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Children of India: Rights and Opportunities

Including Scheduled Tribes in Orissa's Development:

Barriers and Opportunities

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Foreword

Children below the age of 18 years account for nearly 40 per cent of India's population. It goes without saying that enabling all children to realize their full creative potential is critical for sustaining India's economic growth and accelerating human development. Not all children have benefited equitably from the remarkable progress and transformation that the country has witnessed in recent years. Tens of millions still face basic challenges of survival and healthy development.

Children are first and foremost individuals, born with indivisible and inalienable human rights. They also belong to families and communities that need to have access to resources and services, as well as capacities to ensure realization of their rights. Policy approaches are needed that address both the income and non-income dimensions of children's deprivations. Continued neglect of material, human and psycho-social dimensions of child well-being can prevent children from living a full life and from making informed decisions later on in their life. India too would miss out on the dividends that can accrue from a full expansion of children's capabilities.

The Institute for Human Development (IHD) and UNICEF are partnering to offer a platform for examining different dimensions of child rights. Experts and commentators were invited to explore the impact of development policies on children and women and suggest alternative approaches to the elimination of children's deprivations. They have explored how best to ensure that all children benefit from equal and non-discriminatory access to basic social services. They have looked at ways of capitalizing on the demographic dividend, creating fiscal policy space for investing in children and strengthening the legislative and institutional framework for protecting children.

These contributions are being brought out as IHD - UNICEF Working Paper Series *Children of India: Rights and Opportunities*. We hope that the series will contribute to enriching public discourse and strengthening public action to promote the rights of children.

Alakh N. Sharma
Director, Institute for Human Development

Karin Hulshof
India Country Representative, UNICEF

Including Scheduled Tribes in Orissa's Development:
Barriers and Opportunities

Soumya Kapoor Mehta*

Summary

Orissa suffers the ignominy of having the highest poverty rate among Scheduled Tribes (STs) in India, with nearly three-fourths of its tribal population below the official poverty line in 2004-05. With Scheduled Tribes in the state falling behind other groups on practically every development parameter, there is an increasing recognition in policy circles to focus on their development. Rapid alienation of tribals from forests and their traditional land and a rise in extremist movement in tribal areas in Orissa

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Opinions expressed in this paper are entirely the author's. Comments/inputs are welcome (Email: soumyakapoor@gmail.com)

has given a sense of urgency to 'including' Scheduled Tribes in Orissa's growth, driven by mineral based industries located mostly in tribal pockets.

This paper examines the poor outcomes documented for Scheduled Tribes in Orissa to identify the reasons thereof, policies that exist currently to address tribal deprivation, gaps in these policies, and a future agenda for promoting inclusion of Scheduled Tribes in Orissa's growth. Not only does it establish the extent of divide that tribals experience with respect to other groups, but also delves into the history of the divide and how it has, over time, restricted access of Scheduled Tribes to assets, markets, livelihoods, social services and more broadly, to political spaces in the state. It argues that any agenda to promote social inclusion in Orissa should be set against the challenging context in which Scheduled Tribes in the state find themselves in.

While there are several policies in place to promote the interests of Scheduled Tribes in Orissa, implementation is a problem. A common refrain from planners, programmers and functionaries in tribal areas is one of demand being weak and supply non-responsive. Lack of demand is mostly attributed to poor education and awareness levels in tribal communities. Although the state has initiated awareness interventions, most come in a language (Oriya) alien to tribals instead of in their local dialects. The bigger lacuna however is that of supply. Despite a considerable drive to improve school and health infrastructure in tribal areas, these structures remain empty, afflicted by high absenteeism of functionaries and inadequate supply of materials and basic facilities like water. A larger issue is that of mistrust between tribals and the usually non-tribal service providers. The latter also rue the inflexibility in central government programmes that do not allow them a window to innovate and involve tribal communities. Most programmes are therefore provided in the routine, without any involvement of the community, to achieve some perfunctory number. Worse, lack of data on services disaggregated by provision to tribals versus others makes monitoring of programme delivery to the former difficult.

The paper concludes with some principles that can help facilitate inclusive programming for Scheduled Tribes in Orissa followed by some specific interventions that can be undertaken in the areas of health, education and building voice for these groups. It acknowledges that there are no easy answers and policy inevitably involves trade-offs with support for one group being seen as working against the other. However, given the low base that

tribals start off with, some targeted interventions are necessary. Having said that, true inclusion can be achieved only through equitable outcomes in the mainstream. This will involve cohesion and collective thinking from policy makers, civil society, academics and donor organisations as well as a shift in the paradigm – that of viewing the Scheduled Tribes as one of 'us' rather than as 'them'.

Abbreviations and Acronyms

ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
BJD	Biju Janata Dal
BPL	Below Poverty Line
BRGF	Backward Regions Grant Fund
CAG	Comptroller and Auditor General
CMS	Content Management System
CRM	Common Review Mission
DISE	District Information System for Education
DFID	UK Department for International Development
HMIS	Health Management Information System
HRD	Human Resource Development
ICDS	Integrated Child Development Services
IEG	Independent Evaluation Group
IFA	Iron and Folic Acid
IFAD	International Fund for Agricultural Development
IFPRI	International Food Policy Research Institute
IIPS	International Institute for Population Sciences
IMR	Infant Mortality Rate
ITDA	Integrated Tribal Development Agency
MDG	Millennium Development Goal
MGNREGS	Mahatma Gandhi National Rural Employment Guarantee Scheme
MIS	Management Information System

MLE	Multilingual Education Intervention
MLP	Micro-level Planning
NFHS	National Family Health Survey
NGO	Non-governmental Organization
NIPDIT	National Institute for People's Development, Investigation and Training
NRHM	National Rural Health Mission
NSS	National Sample Survey
NTFP	Non-timber Forest Produce
OBC	Other Backward Classes
OPEPA	Orissa Primary Education Programme Authority
PDS	Public Distribution System
PESA	Panchayat Extension to Scheduled Areas Act
PHC	Primary Health Centre
PMGSY	Pradhan Mantri Gram Sadak Yojana
PIP	Project Implementation Plan
PRI	Panchayati Raj Institution
RCH	Reproductive Child Health Survey
RTE	Right to Education Act
SC	Scheduled Caste
SHG	Self-help Group
SIRD	State Institute of Rural Development
SSA	Sarva Shiksha Abhiyan
ST	Scheduled Tribe
TBA	Traditional Birth Attendant
TSP	Tribal Sub-plan
U5MR	Under Five Mortality Rate
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
VTC	Vocational Training Centre

Including Scheduled Tribes in Orissa's Development:
Barriers and Opportunities

1. Introduction

One of the primary objectives of the Government of Orissa is to "achieve all round development, transforming Orissa into one of the most prosperous states along with complete development of women, children and under-developed classes" (Biju Janata Dal [BJD] Manifesto, 2009). The goal of inclusion is by no means peculiar to the state of Orissa. The 11th Five Year Plan (2007-12) of the Government of India too is structured around a vision of "faster, more broad-based and inclusive growth" and bridging divides – between the rich and the poor, between urban and rural areas, between different regions, and groups that have hitherto been excluded socially such as Scheduled Castes (SCs), Scheduled Tribes (STs) and women. However, the state of Orissa is peculiar in the high share of SCs and STs in its population. According to the 2001 Census, SCs and STs comprise 22.1 per cent and 16.5 per cent of the state population respectively, bringing the overall share of these groups to 38.6 per cent. Further, about 45 per cent of Orissa is classified as Scheduled Area under Schedule V of the Constitution, which identifies special privileges for those areas where the majority of the population belong to Scheduled Tribes.

Given the high share of tribals in the state's population, a focus on tribal development has always been high on Orissa's policy agenda. But of late, tribal concerns have come to occupy a prime place in policy thinking within the state. This is driven by the fact that Orissa's current source of growth, i.e. mineral resources lie predominantly in areas where the tribals reside. Setting up mineral based industries in these pockets has therefore resulted in large-scale displacement of tribals from their traditional land with accompanying problems of resettlement and rehabilitation. This has fuelled resentment against the government, with several analysts calling such alienation the predominant cause of tribal angst and their joining anti-state groups including the naxalites. Not surprisingly, calls for identifying the processes that result in tribal deprivation have gained salience in recent years.

The objective of this review is to identify the underlying processes and pathways that result in poor outcomes for Scheduled Tribes in Orissa, policies that currently exist to address their deprivation, gaps in these policies, and a future agenda for promoting inclusion of tribals in the state, so they too can share the benefits of the growth Orissa is experiencing.

Before this paper delves further into the data and challenges specific to addressing tribal concerns in Orissa, it is critical to dispel some notions that often arise about Scheduled Tribes in general. First, the term Scheduled Tribes in itself is derived from a schedule in the Constitution Order of 1950 that grouped tribal populations in independent India into one category for purposes of affirmative action and protective discrimination. In that sense it is more an administrative category. Sociologically speaking, Scheduled Tribes comprise very diverse tribal groups with each tribe having distinct customs, including language, food, etc. Any aggregate analysis of 'Scheduled Tribes' therefore is meaningless because it cannot capture the uniqueness that defines each distinct tribal group. However, most national data is gathered according to the broader, administrative nomenclatures that exist as per the Constitution (e.g. SC, ST, Others). This is a restriction imposed by data and should not be read as an attempt at generalisation.

Second, from a historical lens, Scheduled Tribes are seen as the 'original inhabitants' or the 'indigenous peoples' of India – hence the translation into Adivasi (Adi = earliest time, Vasi = resident of). But the Indian state rejects the term 'indigenous peoples' as it considers it 'divisive, undermining the unity of the Indian nation' (Ghurye quoted in Chopra 1988). For this reason, this paper refrains from using the term Adivasi, but does use the word 'tribals' interchangeably with Scheduled Tribes.

