

Historical exclusion, conflict, health systems and Ill –health among tribal communities in India: A synthesis of three studies



“Health Inequities and health of tribal communities in India”
Research Team

Closing the gap: Health equity Research Initiative in India

September 2018



ACHUTHA MENON CENTRE FOR HEALTH SCIENCE STUDIES
SREE CHITRA TIRUNAL INSTITUTE FOR MEDICAL SCIENCES & TECHNOLOGY,
TRIVANDRUM

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**By
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**A project of
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Table of Contents

Title	Author	Co-author	Page No:
1. Introduction	TK Sundari Ravindran	Ganapathy Murugan Antony Stanley Hisham Moosan Rama Baru Aditi Hegde	3
2. Methodology	Renu Khanna	Jennifer Liang Sulakshana Nandi Antony Stanley Hisham Moosan Nakkeeran N	36
3. Findings			
3.1 Status	Jennifer Liang		65
3.2 Role of the health system	Vandana Prasad	Nakkeeran N Rama Baru Jennifer Liang	73
3.3. Inter-sectionality	Sulakshana Nandi	Renu Khanna	82
3.4. Proximate determinants	Renu Khanna	Vandana Prasad	89
4. Discussion and Recommendations	TK Sundari Ravindran	All authors	119
Annexures			137

Chapter 1

Introduction

1.1. Background

This report presents the results of a research project on ***Health equity and health of tribal communities in India***. The project was one of the activities under “*Closing the Gap: Health equity research initiative in India*” implemented during 2014-2018 by Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum, Kerala, India. The ‘*Closing the Gap*’ initiative was financially supported by the International Development Research Centre (IDRC), Canada.

The motivation to initiate a project on inequities in health experienced by the tribal population in India emerged from the findings of an evidence- synthesis exercise on health inequities in India. The synthesis found that while there were many studies on the disadvantaged social, economic and health situation of tribal populations in India, there was very little known about intra-group differentials in the disadvantages. Moreover, few studies addressed themselves to how these disadvantages had come about, and why they had persisted, despite many policy and programmes.

This research project was an exploratory attempt to address this evidence gap, by going beyond documenting the nature and extent of health inequities and focusing on the ‘why’s – why they may have come about, and more importantly, the reasons why they persist.

The research project was an experiment in transformative research – research that would help inform action. It is for this reason that the initial call for expressions of interest specified engagement with tribal communities as an eligibility criterion.

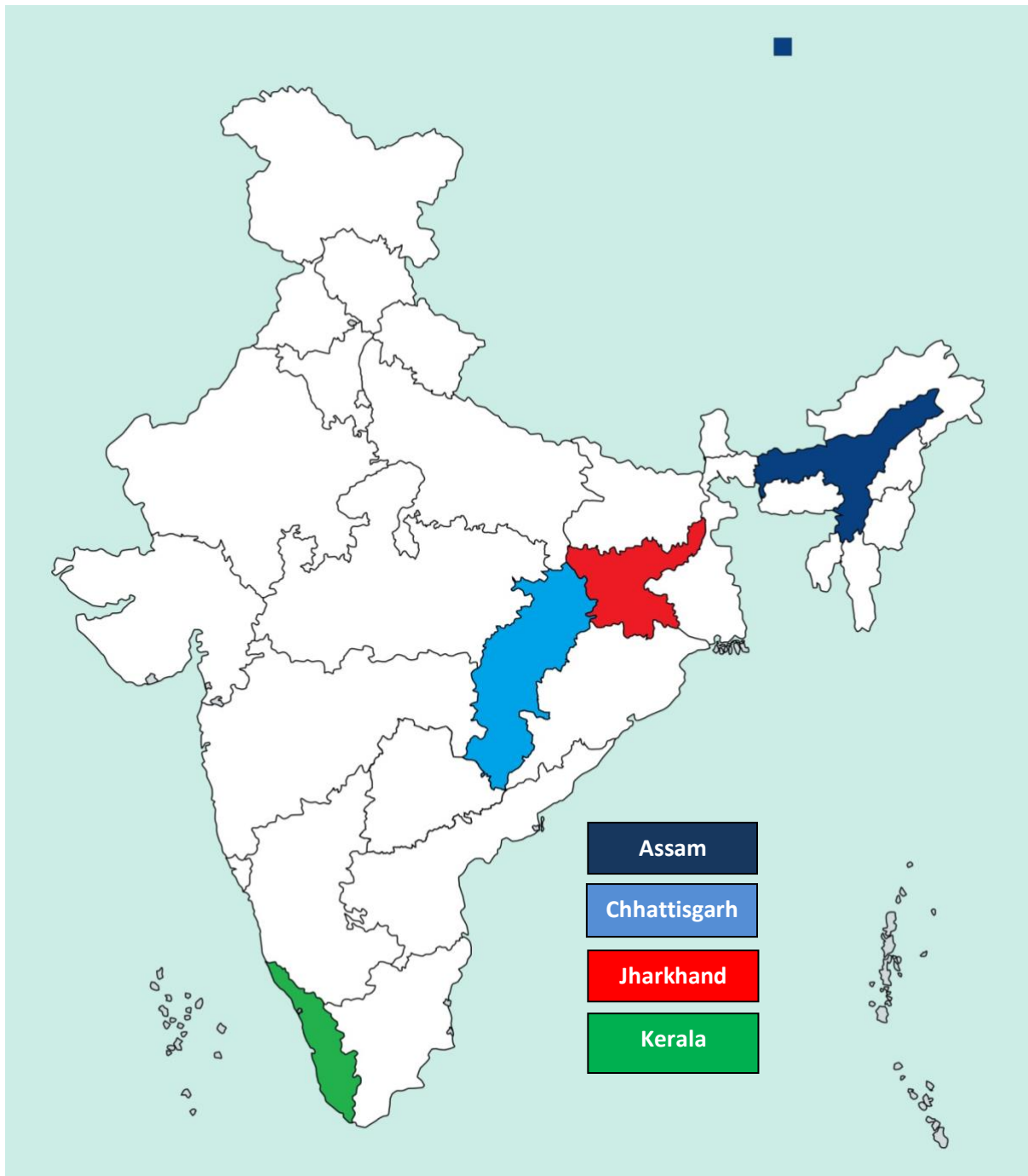
Actors and process

The research project on Health equity and health of tribal communities in India included three research studies carried out in four locations in India. Three research partners implemented the studies: The Action North-East Trust (the ant) in Assam; Public Health Resources Network (PHRN) in Chhattisgarh and Jharkhand; and Health Action by People (HAP) in Kerala, during 2016-2017. The findings of these individual research studies have been presented in three detailed reports [1-3] published in late 2017.

the ant (The action northeast trust) is a voluntary organisation whose work is focused on bettering the lives of the poorest and disadvantaged sections of the north-eastern region of India. It works in more than 250 villages in the Chirang district of Bodoland, Assam for holistic

development with children, youth, women, farmers, mentally ill patients & those affected by ethnic conflicts, and nurtures safe spaces for non-violent conflict resolution. *the ant's* study was on health inequities in a conflict area and was based in the conflict areas of Chirang district in Bodoland, Assam [4].

Figure 1.1 Map of the study states



Public Health Resource Network (PHRN) is a network of individuals and organisations whose main objective is to contribute and strengthen all efforts directed towards the goal of 'Health for All' through promotion of public health, social justice and human rights related to the

provision and distribution of health services, especially for those who are generally left underserved. PHRN is currently working directly in the states of Bihar, Chhattisgarh, Jharkhand, and Odisha. PHRN's study was focused on the *Sabar* and *Baiga* tribal communities belonging to the particularly vulnerable tribal groups (PVTGs) of Jharkhand and Chhattisgarh respectively, with whom the network has been working for many years [5].

Health Action by People (HAP) is a not-for-profit health research organisation based in Trivandrum, Kerala. HAP is led by a group of professionals committed to serving the people in the field of health and development. HAP is at the forefront of health education, public health research and health policy interventions in Kerala [6]. The study by HAP examined inequities in access to and utilisation of health care among the tribal populations spread across various districts of Kerala, intending to inform policy.

The three research partners chose to explore different facets of health inequities among tribal communities in India from diverse historical and geographic contexts, with many differences in their lived experiences of marginalisation. The intention was not to carry out a multi-centric study with the same objectives and tools replicated across sites but to capture the diversity of pathways through which health inequities among tribal communities have resulted. Each organisation decided on the research questions and methodology that it would pursue, based on the exigencies of the local context. At the same time, the studies were guided by a shared conceptual understanding of health inequities and the forces and factors which shape them. This shared standpoint is described in the next chapter on methodology.

The project was carried out during 2016 March – 2018. The project design included a series of annual meetings to facilitate exchanges across the research teams as well as mentoring of the research teams by senior researchers. The meetings were hosted by the "Closing the Gap" project team in Trivandrum. The teams received expert-feedback on their proposals and at various stages of their analysis; were exposed to new concepts and frameworks, and engaged in methodological discussions in these meetings (See Annex 1 for details of the meetings).

Each research team was teamed up with a mentor who was a senior researcher, and who engaged with and provided technical support to the respective teams from the inception of the project right through to producing the final report. The research teams also set up Advisory Committees in the four states where the study was implemented. The state-level Advisory Committees guided the research teams at various stages of data collection. All three studies obtained ethical clearance from the Institutional Ethics Committees (IECs) of their respective organisations.

In all four states, a state-level dissemination meeting was conducted with the participation of relevant policy-makers, programme managers, civil-society actors and in some instances, representatives of the community. The purpose of the meetings was to share the key findings

of the study with those who are responsible for delivering health and social welfare services to the communities concerned. In Chhattisgarh, the dissemination meeting with policymakers led to an invitation to develop an action plan for the development of 'Baigas,' the community whose health situation had been studied. The action-plan has now been integrated into the State's Project Implementation Plan (PIP), with budgetary support. (See Annex-2 for a copy of the Action-Plan).

The present report

The present report is an attempt to consolidate the key findings across all three studies. It aims to understand and explain the diverse **nature** of health inequities along with **processes** and **historical contexts** which create, configure and sustain health inequities among tribal populations in India. As a corollary, the report also aims to question the existing understanding of health inequity.

The report is based on intense discussions held during the third annual meeting of the research teams held in May 2018. The meeting included the research teams, their respective mentors and resource persons from the annual meetings. Participants worked in small groups to draw out and to make meanings from the key findings across the studies. A detailed outline for this report was jointly developed in the meeting.

The report is divided into four chapters. Following this introductory chapter, chapter two describes the research methodologies adopted by the studies. Chapter three, the results chapter, first presents the extent and nature of health inequities and their determinants. It then explores the influence of multiple intersecting axes of vulnerabilities on health inequities. A detailed sub-section examines the role of the health system in health inequities experienced by the tribal communities. Chapter four discusses the 'so what' of the findings – the significance of our findings and reflects on the implications of the findings for health and other macro policies and programmes.

This first chapter is organised into five sections. After the background to the project presented in this first section, section two presents the research teams' approach to an understanding of health inequities. Section three discusses the nomenclatures used about the tribal communities who form the subject of our inquiry. Section four traces the historical trajectory of the marginalisation of tribal communities in India and presents an overview of the current social inequalities between tribal and non-tribal populations in the country. Following this, section five provides a summary of what is known on health inequities by tribal status in India and the three study sites.

1.2. What is our understanding of inequities in health?

In public health, the concept of health inequity is often used to describe inequalities in health that are perceived to be avoidable, unnecessary and unfair [7]. Equity – the absence of particularly unfair differences - is different from equality – the absence of differences in general. *“In other words, health inequality is a descriptive term that need not imply moral judgement”* [8]. The use of equity rather than equality when assessing the nature of differentials in health arises from the recognition that there are bound to be differences in the health status of individuals, and for a number of reasons, many of these are random or biological (for example, differences in mortality rate across different age groups).

Social group or structural differences versus individual differences in health status

There is broad agreement that health equity is a concept used with reference to social groups rather than individuals. For example, the International Society for Equity in Health (2000) defined equity in health as *“...the absence of systematic and potentially remediable differences in one or more aspects of health across socially, demographically, or geographically defined populations or population subgroups”* [9].

Paula Braveman (2005) refined this definition to include differences, not just any population group or subgroup but to *“... disadvantaged social groups (such as the poor, racial/ethnic minorities, women, or other groups that have experienced social disadvantage or discrimination in the past) systematically experience worse health or greater health risks than other social groups.”* [10].

The Report of the Commission on Social Determinants of Health which concluded that *“social justice is killing people on a grand scale”* [11] explicitly defined health inequities from a social justice perspective and identified the inequitable distribution of power, money, and resources as one of the underlying causes of inequities in health.

In contrast, the World Health Report 2000 used the term inequities to refer to the degree of differences across individuals in the population [12]. The argument is that this is a value-free description of the distribution of health across individuals, which steers clear of taking *apriori* positions on the origins of health inequalities across social groups. This position has been widely criticised for its obfuscation of the structural and social justice dimension of health inequities [13-17]. In our view, such an approach also indirectly posits the causes of health inequities to individual choices related to lifestyle, self-care and health behaviour (e.g., smoking, physical exercise, diet, visits to the physician for routine check-ups). The approach to addressing health inequities will consequently focus on individual behaviour –change interventions.

There are other individual-focused approaches which link health inequities to the differential distribution of attributes and resources across individuals but define fairness as an equal

opportunity to be healthy. Failing to see the underlying structural processes that deny people equal opportunities, the solution to this situation of unequal opportunities is often seen as providing good quality education, which would make possible better incomes and consequently, improved conditions of living [18].

In contrast, the social group approach to health inequities recognises that attributes such as the extent of education and nature of employment are not merely the result of individual efforts or actions but are significantly determined by the differential distribution of power and resources across different social groups. The question of fairness is thus more than having equal opportunities but about equal distribution of power [18]. The social group or structural approach to health inequities focuses on the relational aspects of inequities, i.e., on the relative distribution of power across social groups and the consequences for their health and wellbeing.

Policy approaches to addressing health inequities: 'Poor health of the disadvantaged,' social gradients in health or intersectional approaches?

Another dimension of health inequities to consider is about policy approaches to the issue. Admitting that there are health inequities, what do we do about it?

The literature on policy approaches to health inequities often focuses on 'health disadvantage' or the 'poor health of the poor (or disadvantaged) people.' The disadvantage may be by spatial location (e.g., less developed regions), household characteristics (e.g., households with income below-poverty-line, migrant households) or individual characteristics (e.g., teenage mother, a person living with disability).

The problem with such an approach is that the 'disadvantage' becomes akin to a personal attribute that one is born with, and a structural factor such as socio-economic inequality is transformed into a 'condition' affecting only those at the bottom of the rung [19]. In today's world, the focus on 'poverty groups' to address health inequities has evolved perversely into a focus on 'diseases of poverty' such as tuberculosis, malaria and HIV tackled through vertical interventions providing treatment rather than primary prevention through addressing the social determinants. Such an approach also runs the risk of widening health inequities in situations where rates of health are improving more quickly in better-off groups.

The existence of a 'social gradient' in health has been found across high-income and also middle and low-income countries. In other words, for any system of social stratification such as class, race or gender those in successively lower positions are observed to have poorer health and a shorter lifespan. A 'social gradient' approach to addressing health inequities, acknowledges that structural factors driving social inequities affect the entire population, and is consistent with the "social group" or structural understanding of health inequities discussed

above. The policy approach then seeks to flatten the gradient, thus addressing disparities at all levels [19-20].

Feminist scholarship in countries such as the USA and Canada has challenged the study of health inequities to go beyond according primacy to any one single category and address the simultaneous effect of multiple axes of oppression such as gender, class, and race. This approach, known as the 'intersectional approach' to the study of health inequities, defies homogenisation of social groups and considers variations within and between categories such as women, non-white or heterosexual. It is based on the premise that various axes of stratification/differentiation/oppression interact to produce something 'unique and distinct' from any single category acting alone. Intersectionality is an emerging approach that poses considerable conceptual and methodological challenges and represents the way forward in the study of inequities in health [21-22].

Based on this understanding of health inequities, we define 'health equity research' as research that enquires into inequities in health across social groups; recognises that factors influencing health inequities operate at multiple levels from the global to the individual, and acknowledges the simultaneous operation of multiple axes of deprivation or oppression to create inequities. Health equity research would include *among other things*

- identifying disparities in health and health care across caste, economic status, gender and other relevant axes of social stratification
- Enquiring into the proximate and distal factors and mechanisms across multiple levels contributing to health inequities
- Examining the intersection of multiple axes of deprivation/oppression in creating and reinforcing inequities
- Studying the outcomes of interventions aimed at reducing health inequities.
- Examining how the current trajectory of health governance impacts on accentuating or mitigating health inequities (e.g. position taken vis-à-vis promotion of privatisation in health) and on whether and how health equity features as a priority objective for health and health research (e.g. awareness and understanding of policymakers and programme managers on health inequities and their determinants) [23]

Following this section about our position on health inequities and health equity research, the next three sections engage with concepts and evidence on the status of tribal communities in India and in the study sites, including their health status.

1.3. Tribal communities of India

Tribal communities constitute 8.6% of the nation's total population, over 104 million people according to the 2011 Census. They are comprised of more than 630 communities (including around 75 particularly vulnerable tribal groups), contribute to about half of the world's population of indigenous communities. More than one-fourth of the tribal population is concentrated in Central Tribal Region comprising the tribal belts of Andhra Pradesh, Chhattisgarh, Jharkhand, Orissa, Madhya Pradesh and West Bengal [24].

Tribal communities are ethnically different from non-tribal communities due to their distinct culture, language, social organisation, and economy [25]. According to Xaxa (2008), tribal communities populations should be seen as a whole group or community, similar to regional communities such as Bengali, Tamilians, and Assamese. In essence, their counterparts are not castes or peasants, but instead are societies where castes or peasants only form an element of the whole [26].

In 1950, the first Constitution of the Republic of India under Article 342, listed in a particular Schedule several communities identified as "tribal" by the erstwhile colonial government with the purpose of extending certain administrative and political concessions. While the Constitution is silent about the criteria for specification of a community as a Scheduled Tribe, primitiveness, geographical isolation, shyness and social, educational and consequent economic backwardness have been the main traits defining 'tribal communities' in the Census of 1931 and underlie the identification of tribal communities to be included in Schedule 342 of the Constitution [27]. The Constitution guarantees the "Scheduled Tribes" political representation through reservations and lays down general principles of affirmative action for improving their educational and economic and social status.

Nomenclature: 'Tribal, Scheduled Tribe, Adivasi....?'

A brief note on the use of terminology is in order before we proceed further. Members of tribal communities of India have been referred to using diverse terms such as "Tribal," "Scheduled Tribe" and 'Adivasi.'

Several authors have considered the category of a tribe to be a colonial construct. Tribal communities, who were and are a heterogeneous population with distinct physical, sociocultural, linguistic, and demographic traits, as well as divergent living conditions in various geographies, and different levels of acculturation, were brought together under one umbrella of 'tribe' by colonial administrators [28]. However, the term 'tribe' has often been associated with primitiveness, and its use considered pejorative by many.

The term 'Scheduled Tribe,' although originally an administrative term, is now widely used to refer to tribal communities to collect data for the Census and large national surveys. Under the provisions of Article 342 of the Constitution, the list of Scheduled Tribes is notified and valid for each State or Union Territory. The result is that while there are well-defined criteria,

they are not applied systematically, and a community may be considered as a tribe in one state and not in another. Moreover, Scheduled Tribes is not an inclusive term, and there are several tribal communities not included in this category, either all over India or in specific states.

'Adivasi' is a Sanskrit word coined from 'Adi' meaning origin or beginning and 'vasin' – meaning dweller [29]. However, not all tribal groups in India are indigenous to the land they currently occupy [30], and it may not be accurate to refer to them as Adivasis in the same sense as the term aborigine, or indigenous is used in other parts of the world. All the same, movements for the rights of tribal communities have chosen to use the term 'Adivasi' to represent themselves, and the term has a political underpinning, used to focus on tribal rights and their resistance and struggles, and to convey a sense of empowerment of the tribal communities [31].

While the use of the term 'Adivasi' would be preferable to the term 'tribal' because that is how the movement of tribal peoples choose to refer to themselves, there are other complexities. In the North-Eastern states of India, the term 'Adivasi' refers to the migrant tribal communities from the Chota Nagpur plateau, while the dominant tribal communities, who are on the list of Scheduled Tribes call themselves "tribal communities." "Adivasis" do not have the ST status and hence are non-tribal communities in all North-Eastern states except in Tripura [32].

We take into consideration these complexities of nomenclature, and have, therefore, in this report, used the actual name – "Santhal," Paniya," etc. of each community when referring to specific tribal communities. The term "tribal communities" is used when referring to many different groups. However, when using secondary sources and data which specifically refer to Constitutionally defined "Scheduled Tribes," we have used the term Scheduled Tribes. Two other important governmental classifications of tribal communities which refer to specific histories and vulnerabilities of these communities are Particularly Vulnerable Tribal Groups (PVTGs), and De-notified, Nomadic and Semi-and Nomadic Tribes. We give a brief overview of these tribal communities because they constitute the study population in two of the studies included in this report.

Particularly Vulnerable Tribal Groups (PVTGs) [2]

During India's fourth Five-Year Plan (1969-1974), a subcategory was added within the Scheduled Tribes to identify those groups who were relatively at a lower level of development. They have been identified on the basis of the following criteria: 1) forest-dependent livelihoods, 2) pre-agricultural level of existence, 3) stagnant or declining population, 4) low literacy rates and 5) a subsistence-based economy. In 2006, the government changed the nomenclature to "Particularly Vulnerable Tribal Group" (PVTG) as it was realised that using the terms "primitive" and "backward" to denote these groups of

people undervalues their rich culture and heritage [33: p. 60). In general, PVTGs are socially as well as economically marginalised, in the sense that they have little access to resources for their development, low rates of literacy, relatively small populations which are dwindling further, so much so that some of the groups are on the verge of extinction [34].

There are at present 75 PVTG communities distributed among 18 States and UT of Andaman & Nicobar Islands. As per the 2001 census, these 75 PVTGs together had a total population of about 27.7 lakhs [35]. Updated figures from Census 2011 are not available at the time of writing this report. The population size and number of Particularly Vulnerable Tribal Groups vary in different states.

De-notified, Nomadic and Semi-Nomadic Tribes [2]

The Criminal Tribes Acts (CTA), 1871 had notified certain tribes as 'hereditary criminals,' based on certain colonial prejudices against wandering and rebellious activities of these communities. This Act had a draconian provision of confining these communities to specific areas to control their so-called "criminal activities" [36].

Later in 1952, on the recommendation of the All India Criminal Tribes Inquiry Committee these 'Criminal Tribes' came to be known as 'De-notified Tribes' (DNT). Even though the law has been repealed, the identification of these communities as ethnic groups having criminal antecedents continues to this day, leading to everyday discrimination in terms of access to education and jobs as well as brutal violence carried out by neighbouring communities and police personnel. For instance, Sabars, a PVTG of Jharkhand and West Bengal bear this stigma till date [37].

Traditionally, de-notified, nomadic and semi-nomadic communities practice a range of occupations and are remarkably internally diverse. Scholars have classified them according to four broad categories: 1) pastoralists and hunter-gatherers, mainly shepherds, cowherds and hunters of small game, 2) goods and service nomads, such as blacksmiths, stone workers, weapon makers, salt traders, basket makers and so on, 3) entertainers including dancers, acrobats, snake charmers, monkey trainers and wrestlers, and 4) religious performers, ascetics, devotional singers, minstrels and astrologers [38]. These tribal communities', due to the anomalies of inclusion in the lists, are bereft of most affirmative policies and development programmes of government.

1.4. History of the vulnerability of Tribal Communities

Pre-independence period

The history of tribal communities is rife with stories of exploitation, subjugation, and marginalisation, from which much of the vulnerability faced by tribal communities arises. Although pre-colonially many aggressors have subjugated tribal communities, it is the British who penetrated deep into the tribal regions. Historically, the tribal communities had a system

of communal holding of agricultural land, and there was no system of holding land as private property by individuals [39]. The British imposed an agrarian structure that facilitated the collection of revenue and appointed upper-caste intermediaries as revenue collectors in tribal areas. The tribal communities who were possessors of land till then were reduced to the status of tenants or labourers. Before long, they were dispossessed of their land, and the upper-caste intermediaries became the owners [40]. The colonial state also assumed control over forest resources. The Indian Forest Act of 1878 and 1927 deprived tribal communities of their rights in the forest [41]. Simultaneously, rampant deforestation resulted from the initiative to lay railway lines, although these were rarely to the benefit of the communities who were affected by the deforestation. Much of the work was also accomplished through tribal labour [39]. The Land Acquisition Act of 1894 made it legal for the colonial government to acquire land from private parties, including tribal communities, for public projects or on behalf of a Company [41], which led to further loss of land. By the end of the 19th century, many tribal communities rose in revolt against the squeeze on their land and livelihood, and against the imposition of colonial laws and governance structures. The British policy towards tribal communities then changed to one of protection and isolation [42]. This was to be done by avoiding laying communication lines, and by disallowing transportation, requiring special permissions for outsider settlements in the area, and limiting missionaries or other religious stimuli in the area. With an emphasis on economic development and need-oriented education, it was believed that the tribal communities would be able to flourish, and lead content lives.

Post-Independence era up to the early 1990s

After India gained independence, national policies and provisions were devised to safeguard the interest of the tribal community. This was in line with Nehru's theory of integration. He believed in undertaking protective and promotive measures that would help tribal communities integrate into the Indian society without losing their own distinct identity and culture [43]. Tribal communities were granted citizenship rights, and democratic institutions were set up.

Special provisions were also made through the Fifth and Sixth Schedules of the Constitution to preserve the autonomy of the ST populations and protect them from exploitation. Schedule Five is concerned with the administration and control of Scheduled Areas as well as of Scheduled Tribes in States with a significant tribal population other than Assam, Meghalaya, and Tripura. Tribes Advisory Councils (TACs) are set up in Schedule Five Areas, to advise on such matters as welfare and advancement of the Scheduled Tribes. The Governors of these states are authorised to make regulations to prohibit the transfer of tribal land as a protective measure against alienation of tribal land [44]. The Sixth Schedule to the Constitution separately dealt with and outlined provisions for the administration of tribal areas in the States of Assam, Meghalaya, Tripura, and Mizoram in the North-East. In these states, tribal areas are constituted as autonomous regions and districts with regional and district councils.

The district and regional councils are vested with the power to administer the areas under their jurisdiction including assessing and collecting land revenues [45]. General laws are not applicable in the Schedule Five and Schedule Six areas or are applicable with specific modifications.

Provisions of the Panchayat (Extension to Scheduled Areas) Act 1996 (PESA) and The Scheduled Tribes and Other Traditional Forest Dwellers (Recognition of Forest Rights) Act, 2006 (FRA) were other legislative measures introduced to safeguard the rights of the tribal populations of India. PESA empowers the Scheduled Tribes to govern and control their areas through self-rule in consonance with customary laws. The FRA aims to undo the historical injustices done to tribal forest dwelling communities by recognizing their pre-existing rights over their customary lands, forests, and habitats and empowers gram sabhas to protect and manage forests, wildlife and biodiversity while preventing the destruction of their natural and cultural heritage [46].

The Government of India has also introduced schemes such as Integrated Tribal Development Projects (ITDPs) and Tribal Sub-Plan under Modified Area Development Approach (MADA) to improve the economic situation of the ST populations.

Despite the protective discrimination (the policy of granting special privileges to the downtrodden and the underprivileged sections of society) towards tribal communities on the part of the government, they remain vulnerable and marginalised. This is because the mere provision of protective discrimination is not sufficient in itself. The provision must be supplemented by what may be called substantive equality, i.e., ability, resources, and actual opportunity must be created, in order to become effective [33].

The continued marginalisation of tribal communities in the post-independence era happened through two distinct pathways. One was through measures ostensibly meant to benefit them; and the other was through the development programmes adopted, which were blind to their impact on the marginalised sections of the population, including tribal communities.

In return for citizenship post-independence, tribal communities were brought under the country's governance structure, resulting in the abolition of the power of the tribal chiefs who had until then been community leaders. It is also noteworthy that citizenship rights are individual rights, while tribes are communities or societies. Tribes were originally not part of the social system that was built on the principles of inequality and hierarchy. Thus, they did not demand the citizenship rights that would bestow upon them civil and political rights that they already enjoyed in their society. Nevertheless, these rights were curtailed after the amalgamation of the tribes into the larger Indian society, something they neither demanded nor aspired to [28]. Additionally, the granting of citizenship rights and ascribing groups to defined boundaries meant that their mobility was restricted when they became part of the larger federal state. Most of the federal states in India are based on linguistic identity. Unfortunately, the tribal communities became subsumed into this and became minorities and

powerless within these states as they did not constitute a substantial population in vote-bank politics.

Another challenge has been the subjecting of tribal communities to laws supporting private ownership of land. The land is intricately linked to the identity of tribal communities. Traditionally, tribes governed themselves according to their community-based customary law while the formal law that belongs to the state recognises only individual ownership. Their land continues to be managed under the community-based customary law that is orally transmitted while the individual based formal law depends on a written document. This contradiction between laws of the State and the tribal communities has paved the way for alienation of tribal land through various means, and in spite of recent laws protecting tribal communities from land alienation.

Over the decades, the Indian State has principally attended to development while doing little to enhance the protection for the tribal communities. Rather, the protective measures have been violated by the very State that was supposed to ensure the enforcement of these protections. The rights of the tribal communities who are minorities have been sacrificed at the altar of majoritarian welfare, pursued through a range of development programmes [35].

The post-independence approach to economic growth and development resulted in the widespread displacement of tribal communities especially in the natural-resource-rich Central tribal belt, but also elsewhere. Large sections of tribal populations lived in areas rich in forest, water and mineral resources, which saw the establishment of large-scale mining, industrial and infrastructure projects including large dams for irrigation. A few from the tribal communities found employment in the large factories established in their areas, and many became low-paid workers with insecure and transient jobs. The designation of forest lands as Reserve Forests, Protected Forests, and Wild Life sanctuaries deprived them of their traditional sources of livelihood and food and transformed them into encroachers in their land before the Forest Rights Act of 2006 [35]. It is estimated that one in ten of the tribal population has experienced involuntary displacement, a process that deprives them of their collective identity and cultural heritage.

Tribal communities are particularly vulnerable to the effects of forced displacement as they lack the experience and temperament to negotiate their lives in modern society. Many of their skills, that were so useful in the previous environment, are rendered useless in the new location; their ability to provide for themselves is lost entirely. Thus, they are forced to take on low-paying, transitioning jobs which does little to help them. The loss of land, livelihood, and culture, as well as of the larger social environment is impossible to compensate for and has had deleterious effects on their health, educational and nutritional status. The deprivation of their rights has put them in a vicious cycle of poverty, lack of food security and lack of access to public goods like education and health. Tribal communities are also being displaced in the name of conservation of natural resources, which seeks to remove 'human

interference' from forests, wildlife, and other ecological environments. They bear the brunt of both development and conservation efforts as they are often rendered powerless, having little representation in politics and dominant social groups [24].

The Particularly Vulnerable Tribal Groups (PVTGs) face some of the most difficult consequences of 'development' [2]. They have suffered the loss of their traditional livelihoods, habitats, and customary resource rights through the gradual exploitative intrusion of the market and State into their areas in the form of industrial projects, conservation efforts, tourism, the forest bureaucracy and so on. These conditions have led to the loss of their land and resources resulting in chronic malnutrition, starvation and ill health among these groups [35]. Most of the PVTGs are facing shrinkage of their original habitat, are sometimes uprooted and experiencing cultural shock. Some are afflicted with 'alien' diseases, which they are not able to cope with. Due to changes in their ecological settings as well as outside influences, they are facing the problem of survival in general: in health and nutritional aspects, as well as in the process of acculturation. Some of the groups are even facing the problem of extinction, mostly the tribes of Andaman and Nicobar Islands [34]. Examples of the health consequences of such mal-development on PVTGs are forthcoming in the results of the studies described in the results chapter. The present approach of the State towards PVTGs which is one of 'conservation and development' is reminiscent of the isolation theory adopted in the pre-colonial era.

The Nomadic and Denotified Tribes (NT-DNTs) were officially 'freed' from the label 'criminal tribes' in 1952 when the Act was repealed. However, little attempt was made to provide any space to the nomadic way of life, either in State policies or the nation-building process. As a result, they continue to face stigma and humiliation, harsh treatment at the hand of public servants and communities alike, and exclusion from traditional society [2].

There is also a problem with the way a nation-State works in the form of a centre and a periphery, such that the centre is the holder of power and also the implementing agency. This has proven to be inimical to accommodating diverse social characteristics in a setting shaped by regional multiplicities and inequities. The centre is, sometimes understandably, anxious about retaining control over the peripheries, which also means using coercive measures (armed forces). Presently, the armed conflict surging through tribal areas, specifically in North-Eastern and Central India, and the subsequent imposition of the Armed Forces Special Power Act (AFSPA), have led to limited access to health care and social services. This has led to the deterioration of social, economic and health conditions of the indigenous communities, disproportionately affecting women and children in particular.

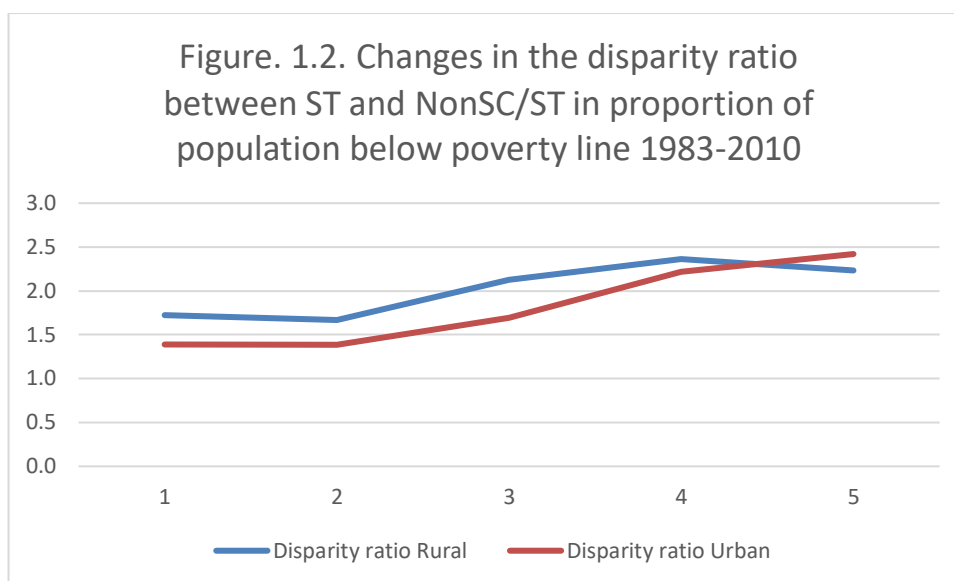
The post-1990s era of economic liberalisation

The period from independence up until the late 1970s was a period of low to modest economic growth in India. Nehruvian socialism was committed to the public-sector-led economic development and channeling the fruits of economic growth towards redistribution in favour of the less-privileged. Education and health sectors were primarily tax-funded. There were many welfare measures for the poor and less privileged, and subsidies and concessions in place for encouraging self-sufficiency in agriculture and industry.

India's GDP growth rate picked up in the early 1980s and reached a high of 8.2% between 2003-04 and 2011-12. The period since 1990 during which the Indian economy grew substantially is also marked by an unprecedented increase in economic inequalities in India. Inequality has continued to widen in the subsequent years. During 2017-18, 73% of the wealth generated in India was garnered by 1 percent of the country's elite, while the bottom 50% of the population (more than 600 million people) witnessed a mere one percent increase in their wealth. The country now (2018) has 101 billionaires, an increase by 17 over last year alone, whose total wealth of Rs 20,913 billion is equivalent to the total budget of Central Government in 2017-18 [47].

Rising economic inequalities have exacerbated existing social inequalities. Tribal communities in India rank among those not only 'left behind' by 'development,' but also rendered worse off. Economic liberalisation has resulted in the entry of many more private corporations into tribal areas and has in many pockets been met with stiff resistance. Some of the most marginalised tribal areas in the country have become hotbeds of left-wing extremism, resulting in their further exclusion from state-supported education, health, and other social welfare services. Tribal populations have gone through a turbulent process of assimilation into the mainstream, best described in the following words of the Tribal Commission: "tribal communities face disregard for their values and culture, breach of protective legislation, serious material, and social deprivation, and aggressive resource alienation [35]." These processes of oppression have not gone without resistance.

The gap between ST population groups and non- SC/ST groups in the proportion living below poverty line widened between 1983-84 and 2009-10, with a greater widening of the urban gap (Figure 1.1 below).



Source: Computed from [24]

Disparity ratio = Proportion BPL among STs divided by proportion BPL among Non-SC/STs

The gap in education between STs and the total population has persisted, as seen from the most recent data from the 66th Round of NSS (2009-10), with close to 60% of rural ST women having no schooling (Table 1.1) [24].

Table 1.1. Educational status of Scheduled Tribes as compared to all social groups, 2009-10, (NSS 66th Round)

Social group	Not literate	Literate & Upper primary	Middle	Secondary	Higher secondary	Diploma/certificate	Graduate & above
RURAL MALE							
ST	35.8	26.4	18.3	11.1	5.7	0.6	2.2
All	26.0	25.3	20.5	14.7	8.0	1.0	4.5
RURAL FEMALE							
ST	58.3	21.7	10.3	5.7	2.7	0.3	0.9
All	49.8	22.0	13.5	8.2	4.2	0.4	2.0
URBAN MALE							
ST	12.7	17.6	19.3	18.2	14.3	2.6	15.3
All	10.4	15.9	17.5	19.5	13.9	2.9	19.8
URBAN FEMALE							
ST	31.3	16.7	15.3	14.7	11.1	1.0	9.8
All	23.6	17.2	15.3	15.9	12.1	1.3	14.7
RURAL PERSON							
ST	47.0	24.2	14.3	8.4	4.2	0.4	1.6
All	37.8	23.7	17.0	11.5	6.2	0.7	3.2
URBAN PERSON							
ST	21.8	17.1	17.3	16.5	12.8	1.8	12.6
All	16.7	16.4	16.4	17.7	13.0	2.0	17.3

Source: [24]

After more than six decades of affirmative action, we have a complex situation of improvement in the average levels of education, income, and health of the ST populations alongside widening gaps between them and the rest of the population. Stratification across and within tribal communities is also emerging as a feature of the current era.

In the present context ownership/non-ownership of land and resources and integration into the market economy have become important in understanding tribal stratification. The capitalist economy, political ideology, and practice have influenced tribal society and have created class differentiation among tribes [49]. As Shah (1979: 464) writes:

"The better-off strata do not share resources with the poor strata belonging to its tribe with a view to fighting the competing better-off strata among the non-tribal communities. It only uses the poor strata for its interests. When its economic interests are threatened by the poor strata of its ethnic group, it joins hands with non-tribal better-off strata. Thus, the clash between the vocal sections of tribal communities and non-tribal communities arises primarily from economic interests" [48].

A similar situation also exists concerning relationships between other tribal communities and PVTGs. For instance, in the state of Jharkhand, the Santhal tribes are better-off than Sabars (a PVTG) and hire Sabars for menial jobs at their houses and on their lands [48]. The PVTGs who are considered to be very vulnerable within the tribal communities have received an unequal treatment, such that the larger tribal communities and major PVTGs can derive a larger share of benefits from government schemes, while the most vulnerable groups lose out [35].

1.5. Health status and access to health care of the tribal populations: A brief overview

This section starts with a description of what is known about health inequities in health status and utilisation of health care services in India and goes on to present the diverse situations in the varied contexts in which the studies described in this report were carried out: Kerala, Chhattisgarh, Jharkhand, and Assam.

The all-India- picture

Members belonging to Adivasi or Scheduled Tribes (ST) have had worse health compared to other sections of the population for many years, and this trend continues to persist.

Health-status

According to data from the fourth National Family Health Survey, both adults and children from the Scheduled Tribes experienced poor nutritional status. ST men and women also had the highest prevalence of anaemia (Table 1.2). Data also showed that among children below

the age of 5 years, ST children had the worst anthropometric indicators of all social groups (Table 1.3) [50].

Table 1.2: Nutritional status of adults belonging to the Scheduled Tribes, 2014-15

	Women with BMI below 18.5 kg/m ² (%)	Men with BMI below 18.5 kg/m ² (%)	Women with any anaemia (%)	Men with any anaemia (%)
Scheduled Tribes	31.7	25.2	59.9	32.0
Scheduled Castes	25.3	22.9	55.9	23.6
Other backward castes	22.9	20.3	52.2	22.0
Others	17.8	16.3	49.8	20.3
All	22.9	20.2	53.1	22.7

Source: [50]

Table 1.3: Nutritional status of children below 5 years of age belonging to the Scheduled Tribes, 2014-15

	Stunted (%)	Wasted (%)	Under-weight (%)	Any anaemia (%)
Scheduled Tribes	43.8	27.4	45.3	63.3
Scheduled Castes	42.8	21.2	39.1	60.6
Other backward castes	38.7	20.5	35.5	58.6
Others	31.2	19.0	28.8	54.2
All	38.4	21.0	35.7	58.5

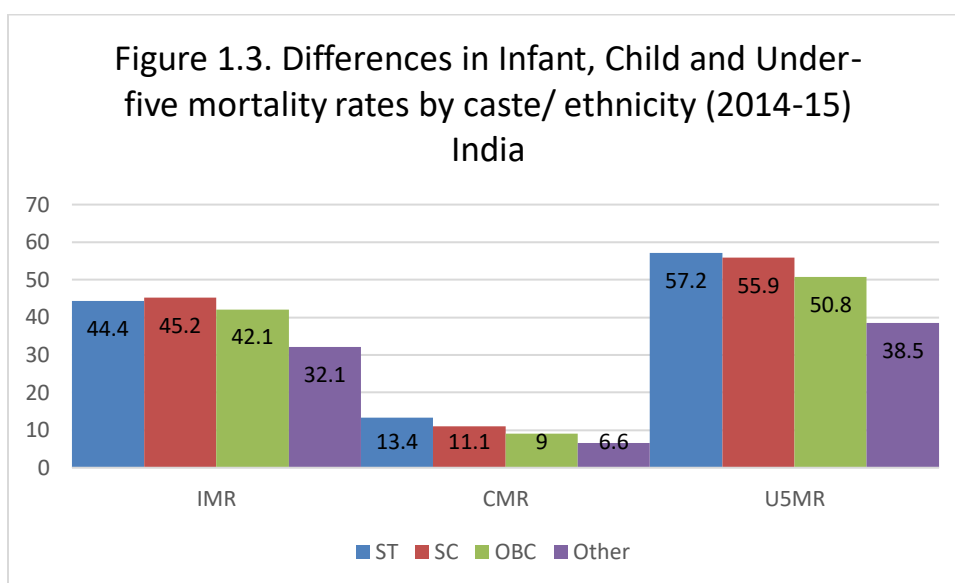
Source: [50]

The many disadvantages experienced by those belonging to the Scheduled Castes and Scheduled Tribes culminate in premature mortality. The average ages at death of ST women, at 40.0 years, was nearly fifteen years less than that for "Forward caste" Hindu women [51]. ST women constituted a much higher proportion of maternal deaths than their proportion in the overall population. Of the maternal deaths covered by the MAPEDIR¹ a project of UNICEF

¹ Maternal And Perinatal Death Enquiry and Response (MAPEDIR) Project was implemented in 16 districts in six Indian states with high maternal mortality (West Bengal, Rajasthan, Jharkhand, Bihar, Orissa, and Madhya Pradesh)

in 2009, 24% were from the Scheduled Tribes (ST), roughly three times their proportion in the total population [52].

Infant mortality rates were slightly lower for the ST populations as compared to the SC populations but much higher than OBCs and Other castes. However, this slight advantage is nullified by the higher rates of child mortality, resulting in higher under-five mortality rates among ST children as compared to all other groups (Figure 2). There has been a decline in under-five mortality rates among ST children. However, the decline has not been faster than that for other groups, resulting in no change in the extent of the mortality gap over the ten-year period from 2004-05 to 2014-15 (Figure 3) [50].



Source: National Family Health Survey -4, 2014-15 [50]

Table 1.4: Changes in the gap in Under-five mortality rates by social groups, 2004-05 to 2014-15, India

Caste	NFHS -3	DR	NFHS-4	DR
SC	88.1	1.5	55.9	1.5
ST	95.7	1.6	57.2	1.5
OBC	72.8	1.2	50.8	1.3
Other	59.2	1.0	38.5	1.0

DR: Disparity ratio (Value of the specific category/ best value)

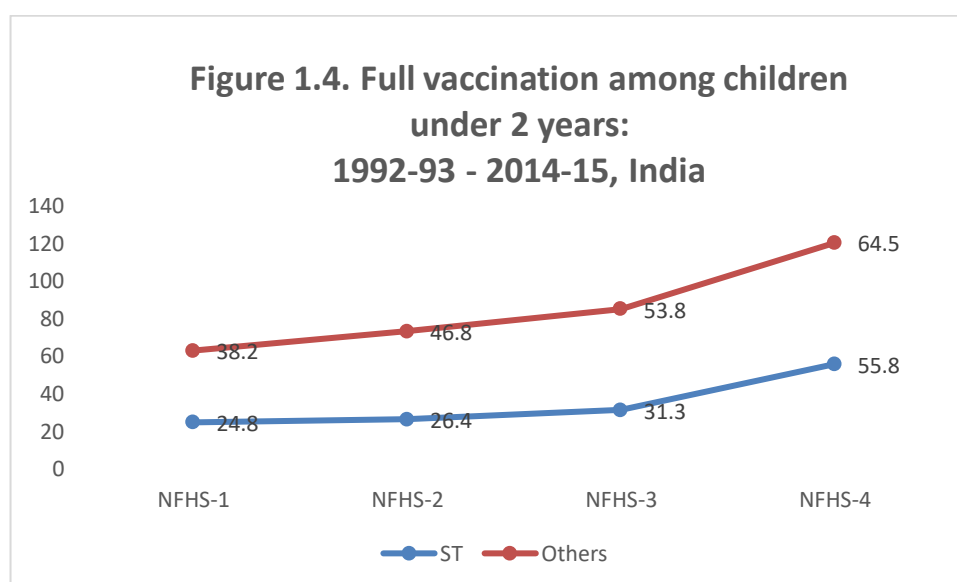
Source: [50]

The utilisation of healthcare services

According to the Coverage Evaluation Survey of 2009, a smaller proportion of ST (18.9%) women had full ANC coverage as compared to women of other social groups (31.2%) [53]. Similar findings were reported from studies conducted in Gujarat [54] and from Uttar Pradesh [55]. Even though all social groups (SC, ST, and others) had shown an improvement in ANC coverage between 1992-93 and 2005-06 (NFHS 1 to NFHS-3), the improvement was more among women of the *other caste* group (20%) than among SC women (10%) [56]. About one-fifth of the women from Scheduled Tribes did not receive any antenatal visits, according to NFHS-4 in 2014-15, as compared to only 11.4% among other castes [50].

There has been a dramatic increase in institutional deliveries between 2004-05 and 2014-15. In 2005-06, only 18% of Scheduled Tribe women delivered in a health facility compared to 33% of Scheduled Caste women, 38% of women from *Other Backward Castes* and 51% of women from other (forward) castes [57, 24]. In 2014-15, the comparable figures were 68% for ST women, 78.3% for SC women, 79.8% for other backward castes and 82.9% for 'other' (forward caste) women. It may be seen that the gap between ST women and all other groups has narrowed considerably [50].

The four National Family Health Surveys covering the period of 1992-93 to 2014-15 revealed that although there has been a steady increase in the immunisation coverage of children below two years of age, ST children accounted for the least proportion of fully immunised and the highest proportion of not immunised across all time points. While the gap between ST and 'other caste' children narrowed over time for no vaccination, there was no change in the gap between these two groups in children fully vaccinated.



