



The 'entomological laboratory' in Miao that is supposed to cater to malaria diagnosis for the entire sub-division

## Healthy Forests and Healthy People: A Problem of First among Equals

Prashanth N. S.

Yuthi was in his twenties when he passed away. In the hinterland of India's largest tiger reserve, few people keep track of their age; nobody here registers for social welfare, they do not have a doctor who asks them to fill up their age on a case sheet. Cystic fibrosis did not dry up his lungs. No, he was not killed by any of those diseases that strike the young. Diseases we study so much about in medical school; diseases with articles written about them in journals, and their correlations to genes with numbers like the latest version of MS Windows. Each has its 'disability adjusted life years' (DALY)<sup>1</sup> index to emphasise its importance for inclusion in new programs that the State might decide to launch. But Yuthi was not affected by any of these rare and publishable afflictions. Yuthi died of malaria. It is quite ironic that a country

with nuclear power still has anaemic mothers and malaria deaths!

Yuthi's home was in Gandhigram, a remote corner in the state of Arunachal Pradesh in north-east India. He used to carry luggage for people like my friends and me, who were working on health and wildlife conservation in the forests around his village. I have been to Yuthi's village a few times with wildlife scientists who work there. His village happens to be surrounded by one of the northernmost primary rainforests of the world. On one side is one of India's largest tiger reserves, the Namdapha Tiger Reserve, and on the other, Myanmar's Hukawng Valley Tiger Reserve, perhaps the world's largest protected area (about 6000 sq. km). The place teems with biodiversity; in the past few years, the forests of Arunachal

Pradesh have witnessed descriptions of a new species of bird, and even a primate. Although it is the tiger that has given this area its protected status, it is not the tiger that this and many forests in Arunachal Pradesh are known for. It is for their rich biodiversity, including several endemic insects, butterflies, birds and plants, that these forests are important. Such rainforests play a central role in wildlife conservation. However, climate change and global warming are distant issues for the Lisus and other tribes living in and around these forests. Tigers are not. Today there is a public debate on tiger deaths in India. Tigers and tribals are being pitted against each other in the hallowed chambers of policy-making conferences. Co-existence of tigers and tribals is being questioned.

In a situation where health care is financed literally out of people's pockets, the fate of the tiger and the health of the people can

<sup>1</sup>DALYs are a health gap measure increasingly used in contemporary public health literature to prioritise health conditions for intervention

get intertwined easily. Hunting becomes a means of supporting any unplanned and sudden catastrophic expenditure. Health invariably falls in this category of unplanned and sudden expenditure. With poor access to primary health care or community health workers, people in such remote regions often find that hunting can finance their long journeys to towns. And it does not help matters that private providers with expensive secondary level care and irrational practices are the first line health providers. The Lisus travel through about 150 km of thick forests, interspersed with rivers (often in spate), to reach 'civilisation'. From there, they take a 6 hour bus journey to reach a town where they inevitably see a private provider. Roads, understandably, are a bigger concern than chloroquine, the antimalarial drug.

I work with another indigenous tribal people in south India, the Soligas. The forests around the Soligas have shrunk, leaving just a 540 sq. km area, that still remains only due to its legal protection by the State. The Soligas were semi-nomadic people, until they were forced to settle due, in part, to the shrinking forests, and in part, to the legal protection accorded to their forests; they couldn't hunt anymore. However, a doctor who settled in these hills 25 years ago began to provide them health care. He went a step further and set up an NGO to assist them with education and livelihoods, in addition to healthcare. Today, the elderly Soligas talk about how climate has changed. They do not question it and do not need evidence. They see how their forests are getting choked from the outside.

These two contrasting cases, from north-east India and south India, exemplify the problems faced by people living in and around forests in India. However, the key is access to basic health care and livelihoods. Wildlife scientists today see this connection between people's basic needs and their conservation ethic. In fact, a group of wildlife biologists started a community health care program and an

education initiative among the Lisus. I went there to train a group of tribal youth in basic health care. Among other things, I wanted these youth to be able to identify and institute treatment against malaria. It was indeed satisfying that wildlife biologists had thought outside the box, and had looked beyond their paradigm of biodiversity conservation. Sadly, those of us in health care are yet to make this connection. A glance at our curricula reveals the level of medicalisation that we undergo. A glance at our policy shows how fragmented and restricted it is.

Shrinking forests are an important reason for climate change, and so are forests devoid of their biodiversity. People living in and around forests depend on them for their livelihood and daily needs. And when there are financial pressures for any of their needs, they turn to their resources, forests, finding themselves in the position of villains accelerating deforestation and emptying the forests. Isn't this what our forefathers did? Can we blame them for destroying forests, just because we have now thought of legal protection for forests? Can we blame them for destroying forests, just because we are now concerned about climate change?

As urban India contends with population pressures and urbanisation, rural and tribal India face a different problem: of access, both physical and financial. It is time for health planners to consider the special needs and contextual factors affecting tribals and others living in or dependent on forests. It would be presumptuous of us to imagine that the widely publicised national programs for any of the diseases will change the situation of these people. Lisus or Soligas or for that matter others like them are not asking for malaria control programs or early cancer detection programs. They are asking for basic health care; financial and physical access to a person who can cure them of their illness and can help them live a healthier life. A malaria program for them is of even lower priority than a road or a source of livelihood, simply because



Yuthi, the young Lisu

they have accepted malaria deaths as their destiny. It is perhaps time to think beyond programs, and address health as a need in itself rather than health as a consequence of our programs.

Yuthi died of malaria in his early twenties only because he was born in a place where climate change and biodiversity mattered more than his life. In many areas the world over, where human-wildlife conflict prevails, the situation is similar. How are we going to prioritise between biodiversity conservation and the needs of people? Are our politicians and policy-makers even seeing this problem of 'first among equals'? The global health research agenda needs to gear up to answer these difficult questions – questions that matter to people dying of malaria in this age, when in many countries research is addressing carpal tunnel syndrome.

Prashanth N. S. ([prashanth.ns@gmail.com](mailto:prashanth.ns@gmail.com)) is at the Institute of Public Health, Bangalore, and a PhD student in public health at Institute of Tropical Medicine, Antwerp. He works with the Soligas in BR Hills, Karnataka.