Finally, and most significantly, it is common to hear of Scheduled Tribe issues being conflated with those of the Scheduled Castes. This is a misnomer as the reasons for exclusion of tribals are very different than that of the latter. Tribals do not strictly fall within the Hindu caste hierarchy and therefore do not face ritually endorsed exclusion, say in the form of untouchability, as do the Scheduled Castes. Instead, they face exclusion largely because of their physical isolation in remote parts of the country. Also, unlike the Scheduled Castes, tribal communities have traditionally owned at least subsistence land and have had some agriculture to fall back upon. It is now with the state taking ownership of most forests and with industries (particularly mineral-based ones) gradually spreading to tribal areas that STs find themselves increasingly alienated from their land and economic livelihoods. Different

policies therefore need to be adopted to address the exclusion of STs, rather than that of SCs. While for the SCs, policies should focus on addressing social discrimination (e.g. the practice of untouchability in schools) along with asset creation; for STs the challenge is one of making available, resources in remote pockets and addressing the issue of displacement.

With this broad perspective in mind, the paper starts by establishing the extent of the divide between STs and other groups (including SCs) in Orissa using available disaggregated data on a range of development outcomes (Section 2). But disaggregated outcomes are only a "symptom" of tribal deprivation and exclusion. Addressing exclusion requires addressing the underlying causes or processes that lead to exclusion. Unfortunately, most policy documents and programmes stop at merely documenting the symptom. That is, they monitor differences in outcomes, disaggregated by groups. There is no differential analysis of the causal pathways that result in exclusion. Such pathways or processes may operate both on the demand and the supply side. To illustrate, health functionaries attribute high maternal mortality of ST women (a symptom) to income poverty and lack of demand among them to give birth at government health centres. But poor demand in turn may be driven by gaps in supply. Tribal women may be willing to go to formal health facilities, but may hesitate to do so because of absenteeism of medical officers and the latter's callous attitude to their treatment. Exclusionary processes therefore unfold at several levels. Moreover, they differ by context. What may hold true for one district or even a village may not hold true for another. Thus any analysis of exclusion needs to be contextual.

Section 3 and 4 summarise some of the gaps and challenges in addressing exclusion of STs in Orissa, both on the demand and the supply side. These are discussed against a broader context of the history, politics, and social institutions of Orissa that have traditionally constrained access of STs to assets, markets, livelihoods, social service delivery mechanisms and more broadly voice and participation. We conclude in Section 5 with some principles for inclusive programming and specific recommendations for promoting the interests of STs in the state.

The analysis contained in this paper is based on data from several sources, including the Indian census; three rounds of the National Sample Survey (NSS 1983, 1994-94 and 2004-5); three rounds of the Indian National Family Health Survey (NFHS 1992-93, 1998-99 and 2005-6); the Reproductive Child Health (RCH) Survey II (2005); data from the District Information System for Education (DISE) and the e-shishu programme in Orissa; and other

independent studies. In addition, it draws on multiple stakeholder interviews conducted by the author during a field visit to Bhubaneshwar, Orissa in October 2009. These interviews held with representatives from the government, civil society, academia and donor agencies such as DFID and UNICEF formed the basis for laying down key demand and supply barriers in existing programmes (as the stakeholders perceived them); wider economic, social, and political economy issues; and areas of opportunities wherein the government could accelerate the agenda of social inclusion in the state. Though stakeholder observations and ideas form the crux of the paper, no specific attribution is made to protect the identities of the interviewees.

2. Extent of Tribal Deprivation in Orissa

One of the first steps to addressing deprivation and exclusion is actually establishing it.

Orissa is among the poorest states in India, with nearly 47 per cent of its rural population below the poverty line (NSS 2004-05). But not only is Orissa a poor state, it is also an unequal state, with inequalities stretching across regions, between social groups and between men and women. There are severe disparities in particular across regions, with coastal and northern Orissa showing much better indicators for health, education and income than southern Orissa. According to Sharma et al. (2009), the poverty headcount in rural parts of southern Orissa in 2004-05 was a staggering 73 per cent (see Table 1). Northern Orissa fared no better with rural poverty levels of nearly 60 per cent. In comparison, rural poverty in coastal Orissa was significantly lower at 27 per cent. The poverty ratio among STs was high across all regions with nearly 83 per cent of them poor in the southern region, also a pocket of tribal concentration in the state.

It is no wonder then that STs, despite being one-fifth of Orissa's population, contribute to about 40 per cent of the state's poor (as measured by the state's official poverty line). In fact, Orissa had the dubious distinction of recording the highest poverty rate for STs across India in 2004-05, when tribal population in the state registered a headcount ratio of 75 per cent

Table 1: Rural poverty is highest in the southern region; STs fare the worst in all regions

Region	ST	SC	OBC	Others	All
Southern	82.8	67.2	64.7	44.1	72.7
Northern	72.8	64.4	48.6	33.9	59.1
Coastal	67.7	32.8	24.4	19.0	27.4
Rural Orissa	75.8	49.9	37.1	23.5	46.9
Rural India	44.7	37.1	25.8	17.5	28.1

Source and Notes: Sharma *et al.* (2009); all numbers are a percentage of population

overall – an increase of about six per cent from 1993-94 levels. Tribals in rural areas of the state were particularly worse-off, with poverty levels among the group declining by only 13 per cent compared with a decline of 44 per cent for other groups (non SCs and STs) during 1983-2005.

With fewer tribals moving out of poverty, the concentration of Scheduled Tribes in the poorest quintiles of the population increased. Table 2 draws from the NFHS data and gives a distribution of STs across population quintiles using a wealth index (International Institute for Population Sciences [IIPS] and Macro International, 2007, p.43). It shows that in 2005, nearly 71 per cent of those belonging to a Scheduled Tribe in Orissa fell into the poorest wealth quintile. If one were to look at the share of the ST population in the bottom two quintiles, the gap is starker with nearly 88 per cent of tribals falling in the bottom 40 per cent of the wealth distribution.

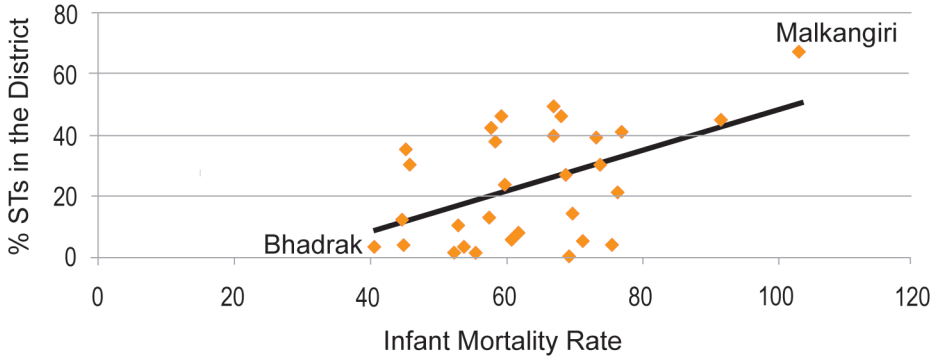
Table 2: Majority of STs in Orissa are concentrated at the bottom of the wealth distribution

	Lowest	Second	Middle	Fourth	Highest	Total	De jure population
ST	71.0	17.4	7.2	2.4	1.9	100.0	4,015
SC	48.9	23.8	17.2	8.0	2.0	100.0	3,339
OBC	31.3	21.6	20.6	17.7	8.8	100.0	4,748
Other	18.1	17.8	21.4	20.8	21.9	100.0	5,424
Total	39.5	19.9	17.3	13.4	9.9	100.0	17,663

Note: Total includes *de jure* population with missing information on caste/tribe of household head that is not shown separately; all numbers are a percentage of population Source: IIPS 2008

In contrast to the not so encouraging numbers on poverty, Orissa registered significant improvements in several human development outcomes between 1992-93 and 2005-06 (infant mortality rates [IMR] declined from 112 to 65 per 1000 live births; vaccination coverage improved for all children below two years of age from 36 to 52 per cent; and there was reasonable decline in the percentage of children under age three who were stunted, wasted or underweight). Yet, there existed substantial gaps between STs and the others. For instance, despite an increase in vaccination coverage and reduction in malnutrition, IMR remained high in districts with tribal concentration (see Figure 1).

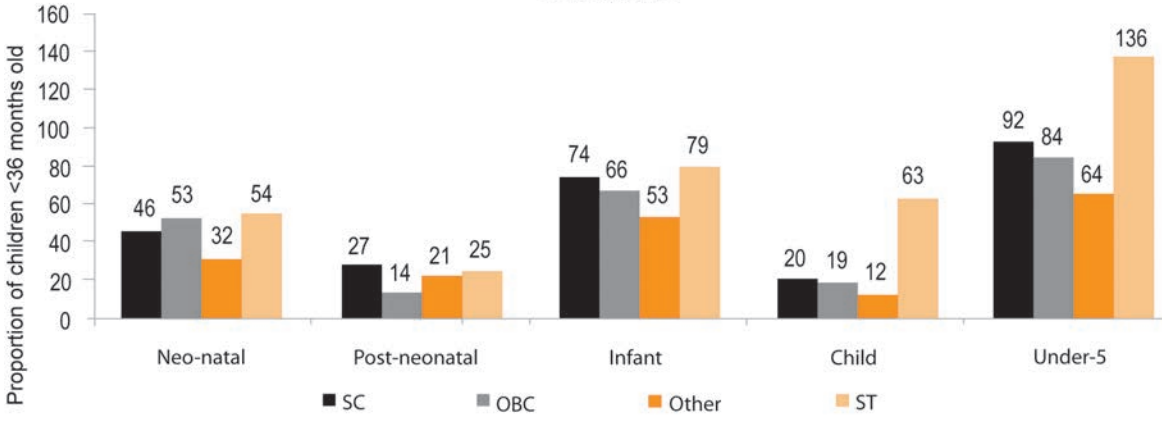
Figure 1: Orissa-District Level Relationship Between
Infant Mortality and Concentration of Schedule Tribes
Source: World Bank Staff Calculations from RCH II Survey



Further, an analysis of age-specific mortality rates for children by social group reveals that in 2005-06, under-five mortality rates (U5MR) for tribal children were nearly two times higher than the U5MR for general category children. What is striking is that tribal children fared even worse than SC children – they were nearly 1.5 times more likely to die before their fifth birthdays in comparison with children belonging to Scheduled Caste communities. Interestingly, the odds of dying faced by children from both groups were more or less similar until they attained the age of one. That is, IMR for both ST and SC children in the state was almost the same in 2005-06, only marginally higher for the former. However between the ages of one and five, a stark divergence appears with tribal children facing three times higher likelihood of dying before their fifth birthday than SC children (see Figure 2).

