson and Murphy, 1991; Das Gupta, 1998, Sen, 2001). There is a simultaneous process between these two. The ultimate goal of the planned economic
development is the good health and overall well being of the citizens of the country so that they can be healthier leading to more productivity and a healthy social life.

Singh, Jaysawal and Hans (1991) have examined the understanding of tribal health taking a sample of 1440 cases. The study found that health and modernity had significant correlation with all the four components of socio-economic status, namely, caste/tribe, education, income and occupation, education having the highest correlation value. Socio-economic status had a significant independent effect on health modernity. In terms of poverty, the samples were examined for both the groups-below poverty line and above poverty line, which had tremendous effect on health because the economic variables are more powerful than the social variables. The study also found their immediate environmental conditions to be a factor of their existing health status. Besides high room density, deprived of basic physical facilities, they lived in squalor and garbage, with pigs and, without electricity, sanitary latrines, poor or absence of ventilation, outlets for smoke, drainage and sewage. Less than 4 per cent had scientifically correct knowledge of physical and mental health, diet and nutrition, and family planning and childcare. The attitude, awareness, knowledge and practice about the diseases and illnesses related to physical health, mental health, diet-nutrition, family planning, breast-feeding and childcare and health habits are found to be extremely backward in terms of health status.

A case study of the Santhal women shown them by Rajyalakshmi (1991) regarding health modernity finds that their houses are aesthetically decorated and painstakingly clean, however, the tribes lacked hygienic personal habits and behaviour. Their houses do not have ventilation, light, fresh air, outlets of smokes and waste water. They utilise the same room for cooking, sleeping and keeping domestic animals. The source of drinking water is a common village well or pond, which is very unhygienic. Singh (1994) advocates for a raise in the socio-economic level of a tribal household should receive topmost priority.

So, there have been constant efforts by the government since the First Five Year Plan. These Plans have created some special provisions for the lagging reasons and the social group of the country to bring them in the mainstream of the national development, where tribal areas and the tribal people have received special attention. A number of policies
and programmes since the beginning of the planned economic development, especially, since the Fifth Five Year Plan, have been initiated to look after the problems of these areas and these communities. The programmes and policies enclose all sectors viz. Physical, economic and social development to attain the overall development and well-being. Within this framework health and nutrition got the high priority in these areas along with the rural development since the First Five Year Plan. Moreover, health and nutrition have also been the part and partial of rural development programmes. The 20-Point Programme and the New 20-Point-Prógramme have also emphasised health sector as their major goal.

The first President of India, Dr. Rajendra Prasad, and the first Prime Minister, Pandit Nehru, strongly advocated for the development and improvement of their living standards mostly through their participation only and the way that does not conflict with their culture (Thakur, 1997). Following all these views, the Multi-Purpose tribal Development Project started during 1954, which was reviewed in 1956 and the Tribal Development Blocks were formed for small areas. This new strategy was conceived as a supplement to the Community Development (CD.) effort in the same region. The Scheduled Areas and Scheduled Tribe Commission (Dhebar Commission) in 1961 made the first comprehensive review on the tribals. This commission noticed among others, that the existing protective measures were inadequate and required urgent attention of the government (Rao, 1989). Gradually new strategies aimed at not only development but also welfare measures (distributive justice). In the Fifth Five Year Plan, the Target Area and the Target Group Development strategies came up, which were followed by the Tribal Sub-Plan within which Integrated Tribal Development Projects and Modified Arca Development Approach Pockets appeared.

The Ninth Five Year Plan Approach Paper evaluates the impact as, “Existing Tribal Development Programmes have not been able to alleviate their condition. An Action Plan incorporating total food and nutrition security, health coverage, education facilities, etc., keeping with their socio-cultural condition will be prepared by the Central/State Governments. The Proposed Action Plan will have in-built flexibility to cater to the
specific needs of such tribe and its environments. The major goal of development policies — human development through health and education — has also been at the lower edge. Number of studies ends up with the conclusion that “Low health and educational status is strongly correlated with poverty/socio-economic status in the tribal areas, especially, Chotanagpur.”

