Social Transformation and Healthcare Practice: A Qualitative Study of Korwa PVTG in Jharkhand

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CERTIFICATE

This is to certify that the dissertation/thesis titled ..Social....Transformation..and...Healthcare...Practice...A Qualitative ..Study....of....Korwa....PVTG....in....Jharkhand.......submitted by Mr/Ms.......Veena......Vandana.......in partial fulfillment of the requirements for award of degree of M.Phil/M.Tech/Ph.D of Jawaharlal Nehru University, New Delhi, has not been previously submitted in part or in full for any other degree of this university or any other university/institution.

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Dedicated to Monisha & Monojit

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List of Abbreviations

ANC	Antenatal care.
ASHA	Accredited Social Health Activist.
BTT	Block Training Team
CHC	Community Health Centre
FPO	Family Planning Operation.
MOI	Medical officer In-charge.
MO	Medical Officers
OBC	Other Backward Caste
PDS	Public distribution system
PHC	Primary Health Centre
PMAY-G	Pardhan Mantri Awas Yojana- Garamin
CHC	Community Health Centre
SC	Sub-Centre
IFA	Iron Folic Acid
PNC	Postnatal Care.
Sahaika	Anganwadi Helper
SC	Scheduled Caste
SC	Sub-Centre
Sevika (AWW)	Anganwadi Worker
Sahiya (ASHA)	Accredited Social Health Activist.
SG	Social Group
ST	Scheduled Caste
T.B	Tuberculosis.
TT	Tetanus Toxoid.
WO	Welfare Office
MNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MOIC	Medical officer in charge
NTFP	Non Timber Forest Produce
ICDS	Integrated Child Development Services
VHND	Village Health and Nutrition Day
IAY	Indira Awas Yojana
TSC	Total Sanitation Campaign
OOP	Pocket Payment
JPE	Jharkhand Panchayat Election

GLOSSARY

Aalata	Feet Red
Amavasya	Less Night.
Arhar	Pigeon Pea
Bahu	Daughter-in-Law
Baniyas	Petty Trader (sub caste of other backward class).
Bayadhaa	Uncooked Meat Eater.
Bhagat	Traditional Healer
Bhueya	Sub Caste of Scheduled Caste
Bodi and Batura	Local Name Use of Pulse
ChappaNahal	Hand Pumps
Chegana	Chicken.
Chmain	Sub Caste of Scheduled Caste
Chunari	Religious Red Cloth.
Dal	Pulse
Devhata	Ancestral God
Dhhat	White Discharge
Dushaman	Evil Spirit
Haat	Village market
Haldi	Turmeric paste boiled with Ghee.
Haluaa	Wheat Powder Cooked With Ghee.
Hariya	Rice-Beer
Jadi Buti	Herbal Medicine (Root, Seed, Leaf and Bark).
Jiv	Soul.
Khatiya	Bed Made of Bamboo and Ropes
Kaccha	Mad by Mud.
Kadha	Liquid form of herbal medicine (Boiled herbs or soke in normal water).
Khcchai	Cooke Mix Rice with Pulse.
Mahajan	Lone
Maharin	Dai (belong to chamarin caste, SC)
Mahuwa	Mahuwa Fruit-Beer
Merge	Epilepsy.
Munng	Green Gram.
Naksha	Map of Land.
Pakka	Mad by Cemented
Pati	Husband
Pawo Roti	Bread.
Pelliya	Jaundice
Purnima	Full Moon.
Rail	Train
Sammelan	Meeting
Sas	Mother-in-Law

Shathe	Naxihal
Shive Guru	Believe on lord Shiva as a Guru. Or praying to Lord Shiva
Tiles	Khapda
Tola	Hamlet.
Moksha	Birth-Rebirth Cycle.
Kuwa	Well
Nazarlagana	Evil eyes
SauriGhar	Lying in room at child birth at home.
Haldi	Turmeric paste boiled with Ghee.
Ganda SandaChiez	After delivery waste material discharge from stomach with Maturation cycle.
Juduwa	Twins.
Mahajan	Lone
Aalata	Red colure for coloring feet
Baramda	Outer room of building.
Mann	Weight

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Introduction

The human society is dynamic.The change in human groups can be slow or rapid and it depends open the pressure of internal and/or external forces (Das, 1962). This can be referred to as transformation. Social transformation is a process where the relationships, beliefs, core principals, norms and hierarchies change over time. This has a ripple effect and ends up transforming the entire structure of the society. The factors can be internal like economic, scientific, technological or external like war or political upheavals (Chaudhari, 1992)

Tribal communities like any other social group are slowly but continuously transforming.This process can be basically divided into two time periods namely pre and post-independence. The colonial tradition of documentation of ethnographic details such as life cycle, rituals and customs continued even after independence. British administrators used the term ‘tribe’ to refer to a group of people claiming to be descendants of a common ancestor and to the people or the communities living in primitive or barbarous conditions (Hasnain, 1991). Terms like, indigenous people, aboriginal people, simple society, traditional society, adivasi were also used to refer to these communities. Tribes are often understood as group of people who are geographically and culturally isolated; relatively non-hierarchal and non-differentiated; and with a low level of techno-economic development (Bose, 1981).

Tribal population in India constitute about 8.6 percent of the total population comprising a total of 705 tribal communities including 75 Particularly Vulnerable Tribal Groups (PVTG) (MoTA, 2018-19). Most of these communities have been subjected to continued discrimination and exploitation both before and after independence.Poverty, hunger, unemployment, exploitation, illiteracy, inequality, discrimination, remoteness, exclusion, deprivation, poor sanitation, unsafe drinking water are part and parcel of the myriad of socio-economic problems that these people suffer on daily basis.

Since Independence, Government of India has been trying to address their leading issues through various Institutions and Development programs like Tribal Co-Operative Marketing Development Federation (TRIFFED), National Scheduled Castes and Scheduled Tribal Finance and Development (NSFDC) Tribal Sub-Plan (TSP), Forest Rights Act, VanbandhuKalyanYojana, Health and Nutrition Initiatives, National Tribal Festival, Protection of Scheduled Areas, Panchayats (Extension to Scheduled Areas) Act, Prime Minister’s Rozgar Yojna (PMRY), Pradhan Mantri Gram Samridhi Yojna (PMGSY), SwarnaJayanti Gram SwarojarYojna (SJGSY), Pradhan Mantri GramodyaYojna (PMGY), Antodya Anna Yojna

(AAY), National Old Age Pension Scheme, National Family Benefit Scheme, National Maternity Benefit Scheme, Mahila SamvridhiYojna (MSY), Balika SamvridhiYojna (MSY) and Integrated Child Development Programme (ICDS). The basic aim of all these welfare schemesis the development of the scheduled tribes by arising their productivity levels in agriculture, animal husbandry, forestry, cottage and smallscale industries; improvingtheir economic conditions; rehabilitating the bonded laborers; educating and training women and children. The Government, thus, seeks to alleviate the life and living conditions of the various tribal communities by addressing the long standing issues that have been plaguing them for generations.

The present study aims to reflect upon the living conditions and the socio-economic and political transformations in the Korwa community of Jharkhand since Independence. It is based on two villages in Palamu District; Gore and Semra that have high concentration of the community and they also share the common habitat with other social groups. This not only helped to identify the transformation with respect to internal changes within the community but also to observe the changes with respect to interactions and dynamics with other groups. Semra has 80 households and Gore has 43 households belonging to the Korwa community. This study is both quantitative and qualitative in nature. Structured interviews, semi structured interviews, group discussions and observations helped to understand the changing patterns. This study examines the changes in social and cultural practice, economic patterns, changes in the healthcare services and health status of the Korw. The study also analyses the past and present situations with respect to the above and tries to understand the reasons for these changes.

The study further delves into the factors behind the transformation and the effect the government policies brought about in their society.

The Korwa community was predominantly a hunter gatherer society who depended on the forest for their livelihood. This changed with the introduction of the Forest Act, 2006 which forced them to look for alternate means of survival. Migration among Korwa community is a very recent phenomenon. Migrations can be understood by two factors namely push and pull (Hasnain, 1991). In case of the Korwa community, socio-economic exploitation, starvation, diseases,natural calamities like drought and epidemics acted as ‘push’ factors whilebetter opportunities for employment, income and living conditions provided the ‘pull’ factors andwere instrumental in stimulating the migratory process.

Health care is one of the sectors which have an over-arching influence on all aspects of life in every community. The Korwas usually repose their faith in local health care providers since they are from the same village or community. These systems and beliefs are culturally infused from centuries. Traditional healers are easily accessible. The Traditional healing practicesinvolve the use of herbs, minerals, metals and animal products which are infused within spiritual practices. The meaning attached with the traditional practices seldom allow the same level of acceptance for western or any other medical system (Chaudhuri,1986). However, in case of serious medical problems they have to resort to biomedicine and Studies in medical anthropology show that the biomedicine co-exists along with the already existing traditional health practices.

The Government health care system is primarily based on the Western practices. Therefore, it has left the traditional health care methods unexplored and under developed.But unfortunately, the public health system more often than not lacks sufficient human resource and infrastructure to cater to these tribal populations. This has resulted in exploitation of these vulnerable groups by private practitioners and quacks.

The State of Jharkhand, with a majority of PVTGs, has made some progress in terms of health service delivery but it still has a long way to go. The primary reasons behind thepoor health of the indigenous populations are lack of awareness, insufficient public health services, poverty lack of sanitary facilities,drinking water and transport facility. They suffer from various chronic, vector borne and communicable diseases but the most commonarethe water-borne diseases. Though over the years access to safe and clean drinking water has increased, the options are still limited and insufficient. Natural ponds and rivers were the basic sources of water. Now wells and hand pumps have been provided in many areas. Communicable diseases such as diarrhea, malaria, leprosy and tuberculosis present major health problemsfor all tribal people in general but they more specifically take a toll on pregnant and lactating mothers. They not only increase mortality and morbidity amongst pregnant women but alsolower immunity levelsand negatively affect fetal developmentresulting in low birth weight, fetal death, premature delivery, abortion and maternal death (Shukla, 2008).

The maternal health care system has seen significant changes with the passage of time.The once preferred mode of home deliveries based on the expertise of village elders and dais is being

gradually replaced by a system where women prefer institutional deliveries, not necessarily for the better facilities and care but for the monetary benefit associated with the same.

Modern medicines to tackle these diseases are less accessible. The health centres are far away with no transport facility coupled with the fact that at most health centres the facilities available are below average. These problems often force the tribal populations to revert back to their traditional methods which are no more able to handle serious health issues.Tribals, therefore, are right in the middle of a transition from traditional to modern medicine, unfortunately in the current phase neither of the facilities available are enough to support the healthcare needs without putting a strain either economically or socially.

Even after 73 years of independence, not much change has occurred in the various tribal communities and even less among the PVTGs in terms of development. Many tribal communities especially the PVTGs do not even have the basic socio-economic facilities and still their status remainsvenerable compared to other social groups. Social and economic equality remain elusive to tribals due to various reasons, such as interdepartmental rivalries, inadequate manpower and poor implementation of schemes, poor connectivity to the modern facilities, exploitation, land alienation, poverty and illiteracy.

Chapter: 1

Development and Social Transformation of Tribal in India

Indian society has always been very diverse. Religion, language, region, caste and tribe have always been considered to be the most important aspects and these contribute to the vast diversity of the society. However, the other major aspect of it is social change. According to Gillin and Gillin, "Social changes are variations from the accepted modes of life, whether due to alterations in the geographic conditions, cultural equipment, the composition of population, or ideologies." (Gillin&Gillin, 1954, p- 561). Social change happen in all societies irrespective of the social hierarchy, structure, values, and norms and is normally a multidimensional and complex process. It results in the replacement of the old by the new and maybe termed as development, which aims to achieve human well-being and improve the quality of life. Indian society also is going through certain modifications that mark a shift in the traditional, social, and structural aspects. Post-Independence, tremendous transformation was brought in the social set-up. The transformation from agricultural to industrial society started the process of change that is still continuing (Sahoo, 2014). This change has also affected the tribal societies to a very large extent.

Most of the tribes in India are continuously undergoing changes and transformation on the socio-economic and political platforms. They have become peasants and socially segregated entities. It is believed by some scholars that the tribes have now entered the realm of Hinduism and most times are forced to change their identity accordingly points out that although the tribals are entering into new socio-cultural and economic practices that are still distinctively a tribe and not caste. Their identity relates to their distinct tribal cultural practices and shared way of life among them. The tribal community had lot of changes in terms of lifestyle, religious practices, family structure, marriage systems, rituals, customs and healing practices (Xaxa, 1999).

The tribal communities live in ecologically marginal areas and are of different races, use different languages and have different education, economic and socio-cultural integration levels. The tribal situation in India is unique and extensive and thus requires special care and consideration while planning and implementing programs and schemes. Government Policy suggests and aim to promote with special care the educational and economic interests of tribes and protect them from all forms of exploitation (Devath, 2014).A lot of literature has been written on the defining features of tribal communities and debates have been occurring regarding their lifestyle, daily life practice, and other aspects of life for decades.

1. Tribals under the centralized government structure

1.1 Definition of Tribes in India:

Sonowal C. J., 2008, study on Indian Tribes and Issue of Social Inclusion and Exclusion described the basic characteristics of different societies vary. The similarities in these basic characteristics across different groups also help to group the societies and as such one of the societies is defined as a tribal across the world. They have derived a social arrangement and characteristics 'whose social, cultural and economic conditions distinguish them from other sections of the national community, and whose status is regulated wholly or partially by their customs or traditions or by special laws or regulations' (Sonowal, 2008, p- 126).

In 1891 a tribe was defined for the first time as a 'Collection of families bearing a common name, speaking a common dialect, occupying or professing to occupy a common territory,' (Mukherjee, 2013, p - 810).

Ghanshayam Shah's classification of tribal groups based on resisting accumulation or absorption features are:

(1) They live away from the civilized world in the most inaccessible part of both forests and hills.

(2) They belong either to one of three stocks-Negrito, Austroloid or Mongoloid.

(3) They speak the same tribal dialect.

(4) They possess a primitive religion known as Animism in which worship of ghosts or spirit is the most important element.

(5) They follow primitive occupations such as gleaning, hunting and gathering of forest produce.

(6)They are largely carnivorous or flesh or meat-eaters.

(7) They live either naked or semi-naked, using tree bark and leave for clothing.

(8)They have nomadic habits and love for drink and dance (Shah, 1997)

Desai A.R. 1978, study on 'Rural Sociology in India', described another important feature of the Tribals with due course of time has emerged is the stratification among them. The tribal population follows particularly two types of stratifications. First, a small section has been emerging who get social privileges after getting an education and are land-owners. Second, the ranks of the lowest, toiling, exploited classes of contemporary India (Desai, 1978). Though there

is some trace of dominance and power exercise to create stratification among tribes, the groups, in general, are the most excluded one from the mainstream population of the country.

1.2 Classification of tribes in India:

The tribes constitute 8.6% of the total population of India and they are classified majorly based on six main criteria: (1) Geographical or regional, (2) Language, (3) economy or occupation, (4) physical and racial characteristic, (5) Ethnic Roots and (6) religious beliefs (Hasnain, 1991). Geographic or regional distribution forms the first base. In this base the following five regions are considered (a) North-Eastern Region, (b) The Sub-Himalayan Region, (c) The Central and East India, (d) South India, (e) Western India

Table: 1 Classification According to Regions of Tribes in India

	Regions	Stats	Tribes
(a)	North-Eastern Region	Assam, Arunachal Pradesh, Mizoram, Nagaland and Tripura.	Garo, Kuki, Khasi, Monad, Serna, Riyang, Miri, Apatani.
(b)	The Sub-Himalayan Region	Himachal Pradesh	Gurjar, Gaddi, Theru, Jaunsri
(c)	The Central and East India	West Bengal, Bihar, Jharkhand, Orissa, Madhya Pradesh and Uttar Pradesh,	Baiga, Joang, Kol, Santhal, Uraon, Ho, Munda, Lepcha, Korwa, Bhil and Pahadiya.
(d)	South India	Tamil Nadu, Kerala, Andhra Pradesh, Karnataka,	Tod, Kol, Kadar, Chenchu, Koya, Gonds, Cholanaiken, Godaba.
(e)	Western India	Gujarat and Maharashtra	Bhils, Ganasia, Gonds, Kolams, Pardhans, Korku, Koli, Thakar, Katkari, Warli, Parwra, Munda, Kol, Khond, Dubla.

(Source: B.S. Guha cited in Hasnain Nadeem, 1991, Tribal India)

1. Linguistic classification: Indian tribal languages can be classified into three families: (a) Dravidian language is spoken in middle and southern India. Tamil, Telugu, Kannada, Malayalam, Gond, Toda, Paliya, Chenchu, Irula and Kader are speeches belong to the Dravidian family. (b) Austric is also known as a Munda speech family. Santhali, Mundari, Ho Kharia, Bhumij speeches are belonging to the same and speak in some parts of the states of Jharkhand (Chotanagpur), Madhya Pradesh, Orissa, West Bengal, Bihar, Madras and the terai region of Himalaya. (c) Tibeto-Chinese language is divided into two sub-languages; first is Tibeto-Burman and the second is Siamese-chines and is spoken in Assam, Meghalaya and some parts of north-east India (Hasnain, 1991).

2. Ethnical Classification: according to B. S. Guha, there are six types of races: (a) The Negrito, (b) the Proto- Australoid, (c) The Mediterranean (d) The Western Brachycephals and (e) The Nardic (Guha, 2013).

3. Economic Classification: Majumdar D.N. divided Indian tribes in eight categories on the basis of economic life. (a) Tribes hunting in forest, (b) tribes engaged in hilly cultivation (c) Tribes engaged in cultivation on leveled or plain land, (d) Simple artisan tribes, (e) Pastoral tribes, (f) Tribes living as folk artist, (g) Agricultural and non- agricultural labour-oriented tribes, (h) Tribes engaged in service and trade.

4. Culture Classification: Majumdar divided the tribes into three categories on the basis of culture (a) *"those who are culturally most distinct from the rural- urban groups: that is, more or less out of contact. (b) Those who are under the influence of the culture of rural urban groups and have development discomforts and problems consequently. (c) Those who, though in contact with rural-urban groups, have not suffered there for, of have turned the corner and do not suffer any more, though they may have in past"* (Majumdar cited in Hasnain, 1991, p -53).

5. Religious Classification: According to the Census, tribes can be classified into six types based on religion: Hinduism, Christianity, Buddhism, Islam, Jainism and Other religious. 90 percent of tribes follow Hindu religion, 6 percent tribal follow Christianity and rest 4% comprise of the other religions. 90 percent population of Nagaland and Mizoram follow Christianity along with Oraon, Munda and Ho Tribes. In Himachal Pradesh, West Bengal and Maharashtra 98 percent of tribal population follow Islam. Arunachal Pradesh, Maharashtra and some part of Himalayan tribes follow Buddhism (Hasnain, 1991)

All the above classifications help to categorize the special characteristics of the Indian tribes. This special characteristic in turn helps to categorize and identify the Indian tribes according to their biogenic needs of food, clothing and shelter.

1.3 The scheduling of tribes in India

Mukharjee, 2013, study on Conceptualisation and Classification of Caste and Tribal by the Census of India', mentions categorizing the population into statistical tables assign identity tags to individuals and groups and are used to reshape the populace into definite orders.Many scholars and researchers have conducted anthropological studies during the pre-independence period, identifying the study in the caste and tribe beyond linguistic and religious categories. In 1885 C. J. Ibbetson, Jone C. Nesfield, and H.H. Risley publish an anthropological survey of India, which was extended all over the country during Census 1901 resulting in the publication of 'The People of India' (1908).The Anthropological Survey of India conducted in 1908 by the British listed 4,635 communities in total. It further divided the communities into 635 Scheduled Tribes (ST) among whom 278 were the main communities, 178 segments, 179 territorial units; 751 Scheduled castes (SC), 1046 other backward classes and the rest 2,203 as mostly general communities (Mukherjee, 2013). The terms Scheduled tribes and Scheduled castes were created as a constitutional category to help better identify and classify the tribes and castes. According to the Article 26 (1) of the first schedule of Government of India Act 1935, Scheduled Caste means "such caste, races and tribes or parts of or groups within caste, race or tribes, which appear to his Majesty in council to correspond to classes formerly known as depressed classes" (Mukherjee, 2013, p- 812).A tribe becomes Scheduled Tribe only when it is notified as one under Article 342 of the Constitution of India (Rai, 2011).

In 1909 "Manual of Anthropometry" was published which was a basic guide for population identification for the British Indian government for the next three Censuses (Mukherjee, 2013).

Dr. J H Hutton as an anthropologist and Census Commissioner, made it a point to count all the 'hill and forest tribes' during the 1931 census 'whatever, their numbers and irrespective of the percentage provision for the individual tabulation of caste' under the head 'primitive tribe' accepting the difficulty in assessing their level of primitiveness (Hutton, 1933, p- 28).

There were two dominant views about tribals. One held by British rule that tribals are native, indigenous groups who are different and isolated from the mainstream population. The other

view, held by the Hindu nationalists, hold that the tribals are a part of Hindu society and at the most, they are backward Hindu (Joshi cited in Shah, 1997, p-146)

In 1941 census, religion was taken as the basis for identification and hence Buddhism or any other tribal religion was excluded and only Hindu members of the castes and tribes were considered as scheduled.

In 1950, Article 341 and 342 of the Indian constitution first listed the SCs and STs with declared 212 tribes located in 14 states (Desai, 1978). In 1951 for the first time, the major criterion for nationality was considered the ethnic origin and not citizenship. In the process of Hinduisation of tribals, a lot of exclusions were made. Out of the total number of tribals of 24.6 million, only one third returned as following indigenous tribal religions with the majority of the remainder as Hindu. It was noted that the transformation of tribes from a cultural perspective was more important over the common belief of religious transformation. In the 1961 and 1971 censuses, the information was collected for each SC and ST. As previously tribal people were considered as Hindu, followers of indigenous tribal religions declined from one third in 1931 to 6 percent in 1981Census.Individual Caste and Tribe wise tables have been published in 1981 and 1991 census with obvious scrutiny and conspicuous delay. Hinduism maintained at 87 percent and Christianity at 7 percent as a religion among the tribals but many were still living without losing their own religious identity (Mukherjee, 2013). The fifth schedule of the Indian constitution gave the provision for each state of forming special tribal Advisory Council for identifying Scheduled Area and Scheduled Tribes to provide special benefits to the tribes. In 2001 the final table on SC and ST were published which is the latest details available.

1.4 Categorization of Tribal Groups in India:

There are 705 scheduled tribe groups notified under article 342 of the constitution with a total population of 10,45,45,716 (MoTA, Annual Report, 2018-19). Among the above 313 are nomadic tribes, 194 semi-nomadic and 198 de-notified tribes. Nomadic tribes are identified according to their livelihood needs of food, clothing and shelter, which they attempt to fulfill through hunting, shifting agriculture, and herding. They do not remain or settle at one place and their food habits and needs make them move around. Semi-nomadic tribes are different from nomadic tribes in terms of the degree of mobility practiced by them. De-notified Tribes are those communities, which had originally been listed under the Criminal Tribes Act of 1871 by the

British government. De-notified Tribes are also known as “Vimuktajati” and “ex-criminal Tribes”. These tribes are struggling for citizenship since the beginning and they lack individual freedom, right to liberty and right to justice. This is mainly because they cannot live in one place for a long time and lack livelihood resources. They do not have any documents like voter ID, ration card, Aadhar card, and thus cannot take advantage of government facilities like government welfare services and public distribution system (PDS) (MandaneUttam, 2016). Renke Commission (2008) identified these communities and prepared a state-wise list according to which 50 percent of DNTs lacked documents and 98 percent of them were landless. Ministry of social justice and empowerment increased their budget 13.7 percent to help the DNTs for 2020-21 but due to the lack of documents they faced lots of challenges. (Sinha &Shipurkar, 2020)

1.5 Tribal Development Planning in India:

During the British period, the policy adopted regarding tribals was one of isolation, which meant minimum interference in their traditional work. Under the same, the tribals lived in forests and hilly areas and remained isolated from the mainstream population for the protection of their unique culture and traditional system (Sharma, 2003). The nationalists opposed the British policy of isolation of Tribals. The efforts for tribal development in India started during the British rule with the British administration creating a separate system for administration in tribal areas (Rai, 2011).After independence, the Government of India implemented tribal development planning along with five-year plans. In the Five-Year Plans, the programmers for the welfare of the scheduled tribes aim at 1. Raising the productivity levels in agriculture, animal husbandry, forestry, cottage and small- scale industries to improve the economic conditions. 2. Rehabilitation of bonded laborers. 3. Education and training programs and 4. Special development programs for women and children. These major tenets of the five-year plans aim to fight against the unsolved problems of the tribes.

The First Five Years Plan (1951-56) was clear in setting its objective to create development programs to address the issues of the backward classes.

The Second Five Years Plan (1956-61) launched "PANCHSHEEL"; the five principles of tribal development to respect and understand the culture and traditions of the tribals and also to develop an understanding of the social and economic problem which they are facing. Under the PANCHSHEEL, 43 Special Multi-purposes Tribal Block (SMPTBs) were created which are also called Tribal Development Blocks (TDBs). For each block Rs.15 lack was contributed by the central government.

The Third Five Years Plan (1961-66) focused on 'Equality of Opportunity' and aimed towards reducingthedifference in income and wealth along with economic power. The Fourth Five Years Plan (1969-74) focused on improving the standard of living of the populace through steps which would also promote social and economic equality and justice. In 1971-72 six pilot projects were set up in Andhra Pradesh, Bihar (Jharkhand included), Madhya Pradesh and Orissa which advocated combating political unrest and leftwing extremism. Each project was granted Rs.1.50 crore for economic developments and Rs.0.50 crore for roads.

The Fifth Five Years Plan (1974-78), saw the launch of the Tribal sub-plan for the development of tribes. Under TSP funds were released by states and central government to ensure proper accountability at different levels and that funds are used for the intended use and utilization for the welfare and development of ST. Beneficiary Oriented Programmers funds were released for the expansion of infrastructure facilities and the enlargement of ST.

In the sixth five years plan (1980-85), the emphasis was on family-oriented economic activities rather than infrastructure development schemes. A "Modified Area Development Approach" (MADA) was devised for packets of tribal concentration with a population of 10,000. 20 more tribal communities were identified as primitive raising the total to 72.

The Seventh Five Year Plan (1985-90), focused on the educational and economic development of Scheduled Tribes. Two national-level institutions were set up (1), in the 1987 Tribal Co-operative Marketing Development Federation (TRIFFED) and (2) in 1989 National Scheduled Castes and Scheduled Tribal Finance and Development (NSFDC).

The Eighth Five Year Plan (1992-97), focuses on the socio-economic upliftment of scheduled tribes. Attention was paid to the special problems of repression of right, land alienation, non-adherence to minimum wages and restriction on the right of collection to minor forest produce.

The Ninth Five Years Plan (1997-2002), focused on education, infrastructure, economic development, housing, water, electricity and healthcare. One of the main points under the plan was to construct new schools and classrooms, laboratories, having adequate lab equipment, computers, basic furniture and the overall upgradation at all levels.The opening of residential schools as well as vocational training centers, provision of basic facilities like toilets and drinking water were also prioritized. Financial assistance was offered to these communities from TAHDCO for undertaking economic activities viz., distribution of bulls, mulch animals and starting of petty trades. Allotment of free sites to build houses, construction of houses for poor tribal people and providing facilities for clean drinking water and electricity facility in villages were also part of the plan. Healthcare facilities like Mobile dispensaries and medical camps were organized to attend to the general and specific health problems. Direct programmers for Primitive Tribes and dispersed tribes were launched, like the supply of safe drinking water food and nutrition security health coverage, educational facilities and housing.

The Tenth Five Years Plan (2002-07), focused on empowering tribes and unsolved problems like poverty, land alienation, displacement, deterioration of forest villages and the tribes living therein and shifting cultivation. This plan had the eradication of deprivation/exploitation of tribes as the center -point and at the same time, the ninth plan objectives were also run to empower the tribes.

The Eleventh Five Years Plan (2007-12), focused on an inclusive growth approach with social justice as it primarily addressed the issues like exclusion, exploitation, marginalization, unrest and governance concerning the tribal and tribal area. ST development sector covered and implemented the tribal sub-plan (TSP). This plan focus on two ways first was social empowerment and second was economic empowerment. (1) Social empowerment through educational development like financial assistance, coaching and hostel facility is being implemented for the benefit of STs. (2) economic development through employment and income-generating activities for better livelihood and social justice through prevention of exploitation, land alienation, displacement and survival protection and development of endangered PTGs.

The Twelfth Five Years Plan (2012-17), focused on the preservation and promotion of tribal culture and heritage and took up numbers of initiatives for their development in strengthening of

institutions, introducing umbrella schemes for education of ST children, scheduling of tribes and change of guidelines, a scheme for minor forest produce, the inauguration of call center, e-commerce portal, strengthening active research in Universities, Implementation of Forest Rights Act, Vanbandhu Kalyan Yojana, Health and Nutrition Initiatives, National Tribal Festival, Protection of Scheduled Areas, Panchayats (Extension to Scheduled Areas) Act, Scheduling and de-scheduling of Tribes, Criteria for the specification of a community as a Scheduled Tribe, Procedure for inclusion in or exclusion from the list of Scheduled Tribes, Authorities Competent to Issue Scheduled Tribe certificates, Scheduled Tribe claims on migration and Scheduled Tribe claims after marriage and status of their children.

Ministry of Tribal Affairs is implementing various schemes and programs for STs. These are known as Integrated Rural Development Programme (IRDP), National Rural Employment Programme (NREP), National Rural Landless Employment Guarantee Programmer (NRLEGP), Training of Rural Youth for Self-Employment (TRYSEM), Rural Woman and Children Development Programmer (DWACRA), Jawahar RojgarYojna (JRY), Indira AwasYojna now Prime Minister AwasYojna, Million Wells Scheme (MSW) or JaldharYojna, Drought Prone Area Programme (DPAP), Integrated Warrant Land Development Programme (IWDP), Restriya Jal ChhajanYojna (National Water-Storage Development Programme) (NWDP), Nehru RojgarYojna (NRY), Self-Employment of Educated Un-Employed Youth (SEEUY), Self EmploymentProgramme for the Urban Poor (SEPTU), Prime Minister’s Integrated Urban Poverty Elimination Programme (PMIUPEP), Prime Minister’s Rozgar Yojna (PMRY), Pradhan Mantri Gram SamridhiYojna (PMGSY), Swarna Jayanti Gram SwarojarYojna (SJGSY), Pradhan Mantri GramodyaYojna (PMGY), Antodya Anna Yojna (AAY), Annapurna Yojna, National Social Assistant Programme (NSAP), National Old Age Pension Scheme, National Family Benefit Scheme, National Maternity Benefit Scheme, MahilSamvridhiYojna (MSY), Balika SamvridhiYojna (MSY), Integrated Child Development Programme (ICDS) (Tripathy and Mohanta, 2016 &MoTA, 2019).

Most ST population is located in remote areas and are not aware of development programs introduced by the central and state governments. In addition to this, STs are a constitutional category and there are a number of tribal groups with varied regional locations and histories.

They are socially, economically, educationally depressed classes of the Indian population. Poverty, lack of healthcare facility, low literacy rate, and exploitation are the leading issues that the Government of India is trying to address through Development (Purkayastha 2015).Within STs, there is stratification based on their socio-economic conditions and levels and the categorization made by the government does not include de-notified tribes. Tribal Development does not address this heterogeneity among STs adequately. There is a need for special attention to be given to ensure an adequate flow of benefits, which are mentioned in Five Years Plans. Some of the tribal groups of India are consuming majority of benefits from the developmental programs, including but not restricted to reservation in seats in educational institutions, employment facilities, political representation and benefits under various programs of government. PVTGs need special attention along with focused developmental programs tailored for them. After independence, all the above development program and schemes have been introduced for STs and PVTGs to give them better lifestyles and uplifting from variability and backwardness but many literature and study show the tribals and PVTGs are still living in vulnerable conditions.

The next section will review studies that provide insight into the quality and standard of living among the tribals during post independence. We will study the socio-economic conditions based on the basic facilities like living conditions, accessibility to water and healthcare facilities. We will also make an attempt based on existing data to compare the living conditions of the tribals with non tribal communities to understand how they have fared over the years. India is known as a land of "Unity and Diversity". This diversity is also depicted in terms of the socio-economic gaps between the tribal groups and the non-tribal groups of India. Even the tribals vary socio-economically and culturally among themselves. Many tribes are still struggling just to survive even today. Even after 73 years of independence, still their status remains venerable (Devath, 2014).

1. Socio-economic Conditions and Patterns

2.1 Living Conditions of Tribals in India:

Hasnain, describe the housing condition on his work on 'Tribal India'. Housing conditions among tribes vary. For instance, the Garo, Mishmi, Naga and Reahgtribals of north-eastern

regions make beautiful houses with wood floor. Gond, Bagata, Koya, Godaba, Saora, Oraon and Santhal tribes of the central belt construct houses with a thick mud wall and they paint with a combination of mud and cow-dung. Yendadis, yerkulas, sugalis, katkaris, dublas, naiks, gujjars, paniyans, and kurubastribals need special attention in terms of housing and sanitation (Hasnain, 1991).

District level household survey (DLHS) 2007-08 covered more than 700 thousand households in the country out of which 112 thousand were STs. The study covered data on the living conditions and health status of tribes in India. The houses among the tribals can be categorized as follows: pakka house 7 percent and kaccha 70 percent semi pakka 24 percent. DLHS 2007-08 suggest that more than 35 percent of STs household use unprotected drinking source such as well or pond (Chaurasia 2012).

Table: 2, shows the sources of drinking water among the tribals is low compared to other social groups, the uses of tap water and hand pump among STs is 53.82% and other social groups use 65.46 %. Sanitation is in very poor condition among tribes compared to other social groups, within the house premises latrine facility is 22.6 % among STs and 46.9% in other social groups. Houses that do not have the latrine within premises is 77.4% among STs and 53.1% other social groups and open defecation 74.7% among STs and 49.8% other social groups. Availability of bathing facilities among STs is 17.3% and is 42 % in other social groups. Good houses among STs is 40.6 % which is 53.1 % among other social groups, livable housing condition among STs is 53.13 % and 41.54 % in other social groups. Very bad condition of houses among STs is 6.25 % and 5.35 % among other social groups. In terms of living conditions, 16 percent of ST households have flush toilets compared to 22 percent other social groups. The source of drinking water among tribal are as follows: 25 percent pipe water supply, hand pump 24 percent, protected well 17 percent and unprotected well 34 percent.

Dash (2012) mentions that the socio-economic condition of tribal population in a village of Sonepur district, Odisha in her study. Housing condition is very poor, 96%of the households have no toilet, 90% of the household use tubes well as a source of drinking water, 77% of the household have no electricity and 82% of the households use firewood for cooking purposes.

Table: 2, Shows the Living Conditions of the STs as Compared to other Social Groups.

	Indicators	All Social Groups	ST
1.	**Houses**		
	Total houses	246,692,667	23,329,105
	Good houses	53.1	40.6
	Liveable houses	41.54	53.13
	Dilapidated	5.35	6.25
2.	**Drinking water**		
(a)	**Households by location of the main source of drinking water**		
	Within the premises	46.6	19.7
	Near the premises	35.8	46.7
	Away	17.6	33.6
(b)	**Households by type of source of drinking water**		
	Perceived full intervention (treated tap water, hand pump)	65.46	53.82
	Perceived partial intervention (untreated tap water, covered well, Tube-well/ Borehole)	21.62	19.58
	Perceived non intervention (Un-covered well, Spring, River/ Canal, Tank/ Pond/ Lake, Other sources)	12.92	26.6
3.	**Sanitation**		
	Households having latrine facility within the premises	46.9	22.6
	Households not having latrine facility within the premises	53.1	77.4
	Open defecation	49.8	74.7
	Availability of bathing facility within premises	42	17.3

(Source: Statistical Profile of Scheduled Tribes in India, 2013, Census 2011)

Lakshmi and Paul (2019) worked on Socio-economic Conditions of Tribal Communities in Telangana and Andhra Pradesh. They mention the Yandi tribals live in forests and it plays an important role for food; they collect food items, tubers, roots, leaves, fruits, flesh of animal and birds. They mention that the living conditions of Yandi tribe is poor because forests are depleting very fast and they are facing food shortages through their traditional means of hunting and gathering.

As per the Tribal Development Plan, In Jharkhand overall 84.8% of people practice open defecation, 4.5% have flush/ pour flush latrines are connected, 10.2% pit latrine without flush/pour flush and 0.5% service latrines. The coverage of rural water supply and sanitation services lacks in Jharkhand. Besides, there are issues with the water quality as well, with many places reporting fluoride, arsenic, and iron contamination. 49% of the population depends on hand pumps and the remaining relies on a variety of sources ranging from wells, ponds to water pipes. The facilities for sanitation in rural areas are also dire. Toilets are rare with only 7.6% of rural households havingthem. The situation gets worse for SC (4.3%) and ST (3.7%) households. Closed drainage facilities are even scarce with only around 2% of rural households (Tribal Development Plan, Draft Final, 2013).

2.2 Changing Forest Policy:

Desai, mention in 'Social Background of Indian Nationalism' that the Traditional economic occupation of the tribes in India can be classified into seven categories: hunting, agriculture on hills and plans, artisan, cattle- herding, artists and agricultural and non-agricultural labor. The traditional tribal economy was mostly a combination of several types of occupations like cultivators and agriculturalists were also hunting and gathering for livelihood. The tribes and PVTGs who had hunting and gathering as the source of livelihood are Birhor, Hill kharia, Pahariya, Birijia, Korwa, Chenchu, Kurumba, Paliyan, Kadar, Jarawa, Onge and Sentinelese. During the British period, various economic and political Acts and Policies came up; these had an impact on the tribal economy, social organization, religion, and cultural life (Desai, 1948).

The emergence of colonial forces and modernization confronted the free-living and self-respect of tribal populations. During colonization, the colonial power started the exploitation of forest

resources and the inhabitants of the forest. They suppressed the resistance of the tribals and carried on with the exploitative and oppressive forest policy (Mohanty, 2005).

The Pre and Post - Independence era has seen various measures being taken to protect and manage the forests:

(1) The first Forest Act of 1865; this Act gave direction and regulation with regards to the collection of forest products by the forest dwellers and controlled the socially regulated practices by the local peoples.

(2) In the Forest Act of 1878, the restrictions over forests were further tightened and prohibition was imposed on cattle pasturing and encroachment in forest areas.Breach of the restrictions was dealt with Imprisonment and fines.

(3) The first Forest policy in 1894 brought forth the regulation of the rights and restrictions of the privileges of the users in the forest. This policy limits and regulates the traditional tribal rights over the forest.

(4) The Indian Forest Act 1927, attempted to regulate the people's rights over forest land and forest products. It regulated the cutting of trees and had provisions for the collection of revenues for cutting trees and forest products. This act gave power to the forest officers to take action or arrest any person who has the motive to harm forest wealth.

According to A. R. Desai, British economic policy affects a larger section of the tribal community. They were reduced to the status of bonded slaves and slave laborers working on plantations, mines, railways, road constructions, and other enterprises. As they started losing their lands and occupation with no other option, they involved themselves in criminal activities and were thus named as criminal tribes (Desai, 1979)

(5) After Independence, the National Forest Policy 1952 was formulated which gave the tribal community some privileges and also imposed some restrictions. They could take water for agricultural purposes, free grazing in open forest was allowed, they could collect timber, bamboos, reeds, canes and wood for house construction, collect deadwood for domestic fuel and grass for cattle from the forest and do fishing and hunting. The above was permitted if it didn't come in the way of the protection of fauna but the Act restricted the cultivation offorest lands.

(6) The Recommendation of National Commission on Agriculture (NCA), 1976 and Tribal Right; recommended that people have no right over the forest and forest product. It was noted that the readyand unrestricted supply of the forest products to the local people has been the main

reason behind the destruction to the forests and thus it was imperative that the process was reversed.

(7) B.K. Roy Burman Committee on Forests and Tribal, 1982 emphasized the importance of forests in tribal life. Forests not only provided free fuel and food for the cattle and the local populace, it also provided materials for construction and maintenance of the houses and the tribes also earned one-third of their income from the sale of the Minor Forest Produce. This report focused mainly on three corners of a triangular forest policy, which were (a) ecological security, (b) Food and fruit, (c) fuel, fodder and other domestic needs of particularly the rural and tribal population. The report gives the community the right on forest land in terms of soil, water, reforestations of tracts by suitable species.

(8) National Committee on Development of Backward Areas (1980) mentions the rights of the tribal communities over the forest land and forest produce. It stated that minor forest produce should not be the source for revenue for the sate but the tribals can use them as economic interests.

(9) The committee for the review of right and concessions (1980), restricted the right on forest and forest products to tribals and others who live around 8 KM to the forest.

(10) New National Forest Policy (1980) and The Tribal Rights focused to reduce the illegal cutting of trees and exploitations of the forests and on protecting, re-generating and efficient collecting of the minor forest produce along with institutional arrangements for its marketing. It had schemes to improve the status of the tribes, development programs for the area to meet the requirements of the tribals and their domestic need like fuelwood, minor forest produce and timber.

(11) Forest Conservation Act (1980) had restrictions on the forest land for the horticultural crops or medicinal plant. This was bound to affect traditional healthcare systems or treatment.

(12) Forest Policy 1988 targeted to stabilize the environment and maintain an ecological balance which included atmospheric equilibrium, which is a must to sustain life in all forms.

(13) Under the Scheduled Tribes and other Traditional Forest Dwellers (forest right act) Act, 2006 those who "primarily reside in forests" and who depend on forest and forest produce as a livelihood or income are eligible. They should be ST and residents in the forest for 75 years.

It was made the responsibility of the state government to ensure that the rights of the MFPs were taken care of. Section 2(i) defines minor forest products to include all products exept timber

which are of plant origin like stumps, bamboo, cane, tussah, cocoons, honey, wax, lac, tendu or kendu leaves, medicinal plants and herbs, roots, tubers, and the like.

This act gives the community the right to protect and manage the forest, section 3 (1) (i) communities have the power to conserve forest resources and section 5 gives the power to protect wildlife, rehabilitation from illegal eviction with the right to protects the forest. Section 4(5) of the Act specifically states that the traditional forest dwellers including the scheduled tribes shall be evicted from the forests till the verification procedure is completed. According to the Act, the people who cultivated any land of the forest before December 13, 2005, can get a maximum of four hectares of land (MoTA, 2014).

According to Statistical profile of scheduled tribes in India, percents distribution of migrate worker by category in India show the cultivators are total is 19.15 percent, whereas SCs are 10.72 percent and STs are 5.03 percent which is very low. As agricultural labour total 27.06 percent, SCs are 10.72 percent and STs are 59.70 percent which is very high among STs. As household workers, total are 4.21 percent, SCs are 25.36, and STs are 23.07 which is low to SCs but high to total population. Similarly other workers total is 59.61percent, SCs are 2.63 percent and STs are 14.76 percent, which is very low to the total population but high to the SCs (SPSTI, 2013).

All the above Acts and Policies made it very tough for the scheduled tribes and other traditional dwellers in terms of livelihood and income who were dependent totally on forest and forest products. The Acts over time were not consistent with each other which made adherence all the more difficult. Various Acts and Policies introduced over time forced land alienation and was a primary cause for transforming the tribal economy. A change in the economy affects the livelihood and alienating the tribes from the age-old practices and their place of domicile made them more chronic and vulnerable.

2.3 Changing Occupational Patterns:

The changing economic system has brought about noticeable changes in Indian society. Although it is not so extensive in tribal society even then the relational aspect has been influenced to a great extent. The division of labor in tribal society has taken a different shape, which may diminish rather than promote social cohesion (Mukherjee, 1986). The economic practice of tribal society in day-to-day life is highly diverse which also varies from one tribal

group to another. Many tribal populations of eastern, southern, central India and Andaman islanders are efficient food gatherers and hunters. Many tribal populations of the northeastern, central and eastern regions still practice shifting cultivation. There are settled agriculturists at par with other peasant communities in many parts of Madhya Pradesh, Gujarat, Rajasthan, Maharashtra, Bihar, West Bengal and Orissa. There are urban industrial workers as well (Mukherjee, 1986).

Many tribes are engaged in traditional work like basket and rope making, tool making by iron and wood, metalwork and ironwork. Hill cultivation known as Podu or Jham among tribes is mainly done in Assam, Meghalaya, Manipur, Tripura, Orisha, Andhra Pradesh, Madhya Pradesh and Chhattisgarh. This is declining due to shortages of land and an increase in the population. Plain land agriculture is the main source of income and livelihood among the tribes. Pastoralists, animal husbandry and animal breeding are decreases as an occupation in many tribes. Few tribes depend on folk arts like singing, dancing, barding, tattoo making, acrobatics and magic. Several Landless and marginal tribes are engaged as agricultural labor, constructer works in mines and industries have taken non-agricultural labor as the primary source of income and livelihood and they are migrated from native land to other states (Ministry of Tribal Affairs, 2014).

According to Statistical profile of scheduled tribes in India and Table-3 show the percentage distribution of marginal worker by category in India show that in total the cultivators are 19.15 percent, whereas SCs are 10.72 percent and STs are 5.03 percent which is very low. Total agricultural labours stands at 27.06 percent, SCs are 10.72 percent and STs are 59.70 percent, which is very high among STs. As household workers, total is 4.21 percent, SCs are 25.36, and STs are 23.07, which is low to SCs but high to total population. Similarly, for other workers total is 59.61percent, SCs are 2.63 percent and STs are 14.76 percent, which is very low to the total population but hight to the SCs (SPSTI, 2013).

Table: 3, Percentage Distribution of Marginal Workers by Category.

	Cultivators			Agricultural labourers			Household workers			Other workers		
	AllP*	SC	ST	AllP	SC	ST	AllP	SC	ST	All P	SC	ST
India	19.15	10.72	5.03	27.06	10.72	59.70	4.21	25.36	23.07	59.61	2.63	14.76
Jharkhand	28.88	13.83	3.28	16.92	13.83	61.06	3.76	21.35	34.05	52.25	2.47	11.23

(Statistical profile of scheduled tribes in India, 2013, Census 2011, Vandana 2020, P*- Population)

After the implementation of the Forest Act, the tribes as well as the PVTG population has been facing a lot of problems regarding livelihood and sustainability. They migrate in large numbers inter-district or intrastate as agricultural labour and construction workers (Planning Commission of India 2010).

2. Health status of Tribals in India:

Every community has their own concept of health, as part of the culture. In some cultures, health and harmony are treatedsimilarly, harmony being the state of being at peace with oneself and everything around including nature, God and the universe. (Naindu, 2007). No matter the definition and perception it can be agreed that health is dependent on overall integrated development of the society. The level of the health and well being of a community or social group is dependent on various factors such as geographical region, socio-economic cultural factors and educational and political development and stability (Balgir, 2004). Each of these aspects has a deep influence on health. The overall transformation in the health status and quality of life is not possible without development in these aspects (Basu, 1990).

Basu, worked upon Health Status of Tribal Women in India. His study found the health status of tribal women to be lower than that of Indian women in general in most aspects. The health status of tribal women has various dimensions such as sex ratio, age of marriage, fertility and mortality, life expectancy, nutritional status, maternal mortality, mother and child health care practices, family welfare programs and sexually transmitted diseases. Basu in his paper has also mentioned that there is a higher infant mortality rate in the tribal population compared to the

national average. The tribal population also has the low nutritional status of the tribals, lower life expectancy than the national average. There is a higher incidence of Sickle Cell disease and Glucose-to-Phosphate Enzyme Deficiency (G-6-80) in some tribal groups and a higher fertility rate in tribal women compared to the national average (Basu, 1993).

According to Kshatriya, in his work on Tribal Health in India: Perspectives in Medical Anthropology show that the concept of health and well being and the notion of the diseases varies between different tribal groups. Among the tribal community, any person suffering from health-related issues is not considered as having a health problem unless they are not capable to do routing work. That is the reason the concept of ill health has become functional, not clinical. Health-related problems like pain and ache, weakness, scabies, prolonged cough, mild fever and wounds are not considered as a serious symptom in many tribal groups like Kutia, Kondha, Muria, Madia, Bhattra, Haiba, Jaunsari, Santhal, Lodha, Kharia, Bhil, Rathwa, Mina, Jatapu, Saora, Pando, Khairwar, Oraon, Munda, Kinnauras and Dhodhi. Health and illness in the tribal communities are considered serious if they concern the individual or family as a whole such as measles, tuberculosis, diarrhea and cholera. (Which are mainly caused by the sanitary condition of the community or individual) (Kshatriya, 2004).

Chrua Giri (nd) focus on the role of culture, tradition and indigenous knowledge in the management of health and nutrition among Hajong and Lius tribes of north-east region, these two tribes not only manage health and diseases but also take care of their members during conception and pregnancy, birth, child care, taking care of old age people, in issues of death and overall health of women. The author also notices that women's health is poor and suggests NRHM to take action for qualitative improvement in the health and nutrition status of these two tribes.

According to Bang mention in ‘Putting Women First: Women and Health in a Rural Community’, the tribal community have understood the cultural perception of what is normal and what is abnormal. Women and girls are traditionally taught to tolerate backache and swelling of feet during pregnancy as well as in normal life. White discharge, indicating reproductive tract infection is considered abnormal (Bang et al, 2011).

According to Baru et al (2010), work on Inequities in Access to Health Services in India: Caste, Class and Region, the human development indicators and health outcomes are very poor in India throughout the years, in terms of maternal mortality and child health. Between 1998-99 and 2005-06 among STs 3.9 percent was lower than SCs 4.2 percent, OBCs 4.8 percent and the rest of the population 4.6 percent.

Reddy, study on health of tribal women and children: An Interdisciplinary Approach, describes that the Poor maternal and child healthcare practices increase the chances of mortality among tribal women. It was found that gynecological complications and communicable diseases are high among adult tribal women. Malnutrition and anemia are high among tribal women than the general population. Vitamin- A deficiency and the problem of underweight are also high among the tribal women compared with women from the general population. Communicable diseases such as tuberculosis, malaria and STD are prevalent among the tribal population (Reddy, 2008).

According to the analysis of DLHS 2007-08, the impact of the poor living condition of the ST households is well reflecting on the health status of the ST women. In the case of utilization of maternity services, the following picture emerges: Full antenatal care 12 percent compare to 15 percent with non-STs. Safe delivery, whether it be institutional or home delivery attended by a professional was only 32 percent compared to 45 percent non-STs. Only 30 percent STs received postnatal examination of women within 48 hours of delivery while their examination of the newborn within 24 hours of birth compared with 42 percent non-STs. The coverage for all these dimensions is much lower in tribal populations than the all India average among states with a significant presence of STs. Jharkhand is one of the biggest states in terms of ST population concentration but is the third-lowest state in India in terms utilization of maternity services across the country (Chaurasia, 2012).

According to Ministry of Tribal Affairs and Table-4,shows infant mortality among tribals is 62.1 percent, neo-natal mortality is 39.9 percent, pre-natal mortality is 40.6 percent, child mortality is 35.8 percent comparatively much higher than total Indian is 18.4 percent, under-five mortality is 95.7 percent, ANC check-ups is 70.5 percent, percentage institutional deliveries is 17.7 percent much lower comparatively is 38.7 percent in total India, childhood vaccination is 31.3 percent, household covered by a health scheme/insurance is 2.6 much lower

comparatively 31.9 percent in total India, the prevalence of any anemia in women is 68.5 percent (MoTA, 2014).

Table: 4, Health Profile of Scheduled Tribes

Indicates	STs (%)	Total
Infant mortality	62.1	**57**
Neo-natal Mortality	39.9	39
Pre- natal Mortality	40.6	48.5
Child Mortality	35.8	18.4
Under five Mortality	95.7	74.3
ANC Check-up	70.5	77.1
Percentage Institutional Deliveries	17.7	38.7
Childhood vaccination (full immunization)	31.3	43.5
% households covered by a health scheme/ insurance	2.6	31.9
Prevalence of any anaemia (<12.0 g/dl) in women	68.5	55.3

(Source: Ministry of Tribal Affairs Government of India, 2014)

The health problems need special attention in the context of the tribes primarily for two reasons. Firstly, many of the tribal communities are backward and secondly, the very uneven growth of the population of the tribal communities. In the case of few communities, which belong to Particularly Vulnerable Tribal Groups, there is a definite decline and there is a threat to their survival. High Mortality and existing health practices are a major reason for this decline. There is a close connection between the above and the socio-cultural habits and health care practices.

3.1 Maternal Health Practices and Beliefs among Tribes:

According to Rai, preventing maternal deaths associated with pregnancy and childbirth is one of the greatest challenges for India. Scarce communication in remote areas, unavailability of clean drinking water, illiteracy and inadequate medical facilities are some of the major problems faced by tribal communities. According to Chauhan et al (2012), pregnancy-related

death is defined as the death of women while pregnant or within 42 days of childbirth, irrespective of the cause of the death. The author is focused on the problem of tribal women due to deep involvement in the community tradition, customs, culture, beliefs and taboos. They follow suggestions given by the family, society, and community at different levels. Tribhuwan R. D. in the study of Thakur Tribals in Raigarh district of Maharashtra showed that women follow some dietary restrictions during pregnancy like not having raw papaya, banana and zimikand, as they believe these fruits produce heat in the body and may lead to abortion. After delivery, they eat rice porridge (Kanji) for the next 15 days. They believe Kanji is best for milk production and they avoid food like potatoes, brinjals, black tea, spices, jaggery, chilies, papaya and gram (Tribhuwan, 1998). Authors found the women have a habit of taking alcohol during pregnancy and continuing their regular activities including hard labor during advanced pregnancy. As per the beliefs of the tribals, the fate of the individual and the community depends on their relationship with the invisible forces (Chauhan et al, 2012 & Mangang, 2012).

Chaudhary, study on Tribal Health and Nutrition. Author mentions the impact of poor living conditions of the ST is reflected in the health status of the ST women. According to DLHS 2007- 08, the very low health position of ST women was due to unsafe deliveries, which had implications on them as well as the health of their children. The institutional delivery system is more instruction based and the tribal community faces difficulty in adapting the same as it does not sit well with their cultural beliefs and therefore utilization of these services by ST women remains very low. Reported maternity service like full antenatal care- 0.34, safe delivery -0.81, the postnatal examination of women within 48 hours of delivery 0.91, the examination of the new-born within 24 hours of birth- 0.91 is very poor in STs in India (Chadhary, 2012 & DLHS 2007- 08). The various health issues, which define the vulnerability of the tribal women, can be understood in light of the following description of health problems.