Source: [50]

The health situation among the tribal populations studied

While the all-India data gives an overall understanding of the gaps in health indicators between ST communities and the rest of the population, it is also important to understand differences across sites. According to the 2011 census Kerala has a minuscule proportion of tribal groups in its total population (less than 1.5%), while Jharkhand (about 26%) and Chhattisgarh (32%) are states with a significant tribal population. Bodoland in Assam is governed by Bodos, a tribal community, and Bodos and other tribal communities together constitute more than 50% of the population [24].

Kerala [3]:

Kerala has the highest life expectancies at birth for women and men of all Indian states, and infant, child mortality rates close to some of the best in the world. While the average situation of tribal communities may, therefore, be better as compared to other states, there is huge health- the divide between the tribal communities and others in the state.

Estimates for 2001 show that the mortality among tribal infants (60 per 1000 live births) children under five years of age (83 per 1000 live births) was almost six times as high as the state average (11 and 14 per 1000 live births, respectively). Female children had a much higher infant and under-five mortality rates than male, and the disparity was much wider in urban as compared to rural areas [24]. High infant mortality among tribal people is also a major problem in the current decade. In Wayanad district, and in the Attappady block, the IMR per 1000 live births was above 30, when the state average was close to 10 per 1000 live births [3, p. 81].

Similar disparities in maternal mortality ratios are reported from the district of Wayanad. Within the district, three-fourths of the maternal deaths were reported from among the tribes, who constitute just 17 percent of its population. From 2008-09 to 2012-13, there were 51 maternal deaths, out of which 32 were tribal women in the age group 19-35 [3].

There are also significant intra-tribal differences in mortality observed. For example, in Attappady block, the Irulas was found to have a comparatively lower life expectancy than Kurumba and Muduga tribe [58].

Recent studies indicate a higher prevalence of hypertension among both male and female populations among Kani tribes of Kerala as compared to the rest of the state [59]. The cardiovascular risk factors were more frequently present among young adults in the tribal population (20-30 years of age) than the non-tribal of same age group [60].

Unlike other states, the PHCs in tribal areas in Kerala are fully staffed with more than the required number of doctors (236 in position as against 131 required) and field workers [3: p.24]. And yet, many studies have reported that tribal communities face severe problems in accessing health care, including the inability to get timely treatment for patients who need emergency treatment. One of the studies [61] notes that this is not because of their

unwillingness to avail the state-provided health services, but because of their inability to do so. According to one estimate [62], the nearest PHC is at a distance of about 6 km. Therefore, even in cases of emergency, they would have to avail private transportation, the costs of which they can ill-afford, thereby making these facilities inaccessible to them. Another study reported that while nearly all non-tribal mothers living in the vicinity of a PHC utilise the antenatal services, 15 to 20 % of the tribal pregnant women don't undergo a single antenatal checkup [63]. In spite of reliance on the public health system, the average out of pocket expenditure on health care was 16% of the household income [62], which may be catastrophic for most households. Most tribal communities do not have access to specialist care at the secondary level and have to travel long distances for referral care.

The PVTGs of the Central Indian tribal belt [2]

Two PVTG groups – the Sabars of Jharkhand and the Baigas of Chhattisgarh are covered by the studies reported in this document. The following is a brief overview of the health situation of PVTGs in the Central Indian Region, including Sabar and Baiga communities, based on the limited evidence available.

The few published studies that are available on the nutritional status amongst PVTG children and adults in Odisha, MP, Chhattisgarh, Jharkhand and other states have all found very high levels of malnutrition among PVTGs. This is the case with both children and adults. The findings on child malnutrition have been tabulated in Table 1.5, which shows very high proportions of malnutrition among school going children [64]

Table 1.5: Malnutrition among PVTG children

PVTG	Underweight Pre-School Children (%)	State
Kamar	90	Chhattisgarh
Onge	85	Andamans
DongriaKondh	90	Orissa
Paharia	86	Jharkhand
Great Andamanese	85	Andaman and Nicobar Islands
Baiga	69.7 <2SD	Madhya Pradesh
Bharias	52 <2SD	Madhya Pradesh

Source: [64]

Malnutrition amongst PVTG adults is also higher than in other communities. While the national average for this dimension (adults with BMI <18.5) is around 35% (NFHS-3), the proportion of underweight adults amongst Baigas was more than double this figure, at 76% [64].

More recently a study by Jain et al. (2015), has analysed gender-disaggregated data that highlights the worrisome status of nutrition in Baiga tribes. The data of 1200 Baiga men and women in Bilaspur district of Chhattisgarh shows the median weights of men and women as 47 and 40 kgs respectively. Further, using the 3rd percentile of the National Centre for Health Statistics (NCHS) standards for height at 18 years of age, it was calculated that 66.4% of Baiga men and 58.2% of women were stunted. When compared to non-Baiga women from the same villages, Baiga women were at least five kgs lighter [65].

A study conducted in the tribal areas of Madhya Pradesh and Chattisgarh found a high prevalence of sickle cell anaemia among the tribal population of the state [63]. The Baigas had the highest prevalence of sickle cell anaemia among all the tribal groups that were studied. Nutritional Anaemia, on the other hand, ranged from 30 to 100% among all the tribal groups studied [66].

One of the distinguishing characteristics of the PVTGs has been their declining or stagnant population, despite high fertility rates. One reason for this has been the high levels of mortality amongst these tribes [67]. For example, while the birth rate among various PVTG groups in Madhya Pradesh (of which Chhattisgarh was a part, till recently) was similar to that of rural Madhya Pradesh, the infant mortality rate and crude death rate are much higher than the state average (Table 1.6).

Table1.6: Selected statistics of the PVTGs of Madhya Pradesh

	Bharias	Birhors	Kamars	Rural M.P.
Birth Rate	33.3	34.8	32.9	33.3
Death Rate	14.9	17.6	14.5	11.6
IMR	139	154	155.4	106.6

Source: [67]

The diseases affecting the PVTGs are mostly similar to other tribal groups, but the severity and prevalence of the disease increase due to malnutrition and lack of access to adequate health services. A study on the burden and pattern of illnesses among the PVTGs was conducted by Jan Swasthya Sahyog (JSS) in its community-based programme in Madhya Pradesh and Chhattisgarh. The study also attempted to see whether these can be linked to the nutritional status of the tribal groups [68].

Table 1.7: Patients seen at Jan SwasthyaSahyog (JSS) Clinics, 2010-13

Illness	All	Non- <i>adivasis</i>	Tribal excluding <i>Baigas</i>	<i>Baigas</i>	<i>P</i> value
OPD attendance	59039	40115	17560	1364	
All tuberculosis	1993	1070 (2.67)	812 (4.62)	111 (8.14)	<0.001
Pulmonary tuberculosis	1272 (of 1993)	587 (54.86)	601 (74.01)	84 (75.68)	<0.001
Sputum positive tuberculosis	894 (of 1272)	451 (76.83)	392 (55.92)	51 (60.71)	<0.001
Rheumatic heart disease	383	258 (0.64)	118 (0.68)	7 (0.51)	0.792
Diabetes	1061	825 (2.06)	224 (1.28)	12 (0.88)	<0.001
Severe hypertension (≥ 180 or diastolic ≥ 110 mm Hg)	1153	734 (1.83)	396 (2.26)	23 (1.69)	0.002
Cancers	1635	1037 (2.59)	559 (3.18)	39 (2.86)	<0.001
Illnesses requiring major surgery	2192	1474 (3.67)	633 (3.60)	85 (6.23)	<0.0001
Leprosy	513	337 (0.84)	156 (0.89)	20 (1.47)	<0.05
Lepromatous leprosy	137	91 (27.0)	40 (25.64)	6 (30)	0.90

Values in parentheses represent percentages, *P* values according to Chi-square Test or Fisher's exact test.

Source: [68]

It can be seen from Table 1.7 that the Baigas suffered disproportionately from tuberculosis (TB) than the other tribes and non-tribals. The prevalence of leprosy is also higher among the Baigas than the other groups. Also, those conditions that require major surgeries are also more common among the PVTGs than the non-tribal groups [70: p. 666]. The study found that people who were suffering from tuberculosis were also severely malnourished.

In contrast to what is generally observed in diabetes, i.e., a positive correlation between diabetes and obesity, the study found that the median BMI of tribals with diabetes was 16.3 and 16.4 kg/sq.m, respectively for men and women and over 70 percent had BMI less than 18.5 (65: p:671). Kapoor et al. [69:19) in their study on Saharia tribes in Madhya Pradesh also noted that *"socioeconomically deprived population represents co-occurrence of high blood sugar level, high blood pressure and high-fat percentage pointing towards the beginning of metabolic syndrome which is a very distinct and recent phenomenon among the primitive tribal group."*

Malaria is a huge public health problem in tribal areas where it is a big contributor to morbidity and mortality. Most of the mortality due to Malaria is reported in forested tribal areas like Odisha, Chhattisgarh, and Jharkhand.

Malaria morbidity in 13 tribal villages in forest and plains was studied by National Institute of

Malarial Research (NIMR) in Sundargarh district of Odisha in 2001. The study found that malaria morbidity was 347.9 per 1000 population per year in the forest villages as against 61.9 per 1000 in the plains. Plasmodium falciparum accounted for 85.0% of the total malaria cases during the study period. In forest and plain areas the number of P. falciparum cases per 1000 population per year was 284.1 and 31.2, respectively, whereas the parasite rate was 14.0 % and 1.7 %, respectively. The study also found that clinical malaria occurred more in children age 0-5 years [70].

Research on access of PVTGs to healthcare or nutrition services is scarce. Government surveys rarely collect disaggregated data for PVTGs. In a study conducted to study the access to reproductive and sexual health among Baigas and Sabars in Chhattisgarh found that more than half the women experienced pregnancy loss due to lack of proper access to services. Among the PVTGs, Baigas had better access to the services than Sabars [71].

One study conducted in Odisha documents information on out-of-pocket expenditure among some of the PVTG tribes in the state. The expenditure on health accounts for 5%, 3% and 4.5% of the total monthly household expenditure among Kutiakondh, DongriaKondh and LanjiaSaora respectively [69]. Incidentally, the expenditure on health was higher than education among all the three groups. Interestingly Kutia Kondh and Dongria Kondh spent more money on alcohol than health. The amount was almost double amongst the Dongria Kondhs. The expenditure on social ceremonies was also higher than health. One plausible explanation for the comparatively lower expenditure on health might be because PVTGs generally consult local healers for healthcare [69: p 154]. Nevertheless, modern medicine is fast replacing the traditional systems and the tribes more and more prefer to go to the modern practitioners even though the rugged terrain retards the growth of adequate health infrastructure [72: p 155].

Scheduled Tribes in Chirang district, Bodoland, Assam, [1]

Information on the health of Scheduled Tribes and Adivasi populations of Bodoland, Assam is sparse. Like the other two sites, health indicators for Bodoland areas in Assam, and especially Chirang district where one of the three studies were carried out, are much worse than the state average [73]. This holds for example, for MMR, IMR, immunisation, institutional deliveries, registration and check-ups of pregnant women. Chirang District is also the poorest district in Assam when it comes to the percentage of people having access to potable drinking water, or sanitary latrines or even electricity. Dutta & Baro in a study found that of 257 Bodo households surveyed, in as many as 135 households, there was at least one person who is either blind or crippled or mentally impaired or chronically sick or had more than one such physical or mental disability. Such cases were more in rural areas in comparison to urban [74].

There are, however, important differences as compared to the other two sites. Assam has also witnessed several violent ethnic conflicts over the past few decades. Based on the evidence of the link between conflict and health, one can hypothesise that the health of

people is worse off when they are affected by conflict than when they are not. There are reports by Humanitarian Aid Agencies such as Oxfam [75] or the IAG Report [76] on the outbreak of diseases, availability of health services and WASH (Water, Sanitation and Hygiene) among the affected populations in relief camps or when conflict-affected people return to their villages.

There are many NGO reports and studies on the immediate effects, including health impact, following an episode of conflict. For example, in a study carried out in Bodoland, Assam, Sinha says that even though the risks and burdens on overall health systems due to armed violence have thus largely remained unknown, yet the adverse consequences of these breakdowns are extremely real. In a field assessment in 2013 following the aftermath of the Kokrajhar ethnic crisis of 2012, he states: "Existing local health system in affected districts was disrupted due to the scale of the problem. This is especially heightened by the need to extend the existing services to new camp populations. This has increased the workload of doctors, ANM and ASHA who are working now with patients for whom they do not have medical records or detailed case histories. For instance, in Dhubri District, Bilasipara sub-division, existing sub-PHC is also now fully responsible for extending services to around 4000 internally displaced persons (IDPs) in 4 camps. This is in addition to the normal workload of the local healthcare workers" [77].

The next chapter starts with the conceptual premise of the studies described in this report. It then presents the objectives of and methodology adopted by the three studies for understanding the pathways through which tribal health inequities have come to be.

References

1. The Ant (The Action Northeast Trust, Assam). 2017. *Health Inequities in a Conflict Area – An In-Depth Qualitative Study in Assam*. Closing the Gap: Health Equity Research Initiative in India, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum.
2. PHRN (Public Health Resource Network, New Delhi). 2017. *Exploring Health Inequities amongst Particularly Vulnerable Tribal Groups: Case Studies of Baiga and Sabar in Chhattisgarh and Jharkhand States of India*. Closing the Gap: Health Equity Research Initiative in India, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum.
3. HAP (Health Action by People). 2017. *Exploring Health Inequity by Assessing the Nature of Healthcare Utilisation and its Correlates among the Tribal Population of Kerala*. Closing the Gap: Health Equity Research Initiative in India, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum.
4. www.theant.org
5. www.phrsindia.org
6. www.hapkerala.org
7. Daniels, N., Kennedy, B., & Kawachi, I. (1999). Why justice is good for our health: the social determinants of health inequalities. *Boston Review*, 128 (4): 215-251.
8. Kawachi, I., Subramanian, SV., & Almeida-Filho, NA. (2002). Glossary for health inequalities. *Journal of Epidemiology and Community Health*, 56: 647-652.
9. International Society for Equity in Health (ISEQH). (2000). www.iseqh.org/conf2000_en.htm (accessed October 2, 2013).
10. Braveman, P. (2005). Health Disparities: Concepts and Measurement. Unpublished manuscript, 2005. As quoted in Starfield B. State of the Art in Research on Equity in Health. *Journal of Health Politics, Policy and Law*, 31(1): 10-32.

11. World Health Organization. (2008). *Closing the gap in a generation: Executive summary of the Final report of the Commission on Social Determinants of Health*. Geneva, WHO, 2008.
12. World Health Organization. (2000). *The World Health Report 2000. Health Systems: Improving performance*. Geneva, WHO, 2000.
13. Almeida, C., Braveman, P., Gold, MR. et al. (2001). Methodological concerns and recommendations on policy consequences of the World Health Report 2000. *Lancet*, 357: 1692 – 1697.
14. Landmann-Szwarcwald, C. (2002). On the World Health Organisation's measurement of health inequalities. *Journal of Epidemiology and Community Health*, 56: 177 – 182.
15. Houweling, TA., Kunst, AE., & Mackenbach, JP. (2001). World Health Report 2000: Inequality Index and Socioeconomic Inequalities in Mortality. *Lancet*, 357: 1671-72
16. Braveman, P., Starfield, B., & Geiger, HJ. (2001). World Health Report 2000: How it removes equity from the agenda for public health monitoring and policy. *British Medical Journal*, 323: 678 – 681.
17. Navarro, V. (2000). Assessment of the World Health Report 2000. *Lancet*, 356: 1598 – 1601.
18. Wright, EO. (2016). *Two Approaches to Inequity and their Normative Implications*. Erik Olin Wright July 5, Sciences Research Council, Brooklyn, New York. <https://items.ssrc.org/two-approaches-to-inequality-and-their-normative-implications/SOCIAL>
19. Graham, H., & Kelley, P. (2004). *Health inequalities: Concepts, Frameworks and policy*. London, NHS Briefing paper.
20. Macintyre, S. (1998). Social inequalities and health in the contemporary world: comparative overview. In Strickland SS and Shetty PS (eds). *Human Biology and Social Inequality*. 39th Symposium Volume of the Society for the Study of Human Biology, Cambridge, Cambridge University Press.
21. Hankivsky, O (ed). (2011). *Health inequities in Canada: Intersectional frameworks and practices*. Vancouver, UBC Press.

22. Schulz, AJ., & Mullings, L. (2006). *Gender, race, class and health: Intersectional approaches*. San Francisco, Jossey-Bass.
23. Ravindran TKS (2014). *Closing the gap: Health equity research initiative in India*. Trivandrum (India), Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology. Grant Proposal submitted to the International Development Research Centre, Canada.
24. Statistical division: Ministry of Tribal Affairs. *Statistical Profile of Scheduled Tribes in India*. 2013.
25. Ghosh, AK., & Munda, RD. (2012). *The other side of development: The tribal story*. New Delhi: Konark.
26. Xaxa, V. (2008). *State, Society, and Tribes*. Noida: Pearson India Education Services Pvt. Ltd.
27. Census India 1931: Caste, tribe and race. Retrieved from [http://indpaedia.com/ind/index.php/Census India 1931: Caste, Tribe, And Race](http://indpaedia.com/ind/index.php/Census%20India%201931:Caste,%20Tribe,%20And%20Race) 10 September 2018.
28. Bhukya B (2008). The mapping of the Adivasi Social. *Colonial Anthropology and Adivasis. Economic and Political Weekly* 43(39): 105-109. Kumar GSJ (1995) *Tribals from Tradition to Transition: A Study of Yanadi Tribe of Andhra Pradesh*. New Delhi, M.D. Publications.
29. Kumar GSJ (1995). *Tribals from Tradition to Transition: A Study of Yanadi Tribe of Andhra Pradesh*. New Delhi, M.D. Publications.
30. Prasad A (2003). *Against Ecological Romanticism: Verrier Elwin and the Making of an Anti-Modern Tribal Identity*. New Delhi, Three Essays Collective.
31. Roy Burman, JJ. (2009). Adivasi: A Contentious Term to denote Tribes as Indigenous Peoples of India. *Mainstream*, Vol XLVII, 32, July 25.
32. The Ant (The Action Northeast Trust). 2016. *Working with the Strengths of the Weakest*. Powerpoint presentations held on February 2016 in the Partners workshop, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum.
33. Xaxa, V. (2014). Constitutional Provisions, Laws and Tribes. *Yojana*, 4-9.

34. Sahani, R. & Nandy, SK. (2013). Particularly Vulnerable Tribal Groups in India: An Overview. *Journal of the Anthropological Survey of India*. 62(2), 851-865.
35. Health Inc Consortium (2014). Health Inc- Towards equitable coverage and more inclusive social protection in health. *Studies in Health Services Organisation & Policy (SHSOP)*, 32, (Series ed) B. Criel, V. De Brouwere, W. Van Damme and B. Marchal, series editor. Antwerp: ITGPress; 2014.
36. Radhakrishna, M. (2008). *Dishonoured by History: 'Criminal Tribes' and British Colonial Policy*. New Delhi: Orient Longman.
37. Devi, M. (1983). Lodhas of West Bengal. *Economic and Political Weekly*, [online] 18(23):947-949. Available at: <http://www.epw.in/journal/1983/23/our-correspondentcolumns/lodhas-west\bengal.html>
38. Bokil, M. (2002). De-notified and Nomadic Tribes: A Perspective. *Economic and Political Weekly*.37(2): 148-154
39. Singh, KS. (1978). Colonial transformation of tribal society in middle India. *Economic and Political Weekly*, 13(30): 1221-1232.
40. Saxena KB (2012). Development is war; underdevelopment is benign: political economy of tribal displacement in India. In Ghosh AK and Munda RD (eds.) *The other side of development. The tribal story*. (pp. 26-79). New Delhi, Konark Publishers.
41. Ghosh AK (2012). Introduction. In Ghosh AK and Munda RD (eds.) *The other side of development. The tribal story*. (pp. 1-15). New Delhi, Konark Publishers.
42. Xaxa, V. (2005). Politics of language, religion and identity: Tribes in India. *Economic and political weekly*, 40(13): 1363-1370.
43. Singh, KS. (1982). Transformation of tribal society: integration vs. assimilation. *Economic and Political Weekly*, 17(34): 1376-1384.
44. Ministry of HRD. Constitutional Provision. <http://mhrd.gov.in/fifth-schedule>
45. Ministry of HRD. Constitutional Provision. http://mhrd.gov.in/scheduled_tribal_areas
46. Patnaik, S. (2017). Proceedings: International Conference on Poverty Reduction and Forests, Bangkok, September 2017, *PESA, the Forest Rights Act, and Tribal Rights in India*.

47. Oxfam India Inequalities. (2018). Oxfam India. <https://www.oxfamindia.org/pressrelease/2093>, accessed 4 September 2018.
48. Shah, G. (1985). Tribal Identity and class differentiation: A case study of the Chaudhri tribe. *Economic and Political Weekly*, 14(7/8): 59-69.
49. Vidyarthi, LP., & Upadhyay, VS. (1980). *The Kharia, then and now: a comparative study of Hill, Dhelki, and DudhKharia of the central-eastern region of India*. New Delhi: Concept.
50. International Institute for Population Sciences. (2017). *National Family Health Survey-4 (NFHS-4)*. (2015-16). Ministry of Health and Family Welfare, India.
51. Borooah, VK., Sadana, N., & Thorat, S. (2012). *Gender and caste-based inequality in health outcomes in India*. Working Paper Series, 6(3), Indian Institute of Dalit Studies, New Delhi. Retrieved from <http://www.dalitstudies.org.in/uploads/publication/1473146220.pdf>
52. Kumar, S. (2010). Reducing maternal mortality in India: Policy, equity, and quality issues. *Indian Journal of Public Health*, 54(2), 57-64.
53. United Nations International Children's Emergency Fund. (2009). Coverage evaluation Survey. National Fact Sheet, India. Retrieved from [http://www.indiaenvironmentportal.org.in/files/National Factsheet 30 August no lo go.pdf](http://www.indiaenvironmentportal.org.in/files/National_Factsheet_30_August_no_lo.go.pdf)
54. Saxena, D., Vangani, R., Mavalankar, D., & Thomsen, S. (2013). Inequity in maternal health care service utilization in Gujarat: analyses of district-level health survey data. *Global Health Action*, 6(1), 19652. Retrieved from <https://doi.org/10.3402/gha.v6i0.19652>
55. Saroha, E., Altarac, M., & Sibley, L. (2008). Caste and maternal health care service use among Rural Hindu women in Maitha, Uttar Pradesh, India. *Journal of Midwifery & Women's Health*, 53(5), e41–e47. Retrieved from <https://doi.org/10.1016/j.imwh.2008.05.002>
56. Pathak, P. K., Singh, A., & Subramanian, S. V. (2010). Economic inequalities in maternal health care: Prenatal care and skilled birth attendance in India, 1992–2006. *PLoS ONE*, 5(10), e13593. Retrieved from <https://doi.org/10.1371/journal.pone.0013593>

57. International Institute for Population Sciences. (2007). National Family Health Survey (NFHS-3), 2005-06. Volume 1. India. Retrieved from http://rchiips.org/nfhs/NFHS-3%20Data/VOL-1/India_volume_I_corrected_17oct08.pdf
58. Sujith AV, Reejo RJ, Dhanush DM, Scaria R (2014). Analysing livelihood status of tribes in Attappady block, Kerala. *International Journal of Remote Sensing and GIS*2(3): 15-24.
59. Priyanka S. (2014). *Prevalence of non-communicable disease risk factors among Kani tribe in Thiruvananthapuram district, Kerala*. Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum.
60. Haddad, S., Mohindra, KS., Siekmans, K., Màk, G., & Narayana, D. (2012). "Health divide" between indigenous and non-indigenous populations in Kerala, India: population based study. *BMC Public Health*. Jan;12(1):390.
61. Nithya, N. (2014). Globalization and the Plight of Tribals: The Case of Kerala, India. *Dawn J*, 727–58.
62. Centre of Excellence IIM. (2006). *Wayanad Initiative: A situational study and Feasibility Report for the Comprehensive Development of Adivasi Communities of Wayanad*. Calicut. Kozhikode; 2006.
63. Jose, JA., Sarkar, S., Kumar, SG., & Kar, SS. (2014). Utilization of maternal health-care services by tribal women in Kerala. *Journal of Natural Science Biology and Medicine*, 5(1):144–7.
64. Public Health Resource Network (PHRN). (2010). *Tribal Health*, Book 15; Eds. Sundararaman T., Prasad V., and Nandi S. New Delhi: PHRN.
65. Jain, Y., Kataria, R., Patil, S., Kadam, S., Kataria, A., Jain, R.,.....Shinde, S. (2015). Burden & pattern of illnesses among the tribal communities in central India: a report from a community health programme. *Indian Journal of Medical Research*, 141, 663-672
66. Chakma, T., Rao, PV., Meshram, PK., & Singh, SB. (2006). *Health and Nutrition Profile of Tribals of Madhya Pradesh and Chhattisgarh*. Proceeding of National Symposium of Tribal Health.
67. Pandey, GD. & Tiwary, RS. (2000). Some aspects of population growth of the primitive tribes of Madhya Pradesh. *Journal of Family Welfare*, 46(2): 66-72.

68. Jain, Y., Kataria, R., Patil, S., Kadam, S., Kataria, A., Jain, R.,.....Shinde, S. (2015). Burden and pattern of illnesses among the tribal communities in central India: a report from a community health programme. *Indian Journal of Medical Research*, 141, 663-672.
69. Kapoor S, Tyagi R, Saluja K, Chaturvedi A and Kapoor AK (2010). Emerging health threats among a primitive tribal group of Central India. *Journal of Public Health and Epidemiology* 22(2): 13-10.
70. Sharma SK, Tyagi PK, Padhan K, Adak T, Subbarao SK (2004). Malarial morbidity in tribal communities living in the forest and plain ecotypes of Orissa, India. *Annals of Tropical Medicine and Parasitology* 98(5): 459-468.
71. Nandi S., Mishra J. P., Kanungo K., Manikpuri H., Yadav C., Paikra G., and Upadhyay V. Public health advocacy to reinstate reproductive rights of Particularly Vulnerable Tribal Groups (PTGs) in Chhattisgarh. Presentation at EPHP Conference, IPH Bangalore, October 5, 2012. <http://www.biomedcentral.com/1753-6561/6/S5/P1>
72. Bera, S. (2012). Baigas in exile. Down to Earth, [online]. Available at:<http://www.downtoearth.org.in/coverage/baigas-in-exile-38674>
73. UNFPA-UNICEF. (2005). *The Effects of Conflict on the Health and well being of women & Girls in Darfur*. UNICEF & UNFPA.
74. Dutta, S., & Baro, PK. (May. 2014). The Level of Ill-Being among The Backward Bodo Community of Assam (India): A Deprivational Perspective. *International Journal of Humanities and Social Science Invention* 3 (5), 26-31.
75. Urdal, H., & Che, CP. (2013). War and Gender Inequalities in Health: The Impact of Armed Conflict on Fertility and Maternal Mortality. *International Interactions Empirical and Theoretical Research in International Relations*, 489-510.
76. Wessells, MG. (1998). Children, Armed Conflict and Peace. *Journal of Peace Research*, 35(5), 635-646.
77. Sinha, S. (2014, November 11). Health Care in Danger: Knowledge mapping and advocacy need of the hour in India. Retrieved March 30, 2016, from <http://blogs.icrc.org/new-delhi/2014/11/11/health-care-in-danger-knowledge-mapping-and-advocacy-need-of-the-hour-in-india/> :<http://blogs.icrc.org/new-delhi/2014/11/11/health-care-indanger-knowledge-mapping-and-advocacy-need-of-the-hour-in-india/>

Chapter 2 Methodology

This chapter describes in some detail the research methodologies adopted by the three studies [1-3]. The chapter is divided into six sections. The first section describes the general standpoint shared by the studies, against which the approaches and methodologies adopted may be understood. Section two presents the reasons why specific research themes were chosen, and the conceptual and value frameworks underlying these. Section three gives information on the study areas and research teams. Section four is a substantive section on approaches and methodologies, which lays out the tools used, ethical considerations, analysis and ways in which quality and rigour were ensured. Section five is about the methodologies adopted for the literature reviews that informed the research questions and the sixth and last section reflects on the limitations encountered during the process of data collection and analysis.

2.1. The common standpoint shared by the three studies

As we will see in the following sections, the three research studies pursued different research questions using a range of different methods. What brings the studies together is a shared understanding of the structural causes underlying health inequities and the desire to go beyond descriptions of inequities to probing the underlying processes. In the first meeting of the research teams in 2016, the teams identified the following as features and concerns common to all the studies.

All the studies:

- Intended to go beyond the “what” and “how much” of health inequities, to the "why" and "so what."
- Were informed by a "social determinants of health" approach – i.e., examining the larger social, economic, political and historical factors at multiple levels influencing health status and access to health care services.
- Understood inequities in access to health care as an issue of rights and justice
- Considered multiple axes of inequities: gender, geography, ethnicity and other relevant axes
- Factored-in the importance of context: i.e., locating the production and sustenance of inequities within, among others, specific historical, political, geographic contexts
- Explored not only demand-side factors affecting health care seeking but also health system and service provision factors which affect access and utilisation

- Attempted to understand how government policies and schemes have affected/influenced health and well-being and their determinants.
- Used diverse methods beyond quantitative approaches, in order to document experiences and perspectives
- Were committed to 'giving voices' to those experiencing health inequities, by embedding suitable methods, processes, and mechanisms throughout the research process

This backdrop of a shared standpoint would help place the descriptions of methodologies presented in the next few sections.

2.2. Choice of research themes and conceptual and value frameworks

Choice of research themes

All the three studies carried out by *the ant*, PHRN, and HAP respectively, were about health inequities among tribal populations. However, as already mentioned, the specific nature and focus of the individual studies were different and depended on the specificities of the vision and value orientations of the three organisations.

the ant chose to examine the consequences of several decades of *conflict on the health and wellbeing* of the Adivasi and Bodo people of *Deosri*, where it has been working for almost a decade, organising men, women, children, youth, and farmers for their rights and development. Right on the Bhutan border with India, *Deosri* with its villages in deep forest areas has been a comfortable hide-out of many gun-wielding rebel militant groups. *Deosri* has witnessed multiple waves of ethnic conflicts over the past decades, and the displacement of large populations of Adivasi and Bodo communities.

The Public Health Resource Network (PHRN) started to focus on the PVTGs, the more marginalised and vulnerable of tribal groups, around 2010. While developing its capacity building module on Tribal Health in 2010, PHRN keenly felt the lack of comprehensive evidence and research on the health status of tribal communities, the other inequities they face and their interface with the health system. PHRN undertook a study amongst the Baiga PVTGs in Chhattisgarh and the Sabar community in Jharkhand. They aimed to arrive at a comprehensive understanding of the health and nutritional status of these PVTGs and their access to health care services, within the wider context of health and nutrition programmes run by the Government. Through the study, PHRN wanted to identify the key issues that need immediate attention of the government, and at the same time, build evidence for advocacy for policy change.

PHRN has been working in Chhattisgarh and Jharkhand since 2006, and its network comprises of individuals and organisations working in these areas, some working directly with these communities. These organisations were engaged throughout the study so that the voices of the PVTGs themselves may come through.

HAP in Kerala is an organisation that has positioned itself at various instances in an advisory capacity for health policy and planning to the state government. The research team at HAP had envisioned bringing out possible policy recommendations to address existing inequities in health care service utilisation among the Scheduled Tribes communities in the state. HAP felt that while Kerala has been in the forefront of social progress in India, there were significant gaps in the utilisation by Scheduled Tribe communities of the government healthcare provisions. One of the glaring extant set of inequities was in the domain of maternal and child health. Previous studies on maternal and child health had tried to establish inequities in health status and health care utilisation, but they focused on one or two districts, and could not provide a state-level picture. Also, the interplay of both the provider -side and the consumer- side factors responsible for the inequity were unexplored.

The HAP study set out to explore the nature of health care utilisation by Scheduled Tribe populations across Kerala by comparing the utilisation of antenatal care services, immunisation services, and supplementary nutrition services among the tribal and non-tribal population of Kerala. The study intended to use both quantitative and qualitative tools to bring out the differences in health care utilisation among the tribal and non-tribal population and the factors contributing to the inequities. Further, the study also attempted to describe how policy and the health care system have addressed these issues.

Conceptual and value frameworks

The three studies drew from the conceptual frameworks shared in the Methodology Workshops held over the research period. The frameworks were: the WHO Social Determinants of Health, Health Inequities, Intersectionalities, Indigenous Health frameworks.

All three studies draw on the intersectionality framework for understanding the inequities, which result from the interaction between various vulnerabilities like geography, ethnicity, gender, age and other axes that emerged during the study [4]. Besides, to understand access to healthcare, health seeking and utilisation of health services, the PHRN study used the Access framework with its dimensions of Availability, Affordability, and Accessibility [5-7]. PHRN also adapted the framework on social determinants of health to explore the wider socio-cultural, political and economic determinants of health of indigenous people [8]. The concepts of equity, community participation, cultural safety [9] and the rights of indigenous people, especially women further provided key elements for analysis.

Apart from the conceptual framework, there was also a value framework guiding the studies. Both *the ant* and PHRN worked with the value framework which looked up to the State as the

principal provider of health care, and thus the research had an intent to hold the state accountable for its role as duty-bearer vis-à-vis its people, who are entitled to the Right to Health. The purpose of the study was to engage with the state to change the situation and not merely describe the situation. HAP's position was more to 'unearth' what has been happening and 'present' that to the policy-makers and other decision-makers. Though the difference may be only in degrees, yet there was a difference in the value framework which guided the three studies.

2.3. Study areas and Research teams

the ant's study area

The topic of ethnic conflict in Assam being very sensitive, the research team from *the ant* chose villages under the Deosri intervention cluster on the Bhutan border, where the organisation has been working for almost a decade. Building on the rapport and goodwill already present, the researchers got easier access to interviewees on the very sensitive topic of ethnic conflict, pain, and loss. "*We could reach out and interview a range of respondents – community members, community and village leaders, teachers, health workers, militant leaders, members of local government bodies and youth leaders. the ant's reputation over many years helped open doors, and most respondents we contacted for the study were keen meeting the researchers. We got militant leaders willing to share their stories in three-hour-long interviews, doctors who served in Shantipur were willing to meet and share their stories with the researchers at any time*". Through the entire period of data collection, *the ant's* research team was housed in a rented house which belonged to a local Lower Primary School Teacher in the Deosri Nepali Village. This proximity to the villages of the study ensured that data collection was smooth and fast and the team had the flexibility to reach out to different levels of respondents with many opportunities for immersing itself into the lives of the people. The data collection sites were: Homes, offices, pharmacies in different locations, bazaars and tea shops [1].

of the block is 987 females per thousand males and literacy rate is 47%. Pandariya and Bodla blocks are known for a significant number of Particularly Vulnerable Tribal Group (PVTG) populations of the Baiga community. As per district records, the number of Baiga households in Pandariya is 3125 households.

Dumaria Hill Forest block of East Singhbhum, Jharkhand, has the highest proportion of Sabar population in the district. The block is situated 60 km away from the industrial town of Jamshedpur. As a significant proportion of the block is covered with forest, the block is named 'Dumaria Hill Forest Block.' Dumaria block is surrounded by uranium mines in the north and copper mines in the northeast. As per the Census, the whole block is designated as 'rural,' and therefore there is no urban population. The Sabar population in the block is 1714. People mainly from the Santhal and Sabar communities live here. Despite being covered with forest, the water retention capacity of the terrain of the block is very low owing to its topography. Poor infrastructure and availability of drinking water is a major issue faced in the block. The condition of the roads and transport service is also awful for the Sabar communities living in the hilly terrain of the block it is easier for the Sabars of Dumaria to access facilities from Odisha but the official residential documentation is an issue which prevents them from availing the services.

Baigas who have been displaced and were living in the open in Nagadabra at the time of the study.



HAP's study area

Kerala has 14 districts, out of which Wayanad, Palakkad, Idukki, Kasargod, Kannur, and Thiruvananthapuram are home to most of the state's tribal population [11]. Five out of the six most populous districts with Scheduled Tribe populations (except Kasargod) were selected for this study. Aaralam was a resettlement area of the tribal population located in the northern district of Kannur. It was included to examine the differences, if any, between the native area and resettlement area. Thus the study area included two *Grama Panchayats* each, of Idukki, Wayanad, Thiruvananthapuram, Palakkad Districts and one *Grama Panchayat* of Kannur District. Case studies were conducted among PVTGs in Attappady, Palakkad, and Wayanad.

Meleboothiyar colony in Attappady, Palakkad district, HAP's case study area



A house in the Meleboothiyar colony



Research teams

The unique nature of the three organisations, the context of their study, what they set out to do and the value framework described above influenced the profile of the research teams.

the ant decided that since they were undertaking an in-depth qualitative study, the team needed a high level of research skills and competence. Hence, the research team was made up mainly of professionals who were familiar with the qualitative research methodology and its data collection tools. Knowing the mistrust that might yet exist among the Bodo and Adivasi rival communities who had undergone violence and displacement, extra care was taken to select and choose field researchers from both these communities to carry out the interviews and the field data collection.

In PHRN, the researchers included team members of PHRN from Chhattisgarh, Jharkhand and Delhi offices, team members of SHRC Chhattisgarh and Astha Samiti, Kabeerdham. All the members had experience in research and were already involved in advocacy for health and nutrition. Most of the surveyors involved in the quantitative data collection had been working in the development sector for a long time. Most of them came from a rural and tribal background. Half of the surveyors were women. A few women surveyors had completed the ANM course while a few were associated with Non-Governmental Organisations. In Jharkhand, there were surveyors from the Sabar community

The research team of HAP comprised of professionals from Public Health and Community medicine background. The PI and co-PI were doctors in Community Medicine. The rest of the team members were mostly doctors who had worked with the tribal population in some of these districts as health care providers. The group also consisted of sociologists and statisticians.

2.4. Approaches and Methodologies

The three studies adopted a reflective, exploratory and iterative methodology. They combined both quantitative and qualitative methods conducive to understanding not only the meaning of health inequity but also experiences of accessing health care and processes that shaped health inequity. Some health status and utilisation indicators for the vulnerable amongst the tribal groups were measured, and qualitative methods helped to go beyond the numbers and to explain the phenomenon of the health inequities experienced by them.

While two of the studies – PHRN and HAP - combined both the quantitative and qualitative methodologies, the study by *the ant* was an in-depth qualitative study with elements of ethnography. The studies by PHRN and HAP explored the inequities in health status and health utilisation of tribal communities in Kerala, Chhattisgarh, and Jharkhand while the *ant*'s study aimed to document experiences of people's lives with respect to conflict, displacement and their experiencing of the health system.

Reflectivity was an essential aspect of all the three studies. The HAP study changed its design based on how their study progressed. This study was conceived as a mixed methodology study, following a sequential explanatory design. After the first formative qualitative assessment to assess the attributes of the communities that were relevant to healthcare

utilisation, a cross-sectional survey was undertaken. The survey was followed by a qualitative research component to bring out the reasons behind these findings. However, the research team felt that the nature of inequities in tribal health in Kerala was not being understood even with the qualitative component. The HAP team then decided to add another component, Case Studies of specific tribal groups in specific locations – Wayanad and Attappady. The case studies attempted to bring out the similarities and differences in their identities, health systems infrastructure, human resources, treatment seeking, disease burden and their concepts of health. Similarly, as described later in this report, **reflexivity** was integral to all stages of the PHRN and *the ant* studies.

Research Questions and Objectives of the Study

As mentioned earlier, each study had specific objectives and questions of research which guided its methodology and methods. Table 2.1 below shows the specific research questions and objectives of the study.

Table 2.1: Research Questions and Objectives of the Studies

Research Questions of <i>the ant</i>, Assam	Objectives of the study by PHRN in Chhattisgarh and Jharkhand	Objectives of the study by HAP, Kerala
<p>1. How have socio-political changes historically shaped health and the public health system in the area? Conversely, how has lack of health contributed to conflict?</p> <p>2. How does conflict affect the health of different ethnic groups differentially? How do critical social determinants such as loss of livelihoods, land, housing, culture, safety and security, community, mediate to create ill health?</p> <p>3. What are the ways in which different people, individuals, and groups, gender, class, ethnicity,</p>	<ul style="list-style-type: none"> • To study the social, cultural, political and economic determinants of health among Baigas and Sabars • To study the access of Baigas and Sabars to government health and allied systems • To study the experience of health-related events among Baigas and Sabars in Chhattisgarh and Jharkhand 	<ul style="list-style-type: none"> • To explore the health care utilisation among the tribal and non-tribal population of Kerala. • To study the reasons behind inequities in health access. • To describe how policy and the health care system have addressed these issues.

<p>religion respond to ill-health in a conflict area?</p> <p>4. How do various groups interface with and benefit from government health services and also health-promoting institutions such as Public Distribution System, Anganwadi Centers, Water, Sanitation and Mid-Day Meal?</p>		
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Ethical Considerations

Since they were researching vulnerable communities and sensitive issues, ***the ant*** team was conscious that a high level of trust and rapport would be necessary for good/ quality data collection. It relied on its history of work in the area since 1996, and the villages selected were within *the ant's* intervention villages that were affected by the conflicts of 1996, 1998 & 2014 between the Adivasis and the Bodo communities. All attempts were made to reduce risks to the respondents, including removing of all identifiers from the data collected, ensuring privacy during data collection. The PHRN chose blocks which had the presence of grassroots organisations working with the PVTGs.

Each organisation's Institutional Ethical Committee (IEC) reviewed the ethical concerns based on the research protocols and the tools. In *the ant*, each member of the research team had to individually complete and pass an NIH-web based training on "Protecting Human Research Participants" before the ethical committee gave its clearance.

In PHRN, the overall effort was to promote a commitment to sensitivity, respect, courteousness, and tactfulness towards the participants. A Participant- Information- Sheet and Informed consent form for the household and the group interviews were prepared and translated into Hindi. We read out both these to the participants and obtained their verbal consent. Consent was taken before taking a photograph or using it in the public domain. An attempt was made to record most qualitative interviews in a voice recorder after taking due consent. Participation was voluntary with the right of the respondents to withdraw at any stage. In an attempt to not be extractive, pamphlets were prepared in Hindi on provisions of social welfare programmes like Janani Shishu Suraksha Karyakram, Integrated Child Development Scheme, Mid-Day Meal, MGNREGA and RSBY/ MSBY(Health Insurance schemes). The entitlements contained in each programme were explained at the end of each interview in simple language, and copies of the pamphlets were given to the respondents. Besides, slips giving height and weight information were prepared and given to the households at the end of the interviews. The results of the study were shared with all the

stakeholders, including the community and the Government. The study was expected to feed into making the health system more responsive to the vulnerable communities, thereby benefitting the respondents. There was a stated commitment to a due acknowledgement being given to all participants (and others) involved in this research and to extending this to any publications emerging out of the study.

In HAP, informed consent was obtained from all the participants in the same manner as described for the PHRN study. Participation was voluntary, and respondents were free nor to answer specific questions or to withdraw from the study at any stage. Full confidentiality of the participants was ensured at all levels of data collection, entry and analysis. All personal identifiers in both the quantitative and the qualitative data were removed. Every informant was given a unique ID to ensure the confidentiality.

Intervention with the community during the study period-

As part of ethical considerations, PHRN had decided that any interventions wherever possible would be made in the community during the study. To give a few examples, in Chhattisgarh there were cases of food grain rations being withheld because the households did not have toilets or did not possess *Aadhar* cards. PHRN complained to the Food Secretary in such cases. In some hamlets of Chhattisgarh, medicines and malaria kits were not available in the *Mitanin* (the equivalent of the ASHA worker) kit. The absence of these drugs was reported to the *Mitanin* programme managers, and the issue was resolved. When someone was found to have symptoms suggestive of Tuberculosis in Dumaria and in instances of Sabars having no ration card, information and intimation were given to relevant authorities for treatment and redress.

Box 2.1: Walking the fine line between researcher and activist (the ant)

At times, we found ourselves treading a thin line between being researchers and being development workers. It was difficult to remain an objective researcher witnessing people's struggles and hardships without intervening. There were times during the fieldwork when we were called to act. In one case, one of the researchers found during an overnight stay that a woman was having labour pain and she could not be taken to the state dispensary the next day morning because her family did not have money to pay for the ambulance. The researcher gave money from her pocket for the ambulance else the woman would have been in danger of a complicated birth. In another case, in one of the displaced villages, researchers found that children, who used to go to school before the conflict had no more school to attend. The researchers had to write to the Executive Director of **the ant** regarding the situation of the children and got them to start some schooling facilities there.

The study findings were shared in dissemination events in Assam, Kerala, Jharkhand, and Chhattisgarh. The events were attended by government officials, members of the community, academics and civil society groups.

Methods

In terms of methods used, in addition to the usual surveys and in-depth interviews and focus group discussions (FGD), the three studies relied heavily on observations and the experiences while doing the studies in difficult and remote areas. These experiences are indicative of how the populations living in these areas experience inequities in their daily lives. The field notes from the diaries of researchers as well as their photographs provided rich information on health inequities experienced by the groups being studied.

Table 2.2 gives details of the methods used by the teams and why they used the different methods and any limitations and constraints that they faced, or the changes that they decided along the way.

Table 2.2: Methods used in the three studies

Method	Purpose & remarks, if any
ANT	
Participatory Rural Appraisal (PRA) disease listing, disease ranking, facility mapping mobility mapping, historical timeline	To get maximum participation from the community to respond to questions of researcher; collective response to cross-check the accuracy of recall of historical incidents. <i>Realised limitations due to very early saturation. Changed to focus on collecting thick "stories of conflict and people's lives in their own words" without any tools.</i>
In-depth interviews with conflict displaced individuals of different communities. Key informants – health providers in different stages of the conflict, community leaders, militant leaders, others who may be identified as having such information.	To construct their life-histories/ thick biographies and understand in-depth their experiences with conflict and its effect on their health and well-being. These were used to construct vulnerability maps and treatment pathways.
Group interviews with women's groups	To jog memories of past conflict; cross-checking accuracy of historical verify the information
Casual conversations - with various individuals in the study area such as shopkeepers, village elders, patients, carers and staff in the hospitals.	to give a deep understanding of the context and for validating some of the information gathered from other methods such as observations and interviews
Observations – e.g., in shops and homes of 'pharmacists' and faith healers observing types of patients, illnesses, and people they treated.	<i>Observations of one of the long-displaced Bodo villages led to the research team's decision to visit their original village of displacement.</i> <i>Observing and comparing the living conditions of the displaced Bodos with those who returned to their village after displacement, gave strong evidence of how conflict-induced displacement lives on even 20 years after the incident of violence.</i>
Maps and construction of life histories: conflict timeline, history of the health	Some maps were drawn while data was being collected and helped point out gaps in data which the research team then filled up.

