CHAPTER – VII

General Observations and Recommendations

Health as a component of human rights gained recognition immediately after the World War II through the establishment of the World Health Organization. The massive killings and atrocities of the war further compounded the pace of establishing health rights. Furthermore, the Constitution of WHO gave this emerging rationale a complete framework by defining health as ‘a state of complete physical, mental and social well-being’. The Constitution of WHO thus became the first international legal document to contain an explicit right to the ‘enjoyment of highest attainable standard of health’.

The Constitution of the World Health Organization (WHO), drafted in 1946 defined health as "a state of complete physical, mental and social well-being", identifying the Organization's goal as "the attainment by all peoples of the highest possible level" of this state. The MDG framework shows that without significant gains in poverty reduction, food security, education, women's empowerment and improved living conditions in slums, many countries will not attain health targets. And without progress in health, other MDG objectives will also remain beyond reach. The Conference in Alma Ata, 1978 strongly reaffirmed that health is a fundamental human right. It also stated that the attainment of highest possible level of health is the most important social goal worldwide. The realization of this social goal requires action of many other social and economic sectors in addition to the health sector. But inequalities in health status of people between developed and developing countries as well as within countries are unacceptable from political social and economic point of view. Hence attainment of health is a common concern for all countries. Health, as a basic human right has been recognized in a number of international human rights instruments like the Universal Declaration of Human Rights (1948), International Covenant on Civil and Political Rights (1966), International Covenant on Economic, Social and Cultural Rights (1966), Convention on the Elimination of All Forms of Racial Discrimination (1965), Convention on the Elimination of All Forms of Discrimination against Women (1979), Convention on the Rights of the Child (1985), Agenda 21 (1992), Copenhagen
Declaration and Programme of Action (1995), Fourth World Conference on Women (1995) and Millennium Development Goals (2000). The Constitution of India guarantees ‘right to health’ as an extension of ‘right to life’ of Article 21 and various Directive Principles has been used to demand access to healthcare to ensure the creation and the sustaining of conditions congenial to good health without which life remains meaningless and unproductive. The indigenous peoples’ protection of health rights also finds place in the international human rights instruments.

The tribes of India, their distribution, characteristics and demographic profile, constitutional definition and safeguards reflect diversified socio-cultural ethos distinctive from that of the mainstream population. The ten major tribes in West Bengal are distributed in the nineteen districts with larger concentrations in Medinipur, Jalpaiguri, Purulia and Burdwan districts. The tribal health situation highlights that tribal communities in general and primitive tribal groups in particular are highly disease prone. Maternal mortality rates and infant mortality rates are also high among the tribes due to their poor nutritional status and traditional practices of child birth. Nutritional anaemia is a serious matter of concern among women of rural and tribal areas. Women receiving ante-natal check up and institutional deliveries are significantly less among tribals when compared to the national average and the scheduled castes. Tribal health practices are strongly rooted with indigenous knowledge system that has developed over time in a community mainly through accumulation of experiences and intimate understanding of the environment in a given culture.

The health of tribal population in India is a matter of serious concern. Tribals are devoid of many facilities of human life and health facility is on one of them. In West Bengal tribals generally live in rural areas which generally lack healthcare system. Though the Independent Government of India promised its citizen for better healthcare but actual access to healthcare system by the tribals is very scant. Though there is a presence of some basic infrastructure of health in and around the tribal area but their services are not unquestionable, rather very limited.

The scope of the study includes the health vulnerability of the tribal people particularly women and children. The maternal mortality trends of selected states in India and child health indicators indicate a grim situation including states with sizeable tribal concentrations. The data on National Family Health Survey on child health indicators and maternal healthcare indicate that the tribal families do not get proper attention of
healthcare and the ante natal care is also very deplorable. The general tribal health problems with regard to forest depletion and its impact on health of the tribal people have failed to draw the attention of the policy makers. The present study is important in many respects. While studying with the health situation of the tribals it has been observed that with regard to access to and benefits from the public health system the tribals have always remained at the receiving end of the system. The public health system has remained largely uneven and concentrated among the better endowed sections of the society. So the socially disadvantaged sections of the society have always lagged in this respect and the tribals have remained excluded. This is particularly true for tribal women and children.

