Women and Multiple Vulnerabilities in an Area of Unrest: Key Issues and Challenges of Tribal Women in Dumka and Jamtara District of Jharkhand

Final Report

November 12, 2013

Submitted to:

Ministry of Women and Child Development

And

Empowerment of Vulnerable and Marginalized Groups and Women in Difficult Circumstances
National Resource Centre for Women
National Mission for Empowerment of Women
Ministry of Women and Child Development

Submitted by:

Knowledge is Power
PRIA

Society for Participatory Research In Asia

42, Tughlakabad Institutional Area, New Delhi-110 062
Phone: 91-11-2996 0931 / 32 / 33, Fax: 91-11-2995 5183
Email: info@pria.org, Web: www.pria.org

CONTENT

		Page No.
	Acknowledgement	i
	List of Abbreviation	ii
	Glossary	iii
	Executive Summary	iv
Chapter – 1	Introduction	1
Chapter – 2	Methodology	23
Chapter – 3	Access to Development Services in Dumka District	34
Chapter – 4	Access to Development Services in Jamtara District	72
Chapter – 5	Comparative Assessment of Development Services in Dumka and Jamtara	109
Chapter – 6	Barriers in Accessing Development Services	130
Chapter – 7	Conclusions and Recommendations	143
References		167
Annexure – I	List of Block and District Officials interviewed for study	173
Annexure – II	Data collection instruments	174

ACKNOWLEDGEMENT

The research on ***"Women and Multiple Vulnerabilities in an area of unrest: Key Issues and Challenges of Tribal Women in Dumka and Jamtara District of Jharkhand*** "has been an extremely enriching experience for the Research Team. The research would not have been possible without the significant contribution by a host of individuals and institutions.

We extend our sincere thanks to the Ministry of Women and Child Development for supporting this study. We would like to thank Ms K. Ratna Prabha, Mission Director and Ms Rashmi Singh, Executive Director of National Mission for Empowerment of Women (NMEW), for providing us this opportunity to undertake this extremely relevant research. .

Our deepest gratitude is to the tribal and non-tribal women of the ten sample villages who have been the main source of inspiration for this research. Their enthusiasm and active participation in each step of the research process has made the experience an extremely meaningful one. In addition we would like to acknowledge the active participation of the men of those communities well, as well as the members of School Management Committees and Village Health and Sanitation Committees who provided valuable information and support during the field work.

In addition, we would like to acknowledge the active support of the concerned state and private service providers and PRI members at the village, panchayat, block, district level. We are thankful to all these officials for actively participating in the interviews and providing valuable insights for the research.

We are grateful to Arbind bhai and staff of Lok Jagriti Kendra, Madhupur district, for their valuable support during the inception phase of this research. We deeply appreciate the support provided by Ms Annu and Mr Nalini Kant from Manavi organisation in Dumka and Ms Rungti Chandra and Mr Renupada Patra from Purna Samarpan, Jamtara in identification of sample villages and in data collection.

Finally, we would like to acknowledge the ongoing support and guidance contribution of Dr Rajesh Tandon, President of PRIA, and Ms Martha Farrell, Dr Sumona Dasgupta and Mr Manoj Rai, senior colleagues of PRIA, for their critical insights and guidance through the research process.

The Research Team (PRIA, Delhi)

Dr. Namrata Jaitli
Ms. Shivani Singh

The Research Team (NRCW/NMEW)

Dr. Deepa Ahluwalia
Dr. Nasruddin

LIST OF ABBREVIATIONS

ANC	:	Antenatal Centre
ANM	:	Auxiliary Nurse Midwife (in RCH scheme)
APL	:	Above Poverty Line
ARI	:	Acute Respiratory Illness
ASHA	:	Accredited Social Health Activist
AWC	:	Anganwadi Centre (under ICDS scheme)
AWW	:	Anganwadi Worker (under ICDS scheme)
BPL	:	Below Poverty Line
BEEO	:	Block Elementary Education Officer
CBOs	:	Community Based Organisations
CDPO	:	Child Development Project/Programme Officer
CHC	:	Community Health Centres
CSOs	:	Civil Society Organisations
DISE	:	District Information System for Education
DPEP	:	District Primary Education Program
FGD	:	Focussed Group Discussions
LWE	:	Left Wing Extremism
MDM	:	Mid Day Meal
MWCD	:	Ministry of Women and Child Development
NGOs	:	Non Government Organisations
NRCW	:	National Resource for Empwerement of Women
NMEW	:	National Mission for Empwerement of Women
GOI	:	Government of India
PESA	:	Panchayat (Extention to Schedule Area) Act,1996
PHC	:	Primary Health Centre
PRI	:	Panchayati Raj Institutions
PRIA	:	(Society for)Participatory Research in Asia
PTA	:	Parent Teacher Associations
PTR	:	Pupil Teacher Ratio
RTE	:	Right to Education Act, 2009
RTI	:	Right to information
SHC	:	Sub Health Centre
SHG	:	Self Help Group
SSA	:	Sarva Shikha Abhiyan
SMC	:	School Management Committee
ST	:	Scheduled Tribe
STR	:	Student Teacher Ratio
ICDS	:	Integrated Child Development Services
IEC	:	Information, Education and Communication
M&E	:	Monitoring and Evaluation
NFHS	:	National Family Health Survey
NSGG	:	Non-School-Going Girls
ORS	:	Oral Rehydration Solution
PDS	:	Public Distribution System
RCH	:	Reproductive and Child Health
WCD	:	(Department of) Women and Child Development
WHO	:	World Health Organization

GLOSSARY

Aadhaar card	:	Aadhaar is a 12 digit individual identification number issued by the unique identification authority of India on behalf of the government of India. This number will serve as a proof of identity and address anywhere in India.
Annapurna Card	:	Annpurna Cards are issued to persons above the age of 65, have none to support and are not getting old age pension.
Antyodaya Anna Yojana(AAY) Cards (Yellow Card)	:	Antyodaya Anna Yojana Cards are issued to poorest of the poor families living in rural areas and urban slums.
APL Cards (Green Card)	:	Above the poverty line (APL) cards issued to above poverty line families.
Below the Poverty Line (BPL) Cards (Red Card)	:	BPL Cards are issued to poor families living in rural areas and urban slums.
Backward Regions Grant Fund (BRGF)	:	It is designed to redress regional imbalances in development.
Gram Sabha	:	A body consisting of persons registered in the electoral rolls within the area of Panchayat at the village level
Jati	:	Communities and sub communities in India
Micronutrient National Investment Plan	:	It has been prepared in response to the Government of India's increased priority towards combatting malnutrition, specifically micronutrient malnutrition.
Mobile Health Units:	:	This initiative under National Rural Health Mission (NRHM) provide health care services to people who are staying in the remote areas and have no access to health care services.
Mamta Vahan:	:	An arrangement of vehicle made by NRHM and UNICEF for smooth transfer of a pregnant mother to facility for institutional delivery.
Mukhiya	:	Elected chairperson of the Panchayat at the village level in Jharkhand
Panchayats	:	Institution of elected self-government in the rural areas in India
Panchayat Samiti	:	Elected rural local government body at the block level in India
Pradhan	:	Traditional Headmen of the community.
Sahiya	:	Elected Health Activist at the village level in Jharkhand
SanthalParganas.		Santhal Pargana is now one of the divisions or commissionaries of Jharkhand. Its headquarters is at Dumka. Presently, this administrative division comprises six districts: Godda, Deoghar, Dumka, Jamtara, Sahibganj and Pakur.
The Integrated Action Plan (IAP)	:	For Selected Tribal and Backward Districts under the BRGF program will cover 82 districts.
Tola Zila Parishad	:	Hamlet Elected rural local government body at the district level in India
Zila Parishad Adhyaksha	:	Elected chairperson of the Panchayat at the district level.

EXECUTIVE SUMMARY

1. INTRODUCTION

The-Left-wing extremism' (LWE), as the Government describes it, or the Naxal/Maoist activities, have swept across Jharkhand. Tribal women in Dumka and Jamtara are disadvantaged and vulnerable on multiple accounts. The role of the government in addressing these vulnerabilities becomes important to ameliorate the unrest and its impact on the lives and livelihoods of women. The study aimed to study how the unrest in Jharkhand affects the lives of the tribal women, and to examine how they are able to leverage basic services provided by the government in the areas of health, education and basic economic entitlements. It also aimed to analyse the barriers in accessing such services and suggest measures for improving utilization of these services by the tribal women. The study was undertaken by PRIA, with financial support from Ministry of Women and Child Development and technical support from National Mission for Empowerment of Women.

The study undertaken during October 2012 -April 2013 period, covered 10 villages from two districts and four blocks of Jharkhand, using purposive sampling techniques. Both districts were under the Scheduled V area, had high percentage of tribal population, and had varying degrees of covert and overt disturbance. Key respondents included about 168 tribal women and 40 non-tribal women and staff of government departments associated with health, education and economic entitlements at village, block and district level. A participatory research approach was used for data collection and analysis.

This participatory research intervention has helped in collectively exploring the multiple vulnerabilities faced by tribal women in these difficult and disturbed areas, and has facilitated exploration of multiple, integrated solutions to address the multi-level barriers.

2. KEY FINDINGS

2.1Status of development services for tribal women across Dumka and Jamtara district:

Access and availability of services: In majority of villages, physical Infrastructure (health and educational buildings) was available at the village level, with readily available transport facilities however an issue of concern for most villages. In

majority of villages the availability of government service providers like Auxiliary Nurse Midwife (ANM), Sahiya and Aganwadi workers (AWW), was as per the programme mandate, though primary government teachers numbers were lower than the mandated requirement. The tribal women's had easy access to most government village level service providers, with access to doctors however identified as a concern area. Majority of the 12 women interviewed did not have a bank account, however most women did have access to one of the economic entitlement cards (APL, BPL and *Antyodaya*). Positively the process of *Aadhaar* card had been initiated in their villages.