<p>system, vulnerability maps, and illness pathway maps</p>	<p>Sharing the health system history map with relevant respondents helped validate and sharpen the information.</p> <p>Using diagrams and maps helped researchers present complex phenomenon concisely.</p> <p>The historical context of the conflict in the larger socio-economic changes through secondary sources also put in a timeline for easier clearer understanding.</p>
<p>Photographs & Visuals</p>	<p>to highlight, corroborate, triangulate data and information collected through interviews and other means To present data in a complete manner.</p>
<p>PHRN</p>	
<p>1.A household level survey using an interview schedule 2. Listing and coding of diseases 3. Developing the Profiles of the survey-villages 4. Developing the profile of Anganwadis in the study area 5. Developing the profile of Sub Health Centres in the study area 7. Household Listing of household-heads covered in every village.</p>	<p>To capture the availability of health and nutrition facilities in the village and distance to the nearest facilities.</p> <p><i>Some village and health facilities' profiles could not be completed due to a paucity of time.</i></p>
<p>Group Interviews "natural group" of the people belonging to the Baiga, Sabar community in the village and non-PVTG (ex-health workers, Village Health Nutrition and Sanitation Committee meetings).</p>	<p>Separate group discussions undertaken, taking into account intersectionalities like gender, age and any other that emerged during the household survey.</p>

<p>Key informant interviews with male and female service providers, stakeholders, community leaders, academics, civil society & public health professionals Intersectionality aspect was taken into consideration when selecting the key informants.</p>	<p>With Frontline workers: to understand their socio-economic profile and perceptions about the PVTGs.</p>
Mapping of resources	PRA techniques to map government health and allied services such as water, sanitation, anganwadis, road, and electricity in the villages selected. Social and revenue mapping of all tolas of Chattanipani village with the help of Burrumtola and Jojoguda community (Santhal and Sabar, men and women).
Casual conversations	
Observations	
Daily debriefing and discussions with Surveyors	To add nuances to the Findings
Content analysis of news clippings	
HAP	
Survey	To collect quantitative data on morbidity and patterns of treatment seeking among tribal communities as compared to other population groups
In-depth interviews	<p>Carried out during two phases: In the formative research-phase, to understand the factors responsible for health inequities from the side of the provider and the user of health services, and to increase the precision of the questionnaire for the cross-sectional survey and inform the qualitative study.</p> <p>The second phase was the actual qualitative study to collect experience-based information from the tribal communities and to get the insights from healthcare providers and officials from the tribal welfare departments on the experience of treatment seeking, and problems faced by the tribal communities</p>

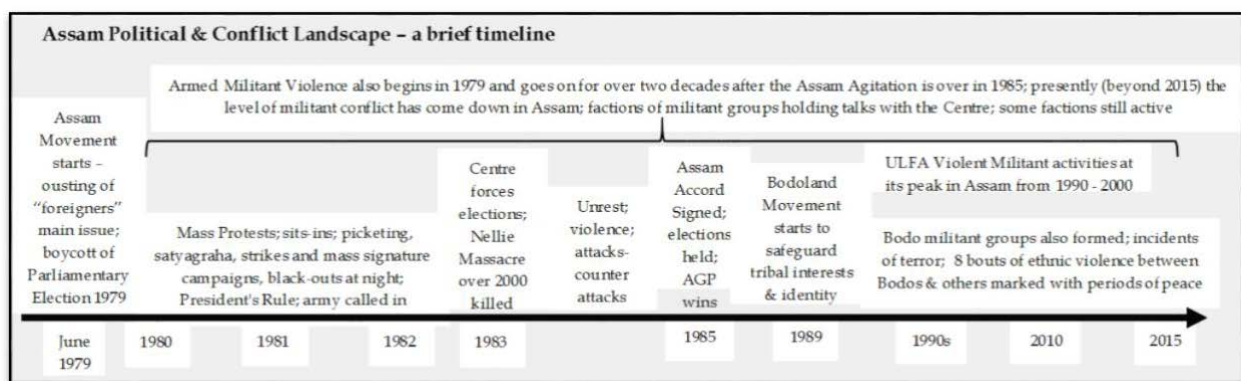
FGDs	Also carried out in the formative research phase, for the same purpose as Key Informant Interviews.
Case studies	Two of five PVTG groups in Wayanad and Attappady were studied, to make-up for the under-representation of difficult-to-reach-settlements in the cross-sectional survey. The purpose was to understand the difficulties in health care seeking among the most vulnerable tribal communities and to contrast this with other tribal communities to highlight diversity within the tribal communities.

Innovations in methodology

These three studies make a significant contribution to the methods that can be used to study health inequities with respect to tribal communities.

the ant team used very innovative data reduction and data representation tools such as historical timelines, vulnerability maps, and treatment pathways maps. This helped present complex data in visually appealing and easily understandable ways. Some of the examples are given below and presented in different sections of the report, for example, the vulnerability mapping and the mapping of displacement given earlier in this chapter)

Figure 2.2: Timeline of Assam’s Political & Conflict Landscape in the last 30 years



Source: [1: p.9]

PHRN used newspaper epidemiology in their methods. Newspaper reports related to health issues, epidemics and deaths among Baigas in Pandariya block and Sabars in Jharkhand were collected and reviewed. The analysis gave critical insights into the status of health and allied public services, the nature of the epidemic and the number of deaths and the response of the government, which included statements made in media. It also revealed the inadequacy of the government's response and the extent of victim blaming.

Data Quality and Rigour

Each research team followed their norms for ensuring data quality and methodological rigour.

Quality of data collected in ethnographic research depends more on the rapport the research team has built with the community and the degree of acceptance the team enjoyed in the team. The fact that the members of *the ant's* research team have been working in the area for a long time and many of were familiar with the village, routes, community and the local culture enhanced this rapport and acceptance. Further, their decision to stay in one of the study villages for a sustained period enhanced this scope.

Similarly, the research team of *the ant* would sit together after two-three interviews to review data and plan the next lines of questioning. Monthly meetings were held regularly with the research advisor and a larger review meeting once in three months helped review the

progress of the study and make changes if any were required. Each review meeting allowed the researchers to go back to the data, find the gaps, and explore more possibilities for exploration.

Box 2.2: The researcher as an Insider and Positionality (*the ant*)

As a researcher, there were also dilemmas about the research team's positionality. In one instance, one of the researchers did a couple of interviews with traditional healers. The researcher personally did not believe in traditional medicine and had to struggle not to let his views show openly in his behaviour. While he tried his best to position himself as an unbiased researcher called to interview, collect data and write the data as it was, his feelings always contradicted what he was listening to. Gradually, over time he realised the importance of registering all perspectives and not allowing his opinion to shape the process of data collection.

Being researchers from the same community gave rise to its own set of issues. While being an insider helped in the data collection as one was familiar with the language and could probe deeper issues, it had its flip side. While researching ethnic conflicts, it is not easy remaining unbiased about the 'enemy' community. Listening to story after story of loss inflicted by the other on 'one's own people' and of their struggle for survival after such losses, did affect the researchers from that community. There were times when one could feel the emotions of anger and awkwardness between the Bodo and Adivasi researchers. It helped the entire research team to sit and acknowledge the negative feelings and deal with it. This helped normalise the situation and created openness among the research team members.

In PHRN, data triangulation was undertaken using the quantitative study, qualitative study, and secondary literature. The sampling methodology in the quantitative study added to the validity of the study. During the survey, for assuring the quality of quantitative data, the researchers (RA) validated at least 20% of the data. The quality checks included the Supervisors looking at all questionnaires and checking for internal and other consistencies, completeness, and depth/quality of answers. Changes in the methodology were made explicit and justified and had been mentioned in the report.

Rigour in the research was attempted through reflexivity. The limitations have been discussed along with the presentation and analysis of data. This includes changes in methodology that had to be made, acknowledgement of limitations of generalisability. Limitations related to areas of transferability were also made clear. The context and background information of the cases have been detailed in order to determine the extent and areas of transferability possible. Further, the findings of the study were presented at different points in time to the Advisory Group, peer-researchers, people working in the area and others and feedback

elicited from them. This helped in maintaining rigour in the study. The draft study report was reviewed by the Research Advisor and an external reviewer, after which revisions were made. The study findings were shared in two dissemination events in Jharkhand and Chhattisgarh. The event was attended by government officials, members of the community, academics and civil society groups.

In the *HAP* study, the same set of trainers visited all the five districts and trained the data collectors. This was to ensure that data are collected in a standardised manner. The structured questionnaire for the Quantitative component was developed in its final form after the formative qualitative research. The final structured questionnaire was pilot tested before the data collection process. The data collection was initially planned using tablets with GPS facility, but due to logistical difficulties and hardware insufficiency, the team had to resort to a paper-based technique. Ten percent of data-reporting-sheets from each site were checked for quality and cross-checked for consistency in data-entry on a weekly basis by research supervisors at HAP.

For the Qualitative Research, interview guides for the formative qualitative component were created in consultation with experts in the field. The Research Advisor gave valuable inputs and timely suggestions which helped the HAP team in fine-tuning the interview guides/schedules for the interview/FGDs. He had also accompanied the research team on various instances during the data collection phase. The original intention was that for both formative qualitative research and the qualitative component proper, data saturation would be the main criteria to determine the number of interviews, FGDs, or case studies. However, considering the data-intense nature of the inputs they received from the interactions and the sheer volume of interviews and FGDs, it was not possible for them to use data saturation as a benchmark. The team achieved data saturation for some key stakeholder categories, but couldn't for District health officials, officials from the Department of ST Development, Project Officers, members of the LSGI and State-level officials, due to time constraints. The transcripts were cross-checked by two other members of the team for quality.

Table 2.3: Strategies adopted to ensure data quality and rigour

The ANT	PHRN	HAP
Combining ethnographic elements with qualitative research	Methods triangulation – using quantitative survey, in-depth interviews, as well as content analysis of news clippings	The systematic process followed in identifying and training data collection team
Staying in the community, long-term process of data collection	Data validation by the supervisor by checking 20% of schedules	Structured and standardised study tools used after pilot testing
Enhanced rapport with the community	An explicit stage of data quality check	Validation of 10% of schedules
Continuity of the research team from the beginning to end, from data collection to data analysis	A thorough literature search that fed into the preparation of the study proposal	Use of GIS for systematic sampling
An iterative process of data collection coupled with periodic debriefing meeting after every stage of data collection		Theoretical sampling in the qualitative component of the study

Analysis

The research team in *the ant*, recorded and transcribed the in-depth interviews. Transcribing and editing of data was an ongoing process in the field. The analysis was an ongoing process along with data collection. If data gaps were identified, the team would revert to the concerned informants/respondents for further clarification. For small talks and observations, the research team kept detailed field notes describing what happened on the day of fieldwork and what was observed. The field notes from observations, small talks and interviews were integrated for analysis. Mapping out the concepts and creating diagrams helped to identify data gaps. These processes of charting and mapping also helped in data reduction, pattern identification which in turn resulted in arriving at explanations and narrations.

the ant team held periodic debriefing and review sessions where a highly iterative process was followed to study the data using a combination of instruments such as field notes, memos, short life-histories, various forms of pictorial representations such as photographs and conceptual maps. During different phases of the study, the team sat together to sift the data from the multiple instruments and sources, keeping in mind one research question after another and generated conceptual representations for each of these questions. These were written out as narrative chapters. These were subjected further to rounds of reflection and refinement.

In the *PHRN* study, the first level of data cleaning was done in the field by the supervisors and research coordinators. The second level of cleaning was done during the data entry of the quantitative data. In the *PHRN* study, the quantitative data were entered into EpiData software and further analysed using SPSS software. For the qualitative study, detailed notes were kept of the interviews. The analysis of the qualitative data was done through the description, classification, and connection. Thematic analysis was undertaken under which data for each PVTG was categorised into themes and attempts were made to find relationships between themes or looking at the context.

The analysis of the multi-case study was two-fold [10]. The case studies were constructed separately for each PVTG and then analysed together for similarities and differences. The themes for analysis covered access to health services, socio-cultural, political and economic determinants of health, experiences, perceptions and attitudes and practices.

In the case of *HAP*, the quantitative data were analysed using SPSS Version 16.0. The analysis was done under the domains of antenatal care utilisation, supplementary nutrition services uptake, and utilisation of immunisation services. Bivariate analysis was done wherever necessary and significant findings were noted.

For the qualitative data, the *HAP team* had initially planned to store the transcripts electronically and apply Weft QDA software for the analysis of interview transcripts and field notes. However, reflecting on the initial transcripts of interviews, they found that, especially with the interactions with the non-English speaking respondents, there were instances of misinterpretations and loss of context when they were translated and transcribed into English. So they changed their strategy and went on to analyse the data in Malayalam, using manual coding and cross-referencing the responses. The coded extracts were organised thematically according to the study objectives and consolidated.

The two cases studies in Attapady and Wayanad were analysed and written up separately. They were presented as a tale of two hamlets. The case studies attempted to bring out the subtle differences between the two groups with respect to access to health services, socio-economic determinants of health and their acceptance of the services rendered by the hospital.

2.5. Methodology for the Literature Review

All the three studies carried out a detailed literature review to foreground their research questions and research methodologies.

the ant

While there were many newspaper reports about the actual incidents of violence, the numbers displaced and conditions in the relief camps, there were no studies on the longer-term effects of violent conflicts on the health and wellbeing of the affected people and its effects on the health systems. The team had to rely on a few books written about the political situation of Assam and on online journal articles for the rest of the literature. The keywords used to get to information were: *conflict and health; conflict and displacement, the impact of violent conflicts on health; conflict-induced displacement; health of tribals in conflict-prone areas; effects of conflict in Bodoland of Assam.*

PHRN

Desk Review primarily focused on, but was not limited to serving the specific objective which was to document the political, historical, social, cultural and economic context of the Baiga and Sabar communities. Further, the purpose was to refine the proposal and methodology and also to understand emerging intersectionality aspects and help develop a theoretical framework. The literature review was conducted in two phases. The first phase was during proposal development and the second phase went parallel to data collection.

The process of searching for literature

- Academic literature search: This was conducted in relevant databases and journals available to the project team
- Grey literature capture: NGO/CSO websites and WHO/UN websites were searched to identify grey literature including project and programme reports and implementation experiences. Search engine (Google Scholar) containing grey literature was searched
- Snowballing: All reference lists were screened to the first degree (i.e., only reference lists from the first identified literature were screened)
- Sourced literature from key informants
- We actively sought advice on relevant publications in the field from the mentor and members of the advisory group and had been reviewing the literature and their reference lists

Selection criteria and scope of the literature analysed

Inclusion

- All literature published in English
- Academic literature available through open sources
- Grey literature including project reports, working papers, newsletters, policy documents, discussion papers, expert/technical group reports.

- Newspaper (Media) reports.

Exclusion

- Literature not published in English
- Academic literature not available through open sources
- Incomplete literature without full text
- Dissertations/Thesis

Limitations while conducting the literature review

- The literature review largely included publications that relate to the broad category of tribal groups since limited literature was available on PVTGs especially the Sabars.
- For literature on the health and nutrition (both status and access) of the PVTG population, we had to widen it to the larger tribal population since the limited information was available on the health and nutrition of PVTG population.
- Academic literature on intersectionality especially studies that dealt with vulnerable populations, indigenous communities or aboriginals is quite limited.

HAP

The objective of the document-review was to summarise the various central and state government orders, government publications, economic reviews by State Planning Board, Budget Circulars and Tribal Sub-plan programmes, Project reports, Annual plan reports of Grama Panchayat, *Vikasana Rekha* (Development Plan), and academic research on tribal communities. The review component was intended for multiple audiences such as Ministry officials (Health, Tribal, Local Self Government persons, Revenue and Forest Department), NGOs working in the areas, students working in the area of tribal health. The purpose was to identify gaps in both tribal health research and lessons learned—what do we need to focus on moving forward and what are the areas which need more research?

A thorough search of potential evidence using several databases was done. Main databases used to identify academic literature on tribal health issues were MEDLINE database through the PubMed gateway, and Google Scholar. Structured web-searches were carried out. The reference lists were screened to the first degree for academic reviews, books, and journal articles in peer-reviewed publications. A sizeable number of documents, especially from the government departments, were available only as hard copies. Grey literature search was done by combing through websites of NGOs, conference presentations and so on.

A substantial body of evidence was derived from the literature search in the first phase of the protocol development. The focus shifted exclusively to the documents on tribal health policies in the second phase. It was done in parallel to the quantitative data collection. New journal

articles, opinion pieces, state policies, and circulars were fed into the review section until the start of the qualitative phase of the study.

The document review fed into the qualitative interview schedule and the case studies. Writing up conclusions was done after organizing the gathered information into different areas. The team faced difficulties during the review phase, the most important of which was acquiring data from government agencies. Despite multiple visits that the team made to the various government departments, numerous key documents could not be secured due to poor record keeping, inadequate storage, and destruction of records (in some cases). Many of the documents were not available in the digital form or an open access repository.

2.6. Challenges

Researching health inequities amongst the vulnerable groups within Scheduled Tribes and in extremely difficult locations was challenging indeed. There were issues of difficult geographical terrains as well as politically sensitive areas. While the PHRN study was in areas that could be termed as Naxal, *the ant* study was close to the Bhutan border.

Both the PHRN team and *the ant* had issues of shortage and attrition of researchers. Since there was no full-time research team member in the Jharkhand PHRN team, data collection and subsequent analysis regarding the Sabars was restricted. *The ant* team tried very hard but failed to hire a suitably trained and skilled Adivasi researcher to carry out the qualitative interviews. There were no qualified persons within the community in Deosri and all the others interviewed from outside the area were hesitant to come and stay in such a conflict-prone and 'dangerous' area. It was two months into field work before the team could get a Santhali male from a neighbouring district two hours away to come and stay with them and do basic translation from Santhali to English. Had they got qualified female Santhali researchers, they feel, they could have done much deeper interviews with Adivasi women.

Difficult access in these remote areas, hilly with scattered households, made data collection very tough. The difficult geography led to various last-minute changes in the field visits leading to delays and changes in the survey schedule. During the rains, fieldwork became even more difficult and had to be halted for a month in the foothills of Bhutan which receives very heavy rainfall, and the villages get cut off.

The season also determined the availability of the respondents. In Chhattisgarh, in the time of weeding (*nindaai*) in the fields, it was difficult to find people in households. Similarly, in the Assam study, most people were out in their fields during the planting and harvesting season and could not be reached. The displaced landless people went for daily wage work to Bhutan and were not available during the day. Similar was the situation in the case of festivals such as *Navakhai* (the first harvest), *Teejaor* Dashgatra (death or marriage ceremonies which the members from the Baiga community would be attending).

In the PHRN study, despite attempts to get information from the district and state administration about government health programmes, and the health indicators, data could not be accessed. One possible reason for this could be that disaggregated data on PVTGs are not collected or documented in government programmes. Data and information about the functioning and budgets of the Baiga Vikas Pradhikaran were not available despite multiple visits to the office of the Assistant Commissioner, Tribal Welfare Department. Getting a credible list of Baiga/Sabar villages to proceed with the sampling was a major challenge especially in Jharkhand. In Chhattisgarh even when the list from the Tribal Department was used, there were differences in the data provided and the observations made in the field. Another challenge was the paucity of relevant research and secondary literature and government data on Baigas, and especially on Sabars and this restricted the review of the literature.

There was no cooperation from the block health administration in Chhattisgarh. A meeting was sought with the Block Medical Officer, but he refused to cite unavailability for two weeks. In both Chhattisgarh and Jharkhand, the research team was questioned by the police of the area.

The existing situation of illness and deaths in the villages had to be dealt with along with data collection. The surveyors also had to maintain various protocols in order to ensure that they do not fall ill themselves.

Another specific and unexpected fieldwork challenge was the high level of alcohol consumption in the conflict displaced villages where *the ant* was conducting its research. Interviewing people in such villages got a bit tough as people when they were not at work and free to talk, would be inebriated. Among the Bodos, only men were found in such a state. However, among the Adivasis alcohol consumption in one of the villages in the study was very high among both men and women. Sometimes the responses given were doubtful. To overcome this, the researchers changed the timings of the interviews to early morning, but to their surprise, many of the respondents were found intoxicated in the mornings too. It was a challenge for the field team to keep their heads steady in some villages where the brewing alcohol fumes hung heavy in the air!

Another challenge for *the ant's* researchers was to manage "expectations" where people had received relief materials from NGOs in the past conflict episodes. Researchers faced questions such as "what will we get?" "what are you giving us now?" which made it difficult for the researchers to explain their project to people. There were also people who refused to speak to 'NGOs' (the proxy for researchers) because they never received anything from them in the past.

Also, the researchers also had to face rejections for interviews from people for personal reasons, which were never explained.

the ant research team during the rains in the Bhutan foothills



The study conducted by **HAP** also had its fair share of challenges. As mentioned earlier in the methodology section, the team had to forgo the idea of digital data collection using tablets and repository, and switch to paper-based data collection. This had obvious repercussions to the timeline planned.

HAP is a not for profit organisation with a collective of researchers at the helm who have full-time jobs elsewhere and contribute their time to the organisation's activities without any monetary compensation. The principal investigator and senior researchers had to find time for this project amidst their other commitments. There was attrition of persons hired specifically for the research project. This challenge was overcome through interventions by some of the research team members, who availed even leave with loss of pay from their full-time jobs, in order to ensure that the timeline for the project was kept as far as possible.

Another major challenge faced was with the policy- landscaping component of the study. Most of the government documents of interest not digitalised and not freely available. They had to be tracked down and acquired through a bureaucratic process and was time-consuming.

Geographical access & seasonal constraints in many of the regions where the tribes resided were also major hurdles faced by the HAP team, in both the quantitative and qualitative

phases. In order to reach the PVTG colony in Attappady, Palakkad, the researchers had to negotiate a trail through the forest by foot.



In Wayanad, though the team was offered the luxury of using the off-road vehicle of the Primary Health Centre, it was quite a difficult journey with the jeep's tires almost getting buried in the mud many times during the travel to the Kurichad colony in Wayanad.



Also, the dialect of the tribes and the difference in their usages of certain terminologies was a hurdle in both the conduct of the interviews and discussions and the transcription and analysis of the data.

REFERENCES

1. The Ant (The Action Northeast Trust, Assam). 2017. *Health Inequities in a Conflict Area – An In-Depth Qualitative Study in Assam*. Closing the Gap: Health Equity Research

Initiative in India, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum.

2. PHRN (Public Health Resource Network, New Delhi). 2017. *Exploring Health Inequities amongst Particularly Vulnerable Tribal Groups: Case Studies of Baiga and Sabar in Chhattisgarh and Jharkhand States of India*. Closing the Gap: Health Equity Research Initiative in India, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum.
3. HAP (Health Action by People). 2017. *Exploring Health Inequity by Assessing the Nature of Healthcare Utilization and its Correlates among the Tribal Population of Kerala*. Closing the Gap: Health Equity Research Initiative in India, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum.
4. Larson E., George A., Morgan R. and Poteat T. (2016). 10 Best resources on . . . intersectionality with an emphasis on low- and middle-income countries. *Health Policy and Planning* (Advance Access): 1-6.
5. Thiede M., Akkweongo P and McIntyre D (2007). Exploring the dimensions of access. In McIntyre D and Mooney G (ed). *The economics of health equity*. Cambridge, Cambridge University Press, pp. 103-123.
6. Levesque JF, Harris MF and Russell G (2013). Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health* 2013;12:18 <https://equityhealthj.biomedcentral.com/articles/10.1186/1475-9276-12-18>
7. [Davy C, Harfield S, McArthur A, Munn Z and Brown A. \(2016\). Access to primary health care services for Indigenous peoples: A framework synthesis. *International Journal for Equity in Health* 15:163. Available at: https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-016-0450-5](https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-016-0450-5)
8. Commission on Social Determinants of Health (CSDH) 2007. A Conceptual Framework for Action on the Social Determinants of Health: Discussion Paper for the Commission on Social Determinants of Health. www.who.int/social_determinants/.../csdh_framework_action_05_07.pdf
9. [First Nations Health Authority \(2016\). FNHA's Policy statement on cultural safety and humility. West Vancouver \(Canada\), FNHA. - http://www.fnha.ca/Documents/FNHA-Policy-Statement-Cultural-Safety-and-Humility.pdf](http://www.fnha.ca/Documents/FNHA-Policy-Statement-Cultural-Safety-and-Humility.pdf)

10. Yin RK (2009). Case study research: design and methods. Los Angeles, Sage, 4th edition.
11. Office of the Registrar -General, Government of India. Primary Census Abstract Data for Scheduled Tribes (India & states/UTs – District Level).
www.censusindia.gov.in/2011census/population_enumeration.aspx

Chapter 3

Findings

In this section, we present the results from the three studies on health inequities among diverse tribal communities in Bodoland, Chhattisgarh and Jharkhand and Kerala. Much of the chapter draws liberally from the individual study reports [1-3]. The type of data being presented here reflects the nature of the three studies and the different methodologies used by these studies. The context and rationale for the methodology for each study has been presented in Chapter 2.

This chapter is organised into five sections. In the first section, we present data on nutritional and health status of tribal communities, mainly from the studies by PHRN and *the ant*. Data on nutrition is exclusively from anthropometry done in the PHRN study. This exercise was undertaken because there is very little data on the individual PVTG groups, although their overall poor health and nutritional status are widely acknowledged. Moreover, government surveys rarely collect disaggregated data for PVTGs, and most studies on PVTGs have not collected gender-disaggregated data. Subsequently, we present data on health and morbidity, including on deaths, mainly from *the ant's* and PHRN's study, because the HAP study was focused on utilisation of health care rather than on health status.

Section two presents the landscape of providers in the study areas with the perceptions and experiences of the community in treatment-seeking that will include dimensions of access (availability, affordability, and acceptability).

A substantial part of all three studies was related to understanding the health system & health service delivery, specifically, the role and response of the government health system. Section three discusses the characteristics of the public health system in the study areas. The conditions of living and the experience of public programmes for work, food, nutrition, water, and sanitation are subsequently discussed in section four.

Section five sets itself the task of drawing out from all three studies the ways in which multiple axes of vulnerability intersect to shape the health and illness experiences of tribal communities in our study populations.

3.1. Status of Health and Well-being

Histories of exclusion have resulted in tribal communities being materially impoverished and socio-culturally marginalised. In all the three studies, we find evidence of how this has affected the health and well-being of the tribal communities studied. In this section, we will look at some direct evidence of the health status, i.e. nutritional status, morbidity, mortality

Nutrition

Nutritional status of Sabar and Baiga children under five years of age [2]

The PHRN study highlights the poor nutritional status of Sabar & Baiga PVTG children compared to other non-PVTG children. Among Sabar children under five years of age, 68% were underweight, 56% were stunted, and 42% were wasted (Table 3.1). In all three categories, severe malnutrition levels were higher than moderate malnutrition, with 39.4% severely underweight, 32.7% severely stunted and 22.4% severely wasted (not shown in table).

All the indicators of malnutrition were much higher and the difference statistically significant when compared to Jharkhand NFHS 4 data. (Table3.1). The proportions of underweight, stunting, and wasting were significantly higher than the district average but comparable to tribal communities of Jharkhand from ten years ago.

Table 3.1: Nutritional Status of Sabar children under five years of age as compared to other groups

Undernutrition under 5 (less than -2 SD)	Sabar study	JH NFHS 4 (2015-16) (p-value)	East Singhbhum (NFHS 4 2015-16)	JH NFHS 3 Tribal (2005-06)
Underweight (N=221)	68% (150)	47.80% (p<0.001)*	49.8 %	64%
Stunting (N=220)	56% (122)	45% (p<0.002)*	39.3%	54.5%
Wasting (N=219)	42% (92)	29% (p<0.001)*	40.6%	40%
* difference between Sabars and Jharkhand NFHS 4 is statistically significant				

Source: [2: p.262]

The situation of Baiga children was somewhat better as compared to Sabar. According to the PHRN study, 55.5% were underweight, 55.5% stunted and 15.6% wasted (Table 3.2). 21.8% were severely underweight and 28.2% severely stunted (not shown in the table). The proportions of underweight and stunting among the study sample were nearly one and a half times more than that of Chhattisgarh as per NFHS 4 data, and the findings were statistically significant. The proportions of underweight and stunting were much higher than the district average and were nearly the same as that for tribal communities of Chhattisgarh from a decade ago, according to NFHS-3 data. It is interesting to note, however, that wasting among Baiga children was lower than that for the children from the general population.

Table 3.2: Nutritional Status of Baiga children under five years of age

Undernutrition (less than -2 SD) (under 5 years)	Baiga Study	CG NFHS 4 (2015-16)	Kabeerdham (NFHS 4 2015-16)	CG NFHS 3 Tribal (2005-06)
Underweight (N=110)	55.5%	37.70% (p<0.001) *	38 %	53 %
Stunting (N=110)	55.5%	37.60% (p<0.001) *	40 %	52 %
Wasting (N=109)	15.6%	23.10% (p=0.063)	18 %	26.5 %
* difference between Baigas and CG NFHS 4 is statistically significant				

Source: [2: p.97]

Nutritional status of Sabar and Baiga adults

More than three-fourths of Sabar men and women were thin for their height. Among Sabars above 18 years of age, 78% of women and 74% of men had a BMI below 18.5. A quarter of the women (27%) and about a fifth of the men (19%) were severely thin, a cause for major concern (Table 3.3). It may be noted that severe thinness proportions for women (27%) were higher than for men (19%). Malnutrition among Sabar women was more than double that among women in Jharkhand (as per NFHS 4), and for Sabar man, it is almost three times more. These differences were statistically significant.

Table 3.3: Body Mass Index (BMI) of Sabar adults (15-49 yrs)

BMI below 18.5	Sabar	NFHS 4 Jharkhand (2015-16) % (p-value)	East Singhbhum NFHS 4 (2015-16)	Jharkhand NFHS 3 Tribal (2005-06)
Women (N=275)	78% (178)	32% (p<0.001)*	20 %	47 %
Men (N=243)	74% (139)	24% (p<0.001)*	15 %	42%
* difference between Sabars and Jharkhand NFHS 4 is statistically significant				

Source: [2: p.263]

As with children, the prevalence of thinness among Baiga adults was lower than their Sabar counterparts. Among Baigas, 56% of men and women (15-49 yrs) had a BMI below 18.5. The proportion of malnourished Baigas was nearly double that of the state average as per NFHS 4 data, and the findings were statistically significant (Table 3.4). District wise also has a similar pattern. Comparing the study data with NFHS 3 data on tribal communities, one finds that the

proportion of malnourished Baiga women and men currently is higher than what the proportion was for Chhattisgarh tribals a decade ago.

Table 3.4: Body Mass Index (BMI) of Baigas age 15- 49 years

BMI below 18.5	Baiga	Chhattisgarh NFHS 4 (2015-16)	Kabeerdham NFHS 4 (2015-16)	Chhattisgarh Tribal NFHS 3 (2005-06)
Women (N=221)	56%	27% (p<0.001) *	33%	50 %
Men (N=205)	56%	25% (p< 0.001) *	20%	41.5%
*difference between Baigas and Chhattisgarh NFHS 4 is statistically significant				

Source: [2: p.97]

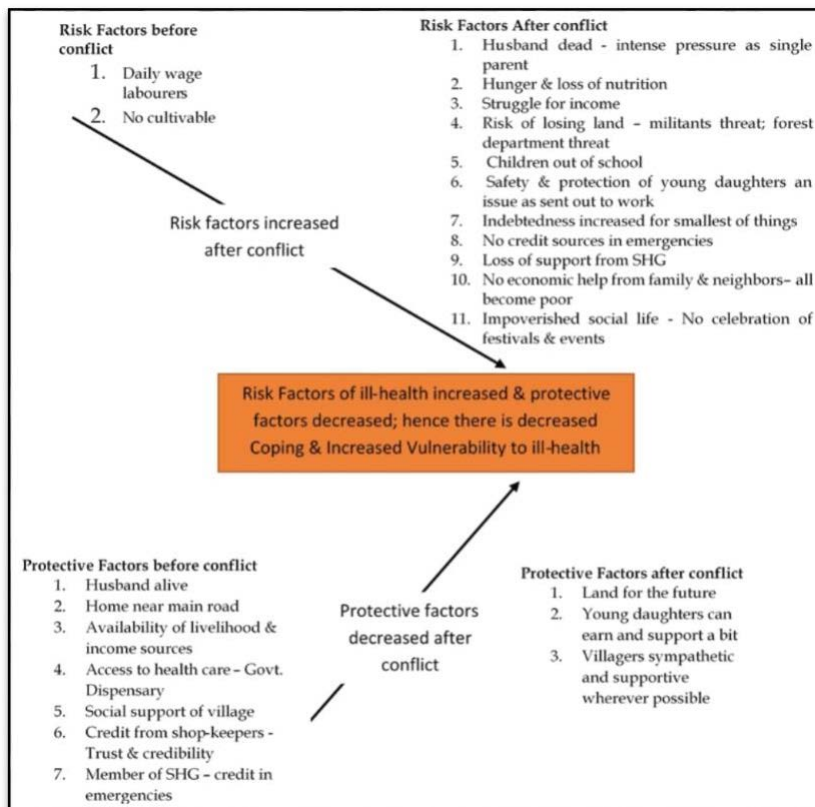
Morbidity and Mortality

Conflict, vulnerability, and ill-health [1]

Already impoverished and vulnerable, tribal communities living in remote and difficult or troubled areas facing tough struggles and hardships are prone to ill-health and premature death. The few protective factors they have are not enough to overcome the risk factors and soon, even the most common illnesses become health crises for them and their families. In the Bodoland study, we see how the risk factors of ill-health suddenly increase while at the same time the protective factors decrease following an episode of ethnic conflict. With no external support – of State and otherwise – households are left extremely vulnerable to ill-health.

The story of Rashmi, a young Bodo widow, illustrates this reality poignantly (Figure 3.1 below). Rashmi's household depended on daily age labour for an income and did not possess any cultivable land. Before the ethnic conflict of 2014, despite their limited means, the household had some protective factors that kept it afloat. Rashmi's husband was alive, sources of livelihood were available, their house was on the main road increasing their access to government health services, among others. Rashmi's household enjoyed the social support of the community. For example, they could get credit from the local grocery shop, and Rashmi was a member of the SHG from where she could mobilise funds for emergencies.

Figure 3.1: Map showing the Risk Factors and Protective Factors of Ill-Health of one young Bodo widow following the ethnic conflict of 2014 in Chirang District, Bodoland, Assam



Source: [1:p.88]

From Figure 3.1 above, we see that the number of risk factors to ill-health having increased greatly for the respondent after the conflict. Her husband died, and Rashmi had to care of the family as a single parent. She had to struggle to make ends meet, and hunger was a frequent experience. The children were out of school, and the safety and security of her young daughters were at stake because they had to be sent out to work. The social fabric of the community had ruptured, and there was no help available from any source since everyone had suffered a major economic setback. Indebtedness had become a major burden to bear.

“With the protective factors decreasing, the vulnerabilities are high, not just for Rashmi but also for her children. Young girls having lost education are at a huge risk of being sent away to work – increasing their chances of being abused or trafficked. [1: p.88]

We thus see that in Rashmi’s life, daily survival becomes a big challenge after a conflict, especially if the household has been forcibly displaced. Women such as Rashmi bear a huge burden of suffering. Adivasi women interviewed also talk about suffering and how that affects their body. [1: p.89]

In the same study, Adivasi women affected by conflict name ‘pain and suffering’ as a cause of their ill health. They point out how stress and tension (following conflict) affects women's

health – violence within the household, struggle for food, repeated childbirth, post-conflict alcoholism and increased wife- beating cause their ill-health.

"Our health while in relief camp was very poor – can give it only one out of ten points as we were very weak. However, even now, we are not in good health... it is only half of what it should be. Women are not healthy as (there is) fighting in the household, illnesses, problems getting food, pain during our periods, difficulties in childbirth ... also every two-three years, women keep getting pregnant and having babies. (We feel) unhealthy as we are not getting enough food.... The head spins, we feel weakness. Nowadays we are unable to work as much as we used to do earlier (before the conflict)". [1: p.89]

"Changing patterns of illness: 'Sarkaari bimari'- among Baigas [2]

Some Baigas perceived that earlier there was less illness that has increased in recent years and that now newer diseases have emerged that cannot be treated through traditional methods. *"More people fall ill these days. Earlier Jadi Booti would heal diseases"* (Mitanin husband). [2: p.104]

One old man said that these days diseases were such that he had to spend Rs. 1300 last year and every year he spends money on getting better, whereas, till the time he was eating jungle jadi he never had to take 'saline.' One Guniya (traditional healer) we spoke to said that earlier most of the disease could be treated by jhaad phoonk, but not anymore and as a result, the number of people visiting him have decreased. A woman leader said that earlier the main diseases were malaria, bade mata, dama, and TB. Now there is more disease, more TB, stomach illnesses, and 'lakwa' or paralysis deaths (GD Women, Achara Village, January 2017). [2: p.104]

People spoke about the changes in food habit and lifestyle as a reason for more illness. Many said that changing lifestyles, food habits, pollution, exposure to outside world, and so on, have led to an increase in illnesses and also the emergence of new illnesses and some of these 'newer' diseases are seen to be treated only by western medicines or in government hospitals.

For instance, Baiga Mitans saw water as a major reason for diseases throughout the year. Accordingly to them, earlier they did not travel out, and the water in the jungle was clean, but now they are exposed to all kinds of pollution and contamination such as soap, products with chemicals, etc. As a result, people regularly fall ill and have to get either injections or IV drips to get well. (*Baiga Mitans GD*). [2: p.105]

They called it 'sarkaari bimari,' i.e., an illness that could only be cured through treatment by the government. *"They say that earlier however serious the ailment was, it could be treated by jadi booti. One of them talked about his grandmother who lived for 155 years. They felt that one reason for today's vaidya guniya not being able to treat disease, is because the new generations have not learnt the tradition of jadi booti and jhaad phoonk (Baiga Mitans GD. [2: p.105]*

The problem in adding pesticides and medicines to crops and its relationship to disease kept coming up as an issue, both from Baigas and non-Baigas. Patelni, who is a Baiga, said that though now medicines are used in crops these days everywhere, they (Baiga) do not use it. According to her, it is because of these medicines that malaria has come, as earlier there was no malaria. She further says that today's fever is different from before and can only be treated by a doctor (Patelni). [2: p.105]

In all the three studies, tribal women's disproportionate burden of ill-health is highlighted. Both the PHRN study among PVTGs and the HAP study talk about malnutrition and anaemia increasing among tribal women [2 - 3]. The Kerala study observes that chronic morbidity was more seen among tribal families when compared to non-tribal.

When maternity outcomes were considered, tribal mothers showed a higher prevalence of poor maternity outcomes when compared to non-tribal. Even in the small sample studied by them, three mothers reported a history of the intrauterine death of a foetus in past pregnancies, while none was reported among non-tribal women. Delivery of low birth weight babies was twice as common among tribal mothers (31%) when compared to non-tribal (15%)". [3: p.172]

Mortality

While none of the studies examined mortality specifically, accounts of deaths of infants and children were spontaneously shared during group discussions with PVTGs and conflict-affected tribal communities.

In a Group Discussion (GD) with Sabar women, they shared their experiences of the death of their children. In Daamdidahi GD, out of 17 women, four women who had experienced child-loss agreed to share about it. One woman said that she had lost five children and five were now living. A second woman said that she lost her child to fever (at an age when the child could not sit up as yet), accompanied by jaundice and convulsions. Another two women had lost two and one children respectively. In the Burutola, Guri Sabar said that four of her children had died and she had only three living children. Another lady, Tara Sabar narrated that she had given birth to 10 children since she got married but had lost five children from amongst them'. [1: p.270]

In a group interview that *the ant* had with Adivasi women in Deosri, who had lived in the Deosri relief camp for many years, they came across many women whose children had died (see Box 3.1).

Box 3.1. Relief Camps: Deadly killers of Children

Seven out of ten women who gave birth said that they had lost children. These ten women had given birth to 41 children, of which only 27 survived, and 14 children (34%) died. This was in stark contrast to a younger group of Adivasi women in Koraihari we interviewed. They were younger mothers and had not lived in relief

Addictions and domestic violence

The mental health and well-being of vulnerable populations are negatively affected by the stress and struggle of survival. Many a time, this leads to self-destructive behaviours like addictions as well as increased violence in the household.

In the Kerala study, many respondents talked about the tribal communities' addiction to alcohol [3]. Increased addiction to tobacco and alcohol by tribal communities, adversely affecting their health, is another issue that is flagged by all the three studies [1-3]. The Kerala study points out that this alcoholism is, 'despite prohibition.' Changing patterns of alcohol consumption – from ritualistic and occasional to daily and habitual – is linked to increased domestic violence among tribal families.

the ant's study found that women talked about the rise of alcoholism and wife-beating after the conflict. In their fieldwork, they also observed that drinking and disharmony were much more among still displaced villages compared to non-displaced or returned villages [1].

"In our earlier village before the 'gondogol' (conflict), out of 10 families, one or two had drinking problem (They were) those who were poor and struggled and did 'hazira' (daily wage labour). However, those who had land and work and money did not drink like this. We were busy. All this 'bottle problem' started when we came to the relief camp. The men started showing more bahaduri [recklessness]. Used to get relief rice which they would sell and also cash which they would buy alcohol with. What we drink now is also different ... it is a water type. Earlier, we made wine with rice in our own house. We used to drink one or two cups for festivals and some occasions. There was no fighting like we now have. Almost no fighting. We

had enough food, and we had land, money, proper house to stay (so no need to drink). But now, they start drinking and don't stop till the end (till they are drunk)". Adivasi women of 3 No. Deosri village. [1: p.91]

"What tensions do men face? As long they have food to eat and can sleep with their wives – what tension will they have? But a woman has to manage everything – manage the money, household needs... food. We worry that there is no money in the house and worry where to get the money from..."- Adivasi Woman; 3 No. Deosri Village; lived in the Deosri Relief Camp for over ten years from 1996-2005 [1: p.90].

In the absence of any coping mechanisms, women had to additionally bear the brunt of men's way of coping with the stress emerging out of the conflict situation.

3.2. Material Factors and the Social Determinants of Health

The relatively poorer health and a deficit of wellbeing observed among tribal communities is in no small measure due to their disadvantaged living and working conditions. Though these are known generally and broadly, data is not disaggregated sufficiently to be able to examine the extent and specific kinds of disadvantage experienced by different tribal communities. This section presents the data from the three studies on the underlying determinants of health in the study areas.

Living Conditions

Housing

the ant's study villages are deep in forests, with mud paths that lead to the village. In Deosri Relief Camp, 46 families lived in mud huts. None of these 46 households had access to toilets, bathrooms, wells and hand pumps. Their source of water was the Nijula River flowing nearby. Located 8 km from Deosri market, there were 160 households with 698 members in **Koraibari Village**. Most lived in make-shift structures with no basic amenities [1: p.65-66].

Topography, the location of the village and accessibility are factors determining the access of the services for the Baiga and Sabar populations. Further, more often than not the Baiga and Sabar hamlets are situated at a more disadvantageous location compared to other population groups. Table 3.6 shows the poor living conditions of the Baiga and Sabar families surveyed in the PHRN study.

The vast majority of the PVTG households studied lived in mud houses, between half and three-fourths of the households had no electricity, almost all depended on firewood for cooking, a small minority owned mobile phones, and a rare household owned a motorised two-wheeler.

Table 3.5 Housing conditions and assets owned by Baigas and Sabars

Dimension	Baiga (%)	Sabar (%)
Type of House (% hhs)		
	N= 289	N=283 (1 missing)
Kuchha mud house	91	67
No Structure	1	17
Semi pucca	5	10
Pucca	3	4
Availability of electricity (% hhs)		
	N= 289	N=284
Yes	49	26
No	51	74
Fuel used for cooking (% hhs)		
	N= 289	N=283 (1 missing)
Wood	98	99
Coal	2	0
Leaves/Straw/Cow dung:	1	1
LPG:	1	0
Others:	1	0
Assets owned (% hhs)		
	N= 289	N=228
Hen or duck	75	94
Cattle, goat, other livestock	68	60
Bicycle	35	44
Mobile phone	32	14
Motorised Two-wheeler	8	1

Source: [2: p.87&255]

In the HAP/Kerala study, while living conditions were slightly better overall, more tribal households had thatched, or sheet roofs (28%) than non-tribal households studied (15%). Overcrowding was more prevalent among tribal families (23%) when compared to non-tribal households (6.5%). The study team observed that in some households, there was an open chulha with smouldering firewood in a small space in which a full-sized human being could barely stand up straight. A respondent explained why they needed to stay close to the *chulha*; it was the only source of warmth in their damp environment. The risk of burns especially among children is therefore high. While 82% of non-tribal households used LPG gas as cooking fuel, the proportion among the tribal communities was only 25%. Three-fourths relied on firewood, leaves and other materials. [3]

The links between inadequate habitation, overcrowding, smoky environments, and health are well known as immediate risk factors for respiratory diseases such as asthma, TB and pneumonia. In children, these are also known to contribute to malnutrition [4-5].

Water and sanitation

In all the study areas, inadequate access to clean potable water emerged as a major determinant of ill-health.

In *the ant's* study area, availability of water is a crisis. There is no water supplied by the government in any of the villages that they studied. Water and sanitation are much neglected in forest villages where IDPs have settled after a conflict. Unavailability of clean water coupled with poor sanitation practices makes people susceptible to diarrheal diseases and death. Villagers depend on their water sources like hand-pumps, public wells or small streams and rivulets. However, humanitarian organisations have helped provide some wells and hand-pumps in affected villages following the 2014 conflict [2].

"When our family first came to settle in Koraibari, the nearest drinking water facility was in Deosiri, 12 km away. I would fetch the water only two times the entire day. It was easier in summer because we could collect water from the stream. In winter when the stream dried up we would wander everywhere looking for water."-Suraj Mardi, village headman of Koraibari Adivasi village [3: p.101]

All the villages practiced open defecation, i.e. except for the Nepali Basti where all households say they have some toilet facilities (though some of them could be temporary pit latrines and maybe not sanitary latrines). The Nepali village has not been displaced from their original habitation, and that could be a possible reason why they are relatively well-off and can afford sanitary latrines. [1: p.146]

Among the Baiga households surveyed, around 40% did not have access to safe drinking water. Most respondents felt that the major source of the disease was unclean water. They stressed that in monsoons when the *jhiriya* (spring) water mixes with rainwater, diseases break out. During fieldwork, broken down hand pumps were observed in villages. It was also observed that hand pumps and bore wells could not be constructed in high altitude areas where the Baigas generally lived. [2]

In Chhattisgarh, there was a policy drive to make all households build their toilets. The Baigas did not have the financial means to build the toilets, but many were forced to do so because various coercive measures were undertaken by the government workers and officials. There were cases where PDS ration was being withheld as a coercive measure to make the Baigas construct toilets. Around 15% of the surveyed Baiga households had toilets, but 99% defecated in the open; only 12% responded that they use toilets. [2: p.334]

A very similar situation existed among the Sabars. The Sabar Pradhan said that availability of drinking water was a major problem. They had to travel far to get water, and there was only one tubewell in the next hamlet from where everybody collected water. Only one out of 284 households Sabar households surveyed had a toilet. [2: p.297]

In Kerala, of the two PVTG colonies studied, one had water pipes connected to their homes, but little availability of water. The inhabitants depended on a water supply scheme which sourced water from a reservoir fed by upstream water. The water had to trickle into the reservoir and was piped into the colony. Very little water was available in the summer. The second colony did not have piped water supply and used a natural spring near the colony for their water needs. They called this "jeevanulla vellam," which loosely translated meant "water with life." The water seemed to collect in a depression created by the elephants that traversed the area. This "Aana chavittiya vellam" (water tread over by elephants) as they called it, was something that they felt was a safe source of water. In both colonies, all houses had toilets, but in the second colony, located within the forest area, the older generation still practiced open defecation. [3: p.155]

Livelihoods

In the conflict-affected areas of the Assam study, we find many accounts of people having lost their means of livelihood and having to start all over again, as wage labourers, as cultivators of small pieces of land, or engaged in fishing in the water bodies, weaving nets and baskets and rearing livestock.

"During the 2014 conflict our houses were burnt, and we did not carry anything with us. Our dhaan (paddy) was also burnt. Our cows, goat, and clothes were all left behind. We could not take anything with us." [1: p.47]

From (Runikatha Relief Camp) we moved to XXX where we bought a small piece of land with the Rs.10,000 we got as compensation. We do not have any relatives in this new village but live together with the people around as our own people. [1: p.50].

More detailed information is available about the livelihoods of Baigas and Sabars [2].