The tribal development policies encompass four areas: (i) economic (ii) educational (iii) health and (iv) communication, where health takes care of provision of safe drinking water facilities, primary health care facilities and nutrition. Health has close relation with the process of development because without minimum level of development health status cannot be improved at desired level. When people are hungry, they have little meaning of health and nutrition. Unless their purchasing power is raised, health and nutritional status of any such society is difficult to be improved. In this respect health status has a direct two-way linkage with development. Moreover, since, health cannot be distributed, it can be achieved not only trough the government’s effort but the participation of individuals, families and communities. Moreover, universal coverage by primary health care cannot be achieved without the involvement of local communities. It is in these lines the above questions have arisen to be examined.

II.8 Methodological Issues

There have been various methods to present the morbidity and the nutritional status. Various measures of morbidity prevalence have been widely explained by Park (1995). NSS 52nd Round (1995-96) has used the proportion of ailing population (PAP) as a measure, which is also known as the morbidity rate. However, it finally says that due to

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non-significant difference between the morbidity rate and the morbidity prevalence rate, it suggest to use the figures as the morbidity prevalence rates. The NCAER has two measures- a) point prevalence rates and b) period prevalence rates for long and short morbidity. The present study, however, has used only the period prevalence rates due to small sample size than the NCAER.

The nutritional measures for adult population and for children are also many. Park (1995) has given many indices to measure the nutritional status of children. However, the major studies to be followed are WHO (1993, 1995), NNMB (1991, 2000) and NFHS (1995, 2000).

The methodology on extracting indices of development and health are dealt in detail in Mitra (1961), Pal, (1975), Kundu (1980), and Mahmood (1993). Pol and Thomas (2002) discusses in detail about the health status index, calculation and types. The association of health indicators with the availability of infrastructure and other indicators of socio-economic development has been done by logistic regression. It was inevitable because of the involvement of the binomial variables involved in the study. The detail account of the logistic regression for social scientists is found in Retherford and Cho (1993) and SPSS (1999).

II.9 Government Intervention

Park (1995) gives an introduction to the committees related to the public health. The first one, Bhore Committee, popularly known as the Health Survey and Development Committee in 1943, which formulated a guideline to attain the goals in the health sector through the Five Year Plans. Since then, various committees and research groups have been formulated time to time to review the existing health situation and for the recommendation of further action. The Committee’s important recommendations were integration of preventive and curative services at all administrative levels, development of primary health centres in two stages and major changes in medical education, which includes three months training in preventive and social medicine to prepare ‘social physicians.’
It was followed by the Mudaliar Committee, 1962, known as Health survey and Planning Committee, to survey the progress in the field of health since the submission of the Bhore Committee Report and to provide guidelines for national health planning in the context of Five Year Plans. The main recommendations were the consolidation of advances made in the first two Five Year Plans, strengthening the districts hospital with specialized services to serve as central base of regional services, regional organization in each state between the various levels and the districts, reasonable threshold population for PHCs improvement of the quality of health care provided by the primary health centres, integration of medical and health services as recommended by the Bhore Committee and constitution of an All India Health Service on the pattern of Indian Administrative Service.

