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Right To Health of Indigenous Community: Innovative Tribal Public Health, Challenges and Policy in India

[1]Swathy P S*, [2]Dr.B. Venugopal, [3] K Hari Hara Sudhan, [4] Manoj Mohan

Author's Affiliation:

[1]Research Scholar, School of Law, **Vel Tech** Rangarajan Dr. Sagunthala R&D Institute of Science and Technology: https://orcid.org/0009-0009-6273-2745

[2]Dean&Research Supervisor, School of Law, **Vel Tech** Rangarajan Dr. Sagunthala R&D Institute of Science and Technology: https://orcid.org/0009-0006-9610-3558

[3] Assistant professor, school of law, **Vel Tech** Rangarajan Dr. Sagunthala R&D Institute of Science and Technology

[4] Assistant Professor, Nehru Academy of Law

ABSTRACT

This paper explores the intricate relationship between the right to health and access to healthcare among India's indigenous tribal communities, who constitute 8.6% of the nation's population. Despite constitutional mandates and international treaties aimed at protecting their rights, these communities face significant challenges in accessing adequate healthcare services. The study delves into the historical, social, and policy frameworks that influence tribal health, highlighting the alarming disparities in health outcomes, such as higher rates of infant mortality, maternal health issues, and malnutrition compared to non-tribal populations. The research critically examines the effectiveness of government initiatives, such as the National Health Mission and the Ayushman Bharat Scheme, in addressing these challenges. It also discusses the socio-cultural factors that hinder the utilization of public healthcare services by tribal populations, including the reliance on traditional medicine and the mistrust of modern healthcare systems. The paper concludes by emphasizing the need for a more inclusive and culturally sensitive healthcare approach, integrating traditional practices with modern medicine, to ensure the holistic well-being of tribal communities.

KEYWORDS

Indigenous Peoples, Right to Health, Tribal Healthcare, Maternal Health, National Health Mission

1. Introduction

Indigenous peoples constitute over 6% of the world's population, with 476.6 million individuals spread over 90 countries and over 5,000 unique tribes. Asia and the Pacific are home to 70.5% of the world's indigenous peoples, whereas Africa is home to 16.3%, Latin America and the Caribbean to 11.5%, North America to 1.6%, and Europe and Central Asia to 0.1%. A number of international treaties and declarations ensure that Indigenous peoples' rights will be protected. One of them is "the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)."

Indigenous Indians number more than 104 million. Residing in 705 distinct tribes, they make up 8.6% of the total population. In order to safeguard and advance tribal tribes, the

Indian government has established three seminal policy documents: "the Constitution of India, the Panchsheel Principles, and The Provisions of the Panchayats (Extension to Scheduled Areas) Act, 1996. These documents reflect the government's understanding of the unique social and cultural dynamics among these communities.

Despite these legislative protections, tribal region leaders often bring up the issue of inadequate health care. There have been many publications in the media highlighting the ongoing issue of inadequate infrastructure, development facilities, and services for the aboriginal community. These regions have alarmingly high rates of malnutrition, infant mortality, and illnesses like malaria.

Indigenous People: International efforts to define Indigenous peoples have been hampered by a lack of consensus due to regional and national variety as well as individual and group distinctions in history, practice, background, culture, and other relevant factors.

The UN and its specialised agencies adopt the practice of self-identification as Indigenous as a crucial criterion, even if there is no common definition. As stated in Art 33 of UNDRIP, Indigenous Peoples have the right to choose for themselves how they identify and what constitutes membership in their communities.

In addition, one of the most cited descriptions of the concept of the Indigenous Peoples is one provided by (Cobo 2014)[i]" in his "Study of the problem of discrimination against indigenous populations", which includes the following elements:

- "Historical continuity with pre-invasion and/or pre-colonial societies that developed on their territories;
- Distinctiveness;
- Non-dominance; and
- A resolve to maintain, improve, and pass on to subsequent generations the lands and identities of one's ancestors in conformity with one's own cultural norms, social norms, and legal system."

Additionally, it is said that an Indigenous person is someone who is acknowledged and accepted as a member of these Indigenous groups, as well as someone who self-identifies as Indigenous. This ensures that Indigenous communities may continue to autonomously choose who belongs to whom.