Among the Baigas, livelihood activities mainly revolved around agriculture, the collection of forest produce, and wage labour. Seasons determined the livelihoods patterns. The survey showed that 65% of the households earned their main income from non-agricultural labour (in the year before the survey), 20% worked as agricultural labourers on other people's land while only 6% worked on cultivating their own land. Two percent cited Non-Traditional Forest-Product (NTFP) collection and employment guarantee to be the major source of their income. The survey also indicated that 10% of the households had at least one member of the household migrating in the previous year. [2: p.172]

Interviews with key informants showed that historically the Baigas would clear parts of the forests/ trees to undertake *bewar* (shifting) agriculture, but once the land got cleared, the Gonds would occupy it. The Baigas thus got pushed further and further up the hills, and the Gonds stayed in the lower more advantageous regions. A recurrent theme from the conversations with the Baigas was the poor quality of land which they possessed, making cultivation possible, if at all, for only one season. Some Baigas also spoke of the forest department retaining the 'good' land and making the rocky fields available to them. There

was also a shift in cropping patterns, from millets to rice, especially where water was available. The reasons for changing cropping patterns are the entry of land improvement techniques like levelling and creating bunds which are part of the MNREGA approved projects. As women were taking up more responsibilities outside the home for wages, families stop growing millets which involve labour intensive processing by women. [2]

The Baigas engaged in collecting forest produce round the year. However, NTFP has been nationalised by the government recently, and the minimum support prices have been cut, significantly affecting the baigas' livelihoods. Collection of *tendu* leaves has also declined as a result of changes in legislation; changing agricultural practices uprooting the wild growth of *tendu*; and decreased forest-cover. [2]

Baiga men and women often mentioned the topic of changing dietary patterns as a significant cause of illnesses in their area. They noted that earlier people would eat what they grew (*bhutta, kodo kutki, and charota bhaaji*), whereas now they had started buying food from the market. They felt that new diseases have developed as a result of a change in food patterns and the increasing use of insecticides and chemicals in crops. [2]

In Jharkhand in the Sabar areas, the household survey revealed that the main sources of income in the previous year for Sabar families was 'own business' (33%), NTFP collection (29%) and agricultural labour in others' land (26%). The 'own business,' as interviews and observations suggest, was mostly making of *jharoo* (brooms) and ropes. For a minuscule proportion, their main source of income was from their own agricultural land (1%). Most of the Sabars interviewed said that they had not been able to earn much from the forest in the current year. There was a drop in availability of forest produce like *kendu* fruit, *mahua, char, chironji*. In one settlement, the researchers were told that the monkeys had eaten all the edible forest products, while in another, elephants had destroyed the bamboo, which Sabars would use for making products for sale. [2]

Weekly markets played a vital role in a Sabar person's economic life. Markets are a place where they came in contact with people of other communities. The cash wages earned were used to purchase essential commodities in the weekly markets. [2]

Conversations with Sabars revealed the extent of poverty and the resulting diet. Women in Burutola, when asked what they had eaten that day, said that they had eaten only rice. They had to purchase the rice from the shop as they had not been getting PDS rice due to some issues. When asked whether they ate anything else with rice, they said: "*Nothing else. What else do you think we would eat? Children also eat rice. We all eat rice*" (Burutola GD women). In order to procure rice, they have to make bamboo brooms and sell them, only after which they can buy something to feed the children. This process is time taking. So if their children ask for food, they don't have anything to feed them at that time [2: p.18].

In Kerala, information on livelihoods is available for the PVTG groups studied. The erstwhile hunters, gatherers and shifting cultivators of Attapady, the Kurumbas, followed means of living which predominantly included manual labour along with rearing of goats and cows. In the PVTG colony in Wayanad, the Kattunayakan community mainly resorted to cattle rearing and gathering resources and produce the forest had to offer, like the fungus that grows on tea bark (which reportedly was in high demand due to its medicinal properties) and honey. [1]

Public Programmes for livelihoods and food security

Food security for tribal communities is intrinsically connected to the issues of land, forest, livelihoods and the impact of public programmes related to food and work. The government of India has responded to these crises of livelihoods and food insecurity to some extent through programmes such as the Mahatma Gandhi National Rural Employment Guarantee Scheme (MNREGA) which ensures employment for rural residents for a minimum of 100 days in a year. The Public Distribution System (PDS) provides households living Below Poverty Line (BPL) with essential food items at highly subsidised costs; and the Integrated Child Development Scheme (ICDS), also known as *Anganwadi* scheme, provides supplementary food to pregnant women and children under the age of six. The collective experience of the investigating groups has been that these schemes are an important resource for the sheer survival of the groups studied and this is further reinforced by the three studies. However, their implementation and access to the same remain far from adequate. The following section examines the evidence from the studies on access to these government programmes. [2]

MNREGA

the ant study notes that although most of the households in the study villages had MNREGA 'job cards' (registration required for getting work under this scheme), there was no work. Adivasi women in a group discussion in Mohanpur village said that there was no proper NREGA work for the past two years. They said that only a few people get 'job card' work (that is what the MGNREGA work is locally referred to) a couple of days in a year. Even if they got work, they did not get the money or got it after many months. They complained that some people in their village who worked six months ago had still not got paid [1].

An Adivasi Village Council Development Committee (VCDC) member of Deosri explained the unwillingness to work under this scheme thus:

People here are not willing to do NREGA work. For one road we built, only 15 people turned up to work. No one trusts that he or she will get paid because earlier, money to the labourers was not paid even after two or three months (if they were paid at all). Now systems are much better, and their wages are deposited into their accounts within 15 days of completing the work, but it was very, very difficult earlier. Also, labourers need the money immediately after working and keep enquiring if their money is deposited. Another problem is that the bank is

so far away from here. It is in Kokrajhar and Bongaigaon (40-50 km away), and it will cost them Rs.200 for one trip just to withdraw their wages. So, who would want to go to the bank to withdraw money? For us (the VCDC), we need NREGA work for if there is some NREGA work, we put in three-four job cards extra and take that as payment for our expenses. If we cannot pay the VCDC members for their work, we can at least reimburse their expenses. If not, how do we function?" [1: p.142].

The coverage and performance of MNREGA seemed to be much better among Baigas in Chhattisgarh than among the Sabars in Jharkhand. Only about one-fourth of Sabar families had MNREGA job cards while more than 80% of Baiga households had job cards [2: p.333].

Nevertheless, the benefit to even Baiga households was limited. Three-fourths of them had not been employed under the Scheme during the past three months, as compared to 70% during the three months before that. The majority (66%) had not received their wages within 15 days of completion of work, and 11% had not received their wages even at the time of the survey [2].

The number of days of work available was much below the "guarantee" of 100 days. During the last year, 4% of Baiga households had gained 80-100 days of work, and another 4%, more than 100 days' work. Almost half the households (49%) received 20-60 days of work and another 23%, less than 20 days. Twelve percent received no work at all [2].

Among the Sabars, 41% of respondents in the study households did not know about MNREGA. Only about one fourth (24%) of the households had job cards. In the previous year, nearly half received less than 20 days of work, while the others got work mainly ranging from 20-60 days. 13% of those with job cards did not get any work [2].

In the Kerala study, most of the members of the colony resorted to manual labour to meet their daily needs, and a lot of them worked under the MNREGA program. But the main problem related to this was the delays in the payments that were due to them [1].

"we haven't got our due wages since January this year... We had started bank accounts as directed by the officials but we are yet to receive any money... we have no choice but to borrow money to meet our daily needs..." – Tribal Inhabitant [1: p.149].

Anganwadis

In all the seven study villages of **the ant**, irrespective of communities, the government's flagship ICDS did not function. This shows the complete collapse of the programme in the area. Failure of a supplementary nutrition programme in a conflict area is a failure to prevent malnutrition of the neediest populations and their possible deaths [1].

The household survey in Baiga villages found that of the households having *Anganwadi* beneficiaries, 62% took the services regularly. The others who did not receive the services had reasons such as the centre being located far away in another hamlet, or because the children were taken to the work-sites by their parents because the closing time of *Anganwadis* was too early and there would be no one to care for the children up after that. Malnourished children referred from the Anganwadi were not getting the Nutrition Rehabilitation Centre's services either because the 'beds were full,' or because the NHM or the Anganwadi staff were on strike owing to dissatisfaction with their working conditions. The government of Chhattisgarh opened *fulwaris* or mini Anganwadi centres in 85 tribal blocks of the state. However Pandariya, the surveyed block, being a non-scheduled area, has not been selected for the *Fulwari* programme [2].

In the Sabar areas surveyed, only 31% of the households had an *Anganwadi* within their habitation. During the household survey, 21 *Anganwadis* were visited. Of them, most had an operational child and adult weighing machines, and had toys available. The *Anganwadi* workers of most of the centres said that they provided hot cooked meals, Take Home Ration, and eggs, though there were gaps in a few centres. Only one did not have staff. In the rest, though they were catering to Sabars and many were located within Sabar hamlets, there was no Sabar worker or *sahayika* [2: p.305].

In Kerala, utilisation of Anganwadi centres for supplementary food during pregnancy and for take-home rations for children was higher (almost 90%) among the tribal communities studied as compared to their non-tribal counterparts. One of the PVTG colonies with only five eligible children reported the Anganwadi's services to mothers and children energy-rich supplements [3].

Public Distribution System (PDS)

In *the ant's* study area, it was found that the PDS was doing very poorly. Most of the Internally Displaced Households did not have BPL (Below Poverty Line) ration cards which entitles them to highly subsidised / free food grains. For example, of the 59 households in Bhurapara Balabari (a village with Bodo IDPs), only five to six of the households had BPL ration cards. Only one of the nine families in North Simlaguri had ration cards of any kind, and of the 160 Adivasi households in Koraihari, only 24-25 families had BPL ration cards. The PDS system is already very weak and irregular, and without ration cards, the poor families cannot avail of food subsidy even in this leaky system [1: p.142].

Chhattisgarh's PDS system is seen as an effective system and better than the programme in Jharkhand. The coverage was over 90% among the Baigas, while only three fourth of Sabar families in Jharkhand had PDS cards. However, in both states, PDS has played a big role in improving the food security of PVTGs. For Sabar families often this was the only food available to them as their diet seemed to consist of rice that has been received from PDS mainly. In such a situation of literally hand-to-mouth survival, the fact that one-fourth Sabars have got

excluded from PDS is a serious food security issue. Among Baigas too people spoke about how PDS has provided them with food security. The aged, disabled and the sick had been especially benefitted. In both states, there were instances of irregularities in PDS [2: p.334].

However, there are issues in the PDS. One is the usual issue of the **distance** between the PDS shop and the Baiga hamlets because of the topography. Community members in Pandripani described how they had to go on foot nearly 5 km– 10 kms to collect their ration and carry it on their back. Another issue was that of **irregularities** in supplies given and those recorded. Community members cited several instances of not getting the right quantity they are entitled to. Complaints around kerosene were rampant. Different forms of **coercion and conditionalities** were described. In Dalamahua village, a surveyor came across a woman who had five children and during card verification (satyapan), for some reason, her ration card was cancelled. She went to the sachiv and sarpanch for redressal who demanded Rs. 700. As she could not get back her ration card, she buys rice from the open market, which is very expensive for her. The research team continued to encounter cases of denial of ration because of lack of Aadhar card or due to not building toilets [2].

In the Sabar areas, despite the Supreme Court's directions to state governments to provide Antyodaya cards to all PVTGs, more than a quarter households did not have Ration cards. Of the 78 households who did not have a card, the major reasons were that the card had got cancelled, the beneficiary's name was not on the list. Some families had applied for the ration card but had not received it as yet. Though all Sabar families are supposed to get a free entitlement of 35kgs of rice, there were families that received less. There were families who were not receiving their entitlement due to non-linkage with their Aadhaar card or due to no Aadhaar card. There were also some problems with using the new technology related to poor connectivity, leading to people not receiving entitlements [2].

In Kerala, the main issue related to PDS was of distances:

“in order to receive the rice and sugar from the ration shop, we have to spend around 500 rupees for jeep fare... So we either try to buy collectively or resort to carrying the rations on our head and walk...” – PVTG person from Attappady [3: p.150].

We see from the description in this section that the welfare programmes of the government are crucial for the survival of the tribal communities in the study areas. However, they are non-functional in the most- needy areas such as in Assam or are beset with avoidable problems which can easily be addressed. Improving the wellbeing of tribal communities would imply addressing these avoidable barriers to access to food security.

3.3. Structures of health care -provisioning and patterns of treatment- seeking among tribal communities

The landscape of healthcare service providers

Treatment- seeking behaviour of any group for its health care needs, is determined by availability, accessibility, affordability, and acceptability of health providers and services. The health services system is a complex of formal and informal providers and institutions. These include traditional healers, informal private practitioners dispensing allopathic medicines, the formal private sector in terms of hospitals and nursing homes and the public sector at different levels of care.

Figure 3.2: Major providers of health care services in Assam

'Dependence on informal health care providers is very high as the public health system is unable to respond to the health needs of the people in conflict areas. Informal health practitioners such as traditional healers, pharmacist and NGOs take over the role of health care providers in an area where there is lack of government health care. The informal health care providers have established an understanding and a relationship with people and people can reach out to them for any illnesses'.
- [1: p.115&116]



In Assam, consequent to the series of ethnic conflicts, there is a near absence of government primary health care. Traditional healers and unqualified private practitioners of allopathic medicine are the main sources of health care for the conflict-affected populations. The NGO sector is also present to some extent, in the form of missionary hospitals and clinics run by Medecins Sans Frontieres (MSF) (Figure 3.2) [1].

The scenario with respect to the PVTGs in Chhattisgarh and Jharkhand differs from that in Bodoland in the presence of government frontline workers – the *Mitanins* and the *Sahiyyas*, respectively. However, the frontline workers mainly provide immunisation and facilitate pregnancy and delivery-related care. For curative care, the main sources are traditional healers and unqualified private providers of allopathic medicines. The formal sector, whether government or private, provide mainly secondary and tertiary level care but involve long commutes and high expenditures [2].

While this is the general picture in three of the four study sites, the situation in Kerala is different. There is a strong presence of public and private practitioners of allopathic medicine as well as ayurvedic medicine. There is also the occasional traditional healer. However, there is no private informal provider of allopathic care, which is the predominant source of private health care in the other three settings [3].

The role of traditional healers

In the conflict-ridden areas of Bodoland, and PVTG habitations of Jharkhand and Chhattisgarh, where is weak, tribal communities rely quite a lot on faith healers and traditional healers using herbal medicine.

Among the PVTGs, especially the Baigas, there is still a vast knowledge of traditional healing practices, while among the Sabars have and still follow traditional practices in pregnancy and childbirth [2]. In Assam, among both the Adivasis and the Bodos (especially among non-Christians in remote areas where there is less education), the line between the treatment of the body, mind and the spirit are somewhat blurred. Faith healers are known to deal with all three and heal more holistically [1].

In Assam, traditional healers, also known locally as 'Ojha,' 'Ojha Guru' or 'Kobiraj' are practitioners who have been curing people either by offering pujas (ritual worship) and sacrifices or herbal medicines. Giving jungle roots, herbs and jadibuti (herbal medicines) is a very common form of traditional healing for any illness. People approach the traditional healers for illnesses such as malaria, jaundice, diarrhoea, abdomen pain, dysentery, typhoid, broken limbs & hands, snake bite, menstrual problems, black magic, or even family problems [1: p.116].

An important finding from Assam is that the expenditure incurred by families for availing 'treatment' from the local religious healers is not small. Sometimes these treatments can turn out to be exorbitant running to a few thousands of rupees. One such healer, in fact, had a notice board with the cost of treatment for different problems indicated.



Established 2015
Notice Board

- Open from 9.00am-12.00 noon (Patients seen between this time).
- Open the following days: Tuesday, Thursday and Saturday.
- Those entering the altar should come along with the following: incense sticks; betel nut; other essentials.
- Slipper and mobile phones prohibited inside and around the altar.
- Non-veg food and drinks prohibited before entering the altar.
- None other than a family member can be present while communicating with the **deosigiri (gonoki)** in the altar.
- Contribution of 11 rupees on first entering the altar.
- Cost for an amulet= Rs. 501
- Cost for gastric medicine= Rs. 101
- Purification of family from evil powers/possession= Rs.201
- Leg massage medicine= Rs. 101
- To revive **goddess of luck** for the family: Rs. 251
- 80 pieces of betel nut and betel leaves to get rid of an evil eye.
- Mobile No.

Figure 3.3: A signboard of a traditional healer giving the rates of various types of services offered; the English Translation is given alongside” Source: Reproduced from [1: p.83]

Treatment-seeking pathways and associated factors

Types of health care providers preferred

Whether in Kerala, Assam, Chhattisgarh or Jharkhand, we see that allopathic treatment and modern medicines have gained prominence in the life of tribal communities. Though there are ‘customary resources’ tribal communities dip into, ‘people prefer modern medicines for instant treatment and relief” [2: p.221].

In the Kerala study, a question was posed to almost all the tribal participants: hypothetically, if the health care service (through modern medicine) they needed was brought to their doorstep and at the same, they had access to services of a quack or things like black magic, what would they prefer. The answer to this question was almost unanimously in favour of the former... ‘If medical services are more accessible, we will not go for this black magic and other means.... But we have to travel that far to get the care, and the health care staff rarely come to this colony....’ - Tribal respondent (Paniya)” [3: p.125].

In the survey of mothers carried out by the HAP, 75% of mothers from tribal communities reported that they preferred the allopathic system of medicine, while among mothers from non-tribal communities, the preference for the allopathic system of medicine was reported by 92.5% of the mothers [3: p.110].

Across all the sites, community members reported a preference for private rather than public sector allopathic health care providers. Even in Kerala which has a well-functioning public health system, it was found that many from tribal communities resorted to private health facilities and said that private facilities were closer and less cumbersome to go to. If they went to a government hospital, they had to address many issues like the rush in the OP and IP wings, the formalities of getting things done in various sections of the hospitals and a long wait to get tested and get the lab results” [3: p. 122].

‘if we go to govt hospital, we have to stand in long queue to see the doctor. Then we have to go to another place to get tested.... Then by the time we get the results, the doctor might have already left, and we have to go to show the results the next day. Sometimes we don't get the results on the same day at all due to rush’ – Tribal respondent (Kurumba)” [3: p.122].

"I don't go to the Govt Hospital (PHC) nearby... Why should I go there? Often I take all the trouble to go there to see that there is no doctor... When I ask, they say the doctor is on leave... I don't get any medicine... If I go to the private hospital they take good care of us... so what if they ask money... we are getting good care..." - Tribal respondent (Kurumba) [3: p. 127].

In Assam, Chhattisgarh, and Jharkhand the difficult geographical terrain, remoteness, and poverty are compounded by a weak public health service system. In Assam, there is a virtual collapse of the public system, due to conflict. As a result, there is limited access to public health services. The next section (3.3) discusses the state of the public health care system in greater detail.

While in Kerala, the private allopathic sector consists of qualified practitioners and facilities, this is not the case in the other study sites. Unqualified private practitioners called "pharmacy" in Assam's villages and "Bengali doctor" among the PVTGs are the first line of allopathic treatment. They are easily found in village markets and dispense medicines according to the money people have and not what is necessarily needed or appropriate. Interviews with some of these unqualified practitioners show that they enjoy the trust of people and are even prominent members of their communities. The unqualified practitioners determine not only the diagnosis, the line of treatment and medication but also the future of certain diseases, like malaria. Wrong doses and incomplete courses can create dangerous forms of drug-resistant malaria.

Box 3.2. Description of a “pharmacist’s” practice in Assam

A day spent with pharmacists in a village market - JM's field notes of 8th & 9th November, 2016



Rajib and Sankar with their medicines in their pharmacy in a village market. They get an average of 10-12 patients a day.

Rajib and Sankar are two pharmacists who share a pharmacy in the local market. Sankar has been providing health service in the area since the past 11 years and tells me that the most common illnesses in the area are malaria, typhoid, itches (skin allergies) and gastric. I spent an afternoon watching Rajib, Sankar’s pharmacist partner treat many different patients. Five patients- three men and two women – came for painkiller tablets. Then, an Adivasi man from Korabari came to buy

medicines for his wife suffering from severe pain because she had delivered a baby in the house that morning. Rajib gave him two tablets worth 10 rupees for the pain. Then, another two persons were suffering from fever and one person from continuous headache. There were three cases of malaria. One woman approached him for skin infection medicines and a newly married woman bought a medicine in private from him and does not want to reveal. Another woman came to buy medicines for her child who is having skin infection. A mother of a 17 year old girl came to get medicines from him because her daughter cannot get up from bed. The medicine taken before did not work so her mother takes medicines for typhoid today. There were a lot of blood tests also done of patients today. He saw a total of 18 patients today.

While personal preferences may influence treatment-seeking to some extent, what emerges is an eclectic mix of provider-types used, depending on affordability, convenience, and assessment of the seriousness of the health problem.

For example, among treatment sought for episodes of ill health in the 15 days before the survey in Chhattisgarh, 44% of the Baigas availed health services from the private sector that mainly consists of unqualified medical practitioners. In 26% of the cases, people went to the village level health workers (ASHAs and ANM), 22% went to the traditional healer, 5% went to government facilities and the rest (3%) took home-remedy. The type of health provider selected for women and men were not very different, with the proportion of men going to Private Health Provider (PHP) slightly higher (46%) than women (42%) and vice versa in case of ASHA and ANM (27% for women and 25% for men) (Table 3.5) [2: p.31]

Table 3.6: Choice of Health Care provider for ambulatory care among Sabars

Place of treatment	Male		Female		Total	
	N	%	N	%	N	%
Private/Private Health Provider (PHP)	52	46%	66	42%	118	44%
ASHA/ANM	28	25%	43	27%	71	26%

Traditional healer	25	22%	34	22%	59	22%
Other Govt (PHC &CHC)	5	4%	9	6%	14	5%
Home Remedy	2	2%	6	4%	8	3%
Total	112	100%	158	100%	270	100%

Source: [2: p.113]

The community's reliance on diverse providers according to need and affordability was also evident from the field. For example, Dalamahua is a village that is in the plains and about 20 km from CHC pandariya. In conversations with the community, they said that they first use *jadi booti* (herbal medicines) in case of any illness. They call 108 ambulance service in case of any emergencies. If they do not get cured after taking treatment at the hospital, they return to taking *jadi booti*. They also said that the doctor's medicines do not suit them- "*phhonk jhaad hee bimari ko pakadta hai*" (Surveyor notes). While in the village, the surveyors found a case where children had chicken pox. They were undergoing *jhaad phoonk*, and no other treatment was being given, and it got cured [2: p.115].

The informal private health practitioners were able to provide insights into the treatment seeking behaviour of the tribal communities. The unqualified private health practitioners from Chhattisgarh and pharmacists from Assam understood the limitations in treatment-seeking imposed on the tribal communities by poverty.

Mr. J, a Private Health Provider (PHP), said that for minor issues like a cough and cold *Baigas* did not come to him and treated themselves with *jadi booti*. Similarly, for light fever/ailment, they did not seek treatment immediately. First, they resorted to *Jhaad phoonk* and came for allopathic treatment only for serious ailments. He was of the opinion that herbal medicines were useful; however, they constituted primary treatment. He gave the example of *harra-behera*, plants that are used in treating cough. He believes that *Baigas* delayed their treatment not out of choice but because of impoverishment. Only when they feel that an ailment is serious enough, did they come for treatment to him (Interview with Dr. J, PHP, Kukdoor, March 2017)" [2].

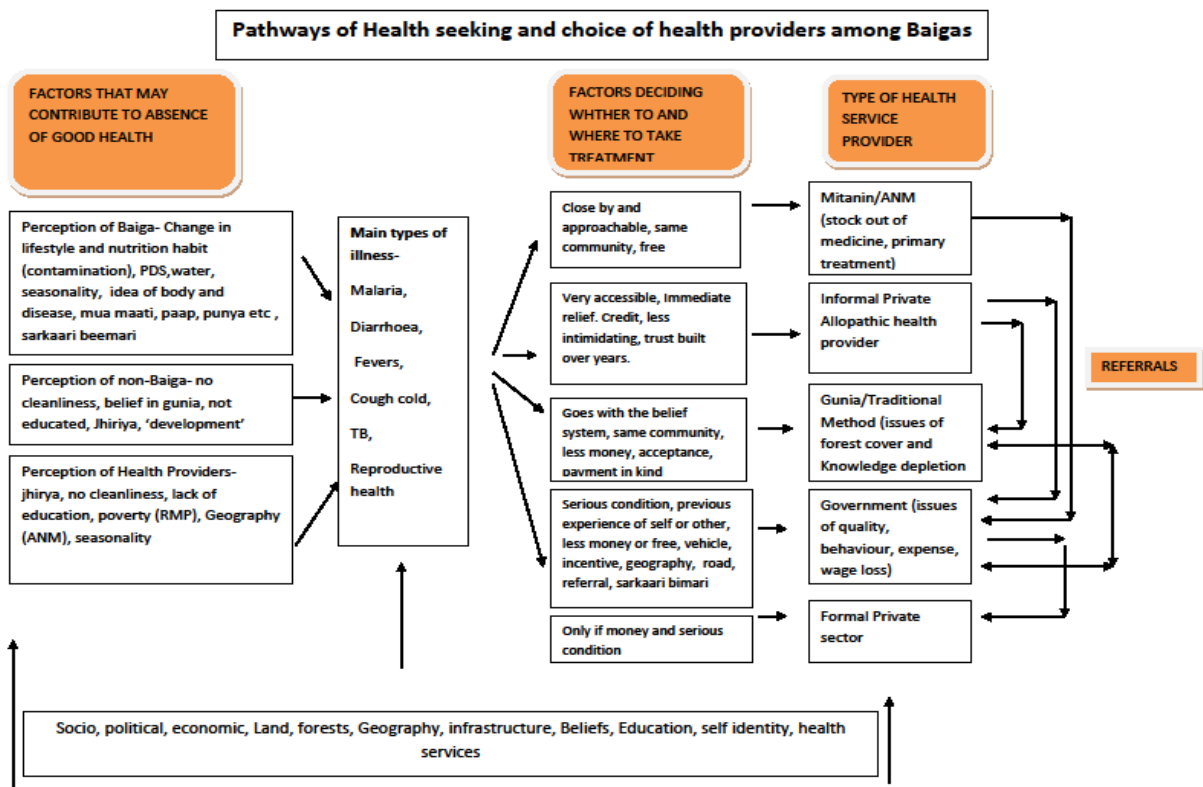
In Assam, there appears to be less reliance on home remedies using herbs. Rajib Mushahary, a popular Bodo male pharmacist, practicing in a village market has both Adivasi and Bodo clients. Of the Adivasis, he says, "*They usually delay in coming for a check-up.*

When a person first falls ill, he/she is first given some tablets which they buy from the pharmacy. The family keeps waiting for better results at least for two days. When the person does not improve, then only they are brought to the pharmacy. Often when a person is found to be shivering and having a high temperature, the person is treated with malaria and typhoid injections even without blood tests. People try to avoid the expense of conducting the tests. Many Adivasis do not complete the malaria treatment course. When they feel better with just

one injection, the person stops the course. On many occasions, people cannot complete the course because they do not have the money for the injections” [1: p.126].

The following figure captures graphically the treatment-seeking pathways of the Baiga community studied. Source of health care for common health problems depends on the convenience and accessibility and acceptability in terms of their belief-systems. In the case of serious illness, the choice of provider is between a government and a private hospital, where affordability is the most crucial deciding factor [2].

Figure 3.4: Treatment-seeking behaviour in the Baiga Community



Source: [2: p.343]

3.4. Public health systems

As discussed in the earlier section of the chapter, health systems in tribal communities encompass a wide range of traditional practices and community-based practitioners; chemists, private practitioners, and public institutions providing mostly allopathic services. The focus of this section will be to examine the status of the public health systems, the perceptions, and experiences of health providers towards tribal communities and vice versa. These insights will help to identify the lacunae in the system in terms of availability, accessibility, affordability, and acceptability that could assist in defining the requirements of a public health service system that can address the 'felt needs' of tribal communities in order to achieve better health equity.

We first discuss the issue of access to public health services, and of the poor infrastructure and human resources, compounded by unhelpful attitudes. Following this is a description of the effects of ethnic conflict on public health systems. The last sub-section examines the consequences of paternalistic state-policies related to health, on the health of PVTGs.

The many barriers to accessing public health care

Access to health care depends upon the complex interplay of many different factors that cannot necessarily be neatly disentangled from each other. However, an attempt is being made to tease out some key factors.

Distance, difficult terrains and wild animals

One of the key characteristics that emerge from the studies is the sheer physical distance from the 'first post' of public health services, namely the Primary Health Centre (PHC). The long distance from a PHC was mostly the case for Jharkhand, Chhattisgarh, and Assam but also for some communities in Kerala. In all the studies, when interviewees were asked about health-seeking behaviour, distances from public health services came up as a major reason for not seeking care during illness. For instance, amongst 348 Baiga respondents in Chhattisgarh, 18% mentioned distance as the main reason for not seeking care. Much of the expense was incurred towards transport. TB patients also reported that though the government does give free treatment within the DOTS programme, there is much expenditure on conveyance, leading to a lack of compliance and drop-out.

Most PVTG settlements of Chhattisgarh and Jharkhand were dispersed, and each hamlet had a very small population. In the vast majority of instances Primary Health Centres were at least 10 km away, and the Community Health Centres, at least 20 km away. The terrain was difficult and mountainous in some instances, and the roads were almost all bad, and inaccessible or unusable in the rainy season. The Auxiliary Nurse Midwife of the public sector often found it difficult to walk to the many Baiga and Sabar settlements. The lack of public transport compounds the problem of access and increases the reliance on private transport [2].

The following are some reports from the community on the difficult distances:

"The geographical terrain of the Achara village determines access in terms of road and transport access to health facilities. In Neeche Achara, the SHC was the closest, but the ANM had been on maternity leave for more than six months. The PHC was 20 km away and the CHC, 36 km. Other than services provided by the Mitandin (CHW), the Baiga families in the lower hamlet find it very difficult to avail rest of the services as they have to navigate through 3-4 km of a difficult trek. There is no way to take a woman who is having labour pains to the hospitals.

To come to a proper road, they would either have to climb a steep hill or traverse through undulating terrain in a motorbike. On the other hand, in the case of Upar Achara, which is part of Achara Village but on the road, there have been cases of people going to hospital for delivery and use of 102 vehicle. [Achara Mitandin, 2: p.149]

In Assam, access to health services is ridden with similar issues. One of the study sites is 11 km from the government dispensary. It is a forest area where the Internally Displaced People (IDPs) from the 2014 conflict between the Bodos and Adivasis were relocated after leaving the relief camp. To reach this place, one had to take an auto halfway, and then people had to

go walking from there to reach their village. There was no electricity in the village because it is in the forest areas [1].

“The ASHA’s house is three km from our village and with wild elephants moving around. During the summer, it is impossible for an ambulance or jeep to enter the village because of the bad road condition, although the distance between the village and the main road is just five km. Once, an ambulance was called in the night, and it reached the village only in the morning. For serious cases, families use a bullock cart to take mothers for delivery [Adivasi leader, 1: p.89]

The situation seems to be much better in Kerala, and the median distance from a PHC is 8 km and from a sub-centre (which is more functional and present as compared to the other two study areas) is 2 km. The cross-sectional survey carried out as part of the study found no significant difference between tribal and non-tribal areas in the median distance to health centres. However, interviews with forest dwellers in the same areas revealed a different story:

If a person is sick and not able to walk, 3 or 4 people will have to carry her/him and travel through the forest on foot till Kolappady and get a jeep from there...the jeep drivers charge around 500 rupees to pick up a person and drop them off at Kolappady” – Tribal Inhabitant [3: p.143]

The government has given us pucca houses in our hamlet... But what we actually need is a road to the main road... It is very difficult for us to go see a doctor without the road... especially in the rainy seasons...” – Tribal respondent [3: p.119]

Wild animals – especially elephants – posed another major barrier to access.

The Assam study notes the danger from elephants.

“I am called to visit patients (in their homes) any time, even at night... A few weeks ago, I was asked to go to Koraibari at 10.30 p.m. I refused to go because of the danger of attack by elephants, but they pleaded and forced me to go. I was so scared and tense as it was so silent and scary in the jungle. We were lucky we did not cross the paths of any elephants that night. Now, whatever happens, I have sworn I will never ever do this again. It is too risky”. –, Adivasi pharmacist practising in Deosri. [1: p.110]

In the Kerala study, a community member narrated an instance where a man was injured by an elephant and could not be taken to hospital for more than a day because no ambulance would come, fearing the elephants [3: p.144].

As evidenced by all the studies, sheer distances are enormous, when one considers that they are to be traversed by people who are ailing, in pain or immobile, often on foot, bicycle, motorcycle or tempos. The distances themselves are heavily compounded by the general lack of availability of roads for much of the distance, poor or absent telephone connectivity and

the threat of wild animals on the way. Rains offer an enormous exacerbation of the physical obstacles to access since even the roads that are present become impossible and rivulets swell up and prevent travel by foot, bicycle and motorbike as well.

The government's 102 and 108 ambulance services are meant to be the public health system's response to the challenge of distances. However, the poor telecommunications network made it difficult to call the ambulance while the bad roads meant that the patient in an emergency situation had to be carried 2-3 km on foot before they could reach the ambulance.

In some cases, the government transport was found to take money. For instance, a 108 ambulance was called to move Rupsi Narzary, a Bodo woman to the Shantipur PHC for her delivery. The ambulance charged Rs.300 one way. [1] Another report from a Sabar village says that the Mamata Vahan generally asks for a 100 Rs / Km when transporting pregnant women. [2]

In one of the Baiga settlements, the Baiga community was unaware of the availability of the 102/108 ambulance service till the research team informed them of it. In one case, a motorcycle ambulance had been provided in Kandavani village, Chhatisgarh, to transport the sick. [2]

References were also made to occasional visits by mobile units. For instance, in one settlement in, Jharkhand, the mobile health unit comes on two specific dates of every month. Villagers living far away usually do not access this.

Mamta Vahans or mobile health unit comes to the village. They are not reachable to the Sabars. The distance from the settlement of Sabars and the place where the Mobile Health Unit Vehicle stops is too much.-A Non-tribal Respondent, Sabar village [2: p.284].

Even in the state of Kerala with much better coverage of its population, a colony (Mele Bhoothayar Colony) consisting of 30 households with a little over 100 persons, was served by a mobile medical unit attached to the nearest PHC came to conduct medical camps only once a month. Moreover, during the rainy season, their jeep could not reach the colony at all [3].

Ultimately, it appears that even more than distance, it is **the proximity to a metalled road** that determines the physical ability to reach a health facility that can cater to ailments beyond the limited repertoire of the health worker can provide.

Reaching a PHC is often only the beginning of a long journey. Further referrals add to the massive distances families have to travel to be treated. As an illustration, referrals from the PHCs in the study area in Assam are usually to the nearby town with CHCs or Civil Hospital. It takes 1.5 hours by road to reach the CHC from the PHC and another two hours by road to reach the 200-bedded civil hospital. From there to a tertiary hospital is a minimum of 3.5-4.5 hours, and the cost of transportation was high.

Financial access: Out of Pocket Expenditures and Publicly Funded Health Insurance Schemes for health equity

Out- of- pocket expenditure for utilising private health care, because of the inability to use government health facilities is reported from all three studies. It must, however, be noted that community members also end up incurring out- of- pocket expenditure while accessing government health facilities. For instance, in all the three studies, community members had reported incurring substantial proportions of money on transport. Government health facilities were often located far away from the tribal villages. The roads were bad, and there was poor public transport connectivity. As a result, members of the tribal communities had no option but to use private vehicles and pay a high price for it. Even the use of paid public transports involved a considerable amount of money.

Cost of transportation as a deterrent for care-seeking even when the services *per se* were free of costs was reported from Kerala. One fifth (21%) of women from tribal communities missed ante-natal care (ANC) as compared to 4% of other mothers and the main reason for missing ANC visits was the shortage of money. Three-fourths (73%) of women from tribal communities in the study reported that ANC visits affect their or their accompanying person's day job. The same was reported among 58% of non-tribal mothers. Around 57% of the tribal mothers had to borrow money to meet the antenatal and natal care expenses. This was significantly more when compared to non-tribal mothers (46%) [3: p.100-101].

Community members have also reported incurring out of pocket expenditure in the form of informal payment government hospitals, which again adds to the out of pocket expenditure.

Weak public health services mean that low-income groups who approach these facilities in the hope of free or subsidised care end up spending considerable sums of money being moved from one facility to another, public or private, and not being able to prevent death or disability even after spending large sums of money.

The following figure and case depict the story of care-seeking for pregnancy-related health problems by Sarna, who after months of struggle with illness and inadequate medical care, finally succumbed to the health problem and became yet another faceless figure in the list of maternal deaths (Figure 3.5) [1].

Sarna was in the relief camp when she became pregnant. Survival was a challenge because her house had been burnt and the crops destroyed. The government hospital was 11 km away, and she could not go for antenatal care. There were no community-based ANC services. Over the next few months, she fell ill. Her body started swelling, but the family, busy with wage work, waited in the hope that the problem would resolve itself. When the problem did not abate even after a month, they sought health care from a government dispensary located 11 km away, going by bicycle and motorcycle to get there [1].

She tested malaria positive in the dispensary but was sent home without any malaria drugs. Over the next few months, she got progressively worse and was taken to a traditional healer for treatment, because there was not enough money to go to the hospital, despite selling their crucial asset for agricultural work: their bullocks. She was shifted to her uncle's house so that medical care would be easier to access. When in the late pregnancy she was taken to the hospital, it was already too late – she was declared dead on arrival. Bringing the body home was possible only after the sale of another young bull [1].

Figure 3.5: Sarna's treatment-seeking pathway for malaria in pregnancy



Source: [1: p.131]

A major policy initiative for ensuring financial access to medical care and a nationwide vehicle for the universalisation of health care services is that of providing insurance cover to all and especially to the vulnerable. This has been rolled out in all States, but the extent of implementation varies. The **Rashtriya Swasthya Bima Yojana** (RSBY) can be considered an early pilot for health insurance in the country.

In the PHRN study, it was observed that despite rolling out of RSBY years earlier the proportion of community members who were enrolled in this program was very small. Of 289

the Baiga households surveyed, 38% had RSBY cards, and most (95%) had RSBY cards that are meant for the BPL. Almost no one received the list of hospitals that should have been given during enrolment. The reasons for no enrolment were mainly related to not having information about the scheme (24%) or enrolment camps (13%), having enrolled but card not given (19%), card expired (18%), and other problems faced when the family went for enrolment. RSBY smart card was used in 7 (12.7%) out of 56 hospitalisation episodes and that too mainly in the district hospital (4 cases). Only 2 of these seven were given Rs. 100 conveyance fee, which is mandated under the scheme. All seven incurred out of pocket expenses with a median expense of 4000 Rs though one of the main objectives of the scheme was to prevent out of pocket expenditures. Not one got a receipt for the amount that was spent from their smart card [2].

In Sabar areas, things were even worse; 3% of 276 households reported having RSBY cards. However, when individuals were asked about enrolment, only 1% of 1450 reported having an RSBY card. RSBY was not used by any of the 26 people who were hospitalised, the median OOPE being Rs 900 [2].

Thus, a scheme that was designed for the financial protection of the most vulnerable afforded them hardly any coverage, even though it seemed to be functioning well with State average of 85% coverage in Chhattisgarh [2].

An absence of data, insufficient staffing and infrastructure, and unhelpful attitudes

The previous section described in detail what tribal communities experienced as barriers to accessing public health services. In this section, we pull together information on health system-factors contributing to this situation.

Absence of data

One of the problems noted by all the studies was the absence in the public domain of disaggregated data on tribal communities that were included in the study. For instance, in Chhattisgarh attempts to get details about Baiga communities served by government health programmes, health indicators and other data from the district and state administration, failed. It was also noted that data on the Sabars was very scarce, and gender disaggregated data was wholly absent. Likewise in Kerala, official data was only available for tribal versus non-tribal communities, and nothing was known about differentials by ethnic, gender and social class within tribal communities.

The absence of data is an indication of the invisibility of the tribal communities for purposes of planning, programme administration and evaluation of programme performance. If one has no information on how poorly the tribal communities are served, there is little one can expect to happen to bring about an "improvement."

Inadequate infrastructure and insufficient staffing

Our studies pointed to major staffing gaps in tribal areas at all levels, from community health workers to doctors, for a variety of reasons.

Some of which have been mentioned above, such as the lack of facilities and infrastructure. A doctor of tribal origin heading the local PHC in a PVTG area in Chhattisgarh recounted how he had put up a budget for six additional sub-health centres (SHCs) for the area of which only two had been approved. The MO also observed that for health services to become regular in the area, health staff would need some basic facilities [2].

“the residential building should be good and safe drinking water should be available for staff. If these arrangements are there, then she will stay. She can give services only if she stays there” – PHC Medical Officer [2: p.216].

Despite the crucial need for additional investment, health budgets for the district showed utilisations that ranged from 62-72% between 2013 and 2016, with a drop of budgetary allocations in 2014.

In Kerala, official statistics show that all sanctioned posts have been filled, and this is given as evidence for adequate staffing. However, staffing norms are based on populations from very long ago:

“the assignment of posts in the health care institutions and the field is quite outdated. It has been a long time since the number of the posts and the distribution of area for the health care field workers have been revised... Little or actually, no effort has been made to formally assess the needs of the tribal settlements and plan deployment of staff in such areas... even the most motivated staff find it difficult to cater to the needs of these people... they(the field staff) are overburdened already...” - Medical Officer working among tribes [3: p.138].

As a result, the health workers had to put in an extra effort and even pay out of pocket to carry out their duties:

“It takes me a whole day to go to most of the "ooru"s and come back... We have other duties as well... we have to bring children for immunisation camps and get pregnant women also... We have to pay out of our pocket for transport to these far reached settlements... We are being paid only small amounts for the children we bring for immunisation and the mothers registered for ante natal care...” - ASHA worker , Kerala [3: p.124].

Another issue is that front-line workers are not from the local tribal communities, creating communication and attitudinal barriers. In Chhattisgarh, very few ANMs were found to be from the Baiga community. Of 30 recent selections, only one was a Baiga [2].

A slightly better situation applied to the ASHA workers or *Mitanins*. In one of the villages, there were three Mitanins. However, none belonged to the Baiga community. In another, two Mitanins were both Baiga. Amongst the Sabar community, only one of 28 of the Sahiyyas present in 21 villages was from the Sabar community [2].

In Kerala, too, it was noted that few of the ASHAs belonged to the community they were supposed to represent [3].

"Sometimes, we can see that an ASHA cannot work well with a hamlet, despite being from the tribal community... simply because she is from a tribe that is different from the ooru she visits. The people cannot relate to her... She is just as alien to the community as any person of non-tribal origin..." - Tribal promoter [3: p128].

When the medical doctor is of tribal origin, or the nurse or ASHA worker belongs to the local community, there is much greater empathy.

A PHC medical doctor of tribal origin described how he and his team would walk to these villages, stay the night at one village and go to next village the next day. His experience was that *'the more you interact with them, the more you go amongst them, the more they will respond'* [2: p.215].

Attitudes

Instead of taking a systemic view of the many constraints in making services accessible to tribal communities and thinking in terms of higher investments, health administrators and service providers are prone to blame communities for their health behaviour.

For instance, it was noted in Chhattisgarh that a health team visiting a remote village where four infants had died of diarrhoea advised the village to pay attention to cleanliness and to avoid eating stale food. The 'victim-blaming' attitude was echoed by the district collector, who added that they should stop consuming liquor and come to the PHC. This village is 16 km from the nearest PHC which has to be approached by foot and are not sure of finding health care providers in the PHC when they eventually get there.

In another area, a spate of deaths occurred amongst the Baiga community, ostensibly from malaria. The administration denied that the deaths were from malaria, but their enquiry suggested no alternative cause, the report of which was never made public. The Mitanins also reported that they often hear hospital staff making disparaging remarks about Baiga patients, such as *'they are dirty' 'they don't take baths.'* A staff nurse and ANM also reported that Baigas are quite reluctant to be referred and often refuse because the language of higher facilities like CHC is different and they feel intimidated. [Surveyor Notes, 2: p.136]

These reports by health care providers are reflected in the communities' observations. In one instance, community members reported that in the District Hospital, where they had to reach after a considerable effort and expense, they were often made to wait for several hours and then referred to a private hospital [2]. Sabar women in one village said that they prefer to give birth at home because the behaviour of nurses in the local PHC was very rough and rude, and sometimes they physically abused the women if they cried out in pain during delivery. There were many such reports from other PVTG settlements.

Negative attitudes towards tribal communities were also reported from Kerala. A Public Health Nurse working with tribal communities had this to say:

"These people (tribes) don't want to change. Despite us trying to help them in many ways, they prefer their own tribal culture, misbeliefs, and rituals than our medicines... If we go to the colonies to try and get mothers and children for immunisation, they run off and hide...."-Junior Health Inspector (JHI) [3: p.124].

The following observation by a woman from a tribal community in Kerala suggests that there may be similar attitudinal problems also in higher-level health facilities:

" I admit that I do have a certain fear of going to the tribal hospital to see a doctor...I am an old lady....And sometimes when I go to the hospital, I feel that I shouldn't be there...People look at us very differently...We get the medicine and treatment we need, but we just come back as soon as possible..."-Kurumba woman [3: p.130].

Even when health administrators do take cognisance of the challenges in reaching out to tribal communities with health services, they do not see it as the public health system's responsibility to make the necessary changes. Instead, they place the entire responsibility of surmounting these difficulties upon the frontline workers, as exemplified by the statement below.

"We need health care employees and all other related government employees to step out of what is required by them and try and put in extra effort... They have to understand that they will have to improvise and sometimes put in more time... Places, where such initiatives have been taken, have shown great results.....like various places in Wayanad and Attapady..." Department official [3: p.128].

Effect of Conflict and Violence on Public Health Systems

The previous sections discussed the extent to which public health services addressed the health care needs of tribal communities in the study settings. The challenges and difficulties highlighted may be considered ubiquitous.

There are far more complex and extreme circumstances that have hurt health services in the areas under study. In this section, we draw on the study in Assam which provides a detailed account of how conflict and violence forms an important backdrop and determinant of health system functioning.

Based on reports by the community and by health care providers who have been present in the area before the era of conflicts, it is evident that there was a functional public health system in place in Assam in the 1970s and 1980s. The Assam Agitation of 1980-1985 was comparatively short-lived and while it did disrupt governance of various systems including the health care system. Before the Bodo Andolan of 1990, there was a working health system in place. There were qualified MBBS doctors and a full team of support staff present in the

government health centres even in remote places. Outreach programmes reached people's doorsteps even in the villages. There is also evidence that every community used the services at the government health centres even though there were severe challenges like shortage of medicines and lack of vehicles [1].

However, the health system in Bodoland (of which the study area Deosri is a part of) showed a sharp decline as a result of the Bodo conflict in 1990, which has been followed by a series of conflicts all through the 1990s and 2000s, with the most recent one in 2014. The groups involved in the conflicts have been varied, and involved Bodos on the one hand and Assamese, Adivasis and Bengali Muslims at different times. As the Bodo movement got violent, public infrastructure, including health centres, schools, electricity, roads, and bridges were destroyed to keep the security forces at bay. In the study area, two hospitals were burnt down by the local people so that the buildings are not used as shelter by the security forces. [1]

When militancy followed soon after, extortion demands by militants became a threat to the doctors, and many non-tribal doctors fled leaving only a few Bodo doctors to manage the health centres. The Bodo doctors who stayed back also did not have it easy in an insecure atmosphere – sandwiched as they were between the militants and the security forces hunting the militants.

“Doctors, including myself were assaulted for trivial reasons, harassed by the public, the police as well as the administrators. They (militants) would come for treatment, and we had to treat them. Once, fearing reprisal from the army and police (for treating militants), I complained to my senior about this. This was a mistake, and I was harassed a lot after that, even physically attacked” Bodo doctor. [1: p.53]

The rise of violent militancy interspersed with waves of ethnic conflicts during that same decade further sounded the death knell of the health system. It collapsed so badly that the health centres could not even respond to emergencies and epidemics following ethnic conflicts.

“After the violence started, electricity was cut off (since the poles were destroyed). I used to conduct deliveries with torchlight. There was no system for sterilisation of syringes, except a stove on which water could be boiled. There was no supply of bandages or even anaesthesia. I remember a case during the Bodo-Muslim conflict in 1993. A man had been injured in his head with a spade. It was a deep gash and required stitches, and I sutured him without any anaesthesia”. Bodo doctor. [1: p.52]

Humanitarian non-government organisations like MSF filled some of the void left by a collapsed public health system and gave medical relief to large numbers of completely impoverished conflict-affected people in the relief camps and surrounding areas. But when they left in 2007, the high quality of care they provided could not be replaced by a collapsed health system which was starting to rise with the launch of NRHM in 2005.