The Chadah Committee, 1963, focussed on malaria through PHCs. The Mukherjee Committee, 1965 suggested to emphasised on Basic Health Service, provided at the block level with special focus on malaria, family planning, smallpox, leprosy, trachoma, etc. Jugalwal Committee, 1967, or the Committee on Health Services recommended integration from the highest to the lowest level services, organisation and personnel. The main steps recommended towards integration were unified cadre, common seniority, recognition of extra qualifications, equal practice, and good service conditions. The Kartar Singh Committee, 1973 (the Committee of Multipurpose Workers under Health and Family Planning) made recommendations for integrated services at the peripheral and supervisory levels; the feasibility of having multipurpose, bi-purpose workers in the field: the training requirements for such workers: and the utilisation of mobile service units set up tinder family planning programme for integrated medical, public health and family planning services operating in the field. The Shrivastav Committee, 1975 emphasised for immediate action on creation of paraprofessional and semi-professional health workers from within the community itself under Rural Health Scheme (school teachers, postmasters, gram sevaks) to provide simple, promotive, preventive and curative health service needed by the community, establishment of two cadres of health workers- multipurpose health workers and health assistants between the community level workers and doctors at the PHC, development of Referral Service Complex by establishing proper linkages between the PHC and higher level referral service centres.
Malnutrition was identified as a multifaceted problem by the Eighth Five Year Plan in the consequence of which a new policy ‘National Nutrition Policy’ was formulated in 1993 and the District Nutrition Project was started in 9 districts in 1996-97 to collect the information on micronutrient deficiency and protein energy malnutrition. The National Health Policy, 1983 had made the issues of tribal health as a major thrust of the plan. There are many spectacular points to emphasise upon, such as mobile clinics, annual check ups of tribal people, Enhances Malaria Control Programme, prompt delivery of drugs, regional medical research centre, etc. But the reality in the tribal areas seems to be far away from the plan.

The Draft National Health Policy-2001 has several special focus areas but does not directly focus the tribal health at any section. Its special sections are urban, occupational and women health. In one section, it prescribes to reduce health inequality and enhance fairer access to health care by the weaker sections.6 The other criticisms about the Draft National Health Policy-2001 are that it ignores the 1983 policy’s objectives of protecting and providing primary health care (PHC) for all, especially the underprivileged. Qadeer7 says, “In fact it appears to be more of a deterrent rather than an instrument for achieving the guideline principles of the past health policies...The NHP 2001 destroys not only the concept of PHC – wherein referral systems are a key to good and complete care- but also the government commitment to PHC for the most deserving...The draft NHP assumes that the private sector can provide both the first referral as well as the secondary and tertiary care support.”8 Duggal (2002) also says, “The entire burden of whatever care PHCs and SCs provide falls on the shoulders of the ANM – the male health worker is being phased out and the health volunteers are vanishing in most states.”9

A brief review of Five Year Plans, which are committed to a process of development, which will raise living standards, and over all well being, reveals the stepwise efforts

6Draft National Health Policy, 2001, aeabop@nb.nic.in
8 Ibid, p. 12.
towards the goal of ‘Health for All’. The broad objectives of the health programmes during the Five Year Plans have been the control of major communicable diseases; strengthening of ‘the basic health services through the establishment of primary health centres and sub-centres: population control; and development of health manpower resources.

The First Five Year Plan started with a vigorous programme of social orientation of medical education through establishment of department of preventive and social medicine and launching of PHCs on the top priority. The Second Five Year Plan attempted the expansion of PHCs in order to cover rural and difficult inaccessible areas aiming to readdress the imbalance by shifting the centre of gravity of health care system from cities to the rural areas and bring these services nearest possible distance from people’s home. The Third Five Year Plan included family planning as an integral part of health planning, which was further enhanced in the next Plan. The subsequent Plan included health, family planning and nutrition as integral components of Minimum Needs Programme, which aimed at more effective integration of preventive, promotive, and curative services to specific target groups. In the Fifth Plan, rural health schemes, which also include rural drinking water, were given the top priority and continued in the Sixth Plan at the cost of urban super speciality hospitals. The Seventh Five Year Plan gave very high importance to the Family Welfare Programmes to achieve high human resource development. In the Eight Plan one of the long-term goal to be achieved was to achieve Health for All by 2000 laid down in the National Health Policy, 1983 along with other goals (elimination of poverty and illiteracy, near full employment). The goal was defined as “attainment of a level of health that will enable every individual to lead a socially and economically productive life” securing satisfaction of the basic needs of food, clothing and shelter. It was also committed for “Human Development” as its main focus. However with apprehension about the success of the programme HFA by 2000, the Eighth Plan restarted the programme as the ‘Health for Underprivileged (HFU) by 2000’. The second programme has also not enjoyed any success story.