An immediate correlate of high mortality among children is malnutrition or poor maternal health. Malnutrition is endemic among tribals in Orissa with 57 per cent of ST children

Figure 2: Divergence in morality of ST and other children appears after the age of one
Source: NFHS-3



showing signs of long-term malnutrition (stunting or deficit in height-for-age), 28 per cent of severe stunting and 54 per cent of being underweight (see Table 3)[1]. According to the 2007 World Development Indicators, these levels of malnutrition were much higher than in Burundi, Niger or Afghanistan (World Bank 2007). The Global Hunger Index report on Indian states called the situation in Orissa alarming, ranking the state behind Rwanda and Malawi (IFPRI 2009). While Orissa did better than other states with lower poverty levels (e.g. Gujarat), its rank on the nutrition scale only worsened over time.

Table 3: More ST children are malnourished

	ST	SC	OBC	Other
Height-for-age, % below -3 SD	28.4	23.1	16.1	12.3
Height-for-age, % below -2 SD	57.2	49.7	40.8	33.6
Weight-for-age, % below -3 SD	22.9	14.8	9.8	6.5
Weight-for-age, % below -2 SD	54.4	44.4	38.1	26.4
Weight-for-height, % below -3 SD	8.2	2.3	5.9	3.4
Weight-for-height, % below -2 SD	27.6	19.7	17.8	12.2

Source and Notes: NFHS-3; all numbers are in per cent

1. Malnutrition is usually measured along three dimensions: stunting (deficit in height-for-age), wasting (deficit in weight-for-height), and underweight (deficit in weight-for-age). Stunting reflects long-term effects of malnutrition; while wasting measures the current nutritional status of the subject, i.e. his/her food intake immediately prior to the survey. The 'underweight' indicator is a combination of the former two and captures both long-term and short-term effects of deficient food intake. A child is considered to be malnourished with respect to each of these measures, if his/her indicator falls below -2 standard deviations from the median (defined for 2006 WHO international reference population). Falling below -3 standard deviations signals severe malnutrition.

Hunger or poor nutrition makes infants and children especially vulnerable to common infections like malaria, measles, respiratory infections and diarrhoea. Repeat infections further deplete their nutrition levels and may result eventually in death[2]. In a cross sectional study of 599 tribal children conducted in tribal villages of Mohana block in Gajapati district of Orissa, Sahu et al. (2007) found about 94 per cent of children under five to be anaemic, with nearly nine per cent among them victims of severe anaemia. More worrisome was their intake of IFA supplements: only four per cent of children in the 5-14 age group had taken IFA supplements in the last one year and none below the age of five had taken such supplements in the last one year.

As for maternal health, despite improvements over the last decade or so, indicators for tribal women continued to be poor (Table 4). In comparison with SCs and Other Backward Classes (OBCs), a relatively smaller proportion of ST women reported three or more ante-natal visits (46 per cent compared with 59 per cent for SC women and 66 per cent for OBC women). Tribal women also remained less likely to receive a post natal check-up. Only one-fourth received such care in 2005 as compared with 37 per cent of SC women and 43 per cent of OBC women. They were also significantly less likely to deliver at a health facility and were less likely to use contraceptives.

Table 4. Maternal health indicators for ST women remain below par, even by comparison to their SC peers

	ST	SC	OBC	Other
Three or more ante-natal visits	46.0	58.6	66.3	74.4
First ante-natal visit during first trimester	39.9	47.5	46.6	58.8
Given or bought IFA	76.6	85.8	85.6	84.9
Women with post natal checkup	25.5	37.3	42.7	56.5
Currently use contraception	35.2	51.1	52.6	59.4
Location of last birth (health facility)	11.7	30.2	40.6	60.4
Birth assisted by health personnel	17.3	39.1	53.6	66.9

Source and Notes: NFHS-3; all numbers are a percentage of population

2. Orissa contributes 23 per cent of India's total malaria cases, and 50 per cent of its malaria deaths. Anaemia is another major health problem among tribal women and children in the state. In the third round of the NFHS, nearly 80 per cent of tribal children of age 6-59 months were classified as having anaemia compared with 63 per cent of SC children and 58 per cent of other children.

Access to maternal health is usually an increasing function of women's education level. More women, including tribal women, seem to use ante-natal care or seem to eat folic acid supplements as their education and subsequently awareness about maternal health rises. Female literacy levels however remain abysmal among tribals in Orissa. According to the 2001 census, only 23.4 per cent of tribal women in the state were literate. Tribal residential schools for girls have significantly aided improvement in enrolment levels (as shown by numbers from the District Information System for Education [DISE]). However, drop-out rates for tribal girls and the number of children out of school remain high in tribal districts. In 2008 for instance, more than 20 per cent children were out of school in the tribal dominated Malkangiri. Similarly, about 18 per cent were out of school in Rayagada with another 17 per cent out of school in Koraput. Numbers out of school were higher for girls (Pratham 2008).

Significant gaps also remain in learning outcomes. In a study of learning outcomes for 6000 children in grades IV and V of 200 government, private aided and private unaided schools in Orissa, Goyal (2007) finds that SC and ST students do worse than students from general and OBC categories. All students, irrespective of the social group they belong to, substantially underperform in government schools compared with private unaided schools. The author attributes poor performance in the former to poorer incentives for government teachers. Unlike private teachers, government teachers face neither risk of firing nor receive any reward or punishment for good/poor performance of school children. However, even after controlling for school effects, the largest differences in test scores are observed with respect to the social group of the child. Pratham's *Annual Status of Education Report* in 2008 finds similar gaps: while 96.2 per cent of students of standard 1 and 2 in Bhadrak district are capable of reading simple words, only 52.9 per cent can do so in Keonjhar which has a significant proportion of STs (Pratham 2008)[3].

Besides education, access to safe drinking water and clean sanitation facilities can have a salutary effect on health outcomes. However, disaggregated data on access to water and sanitation is harder to get, mostly because of absence of any 'barefoot' functionaries like in the case of health (e.g. ICDS worker or Accredited Social Health Activist (ASHA)) or

3. Some argue that poor learning outcomes are a result of poor cognitive development, in particular of tribal children given malnourishment at a young age.

education. A few micro studies suggest caste-based discrimination in water user associations in the state. Another significant barrier for SCs who are landless or marginal farmers seems to be cooption of water distribution sources by upper caste, landed farmers. For STs though, physical access is the key barrier with little provision of water and sanitation facilities in remote blocks. The state has also had limited success in increasing tribal uptake of sanitation.

This is not to suggest that tribal pockets in Orissa (or elsewhere) are 'holy grails' for those working on human development and are synonymous with all that is bad. Tribal societies are known traditionally for their better gender indicators, particularly late age of marriage and better sex ratios. Aborting female foetuses for instance is a violation of the Prohibition of Pre-Natal Diagnostic Technique Act. But according to most people interviewed for this review, it was relatively rare to find such violations in the tribal dominated southern belt of Orissa, compared with other areas in the state – the infamous find of abandoned female foetuses in the district of Nayagarh being one case in point.

Sociologists suggest that socio-cultural practices of tribals are changing with time with their entering the mainstream. For instance, they have increasingly started giving dowry and marrying their daughters early. Yet, civic engagement remains strong in tribal societies, expectedly given their history of communal cultivation. It is this social capital that needs to be tapped to enhance voice and participation of tribal groups in their own development.

3. Barriers to addressing exclusion of Scheduled Tribes in Orissa: Some broader Challenges[4]

The Indian state has put in place several policies that attempt to redress the disadvantages faced by tribal groups. Besides acknowledging special privileges for areas in which STs are a majority (through the fifth schedule of the Constitution), the Indian government extends reservation benefits to STs, reserving 7.5 per cent of seats in all government and quasi-

4. This section draws from Das et al. (2010)

government jobs (which form the major part of all regular salaried jobs). Those belonging to a Scheduled Tribe have similar quotas in public educational institutions and according to the 73rd amendment to the Indian Constitution; they have reserved seats in local governments as well. In addition, there are earmarked development funds both from the central government and the state that flow to tribal areas through a special budgetary instrument called the "tribal sub-plan" (TSP).

More recently, the Indian government has legislated to acknowledge the "rights" of Scheduled Tribe areas by taking them further towards self-rule. In 1996, the Indian Parliament passed the Panchayats Extension to the Scheduled Areas Act (PESA), 1996. The Act covers nine Schedule V states of Andhra Pradesh, Chhattisgarh, Gujarat, Himachal Pradesh, Jharkhand, Madhya Pradesh, Maharashtra, Orissa and Rajasthan and instead of individuals, recognises and stresses on traditional community rights over natural resources. The recent Forest Rights Act or the Tribal Rights Act are a step further as they adopt a rights-based perspective and acknowledge the pre-eminent rights of STs to natural resources. Finally, and in parallel to these legislative instruments, several centrally sponsored schemes such as the Integrated Child Development Services (ICDS) and the National Rural Health Mission (NRHM) target tribal areas.