2. Objectives

The article aims to highlight the health disparities between tribal and non-tribal populations, particularly focusing on malnutrition, maternal health, and infant mortality. It assesses the effectiveness of government programs like the National Health Mission and Ayushman Bharat in addressing tribal healthcare challenges while exploring socio-cultural barriers such as reliance on traditional medicine and mistrust of modern healthcare systems. Additionally, it discusses the role of international treaties and Indian constitutional provisions in safeguarding tribal health rights. The paper advocates for culturally sensitive healthcare approaches that integrate traditional and modern medical practices, identifies policy and infrastructure gaps limiting healthcare access, and provides recommendations for reducing health inequities through better resource allocation, awareness campaigns, and community-driven initiatives**.**

3. Indigenous peoples' conceptualization of health

Health and wellness in Indigenous communities are seen as including not just physical and mental health, but also spiritual, environmental, cultural, and social aspects. They believe that everyone has a right to be healthy, and that this right is heavily influenced by factors such as community, land, and the environment. Spirituality, traditional medicine, biodiversity, and the interdependence of all things are the four cornerstones of Indigenous peoples' conceptions of health. Because of this, one comes to see human beings in a very different light than the general public.

As stated by UNPFII, "the well-being of the

whole community" includes not only the physical health of its members but also their mental, emotional, spiritual, and cultural health. Integral to the attainment of other rights, such as those to "self-determination, development, culture, land, territories, and resources; language;" and free, prior, and informed consent, among many others, are these broader aspects of Indigenous peoples' health rights, which extend beyond the material realm.(UNFII 2000[ii])

Nevertheless, as a result of colonial legacies, non-Indigenous health institutions often overlook Indigenous Peoples' understanding of health, which poses substantial obstacles to access. One factor that might negatively impact the health of Indigenous peoples is a lack of knowledge about their culture and how they define health.

4. Right to health of indigenous peoples

Health is a fundamental human right protected by several international and state accords. Health is linked to many other human rights. Indigenous Peoples have "the right to health." under the UNDRIP.

The longest indigenous rights treaty is the "UN Declaration on the Rights of Indigenous Peoples (UNDRIP)." It recognises Indigenous Peoples' rights individually and collectively and sets basic requirements for their survival, dignity, and well-being that are commensurate with other human rights.

Article 24 of the UNDRIP guarantees indigenous peoples the right to practise their traditional medicine, get the best physical and mental health treatment, and access social and health services without discrimination. Indigenous Peoples have the right to self-determination in Article 3, improved economic conditions in Article 21.1, development, including health development and determination in Article 23, and free, prior, and informed consent in "Articles 10, 11, 19, 28, 29, and 32 of the UNDRIP." Indigenous Peoples need these rights to enjoy their health rights.

Article 24 of the UNDRIP matches Art 12 of "International Covenant on Economic, Social, and Cultural Rights (ICESCR)", which guarantees the right to optimum physical and mental health for everyone. Indigenous Peoples may also use other binding international and regional human rights agreements' health provisions.

5. "Indigenous Peoples" Versus. "local communities"?

Indigenous Peoples hold a distinct constituency as rights holders under international human rights law, as provided by international instruments, including the UNDRIP. Collective rights are essential to their survival, prosperity, and holistic growth as a people, and their unique position grants them such rights.

Indigenous Peoples should not be equated with minorities, vulnerable groups, or "local communities," according to "the UN Permanent Forum on Indigenous Issues, Special Rapporteur, and EMRIP."

6. WHO on the right to health of indigenous peoples

To create a more just and healthy world where everyone's rights to good health are fully realised, WHO is dedicated to collaborating with nations and the UN system.

The work that WHO does on the health of Indigenous Peoples includes capacity building, leadership development, collaborations, awareness-raising, normative actions, and technical assistance to nations. Along with analysing the obstacles Indigenous Peoples confront to the availability, acceptability, accessibility, and quality of physical and mental health care, it involves assisting nations in incorporating the viewpoints of Indigenous Peoples into health policies and programs.

WHO is committed to improving the health of Indigenous Peoples worldwide, supporting group activities that promote their rights, and implementing the "UN System-Wide Action Plan on the Rights of Indigenous Peoples." Inter-agency activities are supported by WHO's Indigenous Peoples Support Group. Co-chairs the group with "the UN Department of Economic and Social Affairs in 2024."