In the Ninth Five Year Plan, assurance of food and nutritional security for all, particularly the venerable sections of the society and provision of basic minimum services of safe drinking water, primary education, shelter, and connectivity to all as time-bound goals, have got important places among all objectives. The approach, paper highlights that “existing tribal development programmes have not been able to alleviate their condition. An action plan incorporating total food and nutrition security, health coverage, education facilities, etc. in keeping with their socio-cultural conditions will be prepared by the Central/State Governments. The proposed Action Plan will have in-built flexibility to cater to the specific needs of such tribe and its environment.”\(^\text{11}\)

The Draft Tenth Five Year Plan also highlights the improvement of the health status of the tribal people indirectly as one of its goal. It says, “Improvement in the health status of the population has been one of the major thrust areas in social development programmes of the country. This was to be achieved through improving the access to and utilization of Health, Family Welfare and Nutrition Services with special focus on under-served and under-privileged segments of population.”\(^\text{12}\)

Jharkhand Draft Annual Plan 2001 - 2002 says, “Although there was a slogan "Health for All by 2000 AD", we have miserably failed to achieve this target. After creation of new State of Jharkhand, the Government is committed to provide better health care front the very beginning and gradually develop centres equipped with excellent medical facilities so that people of this State get best medicare and are not compelled to go out side for specialised treatment. With these noble views, the Government propose to undertake following projects in the 1st phase under State Plan Fund during the financial year 2001-2002.”\(^\text{13}\)

Now, for the universal coverage and equitable distribution of health resources, village health guide, training of local \textit{dais} and Integrated Child Development Schemes are in


\(^{13}\) Jharkhand Draft Annual Plan 2001-2002, \texttt{http://jharkhand.nic.in/governance/anpchap9c.htm}
function.

Besides these, the Government of India and various non-governmental agencies have launched several programmes on health and nutrition aided by the international organisations, like, WHO, UNICEF and FAO.

Health is not uni-dimensional, and is a result of the interplay of overall integrated development of a society including cultural, economic, education, social and political factors, like literacy, educational level, health awareness, employment, income, occupation, food habit and nutrition, housing, source of drinking water, sanitary habit, hygiene, lifestyle, traditions, beliefs and values, religious taboos, health policy, programmes and implementation, empowerment or place in the society, protection against environmental hazards and communicable diseases, etc. which implies more than techno-centric view of medical care. All these factors are interlinked and interwoven when matter of influence on health comes. However, among all these, human behaviour and response to the diseases and health care is most important. Only due to these reasons, other factors are also incorporated in the study as Srivastava et al. (1993) notes, "A focus on linkage between deprivations and ill health also draws attention to the fact that poor health is not necessarily a medical problem. Thus, merely expanding the supply of health services may not yield desired results unless deprivation in several human dimensions, such as in education, social freedoms and so on are simultaneously addressed."

The other studies like that of Chaudhury (1986) also strongly support this view by saying that "the health problem particularly that of tribals is not the exclusive domain of medical science.... Social and economic factors are by now, generally accepted as highly important in the multiple causation of disease.

Therefore, health workers must come to understand such factors if they are to deal effectively in both primary prevention and cure of disease and other disorder of health." 


They further cite with example, “what is clear in this case is that a literate population in Kerala tends to have a greater understanding of illness, whereas an illiterate and ignorant population as in Bihar may have little appreciation of their health predicament.”16 In Kerala, social movements have also contributed a lot in this sector, which is completely absent in Bihar. Where health improvement is essentially related to economic, political and social conditions, improvement of health status of a population is also essentially an economic, political and social issue. The World Health Organisation defines the health as a “state of complete physical, mental and social well being and not merely the absence of disease and infirmity”.17 It needs all round development and not merely the treatment of diseases because lack of infrastructural development like roads, safe drinking water, public health centres, school facilities, etc. have often been depicted as the major sources of hindrances in the health sector.

II.10 Health Finance and Critique of the Government Health Services

There have been many achievements in the health sector. But lots of debates on financial allocation concerning compression on health have been on. Tulasidhar (1993) talks about this with special reference to the Structural Adjustment Policy and says that this kind of financial transfers form the centre and expenditure from the state will make the poor state and the poor people suffer. At the same time he discusses about the alternative to it by rationalising autonomy of public health services for resource generation through those who can bear the cost and saving from the harm who cannot afford.