However, implementation of these far reaching policies and programmes has been difficult in tribal pockets. Service providers cite barriers both on the demand and the supply side. But these barriers to service delivery need to be located first in the challenging context that tribals find themselves in. This section attempts to explore some of the broader, contextual issues that arise in service provision in tribal areas, which make the demand and supply side barriers perhaps doubly difficult to overcome.

Access to assets, markets and livelihoods

Tribal economies are mostly subsistence economies whose survival is closely linked to land and natural resources, including forest products. Estimates from Orissa indicate that over 30 per cent of land in Orissa comprises of commons such as forests[5] and one half to over one-fifth of annual income of tribal households comes from Non-Timber Forest Products

5. Orissa 11th Five Year Plan 2007-2012.

(NTFPs). More so in Orissa, tribal areas are coterminous with mineral deposits and have thus attracted considerable attention by the private sector in recent years, both for extraction and industrial development. All this together with the increasing threat of naxalite violence in these areas has made focus on tribal development a policy imperative[6].

Historically, tribals in Orissa have always been far removed from the economic mainstream, some argue by default not design. While coastal Orissa benefited from colonial development, the tribal hinterland was used by colonizers mostly as an extracting ground for forest produce like timber. De Haan (2004) suggests that the institutions that emerged at the time, particularly in the time of the British, were driven by a priority of maximizing state revenue. Current state policies, De Haan argues, are still reflective of the same objective. Even though Orissa has devolved the procurement and marketing of 69 NTFPs to gram sabhas, the government retains control over high revenue earning products (e.g. kendu leaves) which are prone to commercial exploitation. Further, the lack of capacity of gram sabhas (village assemblies) in these areas has meant that even for NTFPs over which communities have supposed control, middlemen benefit more than tribal people. Tribals who do sell on their own, sell in a buyers' market with no control over prices (Saxena 1999). On the other hand deforestation continues unabated. It is estimated that Orissa has lost more than a quarter of its forests in the last 25 years resulting in considerable decline in the proportion of tribal income contributed to by NTFPs[7].

Besides their tenuous hold over NTFPs another major reason for tribal poverty is the classification of huge tracts of tribal forest land as state property. Although living in these forests for generations, given poor documentation of customary rights, most tribals find it difficult to convert their *de facto* access to forest land and resources to *de jure* ownership. Legislation to prevent sale of ST land to non-tribals too has been largely ineffective as witnessed in the large number of cases involving land grabbing by non STs through marriage or through fraud[8].

6. See in particular the Planning Commission's report on development challenges in extremist affected areas (Government of India, 2008).
7. A study for IFAD in Kandhamal and Gajapati districts showed that collection of NTFP, which previously accounted for a substantial part of household income, now provides only 10 per cent of income. For more details, see RCDC. 2000. "Social and Institutional Analysis and Livelihood Systems Study of Tribal Communities in Selected Villages in Kandhamal and Gajapati Districts." March 2000.
8. Non-STs getting ST certificates and usurping ST lands and other advantages is now a serious political issue in Orissa.

Tribal indebtedness is another important reason for lands being handed over to moneylenders. Studies estimate that more than 50 per cent of tribal land in Orissa has been lost to non-tribals over a period of 25-30 years through indebtedness, mortgage and forcible possession. Worse, the process of tribal alienation, i.e. STs gradually losing their access to traditional commons has accelerated in recent years. While studies vary with regard to the impact of displacement in Orissa, mostly on account of setting up of mineral-based industries, all agree that of those displaced a disproportionate number are tribals. The state also has a controversial track record of resettlement and rehabilitation[9]. Most activists and academics working on tribal issues think that it is alienation from these communal resources which forms the fulcrum of tribal angst and revolt.

Alienation together with reduced income from NTFPs, stagnant agriculture and limited opportunities for non-farm self-employment, push tribal households into a cycle of high-interest debt from private moneylenders resulting in food insecurity and forced migration. The cycle is usually linked to the agricultural season, with most tribals migrating in the months of March-April after harvest to repay the loans taken during monsoons (Kabra 2004). A majority end up working as manual labour employed in construction sites or as domestic workers.

There are several policies in place to secure the rights of tribals to their land, natural resources and livelihoods; but there is a slip between the cup and the lip. One of the most important pieces of legislation in the last decade has been PESA. It is unique in being in consonance with customary laws, focusing more on tribal hamlets based on culture rather than revenue villages. Several steps have been taken to operationalise PESA – state amendments and rules have been passed and monitoring is underway. However field studies in Orissa reveal that many people on the ground are not even aware of the legislation (Upadhyay 2007). Similarly, the Forest Rights Act is a significant step in the direction towards recognising the pre-eminent rights of tribals on forest land, but it doesn't yet harmonise well with forestry/ wild life/environmental laws. In most cases, the latter take precedence over the former and tribals, formerly communal owners, end up as 'encroachers' on protected forests, dependent on the mercy of rent-seeking revenue inspectors.

9. See for instance, Mishra, I. 2007. "Heat and Dust of Highway at Kalinganagar." *Economic and Political Weekly*, March 10, pp 822-25. Also see, Actionaid 2007. *Vedanta Cares? Busting the myths about Vedanta's operation in Lanjigarh, India.*

The Backward Regions Grant Fund (BRGF) is another programme that can positively impact tribal areas in Orissa. A centrally sponsored scheme, the BRGF is designed to redress regional imbalances in development. The fund provides financial resources for supplementing and converging existing developmental inflows into 250 identified districts in 27 states and gives panchayati raj institutions (PRIs or local governments) the discretion to plan for and use these funds. The programme seeks to truly empower the PRIs by making untied funds available to them and has been quite successful in bringing to national focus, decentralised planning. In addition, BRGF also includes special plans for Bihar and the KBK districts of Orissa[10].

A recent World Bank assessment of the scheme however reveals that Orissa spent only 69 per cent of the BRGF funds released in 2007-08 (World Bank 2009). Low utilisation levels were driven by a combination of factors, including late arrival of funds from the centre (almost towards the end of the financial year) as well as the state's own failure to submit utilisation certificates. What was more worrisome was that while BRGF guidelines encourage projects focusing on SC/STs, only one district in Orissa, Ganjam a coastal district, used SC/ST population as one of its criteria to arrive at the status of backwardness of different gram panchayats (the lowest unit of elected representation in India). Thus even in targeting, an SC/ST focus was lost. Where the scheme was operational, it was used mostly for infrastructure creation (ICDS centers, roads, culverts, classrooms, water supply and rural electrification) – activities which several stakeholders suggested could have been financed from other sources (e.g. the Pradhan Mantri Rozgar Yojana or PMRY). Participatory planning too remained a challenge given poor levels of awareness and capacity both of the gram panchayat and the gram sabha and lack of assistance to panchayats to foster participation[11]. Lack of coordination between PRI members and line departments and lack of convergence with other schemes like the Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) – challenges that other states face as well – also hampered effectiveness.

10. The undivided Koraput, Bolangir and Kalahandi districts are popularly known as the KBK districts. In 1992-93, these were divided further into eight districts: Koraput, Malkangiri, Nabarangapur, Rayagada, Bolangir, Subarnapur, Kalhandi and Nuapada. The region is characterized by a high proportion of ST population – according to the 2001 census, about 38.4 per cent of the population of these districts belong to ST communities.

11. According to the assessment, a more systemic challenge in Orissa is the lack of an effective coordination mechanism or an agency that can bring together capacity-building initiatives. While the State Institute of Rural Development (SIRD) presently undertakes this work, it was found to be over-focusing on the training component of capacity-building with less focus on development of HR at the PRI level to coordinate capacity-building activities.

Access to social service delivery mechanisms

The most significant challenge in delivering social services in tribal areas is that of poor physical access. The Special Action Plan for the KBK region (2009-2017) indicates that the average road length in KBK districts is only 1.28 km per sq. km of area, which is much below the state average of 2.49 km. Within the KBK region, districts like Malkangiri and Subarnapur are worse off. Moreover, road quality is poor with many roads "nothing but earthen tracks with frequent missing links" (Government of Orissa, 2009, page 124).

Expectedly, transportation costs are high and tribal people think twice before taking their ill to public health facilities located at a distance. A longitudinal study in Bolangir district found for instance that villagers took a young child to the hospital only when his or her condition was critical given the difficulty with transport (poor road condition) and expenditure associated with hiring a vehicle. They also identified "giving birth" as a risk because mothers could not reach health centres due to inadequate road access, particularly during the rainy season (Van Dillen 2006). In another review of child mortality outcomes in Orissa using RCH-II data, a World Bank report found existence of an all-weather road to be closely correlated with lower infant and child mortality and a higher probability of women receiving ante-natal care or giving birth in a health facility (World Bank 2006a).

While road access is an issue, Orissa has done well in expanding the reach of programmes like ICDS to remote areas. More than 80 per cent of households in the state seem to have an ICDS centre within the village. Sub-centres too are within the village, of around a third of all households in Orissa (World Bank 2006b). A larger issue that most stakeholders note is one of absenteeism of service providers. A World Bank review of the ICDS/Supplementary Nutrition programme in Orissa found a 30 per cent absenteeism rate among Anganwadi workers (World Bank 2006b). High absenteeism in turn is attributed to difficulties with living in tribal areas. Some frontline workers resign even before attending their first training; yet others continue to draw salary despite not visiting the ICDS or primary health centre (PHC) for years' altogether[12]. Incentives to work in tribal areas (e.g. an increase in retirement age; reduced entry level qualifications; re-hiring of retired functionaries) too are largely ineffective in drawing people to tribal clusters.

