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**HEALTH GOALS OF MILLENNIUM DEVELOPMENT AND THE TRIBAL POPULATION IN INDIA: A REALITY**

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**ABSTRACT**

Numerous studies revealed diversified nature of health condition among tribal in India. This paper attempts to explore to what extent the MDGs related to health become realistic and how much they are paradoxical towards tribal people. Whether, the initiatives undertaken to achieve desired health status for tribal population in India needs retrospective and prospective analysis. Have the government and development agencies translated the policy decision into committed plan of actions and reviewed programme and strategies to ensure the needs and rights of tribal people? Have such agencies considered ensuring the tribal participation in the programmes aiming toward MDGs of health and welfare? These few questions need to be analyzed before proceeding towards accomplishment of the MDGs. The present paper utilizes the secondary data on health related to tribal population in India. Analysis revealed that there is lack of information on the extent of tribal peoples' health and development. It demands the need for collection of disaggregated data upholding prescribed set of indicators for measuring progress towards the MDGs so that a revised strategies can be drafted according to cultural perspectives of the tribal people to ensure the maximum impact of MDGs' on these groups. While a set of indicators has been selected to measure progress towards the MDGs, there are no guidelines as to how they should be achieved for tribal and marginalized people.

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**INTRODUCTION**

India has a concentration of 104.3 million tribal people and considered to be the second largest in the world next to Africa. These tribal people constitute 8.6 per cent of total Indian population (Census of India, 2011) of which 93.8% resides in rural areas. They are categorized as 705 Scheduled Tribes (ST) including 75 Particular Vulnerable Tribal Groups (PVTG) scattered in different States and Union Territories of the country (Annual report 2013-14, Ministry of Tribal affairs). The country today is placed in a piquant position: having succeeded in solving some problems while new ones are emerging. Current development in various dimensions has not been able to offer succor to the poor especially the tribal population. Indeed the difference between the poor tribal people and other population groups is widening.

In recent years, the UN has been laying stress not on higher economic growth rate, but on quality of human life. The millennium development goal set by UN points towards quality of life, which also includes tribal people. The post – MDG, 2015 needs better understanding of the current status of this tribal people to develop and design appropriate need based programme strategies towards ensuring better quality of life. The review of studies and research findings during the last couple of decades revealed that the tribal people are downtrodden and vulnerable often suffering from various socio- economic, demographic, physical, nutritional and health problems. Besides, in the context of development being attacked and victimized from different angles such as displacement from their land, ecological settings along with exploitation, discrimination, deprivation, isolation etc. resulting in violation of human rights and social justices. The increasing trend of globalization and technological revolution arise question whether the government developmental programmes in reality benefiting the independent way of life of the tribal people or pushing them into precarious conditions and making them more vulnerable than ever?

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Most of the developmental indicators like level of poverty, nutrition, per capital income, basic education, IMR, MMR, employment etc. appear to be very severe as many of these are tied with the MDGs and calls for international commitments. Hence it is desirable to understand whether the government and development agencies translated the policy decision into committed plan of actions and reviewed their programmes and approaches to ensure better health and the rights and needs of tribal people? Whether these agencies considered ensuring the tribal participation in the development programmes aimed at meeting the MDGs of health and welfare? These are some of the questions that need to be answered before proceeding towards to accomplishment of the MDGs. Actually, the goals of Millennium Development related to health are primarily concerned as core values for assessing progress of indigenous tribal people. Since health status indicates the overall economic and social development under the normal course of actions for development as evident in the past may be helpful in assessing the achievement of MDGs. For developing any strategic plan of action on health goal and its implementation needs an in-depth understanding including its possible ways and means is crucial and challenging task for planners.

It also requires systematic, continuous and consistent assessment to review the progress of development in tribal communities. Scrutinizing the feasibility of MDG related to health in relation to past, present and future status of tribal people may provide a framework of observable boundaries to enhance and ensure the development programme towards the benefits of tribal people in India. In the recent past a number of initiatives undertaken in attaining the MDGs, but in the context of India's tribal population it needs retrospective and prospective analysis. This paper try to examine whether the programme with numerous provision and developmental strategies made any significant differences in achieving the minimum standards of health among tribal people in India and able to address their health needs and rights over the decades for ensuring quality of life? In India to what extent the MDGs is realistic and how much they are paradoxical for the tribal people. Whether any special attention was given to the primitive tribal population for attaining MDGs related to health in the country? Thus, present work attempts to assess MDGs in context of health i.e. (1) Goal- 4: Reduce Child Mortality (2) Goal- 5: Improve Maternal Health and (3) Goal- 6: Combat HIV/AIDS, Malaria and Other Diseases among the tribal by understanding the achievements made and the gaps which exist that need to be addressed for ensuring better quality of life for the tribal in their own environment.