The study has been conducted in Malda district, West Bengal, India and the region has immense historical importance since the Mughal period. The strategic location and the geographical position of the district is unique which serves as a gateway of north Bengal and the north eastern states of India. The district is famous for mangoes and raw silk that keeps the economy of the district vibrant. The area of study was villages of Malda District, West Bengal, India. The total number of villages studied was thirty one which included eleven villages in Old Malda Block, seven villages in Gazole Block, seven villages in Bamongola Block and six villages in Habibpur Block. Most of the studied villages were mono-ethnic except for few villages in Old Malda, Bamongola and Habibpur. The total numbers of families studied were 787 of which 590 were Santals, 48 were Malpaharis, 35 Koras, 50 Mundas and 64 Oraon families. Among the studied communities there were 3567 individuals in all out of whom 1797 were males and 1770 were females.

The objective of the study was to study the socio-economic condition of the tribal families, their actual situation in the course of so called development, human rights issues particularly relating to health rights, health facilities and basic amenities of drinking water sources and sanitation, role of traditional medicines, impact of environmental degradation, family welfare programmes and western treatment.

Villages were selected on the basis of lack of access to western healthcare system. Also the distance of Block Development office was taken into consideration. Locational backwardness of the villages and the underdevelopment of the inhabiting people particularly women were also considered for choosing the villages. Generally the rural area lacks infrastructure and penetration of healthcare facilities also becomes scant.
Also these factors were taken into consideration to select those villages to have a proper understanding of the healthcare system and its impact on the tribals.

The physical health infrastructures in the studied blocks were inadequate and the quality of service provided was also poor. It is evident from the discussion in the previous chapters and the case studies that the villagers faced problems in accessing healthcare facilities. The lack of infrastructure, inadequacy of health institutions, huge patient load and the laid back nature, carelessness of the health personnel in the health delivery system in the tribal villages were dominant features for the poor state of realization of health rights. Also there were shortages in professional manpower and other resources at all levels of health services. There was also a marked inadequacy in health facilities. There was also a marked inequality in health services in the rural and urban areas. The distance of the sub-centres, primary health centres and rural hospitals and the under developed communication facilities have further kept the outreach of western healthcare facilities very limited in the studied villages. In the studied blocks 53.7% primary health centres were located above 5 km distance. If the primary health centres are located at such long distances then how would the villages access them during emergency remains a vital point of concern. Furthermore, the pathetic condition of the roads and transport system prevented the sick patients from reaching the health centres at the proper time. The roads of the remote villages were semi-metalled, unmetalled or kuccha roads which were not properly maintained and their condition used to get worse during the rainy season. The main means of transport were feet, bicycle, van rickshaw and motor driven cycle van in some villages. The service of motor driven cycle van was limited in few villages and they were available only in the day time. Buses, mini buses, trekkers and jeeps were available along the state and national highways and their service disappear after evening. So practically there was no decent means of transport for shifting patients to hospitals at night. Moreover, due to the referral tendency, the tribal patients were further deprived of proper timely care and treatment. Another intricate issue associated with these was that of the ignorance that had been conspicuous of the tribals which made the health situation so dismal. As a result of these, the tribals could not access whatever health facilities were available there. Thus the health facilities were unable to serve the cause of tribal development in the real sense. As human rights is a complimentary issue, non-fulfillment of health
rights among the tribals stand in clear contravention of the national and international provisions.

The developmental projects that have been implemented in and around tribal dominated areas in the Post Independent era have hardly brought any real benefits. The implementation of such developmental projects resulted in massive forest degradation which in turn has curbed the traditional and cultural ethos of the tribals. In the name of development, forests have been ruthlessly cut and depleted. Tribals were primarily dependent on forest. In many ways they are now not getting the required forest resources which have a negative impact on their health. The medicine men among them used to get medicinal herbs and plants to cure the local people are now not getting them easily. The general impact of environmental and forest degradation in their overall life style and their health in particular have made their situation much alarming. The traditional medicine is on the brink of extinction due to loss of vegetation cover. Traditionally, the tribals are dependent on forest in many ways. Their good health is related with their association with nature but due to the loss of vegetation cover their health profile and disease trend is changing. Loss of vegetation cover in the studied area have also generated massive crisis of fuel wood, the main source of energy for the tribal families. The crisis of fuel wood becomes acute in the rainy season. The shortage of fuel wood also particularly affected the health of tribal women and young girls who had to travel long distances for collecting fuel wood which created added burden on them besides their regular household work and hardly leaving any time for rest. Moreover, on account of deforestation, biodiversity loss and rapid urbanization, availability of medicinal herbs is on the decline that has brought the traditional health practice on the verge of ruin. It was found that those tribal families who resided in the interior tribal areas were having better health than those who were more exposed to the urban influence. The tribal families in the remote parts under study could manage to get green vegetables and local herbal plants and include them in their diet which supplemented better nutritional intake than the families who lived nearer to the urban localities. On the face of such grave realities, there has been no gesture on the part of the state to facilitate and promote the traditional medicine and health practices of the tribal communities which can well serve as an alternative of western medicine. Even though an attempt to revitalize the indigenous system of Indian health and medicine has been made by incorporating the AYUSH into modern healthcare system, yet its
expansion has been very limited in the real sense. Since the traditional health practitioners work in close association with the native communities and have a close understanding of their cultural and social ethos, so their experience needs to be properly used to improve the outreach and quality of healthcare. It needs to be mentioned here that ensuring tribal health practices would be cost effective and conformant to tribal culture. Thus to save the ethnic knowledge from falling prey to the lure of modernization, an urgent need is felt to document this precious knowledge for posterity. So the priority of the government should be to promote and protect the tribal medicines otherwise it may not compete to compensate the health services any longer.

