

THE HEALTH PROBLEMS AND STATUS OF THE PARTICULARLY VULNERABLE TRIBAL GROUPS OF MADHYA PRADESH – A CASE STUDY IN ANTHROPOLOGICAL DIMENSION

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World Health Organization (WHO), has defined health in a more holistic approach, which reflects the relationship with a variety of factors such as the individual's physical, social, psychological, emotional; environmental and cultural factors. The health of indigenous or tribal people is the perceptions and conceptions in their own cultural system, based on external stimuli emanating from astrological influences, witchcraft and evil spirits in the etiology of disease, with less awareness of the modern health-care and health services for Health-seeking behavior. They have the various procedures of treatment viz. folk treatment, religious or preventive procedure, magical or curative procedures and modern medical system. Tribal communities in general and Primarily Vulnerable Tribal Groups (from now PVTG, erstwhile primitive tribal groups) in particular are highly disease prone. Also they do not have required access to basic health facilities. They are most exploited, neglected, and highly vulnerable to diseases with high degree of malnutrition, morbidity and mortality. Their misery is compounded by poverty, illiteracy, ignorance of causes of diseases, hostile environment, poor sanitation, lack of safe drinking water and blind beliefs, etc. The paper aims to discuss the health and nutritional status of PVTGs in Madhya Pradesh, analyzing the disease intensities and causes and etiology of disease and also to identify major problems and issues with some suggestions to upgrade the health status of the Primitive Tribal Groups of Madhya Pradesh.

Keywords: Health-seeking behavior, Nutritional status, PVTG, Determinants

INTRODUCTION

A human being requires, along with basic needs like food, clothing and shelter, good health to lead a happy and enjoyable life. As prevention is better than cure, the aim should be to prevent diseases by adopting suitable preventive measures. Health of an individual, to a great extent, depends upon hereditary factors, quality of food, water, air, sanitation, environment, immunization status, good habits and several other factors. Webster's dictionary defines health as a noun which refers to the general condition of the body or mind. Health is associated with the state of functionality of the body of an organism, especially the human body. There is no general agreement about any definition of health since health itself cannot be measured. The concepts of health are thus an apriority condition; and to maintain this some formalities, which are interlaced with the cultural life of the given people,

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are necessary. Likewise, illness and disease, disability and death and so on are viewed by the learned group and various remedial measures are adopted by them to meet the situational exigencies. Traditionally, Health has been defined as “the presence or absence of disease”. The Health is a universal natural and social phenomenon, but the concept is a culture specific. With the establishment of the World Health Organization (WHO), the definition of health has received in its broader sense in 1946 in Preamble to the Constitution of the World Health Organization (as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948), as “A status of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1946). This is a more holistic definition which reflects health in relationship with a variety of factors such as the individual’s physical, social, psychological, and emotional condition; environmental and cultural factors, as well as the creativity and productivity of a person. There are certain factors which make people healthy; these factors are called the Determinants of Health. The determinants of health include:

1. the social and economic environment,
2. the physical environment, and
3. the person’s individual characteristics and behaviors.

The United Nations (UN) members met in 2000 and set themselves eight goals as “Millennium Development Goals” to be achieved by 2015. Of these goals, reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria and other diseases related to the health segment were included. The first goal ‘of eradicating extreme poverty and hunger’ also contains a nutritional element which is health related. In the developing world, death rates in children under five are dropping, but not fast enough. Eleven million children are still dying every year, from preventable or treatable causes. More than half a million women die each year during pregnancy or childbirth. AIDS has become the fourth largest killer worldwide, and in parts of Asia, HIV is spreading at an alarming rate. The blight of malaria and tuberculosis continues. Health-education and periodic screening play an important role in prevention of most diseases.

Tribal Health

The tribal perceptions to nature, world-view and cosmogony vary among themselves and thus put them sometimes in identifiable isolation. Their health is the perceptions and conceptions in their own cultural system based on external stimuli emanating from astrological influences, witchcraft and evil spirits in the etiology of disease, with less awareness of the modern health-care and health services for Health-seeking behaviour. The health status of any community is influenced by the interplay of

health consciousness of the people, socio-cultural, demographic, economic, educational and political factors. The common beliefs, traditional customs, myths, practices related to health and disease in turn influence the health seeking behaviour of autochthonous people (Balgir 2004a). Health is an essential component of the well-being of mankind and is a prerequisite for human development. If general health of an average non-tribal Indian is inferior to the Western and even many Asian counterparts, the health of an average Indian tribal is found to be much poorer compared to the non-tribal counterpart.

