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Critical Analysis of the Right to Health of Tribal Minorities- an Indian Perspective

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Abstract

India has signed the United Nations Convention on the Rights of the Child, but the country's health care system has not received the adequate funding or attention it needs to meet the convention's standards. Health and education are crucial to realizing children's rights, but to do so we must shift away from a welfare model. Special care must be taken to ensure the health of the newborn (survival), baby (immunizations, nutrition), and preschooler (infections, development). Completely functioning health care delivery systems, well executed programs, and comprehensive accountability. All children should have access to free preventative care and basic medical treatment. The disadvantaged need access to practical health literacy education. Because of a severe lack of access to medical care, the health of indigenous people is in a precarious state. Women and children in the neighbourhood are disproportionately affected by malnutrition, which is the leading cause of mortality. The indigenous tribal people of India still face significant obstacles in the health sector, despite India's 68 years of independence. These include a lack of education, the absence of even basic health care, and food poverty. Natural resources are dwindling as a direct consequence of increasing land grabs by corporations, which is wreaking havoc on indigenous communities that have no other means of subsistence. Unemployment among native/tribal youngsters is a major problem. Hence, it becomes important to evaluate the healthcare rights of tribal communities in India. This paper is an attempt to analyse the provision of Right to Health for the tribal communities. It will further argue, whether Right to Health should be explicitly considered as a fundamental right under Part III of the Constitution of India.

Keywords: *Right to Health, Tribal Minorities, Indigenous Minorities*

Introduction

The United Nations Convention on the Rights of the Child has 193 signatories, including India. Included in this group are the rights to: (i) a safe and secure environment free from abuse, exploitation, and violence; (ii) a quality education; and (iii) protection from harm (combating child labor, child trafficking and child sexual abuse).[2] When a country ratifies the Convention on the Rights of the Child, it commits to enshrining its provisions in national constitutions and laws. Thus, the laws may provide protection from violence, prevent sexual abuse and trafficking, or provide standards and guidelines for a variety of child-care services.

A human right to health was recognized in the Universal Declaration of Human Rights issued by the United Nations in 1948. The following is an excerpt from that document's Article 25: *"Everyone has the rights to standards of living adequate for the health and well-being of himself and his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood in circumstances beyond his control."* The

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[2] How is Children's Health a Human Rights Issue? – Health and Human Rights Resource Guide, https://www.hhrguide.org/2014/03/16/how-is-childrens-health-a-human-rights-issue/ (last visited Dec 31, 2022).

promotion of a connection between health and human rights has as its ultimate objective the improvement of overall human well-being. On a more pragmatic level, health care personnel may ask about the appropriateness and value, much alone the need, of bringing Human Rights concepts into their job and vice versa.[3]

The Supreme Court of India in the case of Karukola Simhachalam & Another v/s Union of India, Rep. by its Secretary, Health & Family Welfare Department & Others[4] observed,

> *"To begin with, the right to health as a fundamental right grew as an offshoot of environmental litigation initiated by environmental activists regarding the environment issues. Undoubtedly the right to environment was crucial because a polluted environment affects public health. A pollution free environment as a fundamental right presupposes right to health as a fundamental right. Logically, the explicit recognition of the fundamental right to health should have preceded the fundamental right to good environment. However, the development of jurisprudence in this branch has been the reverse."*

This judgment becomes an important part of the healthcare jurisprudence and necessitates the fact that Right to Health needs to be given more weightage and importance. This is made even worse by the fact that people in these communities are unaware of the steps that must be taken to safeguard their health, that they live a significant distance from medical facilities, that there are no roads that are accessible in all weather and that transportation is prohibitively expensive, that medical staff members behave in a way that is insensitive and discriminating, that there are financial limits, and so on. The results of government initiatives designed to increase the population's health awareness and to enhance their access to primary health care have not been as successful as hoped. It should come as no surprise that individuals who live in tribal communities have diseases that are more severe and last longer. Women and children are particularly susceptible to these ailments.[5]