## MATERIALS AND METHODS

The study utilized secondary data collected from various government reports and publications like National Family and Health survey-III report (2005-2006), Annual reports of Ministry of Tribal Affairs for the year (2007 and 2011-2012) and millennium development goals India report 2014. The variables relevant for the health related Millennium Development Goals were chosen from these reports and presented in tabular form for analysis and interpretation. The present paper selected following variable to make justification against health related MGDs:

**Goal-4 Reduce Child Mortality:** Under 5years mortality rate, infant mortality rate, neonatal mortality rate, vaccination status of children, status of breast feeding of the baby, incidence of diarrhea, ARI, anemia in children etc.

**Goal -5 Improve Maternal Mortality:** Maternal mortality ratio, incidence of anemia in women, Proportion of births attended by skilled health personnel, no. of antenatal visit by pregnant women, IFA tablet intake by pregnant women, birth assisted by trained health personnel's, institutional births & safe delivery.

**Goal- 6 Combat HIV/ AIDS, Malaria and Other diseases:** prevalence of HIV in women, women & men who have heard of AIDS, Knowledge in men & women about the precautionary measures for spread of HIV/ AIDS, prevalence of death due to malaria, proportion of population using prevention measures for malaria, percentage of death rate due to tuberculosis and involved in treatment under DOTS etc.

## RESULTS

### Goal- 4. Reduce child mortality

The infant mortality rate is an expressive indicator which explains how well a nation is doing in protecting their most vulnerable members. Both infant and child mortality have continued with their declining trend but remains at high levels in India. The under five-mortality rate (U5MR) was targeted to be reduced from 125 deaths per thousand live births in 1988-92 to 42 in 2015. According to the Annual report 2006-07, ministry of tribal affairs, government of India, the U5MR was 94.9 for the whole country but for S.T. this figure out to be 126.6. The infant mortality rate for S.T. population was 84.2 which was higher compare to S.C. population (83) and at all India level (70). In the year 2012, U5MR reached 52 and infant mortality reached 52 for the entire country but lack estimation for Rural, urban, S.T and S.C population for designing population target approach for fast achievement of the target under MDGs by 2015. Among the ST population the proportion of one- year-old children immunized against measles in 2005-06 was 46.3%, immunized against all recommended vaccines was 31.4% and those who received vitamin A dose in last 6 months was 18.2% which was low when compared to the whole country. In the year 2009, the proportion of one- year-old children immunized against measles was 74.1% but the same for S.T. population was not estimated for future planning of strategies. The children under 3 years who were breast fed within one hour of birth was 27.2% and 0-6 months exclusively breastfed was 56.3% in ST population which was also higher compared to the whole country (Table1).

### Goal- 5. Improve maternal health

The maternal mortality rate (MMR) was targeted to be reduced from 301 deaths per 100,000 live births to 109 by 2015. However, MMR has reached 178 in the year 2010-2012. Further, MMR estimation lack population segregated estimation for future strategic designing to achieve MDG target set by the country. According to NFHS-3, the institutional delivery among S.T. population was 17.7% which was quite low compared to rural population (28.9%), S.C population (32.9%) and all India average (40.7%).