Tribal communities in general and primitive tribal groups in particular are highly disease prone. Also they do not have required access to basic health facilities. They are most exploited, neglected, and highly vulnerable to diseases with high degree of malnutrition, morbidity and mortality (Balgir, 2004b). Their misery is compounded by poverty, illiteracy, ignorance of causes of diseases, hostile environment, poor sanitation, lack of safe drinking water and blind beliefs, etc. The chief causes of high maternal mortality rate are found to be poor nutritional status, low hemoglobin (anemia), unhygienic and primitive practices for parturition. Average calorie, as well as, protein consumption is found below the recommended level for the pregnant as well as lactating women. Some of the preventable diseases such as tuberculosis, malaria, gastroenteritis, filariasis, measles, tetanus, whooping cough, skin diseases (scabies), etc. are also high among the tribals. Some of the diseases of genetic origin reported to be occurring in the Indian tribal population are sickle cell anemia, alpha- and beta-thalassemia, glucose-6-phosphate dehydrogenase (G6PD) deficiency, etc. (Balgir, 2004b). Night blindness, sexually transmitted diseases are well known public health problems of tribals in India.

Health Problems of Tribals of Madhya Pradesh

The health status of tribal populations of Madhya Pradesh is very poor and worst of primitive tribes because of the isolation, remoteness and being largely unaffected by the developmental process going on in India (ICMR, 1998). The Health problems and issues of the tribal populations are summarized in the following:

1. Alcoholism- An increased number of chronic active blood borne diseases like Hepatitis B, cirrhosis of liver cases and virus infection are likely to be high in the tribal population because of the common social practice of tattooing and together with alcoholism;
2. Problems of drinking water and water-borne diseases-Water borne disease like helminthiasis, amoebiasis, giardiasis and diarrhea diseases are rampant in the tribal population;
3. Malaria and Vector-borne diseases-a number of tribal areas still continued to harbor malaria, primarily because of their inaccessibility and lack of community participation;

4. Genetic disorders-sickle cell anemia, Glucose 6 Phosphate Dehydrogenises deficiency are common in the tribal populations;
5. Traditionally permissive in sexual matters;
6. Malnutrition- Not only is protein calorie malnutrition common, deficiency of micronutrients like iron, is also very common;
7. Snake bites, suicides and accidents;
8. Inadequate Access to Services and inadequate Indoor Residual Spraying;
9. The role of the NGOs is found to be minimal and insignificant in the sample villages covered in Madhya Pradesh;
10. Non-Availability of Government Health Workers and inadequate number of laboratory technicians in PHCs.

Objectives

The paper aims to:

1. To discuss the health and nutritional status of PVTGs in Madhya Pradesh
2. To study the disease intensities and causes and etiology of disease
3. To identify major problems and issues with some suggestions to upgrade the health status of the Primitive Tribal Groups of Madhya Pradesh.

Materials and Methods

Study Area

Madhya Pradesh has the largest state of the country. The state has a total population 726.26809 lakhs as per 2011 census with a total tribal population of 153.16784 lakhs. There is about 21.1% of the total tribal population of the country. There are 46 scheduled tribes spread over in 45 districts of undivided Madhya Pradesh (henceforth Madhya Pradesh means undivided Madhya Pradesh). Out of these 46 tribes, 7 tribes are most backward tribes and are identified as primitive tribes (Tiwari, 1984) based on their pre-agricultural level of technology, low level of literacy and stagnant or diminishing population. The study was conducted in six villages each of three PVTGs in Madhya Pradesh in the districts: Dindori, Sheopur and Patalkot of Chhindwara.