The implementation of government programs such as the Forest Rights Act (FRA) 2006, the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) 2005, the Right to Information (RTI) Act, and Rural health programmes scarcely addressed the health concerns or helped people to prolong their lives. The budget that the Central Government has set out for the Schedule Tribe Sub-Plan has been distributed in a manner that is proportional to the population. An examination of the prior years' budgets over the last five years (2012-2016-17) reveals that the amount of money allocated to the Tribal Sub-Plan (TSP) is, on average, more than fifty percent lower than what is required. In a same vein, out of a total of 303 plans that fall under the Tribal Sub Plan, just 7%, or 22 of those schemes, have direct significance to Scheduled Tribes. Another example would be the appropriation of Rs. 6,376 crore for the National Rural Health Mission, for which records were not kept but which was budgeted under the TSP.[6]

Traditional remedies and naturopathy have been common practices in indigenous societies since the beginning of recorded history. However, wealthy metropolitan societies are

[3] Arun M. Kokane et al., *Determinants of behavioural and biological risk factors for cardiovascular diseases from state level STEPS survey (2017-19) in Madhya Pradesh*, 8 PEERJ e10476 (2020).

[5] Pinak Tarafdar, *Right to Health: The Tribal Situation*, 38 INDIAN ANTHROPOLOGIST 77 (2008).

[6] Dhanush Samvaad, *Ministry of Tribal Affairs, Government of India*, https://tribal.nic.in/ (last visited Dec 31, 2022).

increasingly turning to this therapy method as the most effective choice available. As a result, indigenous people are being routinely denied of access to these resources as a direct result of the corporatization of herbal resources and therapeutic plants. The majority of people who live in India's tribal and adivasi communities are malnourished, have a limited or non-existent understanding of proper hygiene, and do not have access to hospitals. As a result, a great number of people get persistent illnesses. It is common for medical care to never make it to the villages of tribal people or Adivasis because of the negative social stigma associated with these groups. Many people in tribal and Adivasi communities seek spiritual treatment rather than medical aid because of their cultural and traditional practices. Skin illnesses, issues with the uterus, TB, and renal deficits are common conditions that affect tribal and adivasi populations. Drinking alcohol regularly is one of the most important risk factors for a wide range of diseases. The young generation, and teenage females in particular, are impacted when there is a sudden shift in their dietary habits as a result of bad food items that are delivered via the Public Distribution System (PDS).[7]

According to the results of the Census conducted in 2011, the Scheduled Tribes in India make up 8.6 percent of the country's total population. These tribes are recognized under the Constitution of India. There are 990 females for every 1000 men in the tribal community, which is a gender ratio that is beneficial when compared to that of other social groupings in the nation. In the population of Scheduled Tribes, the Infant Mortality Rate (IMR) is around 62 per 1000 live births, while the Under Five Mortality Rate (U5MR) is 96 per 1000 live births. Both of these rates are referred to as "mortality rates." IMR was 27 percent greater than the rest of the population, while the U5MR rate was 61 percent higher than the rest of the population.[8] The mortality rate among people aged one to four years old is 33.6 percent in Scheduled Tribes but just 10.3 percent in non-Scheduled Tribes. There is room for remedial action such as vaccination, care of acute respiratory infections, diarrhoea, and malnutrition. Those are few examples. Urgent action is required due to the very high IMR and U5MR in seven states with a significant population of tribal people. These states are Jharkhand, Odisha, Chhattisgarh, Madhya Pradesh, Gujarat, and Rajasthan.

According to the conclusions of a number of research on maternal health, indigenous people had a worse nutritional status, greater rates of illness and death, and a lower use of prenatal and postnatal treatments. The mortality rate for children under the age of five in remote tribal communities remained shockingly high in 2006, with 95 fatalities for every 1,000 live births, when the overall mortality rate for children was just 70. Eighty percent of tribal women in the Melghat district of Maharashtra weighed less than fifty kg[9], and seventy-four percent of children under the age of five in that region were malnourished, according to a recent research. "Deaths from starvation" are still being recorded from tribal communities, even in more developed states like Kerala.[10]

In the population of Scheduled Tribes, there was only around a ten percent drop in the Infant Mortality Rate (IMR) between the years 1992-98, whereas in the population as a whole there was roughly a twenty-five percent reduction during the same time period. In India, there are

[7] Derek Jennings, Meg M. Little & Michelle Johnson-Jennings, *Developing a Tribal Health Sovereignty Model for Obesity Prevention*, 12 PROGRESS IN COMMUNITY HEALTH PARTNERSHIPS: RESEARCH, EDUCATION, AND ACTION 353 (2018).
[8] *Id.*
[9] Taking healthcare to India's remote tribes, THE HINDU, Sep. 1, 2014, https://www.thehindu.com/opinion/op-ed/taking-healthcare-to-indias-remote-tribes/article6370400.ece (last visited Dec 31, 2022).
[10] Kokane et al., *supra* note 2.