**Table 1. Child mortality among S.T. and other population of India**

Indicator	Year	India	Urban	Rural	S.T.	S.C.	By 2015	
							to be Achieved	Target
1. Under-five mortality rate	2006	94.9	NA	NA	126.6	119.3	50	42
	2012	52	-	-	-	-		
2. Infant mortality rate	2006	70	NA	NA	84.2	83	41	27
	2012	42	-	-	-	-		
3. Neonatal Mortality	2005-2006	39.0	28.5	42.5	39.9	46.3		
4. Postnatal Mortality	2005-2006	18.0	13.0	19.7	22.3	20.1		
5. a. Proportion of one-year-old children immunized against measles	2005-2006	58.8	71.7	54.2	46.3	56.7	89	100
	2009	74.1	-	-	-	-		
b. Proportion of one-year-old children immunized against all recommended vaccines	2005-2006	43.5	57.5	38.6	31.4	39.7		
6. Children age 12-35 months who received a vitamin A dose in last 6 months	2005-2006	21.0	22.7	20.4	18.2	20.5		
7. Children Under 3 years breastfed within one hour of birth	2005-2006	23.4	28.9	21.5	27.2	22.4		
8.Children age 0-6 months exclusively breastfed	2005-2006	46.3	40.3	48.3	56.3	51.6		
9.a.Children with diarrhea in the last 2 weeks who received ORS	2005-2006	26.2	32.7	24	30.0	23.8		
b. Children with diarrhea in the last 2 weeks taken to health facilities	2005-2006	58.0	65.3	55.6	52.4	57.3		
10.Children with acute respiratory infection or fever in the last 2 weeks taken to a health facility	2005-2006	64.2	78.1	59.9	55.3	64.2		
11.Children age 6-35 months who are anemic	2005-2006	79.2	72.7	81.3	85.1	82.3		

**Table 2. Maternal health among S.T. and other population of India**

Indicator	Year	India	Urban	Rural	S.T.	S.C.	By 2015	
							to be Achieved	Target
1. Maternal mortality ratio	2005-2006	301	-	-	-	-	139	109
	2010-2012	178	-	-	-	-		
2.a.Pregnant women age 15-49 who are anaemic	2005-2006	57.9	54.6	59	73.9	59.3		
b.Ever- married women age 15-49 who are anaemic	2005-2006	56.2	51.5	58.2	69.2	58.8		
3. Proportion of births attended by skilled health personnel	2005-2006	46.6	73.5	37.5	25.4	40.6	62	100
	2007-08	52	-	-	-	-		
4.Mother who had at least 3 antenatal care visits for their last birth	2005-2006	50.7	73.8	42.8	40.2	44.3		
5.Mother who consumed IFA for 90 days or more when they were pregnant with their last child	2005-2006	22.3	34.5	18.1	17.3	16.5		
6.Births assisted by a doctor / Nurse/ LHV/ANM/ Other health personnel	2005-2006	48.3	75.2	39.1	26.9	42.3		
7.Institutional births	2005-2006	38.7	67.5	28.9	17.7	32.9		
8.Safe delivery	2005-2006	47.6	-	-	28.4	39.6		
9. Mother who received postnatal care from a doctor / Nurse/ LHV/ANM/ Other health personnel within 2 days of delivery for their last birth	2005-2006	36.4	60.7	28.1	22.1	31.0		

**Table 3. HIV/AIDS, malaria and other diseases among S.T. and other population of India**

Indicator	Year	India	Urban	Rural	S.T.	S.C.	By 2015	
							to be Achieved	Target
1. HIV prevalence among 15--24 year old pregnant women	2011	0.39	-	-	-	-	-	-
2. Population aged 15- 24 years with comprehensive correct knowledge of HIV/AIDS (%)	2006	32.9	-	-	-	-	-	-
3. Condom use at last high risk sex	2010	74	-	-	-	--	-	-
4.Women who have heard of AIDS	2005-06	57.0	80.7	46.4	34.6	50.9	-	-
5.Men who have heard of AIDS	2005-06	80	94.2	73	58.0	76.8	-	-
6.Women who know that consistent condom use can reduce the chances of getting HIV/AIDS	2005-06	34.7	56.3	25.1	17.2	27.9	-	-
7.Men who know that consistent condom use can reduce the chances of getting HIV/AIDS (%)	2005-06	68.1	85.6	59.5	45.1	62.7	-	-
8.Deaths due to HIV/ AIDS	2004	1114	-	-	-	-	Nil	-
9. a. Condom use rate of the contraceptive prevalence rate	2005-06	5.3	10.0	3.3	1.7	4.1	-	-
b. Any method (NFHS-3)	2005-06	56.3	64.0	53.0	48.0	55.0	-	-
10. Prevalence and death rates associated with malaria	2012	0.04	-	-	-	-	Nil	-
10. Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures (% of population using Indoor Residual Spray)	2004	81.21	-	-	-	-	-	-
11. Prevalence and death rates associated with tuberculosis per lakh population	2011	24	-	-	-	-	Nil	-
12. Proportion of tuberculosis cases detected and cured under directly observed treatment short course (DOTS) in %	2013	85	-	-	-	-	-	-