Data base and Methodology

Data Sources

The data gathered for the study was collected through secondary and primary sources. The secondary sources are the books, reports and documents

Primary Data Collections

The primary data collection was carried out through a) Individual interviews and b) Informal discussions. The Interview Schedule was designed to collect detailed information regarding etiology of diseases, health facilities, and health-seeking behavior and also discussing the issues that were raised during the individual interviews. The data were collected from six villages each from three Primitive Tribal Groups:

- (a) Bharia of Patakot in Chindwara district;
- (b) Baiga of Dindori district
- (c) Sahariya of Sheopur district

Overview of Health and Nutritional Status among PVTG in M.P

Health and nutritional status of the population largely depends on the consumption of food in relation to their needs; which in turn is influenced by the availability of food and purchasing power and the nutritional values of the foods intake. The health status depends upon the frequencies of diseases, natural or viral under different socio-economic conditions. For instance, in recent times fluorosis has emerged as a new public health among the tribals of Madhya Pradesh. In Mandla district dental mottling and genuval gum was seen in children and young adults of less 20 yrs of age. Fifty percent drinking water sources of Mandla and Dindori district had high fluoride contamination.

The health status of three PTGs is discussed below from the secondary sources:

- (a) **Baigas:** Baigas are one of the oldest autochthones of Madhya Pradesh, living in the five districts of Madhya Pradesh i.e Mandla, Dindori, Shadol, Anupur and Umaria. But the biggest concentration is found inn the ‘Baigachak’ area of Dindori tehsil (now Dindori district). . The area is surrounded by thick forest patches, rivulets and hillocks. Baigas economy mainly depends upon agricultural pursuits and collection of Non-timber forest produces. The other employment opportunities are unskilled labour and work in forest. They also love to work in the baris (land attached to the house) and grow maize, mustard, vegetables, roots and bulbs. Maize, Kodo, Kutki and Ramtila are the main crops grown by the Baigas. Maize and millets form the major foodstuffs consumed by the Baigas. These are consumed in the form of ‘Pej’, often supplemented by vegetables. Health and nutrition survey carried out by the centre in 1988-89, revealed that mean cereal intake was 425 + 11.6 gm/cu/day. Pulses consumption was much less 17.6 + 2.8 gm/cu/day as compared to RDA (40 gm.) (Table 1). Oil and fat consumption was negligible (2.2 + 0.7 ml/cu/day). The mean energy intake was 1615 + 57.2 kcal/day with protein intake of 50.2 + 1.9 gm/day (RMRCT 1988-89, 1996-98, Chakma *et al.* 2006). The severely malnourished Baiga preschool children were 7.3% though percentage of

normal preschool children was highest (33.3%) as compared to other primitive tribes. The consumption of Calcium, Thiamin, Riboflavin and Niacin were also lower than RDA. Goitre was also common in the areas of Baigas (Chakma *et al.* 2006).

- (b) Bharias are one of the smaller tribal groups of Madhya Pradesh found in the 'Patalkot' area of Chhindwara district, are denoted as primitive. The area is a unique deep depression in the Satpura plateau. There are about 12 village spreads over 79 sq. km. area with a total population of about 1600. The approachability is extremely difficult as the ridges are almost vertical. The economy of Bharias depends on 'Baris' attached to their hutments with grow of Maize Jowar, Kodo & Kutki and Non-timber forest products like Mahua, Amla, Harra etc. also form part of their source of income. Preparation of deo-baharis (brooms) and selling them in the local market is also an important source of cash income. Though the valley is said to be very rich of medicinal plants, they are yet to be exploited as a source of income by the tribe. Maize consists the staple diet along with coarse millets like Jowar, Kodo and Kutki, which are consumed in the form of 'Pej'. Green vegetables are scanty. Vegetables like gourds and vejra are grown in their baris. Apart from it 'Kaccharia' is consumed during winter season, which is then preserved by drying & later consumed during summer/rainy season (RMRCT, 1992). Acute respiratory infection 78.0% and Malaria (24.5%) were the major morbid conditions observed apart from Sickle cell disease, which was 22.3% (Chakma *et al.* 2006).
- (c) Sahariya: Saharias are mainly located in the Chambal division, i.e. Gwalior, Morena, Guna and Shivpuri bordering Rajasthan. Though as per record they are spread over in 21 districts of Madhya Pradesh, their main concentration is in Shivpuri district. Their economy lies mainly on minor forest produce. Because of unemployment the young people migrate to nearby district or town in search of employment especially during summer. Though their staple diet is Jowar, Bajra & Maize in the form of Chapati, their detail diet survey is yet to be carried out. Nutritionally only 16.3% of the preschool children were normal, 40.7% were mildly malnourished, 34.5% moderately and 8.5% were severely malnourished. Vitamin A deficiency in the form of night blindness, bitot spot and xerosis was 53.3%. Acute respiratory infection (38%) and worm infestation (9.4%) were the major morbid conditions observed. There were complete absence of sickle cell disease among this tribe, but b-thalessaemia was found to be 5.2%. Cervical lymphadenopathy was observed in 20.4% of the available individuals, which prompted us to take up an in-depth survey on Tuberculosis in Karhal block of Morena district, where more than 50% populations were tribals. The prevalence of Sputum positive pulmonary tuberculosis was 12.7/1000 (Chakma *et al.* 1996, Chakma *et al.* 2006).