As far as the benefits from the governmental schemes and health schemes and facilities meant for tribal development are concerned, it was not equally distributed and there have been contradictions in the response of the tribal beneficiaries and the government officials’ claims. The actual benefits from the developmental schemes for tribal development differ from the official claim and the actual relief received by the studied families. Their underperformance has led to slow upliftment in the socio economic status of the tribal families which had a corresponding impact on their health seeking behavior and awareness levels of the studied families. It can be mentioned here that due to the partial insensitive attitude of the policy makers and the bureaucratic system of administration the outcomes of the tribal development projects have remained so poor and understated. In addition to these factors, lack of education, indifference, lack of communication and lack of overall knowledge about the scheme have made barred the tribal families from getting due benefits.

The poor state of sanitation and safe drinking water facilities aggravated the situation of realizing proper health rights in the studied area. The main sources of drinking water in the area were wells, tube wells and pipelines. The use of pipelines was restricted to only few villages. The major sources of drinking water were the wells and the tube wells. The tribal villages in the blocks of Habibpur and Bamongola were mostly dependent on wells than tube wells for their drinking water as due the physiographical setting and soil conditions of the region, the water table remains low and tube wells are ineffective. The water table further goes down during the dry months and the well water too goes further down creating massive water crisis and the tribal families had to depend on nearby ponds and water bodies for drinking, cooking, bathing and washing purposes. The well water which remained exposed in the atmosphere and the water of
shallow unclean pond water were unsafe and were the main reasons for the occurrence of water borne diseases among the tribal families. Only 7.9% of the studied villages which had access to pipeline water could be considered to have access to safe drinking water facilities. Due to the unsafe drinking water sources 90% of the children suffer from diseases like diarrhea and dysentery which indicate that we could not be able to provide the basic necessities of life to the children who are the future of our country. The poor sense of personal health, hygiene and sanitation among the tribals also affected their health badly and gave rise to some chronic diseases. The improper and unhygienic sources of water used for drinking and washing purposes also made them prey to a wide array of infectious and water borne diseases. The poor health concerns and lack of proper and timely treatment among the tribals were one of the prime reasons for their low life expectancy.

Lack of proper sanitation facilities were another reason that had been neglected as only 10.2% families had sanitary toilet facilities. Another striking issue in this connection had been the lack of basic consciousness about sanitation among the tribals under study and most of the families used the fields or natural grounds. The tribal families were not even aware of the connection of sanitation and health. In the blocks under study, the government programmes implemented by the local panchayats and the Block Development Offices for providing financial assistance to the tribal families for building sanitary toilets in their homes were unsuccessful as most of the families spent that money for other purposes or even if they had constructed a toilet they were not accustomed to use it and the toilets were lying unused. No community toilets were there in the studied villages that were constructed by the implementing agencies.