Similarly, the percentage of safe delivery among S.T. (28.4%) was lower compared to S.C. (39.6%) and all India level (47.6%)(Table2). The maternal anemia among S.T. pregnant women was found to be 73.9% and in S.T. ever married women age 15-49 years was 69.2%. The S.T. mother who had at least 3 antenatal care visits for their last birth was 40.2%, consumed IFA tablets for 90 days or more was 17.3%, received postnatal care represents 22.1% which was very low when compared with other population of the country (Table2). However there was no disaggregating data on maternal mortality and its causes for S.T. population of the country.

#### **Goal- 6. Combat HIV/AIDS, malaria and other diseases: 135-147**

The HIV prevalence among 15- 24 years old pregnant women was 0.39. The condom use rate at last high risk sex was 32.9 %. This information for S.T. population of the country was non- available. The S.T. women who have heard of AID (34.6%) and those who knew that consistent use of condom can reduce the chance of getting HIV & AIDS (58.0%) was also lower compared to S.C., rural and urban population. The prevalence of death rate associated with malaria was 0.04%. The prevalence and death rate associated with tuberculosis per lakh population was 24 and the proportion of tuberculosis cases detected and cured under directly observed treatment short course was 85% (Table3). However there was no disaggregating data for malaria, tuberculosis and DOTs intake for the S.T. population for assessing their position in an attempt to combat against these diseases.

## **DISCUSSION**

Status of good health shows the achievement made under the umbrella of human development and an essential component for ensuring wellbeing of the mankind. The studies undertaken during the past decades showed heterogeneous nature of health status among the tribal population. Surveys showed that due to nutrition deficiency, a high incidence of malnutrition was observed among tribal of Orissa, West Bengal, Jharkhand. It was also observed among adolescents and elderly tribal population (ICMR buttetin, 2003). NFHS-3 (2005-2007) shows that in S.T. population underweight in Children (3 years) was 56.7 %, Anemia in children (6-3) months was 85.1%, Children with acute respiratory infection was 55.3%, Children with recent diarrhea was 30.0 %, Pregnant women (15-49 years) with anemia was 73.9%. There is a wide interstate disparity in Infant Mortality Rates and Under-five mortality rates. The IMR varies from as low as 14 (Kerala) to as high as 96 (Orissa) and there is widespread disparity and performance when compared to national average. Weaker states like Uttar Pradesh, Rajasthan, Madhya Pradesh, Orissa and Assam have IMR higher than the national average. There are substantial differences not only in the IMR but also in the neonatal, and under five mortality rates between states. Measles immunizations for children aged 12-23 months to show similar disparities. The immunization coverage ranges from a high of 90 per cent in Tamil Nadu to a low of 16 per cent in Bihar. Performance of the weaker states like Uttar Pradesh, Bihar, Assam, Rajasthan etc. are well below national coverage (NFHS-3, 2005-2007). There is need for more concentric and region specific policies and programmes.

In a prospective study conducted in primitive tribes of Orissa mainly Bondo (16%) Didayi (19%), Juanga (25.1%) and KutaiKandha (26.6%) were severally malnourished and 66% of primitive tribal population (6-15 years age group) of Mayurbhanj and Sudergarh districts was found to be malnourished. Similarly, the chronic energy deficiency was found to be very high among LangiaSaura (89.4%) and KutiaKandha (88.9%) primitive tribes of Rayagada district of Orissa (Balgir, 1999). It was found that 85% of Great Andamanes children were undernourished and adolescents (<19 years) 77% were stunted, wasted or both and have poor knowledge of iron and iodine deficiency and disorders (Bulliyya *et al.*, 2008). Further, Menon *et.al.* (2011) reported higher iodine deficiency in pregnant tribal women. A review of the ICDS scheme by Government of India suggested modifications in the health and nutrition component of ICDS scheme to improve the program implementation and efficiency hence require better understanding of the health scenario of the tribe's in the country.