7. Indigenous community in India

7.1 Scheduled Tribes in India

"Scheduled Tribes" are defined as "tribes or tribal communities or parts of or groups within tribal communities which the President of India may specify by public notification"(Indian constitution, article 342[iii]). The 705 scheduled tribes in the country can be divided into four major categories namely,

- "Tribal people living in Schedule V areas and in tribal dominated blocks and districts,
- Tribal population in North- East India,
- Particularly vulnerable tribal groups, and,
- Tribal people living outside Scheduled areas."

i) Population growth and fertility**:** From 8.2% in 2001 to 8.6% in 2011, the proportion of STs in India's overall population arose. Based on the NFHS-4, the most current estimates from the IIPS indicate that the TFR for STs is 2.5. This has led to a manageable decline in the tribal population's reproductive rate. With 990 per 1000 men, the sex ratio among STs is far more than the 933 average for all of India. And yet, from 972 in 2001 to 957 in 2011, the Child Sex Ratio among STs has dramatically fallen.

ii) Socio-Economic Status: Collectors of forest produce, hunters, gatherers, pastoralists, nomadic herdsmen, and artisans comprise a substantial portion of Scheduled Tribes.

Compared to the non-tribal population, which employs only 43%, the primary sector employs over two-thirds of the tribal population. The tribal population is primarily dependent on agriculture, either as cultivators or agricultural labourers.

iii) Special governance mechanisms for tribal development

a) Two distinctive administrative structures were established by the Indian Constitution. Native peoples were safeguarded by the Fifth and Sixth Schedules, which established Scheduled Area regulations.

b) The Panchayats (Extension to Scheduled Areas) Act, 1996, has strengthened the Fifth Schedule by granting Gramme Sabhas the authority to operate.

c) In 1999, a separate Ministry of Tribal Affairs was constituted to coordinate and supervise the socio-economic development of Scheduled Tribes.

d) The Scheduled Tribes and Other Traditional Forest Inhabitants (Recognition of Forest Rights) Act 2006 is designed to rectify "historical injustice" and renew the rights of forest inhabitants to land and forest products."

7.2 **State of health and health care in tribal areas**

Life expectancy: The life expectancy at birth for the ST community in India is 63.9 years, as reported in the Lancet 2016 study, which is lower than the overall population's 67 years. Life expectancy may be exaggerated for tribes since teenage death is often not reported. (Table 1)

Reproductive, Maternal, New born, Child Health and Adolescents (RMNCH+A):

i) Maternal Health:

- Several factors contribute to the high rate of maternal death, including early marriage, low body mass index, early delivery, and anaemia.
- The percentage of overweight or underweight ST ladies in the 15–19 age group is about 50%. This figure is rather concerning.
- According to NFHS 3, anaemia affects 65% of Indigenous women aged 15–49,

compared to 46.9% of non-SC, ST women.

- When it comes to Indigenous women in particular, the ANC's comprehensive coverage is still lacking. Among all socioeconomic groups, 81.8% of ST women had gotten at least one ANC, while the lowest proportion was among those who had undergone complete ANC, at 15% (RSoC data).
- The institutional delivery rate among tribal women is the lowest at 70.1%. Nevertheless, it represents a substantial increase from 18% in NFHS 3 (2005-06) to 57% in CES 2009. The most recent RSoC data indicates that up to 54.7% of tribal women benefited from JSY, which is the highest rate among all social categories.
- The cost of institutional delivery, distance, and the absence of transportation remain significant obstacles. The average expenditure on childbirth at a health facility is still approximately Rs. 4000, which is significantly higher than the costs covered by schemes such as JSY, according to the 2014 NATIONAL SAMPLE SURVEY OFFICE data.
- When compared to other demographics, 27% of aboriginal women still give birth at home. Possible causes include the hostile attitude of medical staff, difficulties in communicating due to language barriers, and scepticism about an unfamiliar system.
- Inadequate postnatal care coverage persists, and indigenous people's health beliefs and traditions sometimes conflict with government-provided maternal health treatments.
- Within the first two days after giving birth, around 37% of indigenous mothers said they received a postnatal care package. (Table 2)

Table 1: Life Expectancy of Tribal vs. Overall Population

Population Group	Life Expectancy at Birth (Years)
Scheduled Tribes (ST)	63.9
Overall Population	67

Indicator	Tribal Population	Non-SC/ST Population
Percentage of women with anemia (15-49 years)	50%	N/A
Percentage of overweight/underweight women (15-19 years	65%	46%
ANC (Antenatal Care) - At least one ANC visit	81.8%	N/A
ANC (Antenatal Care) - Complete coverage	15%	N/A
Institutional Delivery Rate	70.1%	N/A
Institutional Delivery - Increase from NFHS 3 (2005-06)	18% to 57% (CES 2009)	N/A
Institutional Delivery - JSY Scheme Beneficiaries	54.7%	N/A
Average Expenditure on Childbirth at a Health Facility	Rs. 4000	N/A
Percentage of Home Births	27%	N/A
Postnatal Care within First Two Days of Delivery	| 37%	N/A

Table 2: Maternal Health Indicators in Tribal Areas

ii) Child mortality:

- The Indian population as a whole had an IMR of 62 in 2008, according to an indirect estimate derived from the 2011 Census, which provided the

IMR for the year 2008. The tribal population, on the other hand, had an IMR of 74.

