Exclusion of Scheduled Tribes from Healthcare Systems: A Case Study of the Tarao and Kharam Tribes of Manipur.

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ABSTRACT

The Tarao and Kharam tribes settled in Manipur are amongst the least populated tribes in the State. Although recognized as Scheduled Tribes by the Government of India in 2003, these tribes fare amongst the neglected groups in terms of healthcare system, access to transport and communication, education, and most government welfare schemes. With total population of around one thousand individuals only, these tribes have long suffered in the shadow of other major tribes, necessitating them to identify themselves with major tribes to avail government welfare schemes and other facilities including availing government issued health, education and social welfare certificates and cards. In instances where immediate health facilities are not available in the village or nearby locations, the villagers rely on their knowledge of traditional medicine to cure ailments. The wisdom of the elders on the medicinal value of herbs and plants serves to fill in the gaps where the State apparatus had not reached the remote villages. For instance, the Tarao elders treasure the properties of the Hakungnaii plant to cure gum injury and treatment of kidney stone. In the age of science, the villagers have to rely on their traditional wisdom and knowledge to fill in the gaps left by the State.

Keywords: Tarao, Kharam, Scheduled Tribes, minority, deprivation of facilities.

INTRODUCTION

Tribals constitute around 8.03 percent of India's total population. It is estimated that there are 427 tribal communities in the country. According to the 1991 Census, Madhya Pradesh had the largest tribal population at 23.27 percent, followed by Odisha at 22.21 percent. Due to multi-dimensional factors, tribal communities face many problems like illiteracy, poverty, difficult terrain, isolation, and inadequate health and educational facilities.

Manipur is inhabited by different ethnic communities including scheduled tribes, scheduled castes, minorities and the general population Meiteis, with population spread in various parts of the state. Manipur has a large percentage of scheduled tribe population accounting for around 34.4 percent of the state's total population. According to the 2001 Census, the total tribal population in Manipur was 7,41,141 individuals. The tribal population is mainly settled in the hilly terrain in the state, with some population spread in small pockets in the central Manipur valley.

Manipur faces different social bottlenecks in terms of lack of infrastructural support to block and sub-divisional level institutions, poor educational, healthcare, roads and communication facilities more particularly in the rural and the far flung areas of the state. Other than the urban population in the central Manipur valley districts, the scheduled caste and scheduled tribe populated areas in the hill districts of the state suffer from deprivation of these essential infrastructural support and other basic facilities. This paper concentrates on the scheduled tribe population in the state, with case studies on two minority scheduled tribes of the state, namely, the Tarao and the Kharam tribes.

The Tarao tribe mainly inhabits in Chandel district of Manipur, with population spread in around five villages, namely, Tarao Laimanai, Leishokching, Khuringmuul and Heikakmuul. There is a small population of the Tarao tribe at Sanakeithel village in Ukhrul district. Folklore tradition indicates that the Taraos are well known for their migratory habits. There are evidences that the tribe kept shifting from one village to the other which continued as recent as 1983 (Bokul, 1989). Of the five Tarao villages, Tarao Laimanai is the oldest settlement in the hills and from which the other villages are split off. The foothill villages of Leishokching (established February 25, 1965), Sanakeithel (1974), Heikakmuul (October 2, 1980) and Khuringmuul (December 20, 1983) are the latest settlements (Morre, Tarao Literature Society). After decades of struggling for their rights, the Tarao tribe was formally recognized by the Government of India as a scheduled tribe of the country in January 2003 (Rajesh, 2004). In 1988 the total Tarao population was only 532 (Bokul, 1989) while in 2003 their total population had risen to 689 (Vedmani, 2006).

The Kharam tribe mainly inhabits in Senapati district of Manipur, with population spread in Kharam Pallen, Tuisenphai, Laikot Pheizol, Laikot and Kharam Tampak villages. Kharam Pallen is the main habitation site of the Kharam tribe, and is located 37 Kilometers west of Imphal, the capital of Manipur state, along National Highway No.37 (Imphal-Silchar highway). The village is reached after travelling on the highway 2 Kilometers past the Kotlen police outpost from where a downhill diversion at Kharam Lamkhai (junction or diversion) northwards leads to the village. From the diversion, it is roughly 5 Kilometers to the village on foot. Similarly as the Tarao, the Kharam tribe was recognized by the Government of India as a scheduled tribe of the country in January 2003. "Kharam" is a compound of two words, i.e. 'kha' meaning 'this' and 'ram' meaning 'land', implying "this land". In another version, 'kha' means 'south' and 'ram' means 'land', here implying "the southern land or the southern highland" (Shangkham, 1994). According to the 1961 census, the Kharam total population was only 177, while according to an independent study Sangkham (1994) reported a total population of 1030 in the mid 1990s.