Table 5, compares NFHS-3 (2005-06) to NFHS-4 (20015-16) and shows that the Antenatal care provided during pregnancy for the most recent live birth by doctors have increased among all social groups. ANC received among STs has increased from 32.3% to 47.9% but still is very low compared to other social groups. ANC services provided by ANM and Dai/TBA have declined among STs. The percentage of not receiving ANC from any healthcare provider has

declined among STs from 29.4% to 19.6% but is still high among other social groups (NFHS-3 & 4)

Table: 5 Antenatal Care (ANC) Provider during Pregnancy for the Most Recent Live Birth and Percentage Receiving ANC from a Skilled Provider

NFHS 4/ 3	Doctor		ANM		Dai/TBA		Anganwadi		ASHA		No ANC	
SC	54.6	42.0	23.0	28.1	0.3	1.5	2.7	1.8	1.4	--	17.8	25.9
ST	47.9	32.8	24.9	28.3	0.6	2.3	5.1	5.9	1.5	--	19.6	29.4
OBC	57.2	48.4	21.1	23.1	0.2	0.7	2.6	1.3	1.0	--	17.7	25.5
Other	70.3	63.6	15.4	17.7	0.2	1.1	1.3	0.7	1.2	--	11.4	15.2

(Source: NFHS-4 & NFHS-3)

3.2 MCH Related Problem (Maternal and Child Health):

Women especially the poor, belonging to rural areas are often trapped in a cycle of poor health by childbearing, doing hard physical labor and due to deprivation of medical services. According to Sample Registration Survey 2001-2003, around 78,050 pregnant women die in India every year. For every hundred thousand live births there are 301 maternal deaths (SRS, 2001-2003). According to Statistical Profile of Scheduled Tribes in India 2013 the following figures can be seen: live birth 436,411, maternal deaths 926, maternal mortality ratio 212 and maternal mortality rate 16.3. Similarly, in Jharkhand live birth 38096, maternal deaths 100, maternal mortality ratio 261 and maternal mortality rate 30.1 (SPoSTI, 2013)

According to Upadhyay, Pandy, study on Tribal Development in India a Critical Approach medical personnel as well as sociologists are of the view that health problems, particularly during pregnancy, are not considered as diseases. PVTGs face more health problem during pregnancy like bleeding, swelling, regular vomiting, abortion, reproductive tract infection and fever just after delivery and cramps in legs. A high level of leucorrhoea due to malnutrition

affects reproduction and child conception (Upadhyay & Pandey, 2003). Poor nutritional status low hemoglobin (Anemia), unhygienic and primitive practices for childbirth are leading causes for maternal mortality among the tribal community (Balgir, 2004).

According to Jharkhand Tribal Development Programe, four out of every 10 women in Jharkhand are undernourished. 70% of women in Jharkhand have anemia and is particularly high among women belonging to ST community; 85% (NFHS-3). Half of the children below three years are malnourished. Half of the children under the age of 5 are stunted and one-third of children are too thin for their height. About 57% of the children are under weightbecause of under nutrition. (JTDP, 2008).

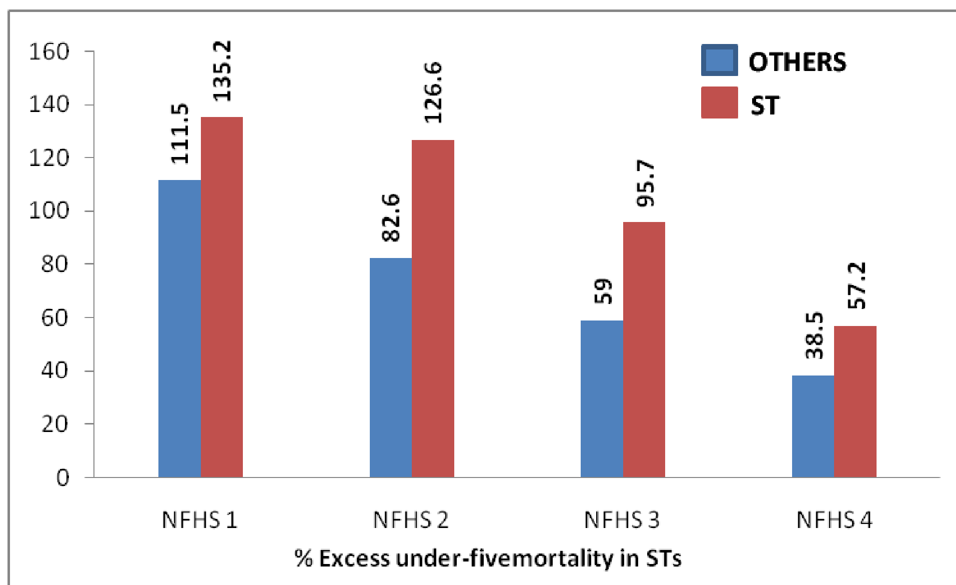
Chauhan, conducted a study on Maternal Mortality in Tribal Women of Bastar region, Chhattisgarh 2012. The sample consisted of 120 tribal patients who attended tertiary care hospitals for medical care between July 2007 and October 2011. Her study shows causes of maternal death during pregnancy, childbirth and post-partum complications. Cause of maternal death during childbirth from Hypertensive Disorders of Pregnancy is 38.3%, Rupture Uterus is 14.9%, Septicemia is 9.9%, Unsafe Abortion is 1.6%, Obstructed Labour is 4.9%, Hemorrhage is 4.9% other direct causes are Pulmonary Embolism is 1.6%, Aspiration is 0.8% and direct causes are Anemia is 8.3%, Sickle Cell Anemia is 1.6%, and Malaria is 12.5% out of a sample size of 120 (Chauhan, 2012).

According to the health plan of Orissa in 2003, the data for Child health is not promising as well, health indicators are very poor in terms of infant mortality rate 84.2, under-five mortality rate 126.6, children underweight 55.9, anemia in children 79.8, children acute respiratory infection 22.4, children with recent diarrhea 21.1 and women with anemia 64.9/1000. Health indicates to show the very poor picture in general health and quality of life of the tribes of Orissa (Balgir, 2004).

According to the Bang committee report, a tribal overview of some finding shows Nutrition 42% of tribal children are underweight, which is 1.5 times higher than nontribal children, Malaria: 30 % of all cases of malaria among ST at century level, Tuberculosis: 703 tribal and 256 out of 10,000 nontribal people suffering from TB. TB among tribal is much higher than the other but a total of 11% of tribal people are treated for TB. Leprosy: 18.5% of all leprosy cases

among tribal people. Tribal population in India is trapped into the heavy burden of infectious diseases and malnutrition generally known as diseases of the poor in which women and children are considered as the high-risk category (Bang, 2018).

Graph 1: Comparison of under-five Mortality in ST and other* during past 25 Years.

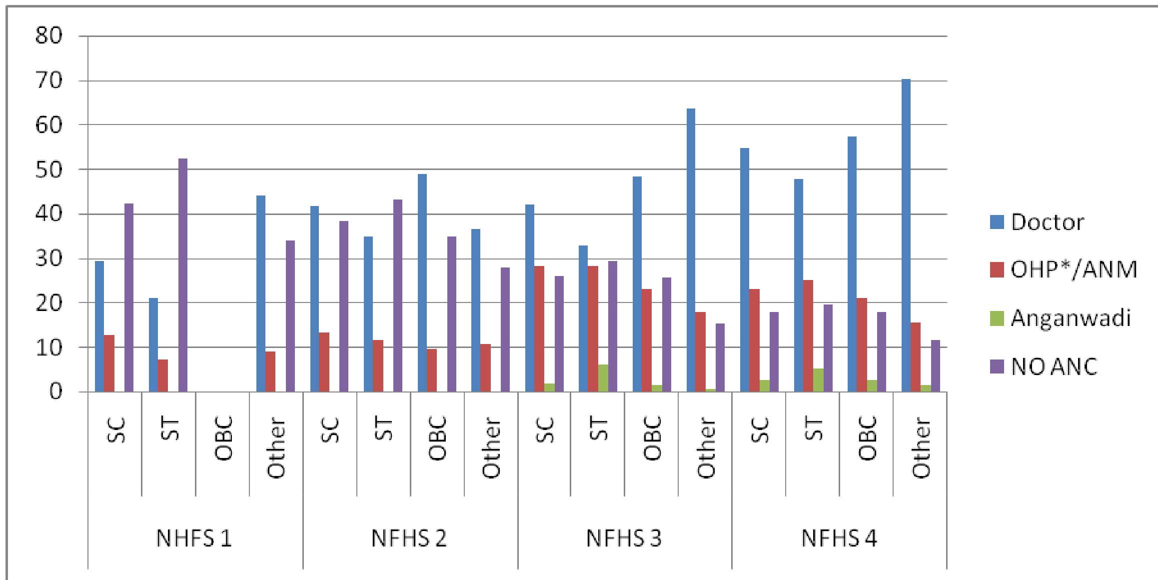


(Source: Bang Abhay Committee Report, 2018)

Graph 1 shows that the under-five mortality over the years declining but still is higher than the others. UN5M 58% decline in tribal from 135 (in 1988) to 57 (in 2014). The spread between ST and others for under-five mortality for NFHS-1, NFHS-2, NFHS-3 and NFHS-4 is 21%, 53%, 62% and 48% respectively.

Graph: 2 shows that the overall infant and child mortality are reducing in 25 years but infant mortality among all social groups has been continually higher. ST IMR in India was highest in the world among the indigenous population (Bang, 2018)

Graph: 2, Infant and Child Mortality Compression with All Social Groups



(Sources: NFHS-1, NFHS-2, NFHS-3 and NFHS-4)

According to Shrivastava work on Status of tribal health and nutrition agenda for action, he mentions the nutritional status of tribal depends on the socio-economic, socio-cultural and ecological background. These play a leading role among tribal communities continually facing deficiency in calcium, vitamin A, vitamin C, riboflavin and animal protein. Phulbani, Koraput of Odisha, Bhil and Garasis of Rajasthan and Panda, Rabris and Charans of Gujarat tribe are suffering high malnutrition (Chaudhary, 2012)

Table: 6 shows the percentage of anemic women among ST has declined with 68.5% to 59.6% but still is higher than the other social groups NAFH-3 and NFHS-4 respectively. Anemia in children among ST 76.8% has declined to 63.3% but is still a higher percentage of anemic children among ST compared with other social groups. The maternal and child health indicators among tribals based on NFHS data show that there is a wide disparity between tribal and non-tribal groups (NFHS-3 & 4).

Table: 6, Prevalence of Anemia in Women (<12.0 g/d)2 and children (<11.0 g/d).

	Women anomic		Anaemia in children	
Social Groups	**2005-06**	**2015-16**	**2005-06**	**2015-16**
SC	58.3	55.9	72.2	60.6
ST	68.5	59.9	76.8	63.3
OBC	54.4	52.2	70.3	58.6
Other	51.3	49.8	63.8	54.2

(Source: NFHS-3 and NFHS-4)

Child malnutrition rates are also much higher among tribal communities in India. According to NFHS-4 data, 94.7 percent of children below five years of age and 83.2 percent of women between the age of 15 to 49 in tribal district Lahaul and Spiti in Himachal Pradesh were suffering from anemia (Narain, 2019)

3.3 Communicable Diseases:

The tribal health condition becomes chronic after frequent infections. Tribes suffer from many chronic diseases like water-borne diseases, skin diseases, diarrhea, dysentery, cholera, guinea worm, tapeworm are mainly due to the poor drinking water. Among the tribals minerals deficiency is also one of the reasons for diseases like thyroid due to iron deficiency and tuberculosis nutrition deficiencies. Scabies, leprosy, ringworm, smallpox and anemia are common in Orissa, Madhya Pradesh, Andhra Pradesh, Bihar, Jharkhand, Uttar Pradesh (Hasnain, 1991).

Particularly vulnerable tribal groups in India are suffering special health problems and genetic abnormalities like sickle cell anemia, G-6-PD red cell enzyme deficiency and sexually transmitted diseases were prevalent among them. Insanitary conditions, lack of personal hygiene, health education and ignorance are the main factors that lead to their poor health status (Shrivastva, 2012)

Jai Prakash Narain, in his work on ‘health of tribal populations in India: how long can we afford to neglect’ described the vector-borne disease like malaria (Plasmodium Falciparum) is very common and has a very bad impact on the tribal population in India. Among the tribal community, 70 percent are diagnosed as having malaria and 47 percent of total deaths are caused due to malaria in the country. Tuberculosis is also higher among the tribal community, 703/100,000 compared to the national average 256/100,000. The Saharias PVTG belongs to Madhya Pradesh, in this community tuberculosis is very high 1518/100,000 population (Narain, 2019).

To summaries the above the living conditions and health status show that the situations of the tribals is dire and a lot is left desired when it comes to the general well being of these groups. Food, health and shelter are considered the basic necessities for survival and the tribals are still struggling on these fronts, comparatively their status is poor and at best sub standard. A lot of efforts have been made to bring the living conditions of the tribals at par with the non tribal society but even after concentrated efforts not much has changed. Let us try to understand some of the major reasons, which caused this disparity and maintained and at times widened the gap between the tribal and nontribal population.

4. **Transformation of Healthcare Services among Tribals:**

According to world health organization, 2000, the healthcare system in India in terms of health policies plans and programs have emerged after independence. Health system refers only to the provision of, and investment in, health services and the health care system including preventive, curative, palliative interventions, whether directed to the individual and the population (WHO, 2000).

Health policies and plans are documented and prepared in India since Independence in 1946. Health Survey and Development Committee Report popularly referred to as the Bhore Committee (1948) proposed that there should be changes at the structural level in the then present healthcare system which could bring about a tremendous change in the health status of the Indian masses, particularly the 80 percent population residing in rural areas.

The relationship between the health of Indian women and their social-economic conditions had also been recognized by the Bhore committee (1946) which says that “The special steps taken

to promote healthy motherhood must include not only medical measures but also certain ancillary services designed to mitigate or remove the socioeconomic factors (promoting the adverse condition of life such as malnutrition, overcrowding and physical strain through overwork) Thus it should not only be to protect maternity but this service should be developed as parts of the wider organization for providing satisfactory health protection to all women" (Bhore Committee 1946, p 98). An analysis of policy towards women's health shows that over the last few decades, maternal health was isolated from the rest of women health and was a converted into a purely medical issue, knowledge about which resided only in a group of socially trained professional (Sagar, 1999)

4.1 Traditional healthcare service:

According to the World Health Organisation in India Ayurveda, Siddha, Unani, and Yoga are traditional healthcare systems, and there are about 500,000 practitioners of traditional medicine and 108 colleges of indigenous medicine in India. Traditional healthcare practitioners and Dais are present in almost all societies. They are generally a part of the community and have a higer standing allowing them to exert influence on the health practices. With the emergence of the formal health system these traditional healthcare practitioners can become a support structure. Thus it becomes imperative to explore their importance and the possibility to train them so that they can work beside the primary health workers (WHO, 1978).

Indian healthcare providers can be divided into two forms, on one hand there are almost six lacks practitioners who are officially certified by the Indian government and on the other hand two million local healers who have semi-legal status. 537,012 registered practitioners of Ayurveda, Unani, Tibb and Siddha and out of whom 478,750 Ayurveda practitioners (Wujastyk, 2008). One and half million providers of folk medicine who deliver to healthcare to nine hundred million people live in the rural areas (Hariramurthi& Bode, 2014). In south India, 760,000 local practitioners and among them 500,000 midwives (Shankar, 2004). In North India 64 registered indigenous practitioners, 19 of them are certified and 45 are not certified practitioners but they were practicing in both Allopathic and Ayurvedic systems of medicine (Kakar, 1983). 250,000 registered practitioners of the Ayurvedic system, as compared to about 700,000 of modern medicine in India. In India 20,000 medicinal plants are recorded but only

7,000 to 7,500 plants are used by traditional healers, use of the plant in Indian system of medicine Ayurveda 2000, Siddha 1300, Unani 1000, Homeopathy 800, Tibetan 500, Modern 200, and folk 4500 (Jaiswal, 2018).

According to WHO, *“traditional healer is a person who does not have any formal medicinal training, but is considered (by the local community) as being competent to provide health care using animal, plant and minerals substances and certain other techniques based on social, cultural and religious background as well as the knowledge, attitudes and belief that are prevalent in the community regarding physical, mental and social well-being and the causation of the disease and disability”* (Singh & Madavan, 2015, p- 1224).

According to Raiand Nath’s, work ‘use of medicinal plant by traditional herbal healers in central India’ is on Baiga, Bhariya, Bhil, Gond, Hill Korwa and Birhor tribals who belong to Madhya Pradesh and Chhatisgarh. The traditional herbal healers belong to the tribal community as well as PVTG tribes. They cure the health-related problems with herbs. They treat many diseases like fever, headache, toothache, earache, body ache, liver disorder, cold, cough, bronchitis, asthma, bone fracture, snakebite and scorpion sting, wounds and skin infection, problems for tribal women in urinary infection, menstrual disorders and bowel infection (Rai and Nath, 2003).

According to Rose, in his study Reproductive Health Awareness among the Tribal Women in Manipur on the charo tribal community, approaches human disorders psychosomatically as well as organically, while the modern system aims at bio-chemical efforts. The traditional healthcare system is based on deep observation and understanding of nature and the environment. The different tribal community also uses different parts of the same plants for particular ailments. This indicates a deep understanding of medicinal plants and herbs and a combination of the doses for the cure of different diseases (Rose, 2008).

According to Sujatha, work on Health by the Pepole Sociology of Medical Lore, study conducted in a village of Tamil Nadu, folk healers are a heterogeneous group, likes snake bite healers, bonesetters, jaundice healers, and midwives and they treat various common and chronic health-related problems. Their knowledge is transferred from generation to generation

in oral form (Sujatha, 2003). At the village level, they belong to their communities and they share a common ethos, social-cultural believes of healthcare with their patients (Sujatha, 2009).

According to Joshi and Kahri, study of the system of health care practices among the Bhils tribe, traditional healers diagnose and treat diseases in the tribal community. Healers diagnose the disease by maize grains and mantra. Treatment is divided into two parts; first is healing (dhagabandhana, jhadana, jadibuti) and second is traditional healing (Badwa and Shaman). The healing process is dependent upon the severity of a disease. The first step is tying a thread around the arm with maize grains and chanting a mantra. If the patient is not cured by this then she/he is treated by a branch of neem stem with leaves. Healer rotates the branch of leaves on the whole body of the patient while chanting the mantra. In the final step, they give some jadibuti. Badwa approach is holistic, where all aspects of a patient's life like emotional and physical symptoms are taken into consideration. And shaman treats with the power of sun and moon. The author also mentions the role of dai and bone-setter (Joshi and Kahri, 2008).

According to National family health survey-1, home delivery as a place of delivery among tribal community was very high in NFHS-1 77.9%, NFHS-2 70.4%, NFHS-3 70.9% and NFHS-4 27.9%. From 2006 to 2016 home deliveries 70.9% declined in NFHS – 4 to 24.9 and on the other hand public healthcare services as a place of delivery increased from NFHS – 311.6% to NFHS-4 55.9%. The Tribal community after 2006 utilized the public healthcare services more.

According to Mahant D. Sushila, his work on Indigenous Traditional Healing Care: Belief & Practices among Tribals of South Bastar in Chhattisgarh, health institution like Sub Center 7.74 percent, PHC 60.83 percent and CHC 16.83 percent and District hospital 13.80 percent in Baster district. The treatment used by the tribal are from traditional healers' 36.66 percent, herbalist 15.33 percent, home remedies 2.22 percent, Government doctor 20.22 percent and private doctor 12.88 percent. 75.33 percent of people prefer traditional healers but among the younger populations 24.66 percent prefer public healthcare and are not interested in traditional healers (Mahant & Sushila, 2015). At the same time, most of the healers are older, in the range of sixty to eighty. It also seems that young people are walking away from traditional medicine. Although research is required to exactly pin point the factors, reasons such as the social

prestige of biomedicine, marketing, legal status of traditional practitioners, heavy investments in Biomedicine and lack of studies on traditional practices are probably responsible for the fact that folk medicine in India is under pressure (Bode & Harimamurthi, 2014)

4.2 Public healthcare services:

According to D Banerji, his work on 'Health Behavior of Rural Populations Impact of Rural Health Services', the concept of the primary health center was first time introduced by the Bhore committee in 1946 with the concept of basic health services provided to the people of integrated, preventive and curative healthcare to the rural population of India. After two decades over 5,000 PHC are in place, one for a population of every 80,000 to 10,000. With integration to various extents of programs for the mass campaign against certain specific health problems, such as malaria, smallpox, leprosy, trachoma and filarial, and rapid population growth, there has been considerable expansion of the activities of these primary health centers (Banerji D, 1973).

According to Baru et al, work on Inequities in Access to Health Services in India: Caste, Class and Religion. Study show the public health service institutions are divided into three levels of care are Primary level cares: Sub-center and PHC, Secondary level care: Community Health Center and hospitals, and Tertiary level of care: teaching hospitals. Over the years there has been an increase in facilities in public and private sectors but this is not fulfilling the universal coverage and access to quality care. The rural, urban, and interstate variation in the distribution of public facilities and human resources lead by insufficient public investment and the failure to focus attention on the synergies between the role of the center and the states adds to the problem (Baru et al, 2010).

Hiramani, his work on Cultural Correlation of Tribal Health, covers the states- Andhra Pradesh, Gujarat, Maharastr and Orisha and analysis the Health infrastructure created in and for the tribal area has a close relationship with the healthy development of the tribal population. The central government has launched several health-related programs to provide preventive, promotive, curative and rehabilitative services under the Minimum need program such as trained Dai (TBA), Village Health Guides, upgraded sub-center, subsidiary Sub-Center, Primary Health Center, Upgraded Family Health Center/CHC supplemented by allopathic and Indian System of Medicines and allopathic hospitals. Schemes like control of Malaria, Filaria,

T.B., Leprosy, Universal Immunization program, National Programme for control of blindness, Polio control, AIDS control program, MCH program, Child Health and Nutrition program (Hiramani 1997, Srinivisan 2020).

The Central Ministry of Health and Family Welfare has relaxed the norm for the establishment of Sub-center, PHC and CHC in tribal /hilly areas these are (1) PHC established in the tribal area to cover a population 20,000 as against 30,000 in other areas. (2) Sub-center can set up for a population of 3,000 in the tribal area as against 5,000 in other areas. (3) CHC for population of 80,000 in tribal area as against 1,20,000 population. (4) Where habitation is more than 5 k.m. from the nearest health delivery point (Hiramani 1997 & IPHS 2006).

Table: 7, Sub- center and PHC in Tribal Areas in 1990-95

		Sub-centre			PHC		
S. No	State	R	Ach	% Ach	R	Ach	% Ach
1.	Madhya Pradesh	5019	3533	70.4	752	473	62.9
2.	Maharashtra	1662	1593	95.8	237	237	100+
3.	Odisha	2300	1485	64.6*	354	344	97.2 +
4.	Rajasthan	1387	564	40.7	214	71	33.8
5.	Gujarat	1930	1590	82.3	294	154	52.4
6.	Bihar	2825	1714	60.0	424	143	33.7
7.	West Bengal	712	91	12.8	107	411	384.1+
8.	Assam	804	398	49.5	121	57	47.1
9.	Karnataka	1855	1734	93.4	266	107	40.2
10.	Andhra Pradesh	915	654	71.4	137	60	43.7

(Hiramani 1997, Eighth Five Years Plan 1990-1995)

Table 7, shows that more than 50 percent achieved the sub-center except West Bengal, Assam and Rajasthan but it did not reach hundred percent in any of the above states (according to largest population). In case of PHCs West Bengal has a surplus with 384.1 percent, Maharashtra has achieved 100 percent, Odisha achieved 97.2 percent, M.P. has achieved 62.9 percent and Gujarat has achieved 52 percent but other states like Rajasthan, Bihar, Assam, Karnataka Andhra parades has achieved less than 50 percent.

According to Sharma, Jharkhand face the shortage of sub-centers, PHCs and CHCs from 1990 to 2000. As per the Government of India guideline there should be 7,260 Sub centers in rural

areas but there are only 4,462. Most of the existing Sub centers are not in working condition in terms of equipment, medicine and health personnel (Sharma P.D., 2004)

Table: 8 shows the Sub Center, PHC and CHC situated in the state of the highest concentration of tribal population in the rural area. Madhya Pradesh, Maharashtra, Odisha, Rajasthan, Jharkhand, Assam, Karnataka are facing a shortfall of the sub-center, PHC and CHC. Gujarat, Chhattisgarh and west bangle have a surplus of sub-centers, and PHCs and Rajasthan and West Bengal have a surplus of CHCs. Overall public healthcare centers in the tribal area are running in shortfall and are not in good working condition.

Table: 8, Sub center, PHC & CHC in tribal area which are in high concentration tribal population state.

S.No.	State	Population in	Sub centre			PHC			CHC		
		Rural area	R	P	S	R	P	S	R	P	S
1.	Madhya Pradesh	14276874	4758	3545	1213	713	332	381	178	104	74
2.	Maharashtra	9006077	3002	2057	945	450	315	135	112	67	45
3.	Odisha	8994967	2998	2701	297	449	427	22	112	133	**
4.	Rajasthan	8693123	2897	1659	1238	434	210	224	108	65	43
5.	Gujarat	8021848	2673	2775	**	401	421	**	100	92	8
6.	Jharkhand	7868150	2622	2465	157	393	165	228	98	94	4
7.	Chhattisgarh	7231082	2410	2811	**	361	396	**	90	80	10
8.	West bangle	4855115	1618	3206	**	242	300	**	60	104	**
9.	Assam	3665405	1212	768	453	183	176	7	45	26	19
10.	Karnataka	3429791	1143	321	822	171	64	107	42	7	35

(Source: Ministry of tribal affairs 2018-19, R: Required, P: In position, S: Shortfall, S: Surplus)

Table 9 shows the requirement of health worker like ANM, Nursing staff and Doctors and the shortfall at sub-center, PHC and CHC in the tribal area. ANM at sub-center and PHC are in a good position in the mentioned states but the nursing staffs at PHC and CHC are not in adequate numbers in states such as M.P., Maharashtra, Odisha and Jharkhand. Numbers of Doctors at PHC show adequacy but M.P., Odisha, Gujarat and West Bengal are still facing problems with shortages.

The infrastructure for the Public healthcare systems like PHCs and Subs Centers were setup in 1980 and the patterns haven't undergone much change over the period. Only increasing the workforce will not have the required impact and improvement on the health status in the tribal areas. The terrain of these areas also makes the accessibility of the health centres and associated facilities more challenging (Mavalankar, 2016).

Table: 9, Health Worker in Sub Center, PHC and CHC in Tribal Area.

S.No.	State	ANM (Female)			Nursing staff			Doctors		
		R	P	S	R	P	S	R	P	S
1.	Madhya Pradesh	3877	5560	**	1060	832	228	332	287	45
2.	Maharashtra	2372	6258	**	784	468	316	315	354	**
3.	Odisha	3128	3259	**	1358	769	589	427	327	100
4.	Rajasthan	1869	2830	**	665	1187	**	210	383	**
5.	Gujarat	3196	1816	1380	1065	1599	**	421	358	63
6.	Jharkhand	2630	4024	**	823	394	429	165	179	**
7.	Chhattisgarh	3207	4403	**	956	1008	**	396	167	229
8.	West bangle	3506	5345	**	1028	1720	**	300	356	**
9.	Assam	944	1581	**	358	433	**	176	227	**
10.	Karnataka	385	242	143	113	93	429	64	38	26

(Source: Ministry of tribal affairs 2018-19, * : Surplus)

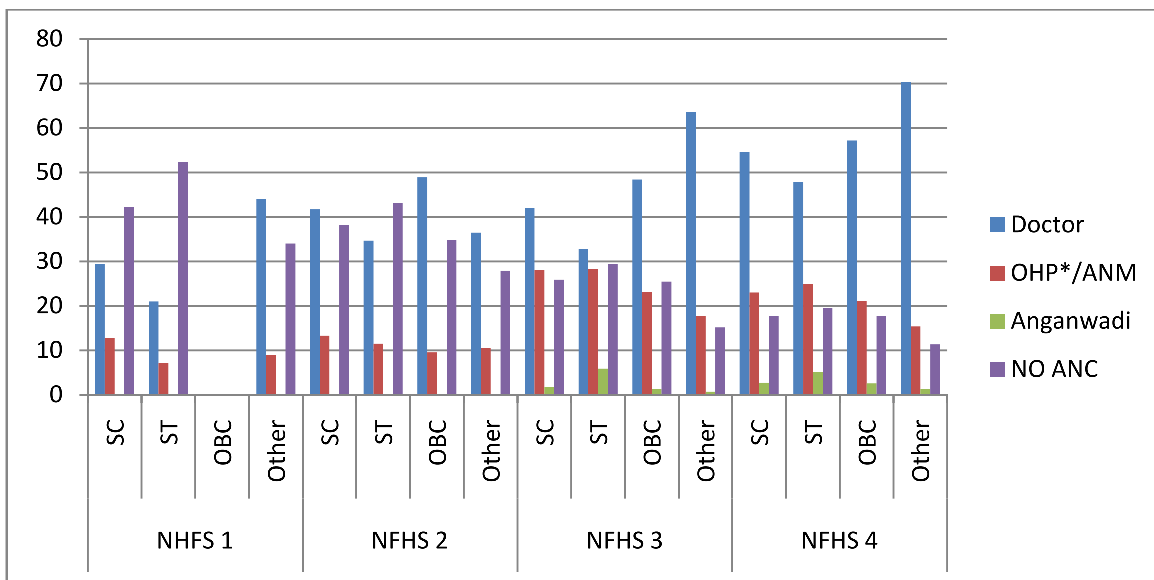
4.2.1Antenatal Care

Over the decades' utilization of ANC care among ST population was lower compared to other social groups but the use of ANM in NFHS 3 and 4 has increased.Having said that the percentage of people not taking ANC by any healthcare professional is still more than the other social groups.

Graph 3 shows the Antenatal care (ANC) used by different social groups by different health providers over the decades. NFHS 1 data shows 21% of ST, 29.8% of SC and 44% other groups take ANC from a doctor. 12.8% ST, 7.1% SC and 9% other take ANC from other healthcare providers and 52.3% ST, 42.2% SC and 34% other do not take any kind of ANC. As per NFHS 2 the percentage of taking ANC are 34% of ST, 41.7% of SC, 48.9 % of OBC and 36.5% of other groups by a doctor, 11.5 % ST, 13.3% SC, 9.6% OBC and 10.6% other groups taking from ANM, 43.1% ST, 38.2 % SC, 34.8 % OBC and 27.9% other are not taking any

ANC. NFHS 3 shows percentage of taking ANC 32% ST, 42% SC, 48.4 % OBC, and 63.6% others by a doctor, 28.3% ST, 28.1% SC, 23.1% OBC and 17.7% other taking form ANM, 29.4% ST, 25.9% SC, 25.5% OBC and 15.2% other are not taking any ANC. NFHS 4 shows percentage of taking ANC 47.9% ST, 54% SC, 57.2 % OBC and 70.3% others by doctor, 24% ST, 23% SC, 21.1% OBC and 15.4% other taking form ANM, 19.6% ST, 17.8% SC, 17,7% OBC and 11.4% other are not taking any ANC. The utilization of ANC among tribal is lower than the others and not taking ANC is in high percentages.

Graph 3: Percentage of Antenatal Care during Pregnancy



(Source: NHFS- 1, 2, 3, 4. OHP*- Other healthcare providers in NHFS 1& 2, ANM in NFHS 3 & 4)

4.2.2 Place of delivery

The utilization of public healthcare services as a place of delivery is increasing among all social groups, which is one of the important factors in reducing maternal and neonatal mortality. Before 2005-06 among tribal communities approximately 71% opted for home delivery, which is very high but in 2015-16 it was 27.9%. Institutional delivery increased in 2005-06 from 39 % to 79% in and 2015-16 at national level (NFHS-3 & 4).

On 12th April 2005, Janani Suraksha Yojana (JSY) was launched under the National Health Mission for safe motherhood to reduce maternal and neonatal mortality by promoting institutional delivery among economically poor women. JSY scheme focuses on low

performing state of Uttar Pradesh, Uttaranchal, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Orissa and Jammu and Kashmir (NHPI, 2015). Pregnant women should be registered under JSY card with Maternal and Child Health card. MCH card monitor the ANC and PNC by the ASHA and ANM at the village level and MO at PHC. JSY scheme is an assistance scheme for pregnant women, in rural areas pregnant women who are BPL holder get 1,400 rupees and in urban area 1,000 rupees after delivery (JSY Guidelines for implementation, 2005).

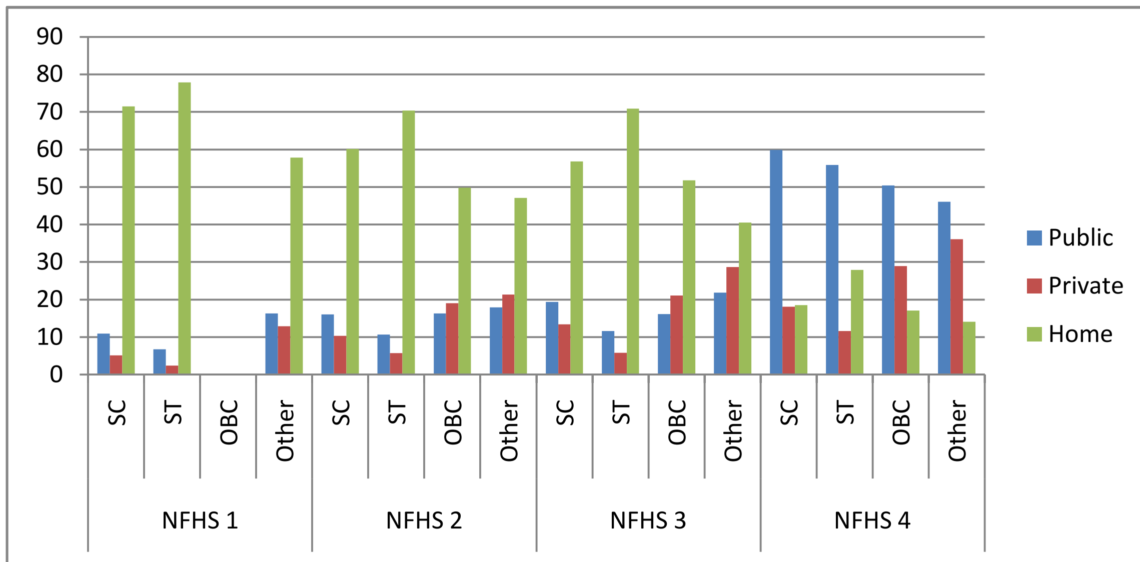
Ministry of Women and Child Development launched conditional maternity benefit (CMB) program under the maternity benefits program, which is a scheme for pregnant women and lactating mothers (PW&LM) in the entire district in India. The scheme focused on health-seeking behavior and increasing nutritional status during pregnancy and after delivery by providing case incentives to the beneficiary. Case incentive are provided in three installments, (1) early registration of pregnancy gets 1,000 rupees, (2) one ANC gets 2,000 rupee and (3) after registration of child, the first cycle of BCG, OPV, DPT and Hepatitis –B they receive 2,000, and after institutional delivery mother gets 1,000 rupees (MW&CD, 2017).

Graph 4, shows the place of delivery among all social groups of women between the age of 15-49. According to NFHS-1, public healthcare is used for delivery by 6.7% ST, 10.9% SC and 16.3% other social groups women. Private healthcare is used for delivery by 2.4% ST, 5.1% SC and 12.9% other social groups. Home delivery among 71.9% ST, 71.5% SC and 57.8% other social groups. Utilization of public and private healthcare services by ST women is very low than other and home delivery among STs is higher than others. NFHS-2, public healthcare used for delivery by 10.7% ST, 5.7% SC, 16.3% OBC and 17.9% other social groups. Private healthcare used by 5.7% ST, 10.3% SC, 19% OBC and 21.3% other social groups. Home delivery was used by 70.4% ST, 60.1% SC, 49.8% OBC and 47.1% other social groups. Among ST women less percent utilized public and private healthcare services they prefer home delivery more than to other social groups.

Graph 4 show public healthcare is used for delivery by 11.6% ST, 19.4% SC, 16.1% OBC and 21.8% other social groups. Private healthcare used by 5.8% ST, 13.4% SC, 21.1% OBC and 28.7% other social groups. Home delivery was used by 70.9% ST, 56.8% SC, 51.8% OBC and 40.5% other social groups. During NFHS-3 public healthcare attracted tribal women but still

approximately 71% ST women delivery baby at home. NFHS -4 show the 55.9% ST, 59.9% SC, 50.4% OBC and 46.1% other women have utilized the public. Private healthcare used by 11.6% ST, 18.1% SC, 28.9% OBC and 36.1% other social groups. Home delivery was used by 27.9% ST, 18.5% SC, 17.1% OBC and 14.1% other social groups.

Graph 4: Place of Delivery, Percent Distribution of Live Births to Women (Age 15-49) of All Social Groups



(Source: National Family Health Servey -1,2,3 and 4)

NFHS -1, 2 & 3 show the place of delivery in public healthcare services utilized 6.7%, 10.7%, 11.6% by ST women less compared to other social groups but after 2006, NFHS 4 showing it is very high utilization with 55.9% and private healthcare services also increases with 11.6% and other hand home delivery is decrees but still home delivery is higher than all social groups in India.

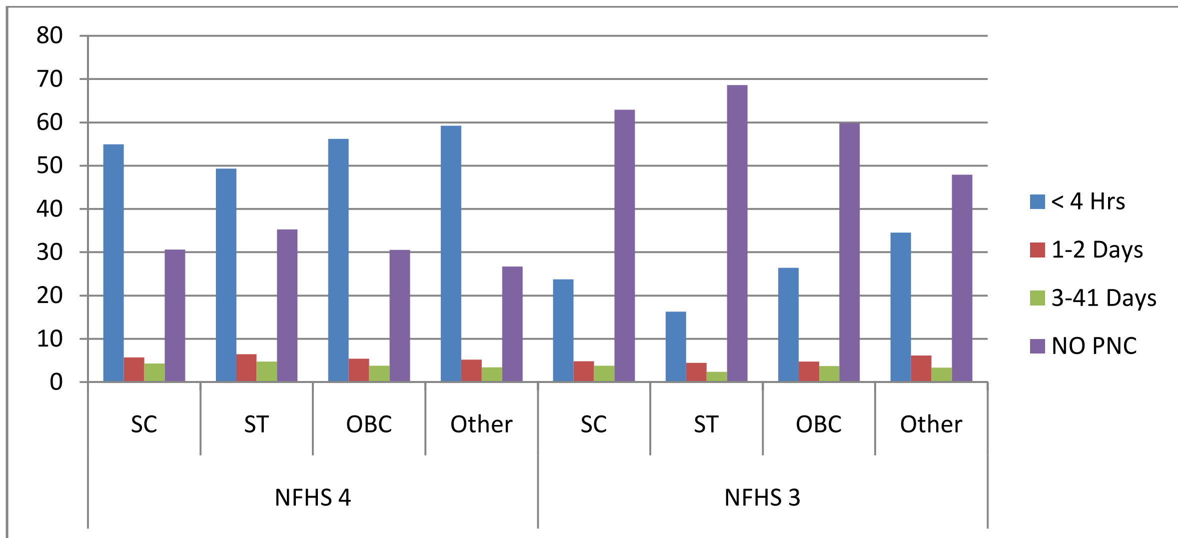
Sample Registration System Bulletins 2015, show the data of maternal deaths 301 per 100,000 live births during 2001-03 have declined to 167 during 2011-13 and IMR 58 deaths per 1000 live births in 2005 have declined to 37 in 2015 (SRS Bulletin 2015). Mahanta et al, work on JSY and its impact on women in Sambalpur Odisha, working in Veer Surendra Sai Institute of Medical Sciences & Research (VIMSAR) Burla, states that after 2006 intuitional delivery has

been increasing, 2,800 in 2007-08, 4,175 in 2010-11, 5,822 in 2013-14, 5,913 in 2015-16, and 6,236 in 2017-18 (Mahanta et al, 2018)

4.2.3. Postnatal Care

The mother and child are healthier if the healthcare received during her pregnancy, delivery and post-delivery are better. The reproductive and child health program recommended three postpartum checkups at the health center. Health care mothers and children receive the first few weeks to two months after delivery (MoHFH, 1998). According to postnatal care received within two months among tribal was received fewer percent than the other social groups like 14% ST, 17% SC, 15.6% OBC and 18.3 others.

Graph 5: Percentage of Postnatal care of all social groups



(Source: National Family Health Servey-3 and 4)

Graph 5 shows postnatal care among ST has increased in NFHS-4 compared to NFHS -3. According to NFHS- 3 the STs taking postnatal care within less than four hours was 16.3% compared to 34.5% of others, within one to two days taking postnatal care among ST was 4.4% compared with 6.1% others, within three to forty-one days 2.4% ST compared with 3.3% others. 68.9% ST compeered to 47.9% were not taking any kind of postnatal care. Overall postnatal care among ST was very low compared with other social groups in NFHS-3. According to NFHS-4, NFHS- 3 postnatal care within less than four hours in ST was 49.3%

compared to 59.2% of others, within one to two days taking postnatal care among ST was 6.4% compared to 5.2% other, within three to forty-one days 4.7% ST compared to 3.4% others. 35.3% ST compared to 26.7% others do not opt for postnatal care. Among the STs the percentage of postnatal care is still very low but compared with NFHS-3 to NFHS-4 is higher. The graph indicates the place of delivery in tribals as private healthcare services utilization over the decades increased, NFHS-1 (1992-93) 2.4%, NFHS-2 (1998-99) 5.7%, NFHS-3 (2005-06) 5.8% and NFHS-4 (2015-16) 11.6%.

Data show that over the years utilization of public health services is increasing but still very low among tribal than the other social groups, in ANC, place of delivery and postnatal care among tribal community.

4.3Availability of Health Facility and Human Resources:

Deogaonkar highlights the effect of social and economic inequality on health in society. The standard of living of a population is affected by factors like life expectancy, mortality and morbidity. He focused on the unequal distribution of healthcare resources in India; the ratio of hospital beds and doctors to population in rural areas is 15 and six times lower than that for urban areas. In remote areas with poor transportation facilities, equipment, doctors and nurses are generally insufficient and ineffective. The maternal mortality among the population living in rural areas is much higher. Having trained medical and paramedic staff during birthing is difficult which makes pregnancy complications challenging. Preference of a specific gender for the child adds to the issue. (Deogaonkar, 2004).

National rural health mission, state program implementation plan 2011-12 mentions that the tribal populations are vulnerable and often face exclusion as they live in remote areas and they normally live a secluded life, a lack of availability and accessibility to healthcare facility adds on.The issue also lies with the lack of infrastructure, lack of doctors, nurses and other human resources in these areas and the vast areas the present healthcare centers are supposed to cover. The tribal areas are under the influence of resurgent forces as well which compounds the issues. (NRHM SPIP 2011-12, Jharkhand, Executive Summary p- 4 & 300).

Availability of human resources have been challenging in Jharkhand and especially rural areas. The state struggles with shortages of skilled and trained medical personnel. Efforts have been put in place by the Jharkhand Government to build capacity and train and create personnel who are skilled at multiple medical tasks. This is also necessary and important from a maternal health perspective. Ramani et. al. mentions that in Jharkhand, over 82% of deliveries happen at home and skilled birth attendants (SBAs) play an important role in the same. The state has started training ANMs/LHVs and nurses to act as SBAs so that they are better equipped to manage common obstetrical emergencies (Ramani et. al. 2009).

Most tribal villages are far from each other and are located in remote, inaccessible areas inadequate road connectivity and limited transport service. Water resources such as wells and hand pumps dry up particularly in summer due to depletion and lowering of the groundwater table. Even if in the rural areas hand pumps are available, the problem persists of timely repair and maintenance (Tribal Development Plan, Draft Final, 2013).

4.4 Accessibility to Health Services:

Singh et al, explored the prevalence and factors associated with the access of maternal and child health care services among married women in India using NFHS-3 data. The author mentions in this study that maternal mortality is affected by a number of reasons which are socio cultural and economic in nature, such as the status of the women in the household, her education and standard of living, accessibility of facility (distance, transport) and availability and quality of care (availability of standard equipment in the health facility). The author also mentions that the income level, expenditure incurred on services and programmatic factors also play an important role inthe use of the services and the indicators like economic status, education and interval among multiple births predict the use of these services. (Singh et al, 2012). According to Jose, et al, the main reason with tribals who wanted to use the institutional services but weren't able to, were the unavailability of public transport. This increased the challenges in opting for healthcare services making it both difficult and expensive (Jose, et al, 2014).

According to Fernandes and Menon, work on 'Tribal women and forest economy, deforestation, exploitation, and status change'. They are mention the in traditional healthcare

facilities being primarily dependant on forests were greatly hampered by the excessive deforestation and exploitation of forest resources. Unavailability of the herbs and plants used as medicine to treat illnesses due to the above made the situation acute for the tribal population, specially for the women (Fernandes and Menon, 1987).

There is a variety of research work defining the tribes and their socio-economic and political as well as health status and healthcare services in India. It very cogently covers the transformation which the tribes in India have undergone and gives a clear picture of health-related issues- particularly tribal women's health and maternal and child-related problems.

4.5 Acceptability of Health Services:

According to Guite& Acharya, the study on the indigenous medicinal substances and health care among Paite tribe of Manipur, acceptance of the health care system particularly among tribal people mostly is dependent on availability and accessibility (Guite& Acharya, 2005). According to Mumbare&Rege, the study on the factors associated with utilization of maternal care services in remote tribal Maharashtra, Education and economic status showed a direct co relation with the acceptance of Antenatal healthcare. Knowledge about the availability and benefits of the healthcare available impacts the use of the same. Home deliveries were a practice used in traditional practices, it was still continued after the availability of institutional deliveries due to unsatisfactory hospital services and unacceptable behavior towards the tribals coupled with lack of transport facilities (Mumbare&Rege, 2011).

According to Bhattacherjee, et. al, acceptance of services was focused on three aspects of maternal health care; 'first: full antenatal care utilization if the pregnant women had received at least one Tetanus Toxoid (TT) injection, Consumption of minimum 100 iron-folic acids (IFA) tablets/equivalent amount of syrup, Minimum three antenatal care (ANC) visits. Second: skilled attendance at birth, if the women had delivered in a hospital or health care institution. Third: adequate postnatal care utilization; if the woman had received any postnatal visits by a health care professional within 48 hours of delivery' (Bhattacherjee, et. al, 2013, p- 78).

According to NRHM SPIP 2011, in Jharkhandthe difficult topography manifolds the problem. The limited access and availability of the healthcare facilities along with the general tendency

of people of not to seek out healthcare presence is further compounded by their low acceptance of services (NRHM SPIP 2011).

According to DLHS 2007-8, THE tribal communities are in the middle of a transition in the healthcare facilities. Traditional and biomedicine co existed since long but the preference given by the government to western healthcare made the traditional healthcare in equipped to manage most health issues. Tribal communities are facing a dilemma and their system of health care is being replaced by state-sponsored hospitals, primary health centers, community health centers and private dispensaries. The situation of traditional medicine is rapidly changing as the government-sponsored allopathic medicine is eroding out the traditional medicine from the tribal areas (DLHS, 2007-08)

5. Particularly Vulnerable Tribal Groups (PVTGs) in India:

In 1975 the Indian government identified the 52 of the most vulnerable and backward tribal groups that were called Primitive Tribal Groups (PTGs). In 1993 an additional 23 groups of PTGs were identified which brought the total to 75 PTGs. (Muniraju& Thakur, 2018)
According to the Ministry of Tribal Affairs 2018-19, 'Among 705 of tribal community living all across the country, there are 75 tribal groups who are relatively more isolated, archaic, vulnerable, deprived and backward' (MoTA 2018-19). They have been identified and designed as Primitive Tribal Groups (PTGs) to receive special attention for protection against exploitation and their development. Dhebar Commission (1961) stated that the PTGs are that category of tribal groups in India who are at the lowest rung of progress and hence need special protection and development. In the year 1971, the planning commission of India constituted a Taskforce on the commencement of the 5th five-year plan. The aim behind this was to review the situation of the program and the advancement of tribal and tribal areas (Upadhayay& Pandey, 2003). According to Pattnaik& Sandeep, study on Recognize Habitat Rights of Particularly Vulnerable Tribal Groups (PVTGs), thereafter the government of India classified and declared some Primitive Tribal Groups as separate within STs and expressed their need for special attention. The government defines the word 'Primitive' as the most vulnerable. In 2006 the government of India proposed to rename the 'Primary tribal group' (PTG) as 'particularly vulnerable tribal group' (PVTG). PVTGs are not a constitutional category, nor are these

constitutionally recognized communities. It is an administrative category, selections/subsections of a particular Scheduled Tribe, but not a whole community (Pattnaik K. S., 2017). PVTGs are identified based on four characteristics:

(i) pre-agriculture level of technology,
(ii) low level of literacy
(iii) Economic backwardness
(iv) stagnant or diminishing population (Radhakrishna, 2009)

The majority of the population lives in the states of Odisha has it has the largest number of PVTGs which can be divided into 13 groups (Pattnaik K. Sandeep, 2017). The other States which have PVTG population are Andhra Pradesh, Chhattisgarh, Jharkhand, Bihar, Maharashtra, Madhya Pradesh, Tamil Nadu, Gujarat, Kerala, West Bengal and Andaman &Nicoba (Muniraju& Thakur, 2018).

The table 10, shows the state-wise number of PVTGs. The name vulnerable is added as these groups have not attained significant growth in terms of socio-economic, educational level and have low health index. They also have very low fertility rate and high death rates hence face danger of extinction. The government gives them special attention and protection by the scheme to improve their social indicators like livelihood, health, nutrition and education so as to decrease their vulnerability (Pattnaik& Sandeep, 2017).

Table: 10, Particularly Vulnerable Tribal Groups (PVTG) in India

S. No.	State /no. of PVTGs	Name of PVTG	Population of PVTGs
1	Odisha/ 13 PVTGs	ChuktiaBhunjia, Birhor, Bozndo, didayi, DongriaKhond, Juang, Kharia, KutiaKandha, LanjiaSoara, Lodha, mankirdia, PaudiBhuyans, Saura.	138,341
2	Andhra pradesh (including	Chenchu, BodoGadaba, GutobGodaba,	277,166

	Telangana)/ 12 PVTGs	DongariyaKondhs, KutiaKhond, Kolam, KondaRaddy, KondaSavaras, BondoPoroja, KhondPoroja, ParengiParoja, Thoti.	
3	Bihar (included Jharkhand)/ 9 PVTGs	Ashur, birhor, birjia, hill kharia, korwa, mal parahia, parhaiya, sauriapaharia, savar.	300,884/ 292,359
4	Madhya Pradesh (including Chhattisgarh)/ 7 PVTGs	Abujh Marias, Baiga, Bharia, Birhor, Hill Korbas, Kamar, Saharia.	950,744
5	Tamil nadu / 6 PVTGs	Irular, Kattunayakan, Kota, Kurumbas, Paniyan, Toda.	255,600
6	Gujarat/ 5 PVTGs	Kolgha, Kathodi, Kotwalia, Padhar, Siddi.	66,728
7	Kerala/ 5 PVTGs	Cholanaickan, kadar, koraga, kurumbas,	25,440
8	Andaman &nicobar island/ 5 PVTGs	Great Andamanese, Jarawas, Onges, Santenelese, Shompens.	769
9	West Bengal/ 3 PVTGs	Birhor, Lodha, Todo.	47,995
10	Maharashtra/ 3 PVTGs	Katari, Kolam, Maria Gond.	173,786
11	Utter Pradesh (included uttrakhand)/ 2 PVTGs	Buksa, Raji.	6,005
12	Karnataka/ 2	JenuKuruba, Koraga.	50,870

	PVTGs		
13	Rajasthan / 1 PVTGs	Seharia.	11,377
14	Manipur /1 PVTGs	MarramNagas.	27,524
15	Tripura / 1PVTGs	Riang	188,220

(Source: Ministry of Tribal Affairs, 2018-19 &Pattnaik, 2016, Sahu, 2019)

Ministry of Tribal Affairs, 2019, has revised the central sector scheme now as “development of Particularly Vulnerable Tribal Groups (PVTG)” as of 1st April 2015. This scheme states that the ministry will provide financial assistance via the state for construction of houses, development of agriculture and land, animal husbandry, construction of roads and other activities focused at socio economic development of PVTGs, based on long term Conservation-Cum-Development (CCD) plan (3-5 Years) prepared by the state government based on their assessment of what is required in terms of ‘(a) Livelihood, (b) Employment opportunities and economic development of PVTGs through Agriculture, Horticulture, Animal Husbandry, Dairy, and Skill/ Vocational Training (c) Education, (Literacy, Drop-out, Residential schools in addition to SSA/RMSA). (d) Health, (Gap filling for effective health service delivery beyond NHM). (e) Provision of safe drinking water (gap-filling where line Ministries do not provide complete/universal coverage), (f) Land distribution, land development, (g) Social security, (h) Housing and Habitat with special focus to maintain the traditional architecture, (i) Connectivity (Road and Telecommunication), (j) Supply of Electricity (gap-filling where line Ministries do not provide complete/universal coverage), Solar power, with provision of maintenance, (k) Irrigation (gap-filling where line Ministries do not provide complete/universal coverage), (l) Urban Development, (m) conservation of Culture and heritage, including documentation of their lifestyle, traditional medicine and medical practices, art, folklore, sport, music, dance, crops foods, (n) Sports including traditional and tribal games and sports, (o) Any other innovative activity for the comprehensive socio-economic development of PVTGs’ (MoTA, 2019, p-2). The scheme is flexible because it enables each State to focus on areas that they consider relevant to their PVTGs and their socio-cultural environment. (MoTA, 2019)

Ministry of Tribal Affair 2019, focus on the Conservation-Com-Development (CCD) plan, Under the CCD plan aspects of health-related schemes are (a) creation of special health centers for PVTGs while relaxing the population norms of National Health Mission (NHM). (b) Provision for equipment & building. (c) They have undertaken a survey of PVTGs including issuing health cards to them indicating their health status especially with respect to sickle-cell anemia (100% screening). (d) Training for paramedic amongst the tribal people. (e) Using of mosquito nets to contain malaria. (f) Composite fish culture to contain mosquito population and also to supplement protein for nutrition. (g) Full health facility coverage of pregnant mothers and immunization of children. State governments established 'Micro Project' for focused development of PVTG population and made efforts to access funds under various Central Sector and Central Sponsored Schemes as well as funds available under State Tribal Sub Plan (STSP) for various development schemes (MoTA, 2019, p- 5-8).

Why it is required or what is the need for all these above schemes and development plans for tribes and specially PVTGs? (Tripathy&Mohanta, 2016).After so many years of independence and innumerable policies and programs to develop the conditions of the PVTG, they are still struggling at all fronts and lag behind on every marker of social development. The major causes have been land alienation, poverty, unemployment, new forest policy, industrialization and urbanization to name a few. The impacts of the policies and programs have been fairly slow and the effort for a rapid growth among the tribals wasn't realized. All these make PVTGs still more vulnerable to the others (Pattnaik, 2016).