- Only the Federally Administered Area in Pakistan has a higher ST IMR among indigenous people than India. India should be ashamed of this.
- According to NFHS IV, in 2014 there was an estimated infant mortality rate (IMR) of 44.4 for the ST population, a 1–4-year death rate of 13.4, and an MR for children under the age of five of 57.2 per 1000 live births. Compared to the IMR estimate of 74 for 2008, which was derived from the Census, this is much lower.
- The tribal IMR fell from 90 to 44 throughout the 26-year period (1988-2014), according to the temporal trend study. I can say with confidence that this is an improvement of great quality.
- On the other hand, after reaching a peak in 2004, the yearly rate of decrease in tribal IMR began to fall in the previous decade, from 2004 to 2014.

- The absolute rate of infant mortality among India's tribal population has decreased by half in the last 25 years, but the gap between the most privileged and the rest of society has grown from 10% to 38%.
- From 135 in 1988 to 57 in 2014, the under-five MR has dropped by 58% in indigenous communities. Compared to other areas, ST now has a 48% excess of under-five mortality, up from 21% before. Even as late as 2014, the ST U5MR was two to three times greater in certain jurisdictions than in others that had a sizable ST population.
- According to 2011 Census and the "National Family Health Survey (NFHS)", almost 146,000 indigenous infants died in India each year before the age of five.

Table 3 :Child Mortality Rates Among Tribal and Non-Tribal Populations in India

Indicator	Year	Tribal population	Overall population	source
Infant Mortality Rate (IMR)	2008	74	62	2011 Census (Indirect Estimate
Infant Mortality Rate (IMR)	2014	44.4	N/A	NFHS IV (2014)
1-4 Year Child Mortality Rate	2014	13.4	N/A	NFHS IV (2014)
Under-Five Mortality Rate (U5MR)	2014	57.2	N/A	NFHS IV (2014)
Decrease in Tribal IMR (1988-2014)	1988-2014	From 90 to 44	N/A	Temporal Trend Study (1988-2014)
Decrease in Under-Five Morta	1988-2014	From 135 to 57	N/A	Temporal Trend Stud

lity Rate (U5MR)				y (1988 - 2014)
Estimated Deaths of Indigenous Infants	2011	146,000 (under five years old)	N/A	2011 Census, National Family Health Survey (NFHS)

iii) Other child health indicators

- The tribal population exhibited the highest percentage of children with low birth weight (less than 2.5kg) in the Rapid Survey of Children (2013-14).
- Nevertheless, ST women exhibited the most effective early lactation practices.
- Despite the high rates of infant and child mortality in tribal areas and the heavy burden of maladies, the ST population's complete immunisation coverage remains persistently low across states, at 56%, compared to 72% for all other social groups.

iv) Family welfare

Among Indian women, 41% of ST women use contraceptives, which is on line with the national average for all women. Despite a greater total fertility rate (TFR) for STs in NFHS-3 (3.1 vs. 2.4 for the general population), the TFR for STs had decreased to 2.5 in NFHS-4, dangerously close to the replacement threshold of 2.1.

1) **Burden of disease:** The indigenous population of the nation is disproportionately affected by three major health issues. Rapid urbanisation, environmental distress, and changing lifestyles have all contributed to an upsurge in the incidence of non-communicable diseases including cancer, hypertension, and diabetes, while the frequency of communicable diseases like tuberculosis and malaria has been relatively constant. Thirdly, there is the problem of mental disorders, especially addiction, which is rather common. Currently, there isn't a centralised database that gathers data on the tribal population; hence, it is impossible to create a national sickness burden profile. The NSSO data shows that the tribal community has a lower reported percentage of non-communicable illnesses (10%) compared to other demographic groups (25%), but it is still a large and necessary amount. Approximately 40% of cases are still due to infections. Concerningly, a large percentage of tribal people describe issues related to the respiratory system (18%), mental/neurological systems (5%), and musculoskeletal systems (10%). The rate of obstetric complications was three times the US average.