The dietary habits of the tribal families had poor nutritional value. Due to economic factors they could not consume milk and animal protein. This was another factor behind the maternal and child malnourishment which is the root of a plethora of diseases. Lack of nutritious diet also affected the health of the tribal families especially women and children. Traditionally women are silent sufferers and remain tolerant in every odd situation. They sacrifice themselves for the well being of the entire family at the cost of their health. Poor economic condition further pervaded the tribal families in gaining consciousness and aspirations about their health and well being. Gross human rights violations were observed in case of the healthcare of women and children. Even during the birth of a child western healthcare system were not approached. Although the rate
of institutional births increased in the last 15 years still 19.3% deliveries were at home attended by untrained traditional mid-wives. The distance of the primary health centres and rural hospitals alongwith under developed communication facilities were the main reasons behind such picture of non-institutional deliveries. Therefore, the risks related to childbirth and pregnancy related complications remained considerably high. Again, 27.1% families had reported incidences of child mortality and only 72% mothers and children received pre-natal care facilities and 60.3% received post-natal care. The health workers in the sub-centres were in the habit of remaining absent in their duty and expectant mothers and infants could not avail the service at the proper time. The supply of medicines in the health institutions also prevented the mothers from getting health tonics and IFA tablets before and after child birth. There was no special care for the child and lactating mother in terms of nutritious food and diet within the families due to the poor economic conditions and the diet given in the anganwadi centres also lacked the prescribed nutritional standards. The study also revealed that the new generation tribal parents were willing to send their wards to the anganwadi centres or khicchudi schools not out of much educational aspirations but for free meals which were however, inadequate in quantity and poor in nutritional value. The perception of health among the tribal families grossly lacked gender sensitivity. Malnourishment and underweight were common among women and children. Early marriages, premature motherhood and closely spaced pregnancies among tribal girls were also another reason for failing health of tribal women which also affected the growth and health of the children. Women’s diseases and good health drew least attention within the tribal families. The low rate of literacy among tribal women was also a result of lesser health consciousness among them. Those tribal girls who received the light of education had better understanding of health than those tribal girls who remained in the dark due to social constraints and got married at early puberty or adolescence. Those tribal girls who got married during early puberty were ignorant about their own health as well as their child’s health. Those who got married after having certain education had better understanding of health, personal hygiene and healthy manners of child rearing.

The mode of treatment preference among the studied families also displayed an interesting revelation; 59% of the families relied on allopathy treatment, 28.7% families depended on both allopathy and traditional treatment, only 0.9% families depended on traditional treatment while .6% families depended on homoeopathy and ayurvedic
treatment and the rest 10.9% families had no preference with regard to treatment. A combination of both the traditional and allopathy treatment was popular among the elderly tribal members than the relatively younger generation members. Even some women also preferred this combination mode for treating gynaecological problems as they are less expensive, culturally acceptable and lesser side effects. It was evident from the study that persons from all religions depended on either traditional and western health practices in one way or the other. Even educated tribal families happened to be follower of traditional medicines. But inspite of inadequate infrastructural facilities of western health, people tended to follow both western and traditional medicine. Different explanations may be attributed to this phenomenon. To get quick relief from illness they depended heavily on western medicine. Another reason for their faith in traditional medicine was that the traditional healer was much more familiar with their socio-cultural life. Traditional medicine was much cheaper and the traditional healer was easily accessible. This particular attitude has been responsible of the prominent role of traditional medicinemen in the tribal areas under study. The mode of treatment preference among the studied families also varied on religious beliefs. For example, those families which practiced Christianity and had better level of education and a better understanding of the outside world showed inclination for western health medicines and health practices.

The perception of diseases among the tribal families was completely different from us. They did not pay any attention to minor diseases and viewed diseases as normal and they did not go for early detection, prevention, treatment and cure. If they did go for early treatment, that too were only traditional practices in most cases. The threat of non-communicable diseases was most common among the studied families with seasonal variations. Skin diseases, fever, typhoid and other water borne diseases were very common during the rainy months because of unsafe drinking water sources. Filaria was also very common during this time because of the damp living conditions of the tribal houses. The main communicable diseases were pox, tuberculosis while fever and leprosy was both communicable and non-communicable.

Since education has a close relation with health status and it is a well recognized fact that better education implies better health. Education seems to be a crucial factor for shaping health behaviour. The poor educational achievement among the tribal families under study was responsible for their poor health status. Those individuals with better
educational achievements had lesser attack of diseases, the study revealed. Although both the State and the Central Government have made special provisions for the betterment of literacy rate among tribals, yet this endeavour has failed to reach the desired level. The occupation type of the tribal families also influenced the health seeking behaviour. The families engaged in the primary sector had poor health concerns than those in the secondary and tertiary sectors. The agricultural labourers and the daily labourers primarily depend on traditional medicinemen and cheaper modes of treatment due to their poor socio economic status. Income level too has a direct relation with health as it guides the health behavior and mode of treatment. Families having higher income showed better health concerns than those in the lower income group. Higher income group families consulted doctors at early stages of the disease while lower income group families tended to ignore them. Moreover, higher income group families were more dependent on the western treatment system and could avail better medical care, visit and consult private nursing homes and doctors. Since most of the tribal families were poor and hardly had any savings they could not follow up with routine checkups, medication and persisting health treatment.