EPW (2001) notices the wrong priorities of the budget where it says that the communicable diseases are the most neglected part of the health ministry. A glaring instance of severely affected area by malaria is the tribal Chotanagpur where there have been no payments for the workers since two years whereas the budgetary allocation reveals a different kind of story. EPW (2001) states that neglect is reflected in the allocations in the central budget year after year. In 2001-2002, public health, which includes four vertical programmes and AIDS control, accounts for 34 per cent of the total

17 Bhat, V.N. (1990): Health Problem and Health Services in Modern India, Delhi: Amar Prakashan, p.3.
health for and 12 per cent of the Ministry’s entire allocation. While this has been a trend over the years, the latest budget offers figures, which are particularly depressing. Most of the unspent amount is from the malaria control programme. The allocation under this head, which accounted for 29.5 per cent of the total for public health, has registered a sharp decrease in 2001-2002, which is 21 per cent of the total provision for public health. Hence, there is a question of malaria being under control. Reports and available statistics indicate that there has been a resurgence of the disease, especially of the more virulent forms but these concerns are not reflected in health budget. Of the total budget 62.7 per cent goes to the family planning. Allocations under this head have gone up by a sharp 32 per cent over the revised estimate for the current year, which can be seen as existing at the cost of public health. Large allocation is needed in public health and research on the family planning programme. The outlay for health sector has also been steadily declining from 3.3 per cent of the total plan outlay in the First Plan to around 1.7 per cent in the Eighth Plan. More than one-third of this investment is by external assistance linked to specific diseases such as AIDS, blindness control, etc. The investment for family planning has been growing over the years. The annual report of the ministry of health states that the public expenditure in the health sector has been a little over 1.5 per cent of the GDP while WHO recommends that it should be at least 5 per cent of the GDP. It also mentions the Structural Adjustment programme for the collapse of the public health system in the country, loss of faith of the people in government health services and ushering in privatisation in the health sector. This collapse of public health system is influencing the epidemiological profile of the country as acute respiratory infections and malaria are showing a rising trend from 1988 onwards with pneumonia, tuberculosis, viral hepatitis, cholera, and enteric fever in recent years. The infant mortality rates have been rising, stagnating or the decline has slowed down in most of the vulnerable states of India. Even in Kerala the IMR has been showing a rising trend.

After the Alma Ata Declaration, in the backdrop of the failure of the Health for All, the People’s Charter for Health was adopted at the People’s Health Assembly (PHA) at Savar in Bangladesh in December 2000, where the principle enshrined in the Charter are the attainment of the highest possible level of health and well being is a fundamental human right, regardless if a person’s colour, ethnic background, gender, age, abilities, sexual
orientation or class. Despite these all, the most neglected part to be essentially included here especially in India is the highest level of health and well being is a fundamental human right, regardless of a person’s residential locations of rural and urban or areas of backwardness or development. It is because in India the good health services, even the lowest level in hierarchy, tend to cluster only around the urban and the developed areas, especially the metropolitan and industrial cities where a substantial amount is invested in the health.

Bose (2001) says that even the Health for All by 2000 has proved to be futile especially towards the public health and for the poor and marginalized section of the society. The most burning example is the failure of the ICDS programme in the rural areas especially in the tribal areas. He comments as what is tragic is that there are no indications that international agencies can set things right. As Antia asserts, the only hope lies in people’s power, and international solidarity of the marginalized people.