A new paradigm in epidemiology is taking shape, Most significantly, RMNCHA is only one part of indigenous peoples' health care requirements. 65,000 adults (15+) would make up each lakh in tribal regions, according to NIRTH's calculations. Most frequent among these disorders are fever (8743 cases), syndromic STI (8255 cases), herpes simplex (8032 cases), ARI (6695 cases), and pelvic inflammatory diseases (PID) (5298). About 39,000 people would suffer from malnutrition, 25,000 from anaemia, 4,000 from ocular xerosis, and 3,000 from dental caries, all of which are nutritional disorders or

deficiencies. These estimates provide a ballpark figure for the health care demand and the massive primary care burden.

2) **Communicable diseases:** The tribal population is disproportionately affected by communicable diseases. HIV, typhoid, cholera, malaria, tuberculosis, cutaneous infections, sexually transmitted diseases, hepatitis, cholera, diarrhoea, and viral fevers are among the conditions that are included.

- **Malaria:** In spite of the fact that tribal groups only account for around 8% of the total population, they are accountable for about 30% of malaria cases, 60% of P. falciparum, and 50% of the malaria-related deaths. The astronomical yearly cost to the economy is Rs. 6,000 crores. Nevertheless, TSP receives only 10% of the NVBDCP's funding. In a 2016 report, the government set a goal of eliminating malaria from the country entirely by the year 2030. Since tribal areas account for the vast majority of malaria cases and deaths, it is clear that tribal health must be given top priority in order to accomplish this goal.
- **Tuberculosis:** The national rate of pulmonary TB is 256 cases per 100,000, whereas indigenous groups had 703 cases per 100,000. Smear-positive tribal pulmonary tuberculosis patients get therapy at 11%.
- **Leprosy:** Although the number of ST population in India is 8.6%, a disproportionate burden of leprosy among tribal people was found in 2012 when the percentage of new cases among the ST community was assessed to be 18.5%. The integration of leprosy treatment with general health care makes patient identification in these settings hard. Unless stronger efforts are made to reach them, they will remain endemic reservoirs.

3) **Non-Communicable diseases:** Observations indicating an unexpected rise in the prevalence of non-communicable illnesses and an early epidemiologic shift in tribal communities have been made.

- **Hypertension:** Among adults in indigenous communities, hypertension affects one in four. Additionally, hypertension was more common among older people, those who smoked, drank excessively, and had sedentary lives. However, the symptoms of the illness were unknown to two-thirds of the adult males and females in the tribe. Even more concerning is the fact that just 5% of men and 9% of women with hypertension were aware of their condition.

4) **Genetic disorders:** Depending on the indigenous group, the frequency of thalassaemia (an additional genetic condition) and sickle cell disease (anaemia and trait combined) may range from one percent to forty percent. The heterozygous type of the illness, however, accounts for the majority of cases. The more severe kind of sickle cell anaemia affects 1 out of every 86 babies born in tribal tribes in central India. Regarding the sickle cell disease (SCD) initiative, two schools of thought have emerged. The first notes that the majority of SCD mortality and morbidity research take place in hospitals, where only the most severe cases are included. Therefore, it may be immature and even immoral to conduct community-wide screenings, single out asymptomatic people, and label them, particularly in cases when they do not have access to adequate

medical treatment. A second school of thought argues that the best way to improve the health and longevity of indigenous communities is to test all members of those communities for SCD and implement effective management strategies. The Indian government, on the other hand, has begun a massive initiative to test three crore individuals for sickle cell trait, reflecting the second viewpoint. Screening for carriers and advising couples throughout their reproductive years to stop the disease's spread has been the main emphasis. However, if there is currently no therapy or cure, even identifying carriers could cause social exclusion and shame.

The G6PD deficiency is another hereditary disorder that affects a large number of Indian tribal communities. The incidence of G6PD deficiency ranged from 0.7% to 15.6% among 14 primitive tribal communities from four states that indicate a high frequency of the sickle gene

5) **Nutrition**

❖ **Daily nutrient Intake:**

According to a research conducted by the National Nutrition Monitoring Bureau (NNMB) in 2008–2009, the intake of most nutrients among tribal populations fell short of what is recommended daily by the Indian Council of Medical Research (RDA). Furthermore, this trend held true regardless of gender or age group. Worryingly, this may make food insecurity worse.