Quality of Services: In majority of villages the tribal women were not very satisfied with the quality of the village level physical infrastructure and development facilities, and a large number of tribal women respondents also expressed dissatisfaction with the performance of village level government service providers like *Sahiya*, AWW, teachers and para teachers. In all the 10 villages *Jholawala* doctors (quacks/unregistered medical professionals) were available and considered important by most women. Further all the 12 women interviewed were dissatisfied with the performance of the PDS centre.

Community Engagement with Services: In both districts the performance of the sectoral community committees like the SMC and VHSC was poor, with most women not aware about their existence. The community engagement in the delivery of education and health service was poor, with development issues not discussed in Panchayat meetings and Gram Sabhas not being held regularly.

2.2 Comparative analysis between Dumka and Jamtara district

A comparative assessment between the two sample districts having varying degrees of covert and overt disturbance, helped to explore the impact of the unrest on access and quality of services. In the sample villages of Dumka district (*with higher incidence of Naxal /Maoist activities and greater perception of fear and insecurity*), access to government transport facilities like Mamta Vahan and government service providers (ie the ANM, AWW and government teachers)at the village level was more difficult, as compared to Jamtara district. Further the dissatisfaction of tribal women with the state enabled service infrastructure and performance of the state service providers was higher in Dumka district. Interestingly availability of and perceived preference of tribal women for private service infrastructure (ie private schools and clinics) and service providers was higher in Dumka district.

2.3 Barriers to services

There was commonality on a number of perceived barriers identified by the tribal women and the service providers. These included:

Barriers at the level of community: These included socio-cultural barriers like traditional beliefs, lack of acceptance for institutional services by the women; discrimination and unrest within the tribal and non tribal community; poverty preventing women to access quality educational and health services; illiteracy and lack of awareness among tribal women of different central and state development schemes and acts like PESA and RTI; restricted decision making, mobility and lack of confidence among women; gender discriminatory practices; and lack of trust in government institutions and service providers .

Barriers at the level of service delivery system: These included *physical infrastructure barriers like* lack of health equipment and separate toilets for girls in schools; *human Infrastructure barriers* like staff shortage, delayed compensation, lack of supporting facilities and inadequate capacity building of village level functionaries; *behavioural barriers* like indifferent and discriminatory attitude towards tribal people, irregular attendance and corrupt practices of government functionaries; *procedural barriers like* the timing of the SHC and PHC not suiting tribal women; and p*oor community engagement* of government service providers with tribal communities .

Barriers due to the disturbed context: There was evidence that in district with higher incidence of Naxal activities, the unrest context negatively affected the access and regularity of the government service providers, their attitude towards tribal communities, and their motivation to effectively perform their mandated duties.

Barriers due to poor governance: Lack of effective functioning by PRIs at the village level and inactive Gram Sabha had resulted in ineffective village level planning and implementation of development programmes and schemes and lack of accountability of service providers to the Gram Sabha and elected Panchayat members.

3. RECOMMENDATIONS

The recommendations are aimed at the policy makers and decision makers of the line ministries and departments dealing with issues of women development and empowerment; the key policy makers and planners of India, as well as the staff of NMEW. They are aimed to ensure that development benefits reach the disadvantaged sections of society in an equitable, affordable and timely manner, and the circle of vulnerability that tribal women face is conclusively broken.

FOR LINE MINISTRIES AND DEPARTMENTS

Capacity enhancement of tribal women and sensitisation of tribal community: Within their programmes, design mobilisation and capacity building strategies to strengthen women's control over decisions related to development services;raise awareness on available development service using multiple, creative and culturally appropriate measures; and strengthen access to timely and regular information on development schemes and services .Further ensure awareness generation and Gram Sabha mobilisation campaign , with active engagement of SMC and the VHSCs, to strengthen demand from the tribal community for timely and quality service provision.

Strengthen local governance in tribal communities: Ensure inbuilt strategies, and their implementation in all sectoral programmes to strengthen and engage the *Gram Sabha* in every stage of the programme management, especially in Vth Schedule area. Further, strengthen capacity of recently elected PRI members at each level and engage them actively in the management of sectoral programmes.

Addressing systemic blockades in the delivery system: Ensure provision and effective implementation of budgetary allocations and procedural reforms in line department to ensure: better availability and maintenance of physical infrastructure and facilities; provision of adequate human infrastructure for service delivery; strengthening inbuilt mechanism of bottom-up planning in each sectoral programme: and procedural reforms to facilitate community-centred measures like changing the timings of the SHC/PHC to suit the needs of the tribal women; and strengthening internal and external monitoring systems.

Addressing human element in the delivery system: This includes capacity enhancement of service providers**,** by undertaking and monitor effective pre-service and on-going technical capacity building of village level para workers, with inclusion of basic unrest resolution training, sensitisation to tribal culture, gender issues and community participation issues; strengthening support systems for service providers by ensuring provision of mandated benefits, as well as incentives and grievance redressal mechanisms; and strengthen service providers engagement with tribal community.

FOR NMEW

Strengthening convergence for effective service delivery for tribal women: Potential areas of sectoral convergence include: health services on maternal and child health issues; education and health services; schemes of the state welfare department in tribal areas, and the centrally- sponsored schemes of education and

health department. In addition exploration of better synergy with the private players, especially in areas of unrest.

Two main strategies to ensure the same are: s*trengthening commitment and institutional mechanisms to strengthen convergence* which include joint convergence meetings at national, state and district level for policy framing and designing integrated implementation strategies; assigning responsibilities within the sectoral departments for different convergence avenues; designing multi-sectoral and integrated capacity building programs for service providers; strengthening joint inter departmental information planning and monitoring mechanisms; and *ensuring* d*esigning of bottoms-up convergence efforts in Tribal areas,* wherein all sectoral programmes having inbuilt strategy to engage with Gram Sabha and panchayats at all level and facilitate comprehensive district planning as a tool for convergence.

FOR POLICY MAKERS, PLANNERS AND GOVT OF JHARKHAND

Evolving an unrest preventive strategy for the State: Need for greater sensitivity to unrest among policy-makers and programme planners while planning and implementing development initiatives in the affected areas. Further policy pressure and administrative will to effectively implement the PESA 1996 Act, as well as the Forest Rights Act, 2006 is also another effective, non-violent and sustainable strategy to counter naxalism in the tribal regions.

CHAPTER-1: INTRODUCTION

1.1 CONTEXT AND STATEMENT OF PROBLEM

1.2 OBJECTIVE OF THE STUDY

1.3 STUDY AREA

1.4 STATE AND DISTRICT PROFILE

1.5 SANTHALS AND PAHARIA TRIBES

1.6 STATUS OF TRIBAL WOMEN IN JHARKHAND

1.7 KEY DEVELOPMENT SCHEMES IN DUMKA AND JAMTARA DISTRICT (SPECIAL FOCUS ON EDUCATION AND HEALTH)

1.8 NATIONAL RESOURCE CENTER FOR WOMEN (NRCW)/NATIONAL MISSION FOR EMPOWERMENT OF WOMEN (NMEW)

CHAPTER 1

1.1 CONTEXT AND STATEMENT OF PROBLEM

The state of Jharkhand was carved out of Southern Bihar on November 15, 2000 essentially as a 'tribal state.' Rich in mineral resources and with sound agricultural potential the major development debate in Jharkhand at the time of its inception was anchored around whether it was the mining potential or the agricultural potential that could be used as a natural launching pad to initiate a decade of development. The existence of a substantial tribal population in Jharkhand who had not been part of the post-independence mainstream development story meant that the growth also had to be harnessed to meet the goals of poverty alleviation and equity. Inclusive growth does not "happen" – evidently steps have to be taken to ensure that the benefits of development reach the right target group.

There are several reports suggesting that the letter and spirit of PESA (Provisions of the Panchayat Extension to the Scheduled Areas Act) of 1996 which among other provisions, made it mandatory to get the people in tribal areas involved in decision making regarding the use of their land and resources through the mobilization of the Gram Sabha, are being ignored in practice contributing to further alienate the tribal population and compounding their historical marginalisation.

In this scenario the left wing extremism' (LWE) as the Government of India describes it[1] or the Naxal/Maoist activities as it is known in more common parlance across India, has swept across the state and while the impact has not been uniform no district in Jharkhand can be completely free from its larger impact (Ministry of Home Affaires, 2012). While Dumka and Jamtara are not among the 35 districts across nine states most affected by LWE as identified by the Government of India in 2010, they fall squarely within the larger affected belt.[2] (Press Information Bureau, Government of India, 2010). South Asian terrorism Portal, basing its analysis on trends through 2011 has identified Dumka as "highly affected" and Jamtara as "moderately affected" by LWE. (South Asia Terrorism Portal, 2012)

While 'left wing extremism' (LWE) and the state's response to this in terms of its unrest management and counter insurgency strategy, has been documented by scholars and media persons, far less attention has been systematically devoted to how this cycle of disturbancehas directly or indirectly impacted women in these areas, particularly *tribal women*.

---

[1] *The government of India and Planning commission refers to and acknowledges the growth of 'Left wing extremism' (LWE) in several key documents including for instance the latest Ministry of Home Affairs outcome budget of 2011-2012, p.8. See http://mha.nic.in/pdfs/OB(E)2011-12.pdf*

[2] *Ministry of Home Affairs in its 10 November 2010 press note "Integrated Steps for Development of Naxal Affected Districts" has referred to the development initiatives in 35 LWE affected districts of the central government's flagship programmes, http://pib.nic.in/newsite/erelease.aspx?relid=66917.*

The research study on women in Jharkhand attempts to plug this gap by breaking the silence around women, particularly tribal women, either directly caught in or affected by this disturbance, and their multiple vulnerabilities especially in relation to access to basic services.