Shortfalls in healthcare system in rural Manipur

In taking up the Tarao and the Kharam tribes as case study, the example of exclusion of minority tribes from availing basic facilities like education and healthcare due to lack of specific government's policy or the failure on the part of governmental departments and implementing agencies to reach out to the grassroots well in time becomes quite evident. For both of these two minority tribes, as in the case of several other minority tribes, other than the poor backup support in educational infrastructure and facilities, the non-availability of basic healthcare facility adequately is a major problem for the villagers as they then have to travel long distances from their native villages to avail of minimum healthcare services from government run institutions or other private facilities.

There are neither primary nor sub-primary healthcare facilities in the villages where they live or in the immediate vicinity of their villages. The nearest proper healthcare facility is either at Pallel as in the case of the Tarao tribe, or in Imphal as in the case of the Kharam tribe, wherein the villagers require spending time, energy and money to avail of the basic facility. Tarao Laimanai, Leishokching, Khuringmuul and Heikakmuul villagers have to travel to Pallel or Kakching for availing medical facilities. For very serious treatments, they have to travel to Imphal – which is costly and time consuming for the villagers. Occasional or periodic visits by medical camp facilitators to their villages are the only solace for the villagers. Otherwise, they resort to traditional healthcare system or procuring medicines by their own means.

Traditional healthcare practices in the absence of availability of adequate or proper healthcare facilities

The Tarao villagers largely depend on their traditional health care system for treatment of different ailments and diseases in the absence of ready availability of conventional health care facilities in the vicinity of their villages. They use a variety of plant and animal parts for treating various ailments such as diarrhoea, fever, cough, headache, high blood pressure, tonsil, toothache, etc. For instance, they consume boiled or steamed passion fruit leaves for treating cough and high blood pressure. They boil leaves of the Amla for treating dry cough, and consume the bile of animals for treating fever. The Tarao consume the new leaves of pomegranate

plant for treating diarrhoea. They make paste out of the buds of Hakungnaii plant to treat injured area of gum, and also boil the leaves of this same plant to treat kidney stone.

It is quite relevant that the use of ethno medicine by the Tarao in their everyday application saves time and money for the villagers, and at the same time it provides source of sustainable livelihood through use of readily available local material. The use of locally available plant and animal parts as medicine through consumption as food also provides sources of healthy living for the villagers.

Similarly as the Tarao, the Kharam tribe too continues to utilize their traditional knowledge on ethno medicine using a variety of plants and animals and their parts for treating different ailments and diseases. This saves them time and money, as well as reducing the risk factor arising out of the non-availability of conventional health care facility in the immediate vicinity of their villages.

CONCLUSION

The issue of deprivation of basic facilities necessary for improvement in conditions of living for those people settled in rural and the far flung areas of the state, in particular for those communities settled in the uplands and other inaccessible parts in the hill districts of the state, has always been in the forefront of discussions at state, regional and national forums. There has also been a continuous process of petition by ethnic communities to the Government of Manipur for formulating policies at the state level to ensure proper and adequate welfare and development schemes in the less developed areas of the state having inadequate facilities of roads and communication.

Among some of the neglected areas of development specifically in rural Manipur, mention can be made of education, healthcare, roads and communication, sanitation, and availability of potable water, electricity and foodstuff. Cases of deaths due to non-availability of adequate and timely medical attention and supplies are often reported from the villages located in the remote areas of the state. Stories of villagers carrying their sick on stretchers for hours to reach the nearest health care facility are heard now and then. Stories of women dying at childbirth due to lack of proper medical facilities, and even stories of primary health centres without doctors and nurses have been reported in the local media.

SUGGESTIONS

It, therefore, is highly required of the Government of Manipur, and also the Government of India, to formulate policies and strategies to ensure that villagers living in the far flung areas of the state avail of adequate and proper medical attention and other health care facilities. There has also to be a firm policy of the Government to depute enough medical officers and staff nurses to all of the primary and sub-primary health centres in the hill districts of the state so that inadequacies in health care system is properly addressed. At the same time, there has to a mechanism of the Government wherein short, mid and long term strategies are in place to provide proper and timely health care facilities to those living at the margin, specifically in areas far removed from the district headquarters.

Finally, there has to be a system of the Government wherein periodic and annual information or baseline data from the grassroots is provided by district administrations to the State Government concerning the availability or non-availability of basic health care facilities for the villagers both at village and block levels, and of the shortfalls such as non-availability of doctors and staff nurses, infrastructures, medical equipments and medicine. The baseline data could also include information on deaths due to improper or lack of medical facilities, and of outbreak of diseases or epidemics and the consequent actions taken up to meet the exigencies.

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