Pattnaik, his discussion paper, Recognize Habitat Rights of Particularly Vulnerable Tribal Groups, mentions Odisha has 13 PVTGs which is the highest with a population of 138,341 which makes it the seventh largest in terms of population in all the states and union territories of India. There are 17 Micro Project and TSP development schemes for the PVTGs, which aims at their overall development. As per the Odisha government survey in 2012, the population was increasing at the rate of 5.20 percent but the literacy rate was 33.38 percent which is much lower than the rest of the community; besides the drop-outs are higher (Pattnaik, 2017).

According to Rao J. work on 'livelihood strategies resource and nutritional status of forest dependent primitive tribes Chenchu in Andhra Pradesh and Telangana States'. Study show

theAndhra Pradesh has 9 PVTGs that is second-largest with a population of 277,166 which is the third-largest size of PVTGs in all the states. A study was done by Rao in 2019 on the Chenchu PVTGs. Study shows the population is 64,227 of Chenchu in AP and Telangana states. The overall literacy rate is 40.6%, life expectancy is below 50 years, sex ratio 998, sanitation 6.0% and household income per month Rs. 1,333. They are dependent on forest products for their livelihood that are mainly root, fruits, tubers, leaves and hunted animals. But at present, they are facing food shortages and poverty due to the depletion of forest products. 41% of adult men and 42% of women are suffering from chronic energy deficiency. Health indicators of below 5 years of children are worse; underweight 44.2 %, stunting 54.7% and wasting 12.5%. Chenchu is facing a high risk of undernutrition, poverty, illiteracy, primitive agricultural practice, poor personal hygiene, inaccessible healthcare services, communication facility and many more. These are showing the poor socio-economic conditions of them. They are slowly transforming in terms of livelihood, the forest is the important resources for them but now they are forced out of forests for food gathering to cultivation (Rao J, et al, 2019)

The study conducted by P Rao shows the health status of PVTGs in Andhra Pradesh. Overall, 46% are facing minor or seasonal problems, 38% of people were suffering from malaria and diarrhea, 3% suffering from skin diseases, 2 % suffering from contagious diseases like Tuberculosis and Leprosy. The study clearly shows the transformation in uses of healthcare services; 7 percent of people take traditional treatment in case of minor/seasonal illnesses and 10 percent in case of serious health-related problems. They still believe and have faith in traditional medicines and healthcare systems but there has been a decline in the same. On the other hand, over the years they are more paying attention to modern allopathic medicine and treatment, for 53 percent minor/seasonal, and for 66 percent serious health-related problem people are using allopathic treatment in the PHC. For 35 percent minor and 65 percent serious health-related problems the PVTGs are taking private allopathic treatment (Rao P. D., 2019).

According to Sharma, study on ‘socio-economic and demographic characteristics of three most backward tribes of Madhya Pradesh’, Madhya Pradesh has 7 PVTGs with a population of 950,744, which is the largest population of PVTGs in the states. According to the Census of 2011, socio-economic indicators in Madhya Pradesh are still lower in the tribal community compared to non-ST population. As per a study done by Sharma in 2016, PVTGs have a

relatively higher growth rate and better sex ratio but the literacy rates and work participation of cultivators are very low compared to ST and non-ST. Studies show the socio-economic indicators are still very low compared to ST and other communities (Sharma, 2011).

According to Muniraju& Thakur, 2018, study on 'development deficits of particularly vulnerable tribal groups (PVTGs) and way Forward', Bihar has 6 PVTGs with a population of 8,525. Most of them are undergoing a change in the occupational patterns from primarily hunter gatherers and dependence on fishery to cultivation and labourers. FRA has also imposed restrictions in entering forests that forced the shift (Muniraju S.B. & Thakur Rachita, 2018).

6. **Tribal and PVTGs of Jharkhand:**

Jharkhand is the 5th poorest state in India with 51.65% rural population below the poverty line (BPL) (TDP, 2013). Jharkhand's tribal communities are highly dependent on natural resources for their survival. The table10, shows the marginal workers by category, like all population, SC, ST, divided in work pattern in Cultivators, Agricultural laborers, Household workers and other workers. The table 11, shows that the ST population overall has a higher percentage of marginal workers except for cultivators. If we look at cultivators all India population is 19.15 percent, whereas SC are 10.72 percent and ST are 5.03 percent, which is very low. Similarly, look at the Jharkhand; overall population has 28.88 percent, whereas SC are 13.83 percent and ST are 3.28 percent which is much lower than other social groups. As agricultural laborers, STs Population with 59.70 percent and in Jharkhand with 61.06 percent is much higher compared to other social groups. As household workers too, the percentage is much higher comparatively being SCs at 25.36 percent and 21.35 percent and STs at 23.07 percent and 34.05 percent India and Jharkhand respectively (Statistical profile of scheduled tribes in India, 2013).

Table: 11, Percentage Distribution of Marginal Workers by Category.

	Cultivators			Agricultural labourers			Household workers			Other workers		
	All P*	SC	ST	All P	SC	ST	All P	SC	ST	All P	SC	ST
India	19.15	10.72	5.03	27.06	10.72	59.70	4.21	25.36	23.07	59.61	2.63	14.76
Jharkhand	28.88	13.83	3.28	16.92	13.83	61.06	3.76	21.35	34.05	52.25	2.47	11.23

(Statistical profile of scheduled tribes in India, 2013, censes 2011, Vandana 2020, P*- Population)

According to Mathur et al, study on 'Socio-economic Ranking of States and Territories in India' Jharkhand is 27th rank on the basis of basic living, 13th rank in economic status, 28th rank in education, 5th rank in status of women, 20th rank in health care and over all 22nd rank in india (Mathur et al, 2013).

In Jharkhand there are a total of thirty-two tribal communities, of which eight are deemed as Particular Vulnerable Tribal Groups (PVTGs) that is the third largest and has a population of 292,359 which makes it second largest of PVTGs among the states. Tribals are: Baiga, Banjara, Bathudi, Bedia, Bhumij, Binjhia,Chero, Chik-Baraik, Gond, Gorait, Ho, Karmali, Kharia, Khairwar, Khond, Kisan, Koda, Kol, Kawar, Lohra, Mahali, Munda, Oraon, Santhal and PVTGs are Asur, Birhor, Birjhia, Korwa, Mal-Paharia, Parhaiya, SauriyaPahadiya, Sawar (Alam& Roy, 2011). Among the Scheduled Tribes, there are certain tribal communities that have been declining or stagnating population, low levels of literacy, pre-agriculture level of technology and are economically backward. Eight such groups which have been recognized as PVTG exist in Jharkhand namely; Birhor, Birija, Hill Kharia, Korwa, Mal Parhaiya, Parhaiya, SauriaParhaiya and Savar. Majority of these groups are limited in numbers and live in remote areas with low levels of infrastructure and low socio-economic progress (Homakawa, 2007).They have become the most vulnerable sections among the ST population and therefore there is a need to protect them and check the declining trend of their population and their overall development.

5.1 Population of PVTGs in Jharkhand

According to Sahu, study 'Demographic Trends and Occupational Structure of Particularly Vulnerable Tribal Groups of Jharkhand' the PVTGs population reflects increase over the decades but remains relatively small. Table 12, show that the overall population of the PVTGs of Jharkhand is small and has varied over the years. SauriaPahariyain1961 had 55,606; at that time, they had the highest population among PVTGs, 1971-59,047, 1981-39,269, 1991-47,826, 2001-31,050 and 2011-46,222. This is showing a declining trend in population growth. Similarly, Sevar PVTGs that was a very small number 1561 in 1961 grew over the years to 9,688 in 2011 (Census 2001 & 2011, Sahu 2019).

Table: 12, Population of PVTGs in Jharkhand from 1961 to 2011

PVTGs of Jharkhand	1961	1971	1981	1991	2001	2011
Asur	5,819	7,026	7,783	9,122	10,347	22,459
Birhor	2,438	3,464	4,377	8,038	7,514	10,726
Birjia	4,029	3,628	4,057	4,529	5,365	6,276
Korwa	21,162	18,717	21,940	24,146	27,177	35,606
Mal pahariya	45,423	48,636	79,322	79,154	1,15,093	1,35,797
Parhaiya	12,268	14,651	24,012	29,256	29,786	25,585
Sauriapahariya	55,606	59,047	39,269	47,826	31,050	46,222
Savar	1,561	3,548	3,014	4,203	6,004	9,688
Total	**1,48,306**	**1,58,717**	**1,83,774**	**2,06,274**	**2,32,336**	**2,92,359**

(According to census 2001 & 2011, Sahu 2019)

Table 13, shows the PVTGs like Birhor, Birjia, Korwa, SauriyaPahariya and Savar have negative decadal growth rates. In the year 2011, Birjia and Mal Pahariya were decreasing but none of them were showing a negative decadal growth rate.

Table: 13, Decadal Growth Rate of PVTGs Population

PVTGs of Jharkhand	1961	1971	1981	1991	2001	2011
Asur	32.6	20.7	10.8	17.2	13.4	117.1
Birhor	-4.4	42.1	26.4	83.6	-6.5	42.7
Birjia	94.2	-10.0	11.8	11.6	18.5	17.0
Korwa	---	-11.6	17.2	10.1	12.6	31.0
Mal pahariya	13.1	7.1	63.1	-0.2	45.4	18.0
Parhaiya	21.1	19.4	63.9	21.8	-35.1	48.9
Sauriapahariya	-5.2	6.2	-33.5	21.8	-35.1	48.9
Savar	-5.1	127.3	-15.1	39.4	42.9	61.4
Total	24.0	7.0	15.8	12.2	8.3	30.9

(According to census 2001 & 2011, Sahu, 2019)

5.2 Literacy rate among PVTGs Jharkhand

According to Sahu, the literacy rate of Jharkhand is 67.6 percent, among STs is of 57.1 percent and PVTGs are 39.5 percent which is very low. Table 14, shows over the decade literacy rate has increased among all PVTGs. In 2001 literacy rate among Parhaiya with 12.3 percent, which was the lowest, Korwa with 14.3 percent was second-lowest, Birhor 17.5 was third lowest and Asur with 29.1 percent held the highest rate of literacy. In 2011 literacy rate increased Birjia with 50.2 percent highest and Parahiya with 33.1 percent which even after the increase was still in the lowest position, Saver with 33.7 percent was second lowest and Birhor with 34.3 percent was third lowest (Sahu, 2019).

Table: 14, Literacy Rate PVTGs, ST and Total Population of Jharkhand.

Communities	2001			2011		
	Persons	**Male**	**Female**	**Persons**	**Male**	**Female**
Jharkhand	53.6	67.3	38.9	67.6	78.5	56.2
All STs Jharkhand	40.7	54.0	27.2	57.1	68.2	46.2
PVTGs (Jharkhand)	20.7	29.5	11.4	39.5	48.7	30.0
Asur	29.1	42.5	14.7	46.9	58.0	35.4
Birhor	17.5	23.6	11.2	34.5	41.3	27.4
Birjia	31.2	43.0	19.0	50.2	61.7	38.4
Korwa	14.3	21.6	6.5	37.9	45.8	29.7
Mal Pahariya	20.9	29.4	12.1	39.6	49.1	30.2
Pahariya	12.6	19.1	5.5	33.1	41.5	24.3
SauriaPahariya	21.7	31.4	11.3	39.7	48.9	30.6
Savar	18.1	25.4	10.7	33.7	43.3	24.0

(Source: Statistical profile of scheduled tribes in India, 2013, Census 2011, Sahu, 2019)

6. Regional Distribution and Occupational Structure of the PVTGs in Jharkhand

Statistical profile of scheduled tribes in India- 2013, Jharkhand had PVTGs in 21 out of 24 districts. The district Godda has five types of PVTGs, which are Ashur, Birjia, Korwa, Parhaiya and Savar, (2) Palamu district has five types of PVTGs, Asur, Korwa, Mal Parhaiya and Savar, and (3) Latehar district lives four types, Asur, Birjia, Korwa and Parhaiya (SPSTI, 2013).

According to the research of Kumar & Kapoor in 2008, Particularly Vulnerable Tribal Groups in India have several health problems. This study while analyzing PVTGs at the macro level will focus its analysis on the Korwa PVTG to have a deeper sense of the situation and problems. According to the research of Kumar & Kapoor in 2008, particularly vulnerable tribal groups in India have several health problems. They are trapped in a vicious cycle of poverty, malnutrition and ill-health. Jharkhand is very rich in terms of resources but the people are poor, especially the tribals. Among PVTGs, there are many problems related to group health. Especially pregnant women suffer more because they do not get proper nutritional food and proper health care (Kumar & Kapoor cited in Pathak, et al, 2008).

Table: 15, Regional Distribution and Occupational Structure of the PVTGs in Jharkhand

PVTGs	District mainly found	Traditional Occupation
Asur, Agaria	Gumla, Loherdaga, Palamu and Latehar	Iron-smelting and also practice settled cultivation
Birjia	Gumla, Latehar and Loherdaga	Iron-smelting and practice shifting agriculture, collect minor forest produce and also make handicrafts
Birhor	Bokaro, Chatra, Dhanbad, East Singhbhum, Garhwa, Hazaribagh, Koderma, Latehra, Loherdaga, Ranchi, Sarikela, Simdega and West singhbhum	Hunting, food gathering, collect wax, honey and minor forest produce
Korwa	Garhwa, Gumla, Latehar, Palamu and Simdega	Collect food, cultivate maize, millet and vegetables, hunting, rope making and contract labor
Mal Pahariya	Deogarh, Dumka, East Singhbhum, Godda, JamtaraPakur, Palamu, Ranchi and Sahebganj	Hunting, gathering and shifting agriculture, collect minor forest produce
Pahariya	Chatra, Deogarh, Garhwa, Gumla, Latehar, Loherdaga and Palamu	Hunting and food gathering
Savar	East Singhbhum, Godda, Palamu and Saraikela-Kharsawan	Collect of minor forest produce, prepare and sell wine, wage earning as contract labor and casual labor

(Sources: Statistical Profile of Scheduled Tribes in India, 2013, Census 2011, Sahu, 2019)

7. Health Status of Tribals in Jharkhand

According to national rural health mission, the tribal population faces exclusion because of their habitat in remote areas. This also leads to a lack of infrastructural facilities which means healthcare becomes that much scarce. The remoteness of these areas also attracts extremist operations, further making the areas in accessible to healthcare practitioners (NRHM SPIP 2011-12, Jharkhand, Executive Summary p- 4 & 300).

The table 16, shows the in-position and shortfall of the health infrastructure and manpower in the tribal area of Jharkhand. Shortfall 264, 247 and 11 in the infrastructure of Sub centre, PHC and CHC in Jharkhand this is a very high no of not functioning Sub- centre and PHC. ANM and doctor at sub-centre and PHC are surpluses but other manpower at PHC and CHC have a high number of shortfalls. Inadequate infrastructure and manpower in the tribal area of Jharkhand play the lead role of the poor health status among the tribal community (NRHM 2018-19).

Table: 16, Status of Health Infrastructure and Manpower in Tribal Area of Jharkhand.

Sl. No	Type of Facility	In position	Shortfall
1.	Sub –centre	2665	264
2.	Primary Health Centre	192	247
3.	Community Health Centre	98	11
4.	ANM (F) at Sub centre	4228	**
5.	ANM (F) at PHC	245	**
6.	Doctor at PHC	240	**
7.	Nursing staff at PHC	21	171
8.	Ayush Doctor at PHC	70	17 (V)
9.	Lab technician at PHC	37	155
10.	Ayush Doctor at CHC	144	44 (V)
11.	Dental surgeon at CHC	0	98
12.	Surgeon at CHC	0	98
13.	Obstetricians & Genealogist at CHC	15	85
14.	Physicians at CHC	5	93
15.	Paediatrician at CHC	10	88
16.	Specialist at CHC	30	362
17.	General MO (GDNOs) at CHC	172	24
18	Nursing staff at CHC	380	306

(Source: Rural Health Mission 2018-19, V: Vacant, *: surplus)

8. Tribal Maternal and child Health in Jharkhand

In Jharkhand many women have severe iron deficiencies and are at high risk as after delivery, their blood does not clot, the uterus does not contract and women may die of post-partum bleeding. Jharkhand government stopped distributing folic acid tablets for two years after the center discontinued providing the iron and folic acid tablets between 2010 and 2012 (Yadav, 2013)

According to NFHS-2, Jharkhand indicates utilization of maternal healthcare services in all social groups in Jharkhand is low but very poor among the ST population. 41% of tribal women in the state had a body mass index (BMI) below 18.5kg/m2 as compared to 31% of other women and over 86% of tribal women in the state were anemic, compared to 60% of other women. Home deliveries were the highest amongst the STs 96% compared to 69-88% among any other group(NFHS-2, Jharkhand).

Table: 17, Antenatal care services utilized by the health professional

	Category	Doctor	LHV	No one
NFHS-4	SC	31.7	30	30.6
	ST	25	33.7	33.1
	OBC	45	30.1	18.2
	Other	60.1	2.5	11.8
NFHS-3	SC	30.3	13.2	48.2
	ST	24.5	19.4	50
	OBC	43.5	10.5	38.5
	Other	66.6	9.8	20.2

(Source: NFHS-3 and NFHS-4)

Data of NFHS-3 to NFHS-4 show the utilization of ANC services among STs have increased. The table 17, shows that the antenatal care take by doctors among ST has increased by 0.5% LHV has increased from 19.4% to 33.7% among ST in years 2005-06 to 2015-16. STs not taking ANC have declined from 50% to 33.1% in years 2005-06 to 2015-16. Taking ANC by LHV (ANM, Nurse, and Midwife) is higher than doctor and an increase in the number of taking

ANC services shows the tribal women are interested to take ANC at the village level (NFHS-3 & NFHS-4).

According to NFHS-4, Jharkhand, the choice by STs in public health services as a place of delivery increased to 40.8% from 7.8% between the years 2005-2006 to 2015-16 respectively. Postnatal care also increased among tribal women 14.3% to 45.2% in years 2005-2006 to 2015-16 respectively. JSY services utilized by tribal women 50.8% is higher than 26.3% the others in years 2015-2016. Data show the tribal women utilized public healthcare for ANC, for delivery and PNC after JSY scheme launch (NFHS-4, Jharkhand).

Table: 18, Child Mortality in Jharkhand in 2005-06 and 2015-16

	Category	NN	PNN	IMR	CMR	UFMR
NFHS-3	SC	52.3	22.4	76.7	48.3	121.3
	ST	64.3	28.7	93	50.1	138.5
	OBC	45	21.9	66.9	36.3	100.8
	Other	60.7	14.8	75.7	18.6	92.7
NFHS-4	SC	40.9	9.5	50.4	9.6	59.5
	ST	32.8	14	46.8	18	64
	OBC	32.8	9.9	42.7	8.2	50
	Other	19.3	8.8	28.2	8.4	36.4

(Source: NFHS-3 and NFHS-4)

The table: 18, shows that among all social groups, child mortality is declining but among STs, it is higher comparatively as per NFHS-3 to NFHS-4. According NFHS-3, 64% NN, 28.7% PNN, 93% IMR, 50% CMR and 138.5% UFMR among ST is higher than 60% NN, 14.8% PNN, 75.7% IMR, 18.6% CMR and 92.7% UFMR among others. Similarly, according to NFHS-4, 32.4% NN, 14% PNN, 46.8% IMR, 18% CMR and 64% UFMR among ST is higher than 19.3% NN, 8.8% PNN, 28.2% IMR, 8.4% CMR and 36.4% UFMR among others (NFHS-3,4, Jahrkhand)

Jharkhand has initiated certain programs to achieve improvements in maternal and child health. A few are, Jannani Suraksha Yojana, Jannani Suraksha Helpline, MamayaVahan, JannaiShishiSurakhshaKaruakaram (JSSK), Mukhya Mantri JannaniSwasth Suraksha, Dular

Scheme, Integrated Management of Neonatal and Childhood Illness (IMNCI), SarvSwasthya Mission.

9. Korwa PVTG:

Shrivastava, work on ‘Tribal dependence on fly ash in Korba’. Her study describe the Korwa belong to PVTG of central India. They inhabit the hills, valleys and forests of Uttar Pradesh, Jharkhand, Madhya Pradesh and Chhattisgarh. They are a sub group of Munda tribe of Chhotanagpur plateau. The Hilly Korwa resides mainly in the Korba and Katghora area. They were originally inhabitants of theKorba town and Korba district. According to folklore it is belived that they came into existence from Kora,or the lap of Goddess mother Koithama (in Hindi, kora means clean/untouched). As the story goes, this baby was born in the presence of Gods, and was thus was named ‘Korwa’. When the Korwa King lost to the British, he along with his subjects took refuge in the jungles of ‘Korea Jhadi’. The British, in search of the King, cleared all the jungles, and since then, the people believe they originated from Korea Jhadi (Shrivastava, 2007). They are branch of Kolarian tribe and speak a Mundari language, which belongs to the Austro-Asiatic language family. Korwa has two sub-tribe known Pahari Korwa and Dihari Korwa (Mohanty, 2004). Korwas were the first habitants of this area and were once master of the savage and were mostly nomadic. They were once the most powerful tribe. It is possible that many of the broken tribes are now found scattered though out this part of India. Socio-economic activity and religious and cultural beliefs and traditional methods of treatment are the few things they follow very strongly (Sharma, 2008).

10.1 Korwa under Transformation:

Korwa community is also transforming like other PVTGs. Korwa have transformed due to many reasons, but two most important reasons are the cultural interaction and programs of development by the government for them. Today after years of gradual transformation a definite change has appeared in their original culture and living patterns, food habits and work patterns (Mohan, 1993).

Earlier many of the scholars like Dalton (1872), Majumdar (1847), Vidyarthi (1958) mentioned that Korwa tribe in Palamu district is backward in all spheres of life. Every aspect of their life process is problematic and the most prominent ones are illiteracy, simple economy, lowest

standard of production and consumption, semi-nakedness and exploitations. At present Korwa are dependent on pre-agricultural level of technology and their economy is dependent on forest however the interruption caused due to forest act has presently changed the economy and lifestyle (Sharma, 2008). The women in the Korwa Community play an important role when it comes to gathering of food, making rope, collectinghoney andherbal medicinal plant, makingbasket, fishing and hunting (Roy, 2012).

Jharkhand has 2nd largest population of the PVTG population in India which is 292,359. Korwa has 3rd largest population that is 35,606 in all PVTGs in Jharkhand. Korwa have increased in literacy rate from 14.3 percent to 37.9 percent respectively according to census 2001 to 2011 but have the 4th lowest literacy rate. There is illiteracy and deprivation and they are living in remote areas away from the mainstream society (Census of India 2011).

Table: 19, Population and Population Growth of Korwa

Years	1941	1961	1971	1981	1991	2001	2011
Population	13021	21,162	18,717	21,940	24,186	24,027	35,606
Growth		62.52	-11.55	17.22	10	0.49	31

(Source: Sahu, 2019)

Table- 19 show the they are situated in all districts of Jharkhand, but later on census of 2001 showed that they are situated in only five districts of Jharkhand which were Garhwa- 18,144, Palamu- 2,126, Latehar- 1,518, Gumla- 1,636 and Simdega- 603. There has been constant change in their population on a yearly basis (Census of 1991).

Gautam Kumar Kshatriya, 2014, study on 'Changing Perspectives of Tribal Health in the Context of Increasing Lifestyle Diseases in India', mentions that traditionally the tribal groups always remained in a special ecological zone such as in and around hilly areas and in forests. But now due to deforestation, plan and policy, and urbanization their ecological structure has been changed. Now they are in interaction with the mainstream society and they are adopting new life style, living pattern, religious practices, and health care practices (Kshatriya 2004). People who belongto this tribal community generally carry bows and arrows. They settle near water bodies where they can access forest products (Shrivastava, 2007).

Narayan, work on 'The Korwa Tribe Their Society and Economic', study on Korwa form Palamu district, Korwa society is patriarchal and they are endogamous. Korwa community initially livedin hills and did not come in contact with other caste groups or outside people but they slowly have started interacting with other community and now they have social, religious, political and economic interdependence. They always build houses near their own clan and forest. They have both types of family structures; joint family (mother and father live with any one married son) and nuclear family (husband and wife lives with unmarried children). Korwa community maintains the social hierarchy with other caste groups, tribes and PVTGS. They do not accept cooked food and water from other caste groups but others caste and tribes like Munda and Oraon do not accept from them, and they do not marry outside the tribe. Korwa interact with other community for agricultural work, food gathering, and hunting in weekly market. Economically the Korwa community of Palamu can be divided into two categories first is agriculturist and second is food gatherers and baskets makers (Narayan, 1990). Even today (2007), they practice barter system (Shrivastava, 2007).

Korwa believe in traditional healthcare services and traditional healthcare provider. Traditional healthcare providers are called Bhagat, Baiga and Ojha and they provide healthcare services by spiritual and herbal medicines. They treat for all kinds of health-related problems. Author describes that the Korwa believe in supernatural power, god (sun and moon), goddesses and spirits. Korwa believe in traditional healthcare services and traditional healthcare provider and both are the only source of treatment in that time. Traditional healthcare providers are called Bhagat, Baiga and Ojha and they provide healthcare services by spiritual and herbal medicines. They treat for all kinds of health-related problems and korwa people are dependent on bhagat for complication during pregnancy and Dai for delivery (Narayan, 1990).

According to Nayak & Khan, study on Health Status of the Hill-Korwa on women in Sarguja District, Chhattisghar, the maternal health has a very important role for mother as well as new born child but among the Korwa women they do not give importance to maternal healthcare. 40.2 percent pregnant women receive special care only a few days before pregnancy. 60.3 percent pregnant women take ANC but 39.1 percent women do not utilize the same. Place of delivery among Korwa; 21.2 percent women give birth in public hospital; 4.7 percent women gave birth in private hospital and 73.1 percent women gave birth in home. Data show the Korwa

women are interested in institutional delivery but at same time home delivery is very high. During pregnancy 43 percent women are facing health related problem like 11 percent women suffered from anemia, 11.5 percent from body swelled, 3.8 percent from heavy bleeding, 8.7 percent women form hypertension and 11.5 percent women suffered from other complications. Health status of Korwa women is very poor due to lack of nutrition and non availability of health services (Nayak & Khan 2019).

All the studies showed that Tribals have a distinct identity, culture and beliefs compared to non-tribal communities. STs and PVTGs are a constitutional category created to register, track and measure the development and changes within these communities. Government over the years has enacted several Acts and policies to benefit these categories and to bring them at par at a socio-economic level of the rest of the populace. But tribals are not a homogenous group; they differ among themselves in their own customs and beliefs. These customs, beliefs and the means of their livelihood has developed over a period of centuries based on the environment they have been living. A tribe of the mountainous regions may very well have a different culture then a tribe living in the plains. The policies and Acts were not tailor cut to suit these differences but they were always more of a blanket scheme to address all the tribes together. That might be one of the reasons why even when we see a growth in the population of the tribals the literacy rates, social status, healthcare facilities, housing and standard of living are at best dismal.

CHAPTER: 2

Research Methodology

The present study aims to inquire into the social transformation since independence of Korwa PVTG tribe of Palamu district, Jharkhand. The major focus of the study was to explore the prevalent problems related to MCH and communicable diseases among the Korwa. This study also attempted to explore the changes at social, economic, political, and cultural aspects of Korwa and its implications on their tribal life and in their healthcare practices. The study employed a mixed method –using both qualitative and quantitative research methods; both primary and secondary data were used for the study.

Conceptualization of the Research Problem

Through the literature review chapter, we got an inference that a lot of changes have been happening in the tribal communities as a result of the various governmental schemes launched for their developments well as changes which happened on the larger society as a whole.

Tribes in India constitute about 8.6 percent of the total population which includes a total of 705 tribal communities including 75 Particularly Vulnerable Tribal Groups (PVTG) (Agarwal, 2013). Tribal communities have been subjected to continued discrimination and exploitation since the post-independence period. Tribes in India have been facing numerous social and economic problems such as poverty, hunger, unemployment, exploitation, illiteracy, inequality, discrimination, remoteness or alienation, exclusion, deprivation, poor sanitation and unsafe drinking water.

Government of India has been trying the address the leading issues through Development programs after independenceto improve the economic conditions, rehabilitation of the bonded laborers, education and training programs and special development programs for women and children. These major tenets of the five-year plans aim to fight against the unsolved problems of the tribes, but even after 73 years of independence, not much change has occurred in the various tribal communities and even less among the PVTGs. Many tribal communities especially the PVTGs do not even have the basic socio-economic facilities and still their status remains prominentcompared to other social groups.

This study largely drawsfrom the conceptual framework of D Banerji n his works, 'Health Behavior of Rural Population: Impact of Rural Health Services' (1973) and 'Rural Social Transformation and Changes in Health behavior' (1989). D. Banerji in his work "Rural social

transformation and Changes in Health Behaviour" noted that most scholarly articles before had a blanket admiration for western medicine and there was derogatory approach towards local practices and the attention to the various health practices were disproportionate. Also he noted that understanding health behavior is necessary to understand health problems. In the study "Health Behaviour of Rural populations Impact of Rural Health Services", the author notes that a study of the interactions between health practices introduced by PHCs and the pre existing health practices within the population can provide valuable data for policy formation, planning and implementation of rural health care. Both studies help to understand and examine the socio-economic condition and challenges faced by people in the rural areas. It explored the transformation of healthcare services from a traditional based system to an infrastructure depended on PHCs and sub centers and the adaptation of western healthcare facilities over the traditional healthcare practices. This transformation is based on a number of factors; accessibility and availability of services being a major one. It also states that the transformation of the socio-economic factors and healthcare practices go hand in hand.

This study attempted to explore the changes and shifts in the traditional practices of healthcare and socio-cultural practices of the Korwa community. Various literature sources show thattribals specially PVTG are secluded, living in forests with less to no interaction with general society. The policies aim to make them a part of the mainstream population and aide them by providing economicsupport as well as socialsupport.Thepresent study shows that there has been a change in the socio-economic condition of the Korwatribals and they are no more secluded from the mainstream society as they once were. At the same time, the social mobility of the community to access modern healthcare facilities or livelihood means has made them more vulnerable. The study raises questions on lack of understanding of the felt needs of the community while making policies for their development and the drawbacks in the effectiveimplementation of the same.

The study attempted to understand the basis on which women's health statusis perceived and the change in the healthcare system and beliefs.Western medicine and traditional medicine co-exist in tribal areas. Traditional medicinal practices comprise of spiritual elements, which include rituals and prayers and herbal medicines attached with their culture and beliefs.Existing literature shows that among tribal community health and illness became a main focus for the policiesfrom the time when thebiomedicine was introduced in the tribal area. There was a transformation

fromthe existing traditional healthcare system to the western healthcare system. It also explored the availability of the type of healthcare facility in the study village and why there is a shift from traditional to the western healthcare system.

It explored the changes in the occupational structures and economic system among Korwa. It examined the effect on traditional economy and occupation after the implementation of the Forest Act 2006. The study examined the pattern of occupation and its effect on social life, in the context of migration, household changes and changing work patterns. The analysis of the social changes that have occurred in the social and economic spheres of Korwa's. The study examines aspects of social organizations that have changed over the period. A study of social transformation necessitates an understanding of social structure as well as social organization of the community.

At a broader level, the study attempts an exploration of the connections between developmental changes in economy, migration, class formation and changes in household economies and relationships and gender relations. Thus the present study aims to inquire into the social and economic transformation of Korwa since independence. The major focus of the study explores the prevalent problems related to Maternal and Child health (MCH) and communicable diseases among the Korwa. This study also attempts to explore the impact of changes at the level of social, economic, political and cultural aspects of Korw and its implications on tribal life in their healthcare practices which is situated in Chainpur block, Palamu district, Jharkhand.

Research Questions:

- What are the social transformations among the Korwa since Independence?
- What have been the changes witnessed by the Korwa in terms of family, kinship, marriage, religious practices and rituals?
- What has been the change in the socio-economic order among Korwa
- How the health care practices among the Korwa has evolved and undergone change since independence?
- What are the health care practices related to MCH and communicable disease in the Korwa?

Broader Objective:

- To examine the social transformation and implications of transformations on healthcare practices among Korwa.

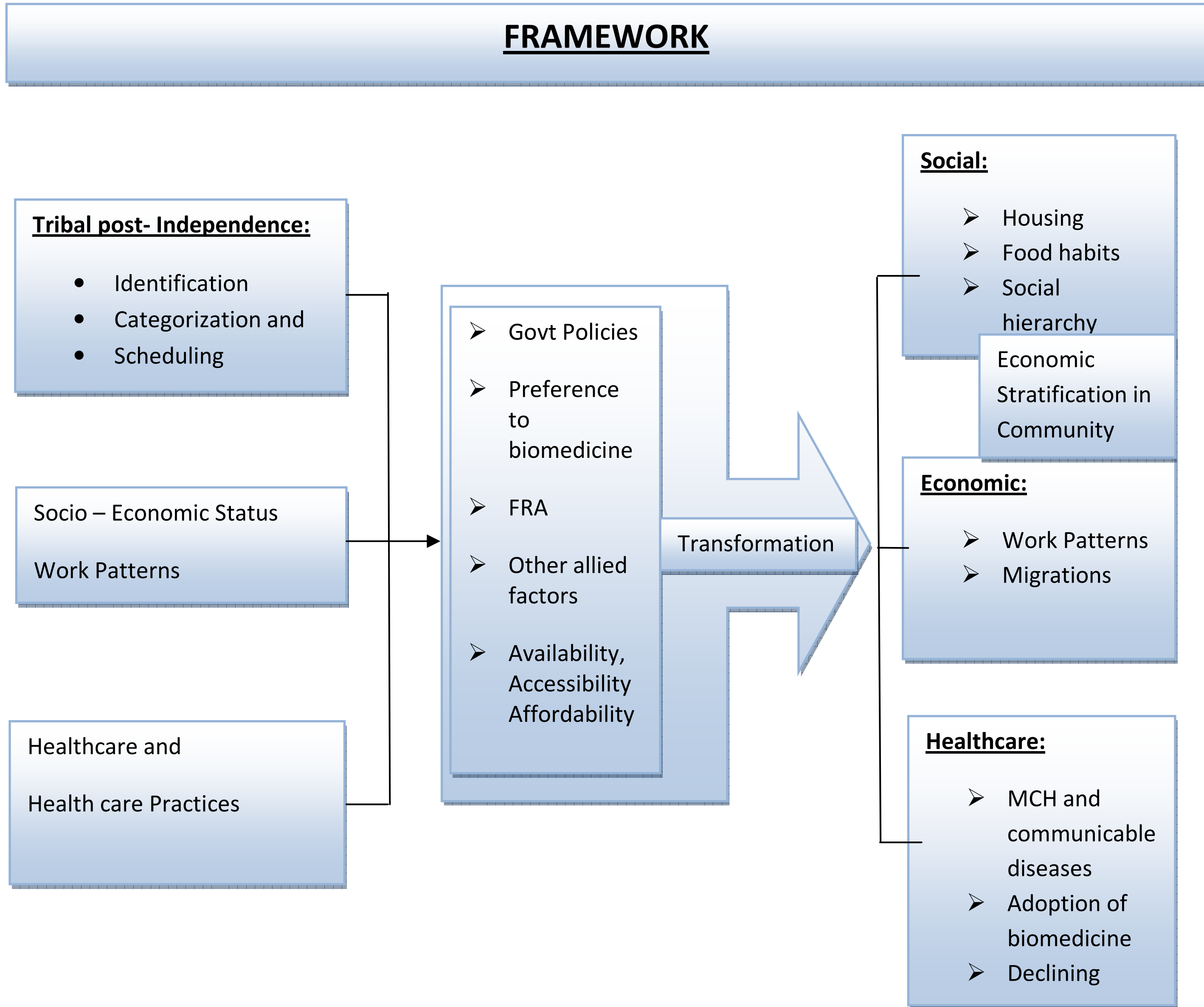
Specific Objective:

- To study the social changes of the community at the level of family, kinship, marriage, religious practices and rituals among Korwa since Independence.
- To examine the transformation of the Korwa in terms of economic differentiation and stratification since the post-independence.
- To explore the implications of transformation on healthcare practices of Korwa.
- To examine the healthcare practices related to MCH and communicable disease among Korwa.

Design of the Data Plan: To address each of the objective specific data and data sources were used. The following table shows the data plan and data sources including the tools.

Objective	**Primary data:** **How to get the data**	**Primary data:** **Who will be interviewed**	**Secondary data**
1. To examine the social transformation among Korwa PVTGsince independence.	-Villagers -Academicians -Key informers -Local leaders	Elder and younger members of the community, academicians who work among them	Literature review (books, articles and Govt document, Govt archive, publish government reports, micro level studies, published studies and articles)
2. To examine the economic transformation among Korwa	Those prefer by family and community. -Academicians -Key informers -Local leaders	Elder and younger male and female members in the family and community.	
3. To explore the implications of transformation on health practices of Korwa	-Villagers (old & young generations) Sub-center PHC/CHC	-Man & women (old & young generations) Key informer Healer and Dai ANM,SAHIYA/ASHA, BTT, MO and MI	
4. To examine the healthcare practices related to MCH and communicable disease among Korwa	-women who had pregnancy experience. -elder women in family and community. - Healer and Dai	-Purposively selecting those family who had pregnancy experience younger and elder women - Children - Household survey: miner and major illness (15 days to 1 year)	

Framework: The study will follow the below framework for investigation and analysis



Design of the Study:

This study is qualitative, quantities and explanatory in nature. The methodology of the study is based on two parts namely:a review of secondary literature available on tribals and primary data collected by field survey.The relevant literature was searched through electronic search engine such Google, J-STOR, Googlescholar.com, Pub-med, JNU library catalogue, as available in the English language using keywords such as - social transformation in tribal, transformation among PVTGs Jharkhand, tribal health women health, socio-cultural practices related to maternal health ofthe tribe, health status of tribal women India, communicable disease effect in pregnancy, food habits particular in pregnancy, delivery and after delivery in tribe, policy and program for maternal health in India or Jharkhand. The review of the literature included books, journal articles and government documents which are relevant to maternal health care among tribal communities and practices related to pregnancy and delivery among tribal.

Field data deals with both qualitative and quantitative details. The data obtained general information about people, their past and present conditions which will also help to identify the key informants and leaders. Their history, social structural changes of the community at the level of family, kinship, marriage, religious practices and rituals, issues of accessibility and utilization of various government development policies, social mobility, types of illnesses and disease, and their healing methods were also explored during the data collection. Secondary data was collected from documents and records of Jharkhand State Government Archives.

Selection of study area:

The study is carried out in Palamu district. Palamu District has been selected for this purpose as it had the second-highest concentration of Korwa PVTG tribe and also one of the economically most backward districts in the state. The socioeconomic setting is different among the Korwa living in three different regions, namely northern, western and southern-eastern regions of Palamu. Poverty is generally higher in regions of tribal concentration. Within Jharkhand, Santhal Pargana and Palamu, in particular, have shown high levels of poverty. According to the NSS-55th round Schedule 10, the poverty headcount varies from 74% in Palamu (Roy, 2012). Almost every year Palamu is declared drought-prone (Annual rainfall 600–1000 mm) (Deka and Wright, 2011). Early marriage and pregnancy are emerging as serious problems in the district. Average

Indian women particularly rural women are under-nourished and early pregnancy along with this malnourishment enhances the risk of hazardous pregnancy outcomes. In Palamu district girls getting married below 18 are 66%, which is the 3rd highest percentage in Jharkhand (Pathak et al, 2008).

Sampling:

For the present study, the purposive sampling method was adopted. The researcher purposively chose two villages, Semra and Gore villages as they have a large number of households in the Chainpur block, Palamu district, 80 and 43 households respectively. It is in the researcher's home district of Palamu, in Jharkhand. One of the important factors is language. Korwa tribes speak Sadari, Magahi and Hindi. Magahi is researcher's mother tongue. The researcher's command on Magahi language was an advantage in the interaction with the research subjects and in the data collection process.

The sample constitutes of 123 households (both villages) including both men and women. The research subjects included the head of the family, female and male members of the family (twelve to sixty above age group), traditional healers and dais. The researcher selected those households who have three age groups of women, such as adult girl, pregnant women and elder women for understanding MCH related practices. Traditional treatment given by healer and Dai is easily accessible by the villagers. The researcher also conducted in-depth interviews with different key-informants. This includes local leader, mukhiya, and public health providers like ANM, Sahiya/ASHA, AWW, TBA and MO.

Map: jharkhand, Palamu District, Chainpur Block

Source: www.mapsindia.com

Tools for data collection:

Data Sources:

The focus of the study is to describe and understand the social transformation and changes in the healthcare practices of Korwa in Jharkhand.

Primary data collection tools:

Different qualitative methods such a semi-structured interview, structured interview participant/non-participant observations, focus group discussions etc. were adopted for the collections of data. Qualitative methods are initially used to collect and obtain general information about people, their past and present conditions, which also helped to identify the key informants. Details about their history of development, their acceptance/resistance to change, coping strategies in dealing with non-tribal population, issues about accessibility and utilisation of various government development initiative, social mobility and elite struggles in preserving their tribal identities, range and types of illnesses, and their healing methods were collected at different levels using different types of data collected.

Narrative Methods:

Qualitative study using narrative analysis was adopted to explore the experience and understanding on the socio-cultural, economic and health services since independence. The narrative method helped to understand the historical experiences, culture, identity and lifestyle of the Korwa community which was shared in their story in own language. Researcher used narrative (oral history and present) story from individuals and small groups of Korwa people. The narrative in Magadhi and Hindi were transcript and translated to English. Verbatim transcription interpreted and analyzed thematically by the researcher herself. Researcher knows both Magadhi (mother tongue) and Hindi language.

In-depth semi-structured interview: helped to collect data related to household information such as family size, age of the family member, income and landholding, occupation and so on. The in-depth study helped in understandingthe experiences of mother and family, their perception of pregnancy, pregnancy care, delivery and post-partum care and ceremonies. The in-depth semi-structured interview also helped in understanding their need and perception about maternal health. The information on their food patterns and work pattern during pregnancy and

after delivery were also collected. And the interviews helped to understand traditional practitioners like healer's and Dai's perception of health and treatment during pregnancy, delivery and post-partum. It also covered Public health provider (PHC/CHC, sub-centre, ANM, Sahiya, Anganwbadi centre) and PDS (Public Distributor System).

The key informant interviews were conducted with the help of semi-structured interview schedule to understand and collect information about the community like history, social-structure, living pattern, behavior, social stratification within the village, availability of health services in the field area, common diseases in the community, perception regarding MCH and communicable diseases etc.

- **Structured interview schedule:** Structured interview schedule help in collecting data around communicable disease by conducting a household survey at field village. It helped to understand the pattern of communicable diseases in the field area and how it leads to morbidity and mortality of child and mother.
- **Observation:** Observation helped in understanding the participation of family, community and healer and Dai regarding MCH and communicable diseases care and daily life activities regarding hygiene and sanitation. It helped in understanding the participation of family, community and healer and Dai in promoting maternal care. This was also helpful in understanding which kind of custom and ceremonies were followed by the community. Observation helped in understanding the hygienic and sanitary system of the community and village.

- **Focus Group Discussion:**

In the study villages, two focus group discussions were conducted with women across two generations. First was with the mother, elder- mother and Dai covering issues like health problems, their maternal healthcare practices (their experiences of pregnancy, delivery and post-partum each time), choice of delivery place, the response of elder women, support system, accessibility of health care services (where and why), the problem associated with accessibility and utilization factor, institutional deliveries. Another focus group discussion was done with villagers from Korwa community male and female (all age group), healer (Bhagat), PDS distributer, Sahiya and ANM covering issues like transformation in terms of social, cultural, economic, political, forest-related, accessibility and utilization factors. Focus group discussions were conducted after taking prior appointments as most villagers did not agree easily for the

discussions and also because everybody was busy with other chores. Mostly elder women and younger women gathered themselves for these discussions.

Food practices:

Observation and interview also helped us to find food practices. This will also help us to know which kind of food is taken during pregnancy, postpartum and in the period of lactation.

Period of Data Collection:

Researcher visited the field work three time; first on 25th October 2016 to 20th march 2017, second on 10th April to 30th august 2018, and third on 25th December 2018 to 26th February 2019.

Sampling Technique:

In this study respondents were chosen based on four layers of care for both study village - first level household data collection with structured interview (male or female who is available at house), second-level mother who had pregnancy experience (including elderly women also), third level traditional healers (Bhagat), Dai and key informer, who belong to same village, forth level; public health provider (PHC/CHC, sub-center, ANM, Sahiya (ASHA), Aganwabadi center) and PDS (Public distribution system).

Reports and Records:

While the collection of qualitative data, the researcher conducted semi-structured interviews, field notes daily diary, chimaera and sound recorder. The daily diary was written based on field notes. Camera used for photos helped to analyses the real situation.The sound recorder was used to record the interviews.

Selection of Respondent:

In the village: Researcher divided the maternal heath related respondent in two age groups first is the younger mother (age group is 18 to 40) and second elder mother (age group is 40 above). In the Semra village total, 65 mothers were the respondents in which 43 are younger and 22 are elder mother and in Gore total 43 mothers are respondent in which 28 are younger and 15 are elder mothers. All women have pregnancy experience except three from Semra and one from Gore village.

Five traditional healers/ Ojha/ Bhagat, two Dai, seven keys-informer, Uppmukhiy/PDS Sahiya (ASHA), Anganwadi Centre, Primary school (teacher and Korwa students) were interviewed.

Dai: Both villages have one – one Dai.In Gore village, not a single woman has taken this as an occupation since 2018. Korwa women are having strong knowledge regarding childbirth. The researcher contacted one elder woman, who has been present in most of the childbirths and is the most preferable person for childbirth at the village.

Bhagat (Traditional healers): traditional healers are three from Semra and two from Gore village. But one Bhagat died in March 2018.

At Sub-Centre: ANM

At PHC/ CHC: Medical in-charge, Medical officer, Nurses, Member of Block Training Team (BTT)

In Block: ICDS office**,** kalian vihagpadadhikare, Garhminrojgarsewak (Under MNREGA), Panchayat representative, Forest Officer, New ranger.

Limitation of Study:

Age: Most women were not sure of their age. This was therefore often estimated by the researcher by taking age of‘marriage’ and adding to it the age of the eldest child, plus the probable time taken to conceive after the ‘marriage’.

Accessibility: Korwa pepole were not easily available since they tend to leave for work early and often returned for a very short time in the day just enough to feed their children and finally came back in the late evening.

At block level researcher wanted to find data regarding the economy, maternal death, child death among Korwa as well as other tribal but there were no data available.

Lack of Transport facilities: The transportation facility was limited in the study area which proved as a major hurdle to the study as the researcher was travelling alone.

However, the researcher made an earnest effort to reduce the limitations by using different research methods, doing in-depth interviews, talking to the community people to understand their health practices.

However, the study provided insights into challenges of social transformation and healthcare practice among Korwa community who belongs to particularly vulnerable tribal group in Jharkhand.

Ethical Considerations

Ethical consideration was taken by researcher in all interviews, discussion and observations. Researcher use a ethical consent form for ethical consent from interviewers by impression of thumb or signature after the verbal informed consent was obtained from the respondents after explaining the nature and purpose of the research. Some of them gave permission to use original name. Researcher changed the name for those who declined for their name to e revealed. Researcher sought prior permission for audio recording and photography but did not get consent for video recording. Researcher took consent for every interview; forpeople who couldn't read the consent form, the contents were read to them by someone in the same community.

Chapterization:

This thesis is divided into seven chapters including the introduction and conclusion. The first chapter will introduce the available literature on 'tribal of India' in order to help define the problem to be studied. This chapter will discuss the social transformation and health care practices and access to health services among Korwa. This chapter will also present information available through literature about perception and practice regarding women's health complication in pregnancy delivery and post-partum practically in tribal population, and discuss the healthcare-related facilities available in the tribal-dominated region as well its accessibility.

The second chapter discusses the 'Research Methodology' dealing with the conceptualization of the problem and the methodology used to study this problem. The methodology for this study has been divided into two parts. The first part will deal with the conceptualization of the problem. The second part deals will with the study design and methods for the specific objectives and research. It will also include the description of the methods and the study sampling techniques,

preparations of tools for respondents and methods of analysis.

The third chapter explores the social structure and change of the community in terms of family, kinship, marriage, religious practices and rituals among Korwa. And this chapter will also look at the settlement pattern of study village, the village structure, housing pattern, geographic, living and work pattern, food habits, and income among the tribes.

The fourth chapter explores the changes in the social-economic pattern and will also try to understand the causes and factors of migration to other district and states and its impact on the korwa.

The fifth chapter explores the transformation of the existing traditional healthcare system to the modern healthcare system. It also explores the availability of the kind of healthcare facility in the study village area and why there is a shift from traditional to modern healthcare faculty.

The sixth chapter will deal with the healthcare practices evolved and changed Korwa. Explore the healthcare practices related to MCH and communicable diseases among women of Korwa. Explore the role of local healers and their treatment practices or continuance of traditional practices along with public healthcare services in the changing social context with the time of Korwa. And the final chapter highlights the emerging trends and summaries the study.

CHAPTER: 3

Changing Social Institutions of Korwa

The main aim of this research is to study the social changes that have occurred in social and economic spheres of Korwa. The chapter will focus on those aspects of social organizations that have changed over a period of time. A study of social transformation necessitates an understanding of social structure as well as social organization. This chapter further outlines the origin of Korwa, settlement pattern, family, kinship, marriage, birth, death, religious practices and rituals.

3.1 Origins of Korwa:

The mythical stories of origin of Korwa bring forth a different identity and distinction from other social groups. Jagdhish Korwa (65), a traditional healer narrates the story of the origin of Korwa which he heard from his grandfather. "*Many years ago, lord Mahadev and Goddess Parvati came to earth to collect a seed (he didn't recall the name of the seed) from the forest and plant in the field. But they had to leave for Kailas Parwat, so they created some men usingclayhaving bows and arrows and told them to protect the field from wild animals and birds. After some time Mahavev and Parvati came back to harvest the crops. They saw that the crops were not damaged and they were pleased. Mahadev gave the people he created with clay life and told them that bows and arrow will henceforth be their identity and asked them to live in the forests.*

As we used bows and arrows to protect the fields, we had become accustomed to using them. Later on, people started to steal and loot using the same. To stop the stealing and looting the zamindar then suggested us to use the lands to grow crops. Some Korwas agreed to the same and became cultivators. Currently we are divided into two sub-group;dhari Korwa (Pale Korwa) and Pahari Korwa (Hill Korwa).Dhari Korwa are cultivators and Pahari Korwas hunt and gather food items from forest, though both groups use bows and arrows.

My grandfather and grandmother along with four other Korwa familiescame to Gore hill from Chotanagpur district.They settled atop Gore hill, Pahadiya PVTG lived in the center of the hill and others tribes and castes lived in lower parts of hill. During the time of my father Korwapeople came down from the hill and started livingin nearby villages and close to the forest. We used to hunt wild animals like deer, pig, chicken, rabbit, rat, and collect edible foods like Kanda, Gathi and fruits from the forest.We also sold these items or exchanged them for

other products. In the last 10-15 years we have been restrictedfrom hunting and gathering items by forest officers and our lands are also under the forest department" (Jagdhish Korwa, 65, 17/03//17, Semra village).

3.2 The settlement pattern of the village:

3.2.1 Village profile:

The Korwa of the hill villages had lesser contact with the people who live in the villages in the plains. The Korwa of Palamu were leading an isolated life in the past, but in the last twelve years they have been moving and came in contact with other tribal and non-tribal communities. In the Chainpur block, the Semra and Gore villages are situated on the top of a hill and are surrounded by forest. In both the villages Korwa are called Pahari Korwa. Semra village comes under Semra panchayat in the Chainpur block. The village is divided into four tolla (hamlet) namelyBalahiya, Lali, Damar and Semra. There are 792 households with a population of 4,154, 2,198 and 1,956 out of which (53%) are male and (46%) are female. 69% of the population belong to general caste, 26% belong to schedule caste and 4% belong to schedule tribes (according to census 2011, and https://indikosh.com/vill/383911/semra/ 04/11/19).

Table 3.1, Caste Wise Male Female Population of Semra and Gore Village (census 2011)

	Semra Village			**Gore Village**		
	Total	Female	Male	Total	Female	Male
Total	4,154	1,956	2,198	1,119	543	576
General caste	2,886	1,365	1,521	360	179	181
SC	1,090	512	578	101	49	52
ST	178	79	99	658	315	343
Child	857	421	436	239	115	124

(https://indikosh.com/vill/383911/semra, https://indikosh.com/vill/383910/gore/ 06/11/19)

In Semra village 80 households belong to Korwa. Semra village has a mixed population with Korwa, Munda, Oraon, Bhiur, Dhshadh, Shaow, Chamar, Charo, Pal, Lohar and Muslim members. In this village, there is no caste-based separation of houses, and different caste groups live with the Korwa. Population of the village has increased by 25.1% in between 2001 to 2011. General caste population has increased by 25.5%, SCs population has increased by 24.4%, and STs Population has increased by 22.8%.

The Gore village is also known as Gore hills. This Gore hill is important from the religious point of view because they believe a number of their gods and goddesses reside there. Gore village comes under Ramghadh panchayat. The village is divided into five tolla (hamlet), Gore 1 (MaaurPafadi),Gore 2 (Karimadh), Mannjrahikhadh, Piparatadh and Ambakhai. In Gore village, there are 230 households with a total population of 1,689 out of which is 407 are Korwa. 576 (51%) are male and 543 (49%) are female. (According to Census 2011 and https://indikosh.com/vill/383910/gore, 04/11/19).

Table, 3.2 Growth of Population (%) of Semra Village 2001 to 2011

	Semra Village			**Gore Village**		
	Total	Female	Male	Total	Female	Male
Total	25%	24%	26%	68%	63%	74%
General caste	26%	24%	27%	35%	31%	39%
SC	24%	24%	25%	-36%	-36%	-35%
ST	23%	30%	18%	17.30%	16.50%	18.10%
Child	27%	26%	28%	72%	58%	88%

(https://indikosh.com/vill/383911/semra, https://indikosh.com/vill/383910/gore/ 06/11/19)

In Gore village there are 43 households of Korwa. The Korwa community live alongside the general population which can be broken up as general caste 32%, 9% are SCs and 59% are STs and other religious groups. Gore village also has a mixed population with Korwa, Parhiya, Charo, Munda, Yadav, Shaow, Pal, and Muslim members. Population of the village has

increased by 68.35% in between 2001 to 2011. General caste population has increased by 34.8%, SCs population has decreased by (35.7%) and STs Population has increased by 17.9%. According to a key informant who belongs to the Korwa community, in both the villages, members of the tribe prefer to build their house near forests or plains.

Above data show the overall population growth of the village. In the Semra village the population has grown by 23% for the STs Population and in Gore village by 17.3%.

3.2.2 Sex Ratio in Village

Table: 3.3, show census 2011, the sex ratio in general castes is 897, in scheduled caste is 886 and in scheduled tribe is 798. There are 966 girls under six years of age per 1000 boys of the same age in the village. Overall sex ratio in the village has decreased by 14 females per 1000 male since the year 2001.