During the second NNMB study (1988–1990) and the third survey (2008–2009), the average grain and millet consumption in tribal regions was 50 g/CU/day. There was a 117 µg/CU/day drop in vitamin A consumption and a 3 g/CU/day drop in average daily protein intake. There was a 150 kcal/CU drop in average daily energy consumption.

Meals that are high in protein and calories are only eaten by 29-32% of kids and 63-74% of adults.

Of the women who were pregnant or breastfeeding, only 25% met their calorie and protein needs. Mothers and children suffer from malnutrition, which leads to risky pregnancies.

❖ **Malnutrition:**

a) The nutritional status of tribal children differs significantly from non-tribal children, especially in northern regions.

b) The proportion of underweight ST children decreased from 54.5% in NFHS-3 (2005-6) to 42% in NFHS-4 (2015-16). Tribal children remain the most malnourished. In indigenous youngsters, underweight is about 1.5 times higher than in 'other' castes.

c) Tribal children have increased under-nutrition with age, similar to the overall population. The frequency of underweight and stunting was greater in preschoolers than babies.

Malnutrition among indigenous children has been steadily declining over time, according to the temporal trend (NNMB 2 and 3, then the RSoC). But the media and state legislators keep reporting on tribal enclaves (Melghat, Nandurbar, Thane) as having higher rates of child mortality and malnutrition. It is critical to determine the kind and causes of these devastating spikes so that appropriate actions may be taken. These outbreaks tend to occur during the rainy season, which might be due to a combination of factors including a seasonal food shortage, an uptick in infectious diseases like malaria and diarrhoea, and a decrease in access to healthcare.

❖ **Micronutrient deficiencies**

a) **Anemia:** Among indigenous women, maternal malnutrition is prevalent, particularly among those who have many pregnancies at close intervals. Anaemia affects 65% of tribal women in the 15–49 age bracket, compared to 56.7% of SC women and 46.9% of all women, according to NFHS 3. Additionally, compared to

children from other socioeconomic categories, the prevalence of anaemia in ST children (6-59 months) is much greater. Approximately 77% of ST children were anaemic, while 64% of children in other categories were, according to NFHS 3.

b) The main reason for the high prevalence of anaemia among these persons is that around two-thirds of the preschool children were ingesting iron below 50% of the Recommended Dietary Allowances (RDA). Reportedly, only 4.2% of mothers with small children have taken iron supplements in the last week.

Paradox of tribal nutrition

1. Tribal people have higher rates of malnutrition (stunting in children and low BMI in adults) compared to non-tribal populations, which is unacceptable.(Jaleel, Abdul et al. 2023)[iv]
2. Over the last decade, the tribal community has seen a drop in food consumption and nutritional intake, including proteins, calories, and vitamins (.Kapoor, Ridhima et al 2022)[v]
3. In the last decade, the incidence of clinical malnutrition in children and low BMI in adults has declined, perhaps owing to lower physical activity and reduced nutritional waste from illnesses..

6) **Mental health and addictions**

a) These addictive substances are known to be easily accessed by tribal populations worldwide. In addition, the modern era has presented tribal people with a variety of existential hazards and mental duress.

b) **Prevalence:** Compared to 56% of non-tribal men, nearly 72% of tribal men in the 15-54 age group were using tobacco, according to NFHS 3. At the national level, a slight majority of ST males consume alcohol in some capacity. This is greater than the consumption rate of non-ST men, which is approximately 30%.

c) Tobacco and alcohol in gadchiroli: The more recent district sample surveys by SEARCH (2015) in Gadchiroli found that-

- Men aged 15 and older had a 41% prevalence of alcohol usage. The district spent Rs. 79 crore on booze annually.
- The 2016 district sample study revealed 44% tobacco usage across all age categories, with an annual spending of Rs 298 Cr.
- Annually, individuals spend Rs. 377 crores on alcohol and tobacco out-of-pocket. More than double the size of the previous year's Annual District Plan (Rs 157 crores). This is scary.

d) Tobacco, alcohol and drugs threaten the tribal people in five ways:

- "Harm health and increase the incidence of serious diseases and mortality;
- Reduce productivity and increase poverty.
- Disrupt family and community harmony;
- Generate law and order problems;
- Constitute a major out of pocket expense and adversely affect the family economy."