Statement of problem

Tribal women in Dumka and Jamtara are disadvantaged and vulnerable on multiple accounts, which include their gender in a traditional patriarchal set up, their identity as members of marginalised tribal communities in India and the fact that they currently live in a disturbed and difficult area. These vulnerabilities impact their access to basic services like health, education and entitlements, in a regular and affordable manner, meeting basic quality parameters.

1.2 OBJECTIVES OF THE STUDY

The research aimed to examine:

- How the unrest in Jharkhand affects the lives and livelihoods of the tribal women, and in this context examine how they are also able to leverage basic services provided by the government in the areas of health, education and basic economic entitlements

- Analyse the barriers in accessing such services by the tribal women.

- Suggest measures for improving utilization of these services and in this context identify ways that can be taken to promote greater convergence between government departments and institutions implementing the enabling provisions of PESA.

The study focused on the following issues:

- Impact of the unrest in Jharkhand particularly on tribal women in these districts in terms of their lives and livelihoods
- The nature of the interaction between women in this particular area- both tribal and non-tribal- and the state machinery
- The actual reach of basic facilities like health, nutrition and education to women in these areas of unrest
- The actual barriers on the ground that obstruct direct service delivery to women in the community and the steps that they think can be taken to improve access and utilization of these services

- The changes (If any) in gender relations, gender roles, gender ideologies, gendered institutions in the tribal communities in the midst of this unrest and how other (non tribal) communities being affected
- Suggest measures for improving utilization of these services and in this context identify specific steps that can be taken to promote greater convergence between government departments and institutions implementing the enabling provisions of PESA (including their ability to participate meaningfully in Gram Sabha decisions)

1.3 STUDY AREA

The research was undertaken in the state of Jharkhand, covering 10 villages from two districts and four blocks of Jharkhand. The initial proposal included 8 villages, which was later expanded to 10 villages in order to ensure coverage of villages facing varying degrees of overt and covert unrest. The research was exploratory and qualitative in nature and thus used purposive sampling techniques to select the districts, blocks and the 10 sample villages. The selected districts, blocks and villages thus are not necessarily representative of the other districts, blocks and villages of Jharkhand.

State

The selection of Jharkhand state for the study was due to the existence of left wing extremism (LWE) or the Naxal / Maoist activities across the state, and also due to the poor performance of the state on socio economic indicators, poor performance on implementation of the PESA (Provisions of the Panchayat Extension to the Scheduled Areas) Act of 1996 and of the poor local governance scenario, in light of the recently help local self governance elections.

Districts

The choice of Dumka and Jamtara as focal districts in the study is guided by the fact that both districts have a high percentage of tribal population: Santhals, the most populous tribe in Jharkhand, have the highest population in Dumka district. The adjoining district of Jamtara also forms part of the *SanthalvParganas*. These districts are appropriate sites of study given the special focus on tribal women in the project design. Further, both districts are designated scheduled areas where PESA provisions apply.

In addition both districts are affected by unrest. Though Dumka and Jamtara are not among the 35 districts across states most affected by LWE as identified by the Government of India they lay squarely within the larger affected belt. In fact the South Asian terrorism Portal, basing its analysis on trends through 2011 has

identified Dumka as “highly affected” and Jamtara as “moderately affected” by LWE. (South Asia Terrorism Portal, 2012)

Blocks and villages:

In Dumka district the four villages that were selected were: Uppar Murgathali in Golpur Panchayat with majority of population being Paharia; Jiathar Village of Ghasipur Panchayat with Santhali as majority tribe; Antipur Village in Rampur Panchayat with Mohali tribe; Sagbaheri Village with Santhal Tribe and Amgachi Village in Kathikund Block with Santhali Tribe.

In Jamtara district the four villages that were selected were: Asanchuma village of Udharvani Panchayat with Santhai Tribe; Chandradeepa Village in Chandradeepa panchayat with Santhali Tribe; Niltaha village of Chandradeepa Panchayat and Rupaidi Village of Duladi Panchayat with Santhal Tribe; and Chirudi Village of Bakhudi Panchayat with Santhal Tribe in one hemlet and Muslims population at one hand.

1.4 STATE AND DISTRICT PROFILE

Geographical Setup: Jharkhand, the 28th state of the Indian Union was brought into existence by the Bihar reorganization act on November 15, 2000, which is the birth anniversary of the legendary Bhagwan Birsa Munda. It spreads over the Chhotanagpur plateau and Santhal Parganass. It shares its border with the states of Bihar to the north, Uttar Pradesh and Chhattisgarh to the west, Odisha to the south, and West Bengal to the east. It has an area of 30,778 sq mi (79,710 km^2). Jharkhand is famous for its rich mineral resources like Uranium, Mica, Bauxite, Granite, Gold, Silver, Graphite, Magnetite, Dolomite, Fireclay, Quartz, Fieldspar, Coal (32% of India), Iron, Copper (25%of India) etc. Forests and woodlands occupy more than 29% of the state which are amongst the highest in India. Presently the state has 24 districts. (Government of Jharkhand, 2013)

Dumka is one of the oldest districts of Jharkhand state under *Santhal Pargana*. It has landscapes, majestic mountains, verdant valleys and serpentine rivers. Dumka has predominantly undulating terrain with hard rocks in the underground. Entire District has topography with high ridges and valleys bounded by mountains and rivers. The fertility of soil is poor due to extensive erosion, acidic character and low retaining capacity. (District Administration Dumka, 2013). Nearly 30% of the area in Dumka is under forest area.

Jamtara is a newly formed district of Jharkhand State. It came into existence on 26th April 2001. The district is located at a lower altitude of Chhotanagpur plateau. (Office of the Deputy Commissioner, Jamtara, 2013) 11% area of Jamtara is a forest area[3].

Map of Jharkhand

Source http://jharkhand.gov.in

Administrative Setup: Jharkhand is divided into 24 districts, 38 subdivisions, 260 Blocks and 32621 villages. (Government of Jharkhand, 2013)

The District of Dumka is the sub-capital of Jharkhand since 2000. Under Dumka subdivision, there are 10 blocks namely Dumka, Gopikander, Jama, Jarmundi, Kathikund, Maslia, Ramgarh, Raneshwar, Shikaripara and Saraiyahat. Jamtara was created by carving out four blocks from Dumka district. **(**District Administration Dumka, 2013). As per the 2001 census, the small district of Jamtara comprises of only 6 blocks namely Jamtara, Kundhit, Nala, Naryanpur, Karmatanr Vidyasagar and Fatehpur respectively. It is further divided into 118 Panchayats and 1161 villages. (Office of the Deputy Commissioner, Jamtara, 2013)

Population: As per the 2011 Census, Jharkhand is ranked the 13th most populous state in India with a population of 3,29,66,238 out of which 51.3% are males and the remaining, females. The state makes up about 3.5% of the country's population a figure which was about 3% during the last census in 2001. The majority of the population in the state is rural (75.9%), and 26.22 % of the population in the state

[3]http://www.sameti.org/Soil_Inventory/Jamtara_Soil_Analysis.pdf*Source:http://www.censusindia.gov.in/2011census*

are ST while 12.09% belongs to SC. (The Registrar General & Census Commissioner, 2012).

Table1.1: Population of Dumka and Jamtara

Demographic Indicators	Jharkhand	Dumka	Jamtara
Total Population	3,29,66,238	13,21,096	7,90,207
Male (% Male)	1,69,31,688 (51.3%)	6,69,240 (50.6%)	4,03,450 (51.05%)
Female (% Female)	1,60,34,550 (48.6%)	6,52,928 (49.4%)	3,86,212 (48.87%)
Rural Population (% rural pop)	2,50,36,946 (75.9%)	12,30,976 (93.17%)	7,14,192 (90.38%)
Urban Population (% urban pop)	79,29,292 (24.05%)	90,120 (6.82%)	75,015 (9.49%)
SC population (% SC pop)	39,85,644 (12.09%)	79,614 (6.02%)	72,885 (9.22%)
ST population (% ST pop)	86,45,042 (26.22%)	5,71,077 (43.22%)	2,40,489 (30.43%)

Source:http://www.censusindia.gov.in/2011census

Dumka and Jamtara respectively constitutes 4% and 2.39% of the total population of Jharkhand. Out of the total population of Dumka, 50.6% are males and remaining 49.4% are females and in Jamtara, 51.05% are males while 48.87% are females. The majority of population, both in Dumka and Jamtara are in the rural areas. (The Registrar General & Census Commissioner, 2012).

***Sex Ratio**:* As per 2011 Census, India's sex ratio is 940 females per 1000 males, while Jharkhand's is 947 females per 1000 males. The Sex Ratio in Dumka stood at 962 per 1000 male, similar to the year 2001 when the sex ratio was 961 per 1000 male. Dumka's sex ratio is higher than the sex ratio of Jamtara, which stand at 958 per 1000 males (The Registrar General & Census Commissioner, 2012).

***Scheduled Tribes**:* As per the 2011 Census, 8.6% of India's population is ST, compared to 8.2% in 2001. Jharkhand has 26.2% of its total population as ST. 31.4 % of the ST population is based in urban areas while 9.8% of the population is based in the rural areas of Jharkhand. Santhals are most numerous accounting for one third of the total tribal population followed by Oraon, Munda and Ho contributing more than 10% to the total tribal population. In Dumka, 43.21% of people are ST while in Jamtara, it is 30.4%. (The Registrar General & Census Commissioner, 2012).