Table 3.3, Change in Sex Ratio 2001 to 2011: Semra and Gore village

	Semra Village					Gore Village				
	Total	General	SC	ST	Child	Total	General	SC	ST	Child
2001	904	921	892	726	982	1,003	1,054	963	975	1,106
2011	890	897	886	798	966	943	989	942	918	927
Change	-14	-24	-6	72	-16	-60	-65	-21	-57	-179

(Sources: Census 2011, https://indikosh.com/vill/383911/s)

3.2.3 Geographic Outline:

Both Semra and Gore villages are in the hills with the forest and the plain below. Both villages are neighbors. They are separate by one concrete road; this road divides not only the villages but the Panchayats also. Semra village come under Semra Panchayat, Chainpur block and Palamu district. Total geographical area of Semra village is 15km^2 and is the biggest village by area in the Chainpur block. 10.41 square kilometers (68%) of total village area is covered by forest. Gore village come under Nawadhih panchayat, Chainpur block, which is 16kms from

the village. Geographical area of the gore village is 5 km^2 and it is 44th biggest village by area under Chainpur block.2.61 square kilometers (50%) of the total village area is covered by forest.

The socio-economic life of the Korwa is closely related with the forest. Traditionally, the forests provided them with the materials for shelter, firewood and indigenous medicine. The forest has played an important role in shaping the social, economic, religious, political and cultural system of them. Forest is the main source of income, and they sell wood for their necessities. But nowadays, mostly young family members move to others states for labor work.

3.2.4 Housing Pattern:

A Korwa settlement in the villages is of a mixed type consisting of other castes. Their houses are scattered on the hilly areas because they prefer to build their houses near the forest. In the Semra village, settlements which are situated on the plains, houses are found at one place or close to each other. Houses are situated on both side of Gali (Road). In this village mostly houses are kacha; there are a total of 792 houses out of which 60 houses are pakka, 579 houses are kacha and 153 houses are of amixed nature (half pakka and half kacha). There are 80 houses of Korwa in which not a single house is pakka, 61 houses are kacha and 19 houses are of a mixed nature. The Korwa families who have mix houses get benefit from the Pradhan Mantri Awash Yojana Gramin (PMAY-G) was formally called the Indira Awash Yojana (IAY) in 2006. Initially Korwa family get 48,000 under IAY and parentally they get amount 1,25,000 under PMAY-G but they are not interested to bulled toiled those government give 12,000 Rupee. 19 out of 80 households are beneficiaries of the IAY/PMAY-5. Those who get the money under the scheme have better houses and live in better conditions compared to others.

In the Gore village, houses are scattered on the hilly areas because they prefer to build their houses near the forest. In settlements, which are situated on the plains, houses are found at one place, without any order or arrangement. In the Gore village there are a total of 230 houses, mostly kuccha (167), very few houses are pakka (23) which belong to the non Korwa community and 23 houses are of a mixed nature. There is 43 houses belonging to Korwa in which 26 kaccha houses and 17 mixed houses.

The houses have generally been built with mud and roofed with '*khapda*' (tiles). Most of the

houses consist of one or two rooms with attached veranda (Porch), have a single door and are low roofed. The Korwa, who have mix houses, generally build veranda in front followed by two pakka rooms, which are attached with one or two kutcha rooms. Those who have kuccha houses generally build one veranda (Porch) with two or three rooms. They use veranda as kitchens. All the villagers who have pakka houses including members from the Korwa community cook food in the veranda. They use wood, puwal (stems of grain), and leaves as fouls. They cannot afford to take care for regular maintenance of their houses, which are generally made up of '*khapada'* (Tile), bamboo and log. They say that the poor maintenance is mainly due to restriction of access to the forest. Unlike their ancestors, they do not have access to bamboo, log and other forest materials required to construct houses.

3.2.5 Basic Health status of Korwa in both Villages

Better cleanliness, hygiene, safe water for drinking and sanitations. play an important role for quality of life of family and community, absence of which can play a leading role for disease and death. Various diseases like diarrhea, cholera, typhoid, malaria, tuberculosis and other infectious diseases are transmitted by unclean water, lack of sanitation and poor hygienic condition. The Governments of India introduced Total Sanitation Campaign (TSC), later renamed as Nirmal Bharat Abhiyan in 1999, which focusedon creating sanitary infrastructure, awareness of personal hygiene and proper disposal of waste. In 2014 Swachh Bharat Mission was launch which was a restructure of Nirmal Bharat Abhiyan which focusedto get rid of open defecation, behavioral change in sanitary practices, proper disposal of waste and drainage (Choudhary & Gupta, 2015).

This section explores the availability and habits of the Korwa community regarding sanitation, cleanliness, hygiene and availability of safe drinking water in the study area. An attempt will be made to understand the basic health status at the villages and correlate major health problems like diarrhea, dysentery, skin diseases, malaria, tuberculosis and scabies which are common among the Korwa community in study villages.

3.3.1 Cleanliness and hygienic habits:

TheKorwa communities in both villages are living in the lap of nature and there is sufficient fresh air, sunshine and natural sources of water. Both villages are naturally free from pollution. This section examines the cleanliness and hygiene in the house, kitchen, yard, utensil and clothes and personal hygienic habits like daily baths, dental care and hand wash before meals.

The Korwa community generally cleans their house, kitchen and yard daily in the morning using broom. At the same time, they are less concerned about hygiene, for instance they generally throw the garbage after sweeping their house in front of the houses and if they have animals like cow, ox and buffalo at home they stay at the entrance of the houses. The animals excrete their faeces at the entrance itself and small animals like chicken roam all around the house and they too excrete feces all around. Children do not use toilets to excrete and normally relieve themselves around the house. Flies (Makkhi) were present everywhere and were sitting on food utensil as well as on food. Dogs and chicken were also allowed to sit on kitchen utensils. They are used to serving food to dogs and chicken in the same utensils, which they use for themselves.

Cleaning utensil: Cleaning of utensils was regular, usually with mud and ash of wood. But after they were cleaned, they were placed on the ground in kitchen where the pets roamed freely. They do not clean utensils before cooking or serving food. The Korwa are poor in hygiene as evident by their habits.

Dressing: Usually they have two to three sets of clothes for daily use. During bath, men use Gamccha (Cotton Towel) and women use petticoat to cover themselves to wash and dry their clothes. They either wear the same clothes after bath or wear spare ones. The children were not properly dressed. Children under two to five years were found running around naked (they cannot afford to buy clothes). Even during winters', they were not fully covered and do not have woolen clothes. Most of the time children suffer from running nose, cough and fever. Most of the reported deaths of children happen due to high fever and cold.

Dental care: The children under five years do not clean their teeth daily and mostly have yellow teeth. The adults used to brush daily with sticks of Sagwan and Neem tree.

According to Meena Devi (43) *'we get up in the morning around 4 to 5 and go to field for defecation. When we return we clean our hands and feet. After that we clean the house with broom and every day, we paint the chulha and the floor and walls around it (paint was mixer of mud and cow dung). Then we take care of our animals, if we have cow or goat then we clean their dung and give food to them, if we have chicken than we free them from the cages so that they can feed. Pets are likes family member for us, sometimes my dog sleeps with my husband in the same bed and also eats the leftovers after he is done. After that we clean the utensils and take water from hand pump to cook food. Once we are done making food, we go for our baths near the hand pumps or river, we do not have more than two or three set of clothes so we wash and dry clothes every day. In rainy and winter seasons, clothes don't dry so we don't bathe and only wash our hands and feet. Then we have our food and leave for work in the forest or land. In between we take care of the kids, for instance for children below two years are given oil massage and are fed once they wake up. After that we leave them in the care of the elderly women in the family but the kids play with elder brothers and sisters. When we return from work, we clean our hands and feet, take care of the kids and the animals, cook food, eat and go for sleep'*(Meena Devi, 43, 27/01/17, Gore village).

3.3.2 Source of Water:

Both villages have rivers, wells and hand pumps for both drinking and irrigation purposes. According to Shorae Korwa, 65, *earlier they collected water for drinking purposes only from the river which is in Gore village. Then river was the only source for all purposes like drinking, irrigation, washing, bathing and for cattle (*Shorae Korwa, 65*, Semra village, 21/013/18).* But now in the Semra village there are seven wells (five pakka and two kachakuwa) and ten *chappanahal*(Hand-Pumps). The wells are generally used for irrigation purposes. 3 wells out of seven are clean and six out of ten hand–pumps are in working condition which is used for multiple purposes like drinking, washing, bathing and for cattle.

In Gore village there is one river, eight wells (five pakka and three kacha) and nine Hand-Pumps. Five hand-pumps out of nine are in working condition. The rest have been non-functional since last three years. Hand-pumps and pucka *kuwa* (well) were made under MNREGA. They were built in 2011 and are in working condition till date. Earlier, they were dependent on the river and the kucha wells for drinking water. In both villages not only Korwa

but all other communities and caste groups who live in the village use the same pakka wells and hand-pumps for drinking water, bathing, washing clothes and utensils and agriculture. Only three houses, which belong to OBC community have their own hand – pump and pakka well. But even they use the wells and hand-pumps built by the government.

In the study area they deliberately put fish and frogs in the wells. Fishes and frogs have been put in the three out of seven wells in Semra village and four out of eight wells in the Gore village. They believe that fishes and frogs eat small insects and keep the water clean and germ-free. They use the water from these wells for all purposes like drinking, cooking food, cleaning utensils, bathing, and agriculture.

3.3.3 Sanitation:

Table 3.4 shows that the defecation facility available at village level is very poor. Nine latrines are constructed at Semra village and five at Gore village but they are not functional. In Semra village two are in working condition, one was withDushadh and one was with Shaw community (Upper Caste). Two Korwa families constructed latrines but even they are not in functioning condition. 18 households took the amount given by the government for construction of latrine in the house or premises but the people in the Korwa community did not construct the same.

In Gore village one working latrine was found at the Yadav community. There were other five latrines, two of which were built by the Korwa Community but all were non-functioning. In two Korwa households only sink was setup. After the launch of Swach Bharat Mission in 2014, there was more focus on toilets by the government. A total 45 houses at Semra village and 42 houses in Gore village received money for toilets but only 7 and 4 toilets were half constructed and were non-functioning at Semra and Gore village respectively.

According to key informer BirjaShingh (43), most of Korwa and Parhaiya received money from Government but they did not construct toilets. The people of the Korwa community are very poor, they received 4,500 rupees from Government but the total cost ran approximately 12 to 15 thousand for the construction, hence they were not able to construct the toilets and used the money in other needs for livelihood. They used that money for food and treatment. Most of

the Korwa people drink Mahua and Hadiya (Traditional Alcohol), most of the money was spent on this (BirjaShingh, 43, 25/02/19, Semra village).

In both the study villages even those who have latrine facility didnot use them. Not a single Korwa community member use latrine. Usually they choose a certain field, which is nearby the forest. Generally, they go for defecation far from houses but the children who are under five years use to do in the house or somewhere near the house. Animal defecation can be seen everywhere, creating an unhygienic situation. Children play around in this unhygienic place till the mother come back from the forest and cleans up the area.

The Korwa have poor sanitary conditions. According to Seta Devi (33),*'ihawa khali humain ja he khet me aisan na hae. Pura ke pura ganwo ja hathen. Ihawa latring kaha hai. Aur jinkar ghare hai euhane o to khate me ja hathen'* (Seta Devi, 33, Semra village, 24/12/18). Here we are not the only community who practice open defecation; the entire village practices the same. There is no latrine and even those who have latrine practice open defecation. Everybody has the same practice. In the Semra village four latrines are usable but they are not preferred. These belong to other caste groups and not a single usable latrine is present for the Korwa community.

Toilets in institutions were also in very poor condition, two toilets are present in both village schools but they are not in usable condition. Neither the teachers nor the students were using them and they choose to do in open. At Semra and Gore primary school toilets were not used in years. Both toilets do not have water facility, the doors are broken, no facility for cleaning and no mugs or buckets. According to students, they are used to open defecation but during school they face difficulties. Both girls and boys urinate at the backside of the wall, but for stool they have to go far from school and it takes around 30 minutes. At aganwadi as well there were no toilets.

Table, 3.4, Basic facilities of Semra and Gore village

	Indicator	Semra	Gore	All social groups Semra/Gore	S. Korwa/ G. Korwa
1	Housing condition				
	Housing Number	792	230	712/187	80/43
	Pakka houses	60	23	60/23	0/0
	Kuccha houses	579	167	518/141	61/26
	Mix houses	153	40	134/23	19/17
2	Sources of water for drinking				
	Packa well	44017	44048	--------	0/1
	Kuccha well	44014	44046	--------	--------
	Hand pump	10	9	43831	--------
	Rives / Ponds			For all	For all
3	Sanitation				
(a)	Defecation facility				
	Latrine uses	2	1	43832	0/0
	Latrine not uses	9	5	197/117	43863
	Open Defecation	All	All	All	All
(b)	Bathing facility				
	Open	All	All	All	All
	Close	None	None	None	None
(c)	Drainage	Kacha	Kacha	Kacha	Kacha

(According to the field work 15/07/19)

3.3.4 Bathing facility:

According to key respondents, Korwa peoples are not very conscious about hygiene and cleanliness when it comes to their body and dressing. Children and older peoples generally take bath only two to three times in a week but in winter and rainy sessions they are not taking bath for more than a week. The younger women are much more conscious about their own cleanliness compared to the men. Women usually take bath every day before they engage into house hold work. In the both villages Semra and Gore the situation is not much different for bathrooms. All villagers are used to bathing in the open. Nearby wells, hand-pumps, river and ponds are used for the same. But nowadays few young women make temporary bathing arrangement in the backyard of the house, which is made by hanging saris on sticks with the top open, these are called *Jhalas*. They use *Jhala* for urination during the day as well. Usually, men and women are used to washing hands, feet, face and comb their hair regularly when they return from forest and work place. Younger men and women used to wash hand before taking meals but children don't do the same. They wash hands with mud before taking meals and after defecation.Both villages have poor drainage system. The villages have kutcha and open drainage which passes from the front of the house.

3.3.5 Education: In any community, education plays an important role to bring a change in lifestyle. Education helps in uplifting oneself socially, economically, and politically. In the Semra village out of a total of 1,807 people, 4,154 are literate, among them 1,178 are male and 629 are female (Census 2011, https://indikosh.com/vill/383911/semra, 7/11/19). In the Gore village out of total 1,807, a total of 1,119 are literate, among them 303 are male and 202 are female. The literacy rate of the village is 55%, 67% for males, and 41% for the female population. There has been an increase of 13% between 2001 and 2011 (Census 2011, https://indikosh.com/vill/383910/gore, 07/11/19).

In Semra village there is one high school for both villages Semra and Gore. School regularly opens on time, there were five teachers including the principal who took a class for 1st to 10th standard but the Infrastructure and facility of the school were not good. Within the Korwa community, a total of 69 are literate. Among them 52 are male, 49 are 5th pass and three are 10th pass and 17 are female among whom 14 are 5th pass and 3 are 7th pass. All the children in the Korwa community attend school. According to the mothers they send their children because

the teachers provide food during lunch. The schools provide food and education. According to the school register, there are 57 Korwa students registered, 38 boys and 19 girls, but a total of 39 students were present at school. 6 out of 11 Korwa students were present in a total of six classes (04/01/2019). Korwa students are active and communicated with the researcher very easily.When it comes to interacting amonh themselves Korwa, Parhaiya, and other tribal students interacted within their own tribal groups. Students were sitting in groups as well; one boy student used to sit in the front row every day. According to the teacher, "*students decided their seating themselves and whom to communicate with. We are not discriminating based on caste and class, students interact and play with neighbours, so at school they behave similarly*". But the students gave a different narration; according to Sabita Yadav student of class six who belongs to the upper caste, *"we do not sit with them and boys do not mix with them as well. We eat lunch (Mid Day Meal) separately."* (04/01/2019, Semra Middle School).

There is one school for all the communities. Most of the children attend school; midday meal is the main attraction among Korwa students. According to the school register, there are 33 korwa students registered in the year 2019, 12 in 1st class, 17 in 5th class, and 4 are in 10th class. Within the Korwa community total of 41 are literate. 38 are 5th class pass and three are 10th class pass.

Three and four boy students are studying in class eighth from Semra and Gore village respectively. After the age of 14 korwa boys and girls drop out of the school, most of the boys were helping to earnlivelihood for the family. They were working in MNREGA, as agricultural laborers and migrated laborers. Most girls drop out of school after puberty (Menstruation cycles), after puberty girls are consideredto be of marriageable age in the Korwa community. According to Puja (18), she was studying in class seven when she had puberty. Her parents did not allow her to go back to school after knowing that. After that, her parents searched for a boy in the same community and fixed their marriage. She wanted to study till eight but she got married. At the age of eighteen, she had a one-year child and presently she was pregnant again (Puja Kumari, 18, 19/3/17, Semra village)

Table, 3.5, changing in Literacy Rate 2001-2011- Semra and Gore village

	Semra Village			Gore Village		
	Total	Male	Female	Total	Male	Female
Changes	13	12	13	38	38	38
2011	55	67	41	57	67	47
2001	42	55	28	19	29	10

(Sours: Census2011, https://indikosh.com/vill/383911/semra, https://indikosh.com/vill/383910/gore, 07/11/19)

3.4 Food products:

In the study villages, the Korwa community is facing lack of food. They have a very limited source of food so they have to depend on various sources like the forest, agriculture, and Public Distribution Systems (PDS) for survival. They get Kand (tubers), GethiKand, Kanda, Gethi, Berna Kanda from the forest, maize by agriculture, and rice from PDS.

3.4.1Food items from forest: Both Semra and Gore villages are considered as big villages with the forest playing an important role in many spheres of the life of Korwas. Natural resources are an important source of livelihood, as well as a coping system for Korwa people, particularly in the study area. They not only are dependent on these resources for income, but these are the resources for their survival. As the agricultural production of the Korws is not enough to meet the requirement for the whole year, they have to depend on various forest produce for their subsistence. Many edible roots and tubers, fruits, leaves, flowers of different trees are available in the forest round the year. There are two types of roots and tubers which are considered as main food items of the Korwas. These are: Kand (tubers), GethiKand, Kanda, Gethi, Berna Kanda, and Duru Kanda all these food products are available throughout the year. But, BernaiKhania and Mithara Kanda are available only from December to July. Food-gathering is done by both men and women although mostly it is done by the women.

3.4.2Food items from agriculture: The nature of the land in both villages is mostly hilly and forested, so the agricultural produce is insufficient and does not sustain them throughout the year. They produce maize, ithaene, lotanee, madhuwa, rice, mustard, cereal crops and

vegetables. Very few families are growing *Arhar* (pigeon pea) and Grams pulses for selling. They consume *Arhar*Daal particularly only during festival times. Recently, few started growing vegetables like potatoes, louki and pumpkin. In the lean season, they go hunting, fishing, and gathering food.

3.4.3. Food items from PDS: The Chainpur block has public distribution system office for both villages. Semra and Gore villages receive *Ration* on a fixed date from PDS. Korwa community from both villages have yellow Rashan card. They get 35 kg rice, 2 kg sugar, 2 litre kerosene oil and 3 kg salt. They receive Rice and sugar every month but kerosene and salt are received bi-monthly. Before 2015 Korwa community and other PVTGs used to get ration from Chainpurwelfare office which was 30 km far from villages. They booked tractor with their own money to bring ration from Chainpur PDS to village. Since 2016 they get ration on door step to every household who have card but the irregularity in distribution continues. According to Pccuhu Korwa (44), he complained to PDS distributed. "*PDS distributor used to distribute ration sometimes every three months, sometimes monthly and sometimes every two months but took stamps on the ration cards for all the three months. We complained to the officer but still he didn't take us seriously"* (Pccuhu Korwa, 44, Gore vellage/18/12/18)

Welfare officer said that they give food product directly to beneficiary especially to PVTGs. they were given all the months food products and a register is maintained in this regard. The WO cannot distribute the food product regularly as they also do not receive the food supply. (24/12/18, Chainpur Block)

Table 3.6: Food items from PDS per months

	Items	Quantity
1.	Rice	34 kg
2.	Sugar	2 kg
3.	Kerosene oil	1 lit
4.	Salt	1½ kg

(Source: Field Survey, 2019)

Korwa community have traditionally taken forest foods but these days they prefer agricultural products to forestry. Mostly they are dependent on PDS food items and midday meal. According to Peentu Korwa (42), "*we are from Jungle (forest), we are connected to forest by our language, dance, customs, rituals, culture and food habits. I think I am slowly getting detached from my culture, language, behavior and food habits after forest right act came into effect. I am an expert in hunting but now days I am a cultivator. I have no issue with forest right act, if forest right act protects the forest, it is good. We also want the same but why are the government employees cutting them and we are not even supposed to enter to take food items, medicinal plants and wood to repair our houses. Our existence depends on forests and forests depend on us for their existence (Jungale se hum hain, aur hum se jungale). My son when he was 15-16 moved to Bengaluru city, he liked to eat kanda and ghatha (make by corn) but now he likes to eat chowmien and samosha. He said they are eating chowmien and samoshadaily (Peentu Korwa, 42, 23/12/18, Gore village).*

For the Korwa community in the study area the main source of rice is from the PDS ration. They have very small area of lands that are not good for rice cultivation. Korwa are getting 34 kg of rice from PDS, which is sufficient for 10 to 12 days in a month. Irregularity of food supply by PDS, landlessness, land not suitable to grow rice, limited food gathering and restrictions on hunting animals from forest has reduced the use of meat in food and is continually leading to hunger in Korwa community.

3.5 Alcohol used in Korwa:

The Semra and Gore villages have rice of natural recourses in forest, and Mahua tree is present in larger numbers. Mahua tree is very useful and plays an important role among Korwa community as well as the villageas a whole. Mahua flowers blossom in the month of March and April.Peoples collect flowers and dry it in the open under the sun. In both villages people traditionally drink Mahua and Hadiya, Mahua is prepared by the Mahua flowers and Hadiyais prepared by rice. Among the Korwa community, both men and women drink both traditional drinks. They normally drink during the evening but older peoples drink during the day as well. According to respondents, drinking during pregnancy is common among them. 60% women drink during pregnancy. Children of 10 to14 years are also allowed to drink. In the

Semravillage only nine households and in Gore Village only seven households refrained from drinking.

Researcher had her own experience related to the drinking in the community. When she reached Semra Village on the first day she contacted the Sahiya and Aganwadi Sevika, one of the men from the Korwa community came over and started shouting and using abusive languages. He carried a lathi (Broom Stick). The Sahiya took the researcher inside a nearby home, the other villages caught the man and took him away. Later the researcher came to know that the person was drunk on Mahua, he didn't like Government employees and assumed the researcher was one too. The other villagers also confirmed that normally the people belonging to the Korwa community didn't fight but when they are drunk, they shout, fight and use abusive languages.

3.6 Electricity at the villages: In the Semra village there is electricity connection in all the houses but 31 houses out of 80 houses of the Korwa community have no electricity. In the Gore village there are 19 houses out of 43 households of the korwa community which have no electricity but in this village many houses which belong to other caste groups also do not have electricity.

According to Peentu Korwa (42), *in the Semra village all houses have electric connection but few members of the Harijaan (SC) community and few of the korwa community don't have electric connection because they cannot afford electric wiring. Government set the electric connection all over the village from road to gali. People hook their own wire to the main electricity supply. Electric wire passes from front of my house but we do not have the money to take connection to main electric wire". (*Peentu Korwa, 42, 27/07/18, *Semra* village*)*

Table 3.6, Electricity Connection in Houses of Semra and Gore Village

	Semra	**Gore**
Total Houses	80	43
Not Electricity	31	19
Electricity	49	24

(Source: Field Servy, 2019)

3.7 Social Organization:

Family provides the basis for the social and economic system among the Korwa. Korwa are endogamous. According to respondent Balkesh Korwa (64), *they are divided in to seven sections which are Dhari Korwa, Sinduria Korwa, Birjia Korwa, Koraku Korwa, Ageria Korwa, Tisia Kowra andMandiyar Korwa. In this village Dhari, Birjia, AgeriaandTisia Korwas are living (*Balkesh Korwa, 64, Semra village 16/10/16*)*. The Korwa community at the village maintains their traditions and customs. They have their own traditional Panchayat. Head of Panchayat is Mukhiya who controls the whole community. The whole community has faith on him. Similarly, Bhagat or Baiga (traditional healer) who is a religious head of the village also plays an important role in village organization. He is a mediator of the Korwa and others communities in the village on one hand and the spirit world on the others. The Bhagat as the religious head controls the religious matters for the village.

3.7.1 Family Structure: In the Korwa community families are Patrilineal and Patrilocal. Father is the head of family, mother holds second position, she is an asset to the family and male member are to respect her diction. Both villages have two types of lifestyles, traditional and urban. According to Phulwa Korwa (61), "*korwa basically live in joint family, joint family is one of the institutions which defined the living status, food habit and economic condition. However, there has been change in the family structure, one of the reasonsbeing the change in working pattern. The families who work as agricultural labor live in traditional way whereas the ones who move out to places like Bangalore, Mumbai, Chennai to work as labor have a more urban way of living. Twenty years ago, they were living in joint families, father, mother, son, daughter in-law and her child in a single hut but now they live as nuclear families. The son after marriage builds separate hut in the same village. Mostly they get money from Indira Awas Yojana and build separate house but all the brothers and father do their cultivation jointly and share the proceeds proportionately"*. (Phulwa Korwa (61), 10/03/17, Gore village).

Researcher found one of the minor changes in the culture of Korwa is that the younger men (above fifteen) who work out of state are more dominating over women. According to Umash Korwa (23), who works as a worker in cement factory in Bangalore,he comes to the village in the month of September for agriculture in his own land. He lives in a separate house from his mother, father, brother and sister. His living condition is comparatively better (food, clothes

and cleanliness). He mentions that he is okay to work in a factory, his wife lives in home to take care of the child and does households work and questions his wife's demand work as a construction worker.*"I am the head of the family and if I say something, she should do the same"*.The Wife of one of the cousins he works withfollow the same. *'There is nothing bad in it; if we are providing a better life then she must follow the instructions. But other women who live in village with their husbands are against these kinds of behaviors, they are of the opinion that they have freedom to decide but these days men are more dominating and take decisions as head of the households*' (Umash Korwa/8/07/16/ Semra village).

3.7.2 Marriage: Korwa are endogamous and have clan exogamy. According respondent, Korwa believe marriage is an important function to give the social status to people and their children. They marry in the same community, they believe, if they marry into other communities and castes, they lose their culture, beliefs and ancestral values. According to Pacchu Korwa (44), '*ten years ago one of the boys was belonging to Korwa community marrieda girl of Pahadiya community. She belonged to PVTG and from next village (Semra). Our community did not agree to this marriage in the community meeting. In meeting it was decided that they have to leave the community and village. Then he and his wife left the village and some years later we got information that they are living near daltonganj (District). Another recent story is of a girl marring with a boy belonging to the Munda tribe. The Korwa community did not accept them but Munda community accepted them and now they are living in same village with the munda community*' (Pacchu Korwa, 44, 18/03/17, Gore village).

Mostly they are in favor of marriage after puberty. According to them the marriageable age of a girl is between 13 to 15 years and boy is between 18 to 20 years. Actually, they do not remember the exact year a child was born so they don't mention the exact age. But in the last five years they have made Adhar Cards in which they mention the age of the child. When the girl's menstrual period occurs and breast developed then they believe the girl should be married. So, the girls are married within 16 years of age. In case if a girl is married pre-puberty, she is not sent to her Sasural (in-laws) to live with her husband till the time she does not attain puberty. In the Korwa community of the study village, marriage takes place in the month of March, April and October.

3.7.3 Bride price: In the Korwa community there is very small bride–price compared to other communities. Bride prices are called Dali and Nagi. In the study area Nagi was Rs 10-50, one sari (for mother (Mai Sari)), one cotton cloth mattress (Aji, Ledara), and a very few Korwa are also taking Hadiya (Rice Beer) as bride price.

Types of marriage: In the study area they follow different types of marriage based on economic conditions. Marriages are with bride price, Marriage by service, Polygamy, Dhuka-dhuki and most common and important types of marriage is known as Baiha which has certain complex rituals.

3.8 Religious Practices: The Korwa community is very much devoted to religion. They have their own gods, goddesses, myths and beliefs. They are much afraid of supernatural powers. Whole life of Korwa is associated with religious phenomenon. They believe in Bhagwan (Sun) as their super God, Chandarma (Moon), Dharti Mai (Earth) and Mahadev (God Shiva) who are the creators and protectors of the universe. They believe that they give them light, land, rivers, water, air, forest, birds, animals and human beings.

The religious head of the Korwa community is Baiga (Bhagat, Ojha, Traditional healer). He is not only the religious head but also acts as a healer who heals all kinds of illness by Spiritual Mantra, animal sacrifice and with the use of herbs. The Bhagat is a religious guru not only for Korwa but also whole village and other communities.

According to Chamaru Korwa, 60, "*Korwa are celebrating Karma, Sarhul, Jitia, Sawani puja, Holi (Fagua) and Deuthan (Only by Bhagat). Among these festivals Karma is themost important festival for all Korwa as well as other tribal communities. Karma is the goddess of prosperity and harmony. The feast is celebrated in three day before Purnima in the month of Bhado (September).They meet people, eat good food, drink (Rice Beer, Mahuaa and Hadiya), dance and sing together. Korwa people celebrate their feasts according to their economic condition. My son was suffering from Mirgi (Epilepsy). He could not be cured by the Bhagat, who suggested forManauti to Karama Devi (Pray to Karma Devi). I did Manauti to Karma Devi and my son was cured. I pray every third year for my son's better health. I offer food and drinks as per my economic convenience to Karma Devi(*Chamaru Korwa, (60) *09/03/2017, Gore village).*

According to Phulwa Korwa, 61, "*Pahele bhi Bhagawan (God) halthine aur abhiu hathin unkar sanges ange dusman (Evil) bhi halthine abhuo hathin, zamana katana bhi badal jatae endunojan to rahabe kartathine aur ihanera htathin to humin ke beswash bhi rahate"*. God was present in earlier times and is present now as well and with him evil is also present till date, they are present then and now we also believe in them, no matter how much generation will change. According to her anyone who dies due to health-related problems like tuberculosis, brain fever, malaria, dehydration and diarrhea, or animal attack then it is believed that they made some kind of mistake. Her daughter in law was suffering complication during pregnancy. She had Malaria and after that weakness, during delivery baby was in transverse position. Dai massaged her womb after which the baby reached the right position for delivery. Though out the pregnancy she was treated by Ojha, she prayed to Devata and Dushaman, both helped the Ojha and then he cured her *(Phulwa Korwa, 61*, *09/03/2017, Gore village).*

3.9 Political Organisation in the Village:

In the earlier time in both villages there exist a traditional panchayat with five members. They belonged to the same community, which helps in a better understanding of their traditions, customs and rituals than any outsider. Panchayat discussed and solve social, economic, rituals, religious and political issues within the village.
At the present time, study villages do not have a traditional panchayat, they have mukhiya who is elected as per the government policy and belong to other community. Not a single Korwa person is involved in Panchayat Raj. Korwa people believe more in the judgment given by Shathi (Naxal). They are more comfortable with them and think Shathi understand and solve the issues better and sooner.

According to Shorae Korwa (65), '*I came into this village after marriage around fifty to fifty-five years ago. The Village was structured and had a functional Panchayat. We had our own traditional Panchayat in village. There was one head of Panchayat who is called Mukhiya and three to four Panch members. All panchayat members including Mukhiya belonged to Korwa community, so they had a better understanding of our traditions, customs and rituals than any outsider. In Panchayat they discussed and solved social, economic, rituals, religious and political issues within the village level. They discussed issues like family disputes, divorce, extramarital affairs, religious rites and festivals, traditional law, traditional skills, knowledge,*

land and food items distribution. All issues were discussed and suitable punishments were given to protect and maintain the value of the culture and traditions. They had always believed in the Panchayat systems and believed that they would never do injustice. But presentlyin the Panchayatwe have their own community's Mukhiya and Panch but they are only for namesake. We used to believe in the panchbut the younger generation; twenty to thirty age groups do not follow and refuse the judgment of the Panchayat(Shorae Korwa, 65, Semra Village, 05/01/2019).

According to Binod Korwa (20), "*we used to believein the village Panchayat but we are going for work in the town and return home for a few days in a year. Now we prefer to solve our issues though Shathi (Naxal). If Shathi gives a judgment, we should follow. Only two Korwa issues were discussed with government sponsored village Panchyat but they were not satisfied with the judgment. After that they went to Shathi for the right judgment*" (ShoraeKorw, 65, Semra village, 05/01/2019), (Binod Korwa, 20, Gore village, 05/01/19)

The transformation in the political and governance model also is a leading factor for the area to be under influence of the extremist groups which adds on to the problems. Doctors and health practitioners are not keen to move to these areas due to the same and the more isolated these areas become the farther the benefits of the government programs and infrastructure developments will be.

3.10 Stratification among Korwa

In the village, there is no caste-based separation of houses, and different caste groups live with the Korwas. Both villages follow the concept of a social hierarchy. They strongly believe in their social norms and traditions. In both villages people live with different caste group and religions. Earlier (50- 60 years ago) they lived in dense forests and had no contact with other caste and religious groups. Then there was not much need for interaction as the forests provided with everything that was required. Presently, the Korwa community in both villages is surrounded by other tribal, caste and religious groups. Their needs have evolved and now are similar to the others and thus they have to depend on each other. They are socially, religiously, politically and economically dependent on each other. In both the villages there are two types of stratification; first is inter-tribal stratification and second is inter-caste stratification. Another

type of stratification found by the researcher is economic stratification. Economic stratification has created a space within the Korwa community in the last three to four decades. In the Semra village eleven communities co-exists which are Korwa, Munda, Oraon, Bhihur, Dhshadh, Shaow, Chamar, Charo, Pal, Lohar and Muslim and in the Gore vllage Korwa, Parhiya, Chero, Mundo and Yadav.

Table, 3.7, Social hierarchy of inter caste and inter-tribal in Semra and Gore village:

Semra village	Gore village
Dushadh	Yadhav
Shaw	Ahir
Munda	Parhiya
Oraon	Munda
Korwa	Korwa
Behour	
Pal	
Lohar	
Chamar	
Charo	

(Soure: Field Servey, 12/02/ 2016)

(1) Inter-Tribal Stratifications: Table above shows the position of social hierarchy in both the villages. In Semra village Munda and Oraon both are considered to belong to the upper strata of the social hierarchy and their behavior is similar to that of the general caste. They do not accept food or water from the Korwa except Hadiya (rice beer) which they drink together. But the Korwa accept cooked food and water from Munda and Oraon. Same as in Gore village there are Parhiya and Munda tribals who do not take cooked food but Hadiya which they drink together. The Korwas are considered among the lowest tribes in both villages.

(2) Inter-Caste Stratifications: In both the villages upper caste groups are Dushadhs, Shaws, Yadavs and Ahirs. They are also invited in marriages, birth and funerals by other caste members like Pandits (Brahman), Naai (Barber) and Dhobi (washer men); even though they are not allowed to eat food, they can pack the items and take with them. The Bhagat even if they belong to the Korwa community is respected by both upper tribes and castes. They are invited to all functions and are respected. Upper caste groups offer cooked food and Hadiya to them.

Bhagat is not only spiritual guru for tribes but also for the upper and lower caste groups. According to Jagawa Devi (50), earlier married women did not eat food given by superior castes like Dushadh, Shaw, Yadav and Ahir. These belong to upper caste and are higher in the village hierarchy. Korwas are not supposed to sit parallel to them, eat with them or even touch the upper caste groups. The Korwa are facing untouchability by upper caste groups in village. But now there has been change in their customs, few Korwa women who are engaged in doing households work and who are working on the lands of the upper castesare allowed to eat cooked food and feed the family members. She said "*Payet me bhukhlagalrahate to kaha se dharmkaramhotae"*, if you are hungry then how to follow the customs (Jagawa Devi/ 50/ Gore village/ 16/03/17).

(3) Economic Stratifications: Researcher observed that economic hierarchy also exists within the community. The standard of living of Korwa and other communities in the village are poor especially in terms of income, food, and access to the services given by the government. According to Dhinesh Korwa (38), 'I have one-acre land but no equipment for agriculture, so I moved as a laborer to Daltonganj (district) around ten years ago. I am working there and have a better life comparatively, and they respect me. I also give loans to others (as Mahajan). Seven from Semra and three Korwa people from Gore village act as money lenders to other Korwa and others caste groups (SC). The Study shows that Economic status has become a part of the village economic hierarchy. Hierarchy systems are slowly changing' (Dhinesh Korwa, 38, Gore village, 17/03/17).

If any society or community is undergoing change, it means there is transformation in the social, economic, political, cultural and also the beliefs over time. In the study area the transformation of the Korwa has been very slow till 2005. Since 2006 after the enactment of the forest right act, the changes in terms of social, economic, political, and cultural and also in the beliefs onstructural functional system of the community was faster than ever before.

The data and research on the villages show conformity to the literature review. The conditions of the Korwa are dire and there hasn't been much development over the years. Their progress has been really slow and the gaps between them and the mainstream population in towns and cities are wide. The remote habitats have been a major reason of the same and inspite of the extentive government programs and policies, the benefits have not reached the Korwas. The

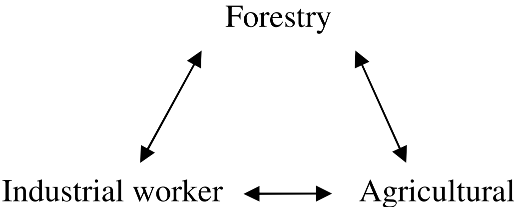
political unrest in the areas and the distrust of the community on the village panchayats and dependence on the naxals adds to the problem. There has been some development when it comes to literacy rates and occupational patterns but the levels are fairly low comparatively. The food patterns have shifted to a government assisted source in the forms of PDS but the abundance and improvement in the same compared to the time when access to forest was free can be argued. The living conditions, awareness and facilities in terms of sanitation, utensils and clothing are worse compared to other social groups. Overall, the situation in terms of development leaves much to desire and the objectives of the Government programs are far from being achieved.

CHAPTER: 4

Transformation in Korwa Economy

Historically, Korwa are associated with the name vulnerable, and they are marginalized because of poor socio-economic condition in terms of work- participation. They are dependent upon utilization of the natural resources for their sustenance. They live on the bare minimum and do not have the urge to gather wealth as opposed to the mainstream populace. But the present economy of the Korwa is changing. The Korwa community's economy especially in the study area is mainly dependent on forestry, agricultural and labor work. Earlier (not more than ten years) economically the Korwa of Palamu was divided into two groups; first was forestry (food gatherers and basket makers) and second agriculture. But recently there is more dependence on labor work. There are two type of labor in the study area; first is agricultural labor and second is industrial labor. Women are equal partners in the contribution to the household economy. Both men and women work hard but after the passing of the Forest Act, the work load has increased for women. After forest Act came into effect the male members migrated outside the village.

All male and female members are busy whole year round in different work. They work according to their tradition, age and income requirement. In the study village area socio-economic transformation can be represented in the below triangles in terms of shifting to forestry to agricultural to industrial worker visuals cycle.



Korwa community are adapting to different types of work in different sectors along with maintaining existing traditional occupations. The change in practices has been due to two major factors which can broadly be divided into external and internal. In the study area the external factors have been more dominant.

In the study area the transforming economy affected and brought about an overall change in social, economic and political scenarios. Early Korwa had only one economic system i.e. forestry but now they are considered as multi-occupational. Due to this reason it is difficult to mark an exact classification of the pattern of labor. In the study in both village Semra and Gore,

most of the Korwa are found involved with numbers of occupation or labor. Researcher divided the total Korwa population of both villages in to three categories in terms of working pattern, which are:

1. Forestry labor: have been divided in to (a) Bamboo and wood cutting (b) Basket making (c) Food gathering.

2. Agricultural labor: have been divided in to (a) Dehadi labor or daily labor or casual labor (part time work), (b) Banihar labor or attached labors (full time work).

3. Laborers: have been divided into (a) working outside and inside village (b) migrated laborers.

If we see the village working profile, in the Semra village 36% (1,502) population are involved in either full time work or part time work. 46% male and 25 % female population are working population. 27% of the total male populations are fulltime workers and 19% are part time workers and 3% of female are full time workers and 21% are part time workers. Gore has 30% (340) population involve in either full time work or part time work. 42% male and 18% female population are working. 28% of total male populations are full time workers and 14% are part time workers and 3% total female populations are involving in full time and 15%are part time workers (Cences 2011).

Table: 4.1, Transforming occupation Structure of the Korwa at study villages.

	Traditional occupation	Changing occupation
Korwa	Collect food & wood from forest, cultivate maize, Millet and Vegetables, Hunting, Rope making.	Cultivators Agricultural Laborers, Contract labor, Castrator labors, Brick maker, Filter, Road making, Cantering on construction side

(Sources: Field Survey, March 2017)

Table: 4.1 shows the transforming occupational pattern and changes in the present occupational patterns compared to the traditional occupation among the. Natural or forest resources are an important source of livelihood for the community. They are not only dependent on these

resources for income, but these are the resources for their survival. Traditional occupations were likecollecting food items, cultivate maize, millet and vegetables, hunting and rope making. Korwa people with these traditional occupations accepted and learned new patterns of work like being cultivators, agricultural laborers, contract laborers, construction laborers, brick making, road making and construction work. Presently among Korwas there is no specific pattern of work, they are termed as multi-workers. These work patterns mostly drag them to other states like Maharashtra, Karnataka, Delhi, Punjab, Assam, UP and Bihar as migrant workers. They are working in construction sites, factories, mines, in brick making and as agricultural labor. Changing occupational patterns play leading role of the economic transforming among Korwas.

The working pattern show how the Korwa are struggling for their existence and adjusting to their ecological settings. According to Vinod Korwa (36), *'humen garreb aur anphadh log heya humen ke kuchu kam mil jaye hai kar leyehe. Humen ke peet pale khater sabe kam kare padeyhae"* 'we are poor and uneducated; we do whatever work comes our way; we do anything to survive. Korwa economy is peculiar in so far as there is no source of income on which we can entirely depend for the fulfillment of their needs. We are doing multiple kinds of work for living within a year' (Vinod Korwa, 36, 15/07/2018). Both villages can be divided based on the working pattern:

Table, 4.2 Working pattern of the both Semra and Gore village

Village	Households	Forestry work	Both Agricultural + labor work	Migrated labor	No agricultural work	No labor work
Semra	80	All	58	23	09	13
Gore	43	All	31	19	05	07

(Sources: Field Survey, March 2017)

Most of the Korwas in the study area are losing their own land under Forest Right Act. They are moving out of the villages to the cities with changing working patterns. Both male and female members are busy whole year round in productive work. Different types of

works are done in different months, so one person does forestry, agricultural and labor work as well. In the both villages Semra and Gore all Korwa are more or less involved in forestry. 58 out of 80 households are involved both with agriculture and labor. There are nine households not involved with agricultural but they are working in forestry and have labor works. 13 households are not involving any kind of labor even with MNREGA (Mahatma Gandhi National Rural Employment Guarantee Act). In the Gore village 31 out of 43 households are involve with agricultural as well as labor. There are five households not involved with agricultural work and seven are not doing any kind of labour work.

4.1. Forest Economy:

Natural resources are an important source of livelihood. They are not only dependent on these resources for income, but these are the resources for their survival. Many edible food are found in the forest. As the agricultural production of both the community is not enough to meet the requirement for the whole year, they have to depend on various forest produce for their subsistence. Many edible roots and tubers, fruits, leaves, flowers of different trees are available in the forest round the year. There are different types of roots, stems, leaves, flowers, which constitute their staple food throughout the year. The forest products can broadly be classified as follow:

(a) Roots and Stems: There are two types of roots and tubers which are considered as main food items. These are Gethi and kanda. They cannot live without these food items. There is a general saying "are humin dal- bhat kha kezindakaiseraham, jab-tak humane Gethi (they can't survive and afford to live on rice and pulse. They have to eat Gethi and Kanda). Gethi is found at the depth of one and a half to two feet and Kanda is found at the depth of one to nine feet. The Gethi is big and weighs about 100 gm to 500 gm. It is almost of a round shape, deep brown in color and bitter in taste. Kanda is different in sizes and shapes. Kanda is sweet and tasty. Both are found almost all around the year.

(b) Leaves, Vegetable, Fruits and Flowers: The forest is the main source of vegetables. There are many leaves and vegetable available all the year round. There are many leaves like Seave (Koinar), Dhai, Halhal (Sarwat), Jeranga Sag, Thuthku Sag, Saru Sag, Dhasni Sag, Maat

(Bamboo), Chankot (Chakor), Kachan (Kheksa), Ai (Khukhri), Aat (Kundri) and Meral (Anwla).

Sarai (Sarjam) the fruit of the Sakhua tree are collected during the months May (Baisakh) and June (Jeth). Its shape and size are almost similar to the Bean. Also, Pear, Dhithior (Makor), Gayandi (Peska), Belly (Sinja), Tend (Tiril), Parki, Dumber, Ghui, Jaamun, Kathal (Jack fruit), Kantai, Aam (Mango) are available.

Mahua is liked not only by the Korwa and Parhiya community but also the other caste groups all over the state (mostly villages). It is one of the important liquors in this area or state. Mahua is found in the months of March (Phagun), April (Chait), and its flower is mainly used for eating and drinking purposes.

(c) Trees, Bamboo and Grass: Treesare needed for house, furniture, baskets, and agricultural equipment. Sal (Sakhua), Seassum, Salai, Karma is used for house and furniture purpose. Aithan, Tend, Khayan Kend, Khayr these are of great economic value. Earlier there was no permission required for cutting trees for personnel use and for selling. But after 2006 state government has become strict and cutting of trees is not allowed without prior permission.

(d) Wild Animals and Birds: Korwa are known as a hunting and gathering community. They are veteran hunters and perfect bowmen. They were clever enough to kill even tigers. But now days they are forgetting the use of bows and arrows. According to the villagers hunting has been forbidden by the government officials from the forest department. More over many of animals migrated in other place due to deforestation and also, they lack weapons to bag the animals. Hunting has almost become a ceremony and is done only as a sport for fun. Very small number of animals and birds are hunted. During the period of Maize and Marua cultivation, wild animals used to come to eat the corn. It was considered the hunting season. Wild animals which are normally found are Suar, Chitar, Kotra, Deer, Rabbit and birds are Teetar, Dhanesh, Lawa, Parnki, wild Chicken and Cocks. In the field area the food habits have changed over the decade.

4.1.1 Market:

Market plays various roles in the Korwa lives. Semra and Gore both villages are mostly going to Nawadih and Chanpur Market. They depend upon the weekly and bi-weekly market. The weekly market of Nawadih is held on Monday, in the Chainpur both types of markets are available weekly and biweekly.

For Korwas, the *Haat* (local market) has an economic and social value. They sell their products and purchase their day-to-day requirement. The market place is where they meet Korwa from other villages. They exchange their happiness, sorrow and news from the outside world. They use the market as a multipurpose site including negotiating marriage alliances. This also becomes a site for the boy and girl to see each other. They collect various types of grass and creepers from the forest and earn money by selling them in the market.

Table: 4.3 show the forest products which are availableseasonally. They collect forest products and sell according to market price throughout the year; like Lac is produce all most all year round which sells at the highest price in market. Fuel wood and tooth brush also sellsaround the year and these two products are main source ofsustenance among Korwa.

Table- 4.3: Numbers of Forest Product Available and Market Price

Slr. No.	Forest Product	Market Price/ Per K. g	Session
1	Lac	150	Jan-Feb,April-Augt, Sept-Nov
2	Fuel wood	15	Full year (expect monsoon)
3	Tooth brush	2/10 pieces	Full year
4	Mahua (flower)	11	April-June
5	Mahua (seed)	13	July-September
6	Ber	08-12	Jan- March
7	Jamun	10-12	May –August
8	Bhelwa	01-10	March-September
9	Khachanar	10	March-April
10	Ithani	01-12	October-March
11	Bel	4/piece	Feb- March
12	Rugara	20-25	June- September

(Source: According to key informers from both villages, 2018)

Korwa community does not have any kind of storage facility. In such a situation they are compelled to sell their produce which is around 10-15 kg to the first contact, which is generally at the '*Haat*' or to a petty trader (Baniya). The sale of almost all the forest resources is mostly done in the local weekly markets where a deal takes place on a mutually agreed price quoted between vendors and petty traders.

According to Baleswar Korwa, Korwa who live in village are fully dependent on the forest, but have been facing problems after The Scheduled Tribes and Other Traditional Forest Dwellers (Recognition of Forest Rights) Act, 2006. Forest guards have been preventing them from digging roots and tubers. They are not allowed to hunt for food and they are allowed in very limited areas of the forests. Earlier they used to hunt pigs, pigeons, deers and birds. The only source for meat was the forest, 10 to 12 years ago they used to eat meat frequently but now days they are able to eat meat only twice or thrice in a month (Baleswar Korwa, 43, Semra village, 13/01/19).

(a) Basket Maker

Both Semra and Gore villages make basket for personal use as well as for trading. Earlier (thirty years ago) basket was one of the main sources of income for the Korwa for both villages. They used to sell baskets or exchange them for grain. But now very small numbers of family members make baskets. Base costs depend on the basket size; they are sold for 5 to 50 rupees according to size.

Sometime they are bringing firewood from the jungle to sell in the market. They make bundle of twenty to fifty kg of firewood and they sell for 200 to 600 rupees. Men and women both are doing this work.

(b) Animal husbandry: In the study area it is seen that there are a number of cows, ox, buffalos, goats and hens in the Korwa family; mostly they have at least one animal. Cows and buffalos are used for milk and very less members produce ghee. Generally, the milk is consumed by the children. If they do not have children then they sell milk in market, but the number of milk sellers are very few. They sell milk at the rate of 15 to 25 rupees per liter, cow milk is sold for 18 to 20 and buffalo milk 20 to 25 rupees /liter.

4.2. Agricultural:

Agricultural economy depends upon the nature of land. The nature of land in the areas where Korwas are living is mostly hilly (upland) and forested. They do not have enough land for agriculture so that produce lasts the whole year. The land holding is very small and many of them have no land. So, the agricultural produce is insufficient and does not sustain them throughout the year. In this village particularly, members of the Korwa community have not divided the land within the immediate family. They do not have any kind of a land map of the village. They have used these lands from generations. *"We have 20, 40, 50, 100,200,250 acres of land, but most of it comes under forest area, so we cannot use it for agricultural purposes."(11/03/17, Gore village).*

Table 4.4: Land of Korwa people in both villages

Villages	Landless	Under 2 acres	Under 5 acres	Under 10 acres
Semra	19	43	13	4
Gore	6	26	9	2

(Source: Field Survey, 2019)

Table: 4.4 show, In the Semra village 61 out of 80 households have their own land and others 19 households don't have land for agricultural and they count themselves as a landless. 43 households have less than two acres, 13 households have less than five acres and 4 households have less than ten acres. Similarly, in the Gore village 37 out of 43 households have land and others 6 don't have land for agriculture. 26 households have less than two acres, 9 households have less than five acres and 2 households have less than ten acres. Most Korwa do not agree with the land map, which shows that they have very less area. Changing agricultural products does not have much effect. Most of land of the Korwa is barren. Day by day their agricultural produce is becoming worse because of small land holding, successive droughts and lack of irrigation facility. They all work on the land together and produce maize, mahua, rice and cereal crops, which are then distributed equally among the families. Korwa mainly produce maize and it is also their main food. Very few Korwa families are growing *Arhar* (pigeon pea) pulses for sale. They consume *Arhar*Daal particularly only during festivals. Recently, few

Korwa started growing potatoes.

(a) Maize and Mahua: It is grown in 'Bari' which is attached to the house. Maize and Maduaare the main crops for the villages and the main food of the Korwa. These two crops are more or less cultivated by all the Korwa in the both villages. It is sown in June and July after the firstmonsoon and harvested in August and September. These products are available for 4-5 months.

4.3 Labor Work

Women are equal partners with men in the contribution to the household economy. Both men and women work hard but after the passing of the Forest Act, the work load has increased for women. After the forest Act was implemented the availability of forest products was restricted. The next source of income is labor work, which can be divided into (a) Agricultural labor, (b) Non-agricultural labor (c) Migrated labor.

(a) Agricultural labor: Around four decades ago, they were not interested in agricultural work even on their own land because they did not have good lands for agricultural, there was lack of equipment and lack of knowledge. Then mostly the lands were covered by the forest, so they were more into forestry. In the Semra village 61 out of 80 households have their own land for agriculture. In the Gore village 37 out of 43 households have land. Those Korwa who have their own land generally perform their agricultural work with the family member. Those who don't have lands engage as laborers to do agricultural work. As shown in table 4.2 In the Semra village 58 households and in the gore village 31 households are involved in agricultural labor. They are also engaged in non agriculturallabor. They work in the lands of Korwa, others caste group and they even move to others village or states. These labors engagement is at times part time and at times full time. Part time laborers are those who irregularly work in the land of different people. Those who work for one year or more are given food, clothes and money. Those who work for a season, a week or a day are given five seers or kg (one seer equal to 0.93311kg) of any grain per day and they are given breakfast and lunch but this is not applicable for daily laborers. They are known as *Banihar*. Male and female both equally participate as agricultural workers. They are doing all agricultural work like plugging the land, laboring the soil, sowing the seeds, harvesting the corps, preparing the grain and thrashing.

(b) Non-Agricultural labor: Earlier (before four decades) there was no concept of non-agricultural labor. They were involved in forestry and very few were involved in agricultural work. But presently they have to do some labor work for sustainability. Table: 4.5 show the Semra village 58 households and in Gore village 31 households are involved in different types of labor work. They are working in Mines, Bhatha and Kath making in nearby villages. Korwa work under the Mahatma Gandhi National Rural Employment Guarantee (MNREGA) scheme, but they are working 02 - 45 days in last two years. Below data shows in Semra village 57 people have MNREGA card, 23 do not have the same, 34 peoples worked for 20 days, 14 less than 20 days and nine worked for more than 20 days. In other village Gore, 27 people have card, 16 don't have the same, 13 people have worked for 20 days, 9 people have worked for less than 20 days and 5 people have worked for more than 20 days.

Table, 4.5 Korwa Working in MNREGA

	Card holder	Non card holder	20 days work	>20 days work	<20days work
Semra	57	23	34	14	09
Gore	27	16	13	09	05

(Sources: Field Survey, February, 2019)

***(c) Migrated laborers*:** Before applicability of Forest Act the people from the Korwa community did not move to other states for non-agricultural labor but after that they have to move for sustainably of life. Most of young male members of the family moved out of the village to cities like Bangalore, Mumbai, and Chennai to work as labor like contract workers. According to a key informant, they do not want to work in their own village and district because there is not sufficient work throughout the year. Other states give them betterment of their economic life, which is deteriorating by the day. For this, forest restrictions and connection with the outside world are responsible to a great extent. Male members of family are generally moving but now day's younger couples with kids are also going outside for work. Generally, they are between the ages of 13 to 40 years. Agricultural laborers come back at the

end of every season, but construction workers come back at festivals like 'Holi' and 'Sarhul Puja'. They come home once or twice in a year.