120 million teenage females, or approximately 10% of the total population. Girls in India are an underrepresented demographic despite their enormous numbers. They have little agency in shaping their destiny because of pervasive social and cultural standards. The primary goal of both state and non-state actors should be to foster an atmosphere in which girls feel secure, are noticed and appreciated, and therefore catalyze a shift that results in healthier and more successful families, communities, and societies. All people have an inherent, inalienable, and inviolable right to the highest attainable degree of physical, mental, and social health. Teenage girls were particularly vulnerable to human trafficking because of the widespread absence of restrooms in schools.[11]

Since commercial healthcare providers have little interest in serving the mostly tribal communities, the majority of the Scheduled Tribe people must rely on the state healthcare system. As a result, it is more crucial than ever to strengthen the current public health system. More over 75% of the tribal population uses government-funded health care, but just 47% of those from non-scheduled tribes do the same. Health Intelligence Bureau, Ministry of Health and Family Welfare, Government of India, also stated in 2012 that there was a severe lack of physicians, paediatricians, and other specialists working in community health centers (CHCs) and primary health care facilities (PHCs) in Tribal regions. There is a pressing need to enhance the public health system because of its potential impact on the wellbeing of indigenous communities.

Reasons For Poor Health for Tribal Minorities in India

Malnutrition and anaemia aren't the only concerns for people's health in tribal communities; endemic infectious illnesses like malaria and TB are also common.[12] Stroke and heart disease have surpassed all others as the major causes of mortality, and it is concerning that formerly uncommon chronic disorders like hypertension and diabetes mellitus are on the rise in these populations.[13] The Sahariya tribe of Madhya Pradesh has been reported to have some of the highest rates of TB in the nation. Malaria is another major cause of mortality in indigenous communities.[14]

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11 Aila Hoss, Securing Tribal Consultation to Support Tribal Health Sovereignty, 14 N.E. U. L.R. 155 (2022).

12 Doctors for Tribal Areas: Issues and Solutions - PubMed, https://pubmed.ncbi.nlm.nih.gov/27385868/ (last visited Dec 31, 2022).

13 Trivedi, D., Majumder, N., Bhatt, A., Pandya, M. and Chaudhari, S.P. (2023), "Global research mapping on reproductive health: a bibliometric visualisation analysis", Global Knowledge, Memory and Communication, Vol. 72 No. 3, pp. 268-283. https://doi.org/10.1108/GKMC-08-2021-0131

14 High incidence of pulmonary tuberculosis in an indigenous Saharia tribe in Madhya Pradesh, central India—A prospective cohort study | PLOS Global Public Health, https://journals.plos.org/globalpublichealth/article?id=10.1371/journal.pgph.0000039 (last visited Dec 31, 2022).

15 Hassan El-Ramady et al., Planning for disposal of COVID-19 pandemic wastes in developing countries: a review of current challenges, 193 Environ Monit Assess 592 (2021).

16 Tribal population in India: A public health challenge and road to future - PMC, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7113978/ (last visited Dec 31, 2022).

enhance the public health system because of its potential impact on the wellbeing of indigenous communities.[17]

Seventy-five percent of India's tribal population urinates in the open, and one-third does not have access to safe drinking water, according to studies. A lack of sanitation, information, education, and healthcare access are major contributors to indigenous people's poor health. Moreover, they are reliant on the public distribution system (PDS) and other forms of government handouts for survival since they have been forced to abandon their customary forest dwellings and natural supply of food.[18] Since most indigenous communities historically subsisted on hunting and gathering rather than farming, they have seen a significant reduction in the availability of healthy plant foods and animal proteins in their diets (including fish and meat). Dietary variety has been replaced with PDS-accessible polished rice and cereals.