There are 32 tribes in Jharkhand, namely: Munda, Santhal, Oraon, Kharia, Gond, Kol, Kanwar, Savar, Asur, Baiga, Banjara, Bathudi, Bedia, Binjhia, Birhor, Birjia, Chero, Chick-Baraik, Gorait, Ho, Karmali, Kharwar, Khond, Kisan, Kora, Korwa, Lohra, Mahli, Mal-Paharia, Parhaiya, Sauria-Paharia and Bhumij. (The Registrar General & Census Commissioner, 2012).

There are 9 primitive tribal groups who are likely to be extinct if special measures are not taken to increase their population and to preserve separate identify and culture. These primitive tribes are: Asur, Birhor, Birjia, Korwa, Mal Pahadia, Pahariya, Sauria Pahariya, Hill Kharia and Savar. Total population of all these primitive tribes is only 207,475 and this constitutes only 3.4 percent of total tribal population. Even among these primitive tribes, the total population of Hill Kharia is 4209; Savar, 4203; Birjia, 4529; Birhor, 8038; and Asur, 9122. The proportion of population of these 5 primitive tribes in total primitive tribal population is only 14.5 percent. The remaining 4 primitive tribes constitute 85.5 per cent of total primitive population. (Government of Jharkhand, 2013).

Each of these tribes has their own culture, dialect, geographical concentration and distinct social systems and institutions. They live in remote areas that are often inaccessible. Several measures have been taken over a period of time to protect tribal land and the exploitation of tribes by general population. The Constitution of India gives statutory recognition to tribal communities; guarantees protection of their rights; and has a provision for job reservation and proportional representation in elected bodies. The Fifth Schedule of the Constitution provides for the delineation of scheduled areas to protect the tribal interest and culture. The issue of land is critical in tribal areas. The Chhotanagpur Tenancy Act, 1908 and the Santhal Pargana Tenancy Act, 1949 have been in operation in Bihar for long. Further to this, the Bihar Scheduled Area Regulation Act 1969 has been appended to the earlier Acts (Government of Jharkhand, 2013).

***Religious Composition**:* According to 2001 census Hinduism comprises 80.5% of the religion in Jharkhand, followed by Muslims (13.4%), Christians (2.3%) Sikhs (1.9%), Buddhists (0.8%), Jains (0.4%) and others (0.6%). (The Registrar General & Census Commissioner, 2012).

Infant Mortality Rate (IMR): Infant mortality rate (IMR) is the number of deaths of children less than one year of age per 1000 live births. As per the Annual Health Survey 2010- 11, current IMR stands at 53 infant deaths per 1,000 live births in India. Jharkhand has an IMR of 41 infants per 1000 live births to 45 in rural India and 26 in Urban India. (Office of the Registrar General & Census Commissioner, 2012). Dumka's and Jamtara's IMR are more than the state IMR, which is at 63 (Dumka)and 46 infants per 1000 live babies (Jamtara). (Jharkhand Rural Health Mission Society, 2012).

***Maternal Mortality Ratio (MMR)**:* MMR measure number of women aged 15- 49 years dying due to maternal causes per 1,00,000 live births. India's MMR is 212 maternal deaths per 100,000 live births (an improvement from 254 in 2004-06). According to the Annual Health Survey 2010-11, the MMR of Jharkhand is above India's MMR, i.e. 278 maternal deaths per 100,000 live births. (Office of the Registrar General & Census Commissioner, 2012) As per District Health Action Plan 2011-2012, Jamtara has a higher rate of MMR at 371, compared to Dumka's MMR at 312 maternal deaths per 100,000 live births. (Jharkhand Rural Health Mission Society, 2012).

Table 1.2 Literacy Rate (2011)

Literacy rate	Jharkhand (%)	Dumka (%)	Jamtara (%)
Total Literacy	67.63	62.54	63.73
Male Literacy	78.45	75.17	76.85
Female Literacy	56.21	49.60	50.08

Source:http://www.censusindia.gov.in/2011census

Literacy rate in Jharkhand has seen upward trend and is 67.63% as per 2011 population census. Of that, male literacy stands at 78.45%t while female literacy is at 56.21%. In 2001, literacy rate in Jharkhand stood at 53.56% of which male and female were 63.83% and 38.87 % literate respectively. Schedule Caste Literacy Rate in Jharkhand as per Census 2001 is 40.7 % of which the ST Male literacy is 54% and the ST female literacy is 27.2%

Key Education Indicators

Table1.3: Enrolment and Retention Indicators

Indicators	India	Jharkhand	Dumka	Jamtara
Gross Enrolment Ratio at primary level(%) (2010-11)	118.62	155.81	99.7	N.A
Retention Rate at primary level (%)(2011-12)	75.94	51.47	51.5	54.3
Gross completion rate at primary level(%)(2011-12)	101.89	124.06	-	-
Average Dropout Rate at primary level(%)(2010-11)	6.50	12.62	-	-
ST children enrolment at primary level(%) (2011-12)	11.40	30.36	47.4	33.3

Source: http://www.dise.in/Downloads/Publications/Publications%202011-12/ Flash %202011-12.pdf; and http://dise.in/Downloads/Publications/Publications%202011-12/DRC %202011-12.pdf

As per the DISE data of 2011-2012 the Gross Enrolment Ratio (GER) at primary school level for Jharkhand is 155.81 which is higher than India's GER of 118.62. The retention rate at primary level at 51.47 however is lower than India retention rate (75.94). Also Jharkhand's average dropout rate at primary level of 12.62 is higher than India's average dropout rate at primary level. The tribal children's enrolment data of Jharkhand however is much higher than India's enrolment (NUEPA, 2013).

Table1.4: Annual Status of Education Report for Jharkhand 2011

Category	Percentage of Children-Jharkhand	Percentage of Children-Dumka	Percentage of Children-Jamtara
Children (Age: 6-14) out of school	4.4	5.4	4.8
Children (Std I-II) who can read letters, words or more	63.5	59.4	63.4
Children (Std I-II) who can recognise numbers (1-9) or more	64	63.9	69.1
Children (Std III-V) who can read level 1 (Std 1) text or more	48.4	31.7	41.8
Children (Std III-V) who can do subtraction or more	41	30.1	38.2

Source: *http://www.pratham.org/file/ASER-2012report.pdf;andhttp://img.asercentre.org/docs/Publications/ASER%20Reports/ASER_2011/DPT_2011/2011districtpage.pdf*

1.5 SANTHALS AND PAHARIA TRIBES

Santhals

According to 2001 census ,out of 30 Scheduled Tribes notified for the state of Jharkhand ,Santhal(also known as Santals) is the most populous tribe having a population of 2,410,509, constituting 34 per cent of the total ST population of the State. Santhal have the highest population in Dumka district followed by Purbi Singhbhum, Pakaur and Sahibganj districts but they constitute the highest proportion of the total ST population in Giridih (90.8 per cent), followed by Dumka (89.7 percent) and Pakaur (85 per cent) districts. (The Registrar General & Census Commissioner, 2012).

As the third largest tribal community of India, Santhals are divided into two groups namely Deswali Santal and Kharwar or Safa–Hor. Santhals are divided into 12 patrilineal totemic clans (pari) namely Hansdak, Murmu, Kisku, Hambrom, Soren, Marandi, Tudu, Baski, Besra, Pauria, Chonney and Bedia, which are further divided into several khunt or subclans. (Singh, 1990). Settled agriculture is their main

occupation. They also work as labourers, school teachers, doctors, nurses, lawyers and government employees. (Arjjumend, 2005).

Their general rate of literacy is low (which varies district to district, block to block and village to village), but there are some well-qualified Santhal persons who have excelled in their respective fields. The Santhals are among the first who waged peasant war, called locally as hul in 1855–56, which was directed against moneylenders and middlemen and was waged in defense of tribal rights in the land. A separate territorial administration for the *Santhal Parganas* was established as a result of the uprising. Major sections of Santhal became involved in the Jharkhand Movement from 1940s onwards (Ekka, 2003). Santhals have their own 3-tier community council. The village council (*morehor*) is headed by a *manjhi*, who is assisted by other council members in looking after village affairs. Ten, fifteen or more villages constitute the jurisdiction of a *pargana,* headed by a *pargana* or *parganait,* who also is helped by his councilors to look after the intervillage affairs. The highest political authority rests with the *khunt council* (*lo bir*), headed by a *dehri.* (Arjjumend, 2005)

Paharia tribes

Paharia tribe is mainly of two types: Mal Paharia and Sauria Paharia. Mal Paharia are presently concentrated more in the plains of non-Damin areas of Rajmahal hills in districts of Dumka, Jamtara, Godda, Deoghar and Pakur. Racially they belong to Proto-Australoid groups. Chief economic activities of Mal Paharia are agriculture, collection of NTFPs, labour works. They have been exploited by moneylenders and coexisting castes. Education level among Mal Paharia is minimal (Singh, 1990). Mal Paharia has 12 clans namely Dahri, Ahadi, Pujahar, Sing, Girhi, Kunwar, Dhanuk, Maal, Paatar, Laya, Manjhi. (Arjjumend, 2005).

Sauria Paharia (Maler) are the first inhabitants of Santhal Parganas, currently residing in north of Rajmahal hills. They speak Malto language and live on hills or hill slopes. Their number is fast dwindling in Jharkhand. Right of property is vested in the father. Presently, their economy rests upon resources like hill cultivation, forest, livestock, products like tussar silk cocoons and wild fruits. Due to the restrictions imposed by state and ever-shrinking forests and hill resources their livelihood is under stress and survival is at stake (Chaudhury 1965, referred in Arjjumand, 2005).

