Chapter 1

Introduction
“In an industrialized India, the destruction of the aboriginals life is as inevitable as the submergence of the Egyptian Temples caused by the dams of the Nile... As things are going, there can be no grandeur in the primitive’s end. It will not be even simple extinction, which is not the worst of human destinies. It is to be feared that the aboriginal’s last act will be squalid, instead of being tragic. What will be seen with most regret will be, not his disappearance but his enslavement and degradation”.


The term, ‘tribe’ originated around the time of the Greek city-states and the early formation of the Roman Empire. The Latin term, ‘tribus’ has since been transformed to mean, ‘A group of persons forming a community and claiming descent from a common ancestor’ (Oxford English Dictionary, IX, 1933).

The citation of the word ‘tribes’ evokes the image of some primitive people in their native habitat, dancing on the wild beats of drum with flute on his lips, hunters, forest land cultivators and minor forest product collector, lived in isolation with near to nature, hence called ‘the son of soil’.

It is estimated that there are about 300 million indigenous people or so called ‘tribes’ world wide (Subramanian et.al. 2006). They are frequently marginalized from the rest of the world; their human rights are often abused and plunged into the dirth of serious mental and physical health hazards.

We feel pride that one phenomenon inherent in the nature of the plural society of the Indian subcontinent is coexistence – often in a narrow space – of populations varying greatly in the level of material and intellectual development within the worlds’ oldest continuously existing civilization. The tribal population in India is larger than that of any other country in the world as
Mayanmar ranks second with 14 million tribes and Mexico ranks third with 10.9 million and the tribal population of India is more than the total population of France and Britain and four times of Australia (Basu 1985). There are over 84 million people belonging to 698 communities and constituting about 8.2% of the total population designated as scheduled tribes in India (http://tribal.nic.in/finalContent.pdf). They are thought to be earliest settlers and the original inhabitants of the Indian Peninsula, with their presence dating back to before the Aryan colonization (Thapar 1990). Embraced within the tune of geographical diversities, the mystical, the mythical, the historical and the natural tribes of different regions of India have their own distinctive traditional songs and dances, colourful handmade clothing, intricately woven bamboo handicrafts, colourful attire and pastoral way of life etc.

The history of Indian independence is also blazed with the active participation of the tribes hand-in-hand with the other so-called higher classes of people. But, it is a glooming fact that even after six decades of independence, the tribes of our country are drowned in problems like land alienation, indebtedness, education, economy, communication, urbanization and health. Though in the era of globalization and information technology, the Governments have taken many development programmes in black and white, but in fact most of them are uncared and unattended in rural areas. As a consequence, the primitive citizen of our country is still primitive in the eye of the world. Health has been acknowledged as an essential pre-requisite for human resource development.

According to the WHO definition, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 1976). There is a general agreement that the health status of the tribal population is very poor and have distinctive problems, not because they have special kind of health, but because of their special geographical placement, traditional attitude towards health practices and circumstances in which they live. In tribal areas, the outside influences, education and
urbanization are minimal. That is why their lifestyles, dietary pattern, social behaviors as well as health behavior pronouncedly prescribed by the deep-rooted tradition.

The overall health status of the tribal communities is the resultant of several interlacing factors, like-

a) Environmental effect in which they inhabit.

b) Attitude towards adopting modern health care facilities and practices.

c) Effect of their regular life-styles and behaviour.

d) Hereditary and genetic effects.

The morbidity and mortality statistics are not always sufficient to measure the actual health status of these thriving populations. Moreover, the pictures depicting this exact health condition and attitude are also scanty. The widespread poverty, illiteracy, malnutrition, hostile environment, absence of sanitary living conditions, ignorance of the causes of disease, lack of health services and inability to use them have been traced out in several studies as contributing factors for the deplorable health conditions prevailing among the tribal group (Ali, et.al. 1995). Different tribal groups are characterized by their individual socio-cultural, socio-biological and socio-economic attitudes and therefore any formula approach for measuring their health status was not only unsuitable but unsatisfactory. Inspite of the fact that the national health programmes are providing greater inputs in terms of man, material and facilities, the situation is still not so improving. There are primary health centers, multi-purpose health workers etc. but the report of this utilization is very poor. Therefore with only linear expansion of health services, the overall health status of the tribal community cannot be improved. The health status and nature of health problems of the tribes of India can largely be dissociated into the following categories-
a) Conspicuous lack of maternal and child health services leading to low
fertility, high maternal mortality and high infant mortality rates.

b) High degree of inbreeding among the tribal groups leading to inheritance
of genetically inherited diseases, like, anaemia, glucose-6-phosphate
dehydrogenase (G-6-PD) deficiency etc.

c) Gastrointestinal disorders like, dysentery and parasitic infestations and
this heavy worm-load also causing malnutrition among women and
children.

d) Physical injuries and trauma resulting from communal fights, encounters
with wild animals, fire etc.

e) Prevalence of infectious or communicable diseases like, measles, pox,
leprosy, tuberculosis, malaria, kalazar etc.

f) The problem of tribal health in India is not only very complex in nature
but also needs human intervention. In fact the urban people are fortunate
enough to grab every fruits of human development and up-to-date
facilities of latest medical and health care facilities whilst the tribes living
in the periphery are able to get only the peel of these fruits.

In view of these perspectives, an attempt was made to study the health
status of selected tribal groups in West Bengal with the following specific
objectives:

1) To develop the standard index to measure the health status.

2) To develop the knowledge test and attitude scale to study the health
status.

3) To find out the health status of tribes in two different agro-climatic
zones (Terrai and Red-Laterite Zone) of West Bengal.

4) To study the relationship of different socio-economic, socio-
psychological and communication characteristics with the health status of tribes.

5) To study the extent of influence of different socio-economic, socio-psychological and communication characteristics with the health status of tribes.

6) To make a comparison among different selected tribal communities in two different zones in relation to health status.

7) To find out the constraints perceived by the tribes in relation to their health status.

8) To find out some clinical manifestation in relation to health status of tribes depending on personal observation.

PRACTICAL UTILITY

The main utility of this study is to observe the health and nutritional status depending on the different geographical location and different climatic condition. It is also directly or indirectly dependent on the occupation, culture, and rituals of the samples of tribes of those specific areas.

While scanning through available literature on the health status of the tribal in India it was observed that comprehensive area-specific health related studies were limited, most of the available studies were isolated, fragmentary and did not cover the various dimensions of health affecting the status of tribal like- i) Sex ratio, ii) Literacy, iii) Marriage practices, iv) Age of marriage, v) Age of mother at first conception, vi) Life expectancy at birth, etc.

It has been noted that there was paucity of studies on many urgent issues affecting the health status of tribals. Detailed information were needed on- i) Nutritional anemia, ii) Nutritional status of pregnant and lactating mother and their nature of work load, iii) Primitive practices for parturition, iv) Infant and childhood mortality and their sex difference, v) Proper distribution of food
within all family members, vi) Regular diets, vii) Prevalence of sexually transmitted diseases. This study will be definitely helpful to chalk out a strategic planning while considering tribal development programme in the state.

LIMITATION OF THE STUDY

Due to limited time and resources the study was confined in Totopara of the Madarihat block of Jalpaiguri district and Bandawan, Purulia-I, Baghmundi, Kashipur, Neturia, Para, Barabazar and Manbazar-II blocks of Purulia district. The findings of the study were obviously based on data obtained from the population covered under the study. Therefore, the results of the study will be directly applicable to that particular area although the results may have relevant application to other similar areas in the country.