The geographical and infrastructural challenges to public health and the lack of health-related knowledge among tribals are exploited by quacks (unqualified medical practitioners), who are often available at the doorstep. Though some traditional practices and superstitions persist, acceptance of modern medicine has increased in recent years, but access to good care is the major issue. Levels of illiteracy are high, with 47 per cent in rural areas and 21.8 per cent in urban areas being unable to read and write.[19] Better educated tribal communities will be better aware of their healthcare needs (and rights) as well as of better care-seeking practices.

The majority of tribal people do not have access to high-quality medical treatment, despite the fact that the government has funded the construction of Primary Health Centres (PHCs) in tribal regions for every 20,000 population and sub-centres for every 3,000 population. Many medical and paramedical positions go unfilled. Inadequate infrastructure, rough terrain, distance, and time restrictions (one Auxiliary Nurse Midwife is responsible for 15-20 dispersed communities), and a lack of transportation and communication facilities all contribute to the inadequacy of healthcare provision.

Teenage boys and girls from indigenous communities (who finish their education but are frequently left with few options) may be encouraged and supported in becoming community health workers or nurses if they were given the chance to pursue such careers in their own communities. The ASHWINI Gudalur Adivasi Hospital in the Nilgiris is a thriving example; the hospital's administration and the vast majority of its workers (apart from the physicians) are all indigenous people.[20] Reducing macro and micronutrient deficits might be aided by nutritional counselling and education, the creation of kitchen gardens, and the distribution of a wider variety of foods via the PDS. Wherever possible, the use of indigenous herbal treatments by tribal people should be promoted and further studied.[21]

Although increasing sums of money have been committed over the course of many Five Year Plans to meet the requirements of tribal communities under various programmes, very little progress has been seen on the ground. More primary healthcare clinics and secondary care facilities will not improve the health of indigenous peoples. The lack of medically qualified

[17] Water, sanitation and hygiene, https://www.unicef.org/india/what-we-do/water-sanitation-hygiene (last visited Dec 31, 2022).
[18] Sanitation, https://www.who.int/news-room/fact-sheets/detail/sanitation (last visited Dec 31, 2022).
[19] Taking healthcare to India's remote tribes, *supra* note 8.
[20] History – ASHWINI, https://ashwini.org/history/ (last visited Dec 31, 2022).
[21] In the Nilgiris, an inheritance of malnutrition – Population Foundation of India, https://populationfoundation.in/in-the-nilgiris-an-inheritance-of-malnutrition/ (last visited Dec 31, 2022).

personnel is a significant barrier to expanding health care to rural and indigenous communities. It is possible to sensitize and teach traditional healers, who are often the first point of treatment, to provide basic care, such as oral rehydration salts (ORS) for diarrhoea and anti-malarial, and to send patients to the primary health care system when necessary.[22]

When young tribal girls reach childbearing age, they are often malnourished and anemic, and their health is further jeopardized by factors such as early marriage, high rates of pregnancy and childbirth, hazardous childbirth practices, and the spread of STDs.[23] Because of their lower social standing, women are more prone to delay medical care until a serious condition has developed. The delivery of prenatal care is hampered by the general public's view of pregnancy as a natural process that does not need any special care or attention.

Health Care: Challeneges and Initiaves Taken by The State Government in India to Improve Their Status

State Health Systems Projects in Rajasthan, Karnataka, and Tamil Nadu, funded by the World Bank, have implemented many novel approaches to better the health of indigenous communities.[24] The implemented treatments were multifaceted and region-specific in light of the great variety among these groups and their varying degrees of socioeconomic development. Public-private partnerships were the primary source for almost all of these projects (PPP).

As a result of the success of these programs in improving the health of indigenous communities, all three states are gradually increasing their investments in them. There is still room to grow these programs for the benefit of tribal communities in locations that remain underserved, despite challenges such as a shortage of reliable private health care providers, limited resources, the need for stronger supervision mechanisms, and ineffective PPP contract administration.