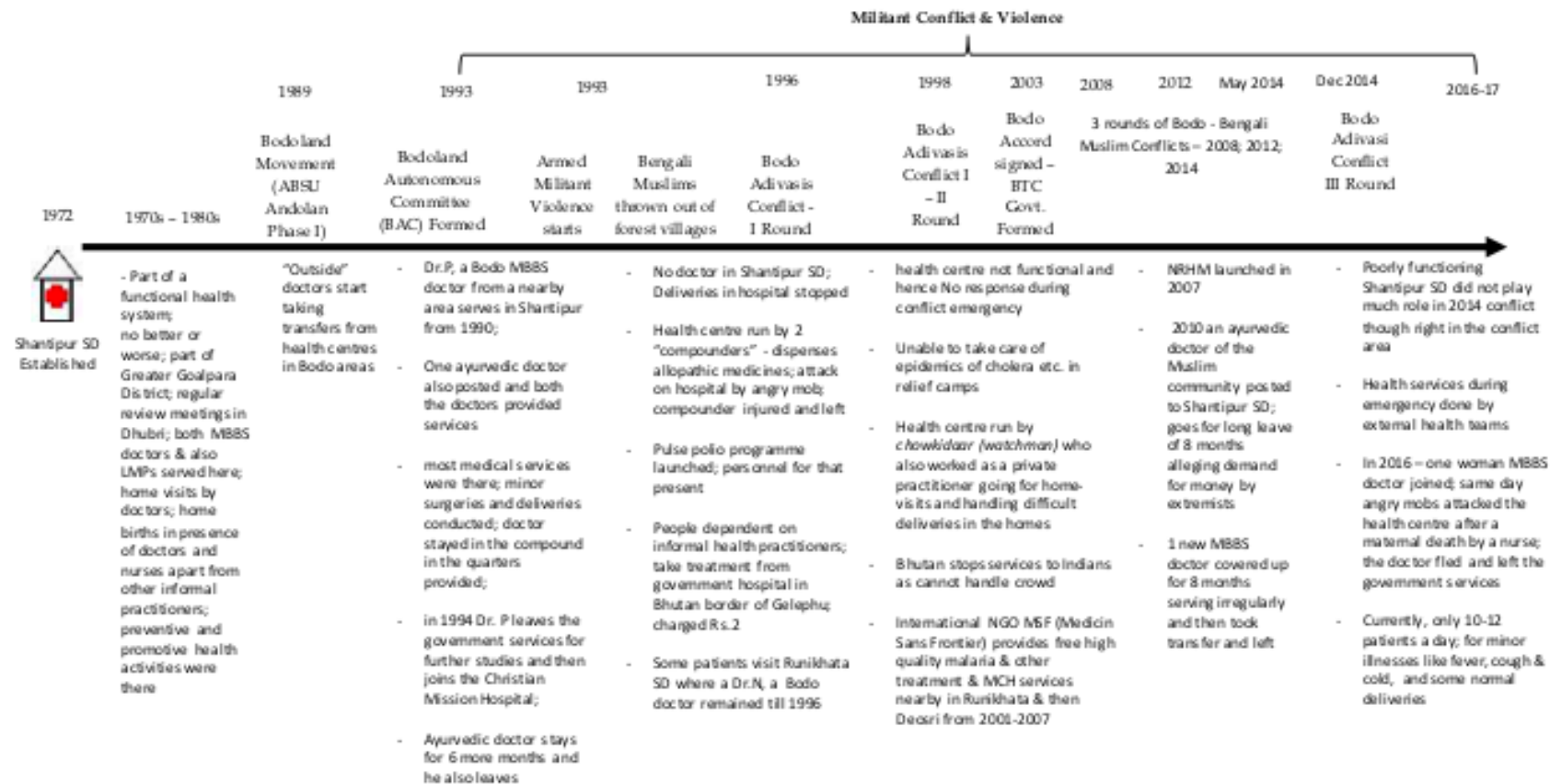
Buildings, equipment, and other physical infrastructure along with some frontline level health personnel improved greatly in the health centres after the NRHM came in. But the health centres in the conflict-affected areas were not able to get qualified doctors to provide quality services. An incident in the 1990s when militants killed a paediatrician in Kokrajar because he was unable to fulfil their extortion demands is still remembered. Bodo doctors who stayed back and the unqualified "pharmacists," all have experienced threats from militants to themselves and their families. The feelings of fear and insecurity persist although encounters with militants are from two decades ago.

Feelings of fear have discouraged health personnel from other parts of Assam from serving here in the conflict-affected areas. Some health centres function but with either inexperienced part-time doctors (fresh MBBS doctors forced to serve a one-year rural posting to qualify for post-graduate studies) or semi-qualified (the three years trained Rural Health Practitioners) or even unqualified (like ayurvedic doctors made to practice allopathic medicine). This has caused people to lose faith in the government health system, which can be catastrophic for families completely impoverished by conflict, as discussed in the section on out of pocket expenditures on health care.

The effect of conflict on the public health system is graphically illustrated using the case of Shantipur State Dispensary (PHCs are called SDs in this area) from the early 1990s to the present day (Figure 3.6). In the early 1990s, there was an allopathic doctor and an ayurvedic doctor posted in the Shantipur SD. In 1994, the allopathic doctor left for higher studies and the ayurvedic doctor left, not wanting to stay on in the conflict area. Two "compounders ran the SD," and after an angry mob attacked one of the compounders, they left. The SD became non-functional, till an ayurvedic doctor was posted in 2010. Since then, doctors have been coming and going, and the health centre remains largely non-functional. At the time of the study, hardly 10-12 patients were seen a day for minor illnesses like coughs and colds, and an occasional normal delivery takes place [1: p.49].

Figure 3.6: Time-line of how conflict affected the Shantipur State Dispensary (PHC) in Deosri, Assam

We studied the Shantipur State Dispensary in depth in order to see if and how external socio-historical events affect the health system. This information gathered from many interviews has been put in a historical timeline below:



Source: the ant, 2017: p.49

Paternalistic Policies affecting PVTGs in Chhattisgarh and Jharkhand

Before we end this section, we present the case of State policy disallowing members of PVTGs from availing of sterilisation schemes in government hospitals. Their socio-economic vulnerability and low population levels have led PVTGs to be treated as 'endangered' and 'on the verge of extinction' - terminologies which deny them their dignity.

Rather than granting them their autonomy and rights to address historical injustices, this perception has led to disastrous State Government interventions in the name of 'preservation.' One such scheme has been the

In 1979, the Madhya Pradesh/ Chhattisgarh government restricted sterilisation services among PVTG groups in order to increase their population. Restriction on sterilisation has meant that PVTG communities are forced to have large families that they are unable to sustain with dwindling resources. In Chhattisgarh, various civil society organisations, led by PHRN, came together in an attempt to get this policy revoked (Nandi et al., 2012). However, the order still stands.

As sterilisation is not done among *Baigas* in Chhattisgarh due to the government order, women go to neighbouring Madhya Pradesh to access the services. According to PVTG women from one village, during the 'sterilisation season' that extends from after the rainy season and throughout the winter, health workers came from MP to PVTG villages and took women in vehicles for sterilisation. Sometimes women got together and hired a jeep to go to Madhya Pradesh, the adjacent state, for sterilisation. Women said that in MP they got around Rs. 600 as the incentive amount for undergoing sterilisation operation. They found the services in Madhya Pradesh satisfactory, and said that they had been treated nicely.

A similar discriminatory policy applies upon the Sabars of Jharkhand who is not permitted sterilisation operations. However, while the Baiga is desirous of sterilisation, the Sabar do not demand it and are suspicious of sterilisation, believing it would do them harm. Thus, in this case, one could say that the State policy regarding contraception resonates with the cultural practices of the Sabar but goes entirely against the stated felt needs of the Baiga. Restriction of sterilisation among Baigas is an important example of the way in which a paternalistic state infantilises the PVTG communities and makes ill-conceived decisions on the communities' behalf, which further jeopardises the health and wellbeing of the PVTG women [2].

Box 3.3. The story of Sukhni Baiga

Sukhni Baiga looks around 40 years old and lives in Nagadabra village.

Like most Baiga women she had a prominent but fading tattoo on her forehead that signifies her identity as a woman belonging to the Baiga community. She first tried to get sterilisation done after six pregnancies, out of which only four children were alive at that time. She went to Kukdoor PHC from where she was turned away. She went to PHC in the two consecutive years after that when they held sterilisation 'camps.' She pleaded with them to do the operation. She said to them; "kakarkeposbo?" [How will I fend for so many kids?]. But they sent her away both times. She says "matha la dekh la nurse nikaal dis" [nurse told me to leave after seeing my forehead tattoo]. Meanwhile, she experienced more pregnancies and infant deaths.

After being turned away from the PHC thrice in three years, Sukhni then went to the CHC in Pandariya, thinking that at the CHC she will be able to get the services. However, there too they refused to operate on her and sent her back home. The refusal happened twice at the CHC. Meanwhile, she kept getting pregnant. After her tenth pregnancy, she had two miscarriages, after which she fell ill for many months.

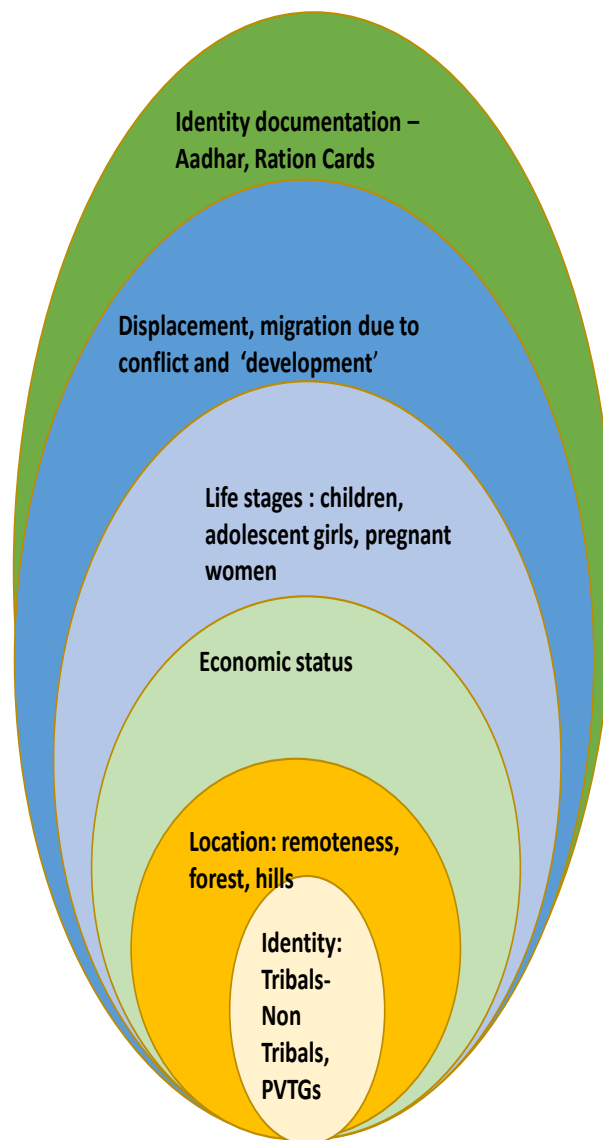
ANM-P, when asked about the spacing/contraception methods available with her, said that she received Copper T supplies only in February, the previous month. Similarly, pills have been given only since the previous month. Before this, neither IUCD nor contraceptive pills had been supplied to her. Condom supply is irregular.

Source: [2: 68].

3.5. Multiple and intersecting vulnerabilities

The various axes of inequity and vulnerability intersected and interacted with each other, resulting in varying experiences among the tribal communities studied. These interactions were also determined by the overall context of the society and study location. This speaks to the 'intersectionality' framework for understanding the 'convergence of different types of exclusion and marginalisation' (Hankivsky, 2014). Certain groups were able to 'leverage' or use their advantage in a particular dimension in order to overcome disadvantages emerging from some other dimension or axes (Sen & Iyer, 2012). In this section, we explore six axes of intersecting vulnerabilities influencing the health status of the tribal communities studied.

Figure 3.7: Findings and analysis of the main intersecting axes that led to inequalities in health



Ethnic identity- Tribal versus non-tribal, Particularly Vulnerable Tribal Groups, Bodos versus Adivasis

In the previous sections, we saw inequities between tribal and non-tribal populations and groups. The marginalisation of PVTGs within the tribal category and the implications of this for their health and well-being have also been discussed. In Chhattisgarh, Jharkhand, and Kerala, the health and other indicators for PVTGs were worse than other tribal communities. Within the same geography, such as district, there were differences between groups belonging to different tribal groups, with specific tribal group identities, geographical location, economic status intersecting. Even among PVTGs, there were differences when it came to health indicators and access to services.

"About 76.85% of the Scheduled tribe families have ration cards.....Non- possession of ration cards reflects the poor socio-economic status of the tribal family. In most cases, the cards are pledged to private money lenders for obtaining loans, or it may be deposited with ration distributors. The community wise data shows that the Paniya community forms the highest number without the ration cards" [3: p.48].

"The Paniya tribal group has a higher prevalence of undernutrition, anaemia, and goitre when compared to other tribal groups in Wayanad district. In Attapady block, the Irulas was found to have a comparatively lower life expectancy than Kurumba and Muduga tribe" [3: p. 24].

"When compared with Chhattisgarh and Jharkhand tribal populations from the NFHS-3 survey, the current malnutrition levels of Baiga and Sabar children are still slightly higher. This shows that with regards to malnutrition, the Baigas and Sabars are currently only about to reach the malnutrition levels of their state tribal counterparts from a decade back". [2: p. 325]

Among the two PVTGs studied in Chhattisgarh and Jharkhand, the Sabars seemed to be worse off on most accounts [2]. Landlessness was more among the Sabars, and the coverage and performance of public programmes for food and work were better among Baigas in Chhattisgarh than among the Sabars in Jharkhand. The malnutrition levels among the Sabar were much higher than the Baigas. Similar differences were also seen in the access to health services, whether access to hospitalisation or primary health care. [2]

"The rate of hospitalisation for Baigas was nearly double that of the Sabars. The difference in hospitalisation between the two communities might reflect the poorer access to services in Sabar areas as compared to the studied Baiga areas" [2: p.326].

The PHRN study also found that multiple dimensions, related to geography, history, economic status, and residence status led to differences between PVTGs and other tribal communities. Health inequities were more pronounced in areas and habitations that were newly formed due to migration or resettlement.

"As observed Nagadabra habitation is particularly bad in terms of access to government services. It probably has to do with the habitation not being very old, and the kabja started happening only 15-20 yrs back. There is no Anganwadi centre, schools or ration shops located in the village. These village-level institutions are located in the Mathpur panchayat which is not only far away but difficult to get through in monsoons making it difficult or impossible for people to access its services especially daily services like a hot cooked meal in AWC or schools." [2: p.93].

In the case of Assam, the Bodos have relatively more power than the Adivasis who are considered as outsiders. The impact of conflict on the Adivasis and the Bodos, though largely similar, were also marked by critical differences in their access to resources to withstand the consequences:

“When militancy followed soon after, non-tribal doctors fled leaving only a few Bodo doctors to manage the health centres. The Bodo doctors who stayed back also did not have it easy in an insecure atmosphere – sandwiched as they were between the militants and the security forces hunting the militants” [1: p.59].

“When the conflict broke out, the ABSU (The All Bodo Student’s Union) pulled in resources like food and cloth from the Bodo villages which were not affected. They also fed the people in the relief camp and this continued till the ration supplies from the government started coming in. Then, the ABSU also negotiated with the government for security and protection of Bodos, right up to the DC (Deputy Commissioner) level. Unlike the Bodo relief camps, the Adivasi relief camps were very disorganised. – Bodo; male; member of Shantipur VCDC[1: p.77].

Geography and topography

In all three studies, geography and location also emerged as a critical axis of inequity. It seems that multiple vulnerabilities converge geographically, resulting in geographical clustering of inequities (Nandi et al., 2018), thereby making geographical inequity both a determinant and a possible result of overall inequity. The findings also seem to point toward a historical process of marginalisation of these areas.

In the study area of *the ant* in Assam, the level of economic development in the villages under Deosri VCDC are worse off than villages under Shantipur VCDC.

“ There are roads and other infrastructure such as schools and health centres in Shantipur. Then, there are also more government schemes implemented there than under Deosri VCDC. A Bodo VCDC member from Shantipur had this explanation to give, “There are forest revenue villages, and then forest encroached villages. Under the Forest Rights Act, families living as encroachers are not entitled to any services. If today some services reach them (Deosri VCDC), it is purely on the ground of humanity (and not an entitlement). Most of the villages under Deosri are encroached villages. Earlier, no development works could be done in these areas, and today, it is the money of BTC and DRDA that is being spent on development in these areas. There are technical difficulties in the implementation of schemes and services in an encroached area” Bodo male; Shantipur VCDC member [1: p.137].

In the PHRN study, geographical inequity was visible from the first visits to the study area. Throughout the study, in all the themes that were studied, both among Baigas and Sabars, this issue kept coming up. It affected their livelihoods, conditions of living, physical access to services, access to service providers to these areas, and so on.

“ In Chhattisgarh, all the thirteen Baiga hamlets in the study had a different story to tell. The differences were a result of factors like geography and accessibility, access to land (rocky or fertile), community distribution, history of the settlement of the Baigas, distance from neighbouring Madhya Pradesh and often a combination of some of these. However, literature

tells us that in the case of Baigas, they may have been forced to flee higher up to the hills due to invasions or under pressure of other tribals or non-tribal (Prasad, 2011). The area where the Sabars live is also the most remote and 'difficult to access' area of Dumaria Block.....The location and topography of the PVTG hamlets were of great significance in determining the community's access to various services" [2: p.334-335].

It was noted in Kerala that a majority of the tribal women lived in highly inaccessible areas inside the forests or the hills, far from emergency obstetric care centres" (HAP, 2017: 25). In Wayanad, as already mentioned, three-fourths of the maternal deaths were reported from the tribal communities, who constitute just 17% of the population [1: p.26].

The issue was not only of distance but topography. Distances that were similar could be very different in terms of the challenges in traversing them. The PVTG hamlets in Kerala had a more challenging topography when compared to other tribal communities.

"Another interesting fact was that geographical access was not only about physical distance. One example is the case of Mele Bhoothayar. Though the distance to the nearest available public transport was 6 km when compared to more than 10 km in the case of the Kurichyad colony, the ordeal of travelling the distance was much greater for the Mele Bhoothayaar inhabitants, because the road was not motorable, and poor access to a vehicle. A bigger problem was the possibility of encounters with wild animals when undergoing such a journey. Hence, when it comes to determining whether geographical access is a constraint and contributes to inequity in availing services, one needs to look beyond just plain distance estimates from point A to B" [2: p.174-175].

Within-ethnic group differences were seen with respect to the extent of their geographical vulnerability and resulting disadvantages. The Baigas who lived in the hills were found to be worse off than the Baigas who lived in the plains [2]. Baigas from the hill tracts had been migrating to the plains as they thought they would get better access to services, better land and assimilate with the other tribal groups [2].

In all three states, forests were a refuge and resource for the many displaced communities. However, with forests came the issue of habitation rights and rights over forests, which also intersected with legal identity, resulting in new struggles.

"In the Baiga villages situated in the hills, the land is extremely infertile and unfit for cultivation. The presence of rocks and rocky terrain make ploughing difficult. This holds even for the revenue and forest patta land in those areas" [2: p.174].

An example of 'upward mobility' is seen below where Baigas gave up both their original location and identity marker in order to assimilate and have a better life.

"Devkuwar Baiga of Devsara does not have a tattoo on her forehead. She said that her mother also did not have one. They had come down from the hills to the plain areas two generations

ago and had stopped doing tattoos as according to her they did not want to look different from the plains people (non-Baigas)" [2: p.160].

"In December, we found that a new group of Baiga families, about 75 households had migrated from the Bihudeeh panchayat post monsoons in 2016 and were living under a tree. The men said that they had moved from Fidi in Bihudeeh as it was an extremely difficult area with no welfare services such as an Anganwadi or a school. So they moved to Badoura from where they were evicted by the administration after which they moved to Nagadabra and were hoping to get land deeds from the administration" [2: p.92].

Depending on where the particular PVTG or tribal family lived, geographical vulnerability resulted in problems in accessing services like schools, anganwadis, health centres and ration shops. It also meant the lack of proper transport facilities and road infrastructure. As a result, there was less access and regularity of health workers and services that were to come from outside the habitation. The monsoon season worsened the situation. The following scenarios are from the Kerala study:

"Difficulty in reaching Anganwadi was the main reason for non-utilisation of supplementary nutrition" [3: p.122].

"The mobile medical unit attached to the nearest PHC did come and conduct medical camps in the colony probably around once a month, but during the rainy season, their jeep could not reach the colony, thus hampering the conduct of camps during that time of year" [3: p.146].

"...there is a program of implementing community kitchens for the tribal communities here. However, less than half of the hamlets could avail the benefits of this program. The program was only implemented in the colonies which had good road access.... The needs of interior tribes were not at all addressed. ... the tribes living in the forests."- Tribal promoter" [3: p.137].

In Chhattisgarh, Baiga families living in some hamlets did not have access to the Anganwadi while those living in other hamlets could. Baiga children may or may not be immunised depending on where they lived, because the health services only reached the more accessible areas:

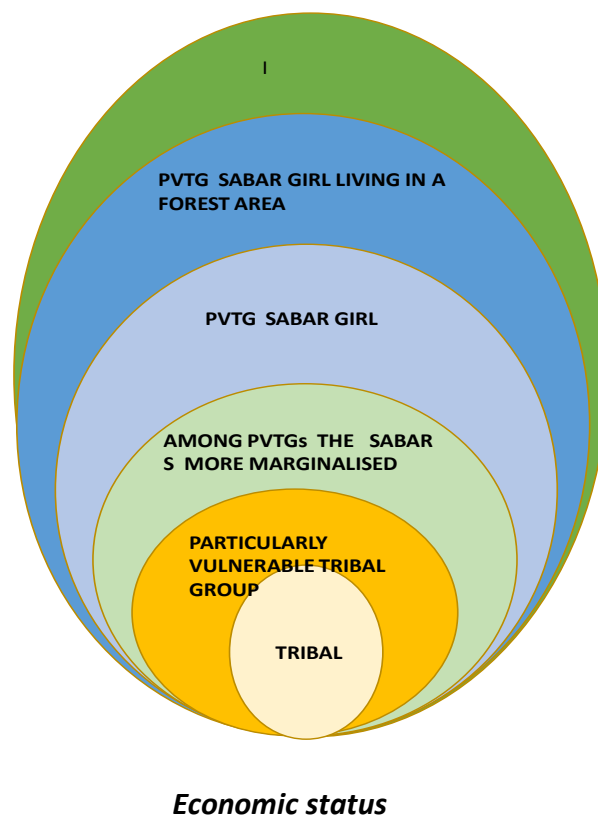
"In Achara, immunisation is mostly done in upar para. The male worker comes to neeche para in 1-2 months. Usually, the mitanin has to take the children and women to the Anganwadi center in upar para for immunisation. The neeche para mitanin says that when a worker comes to neeche para, all people come for immunisation. But very few can go to upar para [one has to climb a steep hill." [2: p.145].

A surveyor in the study from Jharkhand narrated the story of a young girl from Neeche Achara who stayed with her grandparents who are very old. The girl became very ill last year, but they could not get the 108 service till the village, due to bad roads. The girl's condition deteriorated, and she died. On the other hand, in Upar Achara, which is on the main road,

people often went to government facilities and also called the government ambulance to their village [2: p.133].

In the above narrative, we see how the vulnerability of a young orphan girl living with aged grandparents is compounded by their inaccessible location ultimately resulting in her death.

Figure 3.8: The intersection of multiple vulnerabilities resulting in avoidable death of a Sabar girl



Within the vulnerable groups, higher economic status facilitated access to treatment. In Assam where the government health system had collapsed, people with money could afford to get treatment in the private sector. Having money also saved many lives.

"With conflict comes displacement and various losses which affect the daily lives of people. Treatment seeking behaviour of people is also determined by economic factors. If there is enough money, then people do not have to worry about reaching out for treatment" [1: p.132].

"Diseases which broke out amongst the displaced Adivasis in the relief camps affected the Nepalis too. They were hit when a cholera epidemic broke out in the nearby Adivasi relief camp but being relatively well-off, they seemed to have afforded treatment faster in private facilities and hence could save many lives"[1: p.103].

In Kerala, the out-of-pocket expenditure for the non-tribal communities, because of going to the private sector, was more than the tribal communities who mainly went to the government facilities. However, indebtedness due to health expenses was higher among tribals.

“More than 50% of the tribal had to borrow money to meet this expenditure and nearly 40% of those who borrowed were still indebted. Both borrowing and indebtedness were more than that seen in non-tribal communities. Thus though out of pocket expenditure is lower, catastrophic out of pocket expenditure was more among tribal communities” [3: p.175-176].

Gender

The studies found that within the marginalised communities, women and girls were worse off than men in terms of health and other indicators and access to services. The situation existing in the respective study locations affected women and girls more and had a worse impact on them, than on men and boys.

In Attappady, Kerala, the Gender Development Index (GDI) of tribal women is 0.330, which is far behind that for Kerala, indicated the prevalence of greater gender inequality among men and women” [3: p.25].

There were differences between Baiga women and men both in nutritional status and in the prevalence of morbidity. The proportion of adult women with severe thinness was higher than men amongst both Baigas and Sabars. While among Baigas it was only slightly higher than men, among the Sabars, the proportion of women with severe thinness was nearly one and a half times more than men [2: p.331]. More Baiga women reported illness in the 15 days before the survey, and they also had a higher rate of hospitalisation, including for pregnancy. Women were mainly hospitalised for fever and reproductive health issues, including pregnancy, while men were hospitalised for mainly fever and cough with sputum. Among the Sabar, women faced major reproductive health problems, like white discharge and back pain that could be due to infection” [2: p.331].

The dimensions of political marginalisation and geographical vulnerability affected women and girls more than they did men and boys, resulting in a lower educational status. This was seen among the Sabars.

“.....according to Mr. P (schoolteacher), Sabars did not discriminate between girls and boys and send both to school, and as a result, the proportion of girls is equal to that of boys in the primary school. However, there is hardly any girl going to middle or higher school. Those schools are far from the Sabar hamlets and difficult to access”[2: p.297].

Within the context of the conflict in Assam, the study found that women ‘embodied’ vulnerability and suffering.

“Where do women dry their menstrual cloth in a relief camp? The very crowded relief camp situation was a special challenge for menstruating women who used to tie the freshly washed and dripping wet menstrual cloth to their bodies to dry because “where was the place to dry it?” –Adivasi Women; 3 No. Deosri Village; lived in the Deosri Relief Camp for nearly ten years from 1996-2005”[1: p.77].

“What tensions do men face? As long they have food to eat and can sleep with their wives – what tension will they have? But a woman has to manage everything – manage the money, household needs... food. We worry that there is no money in the house and worry where to get the money from...”- Adivasi Woman; 3 No. Deosri Village; lived in the Deosri Relief Camp for over ten years from 1996-2005 [1: p.89].

In the absence of any coping mechanisms, women had to additionally bear the brunt of men’s way of coping with the stress emerging out of the conflict situation. Women talk about the rise of alcoholism and wife-beating after the conflict. The research team observed in the field that drinking and disharmony were much more among still displaced villages compared to non-displaced or returned villages[1: p.90].

Figure 3.9 below shows the ecology of the vulnerability of a couple who were affected by the ethnic conflict of 2014. Mohan and Rupsi, who already lived in a disadvantaged situation before the conflict, were much more fragile after the conflict. The vulnerability impacted their bodies, the choices they can or cannot make, their health and well-being as a family. Before the conflict, their two sons were born in the government hospital which meant they had the money and agency to decide for what they saw as safer childbirth practices. It was after the conflict that their two young sons died because they could not afford good treatment. It was after the conflict that Rupsi had to send her two young daughters away to work as maidservants. It is ironic that by sending her second daughter, a 13-year-old girl to work meant money for safe childbirth for the mother but the exposure of the daughter to risks of abuse and trafficking.

Figure 3.9: Post-Conflict Vulnerability Map of Bodo Household following the 2014 Conflict



Source: [1: p. 81]

The effect on women of gender and other intersecting axes:

Not all women were affected in the same way as compared to men. The extent of women’s vulnerability increased for those who were poorer, less educated, younger, located in geographically difficult areas, and so on. Differences were seen in health and social indicators and their access to health and other services.

Differences were seen between tribal and non-tribal women. This aspect was studied more in the Kerala study, where the educational and economic status of the tribal mothers in the study was much lower than the non-tribal mothers living in the same area [3: p.171]. *Up to a fifth* (15 to 20%) of the tribal pregnant women do not even undergo a single antenatal check-up. Only 67% of tribal mothers had schooling above eight years (above primary school) while the same was seen in 90% of non-tribal mothers” [3: p.23].

Within tribal groups, the situation of PVTG women was worse. In Chhattisgarh, the ‘ban’ on sterilisation for PVTGs made the Baiga women more vulnerable than non-PVTG tribal women. Even within Baigas, access to permanent contraceptive services depended on their identity.

Baiga women traditionally have a distinct tattoo on their forehead. Most women have the tattoo, but the practice is reducing. Because of the tattoo, women are recognised as Baigas everywhere. If they go to a facility in Chhattisgarh for sterilisation, they are immediately identified as Baigas and sent away. In Gangpur the PHRN research team spoke to a Baiga woman. She had four children. She had not got sterilisation done. When asked if she wanted

to get it done, she said that she did want it but that here Baigas are not allowed to get it done and so she will have to go to MP. "If we do not have godna we can get it done in Chhattisgarh. Like me, I have godna, then how will I do?" Her sister-in-law underwent sterilisation three years ago in MP. She went straight to MP. Few women got together and hired a taxi and went. They stayed the night there and came back the next day. In Devsara, many women did not have the forehead tattoo. When asked if they faced any problem in sterilisation they [hesitatingly] said that they do not face any problem....(Health staff) pehchante nahi, Matha mei chinh rehte toh pehchante" (health staff will only recognise if the woman has a tattoo on her forehead. Otherwise, they will not recognise a Baiga]." Women Group Discussion, Devsara village [2: p153-154].

In one instance, a Baiga woman could access the service within the state as her relative was herself a health worker.

The Kerala study found that tribal women with higher education were better able to access ANC services [3: p.101]. In Assam, "*Mansi is considered relatively well-off as she has a small business and good income apart from having a small family. Hence, she first went for specialised medical treatment. For most of the poor families in the study area, using the services of pharmacists or local healers is the only option they can afford*" [1: p.125].

Migration and displacement whether due to conflict or other reasons, made the situation worse for women, though economic status was found to be a leveraging point for accessing health services even in such situations.

Box 2 overleaf describes the story of Rashmi from Assam, whose life is affected in specific ways by conflict and displacement, because she is a woman. We thus see that in Rashmi's life, daily survival becomes a big challenge after a conflict, especially if the household has been forcibly displaced. Women such as Rashmi bear a huge burden of suffering" [1: p.89].

Life History of Rashmi Narzary

Rashmi Narzary, a Bodo woman, is originally from Nijlaguri village and presently living in North Simlaguri which is a distance of 12 km from the main market and the government dispensary of Shantipur. She presently has three daughters and one son. The Bodo-Adivasi conflict of 2014 saw her life turning upside down.

Pregnancy

In all three studies, pregnancy and motherhood emerged as a critical intersecting axis of vulnerability. Specific vulnerabilities related to number of children, access to ANC, safe

delivery and other services like contraceptives, access to nutrition, issues in childcare, maternal mortality and child and infant mortality emerged from all three states interacting with the overall context of discrimination, poverty and geographical inequity (all three states) and conflict (Assam).

High rates of pregnancy along with under-nutrition among women had implications for their health and the health of their children. In Kerala, the incidence of low birth weight among tribal mothers was significantly higher in Idukki, Palakkad and Wayanad districts when compared to Kannur and Thiruvananthapuram. The incidence of low birth weight was more among multigravida tribal mothers [3: p.104].

Among the Baiga and Sabar women, difficulties of terrain made a huge difference to access to supplementary nutrition and emergency obstetric care. The example of Upar and Neeche Achara have been given elsewhere. In obstetric emergencies, too, while women in Upar Achara stood a good chance of accessing an ambulance to reach a health facility for delivery or obstetric complications, in neeche Achara, there was no way to take a woman in labour to the hospitals. To come to a proper road, they would either have to climb a steep hill or traverse through undulating terrain in a motorbike [2: p.149].

Conflict seemed to exacerbate these conditions of vulnerability among women who were pregnant or in the reproductive age group.

"I was pregnant with my third child and about to deliver any moment. The flood water washed away our grains and some small belongings and our house were about to be washed away. A relative seeing my condition asked us to shift to a safer place. But I was reluctant. Where to go? Also, I was scared there would be elephants in the night. We waited but the flood waters kept rising and the next day my husband moved my elder daughter and me...to a house abandoned by the Adivasis from the 1996 conflict. We called our neighbours to help us repair the house which was damaged but still standing..... That very night, I delivered my third child, a girl. The Bodo-Santhal conflict had already started again and a day or two later, we had to flee to Tukrajhar Relief Camp. The umbilical cord of the newborn baby had not yet fallen. I carried her tied on my back with a gamcha (woven cloth) and walked all the way to Tukrajhar Relief Camp along with the other villagers"- Bodo woman [1: p.68].

Different Vulnerabilities across different Life Stages

Children

From all three studies, children emerged as an extremely vulnerable group. Whatever was happening around them, to their community, family or parents seemed to have the worse consequences for them. High rates of malnutrition and child and infant deaths were reported from all sites.

“Within six months of their return to their forest village from the relief camp in May 2016, nine young children and two women (one of them is Sarna in Figure 3.5) of Koraibari Village died in a ‘malaria epidemic’” [1: p.131].

“Moreover, there seemed to be a high number of deaths among infants and children. 62% of Baiga women and 56% of Sabar women had experienced the loss of foetus or child at least once at some stage of pregnancy or later” [2: p.328].

“There were several infant deaths reported from tribal settlements in Attapady, Palakkad district in 2013” [3: p.75].

In Assam, the situation of conflict led to many more health issues, including mental health issues for children.

“Children face malnutrition, ill-health, deaths, loss of education and loss of development apart from mental trauma, fear and insecurity” [1: p. 114].

“Growing up as a young boy in the camp was tough. I have had some very bad experiences. In the camp, the number in my family increased, and my younger brother and three sisters were born there. Among them, one died. I was the second in the family and food was our biggest problem. We did not see such aakal (drought). There was a shortage of food, water, cloth, and shelter. We all cried out of hunger. One day it was raining, and we were all taking shelter under one umbrella. We were hungry. My mother was pained so much that she went around begging for a bit of rice”.....He regrets that the relief camp environment destroyed the childhood of children. There was no space for games. The education environment was destroyed. Children were not taken care of by their parents, “children were like sheep, gathered in one place. They were not cleaned and stayed without clothes. No good food for the children and the health of the children was not good at all” [1: p. 99].

Adolescent girls

In Assam, adolescent girls were amongst the most vulnerable and most affected by the conflict. The study found that young adolescent girls, whether Bodos or Adivasis, became extremely vulnerable after conflict episodes as they dropped out of school and were sent out to work, increasing the risks of getting abused or trafficked [1: p. 93]. In case after case, young girls were seen coming to the rescue of their impoverished households displaced after a conflict. In the absence of external financial and other supports, it is indeed ironic that in poor households, vulnerabilities of the families were reduced at the cost of increasing the vulnerability of its adolescent girls [1: p.95]. For example, it was after the conflict that Rupsi

had to send her two young daughters away to work as maidservants. It is ironic that by sending her second daughter, a 13 year- old girl to work meant money for safe childbirth for the mother but the exposure of the daughter to risks of abuse and trafficking [1: p.81].

In Chhattisgarh among Baigas, early marriage and childbirth affected the health of adolescent girls. The fact that adolescent Sabar girls had less access to education has already been mentioned above. The local ANM talked about how it was not possible for her to work with adolescent girls because they married early: *“Ladkiya nahi mahilaayein ho jati hai”* ANM-C, Chhiadand Village, Feb 2017 [2: p.142].

Identity proof/Aadhaar

The mandatory requirement by the government of ID cards of different nature for accessing public services led to differential access. Possession of cards like ration card and Aadhaar card as required by the government facilitated access. People who had not been able to get these cards were denied welfare services, even though they were eligible. In many of these cases, recent policies mandating requirement of such IDs to access services resulted in previously available welfare being suddenly stopped. It was seen that the most vulnerable were also those unable to get these identity proofs and therefore excluded from social welfare and services like subsidised grain, despite being the ones who needed these services the most.

For instance, Pardesi Baiga of Chhattisgarh, a person with a disability, could not get his Aadhaar made and therefore was denied ration for many months. His hand was deformed. He lived with his wife Mangli Baiga and three children in Nagadabra. Pardesi Baiga’s family has not been getting ration since June 2016 as his Aadhar card could not be made because of his deformed hand. Since they are not getting PDS from ration shop, they have been buying rice from the open market at Rs20 per kilo. He says that they have to borrow money on credit if they do not have money. He takes karza (loan) up to Rs 200 at one time which has to be returned in 15-30 days. He borrows rice also at times. His wife Mangli said that at times they had to go hungry for two days [2: p. 199].

A Sabar man in Burrumtola had got his ration card cancelled said that a year ago new ration cards were made in Jharkhand, and since then his family was not getting a ration. The process he spoke about was most probably the making of cards under NFSA in order for which one also had to provide the Aadhaar number [2: p.309].

A similar situation existed in Kerala, where the ration card was a prerequisite for accessing social security benefits such as state programs for child development, maternal and child nutrition, farm subsidies, drinking water and sanitation. A person without a ration card had no identity; he or she would not be eligible for any of the social security schemes or benefits provided by the government” [3: p.168].

The absence of an identity proof meant more problems for those displaced by the conflict in Assam.

"Many of our villagers have migrated to different places for work, but even over there, they face discrimination by the employers who often suspect them to be militants as they have no identity proof or other papers"[1: p. 80].

REFERENCES

1. The Ant (The Action Northeast Trust, Assam). 2017. *Health Inequities in a Conflict Area – An In-Depth Qualitative Study in Assam*. Closing the Gap: Health Equity Research Initiative in India, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum.
2. PHRN (Public Health Resource Network, New Delhi). 2017. *Exploring Health Inequities amongst Particularly Vulnerable Tribal Groups: Case Studies of Baiga and Sabar in Chhattisgarh and Jharkhand States of India*. Closing the Gap: Health Equity Research Initiative in India, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum.
3. HAP (Health Action by People). 2017. *Exploring Health Inequity by Assessing the Nature of Healthcare Utilisation and its Correlates among the Tribal Population of Kerala*. Closing the Gap: Health Equity Research Initiative in India, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum.

Chapter 4

Discussion and recommendations

This report brought together the findings from three different studies on health inequities and the health of the tribal communities in India. In this chapter, we highlight the many ways in which the studies have added to the body of knowledge on the health of tribal communities in India, as well as to ways in which to conceptualise and study health inequities.

We have organised this chapter into five sections. The first section summarises what we have learnt about the manifestations of health inequities among tribal communities and discusses concepts of health and health inequities that emerge from the studies. In the second section, we attempt to delineate the pathways through which health inequities experienced by tribal communities have come about and the reasons why they have persisted. Section three presents some of our learning from these studies about useful conceptual frameworks and methodological approaches for an inquiry into the pathways to health inequities affecting vulnerable population groups. In Section four, we present recommendations for addressing health inequities experienced by the tribal communities and reflect on the kind of future research needed, to address health inequities experienced by tribal communities in India and their underlying determinants and forces.

4.1. 'Health inequities' and their manifestations

As has been observed by most studies on the health of tribal communities in India, our studies also found that most of the health-status indicators were worse for the tribal communities as compared to the others. Infants and children from tribal communities experienced much higher rates of mortality as compared to their non-tribal counterparts. Women tended to run a high risk of maternal death. Many infections such as diarrhoea, malaria, tuberculosis, pneumonia, were more prevalent among the tribal communities. Also, more than two to three times as many adults and children from tribal communities were under-nourished as compared to the general population.

With respect to utilisation of health services, again, the tribal communities experience inadequate availability of government health services and poor quality of care, though the situation seems to have improved marginally in some of the areas studied. There is an overall dependence on unqualified health service providers in Assam, Chhattisgarh and Jharkhand, leading to high costs of available care.

Beyond homogeneity

Beneath the well-known and oft-repeated story-line of poor health of tribal communities, lies a more nuanced reality of varied experiences across different tribal communities depending on history and context; and within-group differentials among the same community.

For example, the Bodos and Adivasis in Assam are both, what we would call tribal communities. However, there is a major power differential between these groups, manifested in the differences in their health status. The Adivasis with high poverty levels and poor

education suffer the most ill-health and ill-being. In Kerala, there are many differences between the different tribal communities of Kurumbas and the Kattunaikas who live in forests vis-à-vis the Paniyas who are considered to be the most backward and the Kurichyas who are more advanced. In Jharkhand and Chattisgarh, there is a hierarchy between the Santhals (a tribal group in Jharkhand) and Sabars. The former employ them as labourers. In contrast, the Baigas, though marginalised themselves, consider other tribes inferior.

Even within the same tribal community, there were significant differences in experiences of ill-health and access to health care, for example, by geographical location and topography, economic status, gender and by age/life-stages.

Availability of formal health care was much better for tribal communities located close to motorable roads; the Baigas who lived in the hills were worse off than the Baigas who lived in the plains; and among the different states, the scenario in Kerala was much better as compared to the other sites; and within Kerala there were variations across districts across and within tribal communities.

Women and adolescent girls experienced greater vulnerabilities. Women and girls had a poorer nutritional status than men and boys among the Baigas and Sabars, and greater prevalence of morbidity. Adolescent girls were at risk of early marriage and childbirth at a high cost to their well-being. Being a woman or adolescent girl in a post-conflict-setting exposed them to multiple and interacting vulnerabilities such as having to deliver a child amidst the unhygienic surrounding of a relief camp, even while experiencing chronic hunger and the trauma of displacement. Infant losses were common, adding further to their pain and suffering.

The varied experiences of tribal communities across four sites call to question the routine practice in large-scale surveys, of treating 'Scheduled Tribes' as a single, homogenous category across all states of India (not to mention clubbing SC/ST together as one category). Further, such a practice renders invisible communities such as the *Adivasis* of Assam who are not classified as Scheduled Tribes in that state.

Defining health beyond health care and morbidity/mortality status

Our studies forcefully bring home the inadequacy of commonly used health indicators such as nutritional status, morbidity, and mortality to describe the multiple dimensions of lack of well-being experienced by the tribal communities. The everyday violence of loss of livelihoods, displacement, insecurity, poverty, and hunger, not to mention the overt violence of ethnic conflicts, and the consequences of these to people's wellbeing can hardly be captured in terms of disease and death alone.

The three individual research reports [3-5] are strewn with vignettes of untold suffering as a normal part of existence as a person from a tribal community, and of pervasive "ill-being." These include, for example, conversations with Sabar women which reveal that their daily

meal consists only of rice, and that, if they have the money and if the PDS system gives it to them; that there were many days when all of them, including children, barely ate one meal a day. Nothing can be more ironic than to learn that among people living with such chronic hunger and near-starvation, some had been denied rice from the PDS, because of an administrative decision to withhold rations for households who did not build toilets.

Another example is the situation of an Adivasi mother who had to flee with her small baby and three other children during an ethnic conflict; who not only lost all her possessions and her husband, but also her new-born because of the poor conditions in the relief camp; is now resettled in a new place and trying to eke out a livelihood for herself and her surviving children. Life was precarious, and if she did not work even for a day, the children would go hungry.

Yet another story that stays with the reader is of having to contend with elephants and other wild animals, at risk of having their properties destroyed and suffering physical injury, and cut off from health care services because of wild animals.

Humiliation and exclusion are recounted as a part of their every-day experience, more so for those from the PVTG groups. So was denial of access to their traditional food from the forest, and routine displacement from their habitations. To make matters worse, it was as if their suffering was not worthy of notice, as if they were not fellow human-beings at all.

There is a need to evolve concepts and definitions that better reflect the dire situation of the tribal communities in the country. The concept of '*social suffering*' seems more appropriate than 'ill-health' for capturing what the tribal communities experience on an every-day basis. The term '*social suffering*' has been used with slightly different connotations in the works of different sociologists, social-psychologists, and anthropologists. Social suffering, in the work of Bourdieu et al (1999), refers to the cumulative miseries of everyday life for those 'excluded' from the fruits of economic development under neoliberal capitalism – the humiliations of the unemployed, the deprivation faced by those living in poor neighbourhoods, the struggles of those who earn little despite working for many exhausting hours [1]. The use of the term (social suffering) "*aims to provoke us into a critical questioning of the cultural and political processes whereby 'we' are acclimatised to regard the suffering of 'others' as a 'normal' or 'necessary' condition of social life*" [1: p. 1-2].

It may also be useful to employ a comprehensive conceptualisation of health as constituted of not only the physical and the psychological/emotional but also the relational, which is in fact in line with WHO's definition of health as physical, mental and social well-being. The failure to achieve any of these may be defined as "ill-being." This would encompass experiences of physical and psychological ill-health, and also "*social ill-being,*" which is "*...the experience and feeling of being isolated, left out, looked down upon, alienated, pushed aside and ignored by the mainstream socio-cultural and political processes* [2: p. 133]."

Besides social suffering and ill-being as described above, the tribal communities' holistic view of health as a balanced relationship between mind, body, and spirit (and the absence of such a balance as ill-health or ill-being) may constitute useful building blocks in the endeavour of finding an alternative concept to 'ill-health'.

Health inequities as more than 'gaps.'

The well-known and widely accepted definition of inequities in health is about differences or disparities that are unfair and avoidable. Our studies bring home the need to expand this definition, by bringing to light facets of health inequities that are not 'gaps.'

In Kerala, for example, the government's maternal health services cover tribal and non-tribal women almost equally. There is not a significant difference in proportion delivering in institutions. And yet, the experience of accessing care is far from equal. Seeking antenatal care comes at a high financial and time-cost to tribal women, who have to travel long distances and often borrow money to seek care. Thus, while data on 'utilisation of antenatal care' or 'proportion of institutional deliveries' show no gaps, the experiences and human costs involved are unequal [5].

In a poignant story from Assam shared in the previous section, a mother had to send her teenage daughter away to work, to be able to afford institutional delivery. The unimaginable human cost underlying this case of a successful institutional delivery challenges us to look beyond disparities and gaps when trying to understand the extent of health inequities, and factor-in lived experiences and human costs [3].

There is yet another facet to health inequities – that of dignity and recognition. Nancy Fraser (2003) talks about “two-dimensionally subordinated groups” – subordinated in terms of distribution of material resources as well as in terms of non-material aspects such as recognition, participation, and dignity [6]. Such a description fits the tribal communities in our studies. It may be argued that the experience of the communities with the health care system could be the main source of health inequity. For instance, members from Baiga community in Chhattisgarh repeatedly mentioned that their encounter with government health services was humiliating. The Government staff admonished them to bathe regularly and pay attention to cleanliness, not eat stale food, not use “herbs and grass’ or traditional medicine and come to the PHC. Such humiliating treatment and abusive words by the health staff renders the community members into an “othered,” stigmatised group, and seriously devalues the identity of the community.

4.2. Pathways to health inequities

Based on the three studies and on the literature -review carried out to understand the history and current context of the tribal communities studied, we attempt here to delineate the

pathways through which health inequities experienced by the tribal communities have come about and have persisted.