The Ninth Five Year Plan, a government document itself reveals the lacunas, which have already mentioned in the earlier sections for tribes. Nayar (1999) notes that the “existing primary health care institutions, according to the document are functioning sub-optimally because of inappropriate location, poor access; lack of maintenance; lack of professional and para-professional staff at the critical posts; mismatch between the requirement and availability of health professionals especially physicians at PHC; lack of funds for essential drugs; lack of first referral units (FRUs) as linkage for referral services... The primary health care units have been in a shamble as revealed in the plan document. Even the referral units are not functioning effectively. The number of functioning CHCs, which form the first referral unit (FRU) is far below the projected requirement...It is a matter of concern that many of the districts with poor health indices do not have adequate health infrastructure.”18 Therefore, it identifies some of the basic services for the proper health outcomes. These services are safe drinking water, availability of primary health service facilities, universalisation of primary education, provision of public housing assistance, nutritional support to children, connection of all habitations by roads and public

distribution system for poor followed by a proposal for a Nutrition Monitoring and Surveillance System. As an initiative a nation-wide programme called Reproductive and Child Health (RCH) Programme launched in 1997 to control the anaemia.

Jeffery (1998) says that after independence health policy is formulated heavily in tune with the international ideas of how to deliver health services in poor countries. The state is moving in one direction, international advice and funding is pushing in another, and the health care institutions of the state are seriously unable to address the health policy issues, which confront them.

The tribal health has been neglected all across the country. Ashtekar and Mankad (2001) has cited an example of alternative to improve the health care in the tribal areas. For example, a health scheme, ‘Nav Sanjivan Yojana’, started for the tribal villages in Maharashtra, involving the employment of one youth per hamlet in tribal area, with four months’ support at Rs. 400 in the monsoon season and three medicines (chloroquine, furazolidine and paracetamol) is also irregular. He says that the recommendation of the Bhore Committee was 6 doctors for every 10000 population with one doctor for 1500 population, very close to the WHO norm, which later was made 3500 population per doctor by the Government of India. Now the situation is terribly worse. In each PHC there are only two doctors with a population of close to one lakh and sometimes even more than that (for example Simdega and Masalia PHCs in the present study). The country China has ensured provision and presence of doctors in every village. The basic philosophy behind this is that it should be just far that a mother with a sick child could reach on foot.

II.11 Liberalisation and Health

The liberalisation has promoted the health services at a great extent to become urban centric and highly commercial. It has become a source of lucrative business along with education. It has attracted the specialised doctors from the government institutions to the private ‘five-star’ hospitals or nursing home too. The most striking factor is the considerable subsidy by the government to establish these hospitals for the ‘common-man’ but finally becomes beyond the reach of these ‘common-man.’
The Eighth Plan focused on the policy shift favouring privatisation, which resulted in the neglect of public health services. Moreover, the secondary and tertiary health care services work with the World Bank’s instruction, which promotes the privatisation significantly. But the biggest problem of the liberalisation in health care is the gradual neglect towards integrated health care delivery system.

II.12 Tribal Sub-Plan And Health

An evolution of a new strategy emerged after the review of the Multipurpose Tribal Blocks. The new strategy adopted by the Government of India during the Fifth Five Year Plan known as the Tribal Sub-Plan (TSP), which is continuing till date. The objective of the strategy is to improve the quality of life of tribes through various projects. The TSP has been defined on the basis of topography, composition of local resource base, potential of development and administrative boundaries. It is committed to the continuous effort for the understanding of local/regional situation, evolving suitable programmes, their effective implementation and constant appraisal to bring about the well being of the tribal society. It comprises of number of project areas, known as the Integrated Tribal Development Project Areas, formulated for the cause of the upliftment and betterment of tribes.

The TSP has been set-up in 18 States including Bihar. It is operational through 194 Integrated Tribal Development Tribal Projects (ITDPs); 252 Modified Area Development Approach (MADA) Pockets and 79 clusters of villages with more than 50 per cent tribal concentration. 75 primitive tribal groups have been identified in 15 States/UTs on the basis of pre-agricultural level of technology and very low level of literacy.

The government reports and other studies reveal that up to the Sixth Five Year Plan, 75 per cent of the tribal population was covered and 95 per cent habitations were covered by at least one primary school within the area of reach. The ‘reach’ however, was never defined. This does not correspond with the latest figures of the All India Educational Survey.