Results and Discussion

Study of Health Problems and Status of three PVTGs

Socio-economic Conditions of three PVTG

The following table shows the socio-economic conditions of three PVTG:

TABLE 1: SOCIO- ECONOMY OF VILLAGES OF THREE PTGS: BAIGA, SAHARIYA AND BHARIYA

<i>S.No</i>	<i>Socio-Demography Data</i>	<i>Baiga of Dindori</i>	<i>Sahariya of Sheopur</i>	<i>Bhariyas of Chhindwara</i>
1	Total sampled villages	06	06	06
2.	Name of the villages	Talwar Tola, Kapoti, Kharideeh, Bangladadar of Karanjia Block and Kandavani & Sarai of Bajag blockin Dindori distrcit	Upri Khoree, Nichli Khoree, Parond, Chak Bilari, Sonipura of Karhal block and Sironi of Vijaypur block in Sheopur district	Chimtipur, Gal Dubba, Rather, Kariyam, Gurhi Chetri, Ghat Linga of Tamia Block in Chhindwara district
3	Total HH in sampled villages	360	344	218
4	Total ST Population in 6 sampled villages	1711 (100%)	1506 (100%)	1469 (100%)
5	Total ST Male in sampled villages	923	804	748
6	Total ST Female in sampled villages	788	702	721
7	Sex Ratio in sampled villages	854	873	964

In the socio-economic condition the Baigas highly depend upon forestry activities, though they eke out their existence in labour and non-agricultural labour activities. Similarly the Sahariyas and the Bhariyas also depend upon forestry activities, labour and non-agricultural labour activities. In their agricultural occupations the Bhariya population is mostly engaged in agricultural livelihoods, followed by Baiga and Sahariya. Of the total Sahariya working force 25% of them are involved in agriculture labor activities, followed by 19.4% Baiga and only 8.01% Bhariyas are engaged in agriculture labor. Cent per cent Sahariyas work as non-agricultural labor, half of the Baiga community is involved in non-agricultural labor, less than one-fourths, only 15.2% is involved in non-agricultural labor. Whereas 100% population is involved in forest produce collection in all the three PTG communities in the six sampled villages. All the sampled eighteen villages

representing the three PTG communities are situated in close proximity with the forests. The villagers depend on forests for their survival. They have developed a symbiotic relationship with the forests. The Baigas, the Sahariyas and the Bhariyas are dependent on forests for fuel, fodder collection of forest produce, medicinal herbs and plants for self consumption and sales in the local markets. In their land holding pattern the Baigas are landless and marginal farmers having the land area below 2.5 acres. The Sahariyas and Bhariyas are landless, marginal, small and medium farmers. In consequence, most of the Baigas are found below the poverty line. A large number of Baiga families (above 80% of the total families) have income less than Rs. 10,000.00. Similarly a large no. of Sahariya families has average income in a year less than Rs. 10,000.00. All the Bhariya families have average income annually less than Rs. 10,000.00. In their educational status among the Baigas 54.41%, among the Sahariyas 82.6% and among the Bhariyas 60.45% are illiterates. Of the literates in the Baigas above the three-fourths of them have passed out the primary standard and only 6.96% have crossed the secondary standard. The educational status of females of the Baigas is declining. Very negligible population has crossed high school and higher education. On the contrary, among the Sahariyas 15.80% of them have crossed the primary levels and very negligible population has passed out secondary standard, high school and higher education. In the Bhariyas 22.47 % and 8.78% of the literates have crossed primary and secondary standard and of the rest very negligible population has crossed high school and higher education. As these three tribal communities have their own system of healing their diseases in the traditional practices, mostly they depend on that. Now various schemes of the Government have been implemented in the tribal villages for developing their health status. But the tribal peoples have not benefitted to that extent due to unawareness, inaccessibility to their habitation, negligence of the administration, inefficiencies of the implementer.