As a result, these drugs are detrimental to health, harmony, and progress. The rising rates of hypertension and cancer in indigenous communities may be attributable, in part, to their actions.

e) Excise policy for tribal areas**:** Recognising the negative effects of alcohol on tribal populations, the Indian Ministry of Home Affairs issued the Excise Policy for Tribal Areas in 1976. This ordinance prohibits

commercial alcohol sales in certain zones. Home-made alcoholic drinks are allowed for tribal people under community control. Schools, universities, civic society, and tribal leaders should work to wean tribal people off drinking.States routinely breach this precept, either in text or spirit. The policy is not monitored by any agency.

7) **Animal attacks and violence in conflict areas**: Animal bites from snakes, dogs, and scorpions are prevalent in tribal regions since they are typically surrounded by woods. With an estimated 45,000 to 50,000 fatalities each year (or over 125 people per day), snakebite is the leading cause of death in India. The tribal people, who inhabit ecologically fragile regions endowed with abundant natural resources and woods, are the ones who face the fury of both animals and the elements as the war between humans and the natural world escalates and borders are continually being redrawn.

8) **Health care seeking in tribal areas**

- Due to significant geographical and socioeconomic obstacles, the Rural Health Statistics (RHS) show that tribal regions have significant gaps in their health infrastructure and resources. When roads are bad or limited, getting to medical care becomes more of a challenge. Poverty, long wait times at health facilities, linguistic and social obstacles, insufficient equipment, and a lack of available health workers all contribute to access issues.

- Public hospitals see about half of all outpatient visits from tribal people, and government health services account for over two-thirds of all inpatient stays for tribal people. 'Other' castes account for 18.5% and 34.5% of the total. So, public health care is a lifeline for indigenous communities when they need medical attention from outside sources. The message it sends is clear: public health facilities in tribal regions need to be improved, and the people working there must be treated with dignity and respect by trained professionals. That is obviously not the case, however.

9) **Health care infrastructure**

Health Sub-centers (HSCs) should be distributed as follows: one per 3,000 people in tribal and mountainous regions, one per 20,000 people in primary health centres, and one every 80,000 people in community health centres are the current standards.

In 18 states and 3 union territories, researchers looked at data on the "needed versus shortfall" of sub-centers, primary health centres, and community health centres in tribal regions. Reported in 18 different states:

Sub-centres: In seven states, HSCs were in sufficient supply. In the remaining 11 states, 4996 sub-centres were missing, 27% of the needed number.

PHCs: 11 states had no shortage. In the remaining seven inadequate states, 1023 PHCs were missing, 40% of the needed number.

CHCs: No deficit was detected in eight states. A deficit of 209 was noted in the other ten states. In these states, the deficiency represented 31% of the necessary CHCs. Dadra and Nagar Haveli has 8% fewer sub-centers and 1 fewer CHCs than required. No level had another shortage.

Thus, in half of the states, tribal health facilities were 27 to 40% scarcer than usual.

10) **Health Human Resource (HRH)**

i) There is a severe lack of human resources at health centres in tribal areas for many reasons. These include, but are not limited to, poor human resource policies, hostile work environments in public health facilities, a lack of social infrastructure, few chances for staff to advance their careers, and a general sense of social and professional isolation. There is still a severe lack of medical professionals,

despite the fact that some governments have implemented various solutions.

ii) The majority of MBBS graduates in Maharashtra and a few other states disobey the bond for mandatory rural service. The health and medical education agencies don't seem to be able or willing to carry out the bond's execution. Surprisingly and tragically, there are unfilled positions for physicians and specialists in tribal regions' primary health centres and community health centres, and the bond is not being enforced on the 90% of doctors!

iii) About frontline workers, there are no statistics available about the density or average number of individuals served by ASHAs in tribal communities. These professionals may be very important in tribal settings when the public health systems have challenges with acceptance. Strong data suggests that ASHA is a suitable, practical, and successful strategy to close the health care gap in indigenous communities. However, throughout its travels to tribal areas, this committee discovered that the State Health Missions either failed to recognise this truth or were unable to handle this remedy.

iv) Of all ANMs, 64 percent were excess in tribal territories throughout 10 states. Maybe this "surplus" is a reflection of how many ANM positions are really needed. Actually, one ANM is needed for every two thousand individuals, according to this deployment, which is likely driven by need.

v) There is a significant nursing personnel shortage. Himachal Pradesh (77%) has the largest shortage, followed by Jharkhand (56%) and Odisha (54%).Further, the quality of care offered by the existing health personnel also remains questionable due to lack of motivation, understanding and mutual respect.