According to Santosh Korwa (37), '*we are living in the forest; our land is also within the periphery of the forest. Along with me another four members have their ancestral house in side of the forest (belong to same village Gore).In 2008 some officers came and told us forcefully to move and construct the houses near other villages as the land came under the Government. Then we moved approximately 50-60 yards and made houses closer to the village but under the FRA our lands are also under the forest department. At present 3 Acres of land are in my father's name and we are five brothers. We all work together on land to grow food items and distribute grains among each of us, which is not enough for the family for the year. These lands are not fertile and we grow only maize. In my family there are a total of nine members, my wife and five children are with my parents. Earlier we got food items from forests and used to sell them but now forest officers are not allowing us to take these items. MNREGA doesn't provide full time work, maximum 15-20 days work in a year. The overall situation forced me to do different types of work and move out from the village. I was working in Bangalore and now I returned from Chennai. There are lots of work and they provide better salary but all of this is leading to lots of problems like changing food habits, learning new work pattern and new language*' (Santosh Korwa, 37, 18/03/2018, Gore village).

Past mode of income: Gore village was always different from Semra in terms of keenness in work patterns. There was an iron factory which brought about industrialization in the area. The income from the factory was steady as well. But after the factory closed (Approx 4 decades before – the respondents had varied timelines for the closure) the workers were forced to go back to the traditional methods of livelihood due to a lack of alternatives. Even when the factory closed and had no economic impact on the community in the long run, it was able to influence the work patterns within the community. They are keener towards labor work compared to agricultural work. This coupled with other factors leads them to choose migrating to other states as laborers.

Rajkaliya Devi (70), belongs to Gore village, she worked as a laborer in an iron mine factory, which was based in Gore village. *According to her in the Gore hill there was an iron mine*

factory but thirty years ago it was closed. Her work was cleaning of raw iron. She was paid Rs. 3,500 per month. Along with her another thirty people worked in the factory in which twelve belonged to Korwa community from Gore village. At present three people from Korwa are alive who used to work in the factory. When she joined, she was of approx twenty years of age. According to her, Korwa people who were working in the factory had a different way of life in terms of food habits, life style and social status. Food habits were slightly different to others like they used rice and pulses; others could not afford the same. They picked-up grocery from Baniya shop for the month when they got their salary. But she also mentioned that she also ate Kamda and Gadhi (forest edible food). Her husband was not working that time but household work was her duty as well. She mentioned that she had four sarees with blouse, then if you had four sarees with blouses that means you were fashionable and rich. She had money, she ate rice and pulses and she wore saree with blouse and she maintained herself equal to the upper caste groups.

According to her, she believed in traditional healers and she still does. She had delivered a baby girl at home assisted by the dai and took treatment from Bhagat. Other Korwa who were not working in factory were engaged in agricultural laborer. She had food twice a day but others were having once a day. The former drank more hadiya (rice beer). But after the factory closed, she earned her income from work like making basket, selling wood from forest and working as an agricultural laborer' (Rajkaliya Devi, 70, Gore Village, 18/03/2018).

At present her house is kacha (mud house) like others and she has five acres of agricultural land. According to her, she is not getting benefit under Indira Awash Yojana and Briddha Pension because she had work experience in the past. She has become very old. She has a girl but she is married and is far from the Gore village. In this age she is alone and get ration from PDS, which is very helpful. The family member who worked in the factory, are still struggling in their day to day life.

4.4 Expenditure:

The expenditures for a household are depending on the number of people including children are present in a house. Table: 4.6 show the Semra village, 67 out of 80 households have major expenditure (1000 and above) and 13 houses are not expending much. In the Gore village 29 out of 43 households have major expenditure. They include:

(a)Food and drink related items: Generally, the expenditure on food items such as maize, rice, dal, oil and drink (alcohol) are very less, around one thousand to two thousand rupees. The expenditure on drinks is higher at Semra village, they use Hadiya (Rice Beer) and Mahua (made by mahua flowers). On an average per person per day they consume half bottle of Hadiya which costs around fifteen rupees a bottle. Most of the Korwa people included male and female and old age groups drink Hadiya. According to Nagina Devi Korwa (65) *'aaj se paccha shsal pahele humen paisa se kharedare bahut kamkare hale, yetana dam bhina hale, hamen adael-badel kare hale, kuchu saman ke badale me kuch aur saman lawy hale. Tab yetan akharacha na hoye halae, janagle se sab kuch kahyeke mil jatrahae.* 'Around five decades ago we were not expending this much, the cost was very less, we also had exchange system, we exchanged the things and there was not much expenditure like today. The forests fulfilled all food requirements.' According to her not more than one to two rupees was spent on food then. (Nagina Devi Korwa/ 65/ Semra village, 03/11/2018)

(b) Sickness and accident: In the Semra village 35 sick and 7 accidents have been reported, in Gore 21 are suffering from illness and 5 accidents have been reported during last six months. According to Umesh Korwa (36), who works as a laborer in Bengaluru, his mother was suffering from fever for one and half month, his wife took care of her in the village. He spent more than 30,000. She first went to Bhagat, but after 20 days she didn't recover and her condition worsened. After that she went to a private clinic. She never went to government hospitals. After one and half month his mother expired; he came back to the village for the last rights of his mother. He had been suffering from fever since last week and is being treated from a private clinic, where he has already spent Rs. 1,000. He is unable to work in this situation and he had to take a loan to fulfill the expenses. According to Denesh Korwa(40), *'earlier we rarely fell ill. My parents preferred Bhagat for any kind of sickness. Bhagat used to treat with roots, leaves and Mantras; they still treat diseases using the same methods. They do not demand much money like English dawa (allopathic medicine) even now'* (Denesh Korwa, 40, Gore village, 05/02/2017).

Table, 4.6, Last six months' major expenditure in Semra and Gore village (November 2018–April 2019)

Expenditures in last 6 months	Semra village /family	Gore village/family
Major expenditures households	67	29
Items		
Food –Drink	11	3
Illness/ Accident	35/7	21/5
Marriage	5	4
Death	3adult /2 child	2 adult/2 child
Festivals	6	0
How to Manage		
Saving	18	6
Loan	49	26
Expend Money		
1000-2000	13	8
2000-5000	19	13
5000- above	17	11
No Major Expenditure households	13	11

(Source: Field Survey, 2019)

(c) Marriage: The expenses on marriage are around 10,000 to 15,000 in both villages. In Semra village five marriages happened including three girls and two boys. In the Gore village four marriages happened including three girls and one boy. In Korwa community there are two types of marriages in general; first is Dhukadhuki in which very less money is spent and other

is Bahia which is more expensive and all rituals are performed by both sides but the expenditure incurred by the bride side is comparatively less. According to Jagdhish Korwa (65), *there was a time when the expenditure was limited to only 20 to 30 rupees which was a big amount for them. Even then they used to take loans from the Mahajans from the OBC caste groups. To repay the same they used to do some work on their lands* (Jagdhish Korwa/65/Gore village/ 16/03/2017).

(d) Death: In the village the dead bodies of the adults are buried but for the children the dead bodies are cremated. For the children there are no expenses, but for the adults Dhusman rites are performed. Generally, they are performing Dhusman according to economic condition of the family. So, the expenses vary from 2,000 to 10,000. In Dhusman rites they call all the relatives and friends for Bhoj (everyone is fed). In the Semra village deaths have been reported of three adult and two children and in the Gore village of two adult and two children. In the case of death of children there Dhusman rites are performed.

(e) Festival: They celebrate their own festivals, they eat good food, buy new clothes and go out to have meals. Only six families have taken loan for festivals in Semra village.

Table 4.6 shows that one of the major expenditure for the korwa are related to healthcare. It also gives an insight into their lifestyle habits. The item section of the table shows the major expenditure per household. The second part shows how these expenses are managed. It reflects the fact that most of the household have debts. The third part explains what the major expenses amounts to. It shows that even when the expenses are in the range of thousands, the present occupational patterns are not enough to sustain the same. The above data shows that their expendidure exceeds their income which in turn makes them rely on loans to meet their expenses. The households using debt to meet their expenses are 61.25% in Semra and 60.46% in Gore. The interviews also show that the expenditure patterns have undergon a change over the years.

4.5 Effect of the Economy on the Livelihood:

Several Korwa’s are involve in forestry, agriculture and labor (migrant labor included) in the mine and industries. The non- agricultural work is the primary source of livelihood. Over the

decades, the Korwa economy and livelihood have undergone change. Primarily they depended on forest resources but now they have moved to agriculture and have been forced to search for industrial work for livelihood. Economic factors are an important determinant of health and lifestyle. The Korwas have increased in population but at the same time they are facing lot of economic problems, factor associated with lower availability of food and alienation from natural habitats force them to move to industrial work. There is chronic poverty amongst Korwa. There are two types of remote rural regions: first dry lands, the main characteristics of which are frequent failure of crops and which have high level of risks to livelihood due to the lack of employment opportunities; and second, the `forest based' economies, especially in hilly regions with predominance of tribals who belong to particularly vulnerable tribal groups. They have limited access to natural resources on the one hand, and on the other limited information and markets. Factors affecting chronic poverty in this area are the relationship between chronic poverty and climate condition for agriculture, land for agriculture, human capabilities, social structure, and many dynamics of poverty in this area. Impact of availability of natural resources, especially, land, water and forest contribute to poverty directly and indirectly in this area.

As evidenced above the entire economy of the region was affected by the Forest Act. The restrictions imposed on use of forest products along with restricted entry and use of land forced the Korwa to adapt and change their age old, tried and tested methods of livelihood. With no sound alternatives available the only option was to work a labor. Over the years the lack of educational facilities and better employment opportunities threw the community into a vicious circle of poverty. Now the members are moving out as migrant a labor which are making them distant from their culture and beliefs and is diluting their heritage.

CHAPTER:5

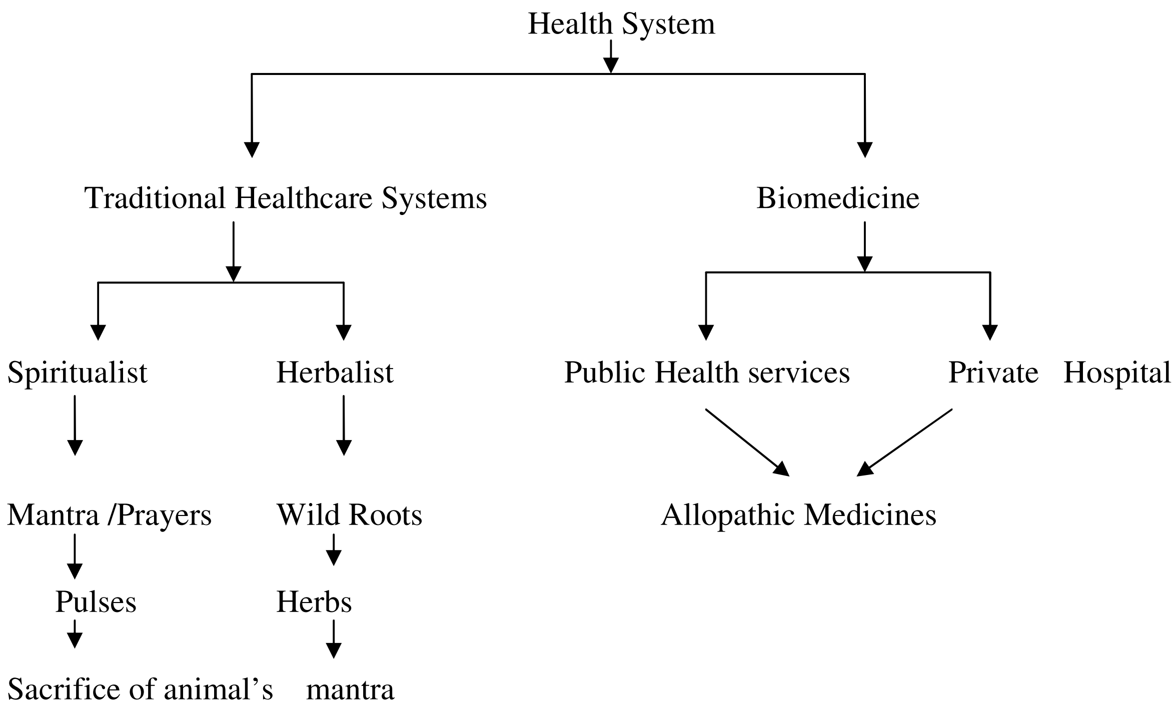
Transformation on Healthcare Practice of Korwa

Healthcare System

A Health system is defined by WHO (World Health Organization) as a system which comprises of all the organizations, resources (Human or otherwise) and institutions that aim to produce health actions. A health action can be further defined as any action undertook to improve health status whether it has an effect on personal or public healthcare (WHO, 2003). Knowledge and practices in traditional healthcare system in India has existed since pre independence. Health care system is equally necessary for each and every human being. Health care is one of the important key points for measuring social-economic conditions in the community or society in terms of effects of environment in which they live, their behavioral patterns and lifestyle. The tribal populace has a prevalence of traditional system and hastheir own perception about health and they have various alternatives to overcomehealth-related problems. The healthcare system of the Korwa is the outcome of several interacting factors; which are connected with socio-cultural and religious practices since ancient times. They have their own indigenous healing practices to heal various kinds of diseases and health related problems. In both the study villages, Korwa have had their own preventive and curative healthcare system but there has been a gradual change inbeliefs infavor ofwestern healthcare system. They are slowly looking forward to western healthcare systems rather than only relying on the traditional practices.

In the study village, the Korwa have a combination of both traditional and western healthcare system (Allopath). Traditional healthcare system can be divided into spiritual and herbal practices.Spiritualistpractice prayers with mantra, pulses and sacrifices of animals whereas herbalist treats with the help of herbs, plant root, leaves and seeds with mantra.Allopathic healthcare system can also be divided in two parts first are the private clinics and second are government hospitals (PHC Chainpur). Previously the tribes believed more in traditional healing practices due to their beliefs, the availability of health facilities, the nature of diseases and the economic conditions of the family. Now there is a change inthe cultural values, beliefs, customs and rituals. This chapter explores the transformation of existing traditional healthcare system to western healthcare system. It also explores the availability of the type of healthcare facility in the study village area.

Diagram: 1, Health system in study village area among Korwa.



(Source: Diagram representing healthcare system of the Korwa people in study village)

According to Nageya Devi (62), *'Hum aapn zindagi me bahute kuch badalte dekhale he aapn gaown me. Khan-piyan, rahan-sahan, uthan-baythak, bole-chala uruppchar me bhi keytana badlao aael hai. Humen ke kuch hoye halae bhagat he thik kare halthin. Humen dawa-daru kaha sunele hale, sab abhi chalet hae. Hum aaj tak dawai naekhekarele doctor se dekhake, leykinhumer beta aurputhoh gel halthinechinpuraspatal, puthodke beta hoye la hlae, gawon me sahiyahaiwahi sab kebacchapaydakareylaaspatal me jane bole hai. Aaj bhagat janbhi ka kartat hineun ka to badhiya gadi-buti bhi na milet hai. Gadi-butijangalkebicchobich me mileyhaiabhi to jangal ja karkuchlewey la dur ja he nasahkehathien. To uppchar me bhi farak aayl hai par ihane humesa humen ke uppercchar lage jadi-buti bhunde jangale jangal ghumaet rahe hathen'*.

'*I have seen a lot of changes in our village during my life with respect to food habits, life styles, and hierarchy, language and healing practices. Before, for any kinds of health-related problems Bhagat was the only option, we did not even hear about allopathic medicines, but now these medicines are used. I am not taking any allopathic medicines or any treatment by the*

doctors, but my son and daughter-in-law go to Chainpur (PHC/CHC). My daughter-in-law gave birth to a baby boy there. Sahiya who belongs to our village advised to go to PHC for child birth. The traditional healers are not getting best quality herbs and leaves nowaday. Medicinal plants (Jadi-buti) are found in mid and dense forest, but now we are not allowed to take away medicinal plants from forest, even entry is also is restricted. They are always searching traditional medicine for us we respect them' (Nageya Devi, 62, Semra village, 25/02/19).

5.1 Traditional healthcare practice

Korwa consider diseases are harmful and detrimental to normal life. They think most of the diseases are caused by supernatural powers and they have own indigenous methods of preventing, diagnosing and curing diseases and health related problems.

According to Jagdhish Korwa (65), '*we have our own Bhagwan (gods), Devi (goddesses,) myths and beliefs. We are religious and highly believe on two types of supernatural powers, that Bhagwan and Devi have and the other is Bhagat (traditional healer). We believe that the whole world is made by Bhagwan and Devi, they have supernatural powers to create us and control our life and Bhagat is a mediator between the god and the people. Bhagats are responsible to perform all the rituals for the different religious functions and they are also responsible for good and bad in the village or within the community. Seven years back Mahamari (Epidemic) spread all over the village, in which many children died. The whole village blamed Bhagat for this, they said Bhagat did not pray properly and that some mistakes were made by the Bhagat and that's why Bhagawan and Devi got angry with us.'* (Jagdhish Korwa, 65, 25/03/2017. Semra village)

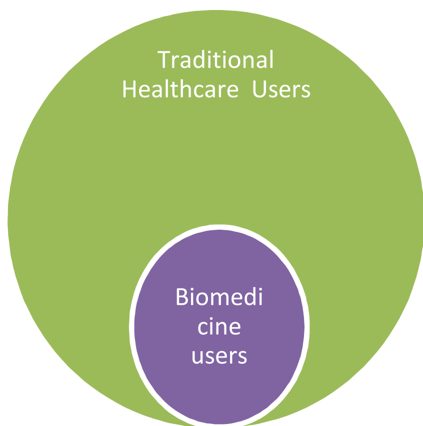
In both villages, Korwas mostly take treatment from traditional healers, who are present in the village and belong to the Korwa community. Among them, there are two types of traditional healers, first is spiritualist and second is herbalist. In the Semra village total 6 traditional healers are present among who 4 belong to Korwa. Three are both spirituals and herbalist and one is herbalist. In the Gore village there is only one Bhagat. There was another but he died in March 2018. According to KarimanManjhi (70) who is also a traditional healer, traditional healthcare practices are influenced by various cultural factors. Korwa people believe in the relationship between sickness, diagnosis, treatment, healing, and medicine. If any family members are sick in the Korwa community they relate it tospiritual aspects (Anger of God or

presence of Evil) and based on that decide on the type of healthcare to opt for (Spiritual or Herbal). (Ramprashad Korwa, 45, 5/2/17, Gore village).

WHO defines traditional medicine as the health practices, approaches, knowledge and beliefs, incorporating plant, animals and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illness or maintain well-being. (Pappappallimama,2010, vol-15,No-3).

The Korwa community carry knowledge about healing practices, which is passed on from generation to generation. Their traditional health practices are not scripted. According to Sohearkorwa (57), '*I am both a spiritualist and herbalist. I took Vidya (healing education) from my father and my father took from his father. This way we carry our Vidya generation by generation. We developed indigenous way of healing practices to protect our health-related problems and diseases. In my belief some of the diseases are caused by anger of god (Bhagwan) and some caused by evil spirits (Duhusman) which are absolved by some rituals done by me in the presence of Rogi (Patient). As an herbalist also I am curing diseases and health related problems by medicines prepared from wild roots, herbs, and plant as well as animal parts*' (Sohearkorwa, 57, 29/04/2018, Semra village)

Diagram: 2, Healthcare services uses by Korwa of both villages over the years:



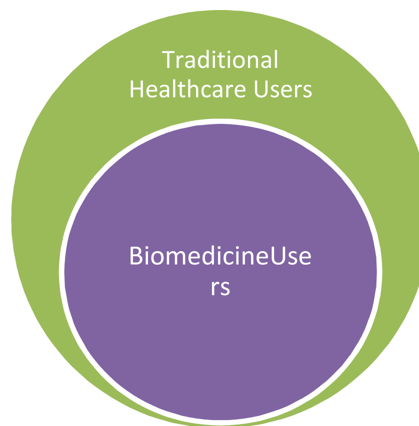


Diagram: A, Before 2012 **Diagram: B, After 2012**

However, with the establishment of western healthcare system there are signs of change in the indigenous healthcare system of the community. Diagramically the increasing influence of biomedicine can be depicted as below. DiagramA, shows the situation before 2012 (in 2017, respondent said five years back). In both the study villages Korwa people were mostly treated by the traditional healthcare providers. Diagram B shows the changes in healthcare practices in the villagers. It shows the increased dependence on biomedicines. The Korwa's first choice of treatment is always to visit traditional healers, ANM and private doctors as a second choice and doctors at PHC as third choice. Among traditional healing practitioners which are Bhagat, there are specialists such as Spiritualist who believe in Bhagawan and Dhusman (God and Evil) and Herbalists who believe in *Jadi –Buti* (medicinal plant). Both practitioners are influence by various cultural factors

Table: 5.1, Traditional Healers in Both Villages:

Sl. No	Name	Age	Tribe	Education	Means of healing	Sources of knowledge/	Duration of practice
Gore							
1	Kariman manjhi	70/died March 2018	Korwa	5th class	Spiritual & herbal	Traditional/ Ancestral	30-35
2	Bondum anjhi	65	Korwa	Nil	Spiritual/ Ojha	Traditional/ Ancestral	30-32
Semra							
1	Soharek orwa	57	Korwa	Nil	Spiritual & herbal	Traditional/ Ancestral	30-32
2	Fhetalko rwa	60	Korwa	Nil	Spiritual & herbal	Traditional/ Ancestral	30-32
3	Jagdhish korwa	65	Korwa	Nil	Herbal	Traditional/ Ancestral	35

(Source: Field Survey, 12/03/17)

At present (2019) in the Gore village only one traditional healer is present who is a spiritual healer (Ojha), BonduManjhi (65). He worked as Ojha for the last thirty-two years and still continues to do so. The second one was Kariman Manjhi (70), who was very renowned within

the traditional healers but he died in March 2018. He was one of the very important respondents. He was both a spiritual healer and an herbalist. Most of the villagers took treatment from him. In Semra village there are three Bhagats present. They belong to Korwa community in which two are both spiritual and herbalist and one is herbalist. All traditional healers took traditional knowledge from their ancestors.

(A) Spiritualist

In both villages four spiritualist Bhagats belong to the Korwa community. Korwa believe Bhagats are mediators between Bhagawan (God) and them. They communicate with Gods, and then they find out the reason behind the disease and health related problem. They believe that disease and death is caused by certain evil Spirits orDhusman. Bhagat defends mainly against five types of evil spirit which are the causes of diseases. These are Bhuts (evil spirits) ikirdhusman (water sprit), burudhusman (Mountain sprit), Dubaldushman (drowned in water-spirit), pasaldhusman (killed by people and sprit), churil (sprit of dying at child or during pregnancy) and Dahein (Sprit of witches). Bhagats relate the diseases with the spirits of person who died in an accident or due to unnaturalcauses like snake bite, killed by animals, suicide and death during pregnancy and child birth. Evil spirits are believed to cause or are linked with various diseases such as Diarrhea (Dashat-ulti), Pneumonia (Sanshchadahana), Goiter (Ghegha rog/Gandhmala), Dropsy (Jalandhar rog), Paralysis (Lankawa), Gout (Gathiya rog), Leprosy (Kushta rog), epilepsy (Mirgee) and (thesediseases name confirmed by the PHC Chainpur). Spiritualist’s arecuring all these diseases according to symptoms related with dhusman. Firstly, they decide which evil-spirit or dhusman is causing the particular diseases, after which they control that evil spirit with prayers using mantra. It takes two hours to two-three days depending on the diseases and the type of evil spirit believed to be associated.

Diseases like measles (Mataji) and small measles (Chotimata ji) are believed to be caused ifBhagwan or Devi (God or Goddess) is angry with people. There are various kinds of measles like Mataji, Chotimataji, Agni mataji and Panimataji which is according to size and color of boils of measles. For measles, Korwa people do not take biomedicine in any condition,generally Korwa people know about the kind of measles, they take advice of Bhagat. If someone in the family is suffering from measles then they are isolated and taken to a separate room, which has a clean bed with Neem leaves (Azadirachta indicia leave)spread all over. The

entire body of the patient is massaged with ghee. The patientsreceive divine treatment; they are prayed to using incense (Dhup- Agarbati) and traditional Devisongs are sung every morning and evening for two and half days. Next Tuesday or Sunday they are bathe with neem water, given clean clothes and the entire house is cleaned. It is hoped that after the same the patient will be cured. Korwa people still believein spirituality as in earlier times, nothing has changed in religious, customs, rituals and beliefs with respect to the relation between sprits and diseases. They think and believe spiritualist Bhagats know about their family history and community and he is the one who can cure them.

(B) Herbalists

In the Semra village there are three and in Gore village there is one Bhagat who belong to korwa community who are herbalists. They cure people with the medicinal plants (herbs), animals' parts and mantra. Both villages are rich in forest product and medicinal plants.Korwa people are having knowledge about their plants and importance of them. Most of the Bhagats are having their own secret names for many of the medicinal plans. Plant name indicates the habit of the plant, color of flowers, shape of leaves, size of fruits and seeds. Bhagat are collectingthe medicinal plants depending on the time of the season and on the plant parts.

Table: 5.2, Bhagat are collecting the medicinal plants depending on the time of season.

Plant parts	Time	Season
Leave and branch	After sunrise to 9 a.m.	Rainy and spring
Root and tuber	After sunrise to 12 noon	Winter and summer
Bask, resin gum and flower	12 noon to 4 p.m.	Autumn season
Seed and fruit	12 noon to 4 p.m.	When the available
Whole plant	Only morning time	After flowering and fruiting
Wood	Sunrise to 12 noon	Earlier winter

(Sources: Ramprwash Korwa/ 62/ Semra village / 15/03/17)

Table 5.2 shows the Bhagats collect different parts of the different medicinal plants. They collect medicinal plants part according to available season and particular time. They diagnose according to the color of the tongue, mouth, eyes, skin and nails. After that they prepare medicine with while chanting mantra according to age and gender of the patient. They make medicine in forms of Mixture, Kadha (syrup), Gholl (Paste), dhure (powder), goli (tablets), and medicated oil from plant and animal fats. These medicines are taken with cold water, honey or rice beer according to Bhagat's suggestion.

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Table: 5.3, Names of tree, their uses of tree parts for medicine uses in diseases:

	Tree	Part use	For medicine
1.	Karanj	Root, leaves, bark, flowers & seed	Skin diseases, sores, chest pain, ear complications, joint pain, cough, cold, eczema, fever, itching, diabetes, leprosy, malaria
2.	Bael	Root, leaves and fruit,	Diarrhea, fever, gastric, dog bite, snake bite, eye issue or conjunctiva, jaundice, vomiting, cuts, stomach pain, asthma and constipations
3.	Jamun	Seed, bark and levees	Sugar rog (diabetes), dysentery, leucorrhea, and stomach pain
4.	Munga	Bark, leaves, flower and fruits	Chest pain, cold& fever, snake bite, scorpion bite, paralysis, asthma and delivery problems
5.	Gular	Fruits, leaves and roots	Asthma, dry cough, diarrhea, leprosy, maturations, increase secretion of milk and dry cough.
6.	Bail	Leaves, pulp, seed and root	Cough, ringworm, skin diseases, malaria, piles and sore.
7.	Chokond bush	Root, leaves and flowers	Body- stomach pain, child birth, bone fracture, eczema, cuts, indignation, jaundice, and skin disease

(Sources: Jagdhish Korwa/60/ Semra village / 15/03/17, KarimanManjhi/70/Gore village/ 16/03/17)

Bhagats have greater influence on villagers then doctors who prescribe allopathic medicine. Korwa communities with their long association with nature have gathered extensive knowledge

on medicinal plants and their properties, which they have used for treatment of various health problemsRamprwash Korwa planted most of the medicinal plants near his home in his own land like Bael, Karanj, Jamun, Munga, Gular, Kathal, Bail, Chok and many more. He also mentioned that he took medicinal plant parts like leaf, bark, branch, rood and whole plant freely from forest till 2005 after which restrictions were imposed by the forest act. 'We live in forest and use forest products for all purpose but now we can only enter particular area of forest and use forest products according to list of government.' '*Sarkar ka manana hai ki humlog jangal ko khatam karrate hain, Jangal baccha nahai. Par humlog se jangal ko kayse khatara ho sakatahai? Humlog to jangal ko puja karte hai, jangale humlog ko khana–pina, aarthic sahayta karta aur humra dawa-daru bhi jangal se hota hai fir humlog ku khatam karyge. Humlog to dahunge kaate the pedh ka par sarkkar to pura ka pura badapedh he kat raha hai, jo dawa me lagata bhai use bhi kat rahehai, unko to pata he nahi hai ki kon sa sadharan pedh hai aur kon sa aurvedit, isme unko jangal khatere me nahi lagata. Hamare sarkkar se newaden hai ki sarkkar humari jangal hume wapshkar de, humlog jangal baccha lenge aur jangal hume baccha lega'*.

'*Government says we are destroying the forest, so protect the forest. But I cannot understand what kind of harm is done to the forest by us, we pray to forest, forest give us food, our economy is based on forest and our medicinal needs are also fulfilled by the forest, then why will we destroy our forest. We mostly cut branches of trees but the government cut down entire tress. They do not differentiate between normal plants and medicinal plants while cutting them down. In this scenario government is also not saving forest. We are requesting government to return back our forests to us, we will protect our forest and forest will also protect us' (Ramprwash Korwa, 50, 20/04/17).*

Table 5.4, shows the changes in use of different healthcare services by korwa people. It is clearly seen that over the years korwa people are slowly shifting to western healthcare services in both villages.

Table: 5.4, Korwa people in both villages have taken treatments by different healthcare system.

	Semra village (80 households)			Gore village (43 households)		
Years/ Treatment taken by	Private clinic	Government hospital /PHC	Traditional healer or Bhagat	Private clinic	Government hospital /PHC	Traditional healer or Bhagat
2016-2017	27	19	77	12	8	42
2017-2018	32	26	78	13	11	42
2018-2019	37	24	76	17	12	40

(Source: Field Survey, 25/10/16 to 26/02/19)

Shifting cultivation and labor work has created problems not only for the preservation of the medicinal plants but also the knowledge, values and importance about the medicinal plants. Deforestation and forest act are most important factor involved in transformation of live style. Korwa people fear losing indigenous knowledge of medicinal plant and their uses. At present there are four traditional healers who belong to Korwa community present in the village but only two young people are interested to learn the traditional medicinal knowledge, most of younger boys go out of the village for work and they have no other option other than to choose biomedicine systems. Thus, the preference of the Government to promote biomedicines and healthcare on one hand and the decline in knowledge, interest and patients for the traditional medicines has a drastic effect on the culture and heritage of the Korwa community. The knowledge is already fading and soon it might be lost when it comes to traditional healing techniques.

Dai (Traditional Birth Attendant)

There are two Dais (traditional birth attendant) in Semra Village and one in Gore Village; most of deliveries are conducted by them. They act as birth attendants for all the villagers including the korwa. According to villagers, '*Dai ke kam sadiyo se chalet aaowaet hae aura age bhi chalat rahate'*.'Dai have been present for centuries and will continue'. Dais are very knowledgeable women regarding pregnancy and delivery. Mainly Daisbelongs to Chamar caste

(scheduled castes) but Korwa women are also interested to learn and do the same work. They do not perform any intraveneoustests for women to check if they have conceived, they touch women lower part of belly toascertain if the woman is pregnant and she also tells a tentative date of child birth. If mothers feel stomach pain during pregnancy, Dai massage the mother's womb with oil and identify the position of baby and sort out any other problems. During delivery, Dai could identify the position of the baby in the mother's womb by examining her abdomen. If the Dai observe baby (fetus) is not positioned properly then she massages with lukewarm karanj oil with is mixed with garlic to correct the same. The key role of a Dai is to assist the pregnant women during delivery with moral support and to cut the umbilical cord with new blade. The earlier practice was to cut the umbilical cord with an arrow. She gives oil massage from the day of the delivery till one month, two times dailyin themorning and evening to the mother and child.

According to Dai (child birth attendant at village), *'aaj kal awrate long ashpatal jaat hathen. Uhawaunka paisha milaey hae. Koi koi jen ke raat me darad hoye haie aur acchanak hoye haie jab unka ghar me koi na hoye hai, unhe log na apawey hathen. Paisa bahut hain akahelachort athinehamhuchahe he ki jaye lakin aspatal me dactore aur naruse acche se baat to dur dekha bhi na hathen humen jaatke. Bada ganda- ganda baat bole hathen jab darad uthehaie to. Laeka paeda ho gela par aise he choddewye hathen na koi teel malish na kuchu. Paisha itana mile hai ki parshute ke baad kahye pieye la ho ja hai maaelog ke. Inn sab me humen jo rasam nibhawye hale wo to khatam ho ja hai aur hospital me kar na sake he'. 'Noway's women prefer to go to hospital. There they get money. If labor pain starts suddenly at night with no one present at home, then they are unable to go to the hospital. The money which is received in the hospitals is a big factor for the women to go there, but they are not treated well in the hospitals by the doctors. They talk in very abusive languages when women are in labor. After delivery they are not given oil massage and there is also no moral support. But after delivery mothers have food and drink and enough money which is good. In between we perform some rituals and customs after delivery which is missing in institutional delivery and we cannot do them in hospital. Government also want people from rural and backward areas to use public healthcare facility, korwa women are also brought up with this mind set but they are also missing own cultural belief, rituals and customs after child birth'*(Kalwatiya Devi, 43 13/07/18, Gore village).

There are schemes launched by the Government which attach monetary benefit with opting institutional deliveries in public hospital. These are one of the major factors for the korwa women to choose western healthcare.

5.2 Western healthcare practice

In both the villages, Korwa people believe in traditional healing practices but they also show interest in biomedicine or allopathic medicine. If we talk about western healthcare practices, they use both public (government healthcare facility) and private healthcare facility.

(A) Public Healthcare Services

The public health services institutions are divided into three levels of care are Primary level care: Sub-center and PHC, Secondary level care: Community Health Center and hospitals, and Tertiary level of care: teaching hospitals. Under this there are three types of healthcare institutions namely, a Sub Center (SC) for 3,000 to 5,000 populations, Primary Healthcare Center (PHC) for 20,000 to 30,000 populations and a community healthcare center (CHC) as referral center for every four PHCs. District hospitals are functioning as a secondary level for urban population and the tertiary healthcare is to be provided by healthcare institutions in urban areas which are specialist doctors, well equipped with diagnostic systems and investigative facilities. Field villages which is in Semra and Gore in Chainpur block have three Primary Health Centers (PHC) but only one PHC is in working condition. But this PHC/CHC is 18 kms away from Semra village and 19 kms far from Gore village. Also, in this block there are a total of 34 sub-centers but only four sub-centers are under field area out of which only 2 are operational.

Table-5.5 show the others do not have any health providers like nurses and even ANMs. The two working sub-Centers only have ANMs and there is also the problem of shortage of medicinal equipment and medicines. The PHC has two doctors, one MBBS and one AYUSH, as recommended under IPHS. But this PHC and CHC are working together at same building but there are only two doctors; one is MO and other one is MBBS, and six nurses. The lab is not functional. There is no AYUSH doctor present. There is only one doctor coming regularly,

the other one is coming only on Tuesdays and Fridays, these two days are for conducting sterilization operations.

Table: 5.5, Primary healthcare in study area with available staff, department and laboratories:

Primary healthcare	Available staff	Department	Laboratory
Sub-centre	2 ANM	All prepuces	-------
PHC	1 MBBS, 1 nurse, 1 pharmacist, 1 ANM, 1 Health educator, Health assistant 1 female and1 male,1 Laboratory technician	MCH, communicable disease, general ward.	Malaria, pregnancy test, hemoglobin,
CHC	1 doctor, 1 female doctor come for sterilization (Tuesday and Friday), 5 nurse, 1 Ward boy, 1 Pharmacist, 1 Laboratory technician	MCH, Leprosy, Communicable disease, MNTC, General ward.	Malaria, Pregnancy test, Hemoglobin,

(Sources: Medical Officer (MO) who present in PHC/CHC, 09/02/19)

(a) Anganwadi centre:

Government launched an Anganwadi center in 1975 as a grassroots programto reach out to women in tribal and rural areas as well as the slums in the urban areas, to impart education on matters of basic health and promote knowledge about hygiene, nutrition, pre-natal and post-natal care. There are two Anganwadi centers present in each of the villages. Both AWC is functional and AWW are present at center but there are no availability of medicines and equipments except one small bottle of Dettol liquid, one roll of cotton and one bandage, which was not used. Overall hygiene of the center is not in good condition, the infrastructure is poor and toilet facility not available. Food items were of very low quality and they serve *khichadi* daily.

In Gore village there is two AWC, Mahuerpahad tola AWC was nearby Korwa community, but there were no basic equipments, tools and first aid box. Many times, there were no meals for

children and rarely lactating mother got any facility from AWC. This center was closed in 2017. In Gore village Anganwadi workers were present but one of the centers was not functioning. There are no essential equipments in center like medicine, books, toys and carpet. Korwa children come to this center because it is nearest to the living area of the Korwa community. Korwa community also does not know what kinds of facility they can provide. In all four Anganwadi centers which are in both villages, medicines were not available during the field work period. Anganwadi worker said that they do not have any kind of medicine provided by ICDS. Since 2018 AWC is closed. Facility of the center is used by children of others social groups as well but social stratification comes into play. Other social groups like OBC and SCs do not want their children to sit and eat with the Korwa children. Most of the families belonging to other social groups want sevika to arrange separate sitting facility at time of feeding. But according to sevika they cannot do this as children sit randomly. However, people of other social groups fought with AWW and this center was closed in 2018.

Mamata Devi (37*)*, belonging to OBC from same village is working as an Anganwadi worker since 2005 in AWC of Semra village. She is not provided with any equipment; medicines and first aids box by the government and also does not receive regularly meals. She mentioned that when she joined, equipments were not in good condition but food items were received on time, but now the food aren't received in good quantity or on time. They receive it once in two or three months. In this situation they have shortage of food items so they do not provide to the lactating mothers and children. Villagers protest and sometimes they even come to the center with sticks to fight. She also mentioned that the salary of the anganwadi workers was irregular. (Mamata Devi, 37, 23/03/17 & 27/12/18, Semra village)

Researcher observes lack of equipment, medicine and studying materials for the children at anganwadi centers at the study area and they have been converted into feeding center. Researcher visited twice each AWC, but not once did any AWC have any educational activity; children were playing randomly and waiting for food. Once they received the same, some ate there and others packed it to eat at home.

According to her, ANM comes every second Friday (Tikka Karan Divash) in a month; she conducts ANC and PNC check-up and gives food supplement for pregnant and lactating

mothers also on the same day. Korwa women do not take injection (TT) and allopathic medicine. There is a perception regarding injection and medicine that if they take injection then they will have fever and the fetus will be bigger in size and it will be difficult at the time of delivery. Sevika keep requesting the women to take the injection but Parhaiya women do not take health care services seriously. Before 2017 very few pregnant women received ANC check-up but after 2017 maximum women came for ANC, reason being restriction on maternity benefit without the same. At present women are also interested in ANC check-up even if they are not eligible for maternity benefit. (Mamata Devi (37), Semra village, 12/02/2017).

(b) Sub-Centre

Semra village Nawadh sub-center and Gore Nawadhe sub-center have two ANMs each. The center lacks basic facility like, electricity, water supply, bed and nurses. According to ANM, there are no boxes to keep medicines and equipments. The equipment is notin good condition and medicines are not available. Sphygmonometer was not in a working condition from the last six months. People come to center from nearby villages. Patients aresuggested to go to PHC Chainpur but they do not visit there, so far PHC/CHC is in working condition. After consultation the patients take medicine from the private healthcare providers.

(c) Primary Health Centre:

Nearest Government hospital is primary health centre (PHC) Chainpur. PHC Chainpur has a major role to play in the transformation in healthcare facility. In Chainpur there are a total of three PHC but only one PHC is in functional condition and share same building of CHC. After introduction of NRHM and maternal benefit program many women who belong to rural areas including the study areas are interested in institutional delivery. Reason being the lack of traditional healers, Dai and case benefits. Child birth is a very important event for every community; they carry beliefs, customs and rituals with child birth. The use of PHCs for the same has an effect on the beliefs and the customs of the community. Thirteen Korwa women from Semra and seven women from Gore village delivered baby in the PHC Chainpurin-

between 2017 and 2018. Others came for all kinds of health-related problems, like tuberculosis, malaria, fever, diarrhea, cough & cold, and fracture.

In Chainpur block there are three PHCs but only one PHC is in working condition. The other two are in bad condition and do not have any health provider like doctor, nurses or even ANM. Only one Primary health care center is working condition, which is called community health center and primary health center Chainpur block. There is a PHC with CHC running in the same building, deliveryward; sterilization center (family planning operation), malaria center, tuberculosis center, leprosy center and malnutrition treatment center (MNTC).Resources available at PHC/CHC in Chainpur are following:

1. In this CHC/PHC have good infrastructure and proper sign board, human resource, facilities, drugs availability and management capacity for the health care.
2. Toilet facility is not in good condition or clean, two toilets are in PHC/CHC one for staff and other one are for all patients. Water, regular electricity with generators back-up, land line phones and mobiles connection for ambulance are available at PHC.
3. At PHC 5 rupee is charged for every patient.
4. This facility has proper arrangement for seating for OPD patients, ANC registration facility are also available.
5. Approximately 4-5 deliveries are conducted every day at PHC. There are 15 beds in delivery ward.
6. Beneficiary mothers are discharged with child birth certificate and cheques for payment of the monetary benefit.
7. The labour room, OT, cold chain, and OPD are in good condition and are well maintained.
8. In this PHC thirty women have undergone operation for sterilization in a week but no bed was available for family planning operated women. This PHC/CHC caters to a population of 2,24,423.
9. It is open 24*7. At night two nurses are present and doctor comes in case of any emergency.
10. Child immunization has been about 87% till December 2018.
11. Diagnostic facility is very poor like no lab facility, poor equipment and poor quality of slide preparation for examination for malaria. There are two Laboratory technicians and tests are done for malaria, haemoglobin and pregnancy.

12. The PHC has two doctors, one MBBS and one AYUSH, as recommended under IPHS. But as this PHC is converted in to CHC there are two more doctors one is MO and other one is MBBS and six nurses. Only one doctor comes regularly, other one comes on only Tuesdays and Fridays, these two days are for conducting sterilization operations.
13. Obstetrician, surgeon and anaesthesia are available at CHC.
14. CHC had facilities for medical termination of pregnancy.
15. At PHC/CHC drug availability is good in fact available in stock and refrigerator and deep freezer for vaccine storage is also available but blood storage facilities and X-Ray facility are not available.
16. Two ambulances are functional and are in good condition but at night they do not work due to connectivity issues.

According to respondent in the study area health care facilities and utilization of primary health care is low particularly among the Korwa community due to poor economic conditions, distance of PHC, lack of transportation from village to PHC and attitude of health providers. Among a smaller number of women come for ANC, child delivery and PNC but last two to three years numbers have increased for ANC and delivery among of them. (27/12/2018, at PHC)

According to Sahiya, Korwa women are very poor and have repeated childbirth, women are in worse condition regarding health perception. Mostly mothers of Korwa community, who deliver baby in PHC/CHC, are interested in money, which is given by JanineSuresh Yojana (JSY). Before 2017 they received Rs1, 400foreach delivery but after 2017 they receive Rs 6,000 for first two deliveries with the condition that the mother should be above 18 years. There are few women who do not complete their ANC but go for institutional delivery just to receive cash benefits. Most of these women had already delivered two or three children and it does not make any difference to them if they deliver at home or a hospital but these big amounts push them for institutional delivery. Six thousand is very big amount for them, government gives them to promote institutional delivery of the babies and mother and child care after delivery.

Table 5.6 shows that the Korwa people prefer private clinics to government hospitals. The first preference is traditional healthcare that is available in the villages. Korwa people when not cured by traditional healers move to western healthcare faculty for any kind of health-related problem. Dr. Pankaj Kumar runs a private clinic in Ramghad panchayath which is 2 km far from Semra village and 3 km far from Gore village. According to korwa people distance is a major factor to not take public healthcare facility.In 2016-17 total 46 Korwa people from Semra and 20 from Gore village and in 2017-18 total 58 from Semra and 24 from Gore village and in 2018-19 total 61 from Semra and 29 from Gore village Korwa people took western healthcare. The interests of the Korwa have increased in western healthcare (Allopathic Medicine) over the years.

Table: 5.6 Western Treatment Taken by Korwa Community for various illnesses:

	Semra village (80 households)			**Gore village (43 households)**		
Years/ Treatment taken by	Total	Private Clinic	Government hospital /PHC	Total	Private clinic	Government hospital /PHC
2016-2017	46	27	19	20	12	8
2017-2018	58	32	26	24	13	11
2018-2019	61	37	24	29	17	12

(Source: Field Survey, 25/10/16 to 26/02/19)

2. Private Clinic

Ramghadh Panchayat has two private clinics one is run by Dr. Pankaj Kumar and other is Dr. Ramjanam Yadav, none are MBBS but villagers call them doctor sahib. Dr. Ramjanam Yadav belongs to Semra village and Dr. Pankaj Kumar belongs to gore village, both are popular and reliable health practitioner after Bhagat in both villages. According to Korwa people, Dr. Ramjanam has his own clinic at Ramghadh and at home also, he gives treatment for illness like fever, cold, cough, malaria, jaundice, diarrhea, gastric, tuberculosis, asthma, stomach pain, joint pain, constipations and eyes, ear, mouth complications. He charges hundred rupees visiting fee and charges separately for medicine. His treatment is good and he treats the patients in a good

manner. He also visits at home if needed. Most of the mothers are taking TT injection after home delivery by him.

According to Fhaguwa Devi (38), '*if we are having any kinds of health-related problems and we think about treatment, first Bhagat (Traditional Healer) comes in our mind. We always give first preference to bhagat. If we are not cured in ten to fifteen days then we go to Dr. Ramjanam. Most of us take treatment from him. After that we go to PHC/CHC in Chainpur. I only went ones to PHC/CHC Chainpur for my treatment. I am suffering from TB (Tuberculosis) since last three years. Since last year I am taking medicine from there but my problem is still continuing. I am also taking medicine from Bhagat'* (Fhaguwa Devi, 38, 10/04/18, Semra village)

According to Umesh Korwa (28), *'I am not taking treatment by the Bhagat; two years ago my mother had fever, Bhagat treated her but she got worse. Later bhagat said she will not survive wherever you take her ("Ab nahi baccheyge jaha kahi bhi lekar jao"). After that we got treatment for her through private doctor. He too said that if we had come to him earlier then he would have tried to save her but we went to bhagat and the conditions had worsened now. (Agar Tum PahaleAate to Bachaya ja SathaTha Par Tumlog Ko Bhagat ke Pass He Jana Hota Hai, Jab HalatKharab ho Jata Hai Tab Aate ho Fre Pass). Then I decided I will not go to Bhagat for treatment but for religious purpose I will always follow him'*.His daughter had been suffering from fever since last three days, and he is taking treatment from private doctor *(Umesh Korwa, 28, 8/3/16, Gore village).*

In the study area Korwa people are in a stage of transforming regarding health system. 23 villagers in the Semra village and 17 villagers in Gore village, the head of house share a story to take allopathic medicine and public healthcare services in last three years but they are also taking treatment by Bhagat. Everyone believes in indigenous practices.

Jagdhish Korwa (65), *Humen aapn zondagi me bahute kuch bahute kuch badalate dekhale he. Humen lag e jangal he sabe kuch halae sab kuch jarurat ke chize wahi se ho ja hale. Kahye ke, fal-sabji, lakadi and jadi-buti sab jangal se, khali nemak aur kapada lagi bazaar ja hale, uho kharede hale jangale se lakadi, kanda, gadhi sab beccheke he lewey hale. Pahele hamen jangal se janwar mar ke du- teen deen par kha hali aaj to mahina me ekbaar mass khayeke mile haie.*

*Lakin abhi humen jangale na ja sakey he, na humen khayeke janwar mar sake he na he jangal se jad-ibuti le sake he' (*Jagdhish Korwa, 65, Semra village*)*

The important thing to understand here is 99.95 % of Korwa people use traditional healthcare services in both study villages. Due to a lack of communication and western medical facilities, indigenous healthcare services have been used from generation to generation. They believe every disease has a link with god and evil spirits and the use of medicinal plants will cure them. Most of the Korwa people do not accept any other medicine until traditional healers give them suggestions. They are dependent on traditional healthcare services and healers (Bhagat). After the introduction of the Forest Act, most of the Korwa people moved out for work in cities that are away from the village and are out of the state also. There is no other option except for western health services. At present slowly there is a shift and they take healthcare facilities from western healthcare. The Korwa people's faith ad beliefs are also changing due to urbanization and industrialization.

Perception of existing health system among Korwa

The perception of the health system partially depends on the availability of and accessibility to health facilities. The Korwa Community has relied on traditional forms of medicine since long and they still continue to do so. But over time due to various internal and external factors, the availability of such medicines and healthcare has been on a decline. The interest of the medical practitioners has been declining as well which further has led to the unavailability of Bhagats or traditional healer. In such a situation the community moved away from the traditional practices over the years and has started relying on biomedicines. Also, the policies of the government aimed at benefiting the people who sought out biomedicine, which has contributed to the shift. The younger generation relies and believes in the western healthcare facilities more comparatively and there has been a steady rise in the numbers who avail these facilities. Unfortunately, the western medical facilities came with their own challenges with regard to availability and affordability. Western healthcare had inherent problems like long hours of travel and lack of availability and accessibility. This is coupled with issues like interdepartmental rivalries, inadequate manpower, poor implementation of schemes, poor connectivity to the plains, exploitation, land alienation, poverty and illiteracy which overall make the use of modern medicine more challenging.

At present, the condition of the Korwa community is dire as they are stuck in the middle of a shift in terms of healthcare facilities. Over time the traditional forms of healthcare that were readily available have been becoming elusive and on the other hand the there is an influx of biomedicine in their environment which is not backed by proper supply chains to make it easily available or affordable. The reliance of the community has been increasing in this scenario on the private doctors and practitioners who are available in the villages or closer proximity compared to Government facilities.

CHAPTER:6

Healthcare Practices Related to MCH and Communicable Disease amongKorwa

There have been several changes over the years concerning healthcare practices for maternal and child health and communicable diseases. Maternal and child care is an important aspect to define the healthcare practice of any community. Every community has its own belief or notion about healthcare practices related to maternal and child health and disease. Existing healthcare practices in every community depend on availability, accessibility, affordability, and acceptability. People of the community are influenced by socio-cultural and economic context; culture explains not only the cultural understanding of diseases, it also explains how people respond to illness in traditional and westernhealthcare system. The health culture of the community has a belief system about health and illnesses. The community responds to ill-health and also provides cultural significance to illness causation, symptom recognition, and categories of disease and treatment.

The factors which influence health-related problems of the Korwa community are socio cultural and economic in nature. The health status is dire due to a multitude of factors like prolonged poverty, illiteracy, unavaibility of safe drinking water, poor hygienic and sanitary conditions and lack of knowledge about the same, malnutrition and poor healthcare services which is compounded by deforestation and a difficult terrain. The diseases like sickle cell anemia, upper respiratory problems, and malaria gastrointestinal disorders like acute diarrhea, intestinal protozoan, micronutrient deficiency, and skin infection are common among PVTGs providing nutritional food, medical facilities, and health awareness on time can prevent many of these diseases.

This chapter is divided into two parts; the first deals with healthcare practices related to maternal and child health and the second part deals with healthcare and disease such as, the process by which Korwa community identify disease and illness, the role of local healers and their treatment practices or continuance of traditional practices along with public healthcare services in the changing social context with time in the Korwa community.

Maternal Health Status of Korwa Women:

If we explore the healthcare facility of maternal and child health, we have to first understand the health status of Korwa women. Korwa as a community is vulnerable in which the situation of women’s health is much more vulnerable and worse. Various dimensions of heath affect the

status of tribal women like living patterns, food habits, sex-ratio, female literacy, marriage practices, age at marriage, age of mother at first conception and life expectancy at birth.

In both villages, Semra and Gore, the age of marriage in the Korwa community are very early, generally the marriageable age of girls is about 13 to 15 and boys' age of 18 to 20. A girl is ready to marry after she has started her menstrual period but early marriage before menstruation is also known. They are malnourished and their dietary intake is not adequate to balance their heavy and hard physical workload. Korwa women with poor health and nutrition have a higher probability of giving birth to an underweight child. They are also less able to provide food and sufficient care to their children. While malnutrition is prevalent among all segments of the population (child, young, old age), poor nutrition among women is there since childhood.

The researcher divided the maternal heath related respondent into two age groups first is a younger mother (age group is 18 to 40) and the second elder mother (age group is 40 above). In the Semra village, there were a total of 65 respondent mothers. Of these 43 are younger and 22 are elder mothers. In Gore, there were a total of 43 mother respondents of which 28 are younger and 15 are elder mothers. There is no change in the earlier and recent situation regarding the age of the first childbearing.

According to the respondents, women tend to neglect their general health, during pregnancy, childbirth, and post-partum. Women from this area complained of frequent headaches, dizziness, cold, cough, body pain, and joint pain but they are not treating it as a serious complication during pregnancy. For these complications, they usually take-home remedies that are given by their mother-in-law, father-in-law, or the Bhagat. They visit the health center when the condition gets worse. However, they did not mention it as a health problem but said that like any other woman they have frequent headaches, dizziness, and body pain. That is normal for women. Five and three women are belonging to Semra and Gore village respectively suffering from tuberculosis during pregnancy. Transformation in healthcare services related to MCH can be divided into three times period; first post-independence to before JSY, second is the period of JSY (Janani Suraksha Yojana) and third is the maternity benefits program.

6.1 Post-independence to before JSY (Janani Suraksha Yojana) 2005:

In the period from post independence to before Janani Suraksha Yojana, women expecting to become a mother brought joy and the whole family and community were involved. Healthcare practices started with the elder woman of family, Dai (Traditional Birth Attended), Bhagat, and Ojha (Traditional Healers). Public healthcare services did not reach to them properly in this period. The elder woman of the family acted as a guide for pregnancy, childbirth, and child care.

(a) **Identification of pregnancy:**

Pregnancy brings a significant change in the life of a woman. A pregnant woman is known as*Asra* or *Peat se*. According to elder women (age fifty above), Korwa women do not know when they become pregnant but certain symptoms help them to understand pregnancy. Korwa women believe that the stoppage of the menstruation cycle approx fifteen to twenty days, frequent vomiting, excessive fatigue, enlargement of breasts and frequent urination are signs of pregnancy. If they conceive for a second time then stoppage of the menstrual cycle and mother-milk are clear indicators of pregnancy. Pregnancy was one of the valuable stages in which an important role was played equally by the elder women of the family or community, Dai or traditional birth attendant, and Bhagat or traditional healers.