When compared to Kerala, Tamil Nadu has better metrics of human development. The vast majority of the 1% of the population that belongs to Scheduled Tribes may be found in the Nilgiri Hills, Eastern Ghats, and Western Ghats' forests. Infant, maternal, neonatal, and under-5 mortality rates for tribals have not improved to the same amount as those for the general population, despite the fact that many women in tribal communities in the state have practically equal status with males, as seen by their balanced sex ratios. Sickle cell anaemia is very prevalent in certain indigenous communities.[25]

Only 6% of Karnataka's citizens are members of the scheduled tribes. Some of the most often reported illnesses are malaria, pneumonia, respiratory problems, snake and scorpion stings, diarrhoea, and fever. There is a greater frequency of reproductive tract and STD infections among tribal people, as well as a lack of prenatal care, institutional births, vaccination, and other preventative measures.[26] Health care standards set by the Indian government were

[22] Melinda K. Munos, Christa L Fischer Walker & Robert E Black, *The effect of oral rehydration solution and recommended home fluids on diarrhoea mortality*, 39 INT J EPIDEMIOL i75 (2010).
[23] Srinivas Goli, Anu Rammohan & Deepti Singh, *The Effect of Early Marriages and Early Childbearing on Women's Nutritional Status in India*, 19 MATERN CHILD HEALTH J 1864 (2015).
[24] New World Bank Project to Improve Healthcare Services in Meghalaya, India, https://www.worldbank.org/en/news/press-release/2021/09/30/new-world-bank-project-to-improve-healthcare-services-in-meghalaya-india (last visited Dec 31, 2022).
[25] There have been considerable improvements in living conditions of the Scheduled Tribes (STs) over the years in the country, https://pib.gov.in/pib.gov.in/Pressreleaseshare.aspx?PRID=1844730 (last visited Dec 31, 2022).
[26] Subarna Roy et al., *Tribes in Karnataka: Status of health research*, 141 INDIAN J MED RES 673 (2015).

determined to have been satisfied, although inadequate access persisted. In addition to free vaccination, basic lab testing, free drugs for a complete course of treatment, and referral of more difficult cases to advanced institutions, the scope of free medical services given was expanded to include paediatric, gynaecological, and general medical care. To make sure that no hospital was ever without medical staff, doctors were rotated in from higher-level institutions and smaller satellite hospitals with reduced patient loads. Popularity of outreach camps has been shown by the constantly promising rate of program adoption by underprivileged communities, with numbers of beneficiaries each camp ranging from 500 to 4000. During the same six-month period in 2006, 15 camps served around 9,400 tribal beneficiaries; in 2008, 433 camps served approximately 45,000.[27]

Mobile health clinics: The initiatives in Tamil Nadu and Karnataka engaged NGOs to operate mobile health clinics to provide access to primary care for neglected tribal communities. Each mobile health clinic has a doctor, two ANMs or nurses, a pharmacist, a lab technician, and male and female support workers, all working out of a huge van.[28] Oxygen, intravenous lines, emergency medications, and printed papers were all present in the car. Care for common ailments, first aid, maternity and child care, and contraceptive treatments were all given by the medical team. As an added bonus, they did a lot of work to educate people about health problems and tallied information on the illness burden among indigenous communities. Particularly for gynaecological and paediatric issues, the Mobile Health Clinics have proven to be highly successful. More than 630,900 people in Tamil Nadu benefited from the medical services provided by tribal outreach vans between May 2008 and September 2010. More than 250,000 tribal patients in Karnataka used mobile outreach vans between June 2008 and May 2011.

The initiative funded the purchase of 385 fully stocked, cutting-edge ambulances, so that pregnant indigenous women have access to free emergency transportation to primary and higher health institutions should they need it.[29] The state government learned from its previous mistakes in managing contracts with different NGOs for ambulance services, and as a result, it has contracted a single professional organization to offer statewide, free emergency transportation services for health, fire, and police crises. To further handle the increased demand and caseloads, the initiative is funding an extra 200 ambulances. Another program pays for the mother and up to two caregivers to stay at a PHC for 10 days at a cost of Rs.100 per day so that more indigenous women would give birth in a hospital.[30] The Department of Medical Services saw success with the program and has now extended it to more than 15 PHCs serving isolated tribal communities. The National Rural Health Mission (NRHM) is enthusiastic about the program and has put aside funds to roll it out to an additional 43 primary health care centers in the most impoverished tribal regions.[31]