vi) Diagnosis of tribal health:Tribal health in India suffers from following ten burdens:

1) Consistent communicable diseases, maternity and child health difficulties, and malnutrition;
2) Rising non-communicable diseases, such as mental stress and addiction.
3) Accidents, snake/animal bites, and conflict-related violence;
4) Geographical, isolated, and hard conditions;
5) Worse social-economic variables, including education, income, housing, connection, water, and sanitation.
6) Poor health care access, coverage, and quality.
7) Limited health personnel resources at all levels, with foreign specialists hesitant to work in tribal communities and local talent underutilized by the health system.
8) Most states fail to provide or use the necessary funding for indigenous health. Tribal health spending is not transparently reported.
9) Insufficient data, monitoring, and assessment hides problems;
10) Political disempowerment of indigenous people, from individual to national levels, worsens issues. Tribal people are seldom involved in planning, prioritization, or implementation.

Health culture and health literacy

A plethora of health-related folklore exists in the majority of indigenous groups. Traditional healers of indigenous communities and those who live in forests often make use of a wide array of medicinal plants, including leaves, fruits, seeds, and nuts. The spiritual safety of the indigenous people is ensured by traditional healers, who mediate between humans, the natural world, and supernatural forces. In times of illness, they are often the first point of contact for the indigenous people. Traditional healers are seeing a decline in their sway, for one thing. Additionally, indigenous people still avoid public health facilities due to the

contemporary health care system's lack of emotional and spiritual support. Particularly in the northeast and areas like Jharkhand, there is a lack of understanding and acceptance of Indian medical systems like Ayurveda and Unani.

Because of their isolation, tribal communities have not had access to scientific information on the causes of illness (microbes, poor nutrition) or how to cure and prevent them (cleanliness, personal hygiene, diet, immunisation, etc.). There is still a lack of knowledge on how to stay healthy and how to recognise the signs of illness. Native American moms also scored lowest on measures of newborn discomfort awareness.

i) Health planning

Historically, when policymakers have sought to promote tribal health, they have mostly resorted to tailoring current programs to specific tribal communities or easing standards for tribal areas under those programs. The unique health issues faced by indigenous communities were acknowledged in the National Health Policy of 2002, which allowed state governments to customise programs for tribal regions based on their specific needs. But there are very few state-level programs tailored to tribal contexts. In cases when such programs are in place, there is zero oversight to determine how effective they have been.

8. Conclusion / Recommendations

In spite of the fact that the United Nations and other international organisations have pledged to ensure that indigenous peoples are able to fully exercise their right to health care, it is clear that this right is being violated. When considering this matter, the Indigenous Peoples Pact suggests that UN member states:

- Indigenous peoples have equal rights to physical and mental health care, which must be recognised and protected.
- Collaborate with indigenous communities to provide health and social services, honouring their right to nationality through legal status determination or citizenship awards.
- Ensure indigenous peoples' ownership, access, use, and control over their lands and resources for livelihoods, food security, and overall wellbeing through the following actions:
- End expropriation of indigenous lands and resources;
- Obtain free, prior, and informed permission for development and conservation initiatives. Indigenous rights violations, particularly over lands and resources, harm indigenous women and girls' health. To address these impacts, it is important to conduct culturally appropriate campaigns that specifically target these women and girls and work towards improving their sexual and reproductive health;[vi]
- Review and amend discriminatory laws and policies against indigenous peoples at all levels to ensure their rights to use, promote, and develop their traditional medicines and health practices, including the conservation of their vital medicinal plants, animals, and minerals;
- Take the necessary actions to enhance indigenous peoples' traditional healing systems by combining indigenous peoples' good practices and values with contemporary health techniques and knowledge;
- Use an intercultural approach to integrate indigenous and state health systems;
- Meet the needs of indigenous peoples, especially indigenous women, youth, and children;
- Create culturally relevant health practices meant for indigenous teenagers and children to maximise their potential by means of promotion of culturally sensitive lifestyles fit for their circumstances;
- Establish a mechanism to monitor and assess the extent to which indigenous peoples' right to health is being respected, with a focus on indigenous children, youth, women, and elders, as

well as indigenous people with disabilities. This should follow international human rights norms, including the UN Declaration on the Rights of Indigenous Peoples.

- Indigenous women and adolescents should be included in health choices. Provide culturally relevant information. Acknowledge the disproportionate impact of climate change on indigenous people, respect their sustainable resource management methods, and provide equal access to cheap, sufficient, and high-quality healthcare.

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