The Plans for development have been modelled and remodelled till the ongoing Ninth
Five Year Plan. Unfortunately, the vital areas like infrastructure, female literacy, drinking water increasing indebtedness and economic disparities still continue to be neglected. Surprisingly, the tribal health has been almost absent in these plans. None of the Government documents focus on the problem of tribal health under the Tribal Sub Plan, while health and development are inseparably related to each other,

The Bhuria Committee Report (Report of the Members of Parliament and Experts Constituted to make Recommendations on Law Concerning Extension of Provisions of the Constitution (Seventy-Third Amendment) Act, 1992 to Scheduled Areas) has also recommended for the overall development with special emphasis on health and education through the decentralisation of power. The various responsibilities for the improvement of health in the tribal areas have been assigned to the various levels three tier *Panchayati Raj* System.

II.13 Tribal Development Plans and Health in Bihar

The tribal regions of Bihar have received a significant attention since the First Five Year Plan in the various forms. Besides the set-up of various industries for the development of such backward areas, the Aboriginal Welfare Scheme was taken up during the Second Five Year Plan. During the Fourth Five Year Plan, emphasis was laid on planning at district level for fullest utilisation of the available material and human resource.

The Tribal Sub Plan was launched in the State in 1974-75. It is in operation in 112 out of 193 blocks of Chotanagpur and Santhal Parganas. These blocks have been placed under 14 Integrated Development Projects. There is a Project Advisory Committee for each project for the assistance of officials and non-officials. A Regional Development Commissioner's office has been set-up at Ranchi and District Planning Councils in each district have been set-up to monitor the developmental work efficiency in the Sup-Plan areas.

A considerable amount of resources has been spent in the papers but the outcome was never marked to this level. According to the estimation of the Planning Commission for the year 1993-94, 52 per cent rural and 41 per cent urban tribal population still lives
below the poverty line in India. Their total illiteracy in Bihar is 73.22 per cent, out of which female illiteracy accounts for 85.25 per cent, rural illiteracy 75.20 per cent and rural female illiteracy is 87.22 per cent. It is remarkable that health sector is totally neglected sphere in the development efforts through the Tribal Development Plans. Among others, health sector lies at the bottom of priorities and efforts in the State.

There is no proper coordination between health and the other developmental activities in the tribal areas. Every activity has been taken in isolation till recently. Such as the agricultural development has hardly been seen in relation with food and nutrition. Similarly the generation of the perennial sources of income are not associated with making people capable to afford their required levels of the standards of lives to be healthy. PDS may be a temporary provision for poor people but not permanent with the vision of developing them and human resource among them. Even if there is a free service of check-ups, without purchasing power one cannot have the medicine. The same thing has happened in education also where there is no fee or minuscule fee, but due to non-purchasing power of books and stationeries, students are not able to continue their studies. Rather they become the helping hands for their parents in their livelihoods.

To elaborate it in a more explicit manner, the whole concept of health and disease should be looked into with a holistic and integrated approach and larger context than just health and disease. Moreover, the complete techno-centric approach can never be successful without consideration of human aspects. Rather technical aspects should come in the framework of the society and not the other way round depending on the suitability of all the technical things to the human spheres.

**II.14 Research Gap in Socio-economic Development and Health of the Scheduled Tribes of Chotanagpur**

There have been a number of studies on various aspects of health of tribes done by anthropologists, sociologists and medical doctors. Recently, the NFHS-2 has also tried to cover some health aspects of tribes Some other studies on health such as NSS 52nd Round and NCAER have also covered the some aspects of tribal health. The NNMB has also left this vast tribal area as its sample region. The gap may again be described as the micro-
level spatial pattern of the health conditions and related behaviour of the tribes in
different socio-cultural, economic, bureaucratic, political, physical and environmental
setting as there is vast inter-tribal variation against well-perceived homogeneity among
the tribal societies. The other shortcomings are the absence of the impact of the
geographical aspects especially the spatial and locational factors on health and health
related behaviour of the community under study. And also the studies have rarely tried to
find out the link between the development levels and health conditions among the tribes
at micro level.

This study, therefore, is an endeavour to explore some of these neglected aspects of tribal
health in Chotanagpur and examines the general perception about the development levels
and the health conditions among the tribal people of Chotanagpur.