Recognising Right to Health as A Fundamental Right

[27] New World Bank Project to Improve Healthcare Services in Meghalaya, India, *supra* note 22.
[28] INITIATIVES & ACHIEVEMENTS-2022, https://www.pib.gov.in/www.pib.gov.in/Pressreleaseshare.aspx?PRID=1887285 (last visited Dec 31, 2022).
[29] Thandiwe Ngoma et al., *Addressing the Second Delay in Saving Mothers, Giving Life Districts in Uganda and Zambia: Reaching Appropriate Maternal Care in a Timely Manner*, 7 GLOB HEALTH SCI PRACT S68 (2019).
[30] Hunter Rogers et al., *An exploratory study investigating the barriers, facilitators, and demands affecting caregivers in a telemedicine integrated ambulance-based setting for stroke care*, 97 APPL ERGON 103537 (2021).
[31] National Rural Health Mission :: National Health Mission, https://nhm.gov.in/index1.php?lang=1&level=1&lid=49&sublinkid=969 (last visited Dec 31, 2022).

A right to health is not spelled out as a basic fundamental right in India's constitution. However, the Constitution makes several mentions of public health and the State's responsibility to provide healthcare for its inhabitants.

Part IV of the Indian Constitution establishes the Directive Principles of State Policy, which includes the right to health. In Article 39 (E), the state is obligated to ensure the health of its workforce; in Article 42, it is obligated to guarantee fair and humane working conditions and maternity leave; and in Article 47, it is obligated to expand citizens' access to healthy food, raise citizens' standard of living, and improve public health. In addition to requiring the State to enhance public health, Article 243G of the Constitution grants that responsibility to local governments like Panchayats and Municipalities.

A High-Level Group on the Health Sector that was established under the 15th Finance Commission in September 2019 suggested that the right to health be designated a basic right. This recommendation was made public in October 2019.[32] And it proposed moving health issues from the State List to the Concurrent List. If the proposal to recognize health as a basic human right is put into practice, it will improve people's ability to get the care they need. The second suggestion to move health to the Concurrent List, however, would create a constitutional dilemma over whether or not the centralization of public health is beneficial in the context of Indian cooperative federalism. Public health and sanitation; hospitals and dispensaries are now listed as a topic for state governments to regulate under the 7th Schedule of the Constitution of India, giving such governments constitutional mandates to do so.[33]

The disparities in Indian states' public health systems were highlighted in a 2019 NITI Aayog study. This disparity originated from a lack of available technological knowledge and financial resources. Transferring health care on the Concurrent List will add unnecessary layers of bureaucracy, red tape, and institutional restraints at a time when states' financial dependency on the federal government remains a key problem.[34] This centralization would strip states of their constitutional rights while leaving their policy decisions still vulnerable to the political orientation of the federal administration. Further, different states in India need different kinds of attention, which a unified plan cannot supply.

Important health issues call for cooperation between the federal government and the individual states without undermining cooperative federalism, a cornerstone of India's constitutional framework. Collaborative efforts to combat the COVID19 pandemic have highlighted the need of well-developed district and local capacity for epidemic containment. The answer taught us that health care must remain on the State List even if efficient communication between states and the federal government is of paramount importance. So, it's crucial to devolve authority and resources to states so they may strengthen their own public health systems.

[32] Fifteenth Finance Commission's high level group on health to work with World Bank on recommendations for health sector - The Economic Times, https://economictimes.indiatimes.com/news/economy/finance/fifteenth-finance-commissions-high-level-group-on-health-to-work-with-world-bank-on-recommendations-for-health-sector/articleshow/76837594.cms?from=mdr (last visited Dec 31, 2022).

[33] *Id.*

[34] Special Correspondent, *'Move health to Concurrent list,'* THE HINDU, Mar. 26, 2021, https://www.thehindu.com/business/Economy/move-health-to-concurrent-list/article34172894.ece (last visited Dec 31, 2022).