12. In some tribal hamlets in Kalahandi, teachers were reported missing for more than seven years (The report of the Comptroller and Auditor General [CAG] 2007).

It is argued that functionaries are simply not inclined to be posted in such remote habitations for want of suitable accommodation, access to urban centres and social support. To address this gap, the Government of Orissa now plans to create additional residential infrastructure for service providers working in tribal areas, i.e. residential clusters where government officials of different categories and different departments can be accommodated. In very remote areas where this cannot be done, mobile health clinics are becoming a popular option. While mobile units reached about 300,000 people in 1995, by 2009 this number was estimated to have increased to 1.9 million beneficiaries in KBK alone[13].

The impact of such schemes on health outcomes is yet to be seen[14]. A Common Review Mission (CRM) of the NRHM in December 2008 reports how deficiencies in health infrastructure, non-residence of personnel, inadequate availability of drugs or even basic facilities like water, and payment of 'informal' fee (read corruption) at primary health centres in KBK districts have led to most people relying on traditional birth attendants. Those who can afford the costs of transportation move to district centres. PHCs therefore remain empty and sub-centres in villages are hardly perceived as service delivery facilities.

Besides absenteeism, reports from the ground suggest significant mistrust between tribal communities and service providers who are largely non-tribal. A recent primary survey to assess the availability and accessibility of and discrimination in NRHM services finds that of the total ASHA workers in the sampled villages, 59 per cent belonged to non SC/ST groups. Only 26 per cent were SCs and a mere eight per cent were tribals. Moreover, both ICDS and ASHA workers were reported to have treated children from SC/ST households "casually", visiting a significantly lower proportion of children in SC/ST households than children in non-SC/ST households (Development Initiative, 2009).

Most stakeholders interviewed by the author agreed that a long-term solution to the problem lies in developing a corp of tribal para-professionals who have filial ties or affinity with the community which would enable the building of trust. Those from within the government highlighted the initiatives undertaken thus far towards recruiting tribal service providers (e.g. lowering the qualifying criteria for recruiting tribal auxiliary nurse midwives [ANMs]). Other

13. Data given to the author in an interview with the Special Secretary to Government of Orissa, Planning and Coordination Department.
14. Some interviewees argued for instance, that mobile health clinics are not a useful long-term strategy. Worse, in some places there was evidence of their serving as carriers of infectious diseases.

ideas tabled include grooming tribal girls/traditional birth attendants or TBAs (as in the famous example of SEARCH in Gadchiroli in Maharashtra), providing them with training and ensuring quotas, but then also ensuring residential status.

However, while administrators realize the value of recruiting local residents as field-level personnel, it is a time-intensive process that requires a completely different paradigm of planning. It is often impossible to find even secondary level educated ST women who can fill the positions of a nurse or a female health worker. Yet another issue is getting trained tribal service providers to return once they become a part of the mainstream. As one interviewee suggested:

> *"In the mainstream, they are made to learn one way or another that tribal issues are not important enough. They end up imbibing the dominant paradigm."*

Access to political voice and participation

At the time of writing this paper, Orissa was witnessing an increasing spate of insurgent incidents, most originating from tribal districts. While economic divide is cited as one of the main reasons for such violence, many in the state now acknowledge that such disparities are rooted in a history of 'marginalisation', not just economic but also political. Political isolation of STs originates from several factors. For one, they tend to live in small clusters of few households and thus influence election results in a few isolated pockets. Two, STs in the state haven't yet witnessed the emergence of a strong political leader amidst their ranks. Rather, they have been represented for the most part by non-tribal elite. Leaders that have emerged have been co-opted too. In the words of one respondent:

> *"While there have been several politically active tribals, the key is to discern political activeness from political consciousness. Consciousness is yet to take root in tribal Orissa."*

Dominance reflects in the administrative ranks too, both at the state level as well as at the lower functionary level, resulting in low voice and low accountability to STs (Guha 2007; De Haan and Dubey 2005; Xaxa 2001). Over time this has led to an increased feeling of alienation and of viewing the politician and/or administrator/line department official as the 'outsider' or the 'adversary' as was the case in the colonial past. Tribals look at non-tribals

with suspicion as do the latter, particularly the police who suspect tribals to be hand-in glove with the insurgents[15]. As anger and resentment grow, politicians and administrators particularly those on the ground gradually lose respect. Displacement due to industrialisation and destruction of forests has only added momentum to tribal anger.

As discussed earlier, there are several policies in place to safeguard the interests of the tribals. But they run into familiar problems of implementation. A majority of the stakeholders interviewed for this paper agreed that at the core of it all are two larger issues. First, policies directed at tribal self-rule imply a shift in the power-axis away from non-tribal elite who have represented the tribals thus far. As one interviewee said to this author:

> *"It all boils down to whether we want a change in condition of the tribals, or a change in position. And I'm afraid, we never want the latter. It is difficult to break through vested interests."*

Thus the very disparities that reform measures try and address affect their implementation since the institutions responsible for implementation are shaped by the inequities they are designed to address (De Haan 2004).

Second, most policy measures are based on a model of decentralised delivery which works when PRIs on the ground have the capacity to do all that is called on them and further, citizens are aware of all schemes through adequate availability of information. While decentralised institutions like Palli Sabhas are in place in most tribal areas in Orissa, they are yet to evolve functionally thus impeding delivery of most programmes. A survey[16] conducted in some of the poorest districts of Orissa before the Panchayat elections of 2007 found that only six per cent of the Gram Panchayat representatives were aware of the 73rd and 74th Amendments to the Constitution which empower PRIs. Less than one per cent of the representatives were aware of the provisions included in the extension of PESA. In terms of attendance, 71 per cent of the village population was shown to attend meetings of the Palli Sabha, while only 39

15. In an interview to NDTV, Prakash Mishra, DG Operations in Orissa Police remarked, "The Naxalite movement has grown from within the population. There is no clear demarcation between the enemy and non-enemy. The major problem that we face is the local militia, which is growing in the tribal area. There is always a danger of collateral damage in such kind of operation but we are trying to keep it to the minimum." (October 31, 2009, Gajapati, Orissa).

16. The survey was conducted by the Centre for Youth and Social Development in March 2007 in the districts of Koraput, Keonjhar, Kalahandi, Sundargarh, Rayagada, and Cuttack in 34 Gram Panchayats. (October 31, 2009, Gajapati, Orissa).

per cent actively attended. The majority of respondents felt that although they had adequate voice in the deliberations, their decisions were often overruled at the higher block level. A large number of respondents felt that officials did not disseminate information about development schemes, and nearly 40 per cent had no idea about budgetary provisions to their area. In yet another survey of anti-poverty programmes across three states – Orissa, Madhya Pradesh and Karnataka – Dev *et al.* (2007) find that programme awareness is significantly lower among STs for eight out of 12 major anti-poverty programmes. Orissa ranks better than Madhya Pradesh and Karnataka in overall programme awareness, but those states rank better than Orissa for programme awareness among the STs and SCs. As an interviewee summed up succinctly:

> *"Though flush with funds, capacity of Gram Panchayats is limited. It is a classic case of good resources, but no people, no ideas, no utilisation, no awareness, no accountability."*

Child mortality among tribals: A case study on how access affects

Although the challenges mentioned in access seem broad, they can all be "instrumentally a cause of diverse capability failures" (Sen 2000). This section shows how one health outcome –mortality of tribal children – is affected by the overall context that tribals live in.

As shown in Section 2, Orissa has achieved rapid progress in reducing mortality of infants over the years. But a huge gap remains in mortality of tribal children under the age of five and the rest, with the former facing significantly higher risk of dying than the latter. Malnutrition or undernourishment of tribal children, poor maternal health indicators and inadequate coverage of immunisation (despite an increase over the past few years) are some of the more proximate causes of child mortality. For instance, while there has been an improvement in full vaccination coverage between NFHS-1 (36 per cent) and NFHS-3 (52 per cent), Orissa still ranks lower than 13 other states in full immunisation coverage. Further, vaccination coverage among ST children is about half the level of coverage among non-ST children – 30 per cent compared with an average of 59 per cent for all non-ST children, including the SCs (IIPS 2008).

Those working in the health sector in Orissa attribute low coverage to the much wider problem of tribal displacement. Besides loss of housing/land, displacement and forced migration

also displaces or alienates tribals from public schemes. This reflects in immunisation gaps, both in breadth of coverage (percentage receiving any basic vaccination) and intensity or quality of coverage (percentage receiving all basic vaccinations). Moreover, as tribal activists argue, for a family that is displaced often getting their child immunised is no longer a priority.

Displacement also affects traditional food habits with most tribals and their children shifting from an earlier balanced diet of fruits, meat and protein-and-iron rich food like ragi and maize to food supplied by the public distribution system (PDS) for cash. Further the introduction of cash crops instead of local crops like ragi and millet also threatens food security with tribals shifting from a practice of multi-cropping (which helps regenerate soil nutrients) to a practice of pesticide-based farming. While the Rs.2 kg rice scheme initiated by the incumbent government has had a positive effect on reducing starvation levels, those working in tribal areas suggest that the scheme favours rich farmers who sell their crop (e.g. rice) to the government at a higher price (Rs. 14 per kg for instance) only for the government to subsidize and resell it to poorer sections at Rs. 2 per kg. Moreover, field studies in tribal areas report dissatisfaction of people with the quality of food grains supplied under the PDS. Since SC and ST households are more dependent on the PDS for their food supply (unlike others who also buy from the market), issues in quality are bound to affect the former more than the latter.