Table 1.5: Primitive Tribal groups and their population in India as per 2001 Census

Name of Primitive Tribal Group	Population as per 2001 Census (Figures in Actuals)
Asur	10347
Birhor	7514
Birjia	5356
Hill Kharia	-
Korwa	27177
Mal Paharia	115093
Parhaiya	20786
Sauria Paharia	31050
Savar	6004
Total	223327

Source: http://pib.nic.in/archieve/others/2008/Dec/r2008121914.pdf

1.6 STATUS OF TRIBAL WOMEN IN JHARKHAND

As the socio-demographic profile of Jharkhand has shown, the women in Jharkhand, and especially the tribal women, are faced with multiple vulnerabilities .The education and literacy level of the women in Jharkhand is very low, as evident from the 2011 census figures of male literacy at 78.45 percent while female literacy is at 56.21 percent. Further as per 2011 Census, Jharkhand's sex ratio is 947 females per 1000 males, which incidentally is higher than India's sex ratio of 940 females per 1000 males (The Registrar General & Census Commissioner, 2012).

According to the Annual Health Survey 2010-11, the MMR of Jharkhand of 278 maternal deaths per 100,000 live births is above India's MMR of 212. Jharkhand has IMR of 41 infants per 1000 live births with 45 in rural India and 26 in Urban India, which is better than India's IMR of 53 infant deaths per 1,000 live births. (Office of the Registrar General & Census Commissioner, 2012)This is an area of concern.

The National Commission for Women report has clearly highlighted that women in Jharkhand are still at the lower end of the labour market in pay and authority, typicallyoccupying lower-paid and lower status jobs. In Jharkhand women's unemployment rate is higher than that of men and far more women than men work in the informal sector. In organized sector the number of women is significantly small even if they have the benefit of education and skills (NCW, 2003).

Tribal women in Jharkhand, like other women, also face discrimination in property rights. The status of tribal female inheritance in society is based on customary laws. Although women shoulder heavy economic responsibilities as compared to men, but the Tribal customary laws deny them equal property rights like any other non-Tribal societies. Generally women are entitled only to maintenance rights and expenses for

marriage while men inherit land and all other moveable and immovable property. Several women amongst Ho and Santhals choose to remain unmarried in order to retain their rights to land (NCW, 2003).

The vulnerabilities get heightened with a growing number of tribal women and young girls from Jharkhand being trafficked to other states of India in the lure of false promises of employment and marriage, and with the gender discriminatory practices like, branding of women as witch and their oppressions, mostly prevalent in the tribal areas. In addition tribal women's participation in political process of their communities is also restricted. Paul, 2003 studied the participation of women in the local governance bodies and in *baisis* and found the participation of women to be very low. Paul argues that Tribal societies are still reserved about giving the space for the women in their traditional systems of governance, while constitutional mandate of PRIs ensures one-third women in the local governance structures. (Paul, 2003)

The Situation of Santhal Women

According to Santhal customary law, women do not have any claim over the movable or immovable property of the father or husband. The law did, however, provide maintenance for widowed women, unmarried girls, divorced daughters and wives. This was codified during British rule, in 1922-23, and after independence by the Santal Pargana Tenancy Act (SPTA) in 1949. (Rana and Rao 1996 cited in Rao, 2001).

The SPTA thus has ruled out the possibilities for women to inherit land .Traditionally, in the absence of a male heir, a man could get a daughter married to a *ghar jawae* (a son-in-law formally adopted at the time of marriage as a son) who would stay in the girl's village and sever all links with his own family. The land could then be legally transferred to the daughter. In actual practice, even if a *ghar jawae* is taken, the male agnates (who would inherit property in the absence of a *ghar jawae*) harass the couple. A widow gets no share and is virtually homeless upon her husband's death unless she has a son. (Rana and Rao 1996 cited in Rao, 2001).

Santhals also have the practice of marrying more than one woman.As in other patriarchal societies, within the gender division of labour, ploughing, hunting, sacrificing animals and other ritual ceremonies are exclusive male preserves. Within the household, however, apart from all the maintenance functions, it is the woman who collects paddy, borrows seed grain, negotiates loans, goes to the market and in general manages the household. (Rao, 2001).

1.7 KEY DEVELOPMENT SCHEMES IN DUMKA AND JAMTARA DISTRICT (SPECIAL FOCUS ON EDUCATION AND HEALTH)

To address the low socio- economic indicators of Jharkhand, especially those related to tribal women, there is a number of Central and State supported development schemes operational in the state of Jharkhand. The section provides a brief overview of these schemes, with special mention of schemes related to education and health services (in keeping with the mandate of the research).

Scheme: 1

Title: Integrated Child Development Service (ICDS) Scheme in Jharkhand
Sponsored By: Central Government Funding Pattern: For all the components of the ICDS scheme (except Supplementary Nutrition Programme (SNP) which is funded by the State), full funds are provided by the Government of India which releases fund for the scheme from time to time through a financial year.
Scheme Description: The Integrated Child Development Service (ICDS) scheme is one of the flagship schemes identified by the Government of India. This scheme is sanctioned and monitored by the Ministry of Women & Child Development, Govt. of India uniformly throughout the country. In the State of Jharkhand this scheme is run by the Department of Social Welfare, Women and Child Development.
Beneficiaries: Women, Children,
Benefits Type: Providing supplementary nutrition and schooling as per the nutritional and financial norms prescribe
Eligibility Criteria: Children belonging to the 0-6 years age-group, pregnant women, lactating mothers and adolescent girls.

Source: http://jharkhand.gov.in/schemes.html

Scheme: 2

Title: Sarva Shiksha Abhiyan (SSA)
Sponsered By: State & Central Government; Funding Pattern: The share of Central Government and State Government 75:25 during the X Plan and 50:50 thereafter
Scheme Description: The motive of Sarva Shiksha Abhiyan is to universalize elementary education. The Abhiyan is to provide useful and relevant elementary education for children in the 6-14 age group by 2010. The programme calls for community ownership of school-based interventions through effective decentralization. Education of girls, especially those belonging to the scheduled castes, scheduled tribes and minorities, is one of the principal concerns in Sarva Shiksha Abhiyan. All Girls/SC/ST children are given free text books at the primary and upper primary level.
Beneficiaries: Children
Eligibility Criteria: All children under the age group of 6-14 are to be benefited by this scheme. How to Avail: The government is pushing the Abhiyan itself to universalize the primary education.

Source: http://jharkhand.gov.in/schemes.html

Scheme: 3

Title: National Rural Health Mission (NRHM)
Jharkhand Rural Health Mission Society is committed to provide accessible, affordable and accountable quality health services to the last person of the last household of the last village. The thrust of NRHM is on establishing a fully functional, community owned, decentralized health delivery system with inter sectoral convergence at all levels,to ensure simultaneous action on a wide range of determinants of health like water,sanitation, education, nutrition, social and gender equality. Institutional integration within the fragmented health sector is expected; to provide the focus on outcomes, measured against Indian Public Health Standards for all health facilities.
In Jharkhand it includes components of Mobile Health Van, Ayush Kendras, untied funds.

Source: http://210.212.20.93:8082/jrhms/DHAP.aspx

Scheme: 4

Title: Janini Suraksha Yojana
Scheme Description: Janani Suraksha Yojana is a centrally sponsored scheme aimed at reducing maternal and infant mortality rates and increasing institutional deliveries in below poverty line (BPL) families. The scheme covers all pregnant women belonging to households below the poverty line, above 19 years of age and up to two live births. It provides assistance in form of cash and integrate it with antenatal care during pregnancy period, institutional care during delivery as well as post-partum care. This is provided by field level health workers called Accredited Female Health Activist (ASHA) through a system of coordinated care and health centres.
Beneficiaries: Individual, Family, Women, ;Benefits Type: Girl students belonging to SC, ST, Minorities, and BPL families
Eligibility Criteria:

Low performing state (LPS)	All pregnant women delivering in Government health centres like Sub-centre, PHC/CHC/ FRU / general wards of District and state Hospitals or accredited private institutions
High Performing State	BPL pregnant women, aged 19 years and above
LPS & HPS	All SC and ST women delivering in a government health

Source: http://jharkhand.gov.in/schemes.html

Scheme: 5

Title: Bicycle Distribution Scheme
Sponsered By: State Government; Funding Pattern: Government of Jharkhand (100%)
Scheme Description: This Scheme has been started by Jharkhand Government to encourage girl students belonging to SC, ST, Minorities, and BPL families to go to schools and continue their studies. This plan was started by the state government for the following two reasons:- (i) The distance between the school & their houses being too much, the family members have difficulties in sending their girls to school. (ii) After passing the middle level school many girl students of the villages discontinue their studies due to lack of transportation facilities
Beneficiaries: Individual, Family, Women, ;Benefits Type: Girl students belonging to SC, ST, Minorities, and BPL families
Eligibility Criteria: Girl students belonging to SC, ST, Minorities, and BPL families studying in class-VIII
How to Avail: Application to be submitted to District welfare officer through the principals of the schools.

Source: http://jharkhand.gov.in/schemes.html

Scheme: 6

Title: Supply of uniform to girl students of Scheduled Caste and Scheduled Tribe
Sponsered By: State Government Funding Pattern: 100% State Government
Scheme Description: The objective of this scheme is to supply free uniform to girl students of Scheduled Caste and Scheduled Tribe category studying in government schools. Under this scheme girl students of SC and ST are given white blouse/top and navy blue skirt.
Beneficiaries: Individual, Community, Benefits Type: Material,
Eligibility Criteria: Should be a girl student of SC, ST category.
How to Avail: Application is submitted to District Welfare Officer through the Principals of the schools.