Against the historical backdrop of colonial exploitation, many interacting and mutually-reinforcing forces appear to trap the tribal communities within an ecosystem of marginalisation, rendering them vulnerable to health risks and compromised well-being. Their vulnerable health situation, mediated by an unresponsive and insensitive health care system, results in poor access to timely and high-quality health care. These forces shape the the 'ill-being' of tribal communities. State policies ostensibly aimed at redressing the health inequities have taken a 'victim-blaming' stance and have responded with high-handed policies that would act upon the tribal communities with or without their consent, "for their own good." (Figure 4.1)

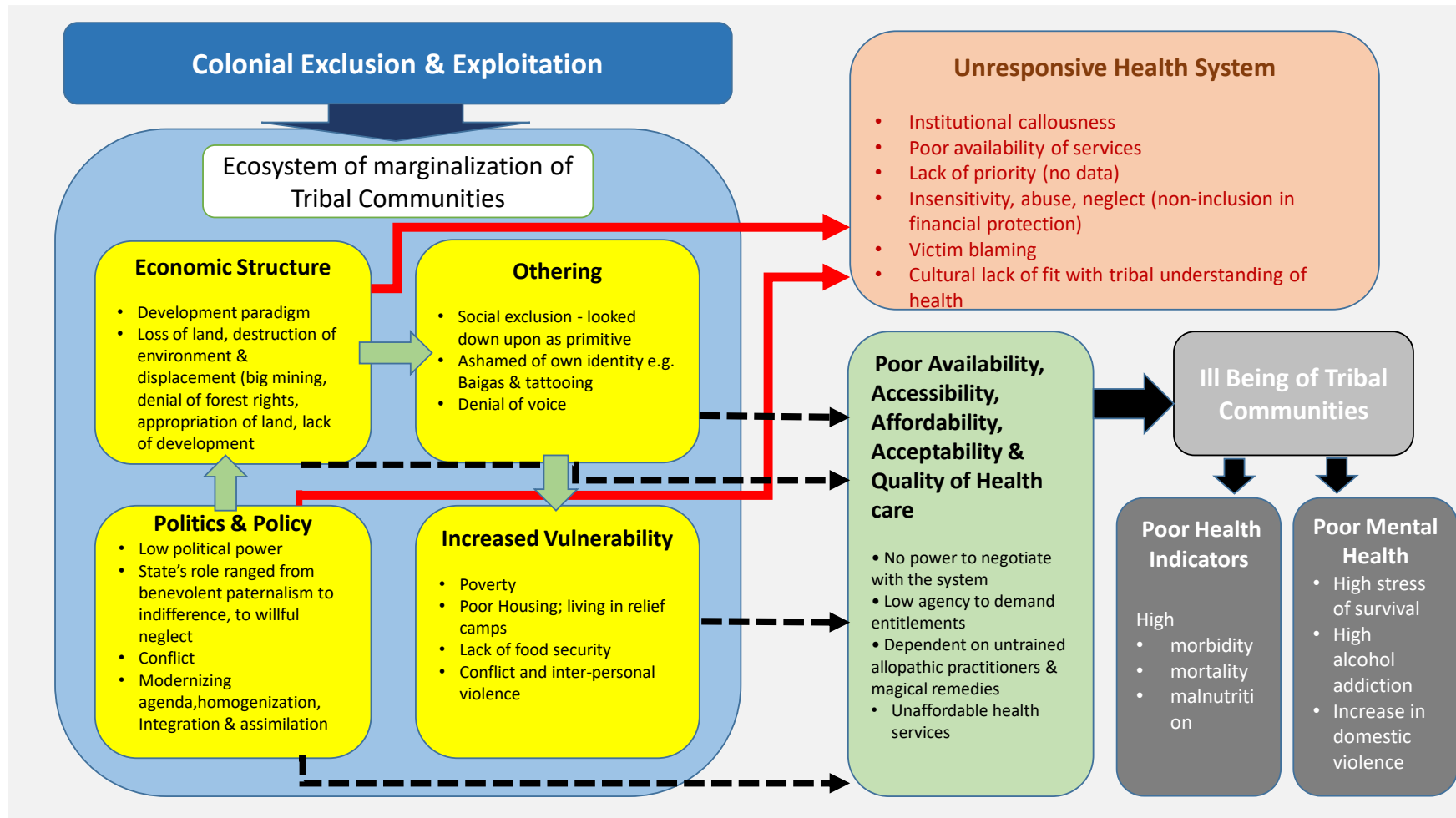
The ecosystem of marginalisation

We identify four major contributors to the eco-system of marginalisation of tribal communities, resulting in their high vulnerability to health risks:

- i) Historical marginalisation during the colonial period (as the backdrop)
- ii) Post-independence policies and politics
- iii) The state's trajectory of economic development
- iv) Social exclusion and 'othering' of tribal communities

Most of these processes have been discussed at some length in Chapter one and are being reiterated here.

Figure 4.1: Pathways to ill-being among tribal communities in the study sites



Historical marginalisation

As a result of colonial policies, tribal communities were dispossessed of their communal holdings and became slaves working in their own lands. The British treated the tribal populations as different from the rest of the population, segregated and isolated tribal populations and created special administrative processes. The tribal communities lived under special laws, ones that were more in line with the tribal system of governance, in scheduled areas. The forests with which the lives of tribal communities were intimately interlinked, were destroyed for the construction of railways and the extraction of minerals. At the same time, no special efforts were made to support their lives and livelihoods.

Post-independence politics and economic development policies

Despite the commitment to affirmative action in favour of tribal communities, post-independence political and economic policies have further marginalised them. The role of the State has ranged from benevolent paternalism to indifference, to willful neglect and to an active perpetuation of marginalisation of tribal populations. Most of the colonial policies related to state-control over natural resources continued till recently. The Land Acquisition Act of 1894 was in force until 2013, and it enabled the government to acquire very large tracts of lands inhabited by tribal communities for its modernisation project involving developing public infrastructure such as roads, railways, constructing dams for hydro-electric projects and extracting minerals. Tribal communities constitute a disproportionately large segment of those displaced for 'development,' and only a small fraction benefitted from resettlement and compensation policies. Having lived in isolation for more than a century, tribal communities found it difficult to negotiate mainstream society and often found themselves cheated out of their land and other possessions, and dependent on wage labour for survival.

The situation of tribal communities in the study sites are varied manifestations of this overall scenario. For example, the Baiga tell stories of clearing and cultivating land only to be thrown out by the Gonds and pushed into infertile and rocky areas on the hills. The study of Baiga and Sabar populations found that few of them owned any land and the land they owned was of poor quality and could barely raise enough food crops to last through a few months. The availability of NTFP for sale was shrinking, and agricultural wage labour in others' farms and migration were the survival strategies. During the survey in Chhattisgarh, Baiga households recounted stories of recent (2016) displacement for expansion of the Kanha tiger reserve, and some were living in makeshift shacks under trees. While the survey was ongoing, another instance of displacement of 75 Baiga families was observed, caused by the expansion of mining areas on the one side and the Tiger Reserve on the other [4].

The Assam study provides insight into how ethnic differences and the inability to manage these has led to violent conflicts. The historical marginalisation of the indigenous Bodo tribals vis-à-vis the dominant Assamese Hindus led to the Bodo uprisings of the late 1980s and early 1990s, at times violently, to demand their rights. As the struggle for resources continues, ethnic conflicts between Bodos and the more marginalised Adivasis, and the Bengali Muslims

have become a regular feature, rendering precarious the lives and livelihoods of the tribal communities [3].

The national objective to build up an industrial infrastructure for imminent development has been given far more priority than the welfare of the tribes. The position adopted by the State, notwithstanding the constitutional provisions, has been one of assimilation into the larger Indian society, rather than protection and promotion of the distinct language and culture of the tribes. This reveals the blasé attitude of the government towards tribal communities and their interests.

'Othering' of tribal communities

The casting of tribal communities as “primitive” and “under-developed” is a consequence of state-policies as well as the trajectory of economic development adopted by the post-independence Indian state, which sought to “bring development” to the tribal communities. Our studies show that there is stereotyping, discrimination, humiliation and stigma inflicted on tribal communities by mainstream society and the representatives of the State. The Baigas with a distinct tattoo on their foreheads are literally ‘marked’ for discrimination. The non-Baiga spoke of Baiga as people in the jungle, living like animals. According to a Gond woman, “*the Baiga lived like Bhalu-Bandar* (Bears and monkeys) and did not deserve any attention. Others talked about the Baiga being dirty, but that they had improved over the years [4:74]. The Kerala study also talks about how historical marginalisation of the various tribes – particularly mentioning how the British alienated the tribes in Kerala which has led them being stigmatised and discriminated till date, even by health care providers [5: p.134].

New forms of social exclusion have resulted from the requirements for Identity proofs such as Aadhar, without which PDS rations, MNREGA, and many social welfare schemes cannot be accessed any longer. It is the most vulnerable among tribal communities that bear the brunt of such thoughtless administrative decisions [3-5].

This process of dispossession and devaluation of tribal communities has not remained unchallenged, as is evidenced by conflicts and flare-ups that occur from time to time. However, wherever their populations are too small to matter as a vote bank, their demands have remained ignored.

Increased vulnerability to health risks and ill-being

Chapter three discussed the remote, difficult and conflict-ridden areas in which the tribal communities lived and their particularly arduous conditions of life. Loss of their land and resources has resulted in chronic hunger and under-nutrition. The shrinking of forests and loss of livelihoods has also resulted in displacement – either forced or voluntary, in search of livelihoods, has caused considerable mental trauma.

Heightened vulnerabilities make even common infections into major illness events that end as health catastrophes for the individuals and their families. To further complicate matters,

their continued interaction with the outside world has exposed them to new diseases that were once absent in their society. In the study of Baiga and Sabar communities, people talk about 'alien' diseases, and they differentiate '*Sarkari Bimaari*' (government diseases) as those which cannot be treated by *jadi booti* (traditional remedies) and need to be treated in government health centres. Among these, they include diarrhoea, malaria and cholera outbreaks [4: p. 48].

Tuberculosis (TB) is another disease which is seen to be on the rise among tribal communities in all three studies. In Assam, the perception among the Adivasis was that poverty, food insecurity, loss of nutrition and shelter following forced displacement was the cause of this 'new' disease called TB. They also saw an association between the occurrence of disease and the lives of families forcibly displaced in the 1996 and subsequent ethnic conflicts. The vulnerability maps based on life-histories of conflict-affected families in Assam shows how deep, complex and inter-related the risk factors to ill-health are [3: p. 54].

The Assam study talks about 'indirect' mortality (i.e., deaths due to the causes other than the actual violence) being much higher. Deaths from fever, malaria, diarrhoea, respiratory infections after conflict form a 'new disease ecology' that people did not have earlier. The physical, as well as psycho-social conditions in relief camps, had made these into high-risk settings for illness and premature death [3].

The role of the public health system: marginalisation by design?

The public health system, mandated with providing universal access to health care, has the possibility of mitigating health inequities resulting from a disproportionate burden of health risks and vulnerabilities borne by the tribal communities. Unfortunately, this possibility has not been translated into reality. On the contrary, all evidence from the studies indicates that the public health system may be actively contributing to the exacerbation of health inequities.

The public services provided by the government have largely followed a top-down approach, one that does little to consider the specific circumstances and needs of the community they intend to serve. For example, the population norms for primary health centres and health sub-centres in tribal areas are 20,000 and 3000 respectively, as compared to 30,000 and 5000 for 'normal' areas. Given the scattered nature of tribal habitations with very few households in each settlement, it would be close to impossible for an ANM running a health sub-centre to be able to visit all the habitations. It is not accidental that the coverage by immunisation and antenatal care services is much lower among the Baiga and Sabar communities studied, as compared to the general population [4].

Deploying community-based frontline workers is one way in which the access barrier is partially addressed, at least for first-level care. Here again, our studies find that the ASHA worker is rarely someone who belongs to the local community. This defeats the purpose of an ASHA worker not only from the perspective of service coverage but also from the

perspective of being able to better respond to community needs and being more attuned to the local culture, increasing the tribal communities' trust in the public health system.

The *Rashtriya Swasthya Bima Yojana* (RSBY) in Assam, Chhattisgarh, and Jharkhand, and the Comprehensive Health Insurance Scheme (CHIS) in Kerala are meant to provide financial protection from catastrophic health expenditures to low-income households. In all the study sites, coverage by these Publicly Financed Health Insurance Schemes was low [3-5]. Obviously, these schemes have not been designed to go the extra mile to tackle the challenges of implementation amongst tribal communities which have a different language, culture, and geographical context, with due respect to their rights as patients.

The social distance between the tribal communities and the public health system, a result of their being stigmatised and stereotyped, poses another major barrier to health care access. Many instances of humiliating-behaviour by health care workers were shared during the studies by members of tribal communities. In the Chhattisgarh and Kerala studies, such behaviour was mentioned especially in the case of referral to higher level facilities [4-5]. The experience of negotiating the health system is also about the extent to which a community's culture and language get represented within the health system. The greater the perceived fit, the greater will be the sense of belonging. However, for the 'tribal' communities the health system continues to be an alien space in terms of culture and language. Greater representation of tribal communities among health care providers is crucial for overcoming this social distance.

There is also limited vital information on health needs and differentials therein, leading to an inability among the policymakers and other stakeholders to make sound decisions in the interest of local tribal communities. This lack of robust data itself indicates the low priority accorded to the health concerns of tribal communities.

Another example of being blind to the specific needs of different tribal communities is the absence of focused and sustained efforts to rebuild the public health system post-conflicts and to equip it to become better prepared for and more resilient to conflict. From the Assam study, it is evident that relief-camps become a major mortality-risk for infants and young children, while post-conflict settlements are devoid of basic needs for survival, leave alone health care facilities [3].

Paradoxically, the apathy and negligence are replaced by overzealous paternalism to "protect" the tribal communities when it comes to the dwindling populations of the PVTG communities in Chhattisgarh. The policy prohibiting Baiga women from undergoing female sterilisation by the State [4] is an entirely misguided approach, which compromises the agency and the right to self-determination of Baiga women. Another such example of a misguided 'superiority of judgement' is the prohibition by government health institutions of Baiga and Sabar women delivering their babies in their traditional squatting position, even though there is much medical evidence vouching for its safety and benefits [4]. Again, not

only does this suggest the assumption by the State that it 'knows better,' but also exemplifies the cultural insensitivity that is typical of the relationship between the health system and tribal communities in general.

These observations capture the lack of fit between the public health care system and the health care needs of the most marginalised tribal communities. There is a deficit of 'inclusion,' 'participation,' 'representation' and 'ownership' enjoyed by members of tribal communities, vis-a-vis the public health system. The lack of power and voice of the communities, results in a lack of public accountability and therefore in the erosion of quality of services. This directly leads to inequity in quantifiable aspects of health such as non-availability of personnel, services, infrastructure, waiting time and so on. More importantly, it destroys the trust of the tribal communities in the public health system, encouraging them to opt out of the system, delaying healthcare seeking or availing care from unqualified persons whom they can afford.

The findings about poor geographic, financial and social access to health care among tribal communities are entirely consistent with what has been known for several decades: The persistence of this scenario, so many decades after an independent country came into being, despite such advances in economic strength and technical capacity, points, at best, to indifference or apathy to the health of tribal communities, and at worst, deliberate negligence and intent to perpetuate marginalisation.

All of the factors and forces described above have dynamically interacted to perpetuate health inequities, in a cumulative rather than additive manner. The pathways explored here are only indicative and not comprehensive, and there are many other issues such as the psychosocial aspects of identity and exploitation that need further exploration.

4.4. Reflections on the conceptual framework and the research process

Conceptual framework

All three studies had been informed by the conceptual framework of the WHO Commission on the Social Determinants of Health (CSDH framework) [7] to the extent that health was seen as determined by the many social, economic, political and cultural factors operating at multiple levels. The health system was also acknowledged as being a major intermediary determinant of health. However, our "common stand-point" sought to go beyond the CSDH framework for a number of reasons.

One, the application of the CSDH framework has happened in ways that reduce the problem of social inequality to a problem of distribution of resources. Two, exploitative processes such as racism, sexism, and classism are represented as 'identifiers' of the social strata to which individuals and communities belong. Thus, one's race, gender or income class is responsible for the material and social deprivation one experiences, which influences one's susceptibility to ill health, and not racism or sexism. Three, the socio-historical perspective as to how a specific health situation came to be, is lost in the static representation of "factors"

determining "health." In fact, the active creation of conditions of ill health by the burgeoning neoliberal globalisation, including fracture of social cohesion and conflict has been rarely identified explicitly as important determinants upon. The CSDH framework, while being a valuable starting point, was found to be inadequate to explain the underlying causal factors and pathways of health inequities. We contend that not only is there need to identify specific social determinants that better reflect the realities of the most vulnerable populations, as proposed by Eshetu & Woldeesenbet (2011) [8], but in addition, that there is a need to go beyond the framework.

Two ways in which we seek to expand on the social determinants of health was to explicitly factor-in the historical background to the current reality and to adopt an 'intersectionality-informed' framework which considers the consequences of intersecting axes of oppression and intersecting vulnerabilities. Thus, a conscious effort has been made to look at the multiple layers of vulnerabilities– by location, economic situation, ethnicity, gender, age, and life-stage. Some of these revolve around axes of power, while others emanate from the interaction of the biological with the social – as in the case of adolescence and pregnancy.

During the process of pulling together the learning from the studies, we realised, as already mentioned, the limitations posed by routinely-used indicators of ill-health, such as morbidity and mortality. These do not adequately capture the devaluation of human life and health that is experienced by tribal communities. There is a need to evolve a multi-dimensional concept.

We have also alluded previously to the limitations inherent in defining health inequities in terms of measurable gaps. There are many examples from the studies of apparent equality in coverage by health care, masking the high human costs and trade-offs for some.

The two dimensions of inequities proposed by Nancy Fraser (2003)– in terms of distribution and in terms of recognition and representation – provide a useful starting point to conceptualising health inequities beyond gaps [6]. More work is needed to explore and draw on other frameworks that would help depict the realities from our studies.

The research process

All the studies aimed to understand the underlying pathways to health inequities. It was evident that prolonged engagement with the communities would be called for. In *the ant* and the PHRN studies, the research teams were constituted of members who had both, many years of experience as researchers, and many years of engagement with communities on the ground. The teams included persons with a bio-medical background (and community experience) as well as social scientists, and community activists. All three teams worked together with a shared vision and commitment to making heard the voices of the tribal communities and making known their lived realities. *the ant* team had worked among the conflict-affected communities for many years and had their trust. The outcomes of the studies owe in no small measure to these characteristics of the research teams.

The research teams were no passers-by, flying in and out. They lived within or close to the communities during the data-collection process and interacted with the community beyond "data-collection." The teams were committed to sensitivity, respect, and tact in their interactions with the local communities.

Data-collection methods went beyond the conventional focus-group discussions and key-informant interviews. Photographs, informal interactions, and discussions, observations of conversations within the community, were all documented in the field notes and constituted a part of the data.

The research teams were "reflexive" in that they were aware of their positionality and made a worked consciously towards minimising power inequities between them and the communities in terms of whose voice would be represented, and how. One of the teams maintained a journal in which reflections were noted on how the researcher's perspective may have influenced a particular interview.

Reflectivity and flexibility were built into the research process. Changes were made to the study process based on findings and reflections from the earlier stages of the study.

the ant team adopted innovative methods of data analysis. It constructed timelines of conflict, created maps of vulnerabilities and traced life-stories of individuals and of the public health system in the area over time, before, during and after the ethnic conflicts.

An important component of the methodology was the annual meeting of all research teams, along with other, like-minded researchers, to share, reflect, compare and contrast the findings of the different teams. This process allowed the research teams to step out and take some distance from the research into which they were fully immersed, and to engage with others in making meaning from the facts.

The research process was time and labour- intensive. However, the financial costs were modest (about US\$ 20,000 at 2016 exchange rates). We would, therefore, assert that such a process is feasible.

All three research teams have shared their research findings with policy-makers within the state and advocated for action. *the ant* and PHRN have the advantage of being civil society organisations working with tribal communities. *the ant* has initiated activities based on some of the findings from its study, while PHRN has succeeded in getting an action plan for the *Baiga* populations included in the State Health Mission's Project Implementation Plan (PIP) for 2018-19. Thus, research has directly informed action for change.

4.5. Recommendations and reflections on the way forward

Recommendations for the health and allied sectors

1. A fundamental requirement is data on tribal communities that would be useful for planning health interventions. This would mean producing and analysing information on
 - a) Scheduled Tribes separately from Scheduled Castes
 - b) PVTG communities separately from other Scheduled Tribes, to- reduce their invisibility
 - c) Tribal communities who are for some reason, not classified as STs (e.g., Adivasis of Assam)
2. The first principle is to *do no harm*. Laws that have resulted in the displacement and impoverishment of tribal communities have to be reviewed and repealed. Within the health sector, specifically, all practices and government orders that have resulted in exclusion from services of tribal communities should be revoked. This includes the ban on sterilisation of PVTGs, the insistence on Aadhar cards to avail social welfare benefits, the denial of subsidised food rations unless a toilet is built, the non-eligibility for benefits from *Janani Suraksha Yojana* for women below 18 years of age and for those having their third or higher order delivery, and so on.
3. Ensuring access of tribal communities to higher-level referral and emergency care should be treated as a top policy priority, and failure to do so treated as a violation of the Right to Life of tribal communities.
4. The population norms for health sub-centres, Primary Health Centres and Community Health Centres and for Anganwadis in tribal areas should be flexible to enable reasonable geographic access by tribal communities, and manageable work-load on the part of front-line workers.
5. Women from the tribal communities (from the same ethnic group as far as possible) should be recruited as ASHA workers, with additional investment for their capacity-building using teaching and learning materials in the local language, and innovative teaching methods.
6. Long-term plans should be put in place to support the training of ANMs, nurses financially, and doctors from the tribal communities, facilitate their successful completion of the courses and to recruit them to serve in their home districts.
7. Health facilities should be better equipped to be responsive to the needs of the tribal communities. Some examples of best practices include ensuring availability of emergency as well as routine transportation at subsidised prices to reach health facilities; a community-help desk staffed by those who can communicate in the language of tribal communities; facilities for accommodation and food for family members; maternity waiting homes; and choice of positions made available for delivery.

8. Programme managers of Publicly Funded Health Insurance Schemes such as the RSBY should be mandated to aim for universal coverage of tribal populations, and to facilitate their use of the Scheme for seeking medical care.
9. The health sector should ensure that tribal communities are not stigmatised or discriminated against, by adopting a protocol for “cultural safety” in health facilities and in clinical settings, and training health providers at all levels to imbibe “cultural humility.” “Cultural safety,” as enunciated by the First Nations Health Authority of British Columbia, Canada “... is an outcome based on respectful engagement that recognises and strives to address power imbalances inherent in the healthcare system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care (FNHA, p. 10).” Offering health care to tribal communities in ways that respect their culture and history requires “cultural humility,” which is “a process of self-reflection to understand personal and systemic conditioned biases, and to develop and maintain respectful processes and relationships based on mutual trust.” (FNHA p. 11).
10. A Comprehensive Tribal Health Action Plan is called for, which takes a holistic view of health, and addresses, besides the many health-sector-specific recommendations above, issues of food security, livelihood issues and safety and security from conflicts and displacement. Such a plan should be developed bottom-up, with the active participation of all sections of tribal communities and allow for flexibility and adaptation depending on local contexts. There are many examples from around the world that one can learn from, towards this.
11. The following is a list of specific recommendations on health sector action in conflict and post-conflict settings. Along the lines of disaster-preparedness machinery, there is a need for conflict-response machinery within the health sector, that would be responsible for these actions:
 - Following an episode of violence, we need to move beyond knee-jerk crises management. We need multi-agency, multi-layered, deep and long-term strategies to help those affected, especially poor and vulnerable families, recover their health and well-being.
 - After an episode of conflict, good quality health services need to be made available beyond the relief camp, i.e. when returnees go back to their villages or when they move to a new place. Mobile and door-step health services will help take care of small illnesses and prevent health catastrophes for the newly impoverished households left with few resources.

- Risk factors for illnesses and ill-health being high post any conflict. Special emphasis needs to be given to monitor, support and facilitate the functioning of health centres and to work of health personnel in conflict-affected fragile areas.
- Following a conflict, special provisions need to be made by the government to ensure that health-promoting services like ICDS, PDS, Mid-Day Meals, water and sanitation services reach the affected / displaced populations for longer periods.
- Children’s nutritional programmes like ICDS scheme is critical for maintaining the nutritional levels of children, pregnant women, lactating mothers and adolescent girls after a conflict. Education and regular provision of mid-day meals can prevent children from dropping out of school and needing to migrate and start working. It can also maintain children’s nutritional levels and prevent illnesses and deaths of children.
- Water and sanitation are much neglected in forest villages where IDPs have settled after a conflict. Unavailability of clean water coupled with poor sanitation practices makes people susceptible to diarrhoeal diseases and even death when health care is unavailable [9].

Reflections on the way forward for research

The present report is a modest attempt at bridging the evidence gap on health inequities and the health of tribal communities in India. The studies informing this report have been small-scale but in-depth and have been able to bring to light evidence on invisible communities such as the Baiga and Sabar and poorly understood settings such as post-conflict areas in Assam. We have barely scratched the surface, and there is much that is not known.

There is a need for many more studies that bring to light the experiences of ‘ill-being’ of tribal communities, in all its complexities, with thick descriptions. Studies that would help arrive at a better understanding of how the social reality is “embodied” by the tribal community would be a part of this genre. More importantly, it is time to focus on studies that examine the diverse pathways to health inequities of tribal communities occupying diverse and intersecting social locations, using an intersectionality lens. Within-group variations among tribal communities are important to capture.

Our experiences with the studies presented in this report suggest that in-depth qualitative exploration is essential to unravel the pathways underlying health

inequities. There is need for substantial engagement with, and involvement of, the local communities. The research teams should be comprised of members from multiple disciplines and experiences, and there should be one or more members with experience in working with the local communities. Time should be factored-in for evolving a shared world-view and approach to the research problem. The team should have the confidence to experiment with out-of-the-box methods of data collection and analysis, which would reduce the power differentials between 'professional' researchers, and community members. The team should be accountable to the communities with and about whom data are being collected, and engage with, at the least, sharing the findings of the study.

Our reflection from this study process, is that when studies do not go beyond an epidemiological portrayal of health status, they may do more harm than good in the current milieu of 'blaming the victim.' When data are presented on the poor performance of Scheduled Tribes in terms of child immunisation or institutional delivery, the response from the authorities has been one of "*Why do these communities fail to do the right thing?*" and "*How can we make them change their behaviour?*". This is also often the query by researchers starting out their research. Instead, authorities, policy makers and researchers should be asking what is it in government's policy, implementation and overall behaviour towards Scheduled Tribes that has contributed to this situation? It seems to us that the responsible way to carry out research on vulnerable populations is to necessarily go beyond describing gaps and explaining, from their perspective, why these gaps exist. This is how we could contribute to the evidence that makes people rethink our stereotypical assumptions.

Research with and about socially oppressed populations should also perhaps always strive to be more than an academic pursuit, and be carried out by a team which includes, as far as possible, members from the community being "studied." Data collection should be carried out with humility and a genuine interest in learning from the communities. Methodological innovations and experiments in research processes are needed, that enable co-creation of knowledge together with the community, for the purpose of achieving greater equity in health, and a more equitable and just society overall.

REFERENCES

1. Bourdieu (1999) as cited in Wilkinson I (2005). Social suffering as an approach to human understanding. University of Kent, Unpublished paper accessed on 14 September 2018 at:
https://www.academia.edu/2521946/Social_Suffering_as_an_Approach_to_Human_Understanding?auto=download

2. Narayan N, Chambers R, Shah M, Petesch P (2000). Social Illbeing: Left out and pushed down. In Narayan N, Chambers R, Shah M, Petesch P (eds). *Crying out for change: voices of the poor*. (Pp. 133-149).New York, The Oxford University Press, for The World Bank.
3. The Ant (The Action Northeast Trust, Assam). 2017. *Health Inequities in a Conflict Area – An In-Depth Qualitative Study in Assam*. Closing the Gap: Health Equity Research Initiative in India, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum.
4. PHRN (Public Health Resource Network, New Delhi). 2017. *Exploring Health Inequities amongst Particularly Vulnerable Tribal Groups: Case Studies of Baiga and Sabar in Chhattisgarh and Jharkhand States of India*. Closing the Gap: Health Equity Research Initiative in India, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum.
5. HAP (Health Action by People). 2017. *Exploring Health Inequity by Assessing the Nature of Healthcare Utilization and its Correlates among the Tribal Population of Kerala*. Closing the Gap: Health Equity Research Initiative in India, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum.
6. Fraser N. (2003). Social justice in the age of identity politics: Redistribution, recognition, and participation. In N. Fraser & A. Honneth (Eds.), *Redistribution or recognition? A political philosophic exchange* (pp. 7-109). London, UK & New York, NY: Verso Press.
7. Solar O, Irwin A (2010). *A conceptual framework for action on the social determinants of health*. Social Determinants of Health Discussion Paper 2 (Policy and Practice). Geneva, WHO.
8. Eshetu EP and Woldesenbet SA (2011). Are there particular social determinants of health for the world's poorest countries? *African Health Sciences* 11(1): 108-115.
9. Prüss-Ustün A, Bos R, Gore F, Bartram J. (2008). Safer water, better health. Geneva, World Health Organization. Accessed on 27 September 2018 at http://www.who.int/quantifying_ehimpacts/publications/saferwater/en/

ANNEXURES

Objectives of the Partners' Workshops, 2016-2018

a) Objectives of the First workshop of Partners: Collaborative research project on Health Equity and Health of Tribal Communities in India: 29 February – 4 March 2016, Seminar Hall, Achutha Menon Centre for Health Science Studies

- Provide feedback on the proposals and facilitate their revision and finalisation
- Arrive at a shared conceptual framework and common definitions and methodological approaches
- Plan modalities for implementation of the research studies: setting up advisory groups; reporting requirements; expected outputs and time line; plans for dissemination and advocacy

The agenda for the methodology workshop has been planned to include time for

- presentation and discussion of the research proposals;
- discussion of key concepts and methodological issues with inputs from resource persons;
- work by research teams towards revision of proposals and tool development with support from resource persons;
- providing opportunity for students of AMCHSS to meet with and learn about the work of resource persons and research-team members through informal meetings and a couple of panel discussions.

The workshop started at 3.30 pm on 29th February with a tea-meeting with students and end on 4th March mid-afternoon

b) Objectives of the Second workshop of Partners: Collaborative research project on Health Equity and Health of Tribal Communities in India: 1 – 4 March 2017, Seminar Hall, Achutha Menon Centre for Health Science Studies

a) have presentations from each of the three research teams and adequate time for inputs from peers and research advisers of other teams on scope for further analysis and areas for modification etc.

b) spend at least an entire morning and ideally more than that, to look at the similarities and differences in findings across sites - and evolving a conceptual framework on how historical/geographic context and specific characteristics of the groups under study have shaped the factors and pathways, which influence their health outcomes.

c) Finalise an outline for the study reports and make a publication plan for journal articles and policy briefs

d) Develop concrete plans for disseminating these findings at the level of states and at the national level

e) Agree on a time line for delivery of final outputs and for meetings

f) Any other matter related to the research projects

c) Objectives of the Third workshop of Partners: Collaborative research project on Health Equity and the health of tribal communities in India: 2 – 4 May 2018, Seminar Hall, Achutha Menon Centre for Health Science Studies

- a) To touch base on developments in (or plans for) the respective states after the dissemination of the three research reports including plans for journal articles and policy-briefs
- b) To examine similarities and differences in findings across sites and evolve a conceptual framework on how historical/ geographic context and specific characteristics of the groups under study have shaped the factors and pathways, which influence their health outcomes.
- c) To finalise an outline for a consolidated report and make a publication plan for an e-monograph and journal articles (including authorship decisions and time-lines)

Details about some of the sessions

In Session 4, we would like each of the research teams to step-back and interrogate their research findings to answer the following:

- a) Are there inequities in health among the tribal populations studied? What are the manifestations of health inequities (e.g. indicators of mortality, morbidity, severity of illness, under-nourishment, patterns of care-seeking, interactions with the formal health and welfare systems, etc.?)
- b) Are there differences within the population in the extent, nature and manifestations of health inequities? By which axes? Examples of intersections of axes and the consequences?
- c) Factors that are associated with the observed inequities and differences in these – micro and macro, contemporary and historical
- d) Pathways through which the inequities seem to have come about (hypotheses would do) and differences across population subgroups

In Session 5 we would like Renu Khanna to attempt talk about observed similarities and differences across the settings in the above – based on her reading of the research reports and the presentations in Session 4.

In Session 6 we would like Arima Mishra to walk us through theories of marginalisation/ discrimination / social exclusion / any other that would help us understand some of the processes and pathways that we see as contributing to the inequities in health

In Session 7 we would like to end up with a conceptual framework – bringing together everything from Sessions 4-6 and beyond. Three facilitators are listed. We would like them to confer to put up a draft framework working together in whichever way they choose to.

ACTION PLAN FOR BAIGA CLUSTER IN PANDARIYA BLOCK OF KABEERDHAM DISTRICT
Prepared by Public Health Resource Network and State Health Resource Centre
Chhattisgarh

INTRODUCTION

In 2016-2017, Public Health Resource Network and State Health Resource Centre with the support of Achutha Menon Centre for Health Science Studies, Trivandrum undertook a research study on “Exploring health inequities amongst Particularly Vulnerable Tribal Groups: Case studies of Baiga and Sabar in Chhattisgarh and Jharkhand states of India”. The primary aims of the study were-

- To understand health and nutrition status of the selected Particularly Vulnerable Tribal Groups (PVTGs): Baiga in Chhattisgarh and Sabar in Jharkhand
- Analyze the barriers and facilitators to accessing public health and allied services
- Understand their perception of health system
- Document their experiences in accessing health and nutrition services

The findings of the research were shared with the various stakeholders in civil society, Baiga community and the health department in a dissemination event in Circuit House in Raipur on 6th November 2017. Subsequently the findings were shared with MD National Health Mission who requested PHRN and SHRC to develop an action plan for the area based on the study.

METHODOLOGY OF FORMULATING THE ACTION PLAN

The Action plan has emerged out of the findings of the study mentioned above and further interactions by the research team with the Baiga community, health workers, NGO workers and district health administration. PHRN members involved in the research study made visits to Kukdoor PHC, Pandariya (that caters to the region) and interacted with the PHC Medical Officer Dr. B L Raj to discuss recommendations based on the evidence from the study and the discussions in the event disseminating the findings.

The team interacted with around 40 members from mitanin programme including mitanin trainers, Baiga mitanins and district coordinator Alka Dubey who added specific issues faced by them in the hamlets and village level. They also supported in developing lists of villages/hamlets for handpump, mitanins, AWC etc.

After initial brain-storming by PHRN and SHRC members on a draft plan, another visit was made by PHRN and SHRC members to Kabeerdhaam district. During this visit, they interacted

with the CMHO, Dr. Akhilesh Tripathi and shared the draft plan. Dr. Tripathi gave his suggestions and ratified the plan.

The following plan is a result of study evidence and of all the interactions and feedback.

I. MITANINS IN BAIGA HAMLETS

A SELECTION OF BAIGA MITANINS AND TRAINING

Situation Analysis

During the research study it was observed that a few Baiga hamlets were still left uncatered or being catered by non Baiga mitanins. Though the process of selection of Baiga mitanins in order to fill this gap, is already ongoing, few Baiga hamlets are still covered by non-Baiga mitanins. There has been evidence to show that for equitable and responsive service delivery at village level, the population should be served from the same community preferably. As per the list provided by mitanin programme members, 15 Baiga mitanins need to be selected for Baiga hamlets.

Main issue /gaps/problems to be addressed

- Ensuring that the Baiga hamlets are served / catered to by Baiga mitanins

Plan

1. Selection of Baiga mitanins in identified villages (The list of hamlets is attached in Annexure 1).
2. Additionally, two more Mitanin Trainers need to be selected for training and supportive supervisions of these Mitanins and also for effective geographical reach
3. Training for new Baiga Mitanins
4. Separate training module (mainly pictorial) may have to be developed for the new Baiga mitanins.
5. Refresher trainings for all Baiga Mitanins on conditions most affecting that area (malaria, pneumonia, diarrhoea etc)

Existing opportunities- SHRC is already going to undertake refresher course for existing mitanins. The old Baiga mitanins can be included in this for the refresher training.

Budget (given below after II)

B SHORTAGE OF MEDICINES WITH MITANINS

Situation Analysis

- Currently Mitanins have RD Kits and ACT but Mitanins don't have paracetamol, cotrim or metronidazole. Moreover, in the past two years, it has been observed that there is irregular supply even of ACT.
- Some Mitanins currently have amoxicillin, not all

Main issue /gaps/problems to be addressed

- Ensuring regular and need-based medicine supply.
- Removing delays/hurdles involved in medicines reaching the mitanins when needed (especially during the more vulnerable seasons, like monsoons).

Plan

1. Two suggestions/recommendations came up for the shortage of medicines with mitanin-

(i) Medicines for mitanin kit can be distributed from PHC Kukdoor rather than CHC Pandariya and District Coordinator of Mitanin Programme agreed on the same. The sector meeting is also held in the PHC Kukdoor (now CHC).

(ii) However, on discussion with the CMHO, he said that issue of medicine supply in general has been resolved recently (in the district) and especially after the Chhattisgarh Medical Services Corporation Ltd (CGMSC) drug warehouse has opened in Kabeerdham.

(During the discussion with PHC MO also, it was told that in the recent supply, the supply to CHC Kukdoor was as per the indent. PHC Kukdoor was having difficulty earlier as instead of sending online indent directly, they would route it through CHC Pandariya).

CMHO suggested that there are four sector meetings in a month and the third sector meeting is a coordination meeting for different departments. The Mitanin Programme members and District Coordinator can raise the issue of shortage of mitanins (beforehand) and accordingly the supply for mitanin drug kit can be made.

However, as per mitanin programme members, raising the issue of medicine shortage in sector meetings has not yielded results, as the shortage or irregular supply is often from CGMSC itself.

2 Advocating with CGMSC- The shortage of medicine from CGMSC and the differences in indent versus supply seems to be common. It has to be seen whether this issue is resolved for

Kabeerdham block as suggested else advocating with CGMSC had to be done to ensure supply of medicines.

Existing opportunities- After PHC Kukdoor has been upgraded to the CHC, the CHC can also indent for the mitanin medicine if it goes for the plan (i).

Table 1: Budget (for I and II)

Item	Unit	Unit cost (Rs.)	Total for 1 year (Rs)
New Mitanins- Incentive	15	24000	3,60,000
Drug kit	15	1000	15,000
New MT	2	7800	1,56,000
Training of new Baiga mitanins (7 days)	15	2100	31,500
Separate Training module for Baiga mitanins		To be developed by SHRC	
Training of Old Baiga mitanins		Budget not required as old Mitanins will be covered under regular training	
Total		5,62,500	

II. SUB CENTRES

Situation Analysis

- There are two sectors under which Baiga population resides- Kukdoor sector and Cheerpani-Kodwagodan sector
- There are currently 11 sub centres under PHC/CHC Kukdoor sector and 2 under PHC Cheerpani that cater to Baiga villages (list of SHCs in Table 2).
- New proposal was sent by PHC MO Dr Raj to the health department for new SubCentres at six places in both the sectors- Kandavani, Amaniya (approved), Teliyapani Ledra (approved), Putputa, Manjoliraman and Saraisat. The two above SHC which seems to have been approved, have been sanctioned or budgeted formally.
- The hamlets and population are quite spread-out with difficult geography and as such in some villages people have to travel long distances for the nearest SubCentre.

Quite a few hamlets get left out from regular immunisation (List of hamlets attached in Annexure 2).

Table 2: HR situation of existing 13 SHC (11 under Kukdoor sector and 2 under Cheerpani Kodwagodan sector)

S. No.	SHC	Female worker	Male worker	Remarks
KUKDOOR SECTOR				
1	Kukdoor	Y	Y	ANM to retire in one year. Also currently attached in Kukdoor PHC.
2	Munmuna	Y	Y	
3	Kamthi	Y	Y	
4	Polmi	N	Y	ANM left in October.
5	Bhakur	Y	Y	Currently attached to Kukdoor PHC.
6	Bhelki	Y	Y	Workers not functional or active
7	Sendurkhar	Y	Y	ANM on emergency leave
8	Rukmidadar	N	N	MPW relieved, ANM transferred
9	Pandripani	Y	Y	
10	Badna	Y	Y	
11	Neur	N	Y	ANM promoted one month back
New	Amaniya (comes un (Under Kukdoor sector)			Approved but no formal/written sanction yet
KODWAGODAN CHERPANI SECTOR				
12	Kodwagodan Cheerpani (approx 8 Baiga villages under the SHC)	Y	Y	Active (HR status informed by community members)
13	Chhiadand (12 villages under the SHC)	Y	Y	Active (HR status informed by community members)
New	TeliapaniLedra (under Cheerpani Kodwagodan sector)			Approved but no formal/written sanction yet

HR issues:

- ANMs (mostly from other districts) who get recruited to the region, do not want to stay there for long and apply for transfers after two years.
- There are 29 Mitanins in the district who have undergone ANM course, and are still unemployed. As per the list provided by mitanin programme members, in Pandariya block there are eight mitanins (three SC, two ST and three OBC) who have undergone

ANM course and are unemployed. In the whole district, there are a total of seven SC, four ST and 18 OBC mitanins who are trained but unemployed.

Main issue /gaps/problems to be addressed-

- There are vacant ANM posts against sanctioned posts.
- Even where the posts have been filled the SHC are not fully functional due to various reasons such as staff being on leave, posted in a higher facility etc.
- ANMs hired from outside the block/state do not stay for longer.
- In none of the SHCs is a second ANM posted.

Plan

State level

1. Formally sanction the Amaniya SHC and Teliapani Ledra SHC and budget for it. This includes infrastructure for building and residence for staff (Table 3).
2. Training of ANM on skilled birth delivery, Intra uterine copper device, managing new born, stabilisation of severe malaria, infection management etc to be given
3. Consider relaxing the population norms for health facilities given the specific issues in the area and consider sanctioning for the feasibility of the already proposed four SHCs (Kandavani, Putputa, Manjoliraman and Saraiset) and budget for it.
4. Support the district health administration in recruitments of ANM/MPW.

District level

5. Advertise and recruit to fill vacant post (ANM/MPW) which is done from district level, with preference to mitanins who have undergone ANM course. (List of mitanins who have done ANM course and belonging to Kabeerdham/Pandariya and their status of employment is attached in Annexure 3).
6. Sanction and recruit two ANMs in each SHC.
7. Ensuring regular immunisation in left-out hamlets. (List of hamlets of Annexure 2 will be shared with CMHO and added to action plan of ANMs)
8. As a long-term, plan 12th pass Baiga women (non-mitanins) should be actively identified and enrolled for ANM course, with scholarship by government.

Challenges-The CMHO informed that the major challenges in filling HR vacancy has been because of age criteria and roster requirements. When told that there are Seven SC, four ST from Kabeerdham who have been mitanins and have done ANM course, he said that they could be immediately recruited. He further said that second ANM s can be posted if trained Baiga ANMs are available.

Budget

Table 3: Budget to make one Sub Centre Functional

A. Item (Recurring Costs)	Unit	Unit cost	Total for 1 year
ANM	2	10000	240000
MPW	1	7500	90000
Sweeper	1	5000	60000
Meals for IPD patients	10	100	12000
Housekeeping			30000
Water & Electricity			200000
Total (A)			632000
B. Training	Unit	Unit cost	Cost
SBA	2	25000	50000
NSSK	2	3000	36000
IUCD	2	5200	62400
IMEP	2	1000	12000
Immunisation and cold chain	2	1000	1000
Total (B)			161400
C. Building and equipments (one time purchase)	Unit	Unit cost	Cost
Building	1 (Double store building with accommodation)	2288000	2288000
BP apparatus with table model	1	1200	1200
Stethoscope	2	1000	2000
Nebuliser	1	2000	2000
Sub Total (I)			2293200
Labour ward & Neo Natal Equipment			
Emergency Resuscitation Kit - Baby*	1	36750	36750
Standard weighing scale	1	7000	7000
Radiant Warmer	1	58123	58123
Room Warmer	2	1250	2500
Nebulizer baby	1	2100	2100
Weighing machine adult	2	300	600
Sub Total (II)			107073
Other			
Auto Clave HP Vertical (1 bin)	1	10000	10000
Suction Apparatus - Electrical	1	11000	11000
Sub Total (III)			21000
Glucometer	1	1000	1000
Haemoglobinometer	1	2500	2500

Refrigerators	1	35000	35000
Oxygen cylinder	1	10000	10000
Sub Total (IV)			48500
Total C (I+II+III+IV)			2469773
Grand Total (A+B+C)			3263173

Table 4: Recruitment of Human Resource

Head	Unit	Unit Cost	Total for 1 year
Salary for second ANM	15 (if two new sub-centres are approved)	As per existing norms	
Training of the 2 nd ANMs	15	As per existing norms	
Sponsoring 12 th pass Baiga women for ANM course	5	75,000	3,75,000

IV. REFERRAL TRANSPORT

Situation Analysis

Currently there is one 102 vehicle stationed at PHC Kukdoor that takes a lot of time (1 or more than 1 hour) to reach the Baiga villages, even if called. Sometimes they also refuse to go to the villages farther away. Further the vehicle takes 1-2 hours to reach a village.

One year back, after a spate of Baiga deaths in the area, the district administration provided for bike for community at Kandavani, however, no arrangement for fuel was made. The MO said that the bike had stopped working, however, Mitans told us that the driver of the bike ended up paying for fuel and now has stopped driving the bike. The administration assumed that the patient's family will pay while the community assumed that the government will provide for fuel.

In the visit to CHC Pandariya it was found that the 108 vehicle had been in the garage for one month. The CMHO said that there are currently only 3 drivers against 14 sanctioned driver posts in the district health department.

There is no drop-back facility for patients (other than maternity cases, from any health facility). During the study, this emerged as a major barrier in access of the Baiga patients to higher level facilities.

Gaps

- Refusal of emergency vehicle to cater to difficult villages.

- Delay in reaching by the 102/108 vehicle.
- No drop back services for non-JSSK patients
- Some remote villages are not connected by motorable roads at all.

Plan

1. Additional vehicles/bikes for referral- One of the following two recommendations may be considered

1.1 Two additional four wheeler vehicles could be stationed at selected HSCs.

Mitanins suggested vehicles to be kept at Badua SHC (to cover Sendurkhar and nearby villages) and Chhiadand SHC (to cover Teliyapani and nearby villages).

While PHC MO suggested that vehicle can be kept at Rukmidadar SHC which covers 17 villages and other vehicle can be kept at Sendurkhar or Bhelki.

Challenges- To keep a 108 vehicle at a designated place, minimum of five trips are required per day. The CMHO informed that they were struggling to make it five trips per day for the whole Pandariya block. So stationing a vehicle at a lower level may not be feasible. A feasibility study of the above plan may have to be done at the block/district level.

1.2 A bike ambulance can be proposed at the SHC level as suggested above instead of a four wheeler vehicle. Time period of wait for patients can be reduced in this manner and community will be less vulnerable to refusal from 108. Already bike ambulances are successfully running in Dantewada and Narayanpur². In Narayanpur, it is funded by NHM, money has been given to a local NGO that manages the ambulance. The bike ambulance in Dantewada is supported by UNICEF.

In case of Pandariya, as previous experience shows, regular and adequate funds need to be provided for the bikes to operate successfully.

2. Recruitment of drivers for 11 vacant sanctioned posts in the district.

3. Drop-Back facility to be provided to all Baiga patients irrespective of delivery or non-delivery case.

As 108 policy does not have a drop back facility, special relaxation/provision needs to be made for the patients in the region that dropback facility for 108 or any other vehicle be provided to attract community to avail government health services(irrespective of delivery or non-

²<https://yourstory.com/2016/02/motorbike-ambulances-chhatisgarh/>

delivery case). As suggested by the CMHO the non-108/102 government ambulances could provide drop-back facility from JDS money.

4. Further, in the inaccessible villages where even two wheelers cannot reach provision of *Doli* can be made. *Dolis* can be stationed at these areas and whenever required community can get the pregnant woman /patient to the motorable road from where the 102/108 takes the person to the facility.
5. Proper monitoring and tracking of existing 108 vehicle is required so that.

Budget

Table 5: Budget required for improving referral facilities

Item	Unit	Unit cost (Rs)	Expense per year (Rs)
Bike Ambulance			
Bike purchase (Bajaj Pulsar)	2	100000	200000
Monthly recurring cost (Driver, Petrol, maintenance)	2	20000 per bike per month	480000
Doli			
One time cost of Doli	10 (no. of inaccessible hamlets)	6000 per stretcher	60,000
Maintenance	10	2000 annually	20000

V. PRIMARY HEALTH CENTRE

Situation Analysis

- There are 2 PHCs in the area- Kukdoor and Cheerpani.
- Kukdoor PHC has recently been upgraded to a CHC
- PHC in Neur has been proposed but not approved.