Finally destruction of forests over time has also resulted in reduced access of tribals to traditional medicines and practices. Tribal activists note the reduction in efficacy of tribal medicines perhaps on account of contamination of the environment due to the influx of mining and other industries.

In addition to displacement, tribal children suffer from poor access to social service delivery mechanisms. Although the incidence of disease among tribal children varies only slightly from those of their non-tribal counterparts (in fact at times is even lower[17]), they are less likely to receive treatment in a health facility than the latter (see Table 5). Poor physical access together with high transportation costs implies that tribal families are more resistant to taking their children to institutional health centres for treatment of diseases like diarrhoea. The opportunity cost of the visit is also implicitly weighed against loss in wages for that day. Smaller infections consequently develop into serious ailments resulting in the death of the

17. Until the late 20th century, tribal mortality (especially infant and child mortality) was observed to be traditionally lower than mortality rates of non-tribals. This was mostly attributed to the ecologically sustainable livelihood patterns of STs. Since then, child mortality rates for tribals have worsened. Some call it the unfortunate outcome of mainstreaming (Maharatna 2005).

child.

4. Gaps in Demand and Supply of Schemes for Tribals

Table 5. Scheduled Tribe children are less likely to have access to qualified medical assistance

	ST	SC	OBC	Other
Diarrhoea over last two weeks	12.2	14.9	9.6	11.1
Taken to health facility for diarrhoea	55.2	59.2	66.2	56.8
Received no treatment for diarrhoea	28.1	26.0	25.7	28.0

Source: Among children under age five, percentage who had diarrhoea in the two weeks preceding the survey and percentage who received advice or treatment from a health provider and who were given no treatment; health facilities exclude pharmacies, shops, any traditional treatments. *Source:* NFHS-3

Set against these contextual barriers, planners, programmers and functionaries in Orissa find it difficult to deliver the multiple schemes on offer for tribals. **Asked to sum up their main challenge, a common refrain is one of demand being weak and supply non-responsive**. This section highlights some of the more specific gaps that exist in both demand and supply of programmes in tribal areas in the state. As reiterated earlier, these cannot be disentangled from the larger changes experienced by STs in Orissa, more so over the past two or three decades.

Gaps in demand

Interviews with people working both in the education and health sector indicated that people in tribal areas presently take up publicly provided services only because they are free. Income poverty, high opportunity and hidden costs for accessing services and lack of knowledge or information about them are huge dampeners on demand. Lack of demand is also driven by gaps in supply. While open to modern treatment and willing to cover distances to reach PHCs, tribals often find them deserted with no medical workers, no drugs, no equipment or water. Unfulfilled promises lead to mistrust of outsiders. Left with no option, tribal families

revert back to traditional healers and old practices.

Having said that, most service providers believe that more can be done to address gaps on the demand side. For one, steps can be taken to **stimulate demand by offering incentives**. For instance, community funds can be initiated to cater to costs of travel, medicine, books, uniform and other direct and hidden costs which keep demand low. Two, education and efforts to spread awareness become doubly important in tribal communities where deep-rooted cultural beliefs need time and persistent effort to change. Demand side interventions should focus therefore on **awareness building and behavioural change** about hygiene (hand washing with soap), water, sanitation, indoor air pollution (use of clean fuels, improved ventilation), malaria (use of bed nets), nutrition and feeding practices, early diagnosis of medical problems, and service provision (what, where and how). The key however is to have **inclusive communication**, i.e. design messages in a language (not just Oriya, but local tribal dialects) that can be understood by all stakeholders, including households, community leaders, PRIs and government functionaries. Using the spoken word is often better than distributing pamphlets on information given poor literacy levels in tribal areas. While education modules have been developed using local dialects (see later in this section), nowhere is health education imparted in the tribals' own language. Some donor agencies like UNICEF in their own behavioural change practice in Orissa are now attempting to address this lacuna by using tools such as community radios and theatre to disseminate information about health issues. Community participation is being ensured by involving local people (particularly the youth) and training them to disseminate key messages. The government on the other hand is working on organising **right to information clinics about government schemes and entitlements** in tribal areas perhaps merging with weekly markets so more people can attend.

Several stakeholders also said that inclusion – or the demand for it – is best addressed at the school level where discrimination begins. Exclusion can be practiced both by the person excluding and those excluded. For example, children of ST groups themselves end up internalising processes of cultural devaluation and of getting 'different' treatment which are passed from one generation to the next. They come to schools with that mindset. In Orissa, language can be another carrier of exclusionary or prejudicial treatment. According to research undertaken by the Orissa Primary Education Program Authority (OPEPA), around 748,000 ST children in Grades 1, 2 and 3 encounter a classroom language other than their mother tongue[18]. The use of a foreign medium of instruction places girls at a

greater disadvantage who in any case face greater hurdles accessing schools relative to boys. Interestingly, some interviews revealed how tribals after receiving mainstream education in English and Oriya, end up ascribing to similar values as the mainstream, unknowingly moving away from their traditional practices and language. As one respondent put it:

"Language then becomes the power to dominate."

In an effort to make education more inclusive, the Government of Orissa along with UNICEF, initiated in 2006 a Multilingual Education Intervention (MLE) in the tribal dominated districts in the state. The intervention focused on **developing curricula and teaching in the tribals' own language/mother tongue** which over time could result in **value transformation and social change**. Until 2008, MLE had been introduced in 200 schools, covering 10 tribal language groups across eights districts in Orissa. The scheme has resulted in several positive outcomes. An evaluation in two tribal villages in Keonjhar district shows the positive impact the intervention has had on enrolment rates. More significantly, the initiative has helped reduce drop-out rates and has raised community demand for education. Curriculum in their own language has also created a new enthusiasm among tribal people to sending their children to school (Cuadra et al. 2008). However, challenges remain. Administrators rue the shortage of qualified tribal teachers. The few that are recruited resort to multi-class teaching resulting in a high student-teacher ratio which affects performance (World Bank 2007). Limited MLE funds, poor school infrastructure and limited community participation further constrain impact. There is also a misconception among tribal parents that use of a non-dominant language would constrain their children's educational progress and career path. A telling remark by an Alang father sums up their apprehension, "How will my son leave the village and get a good job if he cannot speak Oriya?" (Cuadra et al. 2008, page 38). Clearly more awareness and demand building is still needed around the MLE.

Gaps in supply

As evident from the previous section, efforts to raise demand for and awareness about services may come to naught if they run into gaps in supply. In fact, some programmers working

18. OPEPA documentation: 'Sustainable Community Based Multilingual Education Program Strategy', Orissa.

on the ground said it was unethical to raise demand when supply was not assured. Poor road access and infrastructure, absenteeism of service providers and financial constraints are some of the gaps discussed earlier. This section focuses on a few deeper, underlying issues that constrain effective supply of programmes and schemes for tribals.

Constraints in implementation or constraints in design? There is a general consensus among all stakeholders that exclusion starts at the level of policy design itself. Policy prescriptions are rarely disaggregated or targeted, and when targeted are not sufficiently monitored. Moreover the fixed beneficiary criteria of some central government schemes limit the states' flexibility to implement them in tribal areas.

One of the more frequent strait-jacketing criterion cited is that of population. Most people agree that it acts as a deterrent for schemes such as the Sarva Shiksha Abhiyan (SSA) in reaching smaller, more remote tribal communities. Similarly, using population as a criterion for determining road coverage comes at a cost of ignoring smaller tribal hamlets[19]. Yet another deterrent is the use of BPL status as a qualifying indicator for programmes. This has a perverse effect – it makes families resistant to accepting other schemes (e.g. construction of sanitation facilities) lest their household be seen as better-off and consequently disqualified of its BPL status. Stakeholders argue that more **inclusive norms are needed for policies that aim at creation of infrastructure and supply of services**. These should also leave a little room for local level interventions or decision making.

Not that there aren't innovations. In one ICDS centre in Raigada, Gajapati district for instance, ICDS functionaries had successfully overcome the constraint of unavailability of pulses on account of failure to increase the procurement price fixed by the central government. This had been achieved with a shift to a community-run nutrition programme using minor millets and pulses that were grown and harvested locally. The proportion of nutrients was specified by the ICDS functionaries who organised women into self-help groups (SHGs) and then imparted them training on how to arrive at an adequate nutrient mix. The programme was therefore not dependent on a centralised supply of grains. It had not only ensured

19. The new rural roads program – the Pradhan Mantri Gram Sadak Yojana (PMGSY) – uses a relaxed criterion of population for connecting tribal hamlets (a habitation of 250 as opposed to 500 people in other cases). Even so in Orissa, after the implementation of the current phase of the PMGSY, there would be 1049 habitations with a population of 1000 and 1662 habitations with a population of 500 still to be covered. The number is even larger for unconnected habitations of 250 and above (World Bank 2011).

community participation, but had also helped counter malnourishment.

Planners' supply or supply driven by demand? The gap between tribal people and non-tribal functionaries (or even tribal functionaries who speak the dominant paradigm) implies that the latter fail to relate with people and deliver programmes in a mechanical, routine way. While this gap is evident in non-tribal areas as well, it gains more significance in tribal communities which have, generally speaking, lower voice and lower ability to bargain. Consequently, no consultation is undertaken and official priorities or the planners' own priorities in delivering programmes become the people's priorities. Examples cited include water supply schemes such as tube wells supplied without consulting people on their location, merely to meet certain targets.

The root cause of such apathy, many think, is the absence of **local, community-level planning.** Some stakeholders rued the lack of specific household plans, despite STs living in small communities. Unless a bottom-up need assessment became a norm, they felt that both planners and those implementing plans would continue to be driven by achievement of some perfunctory numbers.