Source: http://jharkhand.gov.in/schemes.html

Scheme: 7

Scheme Title: Ayurvedic Health Centre Scheme for Schedule Tribes
Sponsered By: State Government .Funding Pattern: 100% State Government
Scheme Description: The objective of this scheme is to provide free ayurvedic medical facility to the members of Scheduled Tribes. The government is running 35 ayurvedic medical centres in the rural areas. Through these centers members of scheduled tribes are given free medicines and medical advice. Every ayurvediccenters has one ayurvedic Medical Officer and one Assistant to the run the center.

Beneficiaries: Individual
Eligibility Criteria: The patient should a member of Scheduled Tribe. How to Avail: Patient has to go to the ayurvedic medical center for the medicine and medical advice.

Source: http://jharkhand.gov.in/schemes.html

Scheme: 8

Title: Construction of Hostels and their maintenance for SC, ST, OBC and Minorities Students
Sponsored By: Both: State & Central Government Funding Pattern: 100 % by State government
Scheme Description: Schemes aim is to provide free residential facility to the students of SC, ST, OBC and Minority Communities. The Welfare Department has framed Rules for admission in these hostels, for the management of these hostels and discipline of the inmates. Students admitted in these hostels are given free beds, blankets, furniture and utensils etc. Such hostels have accommodation for hundred or fifty students depending upon the number of Rules. The Government has so far sanctioned 235 such hostels. The Government has recently sanctioned 4 hostels for ST
Beneficiaries: Individual
Eligibilty Criteria: Students should be a member of SC, ST, OBC and Minority category.
How to Avail: Students apply to the District Welfare Officer through the Principal of the concerned collages/schools.

Source: http://jharkhand.gov.in/schemes.html

Scheme: 9

Title: Ashram/Eklavya schools for Scheduled Tribe Students:Jamtara
Sponsered By: State Government Funding Pattern: 100 % by State Government
Scheme Description: Ashram/ Eklavya schools have been started for Scheduled Tribe students where teachers and students leave together in the school campus itself. In these schools besides free educations students are also provided food, lodging, and uniform freely.
Beneficiaries: Community, Children, Benefits Type: Material, Any Other Food, lodging, and uniform.
Eligibilty Criteria: The students should belong to Scheduled Tribe Community. How to Avail: Student has to apply to the District Welfare Officer of the concerned district.

Source: http://jharkhand.gov.in/schemes.html

Scheme: 10

Title: Residential Schools of Welfare Department
Sponsered By: State Government Funding Pattern: 100% by State Government
Scheme Description: Under this scheme students belonging to SC, ST, and OBC categories are admitted in residential schools where besides free education they get free fooding, lodging, books, school uniform, soaps, blankets, towels etc. Admissions in the schools are through written/oral examination.
Beneficiaries: Individual, Community, Benefits Type: Material,
Eligibilty Criteria: Students belonging to SC, ST, and OBC categories.

Source: http://jharkhand.gov.in/schemes.html

Scheme: 11

Title: Mid day Meal Scheme for students of Paharia DUMKA
Sponsered By: State Government;Funding Pattern: 100% by State Government
Scheme Description: Paharia Primitive Tribes have a very low literacy rate. Their life standard is also extremely low. Keeping this in view the Welfare Department of Jharkhand has started the Midday Meal Scheme in all its Paharia Day Schools under this scheme students are given midday meal freely on which Rs.10.90 is spent per day per meal. The Midday Meal is allowed for 300 days in a year. The Scheme is attracting PahariaTribals to send their ward to these schools.
Beneficiaries: Children, Benefits Type: Material,
Eligibilty Criteria: Students studying in Paharia Day Schools

Source: http://jharkhand.gov.in/schemes.html

Scheme: 12

Scheme Title: Health Centres for Pahariya Primitive Tribes DUMKA
Sponsored By: State Government Funding Pattern: 100% by State Government
Scheme Description: Pahariya is a Primitive Tribe living in Parts of Jharkhand. They are very poor and have ill health. For their health care Government of Jharkhand has started health centres in those areas where members of this Tribe are living. Free medical checkup and free medicine is provided to the needy persons.
Beneficiaries: Individual, Benefits Type: Material, Eligibilty Criteria: Persons belonging to Pahariya Tribe.

Source: http://jharkhand.gov.in/schemes.html

Scheme: 13

Title: Chief Ministers Special Food Security Scheme for Primitive Tribe Groups**DUMKA**
Sponsered By: State Government Funding Pattern: 100% State government
Scheme Description: Keeping in view the extremely low life standards of Primitive Tribes the Government of Jharkhand has started Chief Ministers Special Food Security Scheme for these Tribes. Under this scheme food grains (rice and wheat) are being made available free of cost to all families of Primitive Tribes. Under this scheme each family of Primitive Tribe will get 35 kg of food grains rice per month.
Beneficiaries: Family, Benefits Type: Material, Eligibility Criteria: The family should be a member of Primitive Tribe.

Source: http://jharkhand.gov.in/schemes.html

Scheme: 14

National Rural Employment Guarantee Scheme Jharkhand formulated under Mahatama Gandhi National Rural Employment Guarantee Act
Sponsored By: State & Central Government (Funding Pattern: 90:10 (Centre : State)
Scheme Description: The main objective of the Act is to enhance livelihood security in rural areas by providing at least 100 days of guaranteed wage employment in a financial year to every household whose adult members volunteer to do unskilled manual work. Other subsidiary objectives are generating productive assets, protecting the environment, empowering rural women, reducing rural-urban migration and fostering social equity etc. Beneficiaries: Family,
Benefits: Wages for unskilled employment Infrastructure in rural areas.
Eligibility Criteria: • Be local residents: 'Local' implies residing within the Gram Panchayat. This includes migrant families of that area, including those that may have migrated some time ago but may return. • Be willing to do unskilled manual work • Apply as a household at the local Gram Panchayat. • Applicants to be adult members of the household.

Source: http://jharkhand.gov.in/schemes.html

Scheme 15

Theme Title: National programme of nutritional support to primary education (NP-NSPE)
Sponsored By: Central Government
Sponsored on: 5th August 1995 in the state (United Bihar)
Scheme Description: To enhance enrolment, retention and attendance and simultaneously improve nutritional levels among children, the national programme of nutritional support to primary education (NP-NSPE) was launched as a centrally sponsored scheme on 15th August 1995 in the state (United Bihar). Dry food grains per student per month at the rate of Rs 3 k.g was being distributed to the students of Primary stage (class I to V) of the Government schools.

Beneficiaries: Class I-VIII students

Source: http://mdm.nic.ins/PAB/PAB-2011-12/AWPB%20Appraisal%20Notes/JHARKHAND.pdf

Scheme: 16

Theme Title: Rashtriya Gram Swaraj Yojana
Sponsored By: State & Central Government
Funding Pattern: 75% Central Government and 25% State Government
Scheme Description: The objective of Rashtriya Gram SwarajYojana assisting efforts of the State Government for training and capacity building of elected representatives of Panchayati Raj Institutions. It focuses primarily on providing financial assistance to the States/UTs for Training & Capacity Building of elected representatives (ERs) and functionaries of Panchayati Raj Institutions (PRIs). Funding of the scheme is applicable only for the non-BRGF districts so the only East Singhbhum district is under this scheme. It has a small component of Infrastructure Development under which the construction and renovation of PanchayatGhars is funded.
Beneficiaries: Community, Benefits Type: Training,
Eligibility Criteria: Panchayati Raj Institutions and their functionaries

Source: http://jharkhand.gov.in/schemes.html

1.8 NATIONAL RESOURCE CENTER FOR WOMEN (NRCW)/ NATIONAL MISSION FOR EMPOWERMENT OF WOMEN (NMEW)

The National Mission for Empowerment of Women (NMEW) was launched by the Government of India (GoI) on International Women's Day in 2010 with the aim to strengthen overall processes that promote all-round Development of Women.It has the mandate to strengthen the inter-sector convergence; facilitate the process of coordinating all the women's welfare and socio-economic development programmes across ministries and departments. The Mission aims to provide a single window service for all programs run by the Government for Women under aegis of various Central Ministries. In light with its mandate; the Mission has been named Mission *Poorna Shakti*, implying a vision for holistic empowerment of women.

The National Resource Centre for Women (NRCW) has been set up which functions as a National Convergence Centre for all schemes and programs for women. It acts as a central repository of knowledge, information, research and data on all gender related issues and is the main body servicing the National and State Mission Authority.

Mission Statement: NMEW will achieve gender equality, and gender justice and holistic development of women through inter-sectoral convergence of programs relating to women, forging synergy between various stakeholders and creating an enabling environment conducive to social change.

Focus areas of the Mission:

- Access to health, drinking water, sanitation and hygiene facilities for women,
- Coverage of all girls, especially those belonging to vulnerable groups in schools from primary to class 12,
- Higher and Professional education for girls/women,
- Skill development, Micro credit, Vocational Training, Entrepreneurship, SHG development,
- Gender sensitization and dissemination of information,
- Taking steps to prevent crime against women and taking steps for a safe environment for women.

Key Strategies:

- Facilitating inter-sector convergence of schemes meant for women, monitor and review the progress on a regular basis,
- Strengthening the institutional framework offering support service for women,
- At policy level commission research, evaluation studies, review schemes, programs and legislation, do gender audit and outcome assessment build the evidence for policy and program reform and scale up implementation of the initiatives,
- Enhance economic empowerment of girls and women through skill development, micro credit, vocational training and entrepreneurship and SHG development,
- Evolve with the support of community representatives and groups' appropriate and localized communication to strengthen public education on gender, change and social mobilization using a 360 degree approach on media and communication.