Intensities of Diseases

The following table shows the percentage of the people of three PTGs suffering from various diseases:

TABLE 2: INTENSITIES OF DISEASES AMONG THREE PTGS

<i>Types of Diseases</i>	<i>Baiga</i>	<i>Sahariya</i>	<i>Bharia</i>
Sickle Cell	22%	Nil	19.7%
Thalassaemia		8.7%	
Malnourishment pre-school children	7%	9%	9%
Goitre			Over 10% among 15 year age
Hookworm infestation	13%		7%

Source: RMRCT Annual Reports 1988-89, 1996-98, Chakma *et al.* 2006

The severely malnourished Baiga preschool children were 7.3% though percentage of normal preschool children was highest (33.3%) as compared to other primitive tribes. The consumption of Calcium, Thiamin, Riboflavin and Niacin were also lower than RDA. Goitre was also common in the areas of Baigas (Chakma *et al.* 2006). In the health survey of the Bhariya an acute respiratory infection 78.0% and Malaria (24.5%) were the major morbid conditions observed apart from Sickle cell disease, which was 22.3% (Chakma *et al.* 2006). The prevalence of Sputum positive pulmonary tuberculosis was 12.7/1000 (Chakma *et al.*, 1996, Chakma *et al.* 2006).

Causes of diseases and procedure of treatment of three PTGs

- (a) In the villages Main causes of diseases as found in the villages:
1. Natural- Malevolent action of some planets and belief in doctrine of karma or bad deeds of the past, failure of performing rituals; environmental effects, wrong combination of foods, contact with some living organisms;
 2. Supernatural- Evil spirits intrusion, evil eye effects, wrath of gods and goddesses;
 3. Human agencies- Sorcerer and witches in finding out the causes of diseases like injury, paralysis, exzema, vomiting, rickets
- (b) Procedure of Treatment:
1. Folk medicine:
 - (a) Religious- preventive procedures- includes use of charms, amulets, animal sacrifices, propitiation of disease causing gods and goddesses
 - (b) Magical- Curative procedures- domestic methods, magical spells, shamanistic treatment
 2. Modern Medical system :
 - (a) Allopathic
 - (b) Homeopathy

Health Facilities in three PVTGs

The following table shows the health facilities in three PVTGs' villages under study :

TABLE 3: HEALTH FACILITIES FOR THREE PTGS IN THE VILLAGES

S. No	Name of PTGs	Available of Primary Health Centre (PHC) facilities	Available of Sub- Health Centre (PHC) facilities	Immunization	Doctor Visit from PHC	Drinking Water
1	Baiga	100 % villages	100 % villages	100% villages	100% villages once in a week	100% Villages available
2	Bharia	83.33% villages	100 % villages	100% villages	100% Nurse Visit rarely	100% Villages available
3	Sahariya	100 % villages	100 % villages	100% villages	100% villages once in a week	100% villages. Acute shortage

Some observations on the health status of three PVTGs

(a) Baiga Villages

1. Severely malnourished pre-school children are found, because milk is not available.
2. Drinking water availability is there but content have the high fluoride.
3. The consumption of calcium, Thamin, Riboflamin, iron and Niacin and other micr-nutrients are lower among Baigas.
4. Sickle cell anemia is the major morbid conditions and goitre is common.
5. Malaria cases are highly reported.
6. The use of medicinal plants is found to the larger extent.
7. They depend on primary clinic as the access to PHC and SHC is difficult.
8. Cases of anemia and RCH among the women are found.

(b) Sahariya

1. Severely malnourished pre-school children are found among the Sahariya
2. The environment in the habitation is highly unhygienic and Inhuman condition of living, e.g because of toilet constructed at wrong place in front of their houses leading to overflow of dirty water, foul smell.
3. Inbreeding ground for houseflies and mosquitoes leading to illness.
4. Due to shortage of water they do not bathe so no concept of hand washing before food!
5. Animals die due to thirst.
6. As per govt. the Sahariya aaganwari children are given 3 times meal a day. No such distribution was found over there.
7. Mid day meal distribution is also irregular.