(b) **Restriction during pregnancy:**

As soon as a woman comes to know that she is pregnant she has to follow many restrictions and taboos. Elder women give suggestions and take care throughout pregnancy. The pregnant woman lives a normal life but she takes certain precautions and avoids movement and activities to save the child as well as herself from evil spirits and other dangers. The restrictions imposed upon the pregnant women have been followed from generation to generation like

a. Pregnant woman is not allowed to visit a forest after sun-set not to pass by places where there are evil-spirits.
b. They are not allowed to go near many giant trees, which are supposed to be the abode of *Dakin*.
c. They are not to sleep in open places. It is believed that an evil spirit will destroy the child in the womb.
d. During the period of Suryagrahan (Solar eclipse) and Chandragrahan (Moon eclipse) the pregnant women are not allowed to come out of the home, she is to lie down in the bed or stand in a corner of the house and stay in a straight position, not cut any vegetables and fruits. They

believe that if the same is not followed then the baby in the womb may get physical abnormality.

e. She avoids strong light, sound, rain, thunder, and jackfruit.

According to Gudiya Devi (17), '*when she was pregnant for the first time her mother-in-law instructed her on what to do and what not to do during pregnancy. During pregnancy chandragharhan happened, her mother-in-law gave instructions not to cook food, and at the time when chandraghrahan starts, she was to stand straight in a corner at home without taking any kind of food and water till the end which is approx three hours. After that, she was to take a bath and have food and water. She also mentions that she never went out after sunset, did not eat joint fruit and vegetables, and sleep in a room (in summer most of them sleep in an open place which is inside the house at night (Aangan)) during pregnancy'*. (Gudiya Devi, 17, 11/04/18, Gore village)

(c) **Food during pregnancy:**

Food for every pregnant woman is very important and defines the good health of mother and child. In the Korwa community, they only avoiding jackfruit otherwise no such restriction is imposed on food and they do not take any special food during pregnancy. Food is entirely dependent upon the economic conditions of the Korwa community even during the period of pregnancy. Maheshware Devi (62) said, *"When I was pregnant around forty-eight years ago, we had lots of food and meat from the forest but now we do not have sufficient food and wild meat. We have food only for living"* (Maheshware Devi, 62, 13/02/19, Gore village).

Sone Devi (20) *said she ate pieces of earth from earth stove throughout pregnancy, other women are doing the same. She said, "Humaraekarsuganghaurkhaye me badhiyalagehaiehe la khae he". I eat because it feels tasty and smells good* (Sone Devi 20, 11/02/19, Semra village)

(d) **Work during pregnancy:**

Like every woman, the women in Korwa are also advised not to do any hard work during pregnancy but they work very hard throughout.They believe that doing work during pregnancy will keep the body parts flexible which will lead to easy delivery. They have land but not for agriculture, so women go to the forest daily and also do very heavy work at home. They are doing daily domestic work even they carry branches of wood which is around twenty to twenty-

five kg for sale in the market on their head, they also have to go to the forest and the field for collecting roots, tubers, and for other fieldwork. Domestic work like bringing firewood from the forest, drinking water from the river or well or hand pump, cook food, cleaning houses, and utensils.

Smita Devi (38), '*eight-month pregnant at the time; had a total of seven pregnancies. Out of that four children were alive, had one miscarriage in the fourth month and one baby died after childbirth. Her past deliveries were conducted by Maharini at home. She was a worker as an agricultural labourer; she went to Bihar with her husband and children. She returned home in the seventh month of pregnancy. In Bihar, she did all kinds of work like dhanboae (rice planting), dhan katana (cut rice) and dhandhona (dhan shifting) and at the village she was doing work like, collecting firewood and edible food from the forest, collect water from the water pump, cook food, cleaning the house and all household work. At present, she is suffering from weakness, body pain, and stomach and back pain, and is taking treatment from Bhagat. She never had a belief in Sahiya, ANM, and public healthcare service and any kind of health-related problems she contacts with Maharini and Bhagat'* (Smita Devi, 38, 08/04/2018, Gore village).

Korwa women during pregnancy do not take time off for rest and care and they believe in the engagement of work during pregnancy will help less pain during childbirth *'kam dam karte rahane se baccha payda hone time takalife kam hoyehae'*. They are advised to take precautions and avoid lifting heavy and doing bending works by elder women and Maharin. But in the study villages, korwa women have to work till the advance stage of pregnancy for livelihood.

Kalawati Devi (28), '*I am a mother of four kids and my husband is working in Bangalore but he did not send money last month so I have to work to fulfil family needs. Yesterday was a day like every day, I woke up in the morning at 4 o'clock and did all the households work, and at 9 o'clock I left the village with seven people from the village for Chainpur. I was lifting a bunch of wood (which was collected from the forest day before by her) over the head and walk for Chainpur market to sell wood (aprox 20 km villages to Chainpur market in short distance). I sold wood aprox 20 kg for 350 rupees and after that, I went shopping for households needs. When I was in the market, I started having labourpain; my friend took me to the PHC of*

Chainpur for delivery. My friend left the hospital after admitting me to inform my mother-in-law. After 30 mins I gave birth to a baby girl. The next day my mother-in-law reached PHC. I was not taking rest during pregnancy and every woman did the same work throughout the pregnancy because of the poor economic condition of the family' (Kalawati Devi, 28, 15/03/17/ At PHC Chainpur)

Total of 22 women were pregnant in the year 2018 from both village, husband of nine women out 22 women were migrant workers. So, all the workload came upon the women, women of the study area work all the seasons and during pregnancy till delivery for the survival of the family.

(e) **Health related problems during pregnancy:**

Traditional healers (Bhagat):

Traditional healers are present in both villages who were knowledgeable persons regarding diseases and treatments. At one time traditional healers were the only facility for healthcare for the Korwa community. Both study villages were and to date rich in forest products and there are various types of medicinal plants. In these villages, every Korwa person has fair knowledge about various medicinal forest products and there uses. Korwa communities through their long association with nature have gathered extensive knowledge of medicinal plants and their properties, which they have used for treatment for various health problems and complications. The respondent said that generally Korwa women experience irregularity in the menstrual cycle, white discharge, fever, weakness, bleeding during pregnancy, vomiting, dizziness, anaemia, stomach pain, pelvic pain, malaria, and diarrhea. They generally get treatment from the Bhagat. Medicinal plants are used in different forms like paste, powder, kadha (juice form), raw plant parts, Goli (a form of Tablet) and massage oil. The most common form the medicinal plants are kadha and goli that is made by them.

According to Rajkuliya Devi (70), *Bhagat listens to all the complications told by the mother-in-law who always accompanies the young women. After listening to the complications, the Bhagat said "I will treat her with herbal medicine and also offer spiritual prayers". She said the Bhagat demanded chicken, alcohol, goat, and food but with time they started taking money starting from Rs. 2 which increased to 100-300 at present. She also mentioned that Bhagats are very poor as they are only doing the treatment, if they do not take money than they will die*

ofhunger. Bhaga treats irregular periods, white discharge, blood loss, leg pain, stomach pain, pelvic pain, loose motions, and issues relating to family planning. One of the common complications during pregnancy was/is bleeding during pregnancy. Bhagat gives her some herbal liquid (Kadha), oil, and Goli made by him. (RajkaliyaDevi, 70, 12/01/17, Semra village)

Table: 6.1, Problems Related to Pregnancy Treated by Bhagat

Sl.No	Problems Related to Pregnancy Treated by Bhagat	How to be Treated	Time Take
1	Blood problems related to Pregnancy	Herbal	8-10 Days
2	Miscarriage	Spiritual/herbal	2 week
3	Irregular periods	Herbal	2-3 Months
4	White discharge (WD)	Herbal	2-3 Months
5	Stomach Pain (during pregnancy)	Herbal	2-4 Days
6	Pelvic Pain (post-partum)	Herbal	1-2 Weeks
7	Weakness After Child Birth	Herbal	1-2 Weeks
8	Loose motion (dysentery)	Herbal	2-3 days
9	Malaria	Herbal	1-2 week
10	Family Planning	Herbal	One week

(Source: Field Survey, Traditional Healers or Bhagat, 25/10/16 to 26/02/19)

According to Bhagat '*KarimanManjhi, age 70, irregular periods, bleeding during pregnancy, urinary tract infection, body pain, and stomach pain are common health complications that affect Korwa women. Weakness during pregnancy happened to most of the women. Malaria is also common generally or during pregnancy which is a big issue. Suffering from excessive bleeding during pregnancy was reported by twenty-two and fourteen mothers respectively in Semra and Gore village. All prefer treatment from Bhagat and at present, very few women took treatment from PHC (KarimanManjhi, age 70*, Gore village, 15/03/2017)

Korwa women are confirming pregnancy after three months to the community due to the fear of miscarriage and evil eyes. Miscarriages are very common in the study area. Women who have experienced more than four pregnancies have gone through at least one miscarriage. In the Semra village, 47 women out of 65 and in Gore 28 out of 43 respondents had miscarriages. The daughter-in-law of Fagune Devi (38), died due to miscarriage. According to her, her daughter-in-law during five to six months of pregnancy did all households and forestry work but she never complained about her health. One day she went to the forest for wood but in the forest,

she had a miscarriage and had heavy bleeding. After two days she died. In the case of miscarriage, women go to Bhagat for treatment. Korwa community depends on traditional healers and home remedies for treatment during pregnancies. Bhagat gives them some herbal medicinal '*kadha*' (liquid) to drink in the morning and at night and oil for massages on the stomach which is to be done with the help of an elder woman. He treats these conditions with a combination of medicine and spiritual interventions that includes praying to ancestors. He also maintains Korwa women are engaged in hard work in the forest and household throughout pregnancy and they do not take proper food and rest so stomach pain, bleeding during pregnancy and body pain are common. They do not take these issues seriously, they say *"ye to hota he hai peat se hone par nayakyahai*" these happen when we get pregnant, nothing new in this (9/02/17, Gore village).

At the time of delivery if women face complications like delay in the birth of the child the mother-in-law goes to the Bhagat for some herbs. Bhagat gives her Jadi which look like a plant root which is required to be tied with mother. But it has to be used with extreme care as it is believed that if the jadi remains attached to the body even after a minute of the birth of the child it may lead to the discharge of other body parts also.

Presently they have a big issue with family planning among the Korwa community. Among the respondents, seventeen women and six men wanted to have Family planning operation but they are not getting operation at PHC because PVTG communities are very small in numbers so it has been banned by the Indian Government. They have traditional methods to control pregnancy but it is not effective comparatively. Bhagat gives a medicinal root (name not mention) to soak in water and drink for women after intercourse. Women believe that if after intercourse they urinate then there is very little chance to conceive. At the age of 40, every woman has experienced seven to eight children, at this age mothers as well as the child are more physically vulnerable.

The Korwa community has its own indigenous and traditional medicines for common pregnancy-related health problems, for instance for loose motions (Dysentery), a new guava leaf is eaten early in the morning, for leg pain massage with karanj oil and for white discharge (Dhat) they make a paste with old gud (Jaggery) and root of juli flower. At present Korwa

women are interested in the public healthcare facility for maternal care but at the same time, they also believe in Bhagat

Birthing Practices:

Traditional Birth Attended (Dai or Maharin): Pancmati Devi (45)

Dai has a very important role to play during pregnancy, health-related complications like stomach pain, back pain and to check movement of the baby. Dai is usually called at the time of delivery; they are not trained but are experienced. In both the villages women generally delivered babies at home but after 2016 they started going for institutional delivery (PHC). In 2015-16 total of 17 women were pregnant in Semra village 14 were delivered at home and 3 were delivered in public hospital and similarly, 7 women were pregnant in Gore village; 4 were delivered at home and 3 in hospital.

Elderly women and Dai of the house conduct delivery at home. The researcher requested to observe the birthing practice, a family member agreed but Maharen (Dai) did not agree, she said they do not allow everybody so that the mother and child is protected from evileye (Nazarlagna or Buri nazar). Only mother-in-law or close family members are allowed, after delivery, you can see the mother and child but not during delivery. The researcher followed the instruction and waited and watched from outside the delivery room. During labor pain, Dai ascertains whether the pain is real or a false alarm. She massages the stomach of pregnant women with oil and then confirms if it is labor pain and the stipulated time of birth. If she identifies that the baby is not in the right position for delivery than she massages with oil for to correct the position for delivery. Generally, birth is conducted on the floor, women lie on a *Bora* or jute mat and old *Sujani* or homemade cotton mat. Maharin prays to god for the safety of mother and child. 2 hours later the baby was delivered and she the umbilical cord was cut using a new shaving blade or one-rupee coin but earlier they used Haseya (arrow) in case of boy and knife in case of a girl. After that, they give a bath with lukewarm water and turmeric to the newborn baby and cover the baby with an old cloth. Approx an hour of birth, the child is given goat milk or cow milk. They dip a cotton cloth in milk (they mix water with milk for easy digestion) and put a few drops in the child's mouth. Korwa community believes that colostrumsis harmful to the newborn that is the reason they do not give the first milk of the

mother to the child. She said *'Maai ke pahele dhudh kharab purana aur pila rang ke hoye hai je kara karan humaen na deywe he baccha log ke. Bakkare ke dhudh thik rahe hai bacchalage. leykin aspatal me to wahi dhudhwa piwaye hathin bakkae ke dhudh deyw se mana kare hathin. Doctorlog ke aapn ilaz humen ke aapana reete – rewaz'*. The first milk of the mother is not good; it is old and had a yellow color so we prefer not to give it to the child. Goat milk is best for a newborn child. But in the hospital, they give first milk; they do not advice to give goat milk. Doctors treat in their way and we follow our customs (Pachmatiya Devi, 45, 20/03/17, Semra village).

Under the age of eighteen, almost all Korwa women conceive their first baby. Before 2014 very few women were going for institutional delivery and they did not take ANC and PNC, all deliveries were done inhome. Home delivery was conducted mostlyby theMaharen, she always belongs to the chamar caste (SC) and they work from generation to generation.

Food restriction is common in the Korwa community, particularly in this village. After childbirth, for around 5-6 hours the mother will not be given anything to eat. After that, they are given only turmeric paste and halwa for 5-6 days. Then on the bathing ceremony (after six days of birth they perform Chatiyare Puja) mother takes rice and '*daal'*. After childbirth women cannot go out for defecation from the room of '*Sawari Ghar'*. Elder mothers clean all the feces due to a belief that if the mother goes out of this room before '*Chatiyare Puja',* then evil forces will attack the mother and child. As a result, the mother may get ill and maybe she will die. As mothers are very weak during this period and can be easily attacked by evil.

Dai perform post-delivery traditional rituals along with elder women of house or community. Post-delivery mother will be not entering into the kitchen till the umbilical cord gets dry or Chatiyare Puja. If the new born baby does not cry after birth they whisper a traditional song in its ear, drop water on its face or hold it upside down by the legs to make it cry. After the delivery mother will take one meal in the case of a baby boy and two meals in the case of a baby girl, the reason being whatever the mother eats, the baby takes through mother milk, the baby boy can't digest heavy food but a baby girl can. Dai assists in most deliveries and stays with the mother for six days until the Chhatiyare puja celebration.

Chhatiyari puja is the day of celebration. On this day people come to see the mother and the child and give them blessings. This day mother and child take bath assisted by the Dai and elder women of the family, after which they perform rituals to protect against evil and sing a traditional song. On the day of childbirth, she gives the mother and baby regular bath and massage, washes the soiled clothes, massage three times in a day for the mother, and five times in a day for the child till fifteen days. For all the work done by Dai or Maharen she receives grain, money, cloth, and hadiya (local liquor) according to the economic status of the family. Dai is to date an important healthcare provider among the Korwa community in both study villages.

Janani Suraksha Yojana:

In April 2005 JSY was introduced which is a safe motherhood intervention under the National Rural Health Mission (NRHM). The main purpose behind this yojana is to encourage the poor and rural pregnant women for institutional delivery and reduce the mortality. Poor women who have BPL card receive Rs.1,400 (NHP admin/ NHP CC DC/ 07/10/19). Korwa women were not interested in institutional delivery when JSY was launched. After 7-8 years, in 2012 first women delivered a boy from Semra village and in 2013 from Gore village. That time many Korwa women did not have BPL cards and they did not get any kind of money from PHC. Money is the only reason for institutional delivery otherwise they believe in-home delivery as it is cheaper and convenient compared to PHC.

Three women in Semra village and one in Gore village had delivered at home in the last six months as on 26/2/19, all deliveries were conducted by Dai and elder women of the family member. According to elderly women (respondent), in earlier times childbirth was conducted and all rituals and customs were performed by the Dai with help of the mother-in-law. But at present times younger women and first-time pregnant women mostly want to go for institutional delivery as there the nurses conducted deliveries at PHC/CHC and ANM conduct the deliveries at the sub-center. In this situation, no one is interested to do the work of Dai and the rituals are also not followed in the hospital. Slowly they are losing both the Dais and rituals.

Institutional Delivery:

Transformation in healthcare relating to Maternal and Child Health came after 2017 in the research area. When the researcher reached the study village in September 2016 there were very few (five) women who were interested in institutional delivery but in March 2017 every woman knew about the maternity benefits program and they were more interested in institutional delivery.

Table: 6.2, Delivery Place Changeswith Time of Both Villages

	Semra village			Gore village		
Years/ Treatment taken by	Total delivery	Home delivery	Government hospital /PHC	Total delivery	Home delivery	Government hospital /PHC
2015-2016	17	14	3	7	4	3
2016-2017	16	11	5	9	5	4
2017-2018	13	5	8	9	3	6
2018-2019	15	4	11	7	2	5

(Source: Field Survey,25/10/16 to 26/02/19, * Year Count by March to March)

Very few institutional deliveries had taken place in both villages till 2016; three from Semra and two from Gore village in 2015 to 2016. Not one woman took ANC and PNC checkups from ANM or PHC. Only five women took ANC checkup by ANM at the village but not one took PNC (2015-16). The decisions regarding utilization of ANC and PNC services made by elder women of the family. According to elder women, those women took tetanus toxoid (TT), iron and folic acid tablets which lead to a larger baby and also increase the weight, however at the time of delivery the women get in trouble. *'Agar shuee aur dawae jo aurat khate hai unka baccha ka wazan aur lambai jayda hota. Jiske karan jaccha aur baccha dono ko khatarara hata hai jaan ka. Baccha attak jata aur kabhi kabhi baccha ka naas ho jatahai'*. If pregnant women take injection and medicines then her child will be bigger and fat in the mother's womb, this will lead to be trouble for mother and fetus. The fetus will be stuck at the time of delivery and at times dead fetus was delivered. If pregnant women do not take medicine, the fetus is of normal size, so it is easier for delivery and that is the reason we are not advising to take medicine and injections. According to the respondent, five dead fetuses were delivered before 2016 and these fetuses died during delivery. All deliveries were done at home.

Table: 6.3, ANC and PNC status of village.

	Semra village			Gore village		
Years	Total pregnancy	ANC	PNC	Total pregnancy	ANC	PNC
2016-17	16	9	----	9	5	----
2017-18	13	11	7	9	8	5
2018-19	15	13	9	7	7	6

(Source: Field Survey, 25/10/16 to 26/02/19)

In both the study villages there is almost the same interest in ANC and PNC check-ups. ANC and PNC check-ups increased since 2017. After Pradhan Mantry (2017) maternity benefits program launched ANC and PNC have increased.

The preference for a healthcare facility is almost the same in both the villages and it depends on their beliefs, the nature of the diseases, and the financial condition of the families. In case of minor health-related problems during pregnancy like swelling of feet, vomiting or weakness, bleeding during pregnancy, abdominal pain, white discharge, and diarrhea, the women at first contact Bhagat, then an ANM/ AWW, and lastly doctors. For diseases like malaria, tuberculosis, piliya rog (jaundice), and heavy bleeding during pregnancy, they first try to get medicine from AWW, and if not, they get the medicine or treatment by visiting the doctor (most of the case they prefer private doctor, not government PHC). Traditional healers and Dai and AWW and ANM are available and accessible in the village but the doctorsare in PHC.

Case Study: Reeta Devi (20)

ReetaDevi (20), has two daughters; one three years (2014) was delivered at home and the other two years (2015) was delivered primary health center (PHC) Chainpur. She had the experience of home delivery as well as institutional delivery. She said both the experiences were different, but if the government had not given 1,400 rupees, she would have never gone to the PHC for delivery. Her experience with home delivery was much better than institutional delivery. Home delivery was done by Dai or maharen, she identified the position of the baby in the womb and she gave oil massage with love, care and support during labor pain in the presence of mother-in-law. She assisted during delivery, cut the umbilical cord, and gave a bath to the baby. She gave body massage to her and the child. For any kind of complication during delivery she

called the Bhagat and they discussed the matter and bhagat gave some jadibuti and they didn't have to move anywhere. Institutional delivery is good as the doctors, nurses, medicine and injections are free but they had problems with transport and the economic condition in the family. When her labor pain started Saheya called for an ambulance but it did not arrive. Her husband arranged a bike and she had to leave on the bike during labor pain for PHC. That was very painful for her. When she reached PHC the nurse attended her and conducted the delivery but she was very rough. But Dai always loves and care never treat anyone roughly during delivery. After delivery, injections were given to the child and her in PHC which was free but they had to return by transport arranged by her husband. With her, her elder kid, mother-in-law, and her husband living with her at PHC they spent 2,500 and the Government gave 1,400 rupees. Her experience was not good for institutional delivery and next time she will prefer home delivery. (Reeta Devi, (20), 10/01/2017, Semra village)

The social-cultural and belief system is reflected in the manner by how people follow their customs and practices. Childbirth is part of social and cultural phenomena in the Korwa community. In case of any complication during pregnancy, childbirth, and the post-partum period they prefer to go to Bhagat.

6.3. Maternity Benefit Program (2017)

After the 2017 maternity benefits program was introduced, most of Korwa pregnant women want to go to the PHC for institutional delivery. Central governments announced the Pradhan Mantri Matritva Vandana Yojana (PMMVY) scheme in 2017. The maternity benefits program (MBP) is a conditional maternity benefit (CMB) program. Under the scheme for pregnant women and lactating mothers receive Rs. 6,000 to improve health behavior and nutrition. The scheme provides an incentive of Rs. 5000 in three installments and Rs 1000 for institutional delivery. Table 6.2, shows that in both study village number of institutional deliveries have increased and table 6.3 shows ANC is also increasing. Most of the pregnant women want to visit PHC/CHC for ANC and institutional delivery. Table 6.2 shows, a total of seventeen and seven deliveries happened in Samara and Gore village respectively in2015-16. Fourteen home delivery and three institutional deliveries out of seventeen in Semra and four home deliveries and three institutional deliveries out of seven deliveries in Gore village. Over the year 2017-18 and 2019 number of institutional deliveries has increased, eight out of thirteen institutional

deliveries in Semra, and six out of nine in Gore village in 2017-18. After the year 2018-19, eleven out of fifteen and five out of seven in Semra and Gore village respectively. Compared between 2016 (three and two) to 2019 (eleven and five) the increase in the number of institutional deliveries is huge in the study village. Table 6.4 shows the maternity benefit amount divided into three steps first is registration (Rs. 1000), the second step is ANC (after six-month pregnancy) (Rs. 2000) and the third step is delivery of the baby and childbirth regression and first-round immunization (Rs. 3000).

Table: 6.4, Case Transfer According to Conditions

Cash transfer	Conditions	Amount in rupees
First installment	Early registration of pregnancy	1000
Second installment	Received at least one antenatal check-ups (after 6 months of pregnancy)	2000
Third installment	Child birth is registered Child has received first cycle of BCG, OPV, equivalent/substitute	2000

(Source: Ministry of women and child development, https://wcd.nic.in/sites/default/files/Maternity%20Benefit%20Programme_1.pdf, 9/01/2020)

Table 6.3 shows that over the year's number of ANC and PNC have increased. Before 2016 most of the pregnant women were not interested in ANC. According to ANMs, they visit the villages for ANC, women came, listened, and took medicines but they did not use the medicines. According to women respondents, they do not take medicines because they are not feeling any illness. Nine and five pregnant women have done ANC out of sixteen and nine in Semra and Gore village respectively and none of them have taken PNC. After 2017 ANC and PNC increased over the years. Thirteen ANC and nine PNC out of sixteen in Semra village and seven ANC and six PNC out of seven in Gore village in 2018-19. They happily mention that Rs. 6,000 is a huge amount and they prefer to go to institutional delivery because of the amount.

According to Mahaswari Devi (40), *'I had childbirth eight times, the last baby was delivered last year (2018). I never complain regarding health-related problems during pregnancy and delivery. I have delivered four children at home and four in PHC/CHC chainpur and all*

children survived and I am in good health as well. I received 1,400 rupees for all childbirth from PHC/CHC but my daughter (Puja Devi) and one of the neighbors (Nameta Devi) delivered the first baby and received 6,000 rupees from PHC/CHC. Six thousand is a very big amount for us so we all prefer to go to chainpur hospital for childbirth' (Mahaswari Devi, 40, Gore village, 23/12/18)

According to Nameta Devi (20), *in 2018 she was pregnant and heard about the maternity benefit amount which is Rs. 6,000. She went to Sahiya and told her that she is pregnant and wants to take benefit amount. She went to PHC/CHC with Sahiya and registered and received Rs. 1,000 when she was approx four months pregnant. After two months she visited PHC/CHC with Sahiya and the doctor did ANC and gave medicine and Rs. 2,000. For the third installment, she received Rs 3,000 when she was released from PHC after delivery. She also mentioned that if PHC would not have given the Rs. 6,000 in installment then she would only go for delivery but if you are not registered and do not do checkups then they do not give you Rs. 6,000, you only receive Rs.1,400. For this reason, she went for checkups. She was only concerned about money and not for health. She needed money to fulfill family needs and not for her health* (Nameta Devi, 20, Semra village, 21/12/18)

According to Sunita Devi (20), *she registered and had her ANC checkups (first and second step) but she couldn't visit for institutional delivery and she missed the Rs. 3,000. She had delivered the baby at home as when she was in labor her husband was not at home and her mother-in-law was not able to take her to the PHC alone. Sahiya called for an ambulance but it did not arrive. Her mother-in-law said that her own younger child is five years old, she could not go to PHC with her or leave her with other family members. There was no money at home and when labor pain started it was evening (Shanjh)so how could she or her husband take her to the PHC* (Sunita Devi, 20, Gore village, 23/12/18)

Factor associated with maternal and child healthcare practices:

1. Distance of health centre from the area
2. Poor rood and transport problem
3. Financial situation:
4. Delay in decision making
5. Poor health infrastructure and facility

The distance of the area from the health center is one of the determining factors for utilization of maternal health services. There is a variation in the utilization of maternal health services in both areas. It takes a whole day to visit the PHC. Very few pregnant women in the study area visited the health center for only deliveries. For the Korwa community living in this area, the distance of the Semra village to the PHC is 18 km and district hospital 24 km and other Gore village 15 km and 23km district hospital. Due to the distance of public healthcare facility, the Korwa community believes that traditional treatment is better than western healthcare.

1. Poor rood and transport problem:

The problem of distance is further compounded by the poor road condition and transport facility in the study area. If a woman wants to go the health centers, she needs to walk for two km, to reach the auto stop. There are only two autos connecting the village to the health center/ PHC chainpur, chainpurblock, bank, market and Daltonganj (district) therefore she has to wait a long time for the transport. In this area auto runs in the morning to evening. Even if the mother takes the morning auto, they find it difficult to get transport while coming back from the health center. She has to wait till 4 to 5 o'clock in the evening.

2. *Financial Situation:*

In the study area financial situation is very poor. Financial situation adds to the problem of utilization of maternal health services. Women from OBC and SC groups do not visit the health centre, as they have to borrow money from upper caste people. If they do not have money, then they have to sell chicken, goat, cow, ox (cow and ox given by government for livelihood) to meet the expenditure. The facilities at PHC/CHC are free but they cannot visit the same unless they have Rs. 500-1000.

3. Delay in Decision Making:

According to Korwa community distance, transport facility and financial status lead the decision regarding utilization of public healthcare facility. Pregnant women want to go to the PHC for delivery but at the time of delivery decision are taken by the elder person of the family. After 2017 if pregnant women get sick like bleeding during pregnancy, fever, TB, malaria and weakness, she visits PHC but before that they were more depend on Bhagat.

4. *Poor Health Infrastructures and Facility*:

Chainpur Block has1 CHC cum PHC and 2 PHCs out of which only one CHC/PHC is in working condition. If women have labor pain than they need to go to a PHC which is located 20 k.ms to 25 km away from village. There is lack of a lady doctor, bed, test machine and manpower.Sub centers are not open or operationaland the ANM is only available in the day.

The respondents' state that health facilities are inadequate, inaccessible, without required staff and, above all, offer poor-quality services. Most of the mothers chose home delivery over institutional delivery but it has also been pointed out by some that if the sub centers near to the villages are in working condition with properequipments, manpower, electricity and water facility,then theywillbe more accessible for them and they would have preferred delivery in the institution.

The sub centers should work as per the government policy and be functional. Another part of the problem of accessibility is the distance to the PHC/CHC. Taking private transport to the same is too expensive for the respondents. Availability of ambulances from and to the PHCs should remedy this issue along with making required beds available.

1.2 **Child Healthcare Practices:**

The husband and elder women of the family generally take child healthcare decisions. Korwa community know about immunization though shaiya but very less number families of Korwa community are interested and are coming forward for immunization while others do not have much faith in it. Practices and beliefs regarding immunization in both study villages slightly differ. In Semra village they are more interested in child immunization. In Semra village AWW/ANM are in same village and she convinced the villagers for immunization. Almost all children those who are delivered at home also get immunization at village level but on the other hand in Gore village there are two AWW out of which one is not working since 2018. ANM visit Gore village but very few of the children are sent for immunization. In 2018-19 every child took immunization in PHC or at village level. Immunization services are mostly provided by the AWW at the center and ANM come to give vaccine on a monthly basis. Polio vaccine, measles, BCG and DPT are given to children at the AWC. But immunization services are not provided among Korwa community since 2018 at Semra village. Korwa people know about

immunization by ANM, but people are complaining after polio drops thatafter taking the injections their children are suffering from fever and pain. They believe that the injections and dropshave expired, but most of the time ANM gives clear information about the vaccination and what kind of reaction will happen after.

Common health related problem in under five-year children are cough and cold, loose motion, malaria, diarrhea, head pain (Sarfatna), measles (Mataji), shrinking of veins (Naskhinchna), jaundice (Pileya), heat hot air in summer (loo lagana) and high fever.

Table 6.5, Diseases of Under Five Years Child at Both Village (2017-18)

Disease / Total	Semra village	Gore village
	67	39
Diarrhea	21	18
Respiratory infection	13	7
Cough & cold	55	31
Fever	19	8
Malaria	28	16
Tuberculosis	2	1

(Source: Field Servey)

Table 6.5 shows that most of the children are suffering from cough and cold, malaria, diarrhea, and fever in both villages. Sixty-seven and thirty-nine children are under five years who belong to respectively Semra and Gore village. Respiratory infection at the time of delivery due to drinking water during delivery (Ganda Pani Pena) and diarrhea are the major causes of illness among infants. Home remedies are used to treat these health-related problems and according to the villagers, these are common. They mostly visit Bhagat and is treated with herbs.

Table 6.6, Neonatal and infant mortality

Neonatal				
Year	Total		Semra	Gore
2017-18	1		0	1
2018-19	0		0	0
Infant				
2017-18	4		2	1
2018-19	1		1	0

(Source: Felid Survey, 25/10/16 to 26/02/19)

In the Semra village, one infant died because of respiratory infection (Ganda pane pina) and one died because of fever and diarrhea. In Gore village, one infant died because of high fever and premature birth in 2017-18. One infant died after birth because of high fever in Semra and none of the infants died in Gore village in 2018-2019.

Table 6.7, Under five years child Mortality over the years.

	Semra village			Gore village		
Years	**Total Children**	**Child Mortality**	**Child Mortality Rate**	**Total Children**	**Child Mortality**	**Child Mortality Rate**
2016-17	**70**	6	8.57%	41	4	9.76%
2017-18	**67**	5	7.46%	39	4	10.26%
2018-19	**64**	3	4.69%	39	2	5.13%

(Source: Felid Survey, 25/10/16 to 26/02/19)

Table 6.7, data shows over the year's child death has reduced. According to the ANM, malaria and diarrhea are the main cause of child mortality, most of the children die because of high fever, diarrhea and malnutrition. According to Namita Devi (20), '*when she was pregnant for the first time at the age of eighteen (2015), she was suffering during pregnancy and having body pain and dizziness. When she delivered the baby at home, the baby was underweight and after two days the baby died. After that within six months she was pregnant again, she was suffering from weakness, morning sickness, body pain, drowziness, and malaria. After childbirth mother and child both were weak, she was referred by PHC to the district hospital where the mother was under observation and the child was in the neonatal intensive care unit (NICU) for ten days. Repeated pregnancy and malnourishment led her and her baby to be weaker'* (Namita Devi (20), Semra village, 10/02/2017).

Sources of treatment are one of the indicators for assessing the existing healthcare practices in the Korwa community. The traditional system of curing, culture, and belief affect how patients receive and define illness and influences the choice of treatment. According to respondents first, they visit Bhagat, after a few days if the kid is not cured then they take them to a private clinic after that PHC or district hospitals.

6.2 Communicable Disease:

Korwa people from both study villages live close to the forest and top of the hill. They are around the healthy surrounding of the natural environment and they see themselves as healthy people. But most of the Korwa people are suffering from one or two different kinds of communicable diseases; these are compounded by poverty, malnutrition, lack of safe drinking water, poor sanitation and hygienic condition, socio-economic status, lack of access to medical facilities. Public healthcare services are also not rich and inadequate in both villages, these situations for the korwa community in such a mixed setting become challenging.The communicable diseases found are common in both villages. Water borne diseases are common as well.

Table: 6.8, Disease According to Season.

Common illness in both villages		
Summer season	**Monsoon season**	**Winter season**
Loo (heat sun stroke), measles, fever, lose motion	Diarrhea, mouth ulcer, malaria, gal fulli (mumps), loss motion, jaundice, malaria	Malaria, pneumonia, cough and cold, fever

(Source: Felid Survey, 25/10/16 to 26/02/19)

Malaria is the most common disease among the Korwa community, which occurs during the rainy and winter season. Over the years' climate changed in the study area, fifteen years back the temperate was low during summers and Loo (heat sun stroke) were less compared to present. It is mostly loo/sun stroke which leads to a condition of dehydration, measles and skin problems. In the rainy session diarrhea, malaria and fever and in winter season fever, malaria

and cough and cold are common and every person of the community is affected ones or twice in a year.

Communicable diseases in both villages:

Table: 6.8, shows the data of 2017-18, Both villages suffer with malaria, fever, cough & cold, ear problems, tuberculosis, diarrhea, worm infection, scabies and AIDS. Malaria, Diarrhea, fever, jaundice and pneumonia are killer diseases for children and as well as for the elderly. Malaria (medical officer of PHC mention Plasmodium Falciparum higher in palamu district) is a major health problem in both study area, thirty-seven from Semra village and twenty-one from Gore village were diagnosed and two from Semra and two from Gore died due to malaria. Malaria is a frequent occurrence and the morbidity and mortality associated with the disease are alarming. The study area has dense forest, heavy rainfall, and high humidity, mosquito fauna is rich and breeding habitats are diverse.Transmission occurs the whole year but peaks in months from September to January after the monsoon season. In summer temperature rises to 41 c so May to mid-June mosquitoes do not survive due to hot wave and dry land. According Sahiya, *Malaria is a very prominent and dangerous disease in both villages. Almost every person in this area has experience of malaria in theirlife. Malaria comes with high fever and a feeling of cold but initially no treatment is sought, after a couple of days they contact Bhagat or local doctors.Meanwhile, malaria turn into brain fever after which they visit PHC/CHC for treatment. In this area, most of the death occurs due to brain fever. In 2018 three children and one young man (21) and a woman (32) died due to malaria among the Korwa community at Semra village* (Bimala Devi, 30, 24/2/19, PHC chainpur).

Table: 6.9 Disease among Korwa in Both Villages, 2017-18

Communicable disease	Semra village	Gore village
Malaria	37	21
Diarrhea	32	17
Cough & cold	29	13
Measles	22	15

`Jaundice	18	13
Worm infection	13	8
Scabies	5	3
Tuberculosis	11	7
Non-Communicable disease		
Fever	33	17
Ear problems	27	11
AIDS	3	0

(Source: Field Survy,25/10/16 to 26/02/19, Exclude under Five Year's Child)

Diarrhea is equally responsible for high morbidity and mortality among the Korwa community. Diarrhea occurs throughout the year but attains peak during the rainy season which is May to October. Thirty-two from Semra village and seventeen from Gore village were diagnosed with diarrhea. Diarrhea is caused basically due to poor hygiene and lack of safe drinking water. According to the medical officer (MO) from PHC/CHC, in these areas, there are most cases of diarrhea and malaria, in 2010 Semra, Gore, and other neighboring village had an epidemic of diarrhea. They conducted cleaning for two days of the sewer for diarrhea especially.

Fever, cough and cold, ear infection, scabies, and worm infection are also high as per the study in the village. According to villagers, all these diseases are very common in these areas and most of the people who belong to the Korwa community are suffering from these diseases.

Lack of immunity due to poor nutrition is also responsible for the people to be infected with diseases like tuberculosis and measles, which are common in study villages. Twenty-two in Semra and fifteen in Gore village are suffering from measles. Measles is a faster-growing disease in this area, if one person of the family is sick then it spreads to other members within a month. Tuberculosis spreads even faster. In the Semra village total of eleven and seven in Gore village across different age groups are affected by tuberculosis. Maximum korwa peoples who are affected with tuberculosis take treatment from PHC/CHC but no one is cured. Multiple reasons are behind this; irregularity in medicine, food, unhygienic condition, and work load being a few. Children and the elderly are at the greatest risk of morbidity and mortality from infectious diseases specially if malnourished.

Case Study (HIV)

One of the key respondents, his wife, and his six-month-old child are suffering from AIDS. He did not want to share his name, photo or his voice to be recorded and used in a public forum, but he came up himself and shared his life story with the researcher. According to him, no one knows about his diseases in the village, not even his family members. He invited the researcher at home and told his life story and said *'Aap likhey hamare zindagi ke bare me jo ki thodi se bacche hai. Ghow me bataye nahi hai, gaow me pata chaleyga to kya karyge pata nahi. Agar gahow nikala kar deya to hum kaha jayge iss ley kise ko bataye nahi. Bemare aise hai ki shaer se bhi wapsh aa gaye'*. '*You write about our life, which is very short. I did not tell anyone in the village, I don't know how they will react on this, if they announce Gawnikala (leave the village) than what will we do? I came back from the city due to the disease.'* Ten years ago, he went to Bangalore as a laborer. He was married then but his wife did not go with him. In Bangalore he had a relationship with two women; one was married and the other was unmarried. In 2016 he had a fever and he did not recover with medicine. Then he had checkups in a hospital in Bangalore. The doctor told him about the disease. He took medicine from the hospital and then he came back to the village. He was taking medicine from the district hospital (Daltonganj). In 2017, his wife and child were also diagnosed with the same disease. At present he has a fever and is very weak, his wife and child were also very weak. In March 2019 his child died.

Sources of the Treatment at Both Villages

Sources of treatments are one of the indicators for assessing the existing healthcare practices in any community. In the traditional system of curing, culture affects the way in which patients receive and define illness and influences the choice of treatment. Table, 6.9 shows, Korwa community prefers various sources of treatment.

Table: 6.10, Sources of the Treatment at Both Villages (2018-19)

Sources	Semra village	Gore village
Traditional healers	67	32
ANM	22	09
Anganwadi centre	11	---
Doctors (PHC/CHC)	24	12
Privat clinic	37	17

(Source: Field Survey, 2018-19)

The preference for the health service provider in the both villages depends on the availability of facilities, the nature of diseases and the financial condition of the families. Korwa people firstly believe in home remedies for diseases like measles. In the summer, cases mostly reported areofsunstroke which leads to conditions of dehydration, measles, and skin problems. All these problems are treated at home. For dehydration, they give saltwater, for measles apply ghee on the whole body, and for skin problem, they take bath with the leaf of neem boiled in water. In cases like fever, swelling of feet, vomiting, weakness, loose motion, the Korwa people first consult with Bhagat (traditional healer). Bhagat identify diseases like jaundice, symptoms like swollen abdomen and yellowing of the body are prominent, in case of malaria is recognized by shivering accompanied by high fever, in case of diarrhea is recognized by loose motions and lack appetite and in case of cough and cold is recognize repeatedly cough is coming out, nose running, fever, and body pain. In this case, they make kadha (Syrup) with herbs and honey. If it's not cured with this herbal medicine then Bhagat tells them to go to PHC/CHC to test for tuberculosis. Two Korwa people who are suffering from tuberculosis take herbal medicine by Bhagat for the last one year (2017).

There are two forms of western healthcare system at village as a source of treatment, (1) AWC and ANM, Anganwadi center (AWC), and Anganwadi workers are present in both villages and (2) Private Doctors. In Semra village, there are a total of two Anganwadi centers and both are working but there is an unavailability of medicines and equipment except one small bottle of Dettol liquid and one roll of cotton, and one bandage that is not used. Another village Gore,

there is also two AWC, MahuerPahad tola anganwadi center for Korwa people, but this center is closed from 2017. According to the respondent in this center there was misbehaving in terms of social hierarchy with Korwa child and daily meals were not given nor any kind of facility for lactating mother and child.

(2)Private doctors as a source of treatment has developed within the village over the time. According to the respondent, access to private doctors is easy and affordable. For diseases like malaria, diarrhea, fever, cough & cold, and jaundice they prefer private doctors.

Third is a public healthcare facility which is basically PHC/CHC, the primary health center is very far from the village but the recent perception in the community is changing, they prefer western healthcare treatment. Basically, the Korwa community prefers PHC for the delivery and treatment of tuberculosis. Since 2018 korwa people go to PHC Chainpur for other health-related problems as well. No other healthcare facility is available at the village level, which also leads to greater belief in Bhagat or traditional forms of treatment. Most of the Korwa people in both villages want to consultwestern healthcare practice of treatment, but due to financial problems, long hours of travel, and lack of availability and accessibility they revert back to Traditional systems.

In the study villages, the Korwa community carries two different perceptions at a time, firstly there is no public healthcare facility like a hospital, PHC, or doctor in the village or near the village. The traditional healers/ojha and Dai were found to be functional in both study villages. The faith in traditional healthcare and treatment within the community is strong, not only due to the absence of western healthcare facilities but also due to the permanence of this form of treatment, along with easy availability and accessibility at a lower cost. At the same time as per respondents,there are too many diseases which traditional healers take time to treat and many diseases which the healers are unable cure. Korwa community has a preference of healthcare dependent upon the availability of and accessibility to healthcare facilities.

There is a dilemma between the traditional healthcare facility and western healthcare facility. Health, sickness, and their traditional methods of treatment are all deeply rooted in the cultural belief of the Korwa community.

COVID -19 Pandemic Effects on Korwa

The novel corona virus pandemic came across as a challenge that no one in the world had foreseen. Everyone was caught unprepared as the World Governments scurried to take measures, implement lockdowns, close borders and get a grip of the impact on the healthcare system. India had to fight the battle on two fronts, one was the direct impact on the healthcare professionals and infrastructure brought about by the pandemic and the other was of the migrant workers. As the lockdown was implemented to curb the spread of the virus the factories and plants were closed, which led to widespread loss of income for the workers. They were stranded in different cities with no income but had to bear the expenses of food and shelter. The situation kept escalating as the lockdowns kept extending over the time with the Government still trying to get a grip of the pandemic (Vandana, 2020)

Researcher was in regular contact with respondents through calls as she was not able to reach to the study villages due to covid-19 pandemic. Government of India announced free rations from April to June after lockdown. As per respondent they did not receive any rations from December 2019 by PDS. Till April 6th the study area did not receive rations so the Researcher contacted the district collector of Palamu to inform him of the same after which action was taken and rations were delivered. At the first time they received a ration of 50 kgs of rice which is very less. They hadn't received ration in the last four months which would mean 140 kg rice, thus they are facing a loss of 90 kg rice. Since then, they received 35 KGS of Rice every month.

Migrant works

Due to covid-19 pandemic, lakhs of workers reverse migrated to their home to survive. Social distancing is the only process to beat the Covild-19 pandemic. But at present when we look at the roads and railway tracks, they are full of migrant workers, who are walking miles hungry, being the poor and marginalized section of our society. They are struggling to reach home, which once they left to survive but now it has become the safest place.

ST and PVTGs are some of the workers who have returned and belong to Semra and Gore village in Jharkhand. Total 135 migrant workers have returned in both villages till 27/05/2020. They can be divided into different social groups as 13 (OBC), 26 (ST), 31 (PVTGs) who

belong to Gore village and 15 (OBC), 34 (ST), 19 (PVTG) who belong to Semra village. They shared their experience of the Covid 19 during the Lockdown.

Case Profiles:1

Name: Birju Korwa
Age: 31
Home: Semra
Return: 9 May
Work: Rod making and Filter
Payment: 6,000 to 10,000
"We are 13 people who belong to Gore and Semra, and came from Nashik. We reached from Nashik to Nagpur average 150 km by foot then we were picked by a truck who charged Rs. 500 per person. From Nagpur to Raipur we took another truck which charged Rs. 120 per person. In Raipur we got health checkup and were moved by bus to Balrampur. The travel from Balrampur to Ramkam to Nawadhi to Bahiya to Gore Panchayat to Chainpur PHC/CHC was completed by bus which was free. We stayed in the village school when we reached the village. After that we went to Chainpur PHC/CHC by bus, which was provide by government, the medical staff there checked our temperature and asked if we had any type of cold and cough, fever or any other health related problems. We told them we did not have any kind of symptoms. Then they took details like where we came from, which village we belong to and noted our mobile number. They suggested us to be home quarantined and not to meet family member and not to walk around randomly. Then they sent us home to be home quarantined. We all followed the suggestions given by them. I went to Nashik around six months' ago through a Thekedar in September. There I worked to build roads in a company, in a month I got from Rs. 6,000 to Rs. 10,000. I am not a registered migrant worker. I did not get payment for the month of March, which is 6,000 rupees.

Due to lockdown work was closed but company provided for food and water for two times for 14 days. During second lockdown from 7th April, they stopped giving food and water and told us to arrange food ourselves. We were given food by government, NGO and other donors. We had to wait from morning, stand in line for 2-3 hours and then we used to get rice and dal. Then again, we had to wait for food for dinner. This routine continued approximately one month. We

had no money to buy ration and make food. There was no transport available to come back to home. We were stuck and hungry had no idea of what to do. If we stayed there, we were afraid of both, one hunger and the other corona virus. Finally, we decided to return home on foot. During the travel we got food from people along the roadside.

I have six children: one boy and five girls, my wife and my parents. It is a big family. Earlier we got food items from forest but now forest office does not allow us to take these items. Government does not allow family planning operation as there are less numbers of our community but how to manage the family when there is lack of food, we face health issues and have many more problems. In this situation I do not have that much agricultural land to get grains for full year. I had to move to other place, but I will never again go this far way, I will work in nearby places. "zindarahanahai to koi na koi kamkarna he padeyga" if I want to live, I will have to do some kind of work." (19/05/2020, Via Mobile Call).

Economic transformation of the Korwa can be represented in the in terms of forestry to shifting agricultural to industrial workers. The change in the occupational and economic patterns has been due to external forces. Early PVTGs had only one occupation which was around forestry but now they are considered as multi-occupational and migrant marginal worker also. Due to this reason, it is difficult to mark an exact classification of the pattern of work.

Maternal Health Status during COVID-19

ANC care and institutional delivery of overall Jharkhand is low during lockdown and situation in tribal area is even worse. The lockdown had harsh impact on tribal area and on tribal women. If we look at Semra and Gore village, there were a total of 6 and 5 pregnant women respectively among the Korwa. Out of whom one from Semra village and two from Gore Village delivered babies during lockdown. Both wanted to go PHC/CHC but they could not reach due to lack of public transport and as they were not able to reachambulance services. They are financially weak and could not afford private vehicles. Sahiya also did not give any information regarding institutional delivery.Husbands of both mothers are migrant workers. During this time the ANMs are also not visiting the villages for ANC and immunization and anganwadi centers was also close so they could not take any food items.

Case Profiles:2

Name: Parbhawa Devi
Age: 34
Home: Semra
Child: 6

Parbhawa Devi (34), who delivered a baby girl; sixth child, never took ANC and PNC care and does not prefer institutional delivery. She opted for all home deliveries. She always preferred to visit traditional healthcare providers (Bhagat) for any kind of health-related problems,pregnancy and delivery.But in last three years she had to visit public and private healthcare facilities as the Bhagat passed away. Presently she is suffering from health-related problems like heavy bleeding, body pain and fever after giving birth to her baby. She wants to visit health center (PHC/CHC) but she wasn't able to reach and also Saheya was not able to help her (Parbhawa Devi, 34 Gore Village, 20/04/2020).

Case Profiles: 3

Name: Rajmati Devi (Korwa)
Age: 30
Home: Gore
Child: 5 (3 at Home and 2 institutional)

"My child was delivering at home on 23 April (during lockdown).Along with a newborn baby I have five children. I wanted to visit Chainpur PHC for the delivery, but I was not able to contact ambulance services. My mother-in-law tried to get in touch with Sahiya (village health attendant) but she did not respond, she never visits our community because she belongs to OBC and feels we are untouchable. She sent her husband, but how do we discuss pregnancy related problems with him?

But if lockdown wasn't effective, I would have definitely visited the PHC. Earlier I had arranged vehicle myself and have had delivered two of my children at the PHC. I want family planning operation, but hospitals are not allowing us. I feel very week after pregnancy and regularly face health related problems.

At present I am suffering from body pain, fever and weakness and my child is also not in good condition.She had fever three days ago. My child and me got TT injection from village doctor (Dr. Ramjanam Yadav). He is giving injections and tablets for fever, but I am not feeling good. If I take medicine, my fever goes away if I do not then fever return. This has been happening for the last 20-25 days. I want to go Chainpur hospital but in this lockdown, we cannot move so I am not taking any treatment from hospital.

I got ration after 10 days of lockdown by government (PDS) 35 kg rice, last month 50 kg rice and 1 kg pulses and Rs 500 was deposited twice into my account. I spent all the money in my treatment, but still am not cured. I want to go to PHC but public transport is not available and I cannot afford private vehicle. My husband returned home from Chennai (migrant worker), and he is in home quarantine. He also cannot take me to PHC right now. (18/05/2020)

Case Profiles: 4

Name: Smita Devi (ST,)
Age: 20
Home: Gore
Child: first child in 10 April
"I delivered a baby boy on10th April. I had registration in Chainpur PHC. Earlier received Rs. 3,000 from there. I and Sahiya regularly tried to contact for ambulance but we could not get in touch. I was not able to reach PHC because of lockdown and non-availability of transport. My husband was not in villageand was in Hyderabad. He works at a construction site. I have no idea about howor if I will get the balance money from PHC, Sahiya is also not responding.

Maharini delivered my baby at home and after that Dr. Ranjanm Yadav gave TT injection. At present my child is good but I am suffering from fever, body pain and weakness. I need to go PHC but am not able to due to lockdown and unavailability of public transport, I cannot afford private vehicles."

Case Profiles: 5

Name: Bimala Devi

Age: 30

Home: Semra

Job: Sahiya

According to Bimala Devi, Sahiya of Semra village "Among the Korwa community total of six women are pregnant, there have been two miscarriage at third and fourth months of pregnancy and four deliveries at home till the date 13/07/2020. Not a single institutional delivery happened since lockdown. ANC, PNC and immunization were done by ANM after the lockdown opened; during lockdown no services were provided by AMN because of lack of transport facilities and distance of PHC.

One infant died after two day of birth (23/6/2020). A mother belonging to Korwa community, delivered her forth baby boy at home, and her mother in-law assisted during delivery. Her family member did not call me and Dai because it was night time and heavy rains. Among Korwa people Dai is reliable and good in assisting during delivery and post delivery. According to her mother in-law, infant was delivered normally but after two day the infant was suffering from fever and within 4-5 hours the infant died. Mother did not receive ANC for last five months (since lockdown). She had her last two deliveries at PHC Chainpur, this time as well she wanted to go to PHC but labor pain started at midnight and she could not contact an ambulance. Mother suffered from bleeding, weakness and body pain. She refused to go PHC because of COVID-19 andtook treatment from private practitioner.

Korwa people are very poor and cannot afford private vehicle for PHC, lack of transport in this area and distance from PHC becomes an hindrance in using the PHC, they are taking treatment for all kinds of heath related problems by the private practitioner Ramjanam Yadav and Bhagat (Traditional healer), who belongs to the same village" (Bimaladevi, 30, 13/07/2020, Via Mobile Call).

In both the villages, women believe in traditional healing practices but they also show interest in biomedicine. If we talk about western healthcare practices, they go toboth public healthcare facility (government healthcare facility) and private healthcare facility which gives only allopathic medicines.

During the pandemic the challenges became even greater due to the lockdown in place. The PHCs are already far from the villages as it is and the shift from in house medical treatment from the Bhagats and local practitioners to the over dependence on the PHCs made availing healthcare facilities a difficult feat during these trying times.

The lockdown has also proved to be trying on the pregnant mothers and in general the STs and PVTGs when it comes to healthcare and maternal services. The expected mothers are not able to reach the PHCs due to the lack of public transport as well as the fact that the ambulance services are not reachable. Even when they are facing health issues like body pan fever, they are not able to avail the basic medical facilities which we take as granted. Presently (2020) they are dependent on traditional healers, Dai and private practitioners.

CHAPTER: 7

Discussion and Conclusion

The present study was carried out in Semra and Gore village of Chainpur district in Jharkhand. Both villages are surrounded by forest.The Semra village consists of 792 households of which 80 belong to Korwa community. In Gore village, out of 230 households, 43 are of Korwas. The overall objective of the study was 'to examine the social transformation and its implications thereof on healthcare practices among Korwa community. An attempt has been made to describe the changes that are happening in the social, economic, cultural and healthcare practices and services among Korwa. In order to understand and study the process of social transformation of Korwa society, researcher has adopted ethnographic methods for collection and analysis of data. Data has been collected by structured household interviews, semi-structured interviews at individual levels and group discussions. The sample normally consisted of 123 households (both villages) including male and female members. In this study all levels of respondents have been included like the head of the family, family members across age groups, Healers and Dais. Researcher selected households with three generations like adult girl, pregnant women (experience of child delivery) and elder women for MCH related practices. Traditional treatment is given by healer and Dai who are easily accessible by the villagers. Researcher also conducted in-depth interviews with different key-informants. This includes local leaders, mukhiya and public health providers like ANM, Sahiya/ASHA, AWW, TBA and MO. The various aspects covered in the interviews included their livelihood patterns, socio-economic conditions, cultural norms, perceptions, practices and treatment seeking behavior regarding pregnancy, childbirth and post-partum care. In the treatment seeking practices both traditional and allopathic health services accessed by the women for maternal health were explored. In addition, the study explored the availability, accessibility, affordability and acceptability of various health services.