A study conducted in West Bengal reported severe malnourishment children in the age group of 12-23 months particularly the female children and in the families where mothers were working and also in the families where numbers of sibling were 2 or more of a tribal community (Ray *et al.* 2000). Further the services available under Integrated Child Development Services Scheme were utilized by 47.3% children (Ray *et al.* 2000). Similarly, Meshram *et al.* (2012) reported under nutrition is a significant health problem among tribal children and is associated with literacy status of mothers, household wealth index and morbidities. Therefore implementation of appropriate nutritional intervention strategies and improvement in households' food security through public distribution systems, food intakes, socioeconomic condition, literacy of parents and personal hygiene may help in improving the nutritional status of tribal children. Ghosh-Jerath *et al.* (2013) reports high prevalence of under nutrition and dietary deficiency exists among Sahariyas and mentioned that system strengthening, community empowerment and nutrition education may play a pivotal role in addressing this.

On the contrary studies found an increasing prevalence of overweight/obesity among Tangkhul Naga women due to urbanization and economic development, nutritional transition, improved socioeconomic status and an increasingly sedentary lifestyle (Mungreiphy and Kapoor, 2010). A study reports that the male Scheduled tribe population lack knowledge and have misinformation regarding male sexual health issues, the gender inequality in Indian society. Further lack of male-oriented reproductive health services was detrimental from sharing the responsibility (Saha *et al.*, 2007). A prospective study reports that there was improvement in health and empowerment of families as a result of watershed management in a tribal area helping them to achieve their right to health which is embedded in their right to access to water (Nerkar *et al.*, 2013). There is an increase of T.B among the Nicobarese tribe of car Nicobar, despite the introduction of National T.B. control programme (Murhekar *et al.*, 2004). Naranget *et al.* (1999) reports a high prevalence of T.B among Mana (730) and Pawara (612) tribes while among Gonds the prevalence was similar to that in the non-tribal population. There found an improvement and acceptability of T.B. control

programme among the patient by involving the traditional healers in tribal areas (Banerjee *et al.*, 2004). Further, there is potentially a precursor for an HIV / AIDS epidemic among Indian tribal community (Eknath Naik *et al.*, 2005). Nimgaonkar *et al.* (2014) reports the need for high quality comprehensive integrated care for patients with sickle cell disease through a community driven network of care in a remote aboriginal tribal population in southern India. This model can serve as a template for healthcare delivery for SCD in low-income communities. In India globalization, post liberalization development initiatives introduced under the name of development could not able to bring equality and equity among all segment of the population. Further it seems to augment human conflicts are more frequent leading a sharp inequality in ethnic/tribal and religious groups in different parts of the country pushing them into the vulnerable situation. As a result the health problems and health practices of tribal community coupled with poverty levels and developmental initiatives are getting influenced by interplay of various factors including social, economic and political ones.

Further, the common beliefs, customs, practices related to health and disease of the people are influencing their health seeking behavior. The ill health and unstable state of minds of tribal are determining their low productivity and forcing them to fall in poverty. This vicious cycle of poverty and ill health are affecting the development initiatives accordingly. In India the developmental programmes and schemes have not been able to percolate much positive impact on their way of life. The new millennium development goals for the tribal population may have some critical implications. Reduction of malarial morbidity and mortality is important to meet the overall objectives of reducing poverty and has been included in the Millennium Development Goals. To achieve these targets it is imperative to have active community participation to control malaria. Community participation in turn depends on people's knowledge and attitude towards the disease. There is a consensus agreement that the health status for the tribal population is very poor. It is worst among the primitive tribes, they are unaffected by the various health development programme and processes going on in the country. The tribal communities in general and primitive tribal groups in particular are geographically distinct, remain isolated, living in remote forest and hilly areas far from civilization.