Micro-level planning has been successfully tried in some tribal pockets in Orissa and is now being scaled up by the government for delivery of livelihood programmes in the KBK region. One example of successful micro-planning is the UNDP-supported Rural Decentralisation and Participatory Planning for Poverty Reduction project in Phiringia block of the Kandhamal district which undertook micro-level planning (MLP) in 236 villages of all the 20 gram panchayats under the block. Studies of the programme establish unambiguously the fact that MLP has "transformed people into agents of change, contrary to the outcome of the role they play in standardised, blueprint based development planning" (National Institute for People's Development, Investigation and Training [NIPDIT], 2008). Villagers involved in the exercise shared that the process of mapping resources and planning for their village in a united manner had given them a common platform to think and plan for the development of the village as a whole. The process had also resulted in some positive externalities. For instance, participation of women in decision-making had improved, as had awareness and demand for work under different schemes (e.g. MGNREGS). It had also led to greater transparency and accountability and reduced capture of existing programmes by the elite. People asked repetitively about the execution of the plan thus ensuring that it was at all stages, a live document.

Infrastructure, incentives or sensitisation? Absence of road access and proper health and education infrastructure (including residential infrastructure for service providers) is undoubtedly a huge issue in remote, tribal areas which depend primarily on government facilities to access these services. Since access/travelling for health services seems to be the main obstacle in tribal areas, strengthening of existing PHCs/sub-centres can be an important tool to increase equity in availability of health services.

Rightly so, the Government of Orissa in its Special Action Plan for the KBK region (2009-17) is focusing on **expanding outreach of services** via infrastructure creation in tribal areas, including establishment of hospitals and medical colleges; and improvement in connectivity to remote clusters vide construction of arterial roads. However, sceptics think that creation of new infrastructure alone will not help.

For one, though efforts have been undertaken in the past to improve infrastructural gaps, several reports and evaluations point to deficiencies even within the existing structures. For example, an evaluation undertaken by the World Bank's Independent Evaluation Group (IEG) of its Orissa Health Systems Development Project showed that there were severe construction deficiencies in buildings that were reported to be complete and performing according to specification (World Bank 2006b). Similarly, a CAG audit of the state undertaken in 2007 suggested that the Eklavya Model Residential Schools (meant to provide quality education to tribal children) ended up with low paid teachers and weak infrastructure (in one case, the school building had been under construction for seven years i.e. from 2000-2007). Similarly, primary school hostels lacked minimum amenities for boarders such as beds, proper sanitation and safe drinking water. Two, infrastructure creation frequently comes with charges of misappropriation of funds. The same CAG review reported undue benefits given to contractors under various schemes. Three, there seems to be undue preference for financing infrastructure in all schemes – from the BRGF to the KBK plan – suggesting significant overlap.

To be effective, infrastructure creation needs to be combined with a focus on quality in delivery. Tribal education for instance is significantly hampered by lack of funds for curriculum development and human resource development. Most funds allocated for educational schemes are spent on physical goods – be it construction of a school or hostel or purchase of cycles and uniforms for distribution among children – leaving little or no

funds for HRD activities. "*Opening schools alone is not education*," said one respondent.

It is argued that a focus on improving quality of education instead, say by including efforts for vocational training of tribal children that can enhance their employment options later, would go a long way in improving eventual outcomes. But there are gaps here too. While the government has opened vocational training centres (VTCs) in tribal pockets, the 2007 CAG report revealed that several VTCs were defunct, closed due to non-receipt of funds from Government of India. Of the youth who had received training, only a few were employed in the private sector. Information on the remaining trained youth was not available with the Integrated Tribal Development Agencies (ITDAs). Further, no trained youth was given financial support under the different micro credit schemes operated by the government so he or she could be self-employed.

Similarly, several people feel that a focus on multiplying people power (including tribal service providers) in tribal areas or **HR reforms using a combination of incentives, punishment and supervision** would not help address the problem of absenteeism. In an experiment carried out with the help of a district administration and an NGO in Rajasthan, Banerjee et al. (2008) found that taking steps to punish delinquent government health providers (e.g. nurses) helps, but only initially. In the experiment, new ANMs were told that their pay would be locked if they didn't show up half the days they were called to work. The NGO provided independent checks of the time attendance stamp. However, nearly 18 months later, the scheme was completely ineffective with no difference in attendance rates between the new ANMs and the rest (the attendance rate for both was only 30 per cent). The failure of the scheme was attributed to the local health administration which itself appeared to have let nurses claim an increasing number of "exempt" days. Punishment thus was akin to what Banerjee et al. called, "putting a band-aid on a corpse".

Punishment or reward – sceptics claim – do not work unless service providers, particularly frontline workers and mid-level management functionaries (PRI officials, teachers, ANMs) are trained and made sensitive to the needs of the local population. **HR reforms aimed at sensitizing service providers** are critical to bringing an inclusionary orientation in their day-to-day work including equal treatment in behaviour towards clients. More than empathy, sensitization trainings need to focus on making service providers familiar with the special needs of tribal populations so they can speak to them on an equal footing, rather than look down upon them. The existence of such prejudices, which translate into differential

treatment meted out to tribals over generations, has ingrained a sense of low self-efficacy among the latter – both at an individual as well as a collective level. This can be an important factor in explaining low demand of formal services among tribals who self-exclude by 'accepting' the prejudice as the norm.

No data, no monitoring, no accountability. One of the most gaping hurdles in delivering schemes to tribal populace is the difficulty in getting disaggregated **MIS data to monitor inclusion**. While data on education outcomes and indicators, disaggregated by SC, ST and other groups is readily available, no such disaggregation exists for health indicators[20], less so for water and sanitation – a sector that has fewer foot soldiers than either health or education to gather data. It is also difficult to gather disaggregated data on quality or process or on allocation of budgets and their utilisation for excluded groups. Administrators say that data by SC/ST is not captured at facility levels due to concerns of sensitivity of population in recording such data. However, the ability to gather such data in education and not in other sectors indicates that the problem is much wider.

First, most disaggregated data is available from periodic sample surveys such as the NFHS which are conducted once in five to six years. There is no state-wide regular MIS that collects data distinguished by SC, ST and other groups or generates knowledge about day-to-day field operations. This makes continuous monitoring difficult. Second, while some field assessment studies capture impact by social groups, they are too far and few in between and further, cover only a small sample with findings limited to only one tribe or a few villages. Finally, data is good as long as it is monitored regularly. The 2007 CAG review of ITDAs showed that most had not prepared annual accounts since inception and district monitoring committees, though functional in name, did not even meet once in seven years.

Monitoring, however, is a function of **accountability from below**. Unless accompanied by systems of increased voice and accountability – more so accountability ensured through continuous community-based monitoring – no amount of data can help. This gets us back to the issue of capacity-building and engagement with local communities. Else, as suggested by the Rajasthan experiment, facts too may be twisted to suit the needs of those in power.

20. The HMIS for instance has no SC/ST table. However there has been an initiative, recently, to start annual surveys in the health sector. It is possible that they address the gap of disaggregated data in health.

5. Implications for Policy

Orissa is unique in having one-third of its population comprising of 'excluded' groups. This paper focuses on the deprivation and exclusion of Scheduled Tribes, the programmes in place to address their interests and the challenges faced – both broad stroke and those more specific – in implementing such programmes.

As the discussion above suggests, there are no easy answers. While there are several noteworthy efforts on the ground and in policy to improve outcomes for tribals, there are inevitably tradeoffs. Do you bring tribals in the mainstream or have a more targeted approach? Do you build infrastructure first or focus on quality in delivery? Do you address absenteeism through provision of adequate residential infrastructure, incentives, through development of a corp of tribal service providers (time-intensive) or through sensitization? Given poor voice, do you build capacity first or transfer funds and responsibility to lower tiers of government (Palli Sabhas in tribal areas) so capacity is built?

Most stakeholders acknowledge that both mainstreaming and targeting is essential. The policy for expanding infrastructure or education for instance has so far been conflicting, wavering between reaching tribal villages and having minimum intervention so they preserve their unique identity. There is a perception that a generalised, uniform, routine response does not work in tribal areas given their unique situation. What is needed is focused attention – targeted programmes that positively discriminate until tribals achieve a threshold before they are mainstreamed.

But inclusion can truly happen once equity is achieved in mainstream policies and practices. "*One standard for us and another for another area doesn't work. That by definition is exclusion*," said one government representative interviewed by this author. Kabeer argues (2006) that targeted programmes, in general, serve as a means to compensate government weaknesses in delivering 'universal services' in these areas rather than act as a means of addressing social exclusion. In fact they could end up marginalising excluded groups even further if they do not act as a bridge to otherwise mainstream services (like mainstream education) or if they lead to labelling of particular groups. Moreover, while targeted interventions (such as those in the KBK region) help expand coverage, exclusion can continue even in well-covered areas.

There is no right or wrong way of achieving inclusion in programmes. And the tradeoffs faced by a policymaker or a programmer are unenviable.

Given the complexity of issues involved and the context of Orissa, this paper chooses to highlight a few principles that can help facilitate inclusive programming for tribals in Orissa followed by some specific interventions that can be undertaken in the areas of health, education and building voice, with a focus on the Scheduled Tribes.

Principles for inclusive programming

1. Move from a short-term sectoral approach to a long-term comprehensive approach

Although ahead of many other states in the number of schemes it has in place for tribal groups, Orissa still does not have a cohesive "policy" for tribal development. For instance, there is no state policy for tribal education. Neither is there one for improving tribal health outcomes. In other words while there are several piecemeal programmes, there is no long-term policy vision. This is not to deny the importance of smaller programmes. They are needed to address immediate needs and crisis situations in tribal areas (e.g. floods, droughts, even poverty). But an equal priority needs to be attached to a region-specific development perspective that is visionary enough to link to long-term state or national plans. Why is a vision needed? Because achievement of outcomes like reduced tribal child mortality require different sectors and programmes (both state and central) to come together. Further, they need to come together from the stage of planning itself. Else, roles and responsibilities of each towards the common goal are lost. Stakeholders across the board believe that development of such a cross-sectoral vision or plan is the primary condition for moving forward on an agenda of social inclusion.