International Conventions and Dialogue Around Right to Health

The "State should realize everyone's right to the best possible quality of health" is a requirement outlined in Article 12 of the International Covenant on Economic, Social, and Cultural Rights. Based on Article 12 of the Covenant and its own interpretation of Article 21 of the Indian Constitution, the Supreme Court of India ruled that the right to health is inherent in the basic right to life under Article 21.

Right to health is not to be construed as a right to health, according to General Comment No.14[35] on Article 12 of the International Covenant on Economic, Social, and Cultural Rights. The freedoms and privileges guaranteed by the right to health go hand in hand. The right to regulate one's own health and body, including sexual reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment, and experimentation, are all included in the list of freedoms. In contrast, the entitlements include the right to a health care system, complete with protections that ensure everyone has a fair shot at the best possible health.[36]

Article 24 of the Convention on the Rights of the Child[37], also does mention about the enjoyment of Right to Health and has directed the states the following directions under the same article:

(a) to reduce rates of infant and child mortality;

(b) to guarantee that all children receive the medical attention and health care they need, with an emphasis on the growth of primary health care;

(c) to combat diseases and malnutrition, including within the framework of primary health care

(d) To make sure mothers receive quality prenatal and postnatal care;

(e) To make sure families, and especially mothers and fathers, have access to and are encouraged to use information about child health and nutrition, breastfeeding's benefits, proper hygiene and sanitary conditions, and the prevention of accidents;

(f) To create programs that promote preventive health care, parent counseling, and family planning education and services.[38]

Judicial Pronouncements

The Supreme Court of India, in the case of Mohd. Ahmed (Minor) vs Union Of India[39] observed:

> "*Violations of the obligation to fulfil occur through the failure of States parties to take all necessary steps to ensure the realization of the right to health. Examples include the failure to adopt or implement a national health policy designed to ensure the right to health for everyone; insufficient expenditure or misallocation of public*

[35] [E/C.12/2000/4; 11 August 2000]
[36] James O. Mason, *Improving the Health of Minorities*, 104 PUBLIC HEALTH REPORTS (1974-) 523 (1989).
[37] The Convention on the Rights of the Child: The children's version, https://www.unicef.org/child-rights-convention/convention-text-childrens-version (last visited Dec 31, 2022).
[38] Mason, *supra* note 34.
[39] W.P. (C) 7279/2013

> *resources which results in the non- enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalized; the failure to monitor the realization of the right to health at the national level, for example by identifying right to health indicators and benchmarks; the failure to take measures to reduce the inequitable distribution of health facilities, goods and services; the failure to adopt a gender-sensitive approach to health; and the failure to reduce infant and maternal mortality rates."*

Court precedent in the case of **Devika Vishwas vs. Union of India**[40] established that the "right to health" is a component of the "right to life" protected by Article 21 of the Constitution. According to the Court's reasoning presented in paragraphs 107, 108, and 109, the following was held:

> *"It is well established that the right to life under Article 21 of the Constitution includes the right to lead a dignified and meaningful life and the right to health is an integral facet of this right. In CESC Ltd. V. Subhash Chandra Bose, (1992) 1 SCC 441 dealing with the right to health of workers, it was noted that the right to health must be considered an aspect of social justice informed by not only Article 21 of the Constitution, but also the Directive Principles of State Policy and international covenants to which India is a party."*

Based on a review of precedent, the Constitution Bench of the Supreme Court of India decided in **Navtej Singh Johar and others vs. Union of India**[41] that Article 21 of the Indian Constitution protects the right to life, including the right to health and health treatment. This view prevailed:

> *"the right to life is meaningless unless accompanied by the guarantee of certain concomitant rights including, but not limited to, the right of health. The right of health is understood to be indispensable to a life of dignity and well-being, and includes, for instance, the right of emergency medical care and the right to the maintenance and improvement of public health".*

In the case of **K. Mani v. Secretary to Gov., Health & Family Welfare Dept**.[42], the Hon'ble Court mentioned abput the Right to Dignity. It was mentioned by the Hon'ble Court:

> *"Right to life includes protection of the health and strength of the worker is a minimum requirement to enable a person to live with human dignity. The State, be it Union or State Government or an industry, public or private, is enjoined to take all such action which will promote health, strength and vigour of the workman during the period of employment and leisure and health even after retirement as basic essentials to live the life with health and happiness. The health and strength of the worker is an integral facet of right to life. Denial there of denudes the workman the finer facets of life violating Article 21."*

In order to address the issue of poor tribal health and nutrition, a three-pronged strategy is required. Prior to making policy based on evidence, there has to be sufficient information and tribally de-segregated data. Understanding the origins of a problem is essential before trying to find a solution, especially for more complex issues. Because of language hurdles and general

[40] AIR 2016 SC 4405, 2016 (4) RCR 461 (Civil), 2016 (8) SCALE 707, 2016 (10) SCC 726
[41] (2018) 10 SCC 1
[42] (2007) 3 MLJ 34

lack of data, it may be difficult to implement policies and programs in India that are tailored to the unique needs of the country's diverse people.[43] It is also crucial to generate and share information about tribal health and nutrition in order to educate policymakers and dispel stereotypes prevalent in local communities that may deter people from seeking medical attention even when it is accessible.

Secondly, we need to improve health care delivery in the last stretch by partnering with governments at all levels.[44] Despite the fact that universal healthcare is still out of reach, the government is making concerted efforts to close the gap via tribally targeted strategies, such as making health and wellness centres available in outlying and indigenous communities. From our prior experiences in both India's aspirational districts and abroad, we know that until both the delivery of health services and the health-seeking behaviour of the population cooperate towards each other, inexpensive and accessible healthcare will not become a reality. That is to say, improving access and improving the quality of health care services are both necessary if the ambitious aim of affecting 104 million people is to be realized.[45]

Finally, using modern tools and collaborative efforts may boost healthcare administration and delivery. Connecting individuals longitudinally, vertically, and laterally is a key feature of new digital technologies, notably mobile applications and platforms. The introduction of point-of-care devices has the potential to boost data collecting and accountability in the health care industry as a whole. The national digital health mission is a constructive initiative that may hasten this transition.

Conclusion

Societies can't prosper if its members aren't healthy, but for those on the periphery of society, that's often easier said than done. Lower life expectancy, poor mother and child health, and higher rates of infectious and noncommunicable illnesses have been common among the world's indigenous and tribal populations even before the advent of covid. The effects of the recent coronavirus pandemic—including increased food insecurity, isolation, and economic hardship—have only served to worsen these tendencies and further marginalize already marginalized tribal and indigenous groups.

Though India has failed miserably to accomplish the MDGs, India it has accepted the SDGs and is working toward providing health care to everyone who needs it and ensuring that everyone has access to health insurance. It is crucial to create a health system that emphasizes the tribal people, equity more than equality, and to do it in a way that encourages improvement on the lagging indicators and facilitates the creation of a healthcare delivery system that is appropriate, accessible, acceptable, and inexpensive. Traditional healers, local Tribal boys and girls, might be useful in situations when the lack of modern medical infrastructure cannot improve the health of the community. The time has come for individual states to conduct needs assessments, determine priorities, and establish objectives and targets for their local indigenous community using tried and true public health practices.

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[43] Issues and trends in education for sustainable development - UNESCO Digital Library, https://unesdoc.unesco.org/ark:/48223/pf0000261445 (last visited Dec 31, 2022).

[44] INSTITUTE OF MEDICINE (US) COMMITTEE ON ASSURING THE HEALTH OF THE PUBLIC IN THE 21ST CENTURY, THE GOVERNMENTAL PUBLIC HEALTH INFRASTRUCTURE (2002), https://www.ncbi.nlm.nih.gov/books/NBK221231/ (last visited Dec 31, 2022).

[45] Samvaad, *supra* note 5.

India, though, is in a prime position to turn things around. Since it is home to 28% of the world's tribal population, it is essential to work from the ground up to enhance the quality of life for these people. India has the potential to lead the way in developing innovative programs to enhance tribal health, setting an example for other countries seeking to strengthen their own indigenous peoples. India can greatly enhance the lives of its 104 million tribal residents and aid in the achievement of the 2030 Sustainable Development Goals by engaging with local leaders to close knowledge gaps, boost last-mile service delivery, and use the possibilities of new technologies and collaborations.