Transformation in socio-economic statues

In the Chainpur block, the Semra and Gore villages are situated on the top of a hill and are surrounded by forest. Around 50-60 years back they lived on top of the Gore hill and in dense forest, but, over the years moved to live within a mixed community. In both the villages, the Korwas are called Pahari Korwa. The other communities in Semra village are Brahmans, Yadavs, Thakurs, Dushadhs, Shaws, Pals, Lohars, MlahCharos, Chamars, Bhiyas, Oraons, Mundas, Bhiurs, Parhaiyas, Korwas and Muslim community. There is no segregation based on

caste among the households but Korwa prefer to live in areas closest to forest. Yadav, Pal, Shaw, Charo, Baniya, Munda and Korwa community lives in the Gore village but here the Korwa community live closest to forest in a separate tola.
According to Census 2011 population growth rate, sex ratio and literacy rate have slightly increased over the decades among all communities including Korwa belonging to Semra and Gore villages. At the village level basic facilities like houses, sanitation, hygiene and electricity are very poor.

In both villages, Korwa people have mixed types of houses i.e both Kaccha and Pakka. Kaccha houses are traditional houses that are made of mud walls, woodenroof supports and stems of rice or Khapdas roof cover. These houses had two rooms and one gate, very small space for ventilation, no window, no separate kitchen and poor lighting. At present Kaccha houses are extended with Pakka house with two rooms. They get benefits under the Pradhan Mantri Awash Yojana Gramin (PMAY-G) which was formally called the Indira Awash Yojana (IAY) in 2006. Initially, Korwa families used to get 48,000 under IAY and now they get an amount of 1,25,000 under PMAY-G but they are not interested in building toilets for which the government pays 12,000 Rupee. Very few Korwa people get housing benefits. In Semra village 76 percent houses are kaccha and 24 percent houses are mixed. Similarly in Gore village 60 percent houses are kaccha and 40 percent houses are mixed. Swach Bharat Mission launched in 2014 after which the government was more focused on toilets.In Semra village total 45 houses and at Gore village, 42 households received money from the government for toilets but 7 and 4 toilets were half-constructed and not functioning in Semra and Gore villages respectively. While the Korwa used the entitlements under rural housing to actually build houses, the amount received for the toilets was mostly used for food, drink, health treatment and other needs. In the korwa community, toilets are not used in both villages. All villagers, including Korwain both villages, are used to open defecation. In both villages, Swach Bharat Abhiyan is not functioning at ground level.

The Source of drinking water earlier was river and ponds but at present hand-pumps are used as well. In the Years 2018 and 2019, total of four new hand pumps were installed at Semra and five at Gore village, but only two at Semra and Gore village were in working condition because the ground water levels have been depleting.

The Korwa communities generally sweep their house, kitchen and yard daily in the morning by broom. However, they are less concerned about hygiene, for instance, they generally throw the garbage after sweeping their house in front of the houses and if they have animals like cows, ox and buffalos at home they stay near the entrance of the houses. The animals excrete their feces at the entrance itself and small animals like chicken roam all around the house and they too excrete feces all around. Children normally relieve themselves around the house. Both villages have a poor drainage system. The villages have kutcha and open drainage which passes from the front of the house.

In the Semra village, there are seven wells (five pakka and two kachakuwa) and ten *chappa-nahal* (Hand-pumps). The wells are generally used for irrigation purposes. 3 wells out of seven are clean and six out of ten hand–pumps are in working condition, which is used for multiple purposes like drinking, washing, bathing and for cattle. In Gore village, there is one river, eight wells (five pakka and three kacha) and nine Hand-Pumps. Five hand-pumps out of nine are in working condition. The rest have been non-functional for the last three years. Hand-pumps and pucka *kuwa* (well) were made under MNREGA

Within the Korwa community, while all the children attend school, only total 69 adults are literate of which 52 are male and 17 are female. Among the males, 49 have completed 5^{Th} standard and only three have completed 10th standard. Amongst the literate females, 14 have completed 5^{Th} standard and only three have completed 7^{th}standard.

In the study villages, the Korwa community is facing a lack of food. They have very limited food so they have to depend on various sources like the forest, agriculture, and Public Distribution Systems (PDS) for survival. They get Kand (tubers), GethiKand, Kanda, Gethi, Berna Kanda from the forest, maize by agriculture, and rice from PDS.

Food items from the forest: There are two types of roots and tubers which are considered as main food items of the Korwas which are Kand (tubers), GethiKand, Kanda, Gethi, Berna Kanda, and Duru Kanda which are available throughout the year. But, Bernai Kanda and Mithara Kanda are available only from December to July. Food is gathered primarily by women. Food items from agriculture**:** The nature of the land in both villages is mostly hilly and forested, so the agricultural produce is insufficient and does not sustain them throughout the

year. They produce maize, ithaene, lotanee, madhua, rice, mustard, cereal crops and vegetables. Food items from PDS: The Chainpur block has a public distribution system office for both villages. Semra and Gore villages receive *Ration* on a fixed date from PDS. Korwa from both villages have yellow ration card. They get 35 kg rice, 2 kg sugar, 2-liter kerosene oil and 3 kg salt. For the Korwa community in the study area, the main source of rice is from the PDS ration. They have a very small area of land that is not good for rice cultivation. Korwas get 35 kg of rice from PDS, which is sufficient for 10 to 12 days in a month. Irregularity of food supply by PDS, landlessness, land not suitable to grow rice, limited food gathering and restrictions on hunting animals from the forest has reduced the use of meat in food and is continually leading to hunger in Korwa community.

Among the Korwa community, both men and women drink traditional drinks. People collect Mahua flowers and dry them in the open under the sun. In both villages people traditionally drink Mahua and Hadiya, Mahua is prepared using the Mahua flowers and Hadiya is prepared using rice. They normally drink during the evening but older peoples drink during the day as well. According to respondents, drinking during pregnancy is common among them. 60% of women drink during pregnancy. 10 to14 years children also drink.

Kinship provides the basis for the social and economic interactions among the Korwa. Korwa are endogamous. In the Korwa community families are Patrilineal and Patrilocal. Father is the head of the family. The mother holds the second position but she is an asset to the family and male members are expected to respect her diction. In both study villages of Korwa, the people generally live in nuclear families due to economic conditions but seven families in Semra and four families in Gore village live in joint families' where father, mother, sons, son's wife and all children reside in the same house. In Korwa families, usually husband, wife and unmarried children live in the same house. After marriage, the sons move into a separate house with their wife, but elder people of the family are respected and remain as the decision-maker. In ~~a~~ few cases, parents live with their younger son. In case of the death of either parent, the other one stays with the children.

Among the Korwa community marriageable age of girls is between 13 to 15 years and for boys is between 18 to 20 years. Mostly they are in favor of marriage after puberty. In the study area, they follow different types of marriage based on economic conditions. Marriages are with bride price, Marriage by service, Sorority, Polygamy, Dhuka-dhuki and most common and important

type of marriage is known as Baiha with certain complex rituals. In the study village area, marriage rituals are similar to the rituals followed by the Hindu community in general. There are muslim families in the area as well, who have a stark difference in the ceremony or rituals that are followed during marriag. Due to their strict rules regarding marriage they cannot marry outside the community but in few cases marriage outside the tribe and another caste do take place. In this scenario, gram panchayat takes strict action against them.

The Korwa community is very devoted to religion. They have their own gods, goddesses, myths and beliefs. They are much afraid of supernatural powers. The whole life of Korwa is associated with the religious phenomenon. They believe in Bhagwan (Sun) as their super God, Chandarma (Moon), Dharti Mai (Earth) and Mahadev (God Shiva) who are the creators and protectors of the universe. They believe that they give them light, land, rivers, water, air, forest, birds, animals and human beings. The religious head of the Korwa community is Baiga (Bhagat, Ojha, Traditional healer). He is not only the religious head but also acts as a healer who heals all kinds of illness by Spiritual Mantra, animal sacrifice and the use of herbs. The Bhagat is a religious guru not only for Korwa but also for the whole village and other communities. Since the last eight years in 36 percent households from the Semra village, and 53 percent households from Gore village have adopted and follow Shiv Guru which is what the Hindu community follows. Every Monday they gather in one of the Shiv Ghuru Bhai and they sing devotional songs for Lord Shiva.

Earlier both villages had a traditional panchayat with five members. They belonged to the same community, which helped in a better understanding of their traditions, customs and rituals than any outsider. Panchayat discussed and solved social, economic, rituals, religious and political issues within the village.

At present, the study villages do not have a traditional panchayat. They have mukhiya who is elected as per government rule and belongs to other communities. Not a single Korwa person is involved in Panchayat Raj. Korwa people believe more in the judgment given by Shathi (Naxal). They are more comfortable with them and Korwa people think Shathi better understands their problems and solves the issues sooner.

Korwatribals follow the concept of a social hierarchy. They strongly believe in their social norms and traditions. Over the years Korwas moved near to other caste groups, tribes, and

religious people though they remain at the lowest social hierarchy in both villages. The Korwa are facing untouchability by upper caste groups in the village. In both the villages there are three types of stratification; first is inter-tribal stratification, second ~~is~~ inter-caste stratification and third economic stratification. Economic stratification has developed within the Korwa community in the last three to four decades. In the Semra village, eleven communities co-exist which are Korwa, Munda, Oraon, Bhihur, Dhshadh, Shaw, Chamar, Charo, Pal, Lohar and Muslim and in the Gore village Korwa, Parahiya, Chero, Mundo and Yadav. Korwa and Parahiya both belong to PVTGs and are lowest in the social hierarchy.

Korwa community is undergoing change. There have been transformations in the social, economic, political, and cultural and also the beliefs over time. In the study area, the transformation of the Korwa community has been very slow until 2005. In 2006 after the enactment of the forest right act, the changes in terms of social, economic, political, and cultural and also in the beliefs on a structural-functional system of the community was faster than ever before

Transformation in occupation and economy

Early Korwa had only one economic activity i.e. forestry but now they are considered as multi-occupational. Due to this reason, it is difficult to mark an exact classification of the pattern of labor. In the study in both village Semra and Gore, most of the Korwa are found involved with numbers of occupation or labor, these are (1) Forestry labor: have been divided into (a) Bamboo and woodcutters (b) Basket makers (c) Food gathering, (2) Agricultural labor: have been divided into (a) Dehadi labor or daily labor or casual labor (part-time work), (b) Banihar labor or attached labors (full time work), (3) Laborers: have been divided into (a) working outside and inside the village (b) migrant laborers. Natural or forest resources are an important source of livelihood for the community. They are not only dependent on these resources for income, but these are the resources for their survival. Traditional occupations were like collecting food items, cultivating maize, millet and vegetables, hunting and rope making.

Korwa people along with these traditional occupations, accepted and learned new patterns of work like being cultivators, agricultural laborers, contract laborers, construction laborers, brick making, road making and construction work. Most of the Korwas in the study area are losing

their own land under Forest Right Act, 2006. They are moving out of the villages to the cities with changing working patterns. Both male and female members are busy the whole year round in productive work. Different types of works are done in different months, so one person does forestry, agricultural and labor work as well. In both villages Semra and Gore all Korwa are more or less involved in forestry. 58 out of 80 households are involved both with agriculture and labor. There are nine households not involved with agriculture but they are working in forestry and have labor works. In the Semra village, 71 percent Korwa households have their own land and others 24 percent households do not have land for agriculture and they count themselves as landless. 54 percent households have less than two acres, 16 percent households have less than five acres and 5 percent households have less than ten acres. Similarly, in the Gore village, 79 percent households have land and others 14 percent do not have land for agriculture. 60 percent households have less than two acres, 21percent households have less than five acres and 5 percent households have less than ten acres. 72 percent households are involved with agricultural as well as labor including MNREGA. There are 12 percent households not involved with agricultural work and 16 percent are not doing any kind of work.

Before the applicability of the Forest Act 2006, the people from the Korwa community did not move to other states for non-agricultural labor but after that, they have to move for sustainability of life. Presently among Korwa there is no specific pattern of work, they are termed as multi-workers. These work patterns mostly drag them to other states like Maharashtra, Karnataka, Delhi, Punjab, Assam, UP and Bihar as migrant workers. They are working in construction sites, factories, mines, in brick making, and as agricultural labor. Changing occupational patterns play a leading role in the economic transformation among Korwa. For this, forest restrictions and connection with the outside world are responsible to a great extent. Traditionally only male members used to migrate in search of employment but nowadays younger couples with kids are also going outside for work. Generally, they are between the ages of 13 to 40 years. Agricultural laborers come back at the end of every season, but construction workers come back at festivals like 'Holi' and 'Sarhul Puja'. They come home once or twice a year. As a seasonal migrant worker, they move to other states for four months to one year for economic support to the family. 31 PVTG belongs to Semra and 19 PVTG belong to Gore village returned back to their village from other states during COVID-19 pandemic.

The market plays various roles in the Korwa lives. Semra and Gore both villages ~~are~~ mostly go~~ing~~ to Nawadih and Chanpur Market. They depend upon the weekly and bi-weekly market. For Korwas, the Haat (local market) has an economic and social value. They sell their products, which are collected from the forest (Wood, Kanda –Gathi, Mahuwa, Lac, Tooth burse, Ithani, Medicinal plant, Fruits and Lives) and purchase their day-to-day requirement (Muster oil, salt and rice). They collect various types of grass and creepers from the forest and earn money by selling in the market. In the study villages, Semra and Gore, there are certain expenditures which are half-yearly. The expenditures depend on how many people including children are present in a house. In the Semra village, 84 percent households have major expenditure (1000 and above) and 16 percent houses are not expending much. In the Gore village, 67 percent households have major expenditures. Korwa people expend money mostly on Food and drink related items, Sickness and accident, marriage, funerals and festival.

In the study area, Korwa poor economic conditions lead to equal economic burden on both men and women. Due to uneven division of labour women endure even more economic burden as compared to men all work related to forestry, agriculture and labor have to be undertaken with household work throughout pregnancy. They do almost all types of labor works for sustainability. There is chronic poverty amongst Korwa. Factors affecting chronic poverty in this area are the relationship between chronic poverty and climate condition for agriculture, land for agriculture, human capabilities, social structure, and many dynamics of poverty in this area. Impact of availability of natural resources, especially, land, water and forest contribute to poverty directly and indirectly in this area.

Transformation in healthcare system

After independence, the tribal and PVTGs communities had lots of change due to external and internal forces. According to respondents, the existence of traditional healthcare services existed with them since they exist. After independence, both study villages show the continuous transformation in healthcare services and practices in terms of availability, accessibility and affordability of healthcare due to changing socio-economic conditions.

The healthcare system of the Korwa community is the outcome of several interacting factors; which are connected with socio-cultural and magical-religious practices since ancient times. In

both the study villages, Korwa have had their own preventive and curative healthcare system. They have their own indigenous way of healing practice to heal various kinds of diseases and health-related problems. But there has been a gradual change in beliefs towards modern healthcare systems. They are slowly looking forward to modern healthcare systems rather than only relying on traditional practices.

In the study village, Korwa community have two types of the healthcare system at present, first is the traditional healthcare system and the second is the western healthcare system (Allopath). The traditional healthcare system can be divided into two parts; first spiritual and second herbal.

Spiritualists practice prayers with mantra, grams and sacrifices of animals whereas herbalists treat with the help of herbs, plant root, leaves, seed with a mantra. The allopathic healthcare system can also be divided into two parts first is private clinics and second is government hospitals (PHC Chainpur). Both place treat using biomedicines. Previously the Korwa people believed more in traditional healing practices due to their beliefs, the non-availability of health facilities, the nature of diseases and the economic conditions of the family.

Korwa community considers diseases are harmful and detrimental to normal life. They think most of the diseases are caused by supernatural powers and they have their own indigenous methods of preventing, diagnosing and curing diseases and health-related problems. The Korw carry knowledge about healing practices, which is passed on from generation to generation. Their traditional health practices are not scripted.
In both villages, Korwas mostly take treatment from traditional healers, who are present in the village and belong to the Korwa community. Among them, there are two types of traditional healers present in the village, first is spiritualist and the second is an herbalist. In the Semra village total 6 traditional healers are present, of whom, 3 belong to Korwa. Three are both spirituals and herbalist and one herbalist. In the Gore village, there is only one Bhagat.
However, with the establishment of the western healthcare system, there are signs of change in the indigenous healthcare system of the community. Study shows before 2012, in both the study villages Korwa people were mostly treated by the traditional healthcare providers. Over the time there has been an increased dependence on biomedicines. The Korwa people's first

choice of treatment is always to visit traditional healers, ANM, and private doctors as a second and doctors at PHC as the third choice. Among traditional healing practitioners, which are Bhagat, there are specialists such as Spiritualists who believe in Bhagawan and Dhusman (God and Evil) and Herbals who believe in Jadi –Buti (medicinal plant). Both practitioners are influenced by various cultural factors.

At present (2019) in the Gore village only one traditional healer is present who is a spiritual healer (Ojha). In Semra village there are three Bhagats present. They belong to Korwa community in which two are both spiritual and herbalist and one is an herbalist. All traditional healers took traditional knowledge from their ancestors.

Korwas believe Bhagats are mediators between Bhagawan (God) and us. They communicate with Gods, and then they find out the reason behind the disease and health-related problem. They believe that disease and death is caused by certain evil spirits or Dhusman. They are cause or linked with various diseases such as Diarrhea (Dashat-ulti), Pneumonia (Sanshchadahana), Goiter (Ghegharog/Gandhmala), Dropsy (Jalandhar rog), Paralysis (Lankawa), Gout (Gathiyarog), Leprosy (Kushtarog) and epilepsy (Mirgee). If they believe Bhagwan or Devi (God or Goddess) is angry with people then they link the diseases like measles (Mataji) and small measles (Chotimataji) with the same.

In the Semra village, there are three and in Gore village there is one Bhagat who belong to the korwa community who are herbalists. They cure people with the medicinal plants (herbs), animals' parts and mantra. Most of the Bhagats are having their own secret names for many of the medicinal plans. Plant name indicates the habit of the plant, color of flowers, shape of leaves, size of fruits and seeds. Bhagat are collecting the medicinal plants depending on the time season and on the plant parts. They collect medicinal plants part according to available season and a particular time. Bhagatsdiagnose according to the color of tongue, mouth, eyes, skin and nails. After that, they prepare medicine with mantra according to age and gender of the patient. They make medicine in forms of Mixture, Kadha (syrup), Gholl (Paste), Dhure(powder), Goli(tablets), and medicated oil from plant and animal fats. These medicines are taken with cold water, honey and rice beer according to Bhagat's suggestion.

There are two Dais (traditional birth attendants) in Semra Village and one in Gore village, most of the deliveries are conducted by them. They act as birth attendants for all the villagers including the korwa. Dais are very knowledgeable women with regard pregnancy and delivery.

They do not perform any test for women to check if they have conceived a child, they touch lower part of the stomach of the women for a few minutes to know if she is pregnant and she also tells a tentative date of childbirth. If the mother experiences stomach pain during pregnancy, Dai gives oil massage to mother's womb and identifies the position of baby and sorts out any other problem. During delivery, Dai can identify the position of the baby in the mother womb by examining her abdomen. If the Dai observes the baby (fetus) is not moving properly then she gives massage with lukewarm karanj oil with is mixed with garlic. The key role of a Dai is to assist pregnant women during delivery with moral support and to cut the cord with a new blade. The earlier practice was to cut the umbilical cord with an arrow.

At present not a single Korwa person is interested to learn and work as a traditional healer because of transformation in socio-economic pattern and arrival of the western healthcare system in the village but Korwa women are interested to learn and do the same work as a Dai.

Korwa people believe in traditional healing practices but they also show interest in biomedicine or allopathic medicine. If we talk about western healthcare practices, they go to both public healthcare facility (government healthcare facility) and private healthcare facility whichgives only allopathic medicines

In the ~~field~~ village, The public health services are provided through Anganwadi center and Sahiya at village, Sub-center at panchayat level, PHC/CHC at block level. There are two Anganwadi centers present in each of the villages. Both AWC are functional and AWW are present at center but there is no availability of modern medicine and any equipment except one small bottle of Dettol liquid, one roll of cotton and one bandage, which is not used. Overall hygiene of the center is not in good condition, infrastructure is poor and toilet facility not available. Food items were of very low quality and *khichadi* is served daily in all AWC.

Semra village Nawadh sub-center and Gore Nawadhe sub-center have two ANMs each. The center lacks basic facility like, electricity, water supply, bed and nurses. According to ANM, there are no boxes to keep medicine and equipment. The equipment is not in good condition and medicines are not available. Sphygmonometer is not in working condition from the last six months.

Field villages which is in Semra and Gore in Chainpur block have three Primary Health Centers (PHC) but only one PHC is in working condition. But this PHC/CHC is 18 kms away from Semra village and 19 kms far from Gore field village. There are six nurses and the lab is not

functional. Only one doctor is present regularly, the other one is available only on Tuesdays and Fridays. These two days are for conducting sterilization operations.

In the study area, health care facilities and utilization of primary health care is low particularly among the Korwa community due to poor economic conditions, distance of PHC, lack of transportation from village to PHC and attitude of health providers. Among PVTGs a smaller number of women come for ANC, child delivery and PNC but since the last two to three years numbers have increased in ANC and delivery among of them.

There are few women who do not complete their ANC but go for institutional delivery just to receive cash benefits. Most of these women had already delivered two or three children and it does not make any difference to them if they deliver at home or a hospital but these big amounts push them for institutional delivery. Six thousand is very big amount for them, which government gives them to promote institutional delivery of the babies and mother and child care after delivery.

For them government hospital is primary health centre (PHC) Chainpur. PHC Chainpur has a major role to play in the transformation in healthcare facility. In Chainpur there are a total of three PHC but only one PHC is in functional condition and share same building of CHC. After introduction of NRHM and maternal benefit programmes many women who belong to rural as well as study areas are interested in ~~to~~ institutional delivery. Reason behind it is lack of Traditional Healers, Dai and cash benefits. Korwa women are very poor and have repeated child birth. Women are in worst condition regarding health perception. Mostly mothers of Korwa community, who deliver baby in PHC/CHC, are interested in money, which is given by Janani Suraksha Yojana (JSY). Before 2017 they received Rs1400 for each delivery but after 2017 they receive Rs 6000 for first two deliveries with the condition that the mother should be above 18 years. This is change in beliefs, customs and rituals because PHC is majorly used for child birth. Child birth is a very important function for every community, they carry beliefs, customs and rituals with child birth. Total thirteen Korwa women from Semra delivered baby, of which 13.46 percent were home deliveries and 62 percent at PHC. Nine women from Gore village delivered baby, 33 percent women at home and 67 percent women at the PHC Chainpur

in between 2017 and 2018. Others came for all kinds of health-related problems, like tuberculosis, malaria, fever, diarrhea, cough & cold, and fractures.

In both villages, Semra and Gore, the age of marriage in the Korwa community is very early. Generally the marriageable age of girls is about 13 to 15 years and of boys' age is 18 to 20. A girl is ready to marry after she has started her menstrual period but early marriage before menarche is also known. They are malnourished and their dietary intake is not adequate to balance their heavy and hard physical workload. Korwa women with poor health and nutrition have a higher probability of giving birth to an underweight child. They are also less able to provide food and sufficient care to their children. While malnutrition is prevalent among all segments of the population (child, young, old age), poor nutrition among women is there since childhood.

Korwa women tend to neglect their general health, during pregnancy, childbirth, and post-partum. Women from this area complained of frequent headaches, dizziness, cold, cough, body pain, and joint pain but they are not treating it as a serious complication during pregnancy. For these complications, they usually take home remedies that are given by their mother-in-law, father-in-law or the Bhagat. They visit the health center when the condition gets worse. However, they did not mention it as a health problem but said that like any other woman they have frequent headaches, dizziness, and body pain. That is normal for women. Five and three women from Semra and Gore village respectively were suffering from tuberculosis during pregnancy.

Before Janani Suraksha Yojana, the whole family and community were involvedin the motherhood of an expecting woman. Healthcare practices started with the elder woman of family, Dai (Traditional Birth Attended), Bhagat, and Ojha (Traditional Healers). Public healthcare services did not reach to them properly in this period at study village. The elder woman of the family acted as a guide for pregnancy, childbirth, and child care.

Korwa women believe that the delay of the menstruation cycle by approx fifteen to twenty days, frequent vomiting, excessive fatigue, enlargement of breasts and frequent urination are signs of pregnancy. If they conceive for a second time then stoppage of the menstrual cycle and mother- milk is a clear indicator of pregnancy.

The restrictions imposed upon the pregnant women have been followed from generation to generation like, pregnant woman are not allowed to visit a forest after sun-set not to pass by places where there are evil-spirits. They are not allowed to go near many giant trees, which are supposed to be the abode of *Dakin*. They are not to sleep in open places. It is believed that an evil spirit will destroy the child in the womb. During the period of Suryagrahan (Solar eclipse) and Chandragrahan (Moon eclipse) the pregnant women are not allowed to come out of the home. She avoids strong light, sound, rain, thunder, and jackfruit. Otherwise, no such restriction is imposed on food and they do not take any special food during pregnancy. Food is entirely dependent upon the economic conditions of the Korwa community even during the period of pregnancy.

Like every woman, the women in Korwa tribe are also advised to refrain from hard work during pregnancy but they work very hard nonetheless. They believe doing work during pregnancy will make the body flexible so the delivery of the baby is easier. They have land but not for agriculture, so women go to the forest daily and also do very heavy work at home. Theydo daily domestic work like bringing firewood from the forest, fetching drinking water from the river or well or hand pump, cook food, cleaning houses, and utensils, even they carry branches of wood which is around twenty to twenty-five kg for sale in the market on their head. They also have to go to the forest and the field for collecting roots, tubers, and for other fieldwork.

Korwa women experience irregularity in the menstrual cycle, white discharge, fever, weakness, bleeding during pregnancy, vomiting, dizziness, anemia, stomach pain, pelvic pain, malaria, and diarrhea. They generally got treatment from the Bhagat before 2005. Medicinal plants are used in different forms like paste, powder, kadha (juice form), raw plant parts, Goli and massage oil. The most common form in which the medicinal plants are taken are kadha and goalie that is made by them.

Korwa women confirm pregnancy after three months to the community due to the fear of miscarriage and evil eyes. Miscarriages are very common in the study area. Women who have experienced more than four pregnancies have gone through at least one miscarriage. 72 percent women from Semra and 65 percent women from Gore had experience of miscarriages.

At the time of delivery women face complications like for women undergoing labor pain there is a delay in the birth of the child. Bhagat gives her Jadi which looks like a plant root that is tied with mother. Dai has a very important role to play during pregnancy with regard to health-related complications like stomach pain, back pain and to check movement of the baby.

Post-delivery traditional rituals are performed by Dai along with elder women of house or community. Post-delivery mother does not enter into the kitchen till the umbilical cord dries or Chatiyare Puja. If the new born baby does not cry after birth they whisper a traditional song in its ear, drop water on its face or hold it upside down by the legs to make it cry. After the delivery mother will take one meal in the case of a baby boy and two meals in the case of a baby girl, the reason being whatever the mother eats, the baby takes through mother milk and the baby boy can't digest heavy food but a baby girl can. Dai assists in most deliveries and stays with the mother for six days until the Chhatiyare puja celebration.

Korwa women were not interested in institutional delivery when JSY was launched. After 7-8 years, in 2012 first women delivered a boy from Semra village and in 2013 from Gore village. That time many Korwa women did not have BPL cards and they did not get any kind of money from PHC. Money is the only reason for institutional delivery otherwise they believe in-home delivery as it is cheaper and convenient compared to PHC. If we look at the numbers, before 2016 the number opting for institutional deliveries were very low, which spiked after that.

Presently there is a big issue with family planning among the Korwa community. Among the respondents, seventeen women and six men wanted to opt for Family planning operation but they are not being allowed at PHC because it is banned by the Indian Government for PVTGs communities as their populations have dwindled over the years. They have traditional methods to control pregnancy but it is not as effective as operation. Bhagat gives a medicinal root (name not mention) to soak in water and drink for women after intercourse. Women believe that if after intercourse they pass urine then there is very little chance to conceive. At the age of 40, every woman has experienced seven to eight children, at this age mothers as well as the child are more physically vulnerable.

Factors associated with maternal and child healthcare practices: Distance of health centre from the area, Poor rood and transport problem, financial situation, Delay in decision making, Poor health infrastructure and facility

Child healthcare decisions are generally taken by husband and elder women of the family. Korwa community know about immunization though shaiya but very less number families of Korwa community are interested and are coming forward for immunization. In Semra village they are more interested in child immunization. In Semra village, almost all children those who are delivered at home also get immunization at village level. ANM visit Gore village but a small number of children are sent for immunization. In 2018-19 in both villages every child has been immunized in PHC or at village level. Immunization services are mostly provided by the AWW at the center and ANM come to give vaccine on a monthly basis. Polio vaccine, measles, BCG and DPT are given to children at the AWC. Common health related problem in under five-year children are cough and cold, loose motion, malaria, diarrhea, head pain (Sarfatna), measles (Mataji), shrinking of veins (Naskhinchna), jaundice (Pileya), heated hot air in summer (loo lagana) and high fever. In the Semra village, one infant died because of respiratory infection (Ganda pane pina) and one died because of fever and diarrhea. In Gore village, one infant died because of high fever and premature birth in 2017-18. One infant died after birth because of high fever in Semra and none of the infants died in Gore village in 2018-2019. Over the year's child death is reducing but deaths have happened. Malaria and diarrhea are the main cause of child mortality, most of the children die because of high fever, diarrhea and malnutrition.

Korwa community is vulnerable and is suffering almost same problems at both villages. Both villages suffer with malaria, fever, cough & cold, ear problems, tuberculosis, diarrhea, worm infection, scabies and AIDS. Malaria, Diarrhea, fever, jaundice and pneumonia are killer diseases for children and as well as for the elderly. Malaria (medical officer of PHC mention Plasmodium Falciparum higher in palamu district) is a major health problem in both study area, thirty-seven from Semra village and twenty-one from Gore village were diagnosed and two from Semra and two from Gore died due to malaria. Malaria is a frequent occurrence and the morbidity and mortality associated with the disease are alarming. Measles is also high in these areas, twenty-two in Semra and fifteen in Gore village were suffering measles. Maximum korwa peoples who are affected with tuberculosis take treatment from PHC/CHC but no one is cured. Multiple reasons are behind this, irregularity in medicine, food, unhygienic condition, and workload. Children and the elderly are at the greatest risk of morbidity and mortality from infectious diseases especially if malnourished.

The preference for the health service provider in ~~the~~ both villages depends on the availability of facilities, the nature of diseases and the financial condition of the families. Korwa people firstly believe in home remedies for diseases like measles, dehydration, measles, and skin problems. In cases like fever, swelling of feet, vomiting, weakness, loose motion the Korwa people first consult with traditional healer. If it's not cured with this herbal medicine then Bhagat tells them to go to PHC/CHC.

Second is AWC and ANM, Anganwadi center (AWC), and Anganwadi workers are present in both villages. Anganwadi centers are working but there is ~~an~~ unavailability of modern medicines and equipment except one small bottle of Dettol liquid and one roll of cotton, and one bandage that is not used. Source of treatment is private doctors who belong to the same village one in Semra and one in Gore village. According to the respondent, access to private doctors is easy, available and affordable.

Third is a public healthcare facility which is basically PHC/CHC, the primary health center is very far from the village but the recent perception in the community is changing, they prefer western healthcare treatment. Basically, the Korwa community prefers PHC for the ANC, delivery, PNC, immunization and treatment of tuberculosis.

No other modern healthcare facility is available at the village level, which also leads to greater belief in Bhagat or traditional forms of treatment. Most of the Korwa people in both villages want to prefer modern healthcare practice of treatment, but due to financial problems, long hours of travel, and lack of availability and accessibility, they are unable to avail it.

There is a dilemma between the traditional healthcare facility and western healthcare facility. In the study villages, the Korwa community carries two different perceptions at a time, firstly there is no public healthcare facility like a hospital, PHC, or doctor in the village or near the village. The traditional healers/ojha and Dai were found to be functional in both study villages. The faith in traditional healthcare and treatment within the community is strong, not only due to the absence of public healthcare facilities but also due to the permanence of this form of treatment, along with easy availability and accessibility at a lower cost. And other perceptions, as per respondent are that there are too many diseases which traditional healers take time and many diseases are not cured by them. Korwa community's perception of healthcare depends upon the availability of and accessibility to healthcare facilities.

Holistically the numbers show an increase in the population, sex ratio and literacy but the growth is not promising when it comes to quality of life. Housing patterns have changed from mostly kaccha houses to houses of mixed nature. There has been a gradual shift across all aspects of life including availability of the basic resources of livelihood, sources of water, occupational and economic patterns, health practices and priority of healthcare services. These changes have also widened the gap between the traditional beliefs and customs and the ones prevalent in present times. There is a shift towards nuclear family structure as well which also contributes in widening the gap. One thing which remains a constant is the poor socio economic conditions and the vulnerability of these tribes.

Conclusion

Historically and as per the existing literature, the Korwa's are vulnerable because of a number of socio-economic factors. Their poor conditions in terms of work participation, low education level, practice of isolation, topography of the areas they reside in and primitive methods of production creates a vicious cycle of poverty and backwardness. The present study shows that over the years there have been changes in the living conditions like lifestyle, food habits, beliefs, customs, housing, education, drinking water, occupational patterns and healthcare services and these changes slowly diluted the identity, heritage and beliefs of the Korwa community. Transformation observable at the social and economic level shows both positive and negative changes. Korwa from study villages are living in a better housing facility than earlier, are interested in education, use hand-pumps for drinking water, have evolved into a multi worker for livelihood, have more options for healthcare services but on the other hand, they are losing their beliefs, customs and rituals, traditional occupational identity, traditional healers and medicines.

This study shows the transformation in the utilization of maternal and child health and communicable diseases from traditional healthcare to western healthcare services among Korwa induced by various factors, making them more vulnerable. In terms of health practices, the changes show only negative repercussions on the traditional practices.

Their local knowledge of herbal medicines and traditional birthing practices have been ignored by the allopathic health system, there has been a push on them to bring them to the hospitals where the treatment is at best subpar. Besides, the transport facilities available to reach hospitals are very poor.

Women with poor health status are likely to give birth to underweight babies and may not be able to provide adequate food and childcare. Out of many serious health issues of women's health in PVTGs, reproductive health is a major concern, followed by planning programs as well as the programs for child survival. Poor Ante-Natal Care, unhygienic condition at childbirth, and risky abortions continue in spite of known risks.

The study has shown that there are gaps in Accessibility, availability and affordability of health services and are the major problems in these areas. The reflection of the reality of health care is the function of state intervention and people's awareness.

In such a challenging situation, the best results can be obtained if the government departmental staff working on forestry, agriculture, ICDS, women and child development, tribal affairs, rural development and health work together in an intensive policy for improving the situation of the PVTGs. There is also a need to look at the policies and the targeted impact from a point of view of the tribals rather than from a point of view of an urban society. The major problem that can be inferred out of the study is that the tribal populace is moving away from the traditional healthcare system which is threatening to the livelihood of the traditional healers. There is a reluctance in the healers to pass on their knowledge and know how to present and future generations, the dwindling number of bhagats is a testament to the same. Also the migration of the tribals in search of better opportunities to the cities and towns adds to the issue where the youth are not available to learn the traditional knowledge. On the other hand the sub centers are far and inaccessible in terms of facilities and physical distance. This has created a situation where the tribal population is stuck somewhere in the middle facing non availability of both the mediums.

The Biomedicine should be made available to the people. Although there has been some progress in terms of availability, efforts should be made to bring the healthcare facilities to the people rather than bringing the people to the facilities. If opportunities for employment and

livelihood is presented in the tribal areas itself, the migration can be checked which can help to conserve the knowledge and heritage of the tribals. Also the implementation of the policies and programs should be at a ground level and execution should be tracked to ensure there are no slippages between the plan and execution of the same. The occupations pattern alternatives, restrictions imposed on use of forest resources, healthcare alternatives and preferences and benefit programs have all been created keeping in mind what an urban society will want and what steps are required to develop an urban civilization. The tribals are in core a different society with different belief system and perceptions of growth and success and that should be considered while formulating the programs.

BIBLIOGRAPHY

Journal Articles:

1. Agarwal R. (2013). Sustainable Livelihood Options for Primitive Tribal Groups in Jharkhand: CSR Initiatives by Tata Steel. *AIMA Journal of Management & Research, vol-* 7, Issue ¼, ISSN 0974-497.

2. Alam. S., Roy. K., (2011) Conservation of Tribal Heritage in Jharkhand. In Shym M. & Verma S. K. (ED) *Anusandhanika / Refered Research journal of social science.* Vol. IX / No. II / July 2011: 27-33

3. Agrawal S. (2013). Disadvantageous Situation of Tribal Women and Children of Orrisa, India: A Special Reference to Their Health and Nutritional Status. *Journal of Community Nutrition & Health* vol.2.

4. Baru et al (2010). Inequities in Access to Health Services in India: Caste, Class and Region, *Economic& Political Weekly*, VOL, XI,V No 38

5. Basu S. (2000). Dimensions of Tribal Health in India, *Health and Population Perspectives and Issues*, 23(2): 61-70.

6. Bench A. (2020). One of India's poorest States, Jharkhand Shows that Nothing Impossible it Arranges Planes for Migrants", *Arre*, May 28, 2020. https://www.arre.co.in/coronavirus/jharkhand-arranges-planes-for-migrants. 7/10/2020.

7. Debashis D. (2014). The Health Problems And Status Of The Particularly Vulnerable Tribal Groups Of Madhya Pradesh – A Case Study In Anthropological Dimension, *Man in India,* 94(4): 597-609

8. Deogaonkar M., (2004): Socio-economic inequality and its effect on healthcare delivery in India: Inequality and healthcare. *Electronic Journal of Sociology*. ISSN: 1198,

Furer-Haimendorf C. V. (1982): Tribes of India: The Struggle for Survival. *University of California Press*, http://ark.cdlib.org/ark:/13030/ft8r29p2r8/https://himalaya.socanth.cam.ac.uk/collections/rarebooks/downloads/Haimendorf_Tribes_of_India.pdf. Access on 12/10/2016.

9. Hashempoura M. R. (2016). Health and Medical Socilogy. *J. Health Edu Res Dev, Medical Sociology,* 4(3), ISSN: 2380-5439 JHED, http://dx.doi.org/10.4172/2380-5439.C1.002, Access on: 12/11/2019.

10. Humairah I. (2010), History of Healthcare in India: The Golden Age of Medicine, *Health Opinion*, http://healthopine.com/history-of-healthcare-in-india-the-golden-age-of-medicine-in-pre-independent-india/ Access on: 4/09/15.

11. Khan I. & Nayak J. K., (2019): Health status of the Hill-korwa women in Sarguja district, Chhattisgarh: an Anthropological assessment, *The research journal of social sciences*, 10(3). ISSN 0025-1348 (P), 2456-1356.

12. Kshatriya G. K., (2014), Changing Perspectives of Tribal Health in the Context of Increasing Lifestyle Diseases in India, *Environmental and Social Sciences*, vol. 1., access on 21/09/15.

13. Kumar S. (2015): Profile of Diseases Prevalent in a Tribal Locality in Jharkhand, India: A Family Medicine Practitioner's Perspective, *Journal of Family Medcine and Primary care,* 4 (1): 110-116 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4366980/, Access on 2/03/2020.

14. Laksmi V. V. & Paul M. M. (2019):"Socio-Economic Conditions of Tribal Communities in Telangana and Andhra Pradesh", *ACTA Scientific Agriculture,* ISSN: 2581-365X, Vol-3 issue 8 August 2019, DOI: 10.31080/ASAG.2019.03.0571.

15. Madane (2016): Social Exclusion and Inclusion of De-notified, Nomadic, Smi-nomadic Tribal in India. *Asian Journal of Research in Social Sciences and Humanities.* Vol. 6, No.9, pp. 1726-1736
16. Maiti S., Unisa S. & Agrawal P. (2005). Health Care and Health among Tribal Women in Jharkhand: A Situation Analysis, *Studies of Tribal and tribal*. 3(1): 37-46, DOL: 10.1080/0972639X.2005.11886518.

17. Mishra A. & Sarma S. (2011). Understanding Health and Illness among tribal communities in Orissa. *Indian Anthropological Association,* Vol. 41, No. 1, pp- 1-16.

18. Mohantly B, (2005). Policy for Tribal Development: Protective Discrimination or Discrimination Protected, *the Eastern anthropologist*, pp-27-59.

19. Mondal A, and Mete J, (2012). Tribal Development In India: Educational Perspective, *Indian Streams Research Journal,* Vol 2 Issue 11, Dec 2012, pp- 8.

20. Mukharjree S. (2013). Conceptualization and Classification of Caste and Tribe by the Census of India, *Journal of the Anthropology Survey of India,* 62 (2): (805-820).

21. Muniraju S. B. & Rachita T. (2018). Development Deficits of Particularly Vulnerable Tribal Groups (PVTGs) and Way Forward. *Journal of Rural Development Review,* 5(6).

22. Muniraju T. (2018). Development deficits of Particularly Vulnerable Tribal Groups (PVTGs) and way forward, *Journal of Rural Development Review* Vol.-VI, No.-6, ISSN No. 2456 -7191.

23. Naindu T. S. (2007): Tribal Health in India Problem and Future Perspactives, *Department of Anthropology,* Pondichery University.

24. Pandey M. M. & et al (2013) Indian Traditional Ayurvedic System of Medicine and Nutritional Supplementation. *Hindawi Publishing Corporation*, Evidence-Based

Complementary and Alternative Medicine. Article ID 376327, 12 pages, http://dx.doi.org/10.1155/2013/376327.

25. Pattnaik S. K. (2017). Recognize Habitat Rights of Particularly Vulnerable Tribal Groups (PVTGs), Discussion Paper. *National Centre for Advocacy Studies.*

26. Purkayastha N. (2015). Tribal Development Policies after Independence: A Study on Oraon Tribal in Barakvaiily Region of Assam, *International Journal in Management and Social Science,* 03(07). ISSN: 2321-1784.

27. Radhakrishana, M. (2009). Starvation among Primitive Tribal Groups. *Economic and Political Weekly,* 44 (18): 13–16.

28. Rai R. & Nath V. (2005). Use of Medicinal Plants by Traditional Herbal Healers in Central India. *World Foresty Congress,* vol: 1.

29. Rao P. Durga, (2019). Health Status and Use of Contraception among Particularly Vulnerable Tribal Groups in Visakhapatnam District of Andhra Pradesh, India", *International Journal of Recent Technology and Engineering (IJRTE).* 7(6S3), ISSN: 2277-3878, https://www.ijrte.org/wp-content/uploads/papers/v7i6s5/F10820476S519.pdf (17/5/2020).

30. Sahoo A. (2014). Traditionalism and Globalization: A Discourse on Tribal Transformation. *Orisha Review.* Pp-92-98, http://odisha.gov.in/e-magazine/Orissareview/2014/April-May/engpdf/92-98.pdf, Access on: 7/8/2015.

31. Sahu S. (2019): Demographic Trends and Occupational Structure of Particularly Vulnerable Tribal Groups of Jharkhand, *Int. J. Rev. and Res. Social social*; 7(2): 316-322, DOI: 10.5958/2454-2687.2019.000212.

32. Sarkar A. & Dasgupta D. (2007) Stratification of Bastar Tribes, Anthropological Survey of India, *Kamla – Raj.* 5(2): 97-102.

33. Sharma R. (2016). Socio-Economic and Demographic Characteristics of Three Most Backward Tribes of Madhya Pradesh. *Tribal Health Bulletin.* 23(1).

34. Sharma V. P. (2008). From Hill to Plain: An Experiment in Applied and Action Anthropology in India. *International Socirty for Research Activity (ISRA).* PP- 1-4. http://www.slideshare.net/guestd4d9e13/applied-and-action-anthropology-korwa-rehabilitation-presentation, Access on 25/08/15.

35. Sharma et. al. (2013). The Transition of Childbirth Practices among Tribal Women in Gujarat, India - A Grounded Theory Approach. *BMC International Health and Human Rights:* 1–15.

36. Shrivastava S. & Sivakami M. (2020). Obstetric Violence During covid-19 is yet Another Challenge for Indian Women. *The Wire.* April 23, 2020.

37. Shrivastava S. (2007) Tribal dependence on fly ash in Korba, journal of ecological anthropology, 11, pp- 69-73.

38. Shukla A. (nd). Tribal Rights and Healthcare System: Reflections on Civil Society's Contribution in Tribal Health in Tamilnadu, access on, 04/09/15.

39. Singh L & et al. (2012): Assessing the Utilization of Maternal and Child Health Care among Married Adolescent Women: Evidence Form India. *Journal of Biosocial Science* 44: 1–26. Doi: 10.1017/S0021932011000472.

40. Sinha M. & Shipurkar T. (2020). Union Budget 2020-21: Denotified, Nomadic, Semi-nomadic Tribaes Left Out Once Again. *Down to Earth, Published*. Sunday 02 February 2020.

41. Sinha P. S. & Tripathi J. P. (2017). Scheduled Tribes Socio-economic Status in Jharkhand. *IOSR Journal of Research & Method in Education (IOSR-JRME)*. 7(4) pp-47-53,ISSN: 2320–7388, www.iosrjournals.org.

42. Sonowal C. J. & Parharaj P. (2009). Traditional Vs Transition: Acceptance of Health Care System among the Santhals of Orrissa, *Studies on Ethno-Medicine.* 1(2), pp: 135-146. https://doi.org/10.1080/09735070.2007.11886306.

43. Sonowal C. J. (2008). Indian Tribes and Issue of Social Inclusion and Exclusion, *Study of Tribes and Tribals,* 6(2): 123-134, http://www.krepublishers.com/02-Journals/T%20&%20T/T%20&%20T-06-0-000-000-2008-Web/T%20&%20T-06-2-000-000-2008-Abst-PDF/T%20&%20T-06-2-123-08-162-Sonowal-C-J/T&T-06-2-123-08-162-Sonowal-C-J-Tt.pdf. Access on: 07-04-15.

44. Sreenivasa et al. (2019). Livelihood Strategies Resource and Nutritional Status of Forest dependent Primitive Tribes Chenchu in Andhra Pradesh and Telangana States". Nutri Food Sci Int J. 2019. 8(2): 555735. DOI: 10.19080/NFSIJ.2019.08.555735.

45. Unnikrishnan P. (2010). Traditional Medicine in Health System Development: A Case Study of Kerala State, India. *Yokohama journal of social scinces,* 15(3), pp- 77-101. https://www.researchgate.net/publication/49288770, Access on: 1/26/2019.

46. Upadhyay V. S. & Pandy G. (2003): Tribal Development in India a Critical Approach, *Pub-crown Publication Ranchi.* 1st Edition.

47. Vammeman R. (2003). Economy servey "Indian district database" department of sociology 'University of Maryland, April 5, 2003.

48. Varadarjan et al (2009). Indigenous health practices among Andhra tribals. *Health and Population: Perspectives and Issues*. 32 (1), PP- 47-53.

49. Verma M. K. (2014). Health, Tradition and Awareness: A Perspective on the Tribal Health Care Practices. *International journal research process,* 2(2). pp. 82-91, ISSSN-2321-211X

50. Vijaya V. & Paul M. M. (2019). Socio-Economic Conditions of Tribal Communities in Telangana and Andhra Pradesh. *Acta Scientific Agriculture.* 3(8). PP: 104-109. DOI: 10.31080/ASAG.2019.03.0571.

51. Xaxa V. (1999). Transformation of Tribes in India: Terms of Discourse. *Economic and Political Weekly,* Vol. 34, pp. 1519-1524.

52. Xaxa V. (2011). The status of tribal childeran in India: A historical perspective. *IHD - UNICEF Working Paper Series Children of India: Rights and Opportunities* Working Paper No. 7.

53. Xaxa V. (2001). Empowerment of Tribes. *Social Development and the Empowerment of the Marginalized Groups: Perspectives and Strategies, New Delhi: Sage Publication, New Delhi,* 205

54. Yadavar S. (2019). World Health Day 2019: Access, Quality of care rank India among lowers globally", *Firstpost,* India Shaend, April 07, 2019.

Books:

1. Arnold D. (1993): Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth Century India, *Berkley: University of California Press,* ISBN: 0-520-0829585.

2. Bailey F.G. (1961). Tribe and Caste in India. In (ED) Contribution to Indian Sociology. *Mouton,* Vol.5. Pp.7-19.

3. Bang R. (2011): "Putting Wonen First: Women and Health in a Rural Community", *Mandira Sen for STREE,* ISBN: 81-85604-94-7.

4. Chaudhary B., (2012): “Tribal Health, Traditional Wisdom and Knowledge Challenge, in Chaudhary S. N. (ED) “Tribal Health and Nutrition”. *Rawat Publication, New Delhi*, ISBN-13: 978-8131605127.
5. Chaudhary S. N., (2009): “Tribal Development since Independence”, *Concept Publishing Company*, ISBN. 10-81-8069-622-7.

6. Chaurasia A. R, (2012): “Living Condition and Health Status of Scheduled Tribes in India: Evidence Form DLHS 2007-08”, In Chaudhary S. N. (ED) Tribal Health and Nutrition. *Rawat Publication, New Delhi,* pp: 64–74. ISBN-13: 978-8131605127.

7. Dash, A., (2012): “Status of Tribal Health and Nutrition Evidence from Rural Odisha, in Chaudhary S. N. (ED) *Tribal Health and Nutrition.* Rawat Publication, New Delhi: 259–63.

8. Desai A.R. (1978):“Rural Socilologyin India”, Popular Prakashan Private Limited., ISBN 978-81-71541546. PP-221-231.

9. Desai I. P. & Shan G., (1997): “Social Transformation in India: Essays in Honour of Professor, P. Desai”, *Rawat Publication,* vol-2, OCOLC: 607662428.

10. Gangolli Leena & et al. (2005). Review of Healthcare In India, Centre for Enquiry into Health and Allied Themes. ISBN: 81-89042-40-8. http://www.cehat.org/publications/PDf%20files/r51.pdf , Access on 3/09/15.

11. Gillin J. L. & Gillin J. (1954): Cultural Sociology, A Revision of “An Introduction to Sociology”, *New York: MacMillan,* OCOLA: 278394638, PP- 561-562.

12. Hasnain N. (1991): “Tribal India”, *Palaka Prakashan,* ISBN: 978818579961X.

13. Jaiswal A. (2018). Traditional Health Care and Traditional Medicine in India. Crimson Publication Wings to the Research Archaeology& Anthropology, ISBN: 2577-1949.

14. Kalla A. K. & P. C. (2004): “Tribal health and Medicines”, concept publication company, ISBN81-8069-139-X.

15. Kshatriya G. K. (2004). Tribal Health in India: Perspectives in Medical Anthropology”. Tribal Health and Medicines. In Kalla, K.A. & Joshi, P.C. (ED). *New Delhi: Concept Publishing Company*. Pp. 17-45. ISBN 13: 9788180691393

16. Kumar R.K. and Kapoor A.K. (2008): “Health Profile of Parhaiya: A Primitive Tribe Jharkhand, in: Bio-Social Issues in Health”. Northern Book Centre, New Delhi, 463–470.

17. Lakshmi G. (1985): “Socio-Economic Context of Maternal and Child Health Practices – A Case Studies of Andhra village”, CSMCH, J.N.U.

18. Majumdar D. N. & Madan T.N. (1986): “An Introduction to Social Anthropology”, *Balaji Printer*, ISBN: 978-93-88392-00-6

19. Mohanty P. K. (2004): “Encyclopaedia of Primitive Tribes in India”, Kalpaz Publications, New York, U.S. A. vol. 2, ISBN 13: 9788178352794. https://books.google.co.in/books?id=qGGWIZ8mrAC&pg=PA392&lpg=PA392&dq=encyclopedia+of+primitive+tribes+in+india,+korwa+tribe&source=bl&ots=P_qkLUTot5&sig=wjVnZFKCRpIFIeV5QuFmqWU42tk&hl=en&1sa=X&ved=0CEUQ6AEwCGoVChMInrPrqq24xwIVkYOCh1O9AUy#v=onepage&q=encyclopedia%20of%20primitive%20tribes%20in%20india%2C%20korwa%20tribe&f=false. Access on: 21/03/2016

20. Parsons T. (1954). An Analytical Approach to the Theory of Social Stratification, *Light & Life Publishers,* New Delhi. In Pathak R. K. & Sinha A.K. (2008): Bio-Social Issues in Health, *Northern Book Center*, chapter- 54-55.

21. Rao K.M., (2008): “Utilization of Reproductive and Child Health Services in Tribal Areas of Andhra Pradesh”, *Health and Nutritional Problems of Indigenous Populations. Kamla Raj Enterprise*: Vol. No. 2, pp-35–41.

22. Sagar A. D., (1999): “The Social Basis of Outcomes of Pregnancy in the Gautam Nagar Slum OF Delhi”. Centre of Social Medicine and Community Health, School of Social Sciences, Jawaharlal Nehru University.

23. Saklani B., (2008): “Folk Perception of Women’s Affections in Garhwal Himalayas in Uttaranchal: A Bio-Social Perspective, Bio-Social Issues in Health”. *Northern Book Centre*, *New Delhi*: 205–15.

24. Sandhwar A. N., (2008). Problem of tribal of Jharkhand. Bio-Social Issues in Health. *Northern Book Centre, New Delhi*: 461–462.

25. Shirvastava V.K., (2012). Status of Tribal Health of and Nutrition: Agenda for Action, In Chaudhary S. N. (ED) Tribal Health and Nutrition. *Rawat Publication, New Delhi,* pp: 104–107. ISBN-13: 978-8131605127.

26. Singh V., and Palak J., (2012): “Tribal Health: Problems and Prospects, In Chaudhary S. N. (ED) Tribal Health and Nutrition. *Rawat Publication, New Delhi,* pp: 179–87. ISBN-13: 978-8131605127.

27. Sisodia Y. S. & Tapas D., (2012).Saharia Primitive Tribal Group in Madhy Pradesh”, In Chaudhary S. N. (ED) Tribal Health and Nutrition. *Rawat Publication, New Delhi,* pp: 173–77. ISBN-13: 978-8131605127.

28. Tribhuwa R. D. (2004):“Health of Primitive Tribes”, *Discovery Publication Houses New Delhi.* ISBN: 8171419038.

29. Tripathy B. & Kumar M. B. (2016). Recent Research on the Tribes of Central India. *Aayu Publications,* ISBN: 978-93-85161-18-6.

30. Upadhyay V. S. & Pandy G. (2003): “Tribal Development in India a Critical Approach”, Pub-crown Publication Ranchi.

Reports:

1. Annual Report, 2012-13. (Ministry of Tribal Affairs Government of India). https://tribal.nic.in/downloads/Statistics/AnnualReport/AR2012-13.pdf , access on 03/02/2014

2. Annual Report, 2018-19. Ministry of Tribal Affairs, Government of India. https://tribal.nic.in/downloads/Statistics/AnnualReport/AREnglish1819.pdf, Access on: 13/05/2020.