They are anthropologically distinct with each tribe having its own unique culture, customs, traditions, beliefs and practices. Over the years, displacement and rapid acculturation, high level of poverty and ignorance, these communities are highly vulnerable to various health problems, especially, communicable, non-communicable and genetic diseases. Majority of them have poor health status, peculiar health needs and a wide prevalence of malnutrition, malaria, sexually transmitted disease, tuberculosis, red blood cell genetic disorders like sickle cell anemia, thalassemia, G6PD deficiency and reproductive health issues that complicates their health problems further. Moreover, the inadequate health infrastructure in tribal areas to deal with such complicated health problems is a matter of grave concern. The Millennium Development Goals upholds its commitment to the right to development, peace, security and gender equality, to the eradication of many dimension of poverty and to overall sustainable development by making efforts to fight against

poverty, illiteracy, hunger, lack of education, gender inequality, infant and maternal mortality, disease and environment degradation. The UN Secretary- General's Millennium Reports states: "Conflicts are most frequent in poor countries ..... where there are sharp inequalities between ethnic or religious groups. The best way to prevent them is to promote healthy and balanced economic development, combined with human rights, minority rights and political arrangements in which all groups are fairly represented". The Country like India having high population growth rate, changing sociopolitical institution, demographic characteristics as well as varied morbidity and mortality patterns have exacerbated the prevailing and emerging public health challenges.. The sub optimal health status of tribal people and the health inequalities between tribal and non-tribal population reflect a fundamental failure to ensure the rights of tribal people to fully realize their human, social, economic and political capabilities.

Studies undertaken in the subject indicate that the tribal people have distinct health problems, mainly governed by the multidimensional factors. These are some of the special health problems attributed to these communities. The situation analyses of health indices of the tribal population in India are worse than the national average. The MDGs related to health does not mention to control and prevent non communicable diseases particularly hereditary diseases which generally aggravated due to their particular socio- cultural practices like blood related marriage and inbreeding mostly prevalent among tribal people. The health culture of a community does not change so easily with changes in the access to various health services. Hence, it is required to change the health services to conform to health culture of tribal communities for optional utilization of health services. India's performance in reducing mortality rates, compared to similar Asian developing countries like China, Indonesia and Thailand, is poor. The level of IMR is much higher in India even compared to some of the Southeast Asian countries like Bangladesh and Sri Lanka. Though, the country aspires the long-term reduction in mortality rates by achieving Millennium Development Goals and Health. Further, during the recent decade India is showing decline in its mortality rate at a slow pace rising concerns for better strategies for fast achievement of MDGs.

In other words the tempo has not been sustained during the recent years. There is urgent need for new approaches and priorities in the overall strategy to reduce mortality rates among children focusing especially on the tribal as they have higher mortality compare to other population. Maternal care, both pre-natal and postnatal is characterized by gross neglect in India, which has one of the highest levels of maternal mortality in the world. The reason for such high maternal mortality is multifactorial, which range from poverty, high fertility rate, gender bias, under – nutrition and high incidence of anemia among pregnant mothers to the lack of access to primary medical care, lack of access to family planning and reproductive health services and non- availability of trained medical personnel in rural areas. One of the most important reasons for high levels of mortality and morbidity in India is under – nutrition. Food security continues to elude many. One of the contradictory aspects of Indian development is the continuing lack of access to food by large sections of the population in a period when national availability of food

stocks per capital is at historic high levels. Endemic under-nourishment claims many more lives than large – scale famine. The former has less political visibility, leading to its neglect in public discussion and the political agenda of political parties. As a result a huge proportion of the Indian population continues to suffer from chronic under-nutrition and the burden of avoidable illness and morbidity. Further, abundance of tribal people's access to forest product and indigenous health care system contributes positively to the tribal health. They have their own system of diagnosis and cure. They prepare their own medicine usually using herbs and other items collected from the nature and processed locally. These nature resources and skills are disappearing. Moreover, traditional system cannot treat of present most of the new emerging diseases that modern medicine can do. Health and sanitation are often worse in regions where Tribal peoples live. In health care facilities, these groups may face discrimination. There is often a lack of medical professionals able to communicate in their languages or to understand their culture, thus inhibiting the delivery of good medical care.

Efforts should be made to reach remote areas inhabited by Tribal peoples, and to address health care services delivery discrimination if child and maternal mortality rates are to decrease. More over in India at state level the system of registering deaths for maternity causes is prone to biases and a standard survey method for the estimate is yet to be placed. The participation of Tribal representatives – particularly women – in health programme design and evaluation is necessary to devise suitable strategies for the MDGs for these communities. In India data on 'annual parasite incidence (annual number of malaria positive cases per thousand population) and deaths due to malaria per 1,00,000 population are collected from PHCs, CHCs and malaria clinics. However, limitation of these rates is that they grossly underestimate the incidence in tribal, hilly, difficult and inaccessible areas, which cover 20% of population with 80% of malaria cases. Success at eradicating illness also depends on information available to people about the cause of illness and their prevention and treatment. Such knowledge is abysmally low, especially among the most vulnerable section of the population. Added to the existing bundle of diseases is the spread of HIV/AIDS, which also requires raising public awareness as a critical component towards combating it.