Empowerment of Vulnerable & Marginalised Groups and Women in Difficult Circumstances (EVMG): The domain 'Empowerment of Vulnerable and Marginalized Groups & Women in Difficult Circumstances' (EVMGs & WDCs) is a cross-cutting domain and plays a crucial role in NRCW. The domain endeavours to identify the issues of the newly emerging groups along with the already scheduled ones; to collaborate with other domains within NRCW for 'holistic empowerment' of women from vulnerable and marginalised groups; and to develop & strengthen network with

relevant partner Ministries/Departments, Commissions, and Civil Society Organizations to facilitate convergence at different levels.

The key Objectives of EVMG are:

- Facilitating an enabling environment for over-all development of Vulnerable & Marginalized Groups and Women in Difficult Circumstances.
- Strengthening existing linkages / network / mechanisms for ensuring participation in decision-making
- Mainstreaming the Vulnerable & Marginalized Groups and Women in Difficult Circumstances in Government run schemes and programs

(National Women for Empowerment of Women, 2013)

CHAPTER-2: METHODOLOGY

2.1 SAMPLING STRATEGY

2.2 STUDY METHODOLOGY

2.2.1 DATA BASE

2.2.2DATA COLLECTION METHODOLOGY

2.3.3 DATA COLLECTION FRAMEWORKS AND TOOLS

2.3.4 DATA COLLECTION VISITS

2.3.5 DATA ANALYSIS

CHAPTER-2

2.1 SAMPLING STRATEGY

The research is *exploratory and qualitative in nature* and has thus used *purposive sampling techniques* to select the districts, blocks and the 10 sample villages. The selected districts, blocks and villages thus are not representative of the other districts, blocks and villages of Jharkhand. The initial proposal included 8 villages, which was later expanded to 10 villages in order to ensure coverage of villages facing varying degrees of overt and covert unrest.

Selection of Districts:

The selection of districts was done in a purposive manner. The choice of Dumka and Jamtara as focal districts in the study is guided by the fact that both districts were under the *scheduled V and had* a *high percentage of tribal population.*The santhals, the most populous tribe in Jharkhand, have the highest population in Dumka district. The adjoining district of Jamtara also forms part of the *Santhal Parganas*. These districts are appropriate sites of study given the special focus on tribal women in the project design. Further, both districts are *designated scheduled areas where PESA provisions apply.*

Both districts have varying degree on covert and overt unrest environment. Though Dumka and Jamtara are not among the 35 districts across states most affected by LWE as identified by the Government of India they lie squarely within the larger affected belt. In fact the South Asian terrorism Portal, basing its analysis on trends through 2011 has identified Dumka as “highly affected” and Jamtara as “moderately affected” by LWE. The selection of Dumka and Jamtara thus provided opportunity to undertake comparative analysis between the highly affected Dumka district and the moderately affected Jamtara district.

Selection of Blocks:

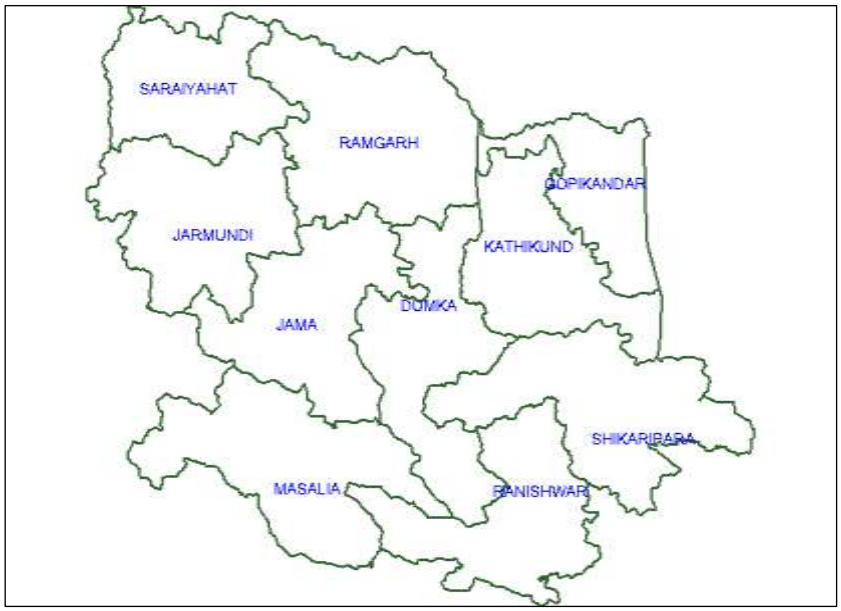
In keeping with the qualitative nature and participatory research, the selection of the blocks was done in a purposive manner. The Sample included blocks which were under the *scheduled V area*, blocks where the *partner NGOs were already working* with tribal women's groups, and also blocks with *varying degree on covert and overt unrest environment*.

The selection of Dumka and Jamtara block was based on the presence of two partner grassroots NGOs. In Dumka district CSO partner “Manavi”, is working on issues of tribal women empowerment, covering social and economic empowerment aspects. In Jamtara district the selected CSO “Purn Samarpan” is working on issues of women’s political, social and economic empowerment. The presence of CSOs in these blocks would ensure selection of villages wherein some existing works with the tribal.

The selection of Kathikund block and Narayanpur block was done to ensure inclusion of villages which had incidences of overt unrest in recent history. Following are the maps of

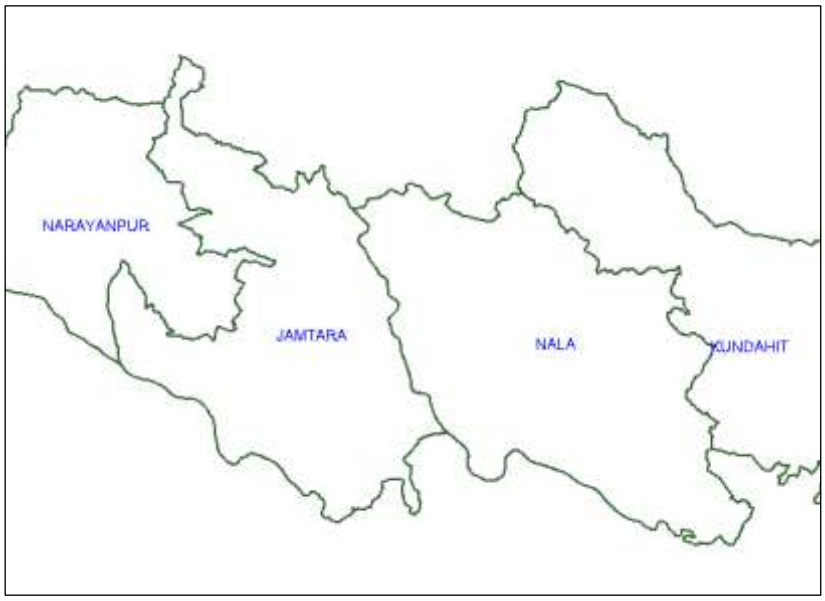
Dumka and Jamtara. In Dumka majorly four block are infected by naxal activities, which include Ramghar, Gopikandar, Kathikund and Shikaripara, whereas as in Jamtara one block Narayanpur is affected by naxal activities.

Figure 2.1 :Map of Dumka district



Source : http://210.212.20.94/dumka/jgis/default.asphttp://
210.212.20.94/dumka/jgis/default.asp

Figure 2.2: Map of Jamtara District



Source :http://210.212.20.94/JAMTARA/jgis/default.asp

Selection of Villages:

The selection of 10 villages from the 4 blocks was done in a purposive manner, in consultation with the local CSO partners during the inception visit to Dumka and Jamtara district in October 2012. The sample villages selected were those where the local partner CSO was working with the tribal women on issues of women's economic, social and also political empowerment. Keeping the participatory nature of the research and the sensitive issue on hand, it was essential to work with the existing women's groups of the CSOs, to get deeper and authentic insight and also to ensure that the findings of the research will be result in some affirmative action at the women and community level. It was decided to select one village from one Panchayat, so as to have variation in the village findings.

Further the sample included villages which had both tribal and non-tribal population. This was important to understand the vulnerabilities faced by women due to their tribal status. Inclusion of some primitive tribes like the Pahariyas, whose concentration is highest in Jharkhand, was also a criterion in the selection of the villages. In addition to variation in the incidences of overt and covert unrest was another criterion for selection of the villages.

Thus out of 10 villages, in 2 villages there was a recent incidence of Naxal disturbance, while in the other 8 villages though the villages were existing in an environment of unrest, though no recent overt unrest incident was reported.