Main issue /gaps/problems to be addressed

- PHC Kukdoor manages most of the patients in the area.
- One MO, 3 RMA, 1 Dental, 1 Ayush MO.
- 2 staff nurses out of sanctioned 10 posts, 3 Lab technicians.
- CRMC incentives have not been received since Feb 2017.
- Autoclave available.

- No food is provided to non-maternity patients as no funds (MO).
- Issue of language & communication between staff and patient.
- Situation of medicines better than before.
- MO suggested that some medicines should be given to Mitadin by PHC to ensure zero stock-out.
- Women have to go as far as District Hospital for complicated delivery services where poor treatment is meted out to them. Plus DH is more alien space for Baiga women.

Plan

1. Approve the PHC in Neur (since Kukdoor PHC is upgraded to CHC).
2. Already one MO for PHC Rengakhar and One for Kukdoor PHC have been planned. Their salary of Rs. 70,000 is to come from the DMF fund (as informed by CMHO).
3. Ensure Emoc facilities in CHC Pandariya. An MBBS can be trained for it or a gynaecologist can be posted from DMF funds
4. Appoint 2 more RMAs for Kukdoor PHC and one MO for Cheerpani PHC. That ways they can serve in the PHC and also the Health and Wellness centres that have been initiated.

(Challenges–There are no more RMAs outside the health department in Chhattisgarh. RMAs will have to be transferred from some other place)

5. **Health and Wellness centres-** RMAs from Kukdoor PHCs can be sent on rotation to the select SHCs for managing weekly health and wellness centre clinics. Provision for medicines, consumables and travel have to be ensured. As a long term plan for health and wellness centres, upgradation of nurses for health and wellness centres could also be done through enrolment of nurses in the IGNOU bridge course.
6. Regular school health programme in all schools and monthly clinics in all Ashramshalas of the area.
7. Training of all health staff (ANMs, Staff Nurse, RMA, MOs) needed on dealing with severe complicated malaria, diarrhoea, pneumonia, emergency care and other medical conditions that are most prevalent in the area.
8. **Maternity waiting room in Kukdoor PHC-** For pregnant women from remote villages, a maternity waiting room can be built so that she could travel to the health facility a couple of days before expected due date. The advantages of such an intervention are well known globally in reducing inequity in health access³and it has already been tried out in the state in Narayanpur and Dantewada districts⁴. The CMHO proposed that they

³<https://academic.oup.com/heapol/article/32/10/1354/4430324?searchresult=1>

⁴Three Maternity waiting rooms are functioning in two districts. Two in Narayanpur one in Dantewada. Non recurring cost i.e. building maintenance, Beds, Fridge, Kitchen set up etc are supported by SATHI and running cost i.e. care taker, cook, food etc are supported by UNICEF. Running cost is currently 15000/month but, this is notadequate.

already have an existing built up area opposite Kukdoor PHC which can be utilised as a maternity waiting room.

Existing Opportunities

SHRC is already facilitating skill-based trainings of RMAs at the state level. The existing three RMAs in Kukdoor PHC can be one by one called in different batches and specialisations of training in January. The CMHO has requested that he be contacted and he would send the RMAs from the Pandariya/Borla block.

Budget

Table: Budget for improving PHC services

S. No.	Item	Unit	Unit cost (Rs)	Expense per year (Rs)
1	New PHC in Neur	1	As per existing norms	
2	Posting lady Gynaecologist or providing Emoc training to MBBS in Kukdoor CHC.	1	As per existing norms	
3	Salary of HR			
	MO in Cheerpani PHC	1	As per existing norms	
	RMAs in Kukdoor PHC	2	As per existing norms	
4	Health & Wellness Centres	6	As per existing norms	
5	Training of ANM and Staff Nurses in dealing with common diseases and managing complication before referrals		As per existing norms	
6	Upgradation of Nurse for H & W centre	6	As per existing norms	
7.	Maternity waiting room			
A	Renovation of existing structure with PHC	1	As per existing norms	
B	Beds	4	As per existing norms	
C	Recurring costs	1 (in Kukdoor)	20000 per month	2,40,000
8	Screening of Children for diseases in schools		Through RBSK	
9	Monthly health Clinics in Ashramshalas		Through RBSK & PHC	

VI. IMPROVING FACILITIES AT ALL FACILITIES FOR BETTER RESPONSIVENESS TO COMMUNITY AND BETTER OUTCOMES

Situation Analysis

A lot needs to be done to make the government health facilities friendlier, responsive and accessible for Baiga community. Out of Pocket expenditure in transport and non-medical expenditure is one major barrier. Food is not provided for non-JSSK cases which deters patient from accessing health facilities. Further the geographical and cultural distance and poor behaviour of the staff adds to the alienation towards health facilities.

District health administration informed that they had already written to the state health department several times for providing meal budget. Of Rs.160 meal budget Rs. 60 is received from NHM. Even their JSSK meal budget is running on credit. They informed of a positive experience of Borla CHC where after delivery Chhuaari ladoo is being provided to women after the initiative of block health administration.

The study also highlighted the problems being faced by Baiga families in accessing contraceptive services, especially sterilisation services that are restricted for them. This was having a negative impact on health of women and their children. High infant and child mortality along with instances of unsafe abortion were also seen.

Gaps

- Non provision of return transport and food for IPD patient (recommendations made above for referral transport).
- Poor behaviour of the staff especially towards adivasi communities.

Plan/Recommendation

1. All restrictions on access of PVTGs to contraceptive services needs to be removed. The condition of taking 'permission' from SDM for undergoing sterilisation should be removed and universal access to free and quality contraceptive services needs to be ensured.
2. Ensure there is no delay in funds in providing budget for meals at health facilities (as is happening for meal budget from the state health department)
3. Meal Budget- Food for IPD patients and attendant for non-JSSK cases is a must at PHC and CHC (PHC Kukdoor and Cheerpani and CHC Pandariya). At the district hospital, food for the attendant must be ensured.
4. Traditionally, Baiga women deliver in a squatting or sitting position, however, health facilities in the area do not provide this option for women. The "World Health Organisation Recommendations on Augmentation of Labour⁵ states that,

⁵http://apps.who.int/iris/bitstream/10665/112825/1/9789241507363_eng.pdf

“Encouraging the adoption of mobility and upright position during labour in women at low risk is recommended”. It further notes that: “GDG (Guideline Development Group) noted that in many settings, traditional practices of enforcing bed rest for all women in labour are common, rather than allowing women’s choices to be informed by their knowledge of the benefits of mobility and upright position. The GDG put its emphasis on providing women with the choice of an intervention that is beneficial, cheap and easy to implement, and therefore made a strong recommendation for this intervention”. And that, “This recommendation should inform and support women’s choices on what position to adopt during the first stage of labour”.

Therefore, such culturally appropriate services need to be provided at all facilities. Such an option should be provided to Baiga women during delivery at the health facilities and imparted in training of nurses, doctors and ANMs.

5. Help desk with a Baiga facilitator at DH. Currently the help desk facilitator in DH is not from ST community. As it is difficult for Mitanins from rural areas to come to Kawardha DH and work in help desk, the mitanin programme members have taken responsibility to identify a Baiga /adivasi from Kawardha town who can be posted at the help desk.
6. BCC training for health staff members for better sensitivity and empathy in behaviour towards Baigas and other STs.

5. Budget

S. No.	Item	Unit	Unit cost (Rs)	Expense per year (Rs)
1	Meals for IPD patients	IPD patients in PHC Cheerpani, CHC Kukdoor and CHC Pandariya	Rs. 160 per patient	As per number of patients
	Meals for IPD attendants		Rs. 100 per attendant	As per number of patients
2	Incentive for Baiga mitanin for being at the help desk in Kabeerdham District Hospital	2	Rs. 300 per day, per mitanin	1,74,000
3	BCC Training for Health staff at PHC and CHC		As per existing norms	

Existing opportunities: Funds from Kendriya Kshetriya Anudan, and MADA are some of the available budget sources, apart from DMF funds.

VII ISSUES AFFECTING HEALTH, THAT ARE TO BE TAKEN UP WITH OTHER DEPARTMENTS AS PART OF INTERSECTORAL ACTION ON HEALTH

I Public Health and Engineering Department

1. Availability of clean water source is a major cause of morbidity in the Baiga hamlets. Most of the hamlets Baiga dominant blocks are dependent on jhiriya for drinking water. Those which have handpump, there are issues of poor water quality or the water table getting low in summer season. Annexure 4 has a list of 85 hamlets which do not access to clean source of water.
2. Water testing was done by the mitanins in one village each. This needs to be expanded and water testing done for all sources of drinking water in all villages.
3. It was informed by the community solar pumps are being used in some villages for pumping water source. Villages can be identified where the same practice can be replicated.

II Women and Child Development Ministry

1. Supreme Court has given instruction on the universalisation of the services under Anganwadi. However, it was found that approx. 63 Baiga hamlets in Pandariya block are without Anganwadi services either due to distance, inaccessibility during rains or due to no Anganwadi in the village (list of hamlets attached in Annexure 4). Provision should be made to cover these hamlets.
2. Eggs are an important source of nutrition and are cost effective and have a long shelf life. As that Baiga/adivasi population primary eat non vegetarian, eggs should be included as part of hot cooked meals in Anganwadis. It has already been introduced and well appreciated in other states like Jharkhand and Orissa.
3. Anganwadi workers, sahayikas should be recruited locally and from the Baiga community. Norms for recruitment should be relaxed for them.
4. WCD Chhattisgarh is already running fulwaris in 85 tribal blocks of the state. These should be expanded to all tribal blocks including the tribal hamlets in non-scheduled areas. Special provision/notification can be made for the same.

III School

1. Ensure functional schools in Baiga hamlets.
2. Provide relaxation in norms for recruitment of Baiga teachers
3. Eggs are an important source of nutrition and are cost effective and have a long shelf life. As that Baiga/adivasi population primary eat non vegetarian, eggs should be

included as part of hot cooked meals in school MDM. It has already been introduced and well appreciated in other states like Jharkhand and Orissa.

4. Better monitoring of Ashramshalas to ensure quality education, nutrition and residential services are provided.

IV Food and Civil Supplies Department

1. Chhattisgarh government has already introduced chana in fifth schedule areas for tribal population under Public Distribution System (PDS). This should be expanded to tribal families living even in non-scheduled areas such as Pandariya.
2. For better nutrition of all adivasis, edible oil should be provided in PDS.
3. As per Supreme Court's orders and the Chhattisgarh Nutrition and Food Security Act it needs to be ensured that no Baiga family is without an antyodaya ration card.

V Forest department

1. Ensure proper implementation of 'The scheduled tribes and other traditional forest dwellers (Recognition of Forest Rights) Act, 2006
2. There is a lot of eviction of indigenous population due to increase expansion of conservation projects especially in Borla and Pandariya block which has resulted in migration and lack of access to health and other public services.
3. It has to ensured that the above is done with the consent of indigenous population.
4. It has to ensured that timely compensation and decent rehabilitation to the displaced population.

V Mining Department

1. Currently a lot of villages have been affected by Bauxite mining in Borla block which is going to expand towards Pandariya Block.
2. It has to ensured that timely compensation and decent rehabilitation to the displaced population as per Land Acquisition Resettlement and Rehabilitation Act, 2013.

VI Roads and Highways Department

1. Even today many villages are cut off from the roads which leads to difficulty and inequity in accessing services. Such hamlets are connected by roads.

Study tools: The ANT

IDP Interview Schedule

Respondent's Profile

1. Name of respondent:
2. Village:
3. Name of respondent's husband/wife:
4. Male/ female :
5. Age:
6. Community & Religion:
7. How many members are there in your family?
8. How many children do you have? How old are they? What do they do?
9. What is your occupation? How long have you been doing this work? What all did you do before? Why did you change?
10. Who else in your family earns? What do they do?

History of Displacement & Conflict

History of Displacement

11. How long have you been living in your current village?
12. Were you born and brought up here? If not, from where?
13. Where all did you live before coming here?
14. If we had to draw a line to show the history of where all you lived from the time of your birth Can you please tell us? (researcher here uses the **timeline** method and chronologically maps out the migration history of respondent.... covering the following questions).
 - a. *Where were you born? Where all did you live after that?*
 - b. *Why did you move? How many times was it because of conflict?*
 - c. *Who all in your family moved with you?*
 - d. *Did you return to your original village? Why? Why Not?*
 - e. *The land where you stated in your original village, who did it belong to?*
 - f. *The land where you are currently staying, who does that belong to?*
 - g. *What all did you lose every time you have moved because of conflict?*

Experience of Relief Camps

15. Have you ever stayed in the relief camps? Why did you come to the relief camps? How often it was because of conflict?

- a. Which all relief camps have you lived in? How long did you stay in the relief camps? (*get the information in chronological order..... may be in the form of another time line*)
- b. What was life like in the relief camps in the beginning?
- c. What did you do for food, water and stay while in the camp?
- d. What did you do for money? What income sources did you have?

Livelihood & other loss

16. What were your income sources before moving to the camp? How did it get affected?
17. What all in your life got disturbed by your moving to the camp? Allow for responses and then researcher could prompt details of how each was affected - *property, children, work, health, food, relationships, mental peace etc.*

Relationships with others

18. When you moved from your original village, did the other families move with you? Where did they go? Did you keep in touch with them? What happened to all of them? Who do you miss the most from your original village? Why?
19. How was your relationship with the other communities around you before the conflict? Which were the communities you were closest to? (the researcher at this stage could map out using *venn diagramme* method/ mobility mapping)
20. How was the social life in the village where you lived earlier before the conflict? How has it changed now? e.g. Festivals, celebrations like marriages, deaths, cultural and religious customs etc.

Study tools: PHRN

Qualitative study tools

I. Interview with Mukaddam (Tribal head)/ aged or young Baiga people (M & F)

Name of the respondent-

Profile of the respondent - Age, village, past history etc

To be asked to a Mukaddam- Institution of Mukaddam-

(i)How did you come to be elected at the position? What is the eligibility/requirement and who are the decision makers? What are the other important leadership positions in Baiga community/Baiga Panchayat system (Village priest etc).

To be asked to the young/aged Baiga people

(i) What are the major community leadership positions in your community? Who occupies these position and these leaders are elected by whom.

(ii) Do you participate in the traditional Panchayat? How do you find it and the relevance of it?

History of traditional Panchayat system. Composition (women representation etc) - socio cultural-work done by the panchayat.

What is the profile of mukaddam in terms of age & gender? What is the role of women in the whole setup?

How do you perceive your role and your power that you have (traditionally and in today's context). What roles have the traditional community leaders been playing traditionally and what roles do they play today. How has the role and the institution of village leadership position itself changed over years.

How to draw the boundaries between mukaddam and state. How have the traditional system interacted with the state's Panchayati system.

Do you take up any health related issues? Any role in terms of health prevention. Any role in ritual/seasonal rituals or during outbreak of diseases. Role of sacred places.

What is your perception about Baiga marginalisation. Do you think you have been pushed out? (Baiga vs Gond, Baiga vs others)

How has the notion of collective/community sharing changed/evolved during all these years? How has it affected Inings / food security in any way. What is the notion of collective. What was its role in re distribution of food.

What are the shared resources/spaces. *Issues around Harnessing water.* Do Negotiations happen through mukaddam

How do people from your community interact and have interacted with the non baiga communities over the years? Do they mix up and interact in what ways. What is the "extent" of interaction. The interaction is in public spheres or limited to private spheres or vice versa. (Does intermingling in terms of dining , festivals etc happens?)

How are people from other categories perceived by Baigas and vice versa. What is the role played by other communities? Is caste hierarchy/ untouchability practiced?

What are the major festivals, events, customs among Baigas? Myths of origin and other important myths and how do the other tribal groups figure in it.

How has the traditions and customs been impacted over time? What are the major reasons for the same.

How does the Jaat system work in Baiga community. How is courtship and marriage practice in your community? What are the types of marriage?

What is the role played by forests in a Baiga culture. How has the relationship with the forest and land changed over the years by the Baiga community?

What has been the major source of livelihood in the Baigas traditionally? What source of livelihood is followed today? What work is done by men in the community and what kind of work is done by women?

How do you view PDS. What has been the role of PDS in assuaging hunger. How has it made a difference to their dietary habits. Do they miss other items like millets that was consumed earlier.

Interaction with market- Do you sell your forest or agricultural produce in the market? To whom and in exchange for what price?

Do the people from your community migrate? If yes then to where and in which part of the year? Do men migrate or households.

When did the transition to a cash based economy start? Does the barter system still exist? How much do they deal in cash as compared to earlier? Has it impacted you in any way.

How has been the interaction and dynamics with state actors (forest officials, land officials, police, health institutions and officials)? When did the interaction with them start and on what purpose?

Quality of interaction with these state and non state actors.- nature of interaction – conflict/cooperative/ friendly/fear/violence. Any instances of violence. Is the attitude from the state actors that of indifference or callousness or somewhere in between. Are the attitudes different in terms of men and women? Whether any instances of sexual exploitation by the actors.

Interaction and dynamics with non- state actors (NGOs, religious orgs if any)- How did the interaction with them start and on what purpose. Quality of interaction.

Baigas and role/representation(if any) in electoral politics. Which political party do people mainly vote? Do people from Baiga community stand for any elections?

Any forest conservation projects / upcoming development projects in the neighbouring blocks (if any) and its impact.

What do you know of the sterilisation ban on the PVTG groups? Why is it so? What do you think about it?

II. Interview with non-baiga community leaders, service providers and NGO heads who have been living/working in the area for long time

Name of the respondent-

Profile of the respondent- (Age, caste village, past history, years that he/she has been working)

What has been your experience of working in the area? What are the major issues/problems faced by the community?

How are these above issues different from those faced by other Gonds/ Agariya, Panka or other tribal communities? Also how is it different from the Baigas residing in other block, other districts of CG and the neighbouring MP state.

What is the traditional political structure of baigas in your understanding? Do you have any information on the working of the Baiga Panchayats and the role of other traditional community leaders?

Has this traditionally community structure changed over time? Or influenced by the intervention of the Panchayati Raj system?

In the years that you have spent working here, what have been the changes in Baiga customs and traditions? Has it been true for other tribal (non baiga) traditions too?

How have Baiga community interacted and continue to interact with the non-baiga communities over the years? Do they mix up and interact in what ways. What is the "extent" of interaction? The interaction is in public places or limited to private spheres or vice versa? (intermingling in terms of dining, festivals etc happens? Inter cast or inter tribe marriages?)

How are people from other category perceived by the Baigas and vice versa? Is untouchability etc practised?

In your time that you have stayed, how has the relationship with the forest and land changed over the years in general for the people residing in the Pandariya and surrounding region?

Interaction with market- Do the people in the region sell your forest or agricultural produce in the market? To whom and in exchange for what? How do the Baigas fare in the same.

When did the transition to a cash based economy start? Does the barter system still exist? How much do they deal in cash as compared to earlier? Has it impacted you in any way.

What is the major source of livelihood in the Baigas? What work is done by men and what kind of work is done by women?

How do you view PDS? What has been the role of PDS in assuaging hunger. How has it made difference to their dietary habits.

Do the people from the Baiga community migrate? If yes, then to where and in which part of the year. How is it in comparison to migration by other communities?

Any forest conservation projects/upcoming development projects in the neighbouring blocks (if any) and its impact in the region and on different tribal communities.

How has been the interaction and dynamics with state actors (forest officials, land officials, police, health institutions and officials)?

Quality of interaction with each of these state actors- When did the interaction with them start and on what purpose? Interaction is that of conflict/ cooperative/friendly/fear/violence with them? Any instances of violence. Attitude is that of indifference or callousness or somewhere in between. Are the attitudes different in terms of men and women. Any instances of sexual exploitation by state actors.

Interaction and dynamics with non- state actors (NGOs, religious orgs if any)- How did the interaction with them start and on what purpose. Quality of interaction.

What do you know of the sterilisation ban on the PVTG groups? Why is it so? What do you think about it?

III. Interview with health care providers (RMPs/ traditional healers/ANM/private doctor/govt doctor)

Name of the respondent-

Profile of the respondent (Caste, years working, no. of villages visited/served, educational qualification)

1. What are the major diseases affecting the Baiga community and seasonality of it-different ailments affecting different groups (women/ men/children/old/disabled), difference in terms of location of the village (are there villages which are more prone to ailment/illness death and why), difference in terms of from other population groups like Gonds, OBC etc.
(Mapping of the area served by the healthcare provider)
2. For what diseases do mostly people come to you and for what disease do people go to the other formal/informal healthcare provider. What are the conditions determining the choice of health care provider? Are these conditions different for Baigas and why?
3. What are the major reasons for illness in the region according to you? Do you think the Baiga population is disproportionately affected by it? If yes then why?
4. Over the years that you have been working (and heard from your elders), how has the incidence of illness/ ailments changed
5. What are the factors behind the above? Probe the role of food habits, changing nutrition, ,changing nature of access to land , forest resources has to play in the health of the people.

6. What type of formal govt or private facilities (including those in MP) do people served by you go to? What are the conditions (physical/financial/cultural) determining it? Why? Are these conditions different for Baigas and other social groups?
7. Do people still come to you for illness in same frequency as earlier or has there been a change. What do you think are the factors behind it?
8. What kind of treatment is given by you for different diseases? How do you receive the payment (cash, kind, credit)? If govt facility on what items is out of pocket expenditure incurred.
9. What are the different kinds of barriers (physical/financial/cultural) faced by people in utilising the public healthcare set up? How are these barriers different for different villages, diseases, social category especially Baigas etc?
10. What role do the other different kinds of health care providers play in health care delivery and keeping people healthy. What role do you see yourself playing in this set up.
11. What is the role played on services given by formal and informal health providers from the neighbouring state. When do and why do people approach it.
12. Status of health facilities in the region-
 - infrastructure
 - HR availability
 - timely availability of quality supplies
 - services to deal emergency handling of cases, emergency response vehicle etc. Which areas/communities are disproportionately served?
13. Are people in the region adequately able to take the nutrition services such as AWC and MDM?
14. What are the difficulties/challenges faced by you in providing healthcare services to Baiga community.
15. What can be done to improve the situation?

Additional question to be asked to RMP

Reasons behind the formation of an RMP union. Its role and work.

Additional question to be asked to traditional healers-

- i. What are the major reasons for illness and how does it obstruct in a healthy body. What are the factors responsible for an episode of ailment/lack of good health? What role do you (faith healers /guniyas) play in healthcare? How has the coming of new ailments/diseases and government hospital set up impacted your institution?
- ii. How has the change in forest and access and control to forests impacted your institution?

Additional question to be asked to PHC MO, CHC doctor.

i. What do you think is the special status of Baigas and the political nature around their status has to do in the treatment of Baigas in a government health set up (in context of increased cases of reluctance to treat serious cases in Baigas by public health facilities) What do you think is the political nature behind it and how can it be resolved.

ii. What do you think are the major hurdles faced by the health department to avoid repeated outbreaks of diseases in Baiga area. What challenges are faced by the health department in the same.

Are you aware of any special measures for the PVTG health by the District administration or health department. If yes how effective it has been.

What are the other departments that have a crucial role to play in ensuring a healthy community in the region.

Additional question to be asked to ANM

What do you know of the sterilisation ban on the PVTG groups? Why is it so. In absence of sterilisation what are the main family planning measures adopted by the people in the Baiga and other communities?

Have there been any measures by the government to clear the information or facilitate sterilisation in the district that you are aware of?

What do you think are the major hurdles/challenges faced by the health department to avoid repeated outbreaks of diseases in Baiga area?

IV. Interview with Dai (Baiga)

Name of the respondent-

Profile of the respondent (Caste, years working, no. of villages visited by him, educational qualification)

1. How did you learn the skills and start practising as a dai? Is it essential to belong to the Baiga community? What area have you been serving?
2. What is the process of childbirth done by you traditionally? Are there any specific customs involved specific to Baiga community that are followed?
3. What is done in an event of failed delivery? What are the reasons behind it.
4. In your experience of serving what kind of changes (positive or negative) have you noticed in all these years? (IMR, MMR, Pre and post partum conditions etc). Does food, nutrition, changing lifestyle etc has any role to play in it?
5. What are the major ailment/health conditions faced by women in their lifetime.
6. How much more have the people started using the institutional set up compared to earlier? Has it served well in your opinion? How has the community taken to this change?
7. Would you like to share any specific/different/unusual instance of childbirth that you remember? Would you like to describe it?
8. How in the mother and child taken care of after an episode of childbirth? What kind of food is she fed and activities she is allowed and prohibited? What are the customs followed in the process of child birth and its bringing up. What role do Baiga men play in the whole process form childbirth and later.
9. What are the rituals involved in the process of pregnancy to childbirth and raising a child. What are the measures taken for the process of sterilisation traditionally? In recent times how do women get themselves sterilised or stop conceiving. What are the types of hurdles faced by them in getting a sterilisation operation done in a formal healthcare set up. In the event of inability to get a sterilisation operation done in a formal health care set up, what do they resort to.
10. Is abortion practiced in your community? How is it done? How is it perceived?

V. Interview with Teachers (Baiga or non Baiga)- residential school

Name of the respondent-

Profile of the respondent (Caste, years and place serving etc)

1. How did you come to be recruited in the profession? (contractual/ regular/wages criteria). What was your initial impression of the region and the communities living here and how has it changed?
2. Tell us about the specific scheme started by the district department for the training and recruitment of teachers from Baiga community.
3. How do you see the HR, infrastructural requirements related to education and its distribution in the region? Where are the major gaps?
4. Students from what all community come to you. Do you see a difference in the students from different communities? What is the gender distribution? How is the dropout rate and distribution rate? What are the hurdles faced by different communities in accessing educational set up.
5. Do Baiga children get any facilities like scholarship, accommodation, nutrition etc.
6. Do you see any difference in socio economic indicators in the Baigas in Pandariya and those in other blocks/districts/states. Elaborate.
7. Does the govt./ education department has any specific approach (taking in account their culture and tradition) for the education of children from Baiga and other tribal communities? Or has the idea been mainly to bring the Baiga children in the mainstream through mainstream education.
8. What in your opinion can be done to make the education process more friendly towards children from Baiga and other tribal groups.
9. What has been the change in the lifestyle of the people of the region since you first came here and today.
10. What are the major diseases affecting the children from the region and seasonality of diseases - difference in terms of location of the village, difference in terms of from other population groups like Gonds, OBC etc. Are Baiga children disproportionately affected by the incidence of diseases and malnourishment?
11. Over the years that you have been working (and heard from your elders), how has the incidence of illness/ ailments changed and overall larger lifestyle habits also. (Probe the role of food habits, changing nutrition, changing nature of access to land, forest resources has to play in the health of the people)
12. What are the different kinds of barriers faced by people in utilising the public healthcare set up. How are these barriers different in terms of different villages, diseases, social category etc.

13. What are the difficulties/challenges faced by you in providing educational services to children from Baiga community. Have things changed from earlier?

(For Baiga teacher, probe more on their experience of becoming a teacher, opportunities & challenges)

How does the MDM run in your school? Do you think it has helped in encouraging children to school? What do you think is the impact and importance of MDM in a tribal area like Pandariya. How is the nutritional status of children? Has things changed in your time of working here in terms of nutrition and food habits?

What kind of background do the children come to your school? Do you see a difference between baiga children and children from other communities? Perception etc.

सहमति प्रपत्र

मैं पब्लिक हेल्थ रिसोर्स नेटवर्क के साथ काम कर रही /रहा हूँ | हम लोग छत्तीसगढ़ और झारखंड में विशेष संरक्षित जनजाति , बैगा और सबर समुदाय पर अध्ययन कर रहे है | अध्ययन का उद्देश्य विशेष संरक्षित जनजाति में उनकी

संस्कृति ,रहन सहना ,स्वास्थ्य और पोषण की स्थिति को समझना है ।हम समझना चाहते हैं की बैगा और सबर समुदाय को स्वास्थ्य और पोषण की सेवाएं लेने में क्या क्या परेशानियां आती है ।और बैगा और सबर समुदाय का स्वास्थ्य और बीमारी से सम्बंधित अनुभव समझना हैं ।

बैगा समुदाय के सदस्य या फिर उनके साथ करीब से काम करने के कारण हम आपसे यह साक्षात्कार कर रहे है । आपके द्वारा दी गयी जानकारी बैगा संस्कृति एवं मुख्यतः स्वास्थ्य ,पोषण एवं सरकारी एवं अन्य स्वास्थ्य सेवा को इस्तेमाल करने के पहलूओं को समझने के लिए इस्तेमाल की जायेगी ।

जो भी जानकारी आप देंगे उसे बिलकुल गुप्त रखा जाएगा ।आपका नाम भी गुप्त रखा जाएगा ।आपके द्वारा दी गयी जानकारी को सिर्फ अध्ययन के लिए इस्तेमाल किया जाएगा ।जरूरत पढने पर सर्वे टीम द्वारा आपसे शायद आपकी सुविधा अनुसार दोबारा मुलाकात की जायेगी अगर कोई जानकारी अधूरी रह गयी हो । हम यह स्पष्ट करना चाहते हैं कि इस सर्वे से आपको कोई निजी रूप से फायदा नहीं होगा लेकिन आपके द्वारा दी गयी जानकारी को हम समुदाय के हित के लिए इस्तेमाल करने का प्रयास करेंगे ।इस सर्वे में आप इच्छा अनुसार भाग ले सकते है या मना कर सकते है हालांकि हम आशा करते है की आप इस साक्षात्कार में भाग लें ।साक्षात्कार में पूछा गया कोई भी सवाल का जवाब देने से आप मना कर सकते है और इस बीच भाग लेने से मना कर सकते है ।

क्या आपको सर्वे के बारे में हमसे कोई प्रश्न पूछने है ?

उत्तरदाता के सवालों का जवाब दे ।

क्या मैं अब साक्षात्कार शुरू कर सकता/सकती हूँ ?

उत्तरदाता की साक्षात्कार के लिए सहमति)हाँ /नहीं(साक्षात्कार शुरू करे

अगर उत्तरदाता साक्षात्कार के लिए मना करता हैसमाप्त

प्रश्नकर्ता का नामप्रश्नकर्ता के हस्ताक्षर

आब्जर्वर के नाम आब्जर्वर के हस्ताक्षर.....

Quantitative study tools

PVTG Hamlet Profile

Respondent: Ward Panch/ASHA

Name of the respondent	
Profile of the respondent	
Date of interview	
Name of the Hamlet	
Name of the Village	
Panchayat	
Block	
District	

GENERAL INFORMATION-

Social Group	PVTG		Other ST		SC		OBC		General		Total	
	M	F	M	F	M	F	M	F	M	F	M	F
Population												
No. of Households												

VILLAGE INFRASTRUCTURE

1a. Nearest Town	
1b. Distance to nearest town	.....kms
1c. How far from the village do you get the nearest public bus/ jeep to above mentioned town?	.....kms
2. Is there Electricity supply in the village	Yes No
3a. Primary source of water for the village	
3b. Distance of the nearest source from the habitation	.....meters
4a. Is mobile network available in the village	Yes No
4b. How far is the ration shop from your village?	In the village....kms from village
SCHOOLS	
5a. Nearest Primary School	
5b. Name/Location-	

5c. Distance	.....kms
5d. The MDM is run by whom. What community do most of them belong to?	
5e. Nearest Middle School.	
5f. Name/Location-	
5g. Distance	.....kms
5h. The MDM is run by whom. What community do most of them belong to?	
6. HEALTH SERVICES	
6a. Nearest SHC	Name
6b. Distance	.....kms
6c. Nearest PHC	Name
6d. Distance	.....kms
6e. Nearest FRU	Name
6f. Distance	.....kms
6g. Does 108/102 come to your village?	Yes No
7a. Nearest Anganwadi	
7b. Name/Location-	
7c. Distance	.....kms
7d. The SNP is run by whom. What community do most of them belong to?	

7. Number of RMP/ jholachhap in the hamlet?

8. Number of doctors/doctors in the hamlet?.....

9a. Number of ASHAs/Mitanin/Sahiya in the hamlet?

9b. What community do the ASHAs/Mitanin/Sahiya belong to-

Social Group

ASHA1

ASHA2

ASHA3

ASHA4

ASHA5

10a. Is there a Village Health Sanitation and Nutrition Committee (VHSNC) formed in the village?
(Yes/No)

10b. Does it meet monthly? (Yes/No)

10c. Who all are part of the VHSNC and what community do they belong to?

**Profile (eg. Panch, ASHA, SHG Social Group
member etc)**

Member 1

Member 2

Member 3

Member 4

Member 5

Electricity-

Whether there is a wired electricity supply in the village.

Ekal connection or metre wala.

If yes then duration of electricity supply in a day.

If no electricity in the village how do you manage.

Migration checklist

Do people from your village migrate?

If yes mostly during which season of the year do they migrate. For how many days?

Why do they migrate in this particular season.

Do men only migrate or the whole family?

Which areas do they migrate mostly to and for what work.

Data collected by:

Mobile no.:

Urban Health Center Facility Survey

General Information		
Name of the SHC/village		
Name of the block and District		
Total population covered by the Sub Centre:		
Total household covered by the Sub Centre		
Distance from the PHC		
Staff availability		
	Yes/No	Number
Health Worker-Female (ANM)		
Health Worker-Male (MPW)		
Part time attendant (female)		
Other staff		
Specify		
Infrastructure availability at Sub centre		
Building		
Water supply		
Regular electricity supply		
Examination table		
Toilet		
Bed for delivery		
Weighing machine in working condition		
Availability of disposable delivery kits		
Availability of Services		
	Yes – 1, No – 2	Remark
ANM/MPW		
ANC/PNC		
24 hours referral facility		
Regular immunization services		
Treatment of diarrhea and dehydration		
Treatment of minor illness like fever, cough, cold etc		
Availability of contraceptive services like insertion of Copper – T, distributing Oral contraceptive pills or condoms		

Home and Institutional deliveries from last 6 month (include all live and still births):

Home delivery : _____ PVTGs.....

Institutional delivery: _____ PVTGs.....

Services (from last six months)

	No.	No. of PVTGs
Total OPD		
Total IPD		
ANC		
Immunization		
Delivery done		
Contraceptive services		
Copper t		
Pills		
Condoms		

Medicines availability

Name of the medicine	Uses	Stock

आंगनवाड़ी की जानकारी

उत्तरदाता : आंगनवाड़ी कार्यकर्ता / सहायिका

सामान्य जानकारी	
गाँव / बस्ती का नाम	
आंगनवाड़ी केंद्र नंबर	
जिला और ब्लाक का नाम	
आंगनवाड़ी के अंतर्गत कितने परिवार आते हैं	
PVTG आंगनवाड़ी के अंतर्गत कितने PVTG परिवार आते हैं	
PVTG बस्ती से दूरी	

कर्मचारी उपलब्धता			
	हां/ ना	समुदाय / जाति/ जनजाति	नंबर
आंगनवाड़ी कार्यकर्ता			
आंगनवाड़ी सहायिका			

आंगनवाड़ी की आधारिक संरचना	गोला लगाए	टिप्पणी
खुद का भवन या किराए का भवन	<ol style="list-style-type: none"> सरकारी भवन आंगनवाड़ी कार्यकर्ता का घर पंचायत भवन किराए पे अन्य 	
पानी की सुविधा (ब्योरा दे)	<ol style="list-style-type: none"> हैण्ड पंप कुआँ नल झिरिया अन्य पानी नहीं है 	
कितने घंटे बिजली रहती है	.... घंटे बिजली नहीं है ....99	
	हां- 1, नहीं - 2 (कोड डाले)	
क्या शौचालय है		
अगर हां तो क्या बच्चे उसे इस्तेमाल करते हैं		
बच्चों के वजन के लिए वजन मशीन क्या चालू हालत में है ?		

बड़ों के वजन के लिए वजन मशीन क्या चालू हालत में है ?		
खिलौनों की उपलब्धता		
चार्ट , पोस्टर , बैनर और अन्य शिक्षा सामग्री		
दवाई की उपलब्धता (ब्योरा दे)		

पिछले महीने में सेवाओं की उपलब्धता		
	हां- 1, नहीं - 2 (कोड डाले)	टिप्पणी
क्या ANM पिछले महीने आई थी ?		
क्या उसने प्रसव पूर्व / प्रसव पश्चात ANC/PNC जांच की ?		
पिछले महीने टीकाकरण हुआ था ?		
वजन / लम्बाई की निगरानी		
साप्ताहिक THR		
बच्चों की स्वास्थ्य जांच		
रेफरल		
आंगनवाड़ी कार्यकर्ता ने घर घर जाके जानकारी ली ?		
क्या कार्यकर्ता ने माता को स्वास्थ्य और पोषण के बारे में जानकारी दी		
बच्चों के लिए गरम पका भिजन		
अंडा दिया जाता है ?		
अन्य		

आंगनवाड़ी चार्ट

दिन

मेन्यु

चालू महीने में आंगनवाड़ी केंद्र में सेवा लेने वाले लाभार्थी		
	कुल संख्या	PVTGs की संख्या
कुल गर्भवती महिलाएं		
इनमें से कितनी रेडी तो ईट लेती है		
स्तनपान कराने वाली कुल महिला		
इनमें से कितनी रेडी तो ईट लेती है		
नामांकित बच्चों की संख्या		
इनमें से कितने नियमित रूप से आते हैं ?		
नामांकित किशोरी बालिकाओं की संख्या		

बच्चों की जानकारी		
	कुल संख्या	PVTG बच्चों की संख्या
जिन्हें NRC रेफर किया (पिछले 6 महीने में)		
स्वास्थ्य केंद्र में रेफर किया गया (पिछले 6 महीने में)		
सामान्य वजन वाले बच्चों की संख्या (वजन की तारीख लिखे)		

कुपोषित बच्चों की संख्या (Moderate) (वजन की तारीख लिखें)		
गंभीर कुपोषित बच्चों की संख्या (वजन की तारीख लिखें)		
रोज़ आने वाले बच्चों की संख्या (मासिक औसत)		
स्तनपान काराने वाली या गर्भवती महिलाएं जो THR लेती है (मासिक औसत)		

प्रश्नकर्ता /सर्वेयर का नाम -

मोबाइल नंबर -

इंटरव्यू की तारीख

सहमति प्रपत्र

मैं पब्लिक हेल्थ रिसोर्स नेटवर्क के साथ काम कर रही /रहा हूँ | हम लोग छत्तीसगढ़ और झारखंड में विशेष संरक्षित जनजाति , बैगा और सबर समुदाय पर अध्ययन कर रहे है | अध्ययन का उद्देश्य विशेष संरक्षित जनजाति में स्वास्थ्य और पोषण की स्थिति को समझना है | हम समझना चाहते है की बैगा और सबर समुदाय को स्वास्थ्य और पोषण की सेवाएं लेने में क्या क्या परेशानियां आती है | बैगा और सबर समुदाय का स्वास्थ्य और बीमारी से सम्बंधित अनुभव समझना है। हम आपसे कुछ प्रश्न पूछना चाहते है क्योंकि आपका घर इस सर्वे के लिए चुना गया है | आपके द्वारा दी गयी जानकारी यह समझने के लिए इस्तेमाल की जायेगी कि आपके स्वास्थ्य को क्या क्या चीजें प्रभावित करती है , इसकी सेवाएं आपको कैसे मिलती है | इस प्रक्रिया में लगभग डेढ़ घंटा लगेगा | प्रश्नों में निजी जानकारी भी पूछी जायेगी जैसे स्वास्थ्य संबंधी परेशानियां , स्वास्थ्य सेवायों का अनुभव आदि।

आपका नाम और आपके द्वारा दी गयी जानकारी को पूरी तरह गुप्त रखा जाएगा और इसका इस्तेमाल सिर्फ अध्ययन के लिए किया जाएगा | जरूरत पढ़ने पर सर्वे टीम द्वारा आपसे शायद आपकी सुविधा अनुसार दोबारा मुलाकात की जायेगी अगर कोई जानकारी अधूरी रह गयी हो | हम यह स्पष्ट करना चाहते हैं कि इस सर्वे से आपको कोई निजी रूप से फायदा नहीं होगा लेकिन आपके द्वारा दी गयी जानकारी को हम समुदाय के हित के लिए इस्तेमाल करने का प्रयास करेंगे | इस सर्वे में आप इच्छा अनुसार भाग ले सकते है या मना कर सकते है हालांकि हम आशा करते है की आप इस सर्वे में भाग लें | आप सर्वे में पूछे गए किसी भी सवाल का जवाब देने से मना कर सकते है और इस बीच भाग लेने से मना कर सकते है |

क्या आपको सर्वे के बारे में हमसे कोई प्रश्न पूछने है ?

उत्तरदाता के सवालों का जवाब दे |

क्या मैं अब साक्षात्कार शुरू कर सकता/सकती हूँ ?

उत्तरदाता की साक्षात्कार के लिए सहमति)हाँ /नहीं(साक्षात्कार शुरू करे

अगर उत्तरदाता साक्षात्कार के लिए मना करता हैसमाप्त

प्रश्नकर्ता का नाम प्रश्नकर्ता के हस्ताक्षर

आब्जर्वर के नाम आब्जर्वर के हस्ताक्षर.....

**परिवार
कोड**

प्रश्न

जवाब

राज्य

01- झारखण्ड , 02- छत्तीसगढ़

जिला

- 01- पूर्व सिंघूम
- 02- कबीरधाम
- 03- पूर्व सिंघूम में दूसरा ब्लॉक

गाँव /पारा /टोला का नाम

.....

और कोड लिखे

परिवार ID (सबर /बैगा)

फॉर्म भरने के बाद प्रश्नकर्ता के हस्ताक्षर फ़ोन नंबर

फील्ड में फॉर्म जांचने के बाद सुपरवाइजर के हस्ताक्षरफ़ोन नम्बर.....

फील्ड में फॉर्म जांचने के बाद रिसर्च कोऑर्डिनेटर के हस्ताक्षर.....