In terms of availability of transportation and communication too, there is large variation across districts. Lack of roads contributes to rural poverty, making access to markets, health and educational facilities difficult. Due to lack of availability of data, a detailed discussion on the availability of roads in Indian districts cannot be provided but it can be surmised that district with a higher infrastructure index also have more roads per 100,000 of population (Nirupam Bajpai and Sangeeta Goyal, 2004) have better health outcomes. While a set of indicators has been selected to measure progress towards health related MDGs, there are no guidelines as to how they should be achieved for tribal and marginalized people. The Millennium Project is attempting to give some guidance but not the process is in achieving the goals to make the difference between successful or harmful outcomes. Further, tribal people's participation is essential if their rights and needs are to be fulfilled and influence the development process. The UNDM says: 'States should consider appropriate measures so

that persons belonging to minorities may participate fully in the economic progress and development in their country' (Article 4.5). ILO Convention 169 states that indigenous peoples have: 'the right to decide their own priorities for the process of development... and they shall participate in the formulation, implementation and evaluation of plans and programmes for national and regional development which may affect them directly' (Article 7.1). The literature review showed that data on tribal people's participation in community development programme is lacking at grass root level. Moreover, the participation of Tribal peoples in civil society consultations is ignored because of their marginalization, their different language or their remote habitats. Special effort is needed to ensure that these groups can participate equally. To begin with, there is a need to recognize that these groups exist. A major barrier to participation concerns states' refusal to acknowledge that certain groups constitute Tribal peoples. The process of participation must be equitable, informed and transparent. These groups must be invited to participate in policy and programme design, implementation and evaluation. Information and knowledge sharing should be available in Tribal languages, and attention should be paid to ensuring that marginalized groups within Tribal communities, such as women, older people, and people with disabilities, also have their voices heard.

Tribal peoples should be asked for their views on policies to reduce inequalities and to support their human development. Such participation will aid policy-makers to respond to the expressed needs and the rights of these groups, and to the key barrier of discrimination. Impact assessments should have the feature of the consultation process, to measure the way in which proposed MDG development plans will impact on these groups' quality of life's. The results of these assessments should be expressed clearly to the tribal peoples to enable an informed participation, and the articulation of alternative proposals. Overall development should be meaningful to all potential beneficiaries. Yet the rights of minorities and Tribal peoples have often been violated in the name of 'development'. The MDGs cannot succeed unless Tribal communities' wishes to terminate or redesign development projects that will affect them negatively are respected. Achieving the MDGs for quality of life for these groups will mean mainstreaming their rights into all of the goals and devising some specially adapted programmes to overcome the particular barriers they face. The result will be improved strategies for meeting all the MDGs to achieve health life.

## Conclusion

The Millennium Declaration aims to strengthen the capacity of countries to implement 'the principles and practices of democracy and respect for human rights, including Tribal rights'. The MDGs of health should be interpreted in the light of the rights of Tribal peoples ignoring the particular barriers and considering the heterogeneous nature of the tribal community and geographical and climatic environment. This will result in positive impact of the programme on specific communities that goes unnoticed. One way to improve health status is to identify tribal communities and to understand their health condition. Some tribes may be living in remote underserved areas, which lack infrastructures and essential

services. While, some tribes were affected by development projects and deprived of their basic necessity of livelihood. The economically marginalized and politically weak circumstances of these groups snatch the power to demand accountability, answerability or respect for their own rights. This is often associated with tribal population's poverty, creating discrimination by reducing their ability to benefit from and to contribute to human and economic development. Discrimination brings inequity and accessibility for decent health, housing, education, financial credit, or political participation. There is also a lack of information on the extent of tribal peoples' health status demanding the need for collection of disaggregated data upholding prescribed set of indicators for measuring progress towards the MDGs related to health so that a revised strategies can be drafted according to cultural perspectives of the tribal people to ensure the maximum impact of MDGs' of health on these groups. Further, measuring health and illness should be sensitive to differing cultural perspectives.

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