The government’s health policies and programmes also lack participatory approach. Its priorities are mainly centered on providing immunization, family planning services and hospital-bed services. There is little concern of the government in improving the general health especially that of the tribals. The government has failed to treat health in a holistic approach. The tribes are at different stages of development and attainment of health and human rights. So the government should formulate policies depending on that while keeping their socio-cultural practices and ethos intact. Although the immunization situation has improved over the last few years and some tribal families have realized the necessity of the polio drops for their children yet they do not have the seriousness of following the polio schedule and remain negligent. The response from the family planning programmes also remained unsatisfactory with variations among different communities. It is still a matter of great concern that in the studied villages 69.2% individuals were not immunized while 68.5% had not yet adopted family planning measures.

The demographic profile of the studied villages indicate that among the studied communities, the Santals, the Mudas and the Malpaharis had sex-ratio above the national average while the Koras and the Oraons had sex-ratio below the national
average. The education scenario of the tribal individuals reveals that 39% of all population under study is literate excluding those who can sign only. Dropout among the male is due to mainly family business and economic constraints. Though there are a number of dependent persons among all communities under study but in general both male and female happen to be earner engaged in different occupations like agriculture, agricultural labour, daily labour, business and service. The annual income varied from below 5000 rupees to above 30000 rupees. The tribal families do not have much savings and whatever they earn are consumed wholly. So they remain in a sustainable position where expending in health treatment remains a luxury. The sources of drinking water are well, tube well and water supply. There is still human rights violation in water sharing and safe drinking water. There was no proper sanitation.

The tribal developments programmes that are undertaken in the blocks under study have very few actual beneficiaries and a considerable number of the tribal families even do not know about them. The state of health infrastructure and services were almost scant in the area under study. There also existed wide gaps between the official claim of the success of the developmental schemes and family welfare programmes and the response of the villagers regarding the outreach and benefits.

The tribals’ believe in traditional medicine and they have traditional healers upon whom they have considerable faith and confidence. The role of quacks, ojhas, gunins or traditional medicinemen in healing practices was prominent among the tribal communities under study. The tribals under study followed allopathy and both the traditional and allopathy modes of treatment and only traditional mode of treatment as well. The elderly persons preferred both traditional and allopathy medicine. The main diseases among the tribal males were jaundice, stomach pain, tuberculosis, skin diseases etc. and the main diseases among the females are gynaecological problems, old age related problems, leprosy and arthritis. Incidences of child mortality were prevalent among all the communities under study. Incidences of institutional deliveries were more prominent in children upto 15 years of age among all the communities. The diseases among the children were diarrhoea and dysentery. The tribals also used their own traditional knowledge of herbal medicines for home remedies of different kind of diseases. The distance of the health centres from the tribal villages and the difficulties in transport and communication prevents them from accessing the health services at the proper time during emergency. The immunization programmes among the studied
communities failed to bring the desired outcomes. The immunization status of the females was poor when compared to that of the males. The immunization status of the children upto 15 years of age showed better outcomes than the adult individuals. The rate of non-institutional deliveries rises above the children above 15 years of age and it increases for older generation individuals. The non-institutional deliveries were attended by the traditional mid-wives. The response of the tribal families towards family planning could not reach the desired success.

Human security emphasizes the protection of people from grave threats to their lives and empowerment against such social threats which include prevention and freedom from the threat of diseases. The simplest definition of security is absence of insecurity and threats. Precisely, it means to be free from both fear and want. The lives of the tribals in the studied villages were also not free from both fear and want given their socio-economic status. The poor economic condition of the tribal families coupled with low level of consciousness about health in the studied area seemed to be responsible for human rights violations. Due to this want they were deprived of many bare necessities that affected their human security including health.

Inspite of their ill-health and poverty, lack of modern living they lived in a cheerful atmosphere. Due to their hedonistic way of life they were glad with what they had. This keeps them miles away in achieving better health and wellness. If the government considers them truly as a citizen of India, much more needs to be accomplished in order to give them a touch of health and actual beneficiaries of the development process.
**Recommendations**

The following recommendations are suggested based on the findings and observations of the present study:

- Actual medical care has to be taken not just infrastructural development.
- Providing trained health personnels and other resources for health services.
- Developing the referral systems at all levels.
- Traditional systems of treatment and herbal medicines should be encouraged and duly preserved.
- Socio-economic condition should be improved and human security to be ensured for better realization of human rights and health rights.
- Basic amenities like safe drinking water and sanitation should be improved for better health.
- Educational status should be bettered for the purpose of good health and healthy lifestyles.
- Awareness to be generated intensively regarding family planning programmes.
- Fullest achievements from immunization programmes should be targeted.
- All child births should be institutionalized.
- The benefits from the developmental schemes should be made to be enjoyed equally by the tribals.