साक्षात्कार का दिनांकसमय

-A सामान्य जानकारी

प्रश्न कोड	प्रश्न	जवाब
A1	उत्तरदाता का नाम	
A2	आईडी नम्बर)टेबल BB ,कॉलम B1b से भरे(
A3	मकान का प्रकार	कच्चा/मिट्टी का मकान 1..... अर्ध पक्का)सीमेंट की दीवार ,बिना सीमेंट की छत2.....(पक्का मकान)दीवार और छत सीमेंट की3.....(

		कुछ कमरे पक्के ,कुछ कच्चे 4..... कोई संरचना नहीं 5.....
A4	आपके घर में कितने कमरे)जिनपे चारों ओर दीवार और छत है (है?	.....कमरे
A5	पिछले एक साल में पीने के पानी का मुख्य स्त्रोत क्या है ? 1. नल सप्लाई का पानी 2. ट्यूब वेल / हैण्ड पंप 3. कुआं 4. झरना/ झिरिया 5. तालाब 6. नदी / कैनाल 98. अन्य (ब्यौरा दे _____)	सर्दी /जाड़ा)कार्तिक – माघ 2/1) (अक्टूबर 2/1 -मार्च(गर्मी)फागुन – जेठ (2/1)मार्च /2/1 –जुलाई(बरसात)आषाढ – अघन(2/1)जुलाई -½ अक्टूबर (
A6	क्या आपके घर पे शौचालय है ? अगर हाँ तो अगले प्रश्न A7 में जाए, अगर नहीं तो A8 पे जाए	हाँ1..... नहीं2.....
A7	अगर हाँ ,तो क्या परिवार के सदस्य उसे इस्तेमाल करते है ? अगर हाँ तो A9 में जाए , अगर नहीं तो A8 में जाए	हाँ1..... नहीं2.....
A8	तो आप कहा जाते है ?	सामुदायिक शौचालय 1..... खुले में शौच 2..... अन्य 98..... ब्यौरा दे _____
A9	क्या आपके घर पे बिजली है ?	हाँ1..... नहीं2.....
A10	क्या आपके नाम से राशन कार्ड है ? अगर हाँ तो अगले प्रश्न A11में जाए नहीं तो प्रश्न A12 पर जाए ।	हाँ1..... नहीं2.....
A11	आपके पास कौनसा राशन कार्ड है ? अगला प्रश्न छोडके A13 में जाए	प्राथमिकता परिवार)झारखंड के लिए गुलाबी ,छत्तीसगढ़ के लिए नीला1.....(अन्योदय कार्ड)झारखंड के लिए पीला ,छ.ग.के लिए गुलाबी2.....(
A12	राशन कार्ड न होने के क्या कारण है ?	किसी सूची में नाम नहीं था1..... कार्ड था पर निरस्त हो गया2..... आवेदन दिया हुआ है पर कार्ड नहीं मिला3..... कार्ड था पर गुम हो गया 4..... अन्य..... 98..... ब्यौरा दे _____
A13	आप खाना <u>ज्यादातर</u> कहा बनाते है ?	चार दीवारी में 1..... आँगन में 2..... परछी /बरामदा 3..... अन्य 98..... ब्यौरा दे _____

A14	घर पे खाना बनाने के लिए <u>ज्यादातर</u> किस तरह का ईंधन /जलावन इस्तेमाल करते है ? एक से ज्यादा जवाब हो सकते है	बायो गैस/गोबर गैस .....1 केरोसिन/ मिटटी तेल .....2 कोयला .....3 लकड़ी .....4 पत्ता/ भूसा /पुआल/ कंडे/ गोइठा.....5 (LPG) .....6 अन्य..... 98.. ब्यौरा दे _____	
A15	आपके पास किस तरह की खेती की जमीन है ? एक से ज्यादा जवाब हो सकते है अगर जवाब 6 है तो A 17में जाए	वन जमीन पट्टे के साथ.....1 राजस्व/पटवारी/रैयती जमीन पट्टे के साथ.....२ वन जमीन बिना पट्टे के 3..... राजस्व जमीन बिना पट्टे के4..... जमीन गिरवी रखा हुआ है 5..... कोई जमीन नहीं है 6..... अन्य..... 98..... ब्यौरा दे _____	
A16	आपके पास खेती की कितनी जमीन है ?	.....एकड़.....डिसमिल	
A17	आप पिछले एक साल में कौन कौन से मौसम में खेती किये हो ? एक से ज्यादा जवाब हो सकते है	गर्मी1..... बरसात2..... सर्दी3..... खेती नहीं करते 4.....	
A18	पिछले एक साल में आपने क्या क्या फसल बोई थी ? एक से ज्यादा जवाब हो सकते है।	धान1..... बाजरा2..... गेंहू 3..... महुआ/माडिया4..... मक्का5..... कोदो6..... कुटकी7..... धान8..... जोवार9..... अरहर/तिवुरा10..... कुल्थी11..... उरद12..... मसूर13..... चना14..... मूंग15.....	मटर16..... लोबिया17..... झुर्गा18..... बरबट्टी19..... रमतिला20..... तिल.....२१ अलसी22..... तीसी23..... सरसों 24..... सुरगुजा25..... कवरा26..... मूंगफली27..... करैत28..... अन्य 98..... ब्यौरा दे _____
A19	पिछले एक साल खेती से उगाये गए अनाज (छोटा एवं बड़ा (से आपके परिवार के कितने दिन का खाना चला था |?)	3-1महीना1..... 6-4महीना 2..... 9-7महीना 3.....	12-10महीना 4..... 12माह से ज्यादा 5..... लागू नहीं 99
A20	पिछले 12 महीने में क्या आपके परिवार को इनमे से कोई घटना का सामना करना	परिवार के किसी सदस्य की मृत्यु या गंभीर बीमारी 1..... आपके प्राकृतिक संसाधनों तक पहुँच या नियंत्रण खतम होना)जमीन,जंगल,जानवर2....(

	पड़ा ?(एक से ज्यादा जवाब हो सकते हैं) सभी विकल्प पढ़के उन्हें बताये और उस अनुसार गोला लगाए अगर जवाब 9 है तो अगला प्रश्न छोड़के सीधे प्रश्न A22 में जाए	खराब उपज 3..... नौकरी छूटना ,मजदूरी कम होना ,घर में कमाने वाले को बीमारी से आय कम होना 4..... प्राकृतिक त्रासदी से जानवरों या उपजाऊ संसाधनों को नुकसान5..... घर में शादी 6..... रिश्तेदारों या दोस्तों में शादी या मृत्यु 7..... कुछ भी नहीं 9.....
A A21	इस घटना से आपके परिवार ने कैसे निपटा ? एक से ज्यादा जवाब हो सकते हैं	बचत इस्तेमाल की1..... उधारी ली)बैंक से लिया2..... उधारी ली)रिश्तेदारों /पड़ोसी /आदि 3.....(घर का कुछ सामान /जानवर /जमीन बेचीं 4..... घर का कुछ सामान /जानवर /जमीन गिरवी राखी 5..... खान पान में कमी की 6..... अन्य खर्चों)खान पान के अलावा (में कमी की 7..... अतिरिक्त काम किया)पलायन 8.....(अतिरिक्त काम किया)बिना पलायन के 9.....(गाँव वालों /समुदाय या दूसरों ने मदद क 10..... अन्य 98..... व्योरा दें
A22	आपके पास इनमे से कौन सी चीजें हैं – जो चालु स्थिति/हालत में हैं सभी विकल्प पढ़े और उत्तरदाता द्वारा दिए गए विकल्प पर गोला लगाए एक से ज़्यादा जवाब हो सकते हैं	पशु)गाय ,भैंस ,बकरी आदि 1.....(मुर्गी ,बत्ख2..... बाइसिकल 3..... दो पहिया वाहन 4..... मोटर गाडी /चार पहिया /ट्रेक्टर 5..... टी वी 6..... मोबाइल फोन7..... सोलार सिस्टम /लैंप 8.....
A23	पिछले एक साल में परिवार के आय/कमाई का मुख्य स्रोत क्या था?	खुद का जमीन 1..... दुसरे के खेत में मजदूरी 2..... रोज़गार गारंटी के अंतर्गत काम 3..... खेती में काम के अलावा कोई और मजदूरी4..... अपनी दूकान .से आय 5..... वनोपज संग्रहण)जैसे महुआ,चिरौंजी6.....(वनोपज संग्रहण के अलावा खुद का कोई धंधा 7..... सरकारी नौकरी8..... प्राइवेट नौकरी9..... अन्य कोई98..... ब्योरा दे

B. परिवार के सदस्यों की जानकारी:

B1	B2	B3	B4	B5	B6	B7	B8	B9	B10	B11	B12	B13	B14
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सदस्य ID No.	सदस्य का नाम	परिवार के मुखिया से रिश्ता *	लिंग 1. पुरुष 2. महिला	उम्र (साल)	वैवाहिक स्थिति **	शिक्षा ***	लम्बाई (सेंटीमीटर)	वजन (किलोग्राम)	पिछले ३६५ दिन में कौनसा सदस्य		पिछले 15दिन के अन्दर में कोई बीमारी हुई ? 1. हां 2. नहीं सभी से पूछे अगर पिछले 15 दिन में कोई भी सदस्य अस्वस्थ महसूस किया ।	क्या RSBY, MSBY या कोई अन्य सरकारी स्कीम में स्वास्थ्य बीमा है ? 1. हां 2. नहीं (या ऐसे पूछे की फोटो खींचते समय कौन कौन लोग थे)	क्या आपके पास आधार कार्ड है ? 1. हां 2. नहीं	
									क्या अस्पताल में एडमिट हुए ? 1. हां 2. नहीं	अगर हां तो कितने बार एडमिट हुए				

B. के लिए कोड:

*परिवार के मुखिया से सम्बन्ध : स्वयं - 1, मुखिया की पति /पत्नी - 2, विवाहित बच्चा - 3, विवाहित बच्चे का पति /पत्नी - 4, अविवाहित बच्चा - 5, पोता /पोती - 6, माँ/बाप /सास /ससुर , 7-भाई/बहन/पति या पत्नी का भाई/देवर/देवरानी /जेठ /जेठानी /अन्य रिश्तेदार - 8, नौकर /मजदूर /अन्य गैर रिश्तेदार - 9

**वैवाहिक स्थिति : कभी शादी नहीं की - 1, शादी शुदा - 2, विधवा /वधूर - 3, तलाक़शुदा /अलग हो गए है - 4

***शिक्षा : पढ़े लिखे नहीं है -1, स्कूल नहीं गए पर पढ़ लिख लेते है ,2-प्राथमिक 1)से पांचवी कक्षा तक ,3-(माध्यमिक 6)ठी से 8वीं कक्षा तक ,4 (हाई स्कूल 9)एवं 10कक्षा , 5 - (हायर सेकेंडरी ,6 -(12-11)हायर सेकेंडरी से ऊपर 7-

C. सरकारी सेवाओं तक पहुँच

कोड	प्रश्न	जवाब
C1	आंगनवाडी	
C11.	क्या आपके घर में ये सदस्य है) ?एक से ज्यादा जवाब हो सकते है अगर जवाब 97है तो अगले भाग C 2में जाए वरना अगले प्रश्न में जाए।	6वर्ष से कम उम्र के बच्चे 1..... गर्भवती माता2..... शिशुवती/धात्री माता 6)महीने से कम उम्र का बच्चा 3..... (इनमे से कोई नहीं 97.....
C1.2	क्या आपके पारा /टोला में आंगनवाडी है ? अगर नहीं तो अगले प्रश्न में जाए वरना C1.4 में जाए	हाँ1..... नहीं2.....
C1.3	अगर नहीं तो सबसे पास का आंगनवाडी कितना दूर है?)दूरी लिखे(	..... कि.मी.
C1.4	क्या परिवार के सभी हकदार सदस्य आंगनवाडी से सेवाएं लेते है ? अगर 1तो C 1. 6में जाए ,अगर जवाब 2या 3है तो C1. 5में जाए	सभी लेते है 1..... नहीं लेते 2..... कुछ सदस्य लेते है 3.....
C1.5	अगर नहीं तो क्यों ? अगर कुछ सदस्य लाभ लेते हैं तो CC 1.6 में जाए अन्यथा C 2में जाएँ.	आंगनवाडी दूर है .....1.. आंगनवाडी कभी खुलता है कभी नहीं 2..... आंगनवाडी में सेवाएं ठीक से नहीं मिलती.....3 अन्य98.....)ब्योरा दे.....(
C1.6	पिछले हफ्ते में आपके बच्चे (3-6 yrs) को कितने दिन गरम पका भोजन मिला? अगर जवाब) 993-6 yrs के बच्चे घर पे नहीं है (है ,तो C1.8 में जाए ।	हर दिन .....1 4-5 दिन .....2 2-3 दिन .....3 2 दिन से कम .....4 एक भी दिन नहीं .....5 लागू नहीं 99.....
C1.7	क्या आपको आंगनवाडी के गरम पका भोजन से इनमे से कोई परेशानियां है ? एक से ज्यादा जवाब हो सकते है probeprobe सभी विकल्प पढ़के उन्हें बताये और उस अनुसार गोला लगाए	नियमित रूप से नहीं मिलता1..... खाने की गुणवत्ता खराब है 2..... रोज एक सा खाना मिलता है 3..... खाना हमारे स्वाद के अनुसार नहीं होता है 4..... अन्य98,.....

		)ब्योरा दे _____ (
C1.8	क्या आपके बच्चे 6)माह 3-साल (को पिछले महीने <u>सारे हफ्ते के लिए</u> सूखा राशन)THR(मिला था अगर जवाब 99है तो C1.10में जाए	हाँ1..... नहीं2..... लागू नहीं 99.....
C1.9	क्याआपको आंगनवाड़ी में बच्चों के लिए मिलने वाले सूखा राशन (THR) से इनमे से कोई परेशानी है ? एक से ज्यादा जवाब हो सकते है सभी विकल्प पढके उन्हें बताये और उस अनुसार गोला लगाए	नियमित रूप से नहीं मिलता 1..... खाने की गुणवत्ता खराब है 2..... एक सा खाना मिलता है 3..... खाना हमारे स्वाद के अनुसार नहीं है 4..... अन्य98,.....)ब्योरा दे _____ (
C1.10	पिछली बार आपके बच्चे का वजन कब किया गया था ?	इस महीने1..... पिछले महीने2..... 3-2महीने पहले 3..... 3महीने से ज्यादा हो गया 4..... कभी नहीं5..... लागू नहीं 99..... पता नहीं 96.....
C1.11	बच्चों का आंगनवाड़ी केंद्र में कितनी बार वजन होता है ?	सप्ताह में एक बार 1..... 15दिन में एक बार .....२ महिने में एक बार ३ 3-2महिने के बीच .....४ तीन महीने से ज्यादा में एक बार5..... कभी नहीं6..... लागू नहीं 99..... पता नहीं 96.....
C1.12	अगर आप गर्भवती या शिशुवती/धात्री माता)छ महीने से कम का बच्चा (है तो क्या आपको सारे हफ्ते के लिए THR मिला था? अगर 99तो C2 में जाए	हाँ1..... नहीं2..... लागू नहीं99.....
C1.13	क्या आप शिशुवती /धात्री माता के लिए मिलने वाले THR से कोई परेशानी है ?	नियमित रूप से नहीं मिलता 1..... खाने की गुणवत्ता खराब है 2..... रोज एक सा खाना मिलता है 3..... खाना हमारे स्वाद के अनुसार नहीं होता है 4..... अन्य98,.....)ब्योरा दे _____ (
C1.14	अगर आप गर्भवती है तो क्या आपको गरम पका भोजन मिलता है ? यह प्रश्न सिर्फ छत्तीसगढ़ राज्य के लिए लागू है	हाँ1..... नहीं2..... लागू नहीं99.....
C1.15	क्या आप बता सकते है कि पिछले ग्राम स्वास्थ्य पोषण दिवस /टीकाकरण दिवस में आपको कौन -कौन सी सेवाएं मिली थी)एक से ज्यादा जवाब हो सकते है(? सभी विकल्प पढके उन्हें बताये और उस अनुसार गोला लगाए	टीकाकरण 1..... वजन /लम्बाई आदि नापना 2..... प्रसव पूर्व जांच 3..... स्वास्थ्य जांच 4..... रेफरल सेवाएं 5..... पोषण आहार वितरण6..... अन्य98,.....)ब्योरा दे _____ (

C2	स्वास्थ्य सेवाएं		
C2.1	क्या आप अपने पारे /टोले की मितानिन /सहिया को जानती है ?	हाँ1.....	नहीं2.....
C2.2	क्या आप उसके पास कभी मदद के लिए गए है ? अगर नहीं तो अगला प्रश्न छोड़के c 2. 4में जाए ,अगर हां तो c 2. 3में जाए	हाँ1.....	नहीं2.....
C2.3	अगर हां तो किस तरह की मदद ? एक से ज्यादा जवाब हो सकते है	इलाज के लिए 1.....	रेफरल के लिए 2.....
		प्रसव /जचकी के लिए 3.....	अन्य98,.....
		)ब्योरा दे _____ (
C2.4	क्या आपके बच्चों या गर्भवती महिला के लिए टोले/पारे में टीकाकरण होता है?	हाँ 1.....	नहीं 2.....
C2.5	अगर नहीं तो कितनी दुरी पे होता है ?	.....कि .मी.	
C2.6	टीकाकरण /प्रसव पूर्व जांच के लिए इनमे से कौन आते है ? अगर 97तो मध्यान्ह भोजन c 3में जाए ।	ANM/नर्स .....1	MPW/पुरुष कार्यकर्ता .....2
		दोनों.....3	कोई भी नहीं.....97
C2.7	ANM या MPW एक माह में कितनी बार आपके पारे /टोले में भ्रमण के लिए आते है ?	हफ्ते में एक बार 1.....	महीने में एक बार2.....
		पता नहीं 96.....	अन्य98.....
		)ब्योरा दे _____ (
C2.8	क्या ANM/MPW पिछले महीने टीकाकरण के लिए आया था /आई थी ?	हाँ1.....	नहीं2.....
		पता नहीं 96.....	
C3	मध्यान्ह भोजन		
C3.1	क्या आपके बच्चे प्राथमिक स्कूल जाते है ? अगर नहीं तो c 4में जाए	हाँ1.....	नहीं2.....
C3.2	अगर हाँ ,तो आपके घर के बच्चे कहा स्कूल जाते है ? बच्चों की संख्या लिखे	स्कूल का प्रकार	बच्चों की संख्या
		.1गाँव में स्कूल	
		.2गाँव के बाहर स्कूल	
		.3आश्रमशाला/छात्रावास	
		.98अन्य	
		ब्योरा दे	
C3.3	अगर आपका बच्चा गाँव के प्राथमिक स्कूल या गाँव के बाहर प्राथमिक दिवा कालीन)Day) स्कूल में जाता है तो क्या आपका बच्चा स्कूल में मध्यान्ह भोजन खाता है ?	हाँ1.....	नहीं2.....

C3.4	अगर नहीं तो क्यों नहीं ? एक से ज्यादा जवाब हो सकते हैं सभी विकल्प पढ़के उन्हें बताये और उस अनुसार गोला लगाए	बच्चा स्कूल नहीं जाता 1..... खाने की गुणवत्ता अच्छी नहीं है 2..... खाना रोज़ नहीं मिलता है 3..... खाना हमारे स्वाद का नहीं बनता 4..... अन्य 98..... ब्योरा दे _____
C3.5	अगर हां ,तो पिछले हफ्ते आपके बच्चे को कितने दिन मध्यान्ह भोजन के अंतर्गत खाना मिला ?	हर दिन .....1 4-5 दिन .....2 2-3 दिन .....3 2 दिन से कम .....4 एक भी दिन नहीं .....5
C3.6	क्या आपको मध्यान्ह भोजन में इनमे से कोई परेशानी है ? एक से ज्यादा जवाब हो सकते हैं सभी विकल्प पढ़के उन्हें बताये और उस अनुसार गोला लगाए	अनियमित 1..... खाने की खराब गुणवत्ता 2..... एक सा खाना मिलता है रोज़ 3..... खाना हमारे स्वाद अनुसार नहीं है 4..... अन्य कोई 98..... ब्योरा दे _____
C4	खाद्य वितरण प्रणाली /राशन)यह पूरा भाग उन्ही से पूछे जिनके पास A 10में राशन है (
C4.1	क्या आपको राशन दूकान /सरकारी ट्रक से हर महीने राशन मिलता है ? अगर नहीं तो सीधे C .44 में जाएँ	हाँ 1..... नहीं.....2
C4.2	राशन दूकान महीने में कितनी बार खुलती है या राशन का सरकारी ट्रक कितनी बार आता है?	बिलकुल नहीं खुलता /आता 1..... सामान आता है तो खुलता है 2..... हर रोज़ खुला रहता है /आता है 3..... अन्य 98..... ब्योरा दे _____
C4.3	पिछले महीने आपको क्या क्या सामान मिला ? सभी विकल्प पढ़के उन्हें बताये और उस अनुसार गोला लगाए उत्तर लिखने के बाद सीधे C 5पे जाए	सामान मात्रा 1. चावल 2. गेहूं 3. दाल 4. तेल 5. चीनी 6. केरोसिन 7. नमक .8चना .98 अन्य ब्योरा दे _____

C4.4	राशन न मिलने के क्या कारण है ? एक से ज्यादा जवाब हो सकते है सभी विकल्प पढके उन्हें बताये और उस अनुसार गोला लगाए	राशन दूकान बंद रहती है 1..... राशन दूकान में राशन नहीं रहता है 2..... पैसा नहीं रहते है 3..... दूकान बहुत दूर है4..... कार्ड नहीं है 5..... कार्ड गिरवी रखा हुआ है 6..... अन्य 98..... ब्योरा दे _____
C 5	MNREGA रोज़गार गारंटी योजना	
C 5.1	क्या आपने MNREGA /रोज़गार गारंटी योजना के बारे में जानकारी है ? अगर नहीं तो ये भाग छोड़ दे और सीधे C5.6में जाए	हाँ1..... नहीं2.....
C 5.2	क्या आपके पास जॉब कार्ड है ? अगर 2या 3तो ये भाग छोड़ दे और सीधे C5.6में	हाँ1..... नहीं2..... आवेदन दिया है3.....
C5.3	पिछले साल MNREGA /रोज़गार गारंटी के अंतर्गत आपके परिवार को कितने दिन काम मिला? अगर एक भी दिन काम नहीं मिला तो अगला प्रश्न छोड़ दे और C5.6में जाए ।	काम मिला ही नहीं1..... 20दिन से कम का काम मिला2..... 40-20दिन 3..... 60-40दिन4..... 80-60दिन5..... 100 -80दिन6..... 100दिन से ज्यादा 7.....
C5.4	आपने या आपके परवार वालों ने आखिरी बार रोज़गार गारंटी के अंतर्गत कब काम किया था ?	इस महीने1..... 3-1महीने पहले 2..... 6-3महीने पहले 3..... 6महीने से अधिक पहले 4.....
C5.5	क्या आपको पिछले काम किये का भुगतान हो चुका है ?	हाँ1..... नहीं2..... पूरा पैसा नहीं मिला है 3.....
C5.6	पिछले साल क्या आपके परिवार में से किसी ने पलायन किया?	हाँ1..... नहीं2.....
C5.7	अगर हाँ तो किस माह में किया ?	_____
C5.8	कितने दिनों के लिए पलायन किया?	_____दिन

C6 .	स्वास्थ्य बीमा rsby)राष्ट्रीय स्वास्थ्य बीमा योजना ,RSBY/MSBY(
C 6.1	क्या आपके पास स्वास्थ्य बीमा कार्ड/बीमा स्मार्ट कार्ड है ? अगर हां तो प्रश्न C 6.3में जाए ।	हाँ1..... नहीं2..... Reasons why some people not have n
C 6.2	क्या कारण है की आपके पास बीमा स्मार्ट कार्ड नहीं है ? सभी विकल्प पढके उन्हें बताये और उस अनुसार गोला लगाए इस प्रश्न को पूछने के बाद सीधे भाग -D में जाए ।	नाम लिस्ट में नहीं था1..... गाँव में कार्ड बन रहा है इसकी जानकारी नहीं थी 2..... योजना के बारे में जानकारी नहीं थी 3..... कार्ड जहा बन रहा था वह जगह बहुत दूर थी4..... फोटो लिया गया पर कार्ड नहीं मिला अब तक5..... बनाने गए पर हमें वापस भेज दिया गया 6..... परिवार जन मौजूद नहीं थी जब कार्ड बन राहा था7.....

		हमारे गांव में कार्ड बना ही नहीं है 8..... कार्ड गूम हो गया 9..... कार्ड बनाने के समय गाव में नहीं थे 10..... कार्ड एक्सपायर हो गया है 11..... अन्य98..... ब्योरा दे _____
C 6.3	अगर हां तो कौन सा ? कार्ड देखके चेक करे	RSBY1..... MSBY2..... अन्य98..... ब्योरा दे _____
C6.4	क्या आपको बीमा बीमा स्मार्ट कार्ड बनवाने के लिए कोई खर्चा करना पड़ा ? अगर नहीं तो प्रश्न C6.6 में जाए वरना अगले प्रश्न में जाए	हाँ1..... नहीं2.....
C6.5	कार्ड बनवाने के लिए कितना पैसा देना पड़ा ? सभी विकल्प पढके उन्हें बताये और उस अनुसार गोला लगाए	30रूपये1..... 30रूपये से ज्यादा 2.....
C6.6	क्या आपको कभी बीमा बीमा स्मार्ट कार्डके अंतर्गत आने वाले हॉस्पिटल की सूची की जानकारी मिली?	हाँ1..... नहीं2.....
C6.7	क्या आपने कभी इलाज के लिए बीमा स्मार्ट कार्डका इस्तेमाल किया है ? अगर हां तो अगले प्रश्न में जाए वरना C6. 9में जाए	हाँ1..... नहीं2.....
C6.8	अगर हां ,तो शुरू से अब तक कितनी बार स्वास्थ्य बीमा कार्ड का उपयोग किया है ?	.....बार
C6.9	क्या आपको कभी कार्ड की सेवा लेने से हॉस्पिटल द्वारा मना किया गया या कार्ड इस्तेमाल के बावजूद अलग से पैसे देना पडा ?	हाँ1..... नहीं2.....

D. घर के उन सदस्यों की जानकारी जिनकी पिछले एक साल 365 /दिन में मृत्यु हुई ।

D1	D2	D3	D4	D5	D6	D7	D8
सदस्य आई डी नंबर	मृत सदस्य का नाम	लिंग १ .पुरूष २ .महिला	मृत्यु के समय की उम्र)साल (	क्या मृत्यु से पहले स्वास्थ्य सेवा) देसी या अंग्रेजी (मिली थी? 1. हां 2. नहीं	क्या अस्पताल में भर्ती हुए थी ? 1. हां 2. नहीं	अगर महिला है और उम्र 1 3-49 से बीच की है तो	
						क्या पिछले 365 दिन में गर्भवती हुई थी 1. हां 2. नहीं	अगर हां तो मृत्यु का समय गर्भवस्था के समय- 1 जचकी/प्रसव के समय -2

							गर्भपात के समय - 3 जचकी/ प्रसव/गर्भपात के 6 हफ्ते 42 /दिन के अन्दर-4 अन्य समय 98-)ब्योरा दे

E. पिछले 365दिन में अगर अस्पताल में भर्ती (IPD) हुए है तो उसकी जानकारी दे | टेबल D 6 - से देहांत के केस और टेबल B-10 में भरी गयी जानकारी से मिलान करे लिखे |(कोई दस्तावीज ,कागज़ ,फोटो आदि रखे)

पिछले 365दिन में अस्पताल में भर्ती हुए परिवार के सदस्यों की जानकारी							
क्रमांक	प्रश्न	जवाब					
E1	अस्पताल में भर्ती हुए सदस्य की ID B1 या D1से देखके लिखे						
E2	उम्र)साल (
E3	भर्ती होने की क्रमांक संख्या						
E4	क्या यह भर्ती पिछले 15दिन में हुआ है ? .1हाँ .2नहीं						
E5	बीमारी का प्रकार (बीमारी के कोड की लिस्ट देखे)						
E6	आप कौन से अस्पताल में भर्ती हुए थे? 1. SHC सब हेल्थ सेण्टर 2. PHC प्राथमिक स्वास्थ्य केंद्र 3. CHC सामुदायिक स्वास्थ्य केंद्र अस्पताल						

	4. सब डिवीज़न/ अनुमंडल अस्पताल 5. जिला अस्पताल 6. निजी अस्पताल 98.अन्य (ब्योरा दे)						
E7	आपने इस स्वास्थ्य केंद्र में जाने का निर्णय क्यों लिया ? (एक से ज्यादा जवाब हो सकते हैं) सभी विकल्प पढ़के उन्हें बताये और उस अनुसार गोला लगाए .1अच्छी सेवाएं .2गाड़ी उपलब्धता .3हमेशा वही जाते है .4घर के पास है .5रिश्तेदार/दोस्त/झोलाछाप ने सुझाव दिया rsbyRSBY .6 RSBY /MSBY के अंतर्गत इलाज मिल रहा था .7सस्ता है .8मितानिन /सहिया ने वहा रेफेर किया .9नर्स /डॉक्टर ने रेफेर किया 98. अन्य (ब्योरा दे)						
E8	इलाज का प्रकार)एक से ज्यादा जवाब हो सकते हैं(सभी विकल्प पढ़के उन्हें बताये और उस अनुसार गोला लगाए 1. दवाइयां 2. जांच /लैब टेस्ट /एक्स रे / ECG /अल्ट्रासाउंड 3. ऑपरेशन /सर्जरी 4. सलाह /सुझाव .5रेफेर किया .6प्रसव 98. अन्य (ब्योरा दे)						
E9	अस्पताल में कितने दिन भर्ती रहे .? दिन संख्या लिखे						
E10	मरीज के साथ कितने सदस्य सारा समय अस्पताल में रहे . ? सदस्य की संख्या लिखे						
	इलाज खर्च)रूपये में लिखे(
E11.1	अस्पताल फ़ीस /चार्ज						
E11.2	डॉक्टर /अस्पताल स्टाफ / नर्स अन्य विशेषज्ञ को दिया गया पैसा)। औपचारिक एवं अनौपचारिक(
E11.3	आने जाने /गाड़ी में खर्चा) ?मरीज का (
E11.4	दवाई/सुई /अन्य consumables में खर्चा ?)रूपये में लिखे (
E11.5	जांच में खर्चा ?)रूपये में लिखे (

E11.6	बेड चार्ज में खर्च ?)रूपये में लिखे (
E11.7	अन्य मेडिकल खर्च (attendant charges, physiotherapy, personal medical appliances, खून , आक्सीजन ,आदि))रूपये में लिखे (
E118.	अन्य गैर मेडिकल खर्च)परिवार के लिए भोजन , परिवार जन के रहने ,आने जाने का खर्च(
E11	कुल लागत)ऊपर से 11.1-11.8 जोड़के देखे और मिलान कर ले()रूपये में लिखे(
E12	यह खर्च आपने कहा से पूरा किया ? एक से ज्यादा जवाब हो सकते है 1. घर की कमाई /बचत के पैसे 2. उधारी 3. घर का सामान बेचा 4. दोस्तों और रिश्तेदारों ने दिए 98. अन्य (ब्योरा दे)						
E13	RSBY बीमा स्मार्ट कार्ड /बीमा कार्ड का उपयोग						
E13.1	क्या आपने अस्पताल में भर्ती होने पर RSBY बीमा स्मार्ट कार्ड /बीमा कार्ड का उपयोग किया ? 1. हां 2. नहीं अगर नहीं तो ही अगला प्रश्न E 13.2पूछे वरना E13.3 में जाए |						
E13.2	अगर आपने कार्ड इस्तेमाल नहीं किया तो क्या कारण थे)एक से ज्यादा जवाब हो सकते है(सभी विकल्प पढके उन्हें बताये और उस अनुसार गोला लगाए 1. हमारे पास RSBY कार्ड नहीं था। 2. मरीज का RSBY में नामांकन नहीं था । 3. अस्पताल स्टाफ ने बीमा स्मार्ट कार्डके लिए नहीं पूछा 4. अस्पताल ने RSBY के अंतर्गत इलाज करने से मना कर दिया । 5. इस इलाज का बीमा स्मार्ट कार्डके अंतर्गत पैकेज नहीं था । 6. कार्ड में पैसा खतम हो गया था । 7. फिंगर प्रिंट्स का मिलान नहीं हो पा रहा था । 8. कंप्यूटर / इन्टरनेट में खराबी थी। । 9. कार्ड एक्सपायर हो गया था .98अन्य)ब्योरा दे (सीधे e E14में जाए						
E13.3	अगर हां तो कितना पैसा कटा?)रूपये में लिखे(96. पता नहीं ।						

E13.4	डिस्चार्ज के समय क्या आपको आने जाने का किराया का 100रुपया मिला 1. हां 2. नहीं						
E13.5	क्या आपको डिस्चार्ज /छुट्टी के समय बीमा स्मार्ट कार्डकी पावती /रसीद मिला ? 1. हां 2. नहीं						
E13.6	अस्पताल में एडमिट होने पे कार्ड इस्तेमाल करने के बावजूद क्या आपको कोई पैसा खर्च करना पड़ा ? उपर खर्च पे पूछे गए E 11 से मिलान करे. यह खर्च E 11 के इलावा होना चाहिए 1. हां 2. नहीं						
E14	इलाज से किस तरह का परिणाम मिला । 1. ठीक हो गए 2. कुछ हद तक ठीक हुए 3. कोई फरक नहीं पड़ा 4. अभी भी इलाज चल रहा है 5. मृत्यु 6.रेफेर किया 98. अन्य)ब्योरा दे(
E15	क्या आप अस्पताल से संतुष्ट है ? 1. हां 2. नहीं 3.कुछ हद तक						
E16	अगर उपर पूछे गए सवाल का जवाब 2या 3है तो उसका कारण लिखे ।						

F. पिछले 15दिन में हुई बीमारी के इलाज की जानकारी (बाह्य रोगी मरीज -टेबल D5 से देहांत के केस और B 12 से अस्वस्थता के केस का मिलान करे करे (कोई दस्तावीज ,कागज़ ,फोटो आदि रखे)

क्रमांक	प्रश्न	जवाब					
	क्रमांक						
F 1	सदस्य ID (जैसे टेबल B1 और डी1 में बतायी)						
F 2	उम्र (जैसे टेबल B5 और डी4 में बतायी)						
F 3	किस तरह की बीमारी (कोड लिस्ट अंत में)						
F 4	कितने समय से आपको वह बीमारी थी ? 1. 15 दिन से पहले से थी और अभी तक चल रही है 2. 15 दिन से पहले से थी और अब ठीक हो गयी है 3. पिछले 15 दिन के अन्दर हुई और अभी तक है 4. पिछले 15 दिन के अन्दर हुई और अब ठीक हो गयी						
F 5	क्या आपने अपनी बीमारी के लिए इलाज लिया या दिखाया ? 1. हां 2. नहीं अगर नहीं लिया तो F14 में जाए						

F 6	बीमारी के लिए क्या इलाज लिया ? 1. घरेलु इलाज/ खुद अपना इलाज किया 2. झोलाझाप / लोकल स्वास्थ्य प्रदाता 3. वैद्य/ जड़ी बूटी 4. ओझा / झाड फूँक 5.मितानिन /सहिया 6ANM	.7PHC प्राथमिक स्वास्थ्य .8CHCसामुदायिक स्वास्थ्य .9अनुमंडलीय अस्पताल .10जिला अस्पताल .11निजी डॉक्टर /अस्पताल .98अन्य (ब्योरा दे)						
F 7	आप इलाज के लिए क्यों इस स्वास्थ्य केंद्र /इलाज को क्यों चुना ? एक से ज्यादा जवाब हो सकते है .1अच्छी सेवाएं .2गाड़ी उपलब्धता .3हमेशा वही जाते है .4घर के पास है .5रिश्तेदार/दोस्त/झोलाछाप ने सुझाव दिया	rsby .6/MSBY के अंतर्गत .7सस्ता है .8मितानिन /सहिया .9नर्स /डॉक्टर ने रेफर किया 98. अन्य (ब्योरा दे)						
F 8	इलाज का प्रकार)एक से ज्यादा जवाब हो सकते है(सभी विकल्प पढके उन्हें बताये और उस विकल्प पर गोला लगाए .1दवाइयां .2जांच /लैब टेस्ट /एक्स रे / ECGई.सी.जी/अल्ट्रासाउंड .3ऑपरेशन /सर्जरी 98. अन्य)ब्योरा दे(	4. सलाह .5झड़व .6जड़ी						
	इलाज खर्चा							
F 9.1	हास्पिटल/क्लिनिक द्वारा ली गयी चार्ज फीस							
F 9.2	डॉक्टर /अस्पताल स्टाफ / नर्स अन्य विशेषज्ञ या वैध /ओझा को दिया गया पैसा)। औपचारिक एवं उनौपचारिक()रूपये में लिखे (
F 9.3	आने जाने /गाड़ी में कितना खर्चा हुआ ?)रूपये में लिखे (
F 9.4	दवाई में खर्चा ?)रूपये में लिखे (
F 9.5	जांच में खर्चा ?)रूपये में लिखे (
F 9.6	अन्य मेडिकल खर्च (attendant charges, physiotherapy, personal medical appliances, खून , आक्सीजन ,झाड फूँक आदि))रूपये में लिखे (
F 9.7	अन्य गैर मेडिकल खर्च)परिवार जन का भोजन ,रहना , आना जाना आदि (
F 9	कुल लागत)F 9.1 सेF 9. 7 तक जोड़ें और मिलान कर लें)रूपये में लिखे (

F 10	यह खर्चा आपने कहा से पूरा किया ? एक से ज्यादा जवाब हो सकते है 1. घर की कमाई /बचत के पैसे 2. उधारी 3. घर का सामान बेचा 4. दोस्तों और रिश्तेदारों ने दिए 98. अन्य ब्योरा दे						
F 11	क्या आप आपको मिले इलाज से संतुष्ट थे ? 1. हाँ 2. नहीं 3.कुछ हद तक						
F 12	अगर उपर पूछी प्रश्न का जवाब 2या 3है तो उसका कारण लिखे						
F 13	इलाज से किस तरह का परिणाम मिला । 1. ठीक हो गए 2. कुछ हद तक ठीक हुए 3. कोई फरक नहीं पड़ा 4. अभी भी इलाज चल रहा है 5. मृत्यु 98. अन्य)ब्योरा दे (
F 14	अगर इलाज नहीं लिया तो इलाज ना लेने के क्या कारण थे ? एक से ज्यादा जवाब हो सकते है 1. आस पास कोई स्वास्थ्य सेवा उपलब्ध नहीं है । 2. अच्छी गुणवत्ता और सेवायों वाला कोई स्वास्थ्य सेवा उपलब्ध नहीं है । 3. अच्छी सेवाएं बहुत महंगी है । 4. अच्छी सेवाएं लेने में जाने में बहुत समय लगता है 5. इतना गंभीर बीमारी नहीं था । 6. पैसे नहीं थे .98अन्य (ब्योरा दे)						

g. परिवार नियोजन)उन सभी महिलाओं से पूछे जिनकी कभी भी शादी हुई हो एवं साक्षात्कार के समय उपस्थित हैं)

कोड	Items	उत्तर दाता 1	उत्तर दाता 2	उत्तर दाता 3	उत्तर दाता 4
G 1	Member ID				
G 2	उत्तरदाता का नाम				
G 3	उम्र)साल (
G 4	शादी के वक्त आपकी क्या उम्र थी ?				
G 5	पहली बार गर्भधारण के समय आपकी उम्र क्या थी ?				
G 6	आप कितनी बार गर्भवती हुई है ? संख्या लिखे				

G 7	अभी कितने बच्चें हैं ? संख्या लिखे				
G 8	क्या आपका कभी गर्भपात हुआ /बच्चा गिर गया /खराब हो गया है ? 1. हां 2. नहीं				
G 9	क्या आपको कभी मृत बच्चा पैदा हुआ है ? 1. हां 2. नहीं				
G 10	क्या आपको कभी स्वास्थ्य कार्यकर्ताओं /सेवा प्रदातों ने परिवार नियोजन संबंधी जानकारी/सुझाव दिए हैं ? 1. हां 2. नहीं				
G 11	क्या आपने कभी कोई परिवार नियोजन के उपाए)सरकारी या प्राकृतिक (अपनाए ? 1. हां 2. नहीं अगर हां तो अगला प्रश्न पूछे वरना G 13 में जाए				
G 12	अगर हां तो परिवार नियोजन का कौन सा तरीका अपनाया ? 1. परिवार नियोजन की गोलियां 5. कंडोम /निरोध 2. महिला नसबंदी 6. कॉपर टी 3 पुरुष नसबंदी 7.जडी बूटी 4.सनयम 98.अन्य)ब्योरा दे(
G 13	क्या आपने कभी स्वास्थ्य कार्यकर्ताओं से अस्थायी परिवार नियोजन के साधनों की मांग की है ? अगर हां तो अगले प्रश्न में जाए वरना G 15में जाए । 1. हां 2. नहीं				
G 14	अगर हाँ तो क्या वह आपको मिला ? 1. हां 2. नहीं				
G 15	क्या आपने या आपके पति ने नसबंदी करायी है ? 1. हां 2. नहीं अगर हां तो अगले प्रश्न पूछे वरना आखिरी प्रश्न G 21 में जाए				
G 16	अगर हाँ तो क्या वह आपसे /आपके पति की सहमति से हुई थी ? 1. हां 2. नहीं				
G 17	कहाँ नसबंदी करवाई ? .1PHC /प्राथमिक स्वास्थ्य केंद्र .5निजी अस्पताल .2CHC /सामुदायिक स्वास्थ्य केंद्र .6नसबंदी शिविर .3जिला अस्पताल .98अन्य)ब्योरा दे(.4सब डिवाइज़न अस्पताल				
G 18	क्या आपको /आपके पति को नसबंदी के लिए राज्य से बाहर जाना पड़ा 1. हां 2. नहीं				
G 19	क्या आपको /आपके पति को कभी किसी ने नसबंदी के लिए मना किया ? 1. हां 2. नहीं अगर नहीं तो अगला प्रश्न ना पूछे और G 21में जाए ।				
G 20	किसने मना किया ? .1ANM .3 स्वास्थ्य अधिकारी ने 2. स्वास्थ्य केंद्र में डॉक्टर ने .98 अन्य)ब्योरा दे(
G 21	अगर मौक़ा दिया जाए तो क्या आप नसबंदी करवाना चाहेंगे ? 1. हां 2. नहीं				

H	मातृत्व स्वास्थ्य)यह प्रश्न उन महिलाओं से पूछे जो अभी गर्भवती है या जिनका पिछले एक साल में जचकी हुआ है(1साल से छोटे बच्चों की जानकारी टेबल बी से ली जा सकती है				
H1	क्या आपने खुद का ANM /नर्स से रजिस्ट्रेशन /पंजीयन करवाया था /है ? 1. हां 2. नहीं				
H2	क्या आप पिछली प्रसव /वर्तमान गर्भावस्था में प्रसव पूर्व स्वास्थ्य जांच के लिए गयी ? 1. हां 2. नहीं अगर नहीं तो H 5में जाए				
H3	पिछली /वर्तमान गर्भावस्था में प्रसव पूर्व स्वास्थ्य जांच के लिए आप कहा कहाँ गयी | एक से ज्यादा जवाब हो सकते है .1आंगनवाड़ी /ग्राम स्वास्थ्य एवं पोषण दिवस 6. निजी अस्पताल 2. सब सेंटर /ANM 7. लोकल गाँव के अप्रशिक्षित स्वास्थ्य 3. PHC/प्राथमिक स्वास्थ्य केंद्र 8. झाड फूँक /ओझा 4. CHC /सामुदायिक स्वास्थ्य केंद्र 98. अन्य)ब्योरा दे(5. जिला अस्पताल				
H4	पिछली/वर्तमान गर्भावस्था में आप कितने बार डॉक्टर या ANM से जांच करवाई ? 3 .1बार 3 .3 से कम बार 3 .2से ज्यादा बार .4 कभी नहीं				
H5	आपका पिछला प्रसव /जचकी कहा हुआ था ? 1.घर .3 संस्थागत प्रसव निजी अस्पताल में 2. संस्थागत प्रसव सरकारी अस्पताल में .4 अस्पताल जाते समय रास्ते में अगर 1 या 4 है तो H13में जाए अगर संस्थागत प्रसव है तो अगले प्रश्न में जाए				
H6	क्या आपको घर से अस्पताल तक मुफ्त साधन मिला था ? 1. हां 2. नहीं				
H7	क्या स्पताल में मुफ्त खाना मिला था ? 1. हां 2. नहीं				
H8	अगर संस्थागत प्रसव था तो किस तरह का प्रसव था ? 1. नार्मल 2. बड़ा ऑपरेशन/सर्जरी (सिजेरियन)				
H9	अस्पताल से डिस्चार्ज कब मिला ? 1. उसी दिन 4 . तीन दिन के बाद 2. एक दिन के बाद5 . सात दिन के बाद .3दो दिन के बाद 98 . अन्य (ब्योरा दे)				
H10	क्या आपको अस्पताल से घर तक जाने के लिए मुफ्त साधन मिला ? 1. हां 2. नहीं				
H11	क्या आपको जननी सुरक्षा योजना का पैसा मिला ? 1. हां 2. नहीं				
H12	अगर हाँ तो कितना ? रूपये में लिखे	_____	_____		
		रु .	रु .		

				— — रु.	— — रु.
H13	<p>प्रसव /जचकी के कितने दिन बाद आपने घर का काम करना शुरू किया ?</p> <p>.1जचकी के 15दिन में .4 जचकी के बाद तीन से 6 महीने में</p> <p>.2जचकी के बाद 15से 1महीने में .5 जचकी के 6महीने बाद</p> <p>.3जचकी के बाद एक महीने से तीन महीने के अन्दर में</p>				
H14	<p>प्रसव /जचकी के कितने दिन बाद आपने घर से बाहर का काम (मजदूरी, वनोपज, खेती, लकड़ी, पानी लेने जाना आदि) करना शुरू किया ?</p> <p>.1जचकी के 15दिन में .4 जचकी के बाद तीन से 6 महीने में</p> <p>.2जचकी के बाद 15से 1महीने में .5 जचकी के 6महीने बाद</p> <p>.3जचकी के बाद एक महीने से तीन महीने के अन्दर में</p>				
H15	<p>क्या जचकी /प्रसव के बाद कोई स्वास्थ्य कार्यकर्ता आपके घर आया ?</p> <p>1. हाँ 2. नहीं</p> <p>अगर नहीं तो अगला प्रश्न पूछे और H16 में जाए |</p>				
H16	<p>अगर हाँ तो कौन आया था)? एक से ज्यादा जवाब हो सकते हैं (</p> <p>AN .1ANM .4 पुरुष कार्यकर्ता</p> <p>2. ASHA/मितानिन /सहिया .98 अन्य)ब्योरा दे(</p> <p>.3आंगनवाडी कार्यकर्ता</p>				
H17	<p>क्या आपको बच्ची के पोषण एवं देखभाल सम्बंधित कोई सुझाव दिए ?</p> <p>1. हाँ 2. नहीं</p>				
H18	<p>अगर हाँ तो कौन दिया)? एक से ज्यादा जवाब हो सकते हैं (</p> <p>AN .1ANM .4 पुरुष कार्यकर्ता</p> <p>2. ASHA/मितानिन /सहिया .98 अन्य)ब्योरा दे(</p> <p>.3आंगनवाडी कार्यकर्ता</p>				
H19	<p>जचकी के बाद क्या हुआ</p> <p>.1बच्चा, अभी स्वस्थ है .3 बच्चा 28दिन के बाद खतम हो गया</p> <p>.2बच्चा 28दिन के अन्दर खतम हो गया .4मृत बच्चा पैदा हुआ</p>				
H20	<p>क्या आपको रोजगार गारंटी के अंतर्गत 4000रुपया मिला) ?सिर्फ छत्तीसगढ़ के लिए (</p> <p>.1हाँ .2नहीं</p>				

उत्तरदाता को उनके समय के लिए धन्यवाद दे, समुदाय के किन्ही सवालों का जवाब दे एवं पृष्ठ 2पे हस्ताक्षर करके साक्षात्कार समाप्त करे |

Study tools: Health Action by People

Anganwadi workers

1. Among the population residing in this area, which strata of the society interact with you often and what kind of services do they seek? Do people outside your survey area utilise services of your anganwadi?
2. In your experience, how adequately do tribal and nontribal populations seek and utilise health care services?
3. Do the socio economic and cultural barriers affect the utilisation of health care services? What are your experiences?
4. In your opinion, has the supplementary nutrition services helped in enhancing nutrition of the population in your area?
5. What are the challenges you face in reaching out women in remote settlement areas?
6. What are the maternal and child health issues you have observed among your population?
7. Do you think that the present health care facilities are adequate for the needs of the people?

8. Antenatal Mother

9. 1. For what all services do you approach the local health facility? What are your experiences? (positive as well as negative)
10. 2. During your pregnancy, which health facility did you approach? What are the challenges you faced when you utilised the health facility? (Accessibility, affordability)
11. 3. Can you share briefly your experience on visiting a gynecology OP?
12. 4. Can you share briefly your experience on visiting while an immunisation clinic?
13. 5. What do you think are the elements that can be included in the services of AWW, ASHA and Tribal health worker?

14. 6. What do you think are the reasons for the delays in receiving the benefits of Jananai Suraksha Yojanaa and Janani Janmasuraksha Yojana?
15. 7. What are the infrastructural needs that can cater to better health care in your area?
16. 8. Do you think that nature of access and utilisation of health care services vary across settlements? In such a context, what do you think are the elements that make up good quality health care services?

ASHA workers

1. Among the population residing in this area, which strata of the society interact with you often and what kind of services do they seek?
2. In your experience, how adequately do tribal and nontribal populations seek and utilise health care services?
3. Do the socio economic and cultural barriers affect the utilisation of health care services? What are your experiences?
4. How adequately do you engage in creating awareness on immunisation and antenatal care services among your population?
5. What are the challenges you face in reaching out women in remote settlement areas?
6. What are the maternal and child health issues you have observed during the visits?
7. Do you think that the present health care facilities are adequate for the needs of the people?

Community leaders and NGO's

1. Your background, personal information and experience in the tribal sector.
2. In your opinion, how do tribal populations seek healthcare services?
3. What are the major health problems faced by women in your community?
4. What are the maternal and child health services (antenatal care, supplementary nutrition & immunisation) available for tribal population in your community?
5. What is your opinion about these services?
 - a. Quality of services provided
 - b. Accessibility of services provided
 - c. Affordability
 - d. Coverage

- e. Usefulness
6. Do these services cover the needs of the community?
 7. Can you recall any instances where the services were not adequately provided? (Probe further) Please describe.
 8. What are the barriers facing the community in utilisation of these services at the point of service delivery? (Doctors and other health staff) (Availability of HR)
 9. What is your opinion about the health workers in your area and their interaction with the community?
 - a. Adequacy
 - b. Attitude
 - c. Knowledge
 - d. Delay in response
 10. What is your opinion regarding the involvement of the following authorities with respect to the provisioning of various health and health related services in your area?
 - a. Health and family welfare
 - b. Tribal
 - c. Social Justice (ICDS)
 - d. Education
 - e. Employment

 - f. LSGD
 - g. PWD
 - h. Any other (please specify)
 11. Do you have any suggestions?
 12. Do you think that there are factors within the community that influence healthcare utilisation?

(Probes) (SN, immunisation and ANC)

 - a. Tribal groups
 - b. Custom
 - c. Culture
 - d. Rituals
 - e. Beliefs
 - f. Gender (focus on substance abuse)
 - g. Income
 - h. Others. (Probe further)

13. What is your opinion about the special government schemes like JSY, JSSK, RSBY, CHIS, insurance schemes etc.?
 - a. Awareness
 - b. Utilisation
 - c. Coverage
 - d. Barriers in receiving benefits
14. In your experience do tribal have any preference for a specific system of medicine with respect to ANC services and the reasons?
15. Are there any NGO's giving ANC services in your area? Comment on the services being provided.

Additional Questions to NGO's (above Questions plus)

1. What are the ANC services provided by your NGO?
2. Ease of doing work in tribal areas.
 - a. Local people, health officials, government staff, community leaders, shortage of staff etc.

Interview Guide – Health Services Dept

1. What are the most important MCH issues (SN, Immunisation, ANC) you have observed among the population? And in tribes and non tribes separately.
2. Are there any special provisions for the tribal population? If Yes, What are they?
3. In your experience, do you find any difference in utilisation of these services between tribal and non tribal population? What could be the reasons, if there is such a difference?

Probe using

- a. Access – geographical, social, transportation, cultural etc
 - b. Affordability (Cost related to Medicine, Lab Investigations, Transport etc)
 - c. Availability issues (HR, Infrastructure & Medicinal / Equipment logistics)
 - d. System responsiveness
 - e. Gender in decision making
 - f. Education
4. Are there any specific measures taken for planning and implementation of services for the tribes?

5. With respect to the special provisions made for the tribal population, have they resulted in better utilisation of the services? If yes/no, what could be the reasons behind it?
Probe into LSG involvement, Intersectoral Coordination, NGO involvement etc

Tribal welfare department –

Project officers / State level officers / Promoters

1. Your background, personal information, experience in the tribal sector
2. In your opinion, how adequately do tribal populations seek health care services?
 - a. Especially maternal and child health
3. Are the services for tribals equally provided?
4. Are the services for tribals accessed by all tribal populations?
 - a. What the barriers if any for reaching certain tribal populations?
5. Can you identify the possible barriers to seeking health care services?
 - a. Physical access / adequacy in terms of geographical reach
 - b. Gender differences
 - c. Cultural acceptability
 - d. Economic
 - e. System not responsive to tribal needs (HR)
6. What are the steps / interventions taken so far to address these barriers? (Probe – programme)
 - a. What has been the outcome of these interventions?
 - b. What is your opinion on why these interventions fail / become only partially successful?
 - c. Why is the overall development of tribals fail in terms of education, socio-economic development, income generation, nutrition and immunisation?
7. In your opinion what are the barriers to tribals receiving services under the already existing schemes for tribals?