8. Sahariya habitat is geographically drought-prone area, hence drinking water is one of major problems.
9. In Sahariya land night blindness, bitot spot and xerosis are prevalent due to Vitamin A deficiency

(c) Bharia

1. The Bharia children are in the better condition regarding health and nutritional status in comparison to Baiga and Sahariya children.
2. The boys and girls in Ashram school are getting proper mid-day meals.
3. There is lack of infrastructure, e.g., drinking water and hospital facilities
4. The people get improper food, and habitation. ,
5. There is no tap water supply. The women and children carry water on their head for miles.
6. Due to topography the medical emergency cannot be provided.
7. They have to consume much energy due to undulation in the habitation of them for the fulfillment of daily requirement.
8. The crop varieties are limited as they cultivate only maize and consequently get less nutrients.
9. Due to inaccessible habitation, the state government health scheme like Janani Suraksha Yojana is implemented in few villages...

Determinants of Health Status

The following table shows the health condition under universal determinants of health status:

TABLE 4: DETERMINANTS OF HEALTH STATUS AMONG THREE PTGS

<i>Determinants</i>	<i>Baiga</i>	<i>Sahariya</i>	<i>Bharia</i>
1. Gender	Nutritional and health status are same among males and females	Marked differences occurred in nutritional and health status among males and females	Differences occurred in nutritional and health status among males and females
2. Personal Behavior	Sense of hygiene not so good, especially in the sense of sanitation	Sense of hygiene not existing at all in all health-seeking behaviour	Sense of hygiene is moderate, but not so good, especially in the sense of sanitation
3. Culture	Causes behind the diseases are supernatural effects. Highly dependence on medicine-men or quack doctors	Causes behind the diseases are supernatural effects. Highly dependence on quack doctors	Causes behind the diseases are supernatural effects. Highly dependence on medicine-men or quack doctors

contd. table 4

<i>Determinants</i>	<i>Baiga</i>	<i>Sahariya</i>	<i>Bharia</i>
4. Health Services	Govt. health services are there, but not so effective. Drinking water available	Govt. health services are there, but not so effective. Acute shortage of drinking water.	Govt. health services are there, but not so effective. Drinking water available
5. Social Support	During illness or sickness family', friend's or relation's support there	During illness or sickness family', friend's or relation's support not found to that extent	During illness or sickness family', friend's or relation's support not found at all
6. Education	Unawareness of health and hygiene due to knowledge and information	Unawareness of health and hygiene due to knowledge and information	Unawareness of health and hygiene due to knowledge and information
7. Working Environment	People who are health-risk in the workplace.	People who are health-risk in the workplace.	People who are health-risk in the workplace.
8. Social Status	Due to poor income the people are incapable of spending money.	Due to poor income the people are incapable of spending money.	Due to poor income the people are incapable of spending money.
9. Genetics	Hereditary factors are there	Hereditary factors are there	Hereditary factors are there
10. Physical Environment	Living in natural conditions with safe drinking water and lack of sanitation facilities.	Living in unhygienic situations with acute shortage of safe drinking water and lack of sanitation facilities.	Living in poor infrastructure with safe drinking water and lack of sanitation facilities.

Some Suggestions

In the course the investigation the following suggestions have been developed:

1. Health education is to be provided from the school education to make freed from the traditional bindings
2. Health care and health services to be provided in the tribal land for the treatment of the highly frequent diseases.
3. Lack of consultation with the people in implementing the Government schemes so Community participation is to be increased
4. The tribal association with the medicinal plants are to be better utilized to generate green jobs

Conclusion

Health status and health seeking behavior are the important parameters and criteria in the development process. The dimensions of tribal health are philosophical, social, economic and developmental. As the tribals have their own system of healing

their diseases in the traditional practices, mostly they depend on that. Now various schemes of the Government have been implemented in the tribal villages for developing their health status. But the tribal peoples have not been benefitted to that extent due to unawareness, inaccessibility to their habitation, negligence of the administration, inefficiencies of the implementer. The approach and methods are to be participatory, as it is in normal practices in the community forest management, where the production and utility of the medicinal plants can help in institution building, livelihood generation and developing health status and health-seeking behavior.

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