3. Bang Abhay (2018) Tribal Health in India- Bridging the Gap and a Roodmap for the Future-executive summary and recommendations. Ministry of Health & Family Welfare, http://nhm.gov.in/nhm_components/tribal_report/Executive_Summary.pdf, Access on 11/03/2020.

4. Census of India (2001): Office of the Registrar General & Census Commissioner, India, Ministry of Home Affairs, Government of India.

5. Chakraborty D. 2019. Jharkhand second from bottom in child well-being index, The Times of India, Ranchi. TNN / Aug 28, 2019, 06:31 IST. https://timesofindia.indiatimes.com/city/ranchi/jharkhand-second-from-bottom-in-child-well-being-index/articleshow/70867878.cms. Access on: 26/11/2019.

6. Daniel U. et al 2016, Odisha Vikash Conclave: Challenges, Opportunities, WAY Forward. Centre for Youth and Social Development (CYSD). http://ncasindia.org/wp-content/pdf/pub/dp/pvtg.pdf, Access on: (6/05/2020).

7. District Agriculture Plan Palamu District, 2008-09 to 2011-12 (Nabard Consultancy Services Jharkhand Regional Office Ranchi), Map of Palamu District Gore Village, 2018, Indikash-All about India, https://indikosh.com/vill/383910/gore/, Access on: 07/12/19.

8. Empowering The Scheduled Tribes The Tenth Five Year Plan (2002-2007), TFYP Steering Committee (2001), "Government of India Planning Commission New Delhi, https://niti.gov.in/planningcommission.gov.in/docs/aboutus/committee/strgrp/stg_sts.pdf, Access on: 13/05/2016.

9. Government of India, (2017), Ministry of Women and Child Development. Shastri Bhawan, New Delhi, Government of India, F.No.11-9/2017-MBP https://wcd.nic.in/sites/default/files/Maternity%20Benefit%20Programme_1.pdf, Access on: 9/01/2020.

10. Health Profile of Scheduled Tribes, (2012), Ministry of Tribal Affairs Government of India, 2012.

11. International Institute for population sciences (2008). National Family Health Survey, Jharkhand (NFHS-3), 2005-06: India. Mumbai, India: International Institute for population sciences.

12. International Institute for population sciences and (ICF), (2017). National Family Health Survey (NFHS-4), 2015-16: India. Mumbai, India: International Institute for population sciences.

13. International Institute for population sciences (2017). National Family Health Survey, Jharkhand (NFHS-4), 2015-16: India. Mumbai, India: International Institute for population sciences.

14. International Institute for population sciences and ORC Macro. (2000). National Family Health Survey (NFHS-2), 1998-99: India. Mumbai: India: International Institute for population sciences.

15. International Institute for population sciences. (1995). National Family Health Survey (MCH and Family Planning) (NFHS-1), 1992-93: India. Mumbai, India: International Institute for population sciences.

16. International Institute for population sciences. (2007). National Family Health Survey (NFHS-4), 2005-06: India. Mumbai, India: International Institute for population sciences.

17. International Institute for Population Sciences, 2010. District Level Household and Facility Survey (DLHS-3), 2007-08: India. Mumbai: International Institute for Population Sciences.

18. Janani Suraksha Yojana, (2015) National Health Portal India, Gateway of Authentic Health Information, NHP CC DC, https://www.nhp.gov.in/janani-suraksha-yojana-jsy-_pg, Access on 21/04/2020.

19. Jharkhand Profile, 2011, Censuesinfo India, UNICEF, Census info India 2011,

http://censusindia.gov.in/2011census/censusinfodashboard/stock/profiles/en/IND020_Jharkhand.pdf , Accessed on 15/05/2014

20. Jharkhand Tribal Development Plan, IPE (2013), Jharkhand rural water supply and sanitation project, The World Bank Assisted, IPP629V2. http://documents1.worldbank.org/curated/en/153061468041654030/pdf/IPP6290v20P1320C0disclosed04050130.pdf, Access on: 13/03/15.

21. Ministry of Home Affairs, Annual Health Survey Bulletin, Jharkhand 2010-11, Annual Health Survey (AHS) bulletins 2010-2011- Data on health aspects of nine states by Ministry of Home Affairs, Government of India, https://www.indiawaterportal.org/articles/annual-health-survey-ahs-bulletins-2010-2011-data-health-aspects-nine-states-ministry-home, Access on: 11/03/16.

22. Semra village, 2018, Indikash-All About India, https://indikosh.com/vill/383911/semra, Acces on 02/06/18.

23. Statistical Profile of Scheduled Tribes in India, (2013), Ministry of Tribal Affairs Statistics Division, Government of India, www.tribal.nic.in, https://tribal.nic.in/ST/StatisticalProfileofSTs2013.pdf, Access on 12/05/14.

24. Tribal Profile at a Glance. 2012. Ministry of Tribal Affairs, Government of India,

25. United Nation Development Program (UNDP) in India, (2009-12) State-Level Support to Livelihood Promotion Strategies-Jharkhand, Department of Rural Development, Government of Jharkhand; Jharkhand State Livelihood Promotion Society.

26. United Nations Children's Fund (UNICEF), 2011, A conceptual Framework and Research Approach for Identifying, Analyzing and Prioritizing Barriers to Effective Maternal, Newborn and Child Health Interventions (Innovations Conceptual Framework and Research Approach, January 2011), United Nations Plaza, New York, UNICEF.

Question	*Response*
राज्य	
जिला	
(खंड)/ **Block**	
गांवकानाम :	
पुरवा/ **Hamlet**	
घरेलूआईडी/**Household ID**	

फार्मकेपूराहोनेकेबादसाक्षात्कारकर्ताकेहस्ताक्षर --------------------------------------- Contact Number(संपर्कसंख्या)
____

क्षेत्रमेंफार्मकेसत्यापनकेबादअनुसंधानसमन्वयककेहस्ताक्षर --

साक्षात्कारकीतिथि _____________________________________
पहर__________________________

A. पृष्ठभूमिप्रोफाइल

Q. कोड	प्रश्न	*Response/* प्रतिक्रिया
A1	प्रतिवादीकेनाम	
A2	परिवारमेंकितनेसदस्यहैं? महिलाकितनेहैं? बच्चाकितनाहैं?	
A3	धर्म	
A4	घरकाप्रकार 1. पक्के *2. कच्चा* 3.अर्धपक्के	
A5	कितनेकमरेअपनेघरमेंदेखतेहैं?	
A6	पेयजलकामुख्यस्रोतक्याहै? 1. नल-जल 2. ट्यूब-कुंआ/ हाथपंप 3. कुंआ 4. तालाब 5. नदी / नहर 6. दूसरों	
A7	आपकेघरपरशौचालयकीसुविधाहै? 1. हाँ 2. नहीं	
A8	कहाआपशौचालयकेलिएजानाहै? 1. सामुदायिकशौचालय 2. खुलेमेंशौच 3. किसीभीअन्य	
A9	आपकेघरमेंबिजलीहै? 1. हाँ 2. नहीं	
A10	आपकेपासराशनकार्डहै? 1. हाँ 2. नहीं	
A11	राशनकार्डकिसप्रकारकीहैआपकेपास? 1. प्राथमिकताघरेलूकार्ड (पीएचकार्ड, नारंगीरंग, तटरक्षककेलिएब्लू)	

	2. अंत्योदयकार्ड (झाकेलिएपीलाकार्डऔरतटरक्षककेलिएगुलाबी)	
A12	कहाआपखानापकानेहै? 1. बंददीवारोंकेअंदर 2. बरामदा / आंगन 3. अन्य	
A13	आपघरपरएकईंधनकेरूपमेंप्रयोगकरतेहैं 1. बायोगैस 2. मिट्टीकेतेल 3. कोयला 4. लकड़ी / पुआल / पत्तियां 5. रसोईगैस (एलपीजी) 6.किसीभीअन्य	
A14	आपकेपासकृषिभूमिहै? 1. हाँ 2. नहीं	
A15	यदिहाँ,जोप्रकार? 1. पत्ताकेसाथवनभूमि 2. पत्ताकेसाथराजस्वभूमि	
A16	आपकितना**कृषिभूमि**केमालिकहै? (एकड़)	
A17	आपक्याअन्यसभीसंपत्ति / निम्नमदोंकेलिएहै? (एकाधिकप्रतिक्रियाओंसंभवहोरहेहैं) 1. खुदघर,2. तालाब,3. पशुधनऔरमुर्गीपालन. 4. बिस्तर,5. गद्दा, 6. बर्तन, 7. मच्छरदानी, 8. रसोईगैस, 9. साइकिल, 10 ट्रैक्टर, 11. मोटरवाहन, 12. टीवी, 13. डिशटीवी, 14. मोबाइलफोन, 15. सौरप्रणाली, 16. गहने, 17 अन्य	
A18	पिछले 6 महीनोंमेंकिसीभीप्रमुखव्ययकियागयाथा? 1. हाँ 2. नहीं	
A 19	व्ययकीकिसप्रकारपिछले 6 महीनोंमेंखर्चकियागयाथा? 1. खपत (खाद्य) 2. बीमारी / दुर्घटना 3. विवाह 4. मौत 5. महोत्सव / सामाजिकअवसर 6. assets- उल्लेखकीखरीद 7. किसीभीअन्य. 1.	
A20	कैसेआपव्ययकोपूराकिया? 1. बचत, 2. ऋण, 3. परिसंपत्तियोंकाबंधक. 4. परिसंपत्तियोंकीबिक्री	
A21	आपअपनेदेशसेपिछलेसालकिसीभीउपजथा? 1. हाँ 2. नहीं	

A 22	आपकिसतरहकेअनाजकीखेतीकिया?	
A23	कितनेपिछलेमहीनेअपनाउत्पादनकिया? (महीनों)	
A24	परिवारकेमुखियाकाप्रमुखव्यवसायक्याहै? 1. अपनेदेश 2. कृषिश्रम 3. गैरकृषिश्रम 4. दुकानें 5. स्वउद्यम 6. वनसंग्रह 7. सरकारीनौकरी 8. निजीकाम 9. किसीभीदूसरों	

B. सार्वजनिकप्रणालीकेलिएउपयोग

Code	प्रश्न	प्रतिक्रिया
B1	आईसीडीएस/ (समेकितबालविकाससेवाए)**/ ICDS**	
B1.1	आपकेगांवमेंएकआंगनबाड़ीकेंद्रहै? 1. हाँ 2. नहीं	
B1.2	नहीं, तोकितनीदूरनिकटतमआंगनबाड़ीकेंद्रहै?	
B1.3	क्याआपनेकभीआईसीडीएससेवाओंकाउपयोगकरें? 1. हाँ 2. नहीं	
B1.4	अगरनहींतोक्योंनहीं? 1. आंगनवाड़ीबहुतदूरहै2. आंगनवाड़ीअनियमितखोलताहै 3. एचएचमें 6 सालयाpreganant / स्तनपानकरानेवालीमांकेनीचेबच्चोंकोनहींकररहेहैं 4. दूसरों (उल्लेख)	
B1.5	अपनेबच्चेकोआंगनबाड़ीकेंद्रमेंदाखिलालियाहै?	
B1.6	पिछलेहफ्ते, कितनीबारअपनेबच्चेकोआंगनबाड़ीकेंद्रकेलिएजानेदिया?	
B1.7	आपका3 सालसेकमउम्रकेबच्चेहैं, आपअपनेबच्चेकेलिएहोमराशन (THR) लातेहै? 1. हाँ2. नहीं	
B1.8	गर्भवतीयास्तनपानकरानेवालीहैं, तोआपअपनेबच्चेकेअलावा THR मिलताहै? 1. हाँ 2. नहीं	
B1.9	आपहरसप्ताहपिछलेमहीने THR मिलताहै? 1. हाँ2. नहीं	
B1.10	बच्चोंकोहरमहीनेकेआंगनवाड़ीकेंद्रमेंतौलाजारहाहै? 1. हाँ 2. नहीं	
B1.11	ग्रामस्वास्थ्यपोषणदिवस (VHND) आपकेगांवमेंएकमहीनेमेंएकबारहोताहै? 1. हाँ 2. नहीं	
B1.12	क्याआपनेकभीग्रामस्वास्थ्यपोषणदिवसभागलियाहै? 1. हाँ 2. नहीं	
B1.13	यदिहाँ, ग्रामस्वास्थ्यपोषणदिवसपरउपलब्धकराईगईसेवाओंक्याकररहेहैंसक्षमहोजाएगा?	

	(कईप्रतिक्रियाएं) 1. टीकाकरण 2. विकासकीनिगरानी 3. एएनसी 4.Health चेकअप 5. रेफरल	
B2	**स्वास्थ्यप्रणाली**	
B2.1	आपआशा /मितानिन/सहियाअपनेक्षेत्रजानतेहैं? 1. हाँ 2. नहीं	
B2.2	आपकभीभीउनकेपासमददकेलिएगएहैं? 1. हाँ 2. नहीं	
B2.3	यदिहाँ, तोक्यामददकीतरह? 1. उपचारकेलिए 2. रेफरलकेलिए 3. प्रसवकेलिए 4. अन्य (उल्लेख)	
B2.4	एएनएम (ANM)एकमहीनेमेंएकबारगांवमेंआतेहैं? 1. हाँ 2. नहीं	
B2.5	एएनएमनेपिछलेमहीनेटीकाकरणकेलिएआएहो?	
B3	**खाद्यसुरक्षा**	
	दोपहरकाभोजन/**Mid Day Meal**	
B3.1	आपमध्याह्नभोजन (एमडीएम) स्कूलमेंसेवाओंकेबारेमेंजानतेहैं? 1. हाँ 2. नहीं	
B3.2	अपनेबच्चेकोस्कूलमेंमिडडेमील (एमडीएम) खानाखाएं? 1. हाँ 2. नहीं	
B3.3	यदिहां, पिछलेसप्ताहमेंकितनेदिनअपनेबच्चेकोभोजनएमडीएमकेतहतमिलताहै?	
B3.4	आपएमडीएमसेवाओंसेसंतुष्टहैं? 1. हाँ 2. नहीं	
B3.5	यदिनहीं, तोक्योंआपसंतुष्टनहींहैं? 1. अनियमित2. भोजनकीखराबगुणवत्ता 3. दोहरावमेनू 4. किसीभीअन्य (उल्लेख)	

B4	सार्वजनिकवितरणप्रणाली/**Public Distribution Systems/ PDS**	
B4.1	आपकीदुकान PDSसेअपनेमासिकराशनमिलताहै? 1. हाँ2. नहीं ((उल्लेख))	
B4.2	यदिहां, तोक्याआइटमपिछलेमहीनेआपकोमिलारहेहैं?	मात्रा	
	1. चावल		
	2. गेहूं		
	3. दलहन		
	4. तेल		
	5. चीनी		
	6. मिट्टीकातेल		
	7. दूसरों		
B4.3	इसकेखुलाकीआवृत्तिक्याहै? 1. एकसप्ताहमेंएकबार 2. पाक्षिक 3. एकमहीनेमेंएकबार 4. कोईनिश्चितसमय 5. कभीखुलताहै 6. अन्य (उल्लेख)	
B5	**मनरेगा/ MNREGA**	
B5.1	यदिआपकभीभीमनरेगाकेबारेमेंसुनाहै? 1. हाँ2. नहीं	
B5.2	यदिआपएककामकार्डहै? 1. हाँ2. नहीं	
B5.3	कितनेदिनअपनेपरिवारपिछलेएकसालमेंमनरेगाकेतहतकाममिला?	
B5.4	आपपिछलेकामकेलिएआपकेभुगतानकियामिलगयाहै 1. हाँ 2. नहीं 3. आंशिक	
B6	स्वास्थ्यबीमा/ **Health Insurance**	

		स
B6.1	आपकेपासएकस्वास्थ्यबीमाकार्ड (आरएसबीवाईआदि) है? 1. हाँ2.No	
B6.2	एककार्डनहींहोनेकेलिएक्याकारणहैं? 1. नामस्वास्थ्यकार्डकेतहतपंजीकृतनहीं 2. योजनाकेबारेमेंजानकारीनहींथी	

	3. स्मार्टकार्डकीजानकारीनहीं 4. जानकारीनहींथी, जबकिकार्डबनाने 5. फोटोग्राफक्लिककियाफिरभीनहींमिलाहैकार्ड 6. परिवारकेसदस्योंकोजारीकरनेसेकार्डकीउससमयमौजूदनहींथे 7. गलतकार्ड 8.किसीभीअन्य 1.	
B6.3	हाँतो, किसप्रकार? 1. राष्ट्रीयस्वास्थ्यबीमायोजना 2. MSBY 3. किसीभीअन्य, निर्दिष्ट	
B6.4	आपअपनेस्मार्टकार्डपानेकेलिएकिसीभीराशिकाभुगतानकियाहै? 1. हाँ 2. नहीं	
B6.5	तुमकार्डपानेकेलिएकितनाभुगतानकिया?	
B6.6	यदिआपकभीभीअस्पतालोंकिस्मार्टकार्डकेअंतर्गतआतेहैंकेबारेमेंजानकारीप्राप्तकीहै? 1. हाँ 2. नहीं	
B6.7	यदिआपकभीभीउपचारप्राप्तकरनेकेलिएअपनेकार्डकाइस्तेमालकियाहै? 1. हाँ 2. नहीं नहीं,	
B6.8	हाँ, कितनीबारआपस्वास्थ्यबीमाकार्डकाउपयोगकियाथा?	
B6.9	यदिआपकभीभीकार्डकेखिलाफसुविधाएंपानेकेलिएमनाकरदियागयाहै? 1. हाँ2. नहीं	
B6.10	यदिआपकभीभीस्वास्थ्यबीमायोजनाकेलिएदिएगएटोलफ्रीनंबरकाउपयोगकरकिसीभीशिकायतदर्जकराईहै?	

C. परिवारकेसदस्योंकीजानकारी:

ID No.पहचान संख्या।	Name of member सदस्यका नाम	परिवार केमुखियाकेसाथरिश्ता	लिंग 1. नर 2. महिला	Age (years) आयु (वर्ष)	Marital Status वैवाहिक स्थिति	Education शिक्षा	Ht (cm) ऊंचाई (सेमी)	Wt (kg) वजन (किलो)	एमयूएसी (से.मी) बच्चे 6-5 वर्ष	पिछले 365 दिनोंकेदौरान		(पिछले 15 दिनोंकेदौरानकिसी भीसमय किसीभी बीमारीसे पीड़ितहै किक्याहाँ	चाहेराष्ट्रीयस्वास्थ्यबीमायोजना, MSBY याकिसी
										पिछले 365 दिनोंके लिएकिक्याअ	यदिहाँ, तोनहीं। बारकेअस्पताल		

										स्पताल मेंभर्तीके दौरान (हाँ -1, कोई -2)	मेंभर्ती	-1, कोई - 2)	भीसरकारehalth बीमायोजनाद्वाराकवर (हाँ -1, कोई -2)

सीकेलिएकोड:
- 1, सिरकेपति - 2, विवाहितबच्चे - 3, विवाहितबच्चेकापति - 4, अविवाहित chiId - 5, पोता - 6, पिता / माता / पिता-जी / मातास्व: परिवारकेमुखियाकेसाथरिश्ताजी - 7, भाई / बहन / भाई-भाभी / बहनकोभाभी / अन्यरिश्तेदारों - 8, सेवक / कर्मचारियों / अन्यगैर-रिश्तेदारों - 9

वैवाहिकस्थिति: शादीकभी - 1, वर्तमानमेंशादी - 2, विधवा - 3, तलाकशुदा

शिक्षा -- नहींसाक्षर -1, कमसेप्राथमिक, कक्षा 10, 4. उत्तीर्णकक्षा 10, 5. उत्तीर्णकक्षा 12, 6. वर्गअधिकसेअधिक 12, 7.Literate withough किसीभीशिक्षास्कूलीसे 2. वर्गकीतुलनामेंकमहै, 3. कम

D. पिछले 15 दिनोंमेंबीमारीकेलिएइलाजकाविवरण (अस्पतालमेंभर्तीबाहर) (नोट: कोईदस्तावेजीसबूत, कृपयाफोटोकॉपी / फोटोग्राफऔररखनेकेलिए)

S. No.	प्रशन	प्रतिक्रिया				
		01	**02**	**03**	**04**	**05**
D1	सदस्यआईडी					

D2	आयु (तालिकासीकेरूपमें)					
D3	बीमारीकीप्रकृति (23-26 पृष्ठोंपरकोडसूची)					
D4	तुमकबतकइसबीमारीसेपीड़ितथा? 1. अधिकसेअधिक 15 दिनपहलेशुरूकरदियाहैऔरजारीहै 2. अधिकसेअधिक 15 दिनपहलेशुरूकरदियाऔरसमाप्तहोगयाहै 3. 15 दिनोंकेभीतरशुरूकरदियाहैऔरजारीहै 4. 15 दिनोंकेभीतरशुरूकरदियाऔरसमाप्तहोगयाहै					
D5	आपअपनीबीमारीकेलिएकिसीभीteatmentकीतलाशथी? 1. हाँ2. नहींनहींतो, D13 करनेकेलिएजाना					
D6	आपकिसतरहकेइलाजचाहतेथे? 1. घरउपाय 2. स्थानीयस्वास्थ्यसेवाप्रदाताओं / नीमहकीम 3. विश्वासचिकित्सकों 4. आशा 5. एएनएम 6. पीएचसी 7. सीएचसी 8. किसीभीअन्यसरकारीसुविधा 9. निजीडॉक्टरों किसीभीअन्य 10, कृपयास्पष्टकरें 1.					
D7	क्योंआपउपचार / सुविधाओंचयनकियाथा? (कईप्रतिक्रियाएं) 1. बेहतरसुविधाएं 2. परिवहनउपलब्ध 3. आमतौरपरवहाँकीयात्रा 4. घरसेनिकटता 5. रिश्तेदार / पड़ोसीद्वारासुझाएगए 6. राष्ट्रीयस्वास्थ्यबीमायोजनाकेतहतकियाउपचार 7. लोअरचिकित्साप्रभार 8. स्थानीयचिकित्सकद्वाराभेजा 9. अन्य (निर्दिष्ट)					
D8	उपचारकीप्रकार (कईप्रतिक्रियाओंसंभवहोसकताहै) 1. दवाओंऔरचिकित्सा 2. नैदानिकपरीक्षण 3. सर्जरी					

	4. दिनदेखभाल 5. किसीभीअन्य।कृपयानिर्दिष्टकरें					
D9	कुललागतइलाजकेलिएखर्चक्याहै?					
D9.1	डॉक्टर / सर्जनकेशुल्क (अस्पतालकेकर्मचारियों / अन्यविशेषज्ञों)					
D9.2	परिवहनपरव्ययक्याथा?					
D9.3	पैसेकीराशिदवाओंमेंखर्च					
D9.4	पैसेकीराशिनैदानिक परीक्षणमेंखर्च					
D9.5	अन्यचिकित्साव्यय (परिचरआरोप, भौतिकचिकित्सा, निजीचिकित्साउपकरणों, रक्त, ऑक्सीजन, आदि)					
D10	वित्तकेखर्चकेलिएस्रोत: 1. घरेलूआय / बचत 2।उधारी 3. भौतिकसंपत्तिकीबिक्री 4. दोस्तोंऔररिश्तेदारोंसेयोगदान 5. अन्यस्रोतों (निर्दिष्ट)					
D11	आपइलाजसेसंतुष्टहैतोमुहैयाकरायागया? 1 हाँ 2 नहीं 3 आंशिक					
D12	उपचारकेपरिणाम 1.स्वस्थ 2. आंशिकरूपसेस्वस्थ 3. कोईप्रभावनहींफिरभीमौत 5. किसीभीअन्य 6. (निर्दिष्ट)					
D13	क्याकारणहैकिचिकित्साउपचारनहींकरापातेहैं 1. कोईचिकित्सासुविधापड़ोसमेंउपलब्धनहीं 2. चिकित्सासुविधाउपलब्धसंतोषजनकगुणवत्तानहीं 3. संतोषजनकगुणवत्ताभीमहंगीकीसुविधा 4. संतोषजनकगुणवत्ताकीसुविधालंबीप्रतीक्षाशामिल 5. बीमारीगंभीरविचारनहींकिया 6. अन्य (निर्दिष्ट)					

E.पिछले 365 दिनोंमेंअस्पतालमेंभर्तीकेमामलेमेंबीमारीकेलिएइलाजकेविवरण (नोट: कोईदस्तावेजीसबूत, कृपयाफोटोकॉपी / फोटोग्राफऔररखनेकेलिए)

पिछले 365 दिनोंकेदौरानघरकेसदस्योंकेअस्पतालमेंभर्ती						
S. No.	सवाल	रिस्पांस				
E1	S. No. अस्पतालमेंभर्तीकीसंख्या	1	2	3	4	5
E2	आईडीअस्पतालमेंभर्तीहुयी सदस्यकी					
E3	उम्र(साल)					
E4	बीमारीकीप्रकृति (23-26 पृष्ठोंपरकोडसूची)					
E5	आपअस्पतालमेंभर्तीकेलिएकहाँगएथे? 1. पीएचसी2. सीएचसी 3. किसीभीअन्यसरकारीअस्पताल 4. निजीअस्पतालकिसीभीअन्य5., कृपयास्पष्टकरें					
E6	क्योंतुमवहाँजानेकेलिएचयनकियाथा? (कईप्रतिक्रियाएं) 1. बेहतरसुविधाएं 2. परिवहनउपलब्ध 3. आमतौरपरवहाँकीयात्रा 4. घरसेनिकटता 5. रिश्तेदार / पड़ोसीद्वारासुझाएगए 6. राष्ट्रीयस्वास्थ्यबीमायोजनाकेतहतकियाउपचार 7. लोअरचिकित्साप्रभार 8. स्थानीयचिकित्सकद्वाराभेजा 9. अन्य (निर्दिष्ट)					
E7	उपचारकीप्रकृति (कईप्रतिक्रियाओंसंभवहोसकताहै) 1. दवाओंऔरचिकित्सा 2. नैदानिकपरीक्षण 3. सर्जरी 4. दिनदेखभाल 5. किसीभीअन्य।कृपयानिर्दिष्टकरें					
E8	कुललागतअस्पतालमेंभर्तीकेदौरानकिएगएक्याहै?					
E8.1	डॉक्टर / सर्जनकेशुल्क (अस्पतालकेकर्मचारियों / अन्यविशेषज्ञों)					
E8.2	परिवहनपरखर्चक्याथा?					

E8.3	दवाओंमेंखर्चहुयी पैसेकीराशि					
E8.4	परीक्षणमेंखर्चहुयीपैसेकीराशि					
E8.5	बिस्तरपरहुयीखर्च पैसेकीराशि					
E8.6	अन्यचिकित्साव्यय (परिचर, भौतिकचिकित्सा, निजीचिकित्साउपकरणों, रक्त, ऑक्सीजन, आदि)					
E9	खर्चकेलिएस्रोत: 1. घरेलूआय / बचत 2. उधारी 3. भौतिकसंपत्तिकीबिक्री 4. दोस्तोंऔररिश्तेदारोंसेयोगदान 5. अन्यस्रोतों (निर्दिष्ट)					
E10	राष्ट्रीयस्वास्थ्यबीमायोजनाकेउपयोगयाअस्पतालमेंभर्तीहोने केलिएकिसीभीअन्यसरकारीबीमायोजना					
E10.1	आपअस्पतालमेंभर्तीकेलिएराष्ट्रीयस्वास्थ्यबीमायोजनाकार्डकाउप योगकरें? 1. हाँ2. नहीं (यदिहाँतोजाना)					
E10.2	) आपकिसकारणसेकार्डकाप्रयोगनहींकेए?(एकाधिकसंभवप्रतिक्रिया एं) 1. हमएकRSBY कार्डनहींहै 2. रोगीराष्ट्रीयस्वास्थ्यबीमायोजनामेंदाखिलानहींदियागयाथा 3. अस्पतालकेकर्मचारियोंकेस्वास्थ्यस्मार्टकार्डकेलिएनहींपूछा 4. अस्पतालआरएसबीवाईयोजनाकेतहतइलाजकेलिएमनाकरदिया 5. आवश्यकताउपचारपैकेजकेतहतकवरनहींकियागयाहै 6. पारकार्डकीसीमा 7. व्यक्तिगतपहचानफिंगरप्रिंटकेखिलाफमान्यनहींकियाजासकताथा 8. मनीअवरुद्धकियागयाथा किसीभीअन्य 9. (निर्दिष्ट)					
E10.3	यदिहाँतोराशिकितनाकाटलियागयाथा? (रुपये)					
E10.4	छुट्टीकेसमय, आपरुपयेकायात्राभत्ताप्राप्तकियाथा। 100?					

	1. हाँ 2. नहीं					
E10.5	आपछुट्टीकेसमयकिसीभीरसीदप्राप्तकियाहै? 1. हाँ2. नहीं					
E10.6	आपअस्पतालमेंभर्तीकेलिएकार्डकाउपयोगकरनेकेबादभीकिसीभीपैसाखर्चकियाहै? 1. हाँ2. नहीं					
E11	आपसंतुष्टहैंजोआपकोइलाजकियागया 1 हाँ2 नहीं3 आंशिक					
E12	उपचारकेपरिणाम 1. स्वस्थ 2. आंशिकरूपसेस्वस्थ 3. कोईप्रभावनहींइलाजपर 4अभीभीइलाज 5. मौत 6. किसीभीअन्य (निर्दिष्ट)					

F. Maternal Health ***(To be asked in the presence of female head of the household)***
मातृस्वास्थ्य (घरकीमहिलाकेसिरकीउपस्थितिमेंपूछाजानाचाहिए

Code	आइटम	प्रतिवादी 1	प्रतिवादी 2	प्रतिवादी3
F1	सदस्यआईडी			
F2	उत्तरदाताओंकानाम			
F3	उम्र(साल)			
F4	तुम्हारीशादीकबहुई?			
F5	पहलीगर्भावस्थाकेसमयअपनीउम्रक्याथी?			
F6	कितनीबारआपगर्भवतीहुई?			
F7	आपकेकितनेजीवितबच्चेजन्मदेई?			
F8	आपकाकभीभीगर्भपातहुआहै? 1 हाँ2. नहीं			

F9	आपकाकभीभीमृतप्रसवहुआहै? 1. हाँ2. नहीं।			
F10	आपवर्तमानमेंगर्भवतीहैं? 1. हाँ 2. नहीं।नहींतो, क्यू E14 केलिएजाना			
F11	यदिहां, तोआपअपनेआपकोअस्पतालमेंपंजीकृतमिलगयाहै?			
F12	आपअपनेपिछले / वर्तमानगर्भावस्थाकेदौरानस्वास्थ्यजांचकेलिएगयीथी? 1. हाँ 2. नहीं			
F13	जहांआपअपनेपिछले / वर्तमानगर्भावस्थाकेदौरानस्वास्थ्यजांचकेलिएगयीथी? ? 1. ग्रामस्वास्थ्यपोषणदिवस. 2. एएनएम / उपकेंद्र3. पीएचसी 4. सीएचसी5. भगत 6. दाई 7. किसीभीअन्य (उल्लेख)			
F14	कितनीबारआपअपनेपिछलेगर्भावस्थाकेदौरानस्वास्थ्यजांचकेलिएगयीथी ?			
F15	आपकापिछलाबच्चाकहाँहुआथा? 1. घर 2. इंस्टीट्यूशन			
F16	आपकाबच्चाकोंपैदाकरवायाथा 1. दाईकीमददसेहोमडिलीवरी 2. आपखुद/ फिरघरकाकोईसदस्य 2. एएनएम 3. डॉक्टर 4. दूसरों			
F17	आपकाबच्चाकिसप्रकारपैदाहुआथा 1. सामान्य 2. ऑपरेशन			
F18	आपकोहॉस्पिटलसेकबछुट्टीदेदीगएथे 1. एकहीदिन 2. एकदिनबाद 3. केबादतीनदिन 4. 7 दिनोंकेबाद			

	5. अन्यउल्लेख			
F19	आपघरकाकामकबसेशुरूकरदीथी			
F20	आपघरसेबाहरकाकामकबसेशुरूकरदीथी			
F21	किसीभीस्वास्थ्यकार्यकर्ताअपनेप्रसवकेबादअपनेघरकादौराकियाथा? 1. हाँ 2. नहीं।			
F22	आपबच्चेकोखिलानेऔरबच्चेकीदेखभालप्रथाओंपरकोईपरामर्शमिलताहै? 1. हाँ 2. नहीं।			

F23 Family Planning/परिवारनियोजन

F23.1	आपकोकभीभीपरिवारनियोजनकेतरीकोंकेप्रयोगस्वास्थ्यकार्यकर्ताओंद्वारासलाहदीगईहै? 1. हाँ 2. नहीं।			
F22.2	आपपरिवारनियोजनकेलिएगर्भनिरोधकतरीकोंमेंसेकिसीकाउपयोगकरें? 1. हाँ 2. नहीं।			
F23.3	यदिहाँ, जोपरिवारनियोजनविधिआपकोअपनायाहै? 1. मौखिकगर्भनिरोधक 2. शल्यचिकित्साकेतरीकों 3. शारीरिकबाधाओं 4. इंट्रायूटेराइनगर्भनिरोधकडिवाइस 5. अन्य (उल्लेख			
F23.4	आपनेनसबंदीकभीकियाहैं? 1. हाँ 2. नहीं।			
F23.5	यहआपकीसहमतिकेसाथकियागयाहै? 1. हाँ 2. नहीं।			
F23.6	कहांसेकियागयाथा?			

G. पूर्वघरकेसदस्योंकोजोपिछले 365 दिनोंयाएकवर्षकेकेदौरानमारेगएलोगोंकेब्यौरे

सीरियल।नंबर	मृतकसदस्यकेनाम	लिंग (पुरुष -1, महिला -2)	मौतपरआयु (वर्ष)	किसीप्रकारकाइलाजकरायागयाथाडेथसेपहले 1. हाँ	अस्पतालमेंभर्तीहैकिक्या 1. हाँ 2. नहीं।	अगरहैं,तोकितनीबारअस्पतालमेंभर्तीकरायागया	अगरमहिलाऔर 15-49 सालकीउम्र, उसकेबाद

				2. नहीं।				
							ऊएकसालकेभीतरगर्भवतीथी 1. हाँ 2. नहीं।	यदिहाँ, तोमृत्युकेसमय (कोड)

कोड: मृत्युकेसमय: लोगोंकीमृत्युगर्भावस्थासेसंबंधित:1.गर्भावस्थाकेदौरान, 2. प्रसवकेदौरान 3.गर्भपातकेदौरान, 4. प्रसव / गर्भपात 5.अन्यलोगोंकीमृत्युके 6 प्रसव / गर्भपातकेसप्ताह -4, अन्यकरणमृत्यु

सूचनानिदानऔर / यामुख्यलक्षण	*Code*	***Reported Diagnosis and/or Main Symptom***	*Code*
INFECTION/ संक्रमण		***EYE***	
बुखार	*01*	लालीयासूजनकेसाथआंखमेंतक लीफ / दर्द / फोड़े	*27*
दाने / घावोंकेसाथबुखार	*02*	मोतियाबिंद	*28*
कालीखांसी केकारणबुखार	*03*	<u>आंखकारोग</u>	*29*
<u>अन्यसभीबुखार</u> (मलेरिया,	*04*	मेंकमीदृष्टि (पुरानी) सहितनहीं, जहांकमीआईविजनचश्मेकेसाथठीकहै	*30*
		अन्य	*31*

सूचनानिदानऔर / यामुख्यलक्षण	***Code***	***Reported Diagnosis and/or Main Symptom***	***Code***
टाइफाइडऔरअज्ञातमूलकेबुखारमेंशामिलहैं, सभीविशिष्टबुखारकिएकनिदानकीपुष्टिनहींहै)		(आँखआंदोलनोंकेविकारोंसहित - तिर्यकदृष्टि, अक्षिदोलन, ptosis और adnexa)	
तपेदिक/ टीबी	*05*		
फाइलेरिया	*06*	<u>कान</u>	
धनुस्तंभ	*07*	मुक्ति / कानसेखूनबहरहा / संक्रमणकेसाथकानकादर्द	*32*
एचआईवी / एड्स	*08*		
अन्ययौनसंचारितरोगों	*09*	मेंकमीसुनवाईयासुनवाईकेनुकसान	*33*
पीलिया	*10*	<u>हृदय</u>	
Diarrheas / पेचिश / औरदस्तकेसाथखूनयाबिनामलबलगमकीवृद्धिकीआवृत्ति	*11*	उच्चरक्तचाप	*34*
		हृदयरोग: सीनेमेंदर्द, सांसलेनेमेंतकलीफ	*35*
कीड़ेप्रकोप	*12*	<u>श्वसन</u>	
कैंसर		एक्यूटऊपरीश्वसनसंक्रमण (ठंड, नाकबहरहीहै, खांसीकेसाथगलेमेंखराश, जुकामएलर्जीशामिल)	*36*
कैंसर (जानाजाताहैयाएकचिकित्सकद्वारासंदिग्ध) औरशरीरमेंकिसीभीबढ़तीदर्दरहितगांठकीघटना	*13*		
		बुखारकेबिनाबलगमकेसाथखांसी औरटीबीकेरूपमेंनिदाननहीं	*37*
<u>रक्तरोगों</u>		ब्रोन्कियलअस्थमाकेसाथ / यालंबीअवधिमेंखांसीयाज्ञातअस्थमाकेबिनाघरघराहटऔरसांसकी आवर्तकप्रकरण)	*38*
रक्ताल्पता (किसीभीकारण)	*14*		
	15		

सूचनानिदानऔर / यामुख्यलक्षण	Code	Reported Diagnosis and/or Main Symptom	Code
रक्तस्रावविकार			
पोषण		गैस्ट्रोआंत्र	
		मुंह / दांत / मसूड़ोंकेरोग	39
मधुमेह *DIABETES*	16	पेटमेंदर्द: गैस्ट्रिकऔरपेप्टिकअल्सर / एसिडभाटा / तीव्रपेट	40
अंडरपोषण	17		
घेंघाऔरथायराइडकीअन्यबीमारियों	18	गांठयापेटयाअंडकोशकीथैलीमेंद्रव	41
अन्य (मोटापासहित)	19	जठरांत्ररक्तस्राव	42
मनोरोगऔरमस्तिष्कसंबंधी		त्वचा	
मानसिकमंदता	20	त्वचाकेसंक्रमण (फोड़ा, फोड़ा, खुजली) औरअन्यत्वचारोग	43
मानसिकविकार	21		
सरदर्द	22	पेशीय-कंकाल वापसयाशरीरमेंदर्द	
बरामदगीयाज्ञातमिर्गी	23	पेशीयसंयुक्तयाहड्डीरोग / दर्दयाजोड़ोंमेंसेकिसीमेंसूजन, यासूजनयाहड्डियोंसेमवाद	44
अंगकीमांसपेशियोंऔरआंदोलनोंमेंकठिनाईमेंकमजोरी	24		
स्ट्रोक / पक्षाघात / अचानकशुरुआतकमजोरीयाभाषणकेनुकसानकेशरीरकेआधेमें	25	कमरयाशरीरमेंदर्द	45

सूचनानिदानऔर / यामुख्यलक्षण	Code	Reported Diagnosis and/or Main Symptom	Code
स्मृतिहानि, भ्रमकीस्थितिसहितअन्य	26		
GENITO-URINARY		चोटों	
किसीभीकठिनाईयापेशाबमेंकठिनाई	46	आकस्मिकचोट, सड़कयातायातदुर्घटनाओंऔरगिर जाताहै	52
दर्दश्रोणिक्षेत्र / प्रजननपथकेसंक्रमण / दर्दमेंपुरुषजननांगक्षेत्र	47		
		आकस्मिकडूबऔरडुबकी	53
मासिकधर्मकेदौरानअनियमिततायाअत्यधिकरक्त स्राव / ।पुरुष / महिलाबांझपन	48	बर्न्सऔर corrosions	54
		विषाक्तता	55
		जानबूझकरखुदकोनुकसान	56
		हमला	57
दाईका		विषैला / नुकसानकेकारणजानवरोंऔरपौधों केसाथसंपर्क	58
पहलेयाप्रसवकेदौरानजटिलताओंकेसाथगर्भावस्था (गर्भपात, अस्थानिकगर्भावस्था, गर्भपात, उच्चरक्तचाप, प्रसवकेदौरानजटिलताओं)	49		
		लक्षणऊपरश्रेणियोंमेंसेकिसीमेंउ चितनहीं	59
बच्चेकेजन्मकेबादमांमेंजटिलताओं	50	यहांतक किमुख्यलक्षणराज्यनहींकरसका	60
बीमारनवजातशिशु	51	बच्चेकेजन्म - सीजेरियन / सामान्य / किसीभीअन्य (दोनोंजीवितजन्मऔरमृतप्र सवकेलिए)	88

Traditional Healer

1. Name of Respondent:
2. Age of Respondent:
3. Gender of the Respondent:
   (a) Male (b) Female
4. Religion of the Respondent:

5. Caste of the Respondent:
   1. ST 2. SC 3. OBC 4. General caste

6. Education background of the respondent:
   1. Illiterate
   2. Up to class 5
   3. Up to class 10
   4. Above matriculation

7. Sources of acquiring skills and knowledge
   1. Traditional
   2. Guru (folk heading teacher)
   3. Own experiences
   4. Book/ Manuscript

8. Means of healing
   1. Spiritual 2. Herbal plants 3. Combination of plants and herbal

9. Economic standard/ monthly income of the respondent

10. Duration of practices
   1. 1-10 years 2. 11-20 years 3. 30-40 years and Above

11. Generation of practice
    1. 1st generation
    2. 2nd generation
    3. 3rd generation
12. Which kind of peasant comes to treatment?

13. Are you treating any pregnant women?

14. Which kind of problem face by pregnant women?

15. How you get treat as an herbalist/ spiritualist?

16. Types of patient who come for treatment?

17. Number of clients treated in days/ months

    1. 1-5 day/month 2. 6-10 days/month 3. 11-15 days/month
    4. 16-20 days/month 5. Above 20

18. Peak session of practices

1. Spring 2. Summer 3. Rainy 4. Winter 5. All session

19. Beliefs in collection of herbal plants

20.

Collection of herbs	Full Moon	No Moon	Panchami	Astami	Tuesday	Saturday	Sunday
Auspicious							

Non-Auspicious							
No comments							

21. Sources of motivation
    1. Gifts 2. Cash Payment 3. Successful Healers 4. Both gift & Payment

22. Status of transformation of knowledge to maintain the tradition

1. No Discipline
2. Son
3. Daughter
4. Outsider

23. Challenges faced by traditional medicine practitioners
    1. Scarcity of Herbs
    2. Means of Transport
    3. Equipments for harvesting
    4. Payment/ provision of required thing
    5. Other

24. Modification of Skills in their Practices
    1. Yes 2. No 3. If yes explain

25. Referral of cases
    1. Health centre 2. Hospital 3. Herbalist 4. Spiritualist

26. Medicinal herb/ plants with their uses by traditional practitioners

27. Relevance of practices of practice with traditional medicine

1. Ayurvedic medicine
2. Siddha/Unani
3. No relation

28. Others question coming from field.

Interview Schedule for Dai

1. Name
2. Age
3. Education
4. Village
5. From whom did you learn the skills of dais?
    1. From mothers/ relative
    2. From other dais
    3. From training
    4. Any other means

6. Why did you learn these skills?
    1. To continued the traditional occupation
    2. To make it a main or subsidiary livelihood option.
    3. Due to advice of family members.
    4. Any other reason

7. How were you recognized in the community as a Dai?

8. Since how many years have you been practices as Dai?

9. Is anybody in your family learning these skills?

10. Antenatal Care

1. Usually when is the first contact between you and the pregnant women/her family?
    - First trimester
    - Second trimester
    - Third trimester

- Delivery
- Any other

2. What is the reason for thesecontacts?
   - Complication during pregnancy
   - Delivery care
   - Consultation for abortion
   - Problem with pervious pregnancy
   - Any other reason (explain)

3. Do women seek any advice during pregnancy from you, if yes what kind of advice is given?
4. You follow the any kind of custom if yes explain?

11. Delivery care

1. At delivery, when are you summoned usually?
   - When the pain start
   - When the baby is about to be delivery
   - Any other (explain)

2. Usually where is the delivery contucred?
   - In Your Home
   - In the client home
   - Any others place (explain)

3. Do carry anything along with you for the delivery services? If yes explain.

4. Do you wash your hand anytime during or after the delivery?

5. How and when do you wash your hands?

6. In what position is the delivery normally conducted? Explain

- Squatting
- Sitting
- Lying down
- Any others

12. Maternal Complications

1. Usually do you handle the following problems yourself?
   - Failure to dilate
   - Transverse lie
   - Breech baby
   - Cord prolapsed
   - Placenta prolapsed
   - Excess prolapsed
   - Retained placenta
   - Any others (explain)

13. Clean surface and cord

1. On what material is the mother made to delivery? Explain

2. What material is used to cut the cord? Explain

3. Is there any care taken of the cord after cutting? Explain

4. How do you remove the placenta? Explain

5. Do you provide these services normally, once in a while or never?
   - Examination of the position of the baby
   - Give advice about food
   - Try to change the position of the baby
   - Take women pulse or blood pressure
   - Do a vaginal examination
   - Push on the stomach during the delivery
   - Vomiting forced during delivery
   - Episiotomy is done during delivery
   - Massaging with oil body partes
   - Help pregnant woman to abort the baby
   - Any others (Explain)

14. Post Natal Care

1. Is the weight of the baby checked immediately after birth? Explain

2. Do you bathe the baby immediately after birth? Explain

3. What are methods used for cleaning? Explain

4. Do you keep the baby warm after the delivery? Explain

5. Do you check on the woman and child again the delivery? Explain

6. Do you advice any food restriction for the mother after child birth? Explain

7. What advice is give on breastfeeding? Explain

8. Do you advice on family planning to the mother? If yes explain

9. Do you get paid by the household after the services? Explain

Interview schedule for village provider:

1. Date of interview:
2. District:
3. Block:
4. Village:
5. Category: 1. ANM   2. SAHIYA/ASHA   3. AWW

1. **Basic information**
2. Name:
3. Age:
4. Marital status:
5. For how many years you been working in this area?

6. What is the major health problem of pregnant women in your area?

7. What is the major health problem related to pregnancy/delivery/post-partum in parhaiya women?

8. Do parhaiya women have access to health services? Yes/No, please specify.

9. What are the major problems in accessing health services by women?

10. How do you address pregnancy, delivery and post-partum related problem?

11. Role and involvement in pregnancy

12. What kind of programme (state & central) done by you for maternal health?

13. What is your role in implementation of programme related to maternal health in your area?

14. What changes do you observe in maternal health services because of implemented of this particular scheme?

15. Has the training helped you in better assistance to pregnant women during delivery?

16. Behaviour pattern

17. What is trend of delivery pattern in your area?

18. Where parhaiya women go for delivery (home/ government/private health centre)? Why pleas specify

19. What are the major resins behind the preferred choice?

20. Has there been any change and preference due to this scheme? What are the major resions?

21. Do you think parhaiya women are known about this scheme (financial benefit)?

22. Do you think such schemes can address the problem of maternal morbidity and motility? Resions

23. As a health provider do you think that the infrastructure provisioning at the state level is sufficient to adders the maternal health problem?

24. What kind of health facility can address their need taking into consideration the socio-economic factor cultural context and role of women in family?

25. What is your opinion about home/ institutional deliveries?

26. What is your opinion about community base practices related to maternal health?

27. What is your opinion about traditional practicenor?

28. What is your opinion about food practices and believes in period of pregnancy, delivery and post- partum?

29. Any other information

Interview schedule for mother

Date of interview:

District:

Block:

Panchayt:

Village:

Category: 1. pregnant mother:

2. Pregnant within a year (how many months):

Basic information

1. Name of the respondent:
2. Age:

Social statues

3. Which kind of role play as a waifs and mother, statues within the family and society?Care?

4. Do you face any kind of domestic violence?

Cultural aspect

5. What is your age at a time you get marriage and conceive first child?

6. What kind of customs and ceremony regarding pregnancy, delivery and post-partum care?

7. What you think (perception and need) about maternal health?

Economic Statues

8. What kind of work were you doing before pregnancy?

9. What kind of work were you during pregnancy?

10. What kind of woke were you doing after post-partum?

11. Who many days have you taken rest in pregnancy and after delivery?

Food Practices

12. What kind your food habited in a day and night?

13. Do you take particular food in pregnancy period? Please specify.

14. Do you think a pregnant woman has a take more food/less food/usual food? Please specify.

15. Are there any food restriction in pregnancy, delivery and post-partum?

Shall be taken	shall be not
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16. Where you abele to take these? Yes/no, if not then why.

17. What kind of food you use fist time after delivery? Who suggest?

18. History of all pregnancy

Year/number of pregnancy	Outcome of pregnancy	Place of delivery	Types of delivery	Any complication of the time of delivery	Statues of mother now	Statues of child now

19. How many children have you ever given birth to male or female?

a. How many are dad?

b. How many are alive?

20. You had how many

a. Still births:

b. Abortion:

c. Miscarriage:

21. **Health services**

1. Traditional health services:

22. What kind of health problem do you face? Please specify.

23. With whom do you discuses your health need?

24. What support do you get at family level?

25. What kind of health facility available in your area?

26. What kind of health services did you available during pregnancy? Why
1. Traditional 2. Allopath

27. Where go for the treatment related to pregnancy, delivery and post –partum? Why please specify.

28. What is the perception of Healer and dai and public health provider for maternal health among parhaiya women?

29. How they are use practices particularly in pregnancy, delivery and post-partum?

30. What other suggestion did you receive from provider for safe pregnancy and delivery care?

31. Do you feel these services are important in accordance to safe motherhood?

32. Where does your family member go for treatment?

33. Are you satisfied in your with the health services in your area? Yes/ no and why?

Delivery Care

34. Why did you choose to deliver at home/government facility/ private health centre?

35. Who conducted the delivery?
1. Dai 2. Trained dai 3. ANM 4. Government provider

5. Private provider

36. What effort and preparation were made by your family member for your delivery? What support did you yet from them?

36. If delivery was at home:

a. What is the position of delivery?

b. What kind of suggestion gives for safe and ease delivery?

c. Any kind of food gives immediately delivery or not?

d. Is any family member present at time of delivery?

e. What instrument was used to cut the curt?

f. Was boiled before using?

g. They are colostrums feed the baby?

h. Do you and your family do any kind of ceremony and rituals during delivery and after delivery?

37. What and how much was given to the birth attendant?

38. Where you go if any complication?

39. Did you face any problem in accessing health services? Please specify.

Post Natal Care

40. What health need did you feel after delivery?

41. Did you health personal (traditional/allopath) visit you after delivery?

42. How many visits were made and what suggestions did they given you each time?

Perception and need

43. Do you feel that home base care is adequate or something else is needed? Please specify.

44. At present time do women in your community opt for home delivery or institutional delivery and why?

45. If home delivery is preferred by women than what are the major constrains?

46. If institutional delivery is preferred by women then what are the major reasons that is contribution to this change?

PHC Facility Survey

General Information	
1. Name of the PHC	
2. Name of the block and District	
3. Total population covered:	
4. Distance from the CHC	
5. Distance from the District hospital	
6. Location of the Primary Health Centre	(Rural/Urban)
7. Is the PHC providing 24 hours and 7 days delivery facilities	(Yes/No)

Available services:	
1. OPD Services	Yes/No
2. Emergency services (24 Hours)	Yes/No
3. Referral Services	Yes/No
4. In-patient Services	Yes/No
5. Are minor surgeries like draining of abscess etc done at the PHC?	Yes/No
6. Is the primary management of cases of poisoning / snake, insect or scorpion bite done at the PHC?	Yes/No
7. Is the primary management of burns done at PHC?	Yes/No

MCH and other services:	
1. Ante-natal care	Yes/No
2. Intranatal care (24 - hour delivery services both normal and assisted)	Yes/No
3. Post-natal care	Yes/No
4. New born Care	Yes/No
5. Child care including immunization	Yes/No
6. Family Planning	Yes/No
7. MTP	Yes/No
8. Management of RTI/STI	Yes/No
9. Facilities under Janani Suraksha Yojana	Yes/No

10. Regular ANC clinic	Yes/No
11. normal delivery for 24 hours	Yes/No
12. Tubectomy and vasectomy facility	Yes/No
13. treatment for gynecological disorders like leucorrhoea, menstrual disorders etc	Yes/No
14. facility for MTP (abortion)	Yes/No
15. Are the low birth weight babies managed at the PHC?	Yes/No
16. Is there a fixed immunization day?	Yes/No

Human Resource			
Staff	Sanctioned	Posted	Vacant
Medical Officer-MBBS			
RMA			
MO-AYUSH			
Accountant/Clerk			
Pharmacist			
Pharmacist AYUSH			
Nurse-midwife (Staff-Nurse)			
Health workers (F)			
Health Asstt. (Male)			
Health Asstt. (Fernale)/LHV			
Health Educator			
Data entry cum computer operator			
Laboratory Technician			
Cold Chain & Vaccine Logistic Assistant			
Multi-skilled Group D worker			
Sanitary worker cum watchman			

Essential Laboratory Services	
Routine urine, stool and blood tests	Yes/No
Sputum testing for TB	Yes/No
Rapid tests for pregnancy	Yes/No
Blood smear examination for malaria parasite	Yes/No
Rapid tests for HIV	Yes/No

Blood grouping	Yes/No
Diagnosis of RTI/STDs with wet mounting, grams stain etc.	Yes/No

Infrastructure	
Building	Yes/No
Rented premises/Own /Other Government building/Any other specify	
Beds	(No. ________)
Separate public utilities for males and females	Yes/No
Prominent display boards regarding service availability in local language	Yes/No
Labour room available?	Yes/No
If labour room is present, are deliveries carried out in the labour room?	Yes/No/Sometimes
If labour room is present but deliveries are not being conducted there, then what are the reasons for the same?	Non-availability of doctors/staff Poor condition of the labour room/No power supply in the labour room/Any other reason (specify
Laboratory	(Yes/No)
Are adequate equipment and chemicals available?	(Yes/No)
Is laboratory maintained in orderly manner?	(Yes/No)
Vehicle (jeep/other vehicle) available?	(Yes/No)
Is there electric line in all parts of the PHC?	1- In all parts; 2- In some parts; 3- None
Regular Power Supply	1- Continuous Power Supply; 2-Occasional power failure; 3- Power cuts in summer only; 4- Regular power cuts; 5- No power supply
Standby facility (generator) available in working condition	(Yes/No)
How the waste material is being disposed (please specify)?	
Type of sewerage system	1- Soak pit; 2- Connected to Municipal Sewerage
Source of water	1- Piped; 2- Bore well/hand pump/tube well; 3- Well; 4- Other (specify)
Whether overhead tank and pump exist	(Yes/No)
If overhead tank exists whether its capacity	(Yes/No)

sufficient?	
If pump exists whether it is in working condition?	(Yes/No)

Medicines availability		
Name of the medicine	**Uses**	**Stock**