There have been initiatives in the government to develop five year perspective tribal plans which can feed into a state tribal policy. The 2009-17 action plan for the KBK region is one example of a comprehensive approach. However many view it as only adding to the complexity of existing programmes. Further, it still divides tribal development across departments or sectors. Critics argue that what is needed is not an exclusive strategy for ST groups, but how they fit into the overall project implementation plan (PIP) for the mainstream project. Similarly, while the NRHM does offer an umbrella approach for

activities in health, the health department has seven to eight directorates that run vertically instead of uniting horizontally. This results in the loss of potential synergies across sectors, say health and nutrition or between supply side investments in health and demand side interventions to raise health awareness. Further, the gap between the short- and long-term remains significant. For example, while programmes for health training are in place, long-term human resource planning for public health systems is yet to take off. One respondent summed up what he thought was the main barrier:

> *"Development is still about committees and domains – the academic domain; the political domain; the bureaucratic domain; the community domain; and the civil society domain. Seldom do they come together."*

There are innovations to learn from. One such example of multi-sector collaboration is ANKUR, a joint initiative of the Orissa government and UNICEF. Initiated in Koraput, the programme was unique in not starting any new activities. Instead, the focus was on establishing linkages between existing programmes (e.g. those related to nutrition, education, infant survival, and drinking water and sanitation) to maximize their impact on the young child. Project activities also included support for micro-planning, capacity-building, training of frontline workers and coordination.

2. Engage with NGOs

In most interviews with this author, respondents highlighted the significant role civil society could play on two fronts – first in sensitizing frontline providers and second in spreading awareness about existing schemes, mobilizing communities and building their voice so they could demand services. There was a general perception that people in tribal villages were presently hesitant to speak out for fear of a backlash against them. While a time-intensive process, several people thought that building community organisations and groups was critical towards ensuring accountability from below and that civil society was in a better position to help build them. Similarly, having worked intensively in the remotest pockets with tribal groups, NGOs were also better placed to sensitize functionaries in the field about the special needs of tribals. However, to fulfil these roles objectively, it was stressed that NGOs work independently of the government or programmes run by donors like UNICEF or DFID, lest their obligations towards their 'client' have a deleterious impact on their work.

3. Engage with communities

Several examples from across the state suggest that tribal societies if involved can become agents of change. ANKUR for instance trained 'child reporters' from within villages in Koraput to report on problems of service-delivery in their communities. Children wrote down their observations in a diary provided by UNICEF which was collated in the form of a newsletter distributed to policy makers, functionaries and the media every month. The reports created a stir with chiefs of departments and bureaucrats asking children to report on progress, if any, in the subsequent bulletins. Some called them the eyes and ears of the village; others monitors.

Similarly, in a project facilitated by Actionaid in Kalahandi and Rayagada, local tribal youth were trained to form Swasthya Vahini groups (or health groups) that took up cleanliness drives in their villages, repaired defunct tube wells, disinfected water bodies, and undertook public information campaigns about health and general hygiene.

These and other experiences demonstrate that community participation can be a powerful tool to engage with tribal societies. It creates more foot soldiers; helps establish community information systems; helps monitor programmes through building voice, awareness and bottom-up accountability; and most importantly creates a sense of enthusiasm and ownership of existing programmes. However mobilisation is a time intensive process. Also, while community forums like Palli Sabhas can be a great platform for engagement, they need sensitive facilitation. Finally, those at the grassroots need to win the rapport of the people by speaking with them on an equal footing, recognising their rights as individuals and ensuring that services are provided on the basis of equal treatment, respect, dignity irrespective of economic, social or political status.

4. Improve monitoring and evaluation

Almost all evaluations of government schemes in the state stress the need for strengthening internal control and monitoring and evaluation (M&E) mechanisms. At the top, this is reflected in unspent funds for SC/ST programmes and at the bottom in misappropriation. Most stakeholders suggest starting with M&E for underperforming schemes and underserved tribal areas to improve targeting and performance. To help achieve the objective of inclusion though, it is critical that any monitoring system follows two basic principles. One, it should be regular in collecting data disaggregated by social groups and then, more importantly, following-

up on progress. Targets/indicators of success should be clearly defined for different points in the programme. Two, it should be accompanied by efforts to increase voice and accountability of excluded groups, engaging communities as discussed above. Finally, monitoring can lead to actionable change only if there is strong management commitment and follow-up at the top. Social audits are an example of good community-based monitoring. However, what happens after a social audit, i.e. how programme managers address community concerns is equally important to maintain people's faith in the monitoring mechanism.

Specific Interventions

Health

There are several strategic interventions which can help reduce disparity in health outcomes between tribal children and the rest. One of the foremost issues to focus on is the lack of convergent planning for health. To address this, a joint policy paper can be developed across health directorates, which can outline barriers and steps to overcome them. A task force to monitor tribal health outcomes and strengthening of health MIS for regular monitoring can be other upstream actions considered.

On the other hand, downstream interventions could focus on capacity building of service providers and awareness building among beneficiaries. For the latter, the civil society and donor agencies can play a critical role, working with PRIs and SHGs, which then spread the word among people on their entitlements, as well as designing training modules for sensitizing service providers to tribal needs. Similarly, a sanitation campaign targeted at ST women could help in improving health outcomes. However, efforts to spread awareness may come to naught unless accompanied by concurrent monitoring – through social audits, RTI and other tools – by tribal communities themselves. Lessons from states that use social audits to monitor services (e.g. the PDS in Andhra Pradesh) can be borrowed to set up community monitoring mechanisms.

Education

As shown in Section 2, literacy rates for tribals are much lower than those recorded for other groups. Moreover, a significantly large proportion of tribal children drop out of school

at the primary or secondary level. Poor quality of education too is an issue as reflected in poorer learning outcomes.

Most stakeholders interviewed for this paper agreed that the Right to Education (RTE) Act can be a huge opportunity for pushing the agenda of tribal education across the state. However, given that the RTE is relatively new, donor agencies can play a critical role vis-à-vis providing technical support to the government to implement the RTE. They can for instance help the government create a separate, functional RTE cell in the education department and build its capacity. Support can also be provided for resource mobilisation; for formation of partnerships with the private sector and with community organisations to implement RTE; and for convergent planning for tribal education across major departments.

Similarly, technical and budget support can be provided for establishing systems, processes and institutions to promote mother tongue education in selected districts in Orissa. While multi-lingual education has shown positive results in the areas where it has been initiated, gaps in capacity remain (see section 4). Here, donor organisations and civil society together can facilitate by providing education materials in 26 tribal dialects along with training to functionaries on the ground on how to use, effectively, these multilingual materials.

Finally, all these efforts need engagement with the client, i.e. tribal communities themselves. Education cannot be made inclusive with the promise of multi-lingual education alone. That promise needs to be monitored by monitoring teachers' performance on how they are able to deliver MLE modules. Donor agencies can play an important role in promoting a state alliance for social audits for education. Community-based institutions could be trained in social audit mechanisms with a goal ultimately to establish a cadre of social jurists for education within communities.

Building voice

Tribal children in Orissa presently lack voice communicated either through a strong civil society movement or through the media. Moreover, most duty-bearers within the government and outside fail to see 'voices for children' as being an important intervention in itself for supply side efforts to make an impact. Given its experience with child reporters, UNICEF can help address this gap. For one, it can bring its knowledge on the difficulties faced by tribal children to the attention of senior policy makers like the Chief Minister or the Chief Secretary perhaps through a policy note or a think piece. It can also stress upon them the

need to facilitate a rights-based forum which raises children's issues periodically and/or create a content management system (CMS) that can serve as a knowledge hub on tribal children in the state. Two, UNICEF can identify and strengthen existing civil society organisations or networks that work with tribal children (akin to the Dalit network that works on the empowerment of Dalits). Finally, it can identify and work with corporate champions, who can take up the cause of enhancing children's voice, at least in tribal areas that they work in, as part of their efforts towards improving their corporate social responsibility image.

Conclusion

In interview after interview with this author, respondents wondered why after several examples of innovations to reach tribals in Orissa, none had achieved scale. Some argued that scaling-up required tenacious champions who have the commitment to start, nurture and spread something that works, with support from the top. However most importantly they said, it needed a mindset of treating tribals as part of 'us', not as some people living on the fringes. But interventions for tribal populations are still largely looked down upon as charity – handouts that need to be doled out to uplift very poor people, with no participation and no monitoring and evaluation.

The urgency of addressing tribal marginalisation is now being acknowledged in top political circles. On a day when Maoists torched a private guest house in Malkangiri, Orissa (November 4, 2009), the Prime Minister while addressing a conference of chief ministers and tribal affairs ministers candidly said:

> *"The alienation built over decades is taking a dangerous turn. There has been systemic failure in giving tribals a stake in modern economic processes. The systematic exploitation of our tribal communities can no longer be tolerated. But no sustained activity is possible under the shadow of gun. Nor have those who claim to speak for tribals offered an alternate economic or social path that is viable."*

Inclusive programming is about building such alternate paths both for their intrinsic and instrumental worth – intrinsic, because exclusion is in a manner, denial of basic rights and instrumental since exclusion leads to poverty and creates obstacles for the achievement of the Millennium Development Goals (MDGs). Developing an alternate path, however, needs a paradigm shift, both in thinking and in implementation. It needs different stakeholders to come together, beyond their ideologies, to work in a cohesive manner with a long-term vision and most critically with community participation.

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