The 10 villages across 2 districts have been selected for the research:

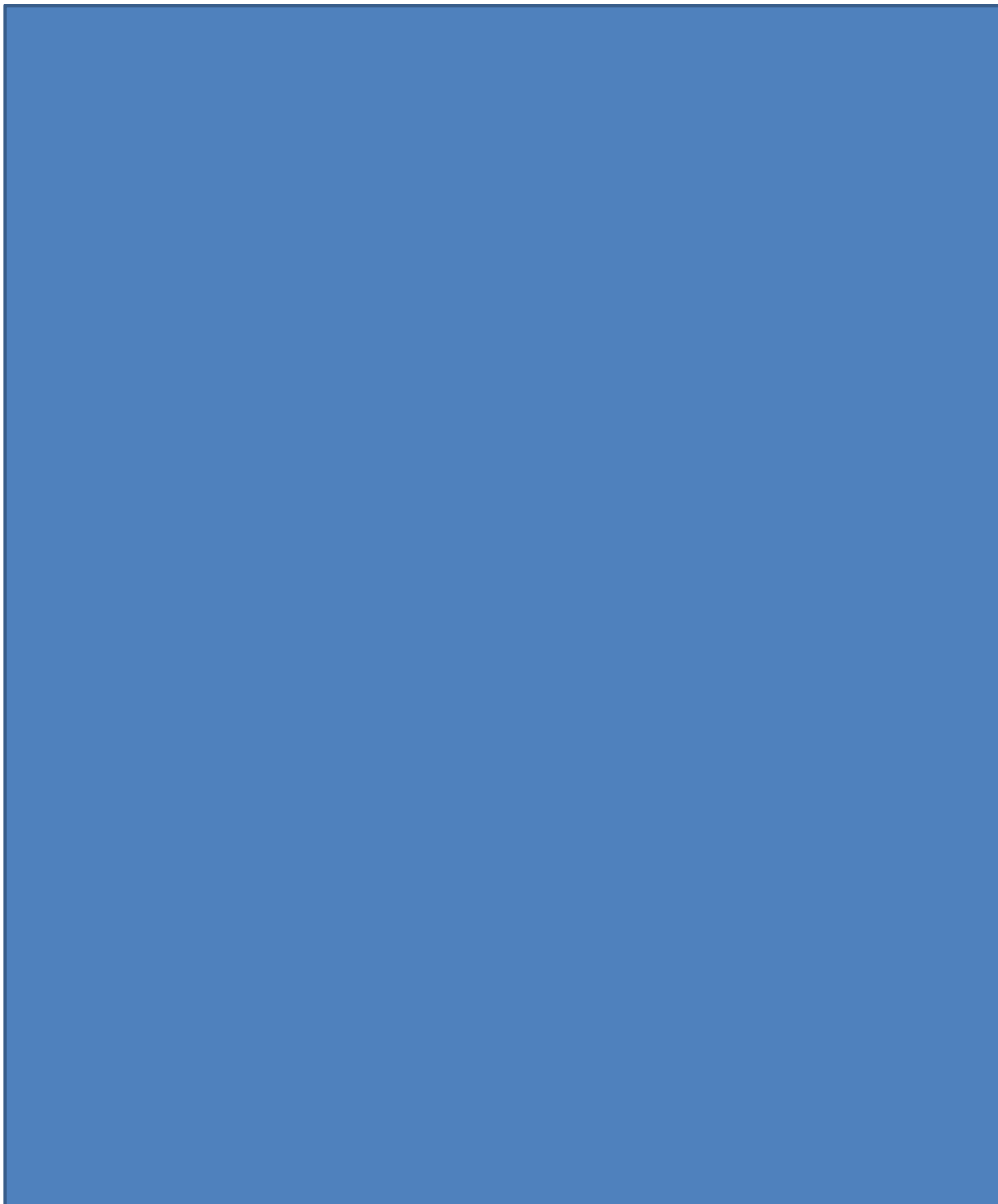
Table 2.1: List of Sample Villages

District	*Block*	*Village*
Dumka	Dumka	Upar Murgthali village, Golpur Panchayat (*Paharia Tribe*) Jiathar village,Ghasipur Panchayat (*Santhal Tribe*) Anthipur village,Rampur Panchayat (*Mohali Tribe*) Sagbaheri village, Sagbaheri Panchayat (*Santhal Tribe*)
	Kathikund	Amgachi village, Pokharia panchayat (*Santhal Tribe*)
Jamtara	Jamtara	Asanchuma village, Udharvani Panchayat (*Santhal Tribe*) Chandradeepa village, Chandradeepa Panchayat (*Santhal Tribe*) Niltaha village, Chandradeepa Panchayat (*Santhal Tribe*) Rupaidip village,Duladi Panchayat (*Santhal Tribe*)
	Narayanpur	Chirudi village Bakhudi panchayat (Santhal Tribes and Muslims)

Selection of Respondents

Data collection covered different category of respondents, whose selection was done in a purposive manner. It included:

- *Tribal Women*: Through Focused group discussion (FGD) interaction with about 144 tribal women on health, education and entitlements related issues was undertaken. In each of the 10 villages, 10-12 tribal women were primary respondents. In addition in depth interviews of 24 tribal women were taken.



- *Others:* In addition data was collected by the School Management Committees, the Village Health and Snitation Committees, and local facilitators like NGOs staff and CBO representatives working with the tribal women

2.2 STUDY METHODOLOGY

2.2.1 Data base

The main source of data for this qualitative and exploratory study is primary data, which is derived from the discussions and interview with the tribal and non tribal women, and the service providers. Detailed assessment of written records and registers of schools, health centers, aganwadi centersetc were not designed as potential sources of secondary data, keeping in mind the non evaluative nature of the study. The focus was based more on the perceptions and views of the women and the service providers. The registers accessed for information include the attendance register of the schools, the SMC meeting register, the mother and child health cards at AWCs.

In addition reviews of secondary literature on issues relevant to the study were undertaken. They included information on Jharkhand; the different development schemes, with special focus on maternal and child health, primary education, tribal development; relevant studies and papers on tribal women and development services; a disturbed environment in Jharkahnd etc was undertaken. This helped in designing the study, developing the data collection tools, substantiating the findings, and drawing out recommendations.

2.2.2 Data Collection methods

As the research is focused on one of the most vulnerable groups living in extremely difficult circumstances, thus rather than use the traditional approach to study this problem of women in unrest through survey methods, a ***more participatory and less extractive approach*** to collect data in ten villages of the two districts was used. Using the participatory research framework, the research had intensive field work and included tribal women at each step of the research intervention. This included problem articulation, collective data collection, critical analysis, and in discussing follow up actions to address the identified issues and problems.

The choice of methods was done to ensure that the primary respondents were active participants in analysing their context and the status of the health services and provide possible solutions. The findings of the research were shared with the respondents in a way that they can use it collectively and non-violently to ensure more effective accesses to quality and timely health services.

Participatory Research methods

The research methodology included participatory methods like social maps on health, focused group discussions, semi structured interviews, and observations. Some key methods included:

- *Village Transect*: This was used to get an overview of the village and identify the current status of health and education services. Village Transect is an observatory walk through the residential area of the village, observing and making notes of the layout of the village, housing, drainage, backyards, infrastructure etc. It helps to locate maps and analyze various aspects of the residential area of the village that normally go unnoticed.It throws as up a number of aspects of rural life that would probably otherwise go unnoticed.

- *Village Social Map*: This was used to get an overview of the village and identify the current status of health and education services. Participatory Mapping refers to maps made or drawn by the members of the community on paper or on the ground. It is a process by which information is presented in a spatial form. Social maps were used to present information on the village layout, infrastructure, population, social stratification, service facilities available, their distance.

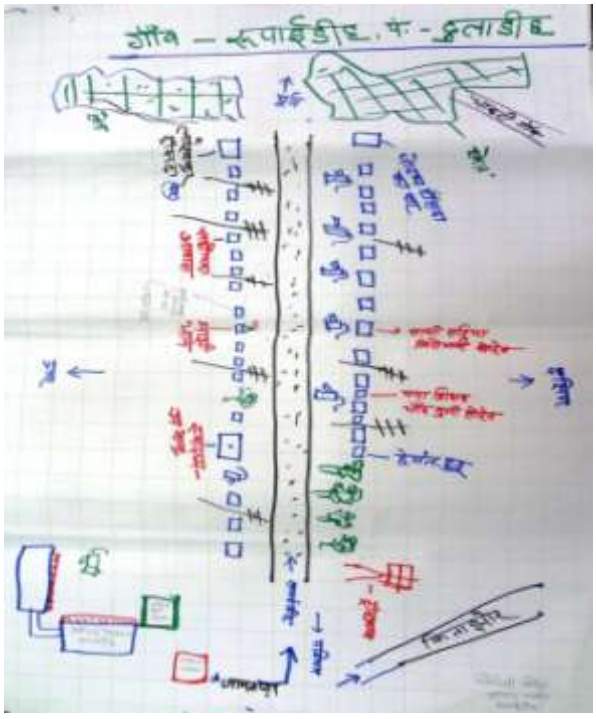


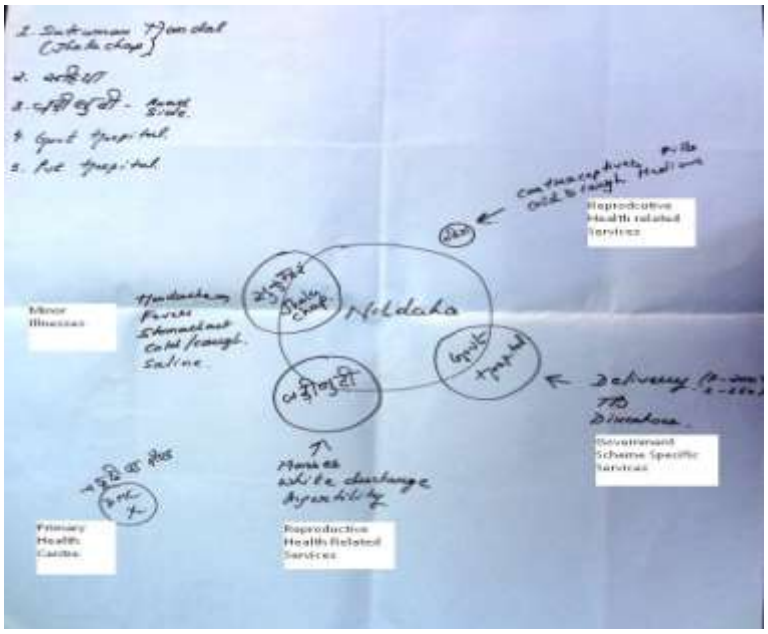
Figure: 2.1: Social Map of Rupaidi Village

The social map drawn by the people of Rupaidi village, Jamtara. The map has details regarding the government provided health and education infrastructure and service providers at the village level. Apart from that people also drew various other infrastructures like a hand pump, agricultural land, a sacred place, roads, trees, temple etc.

- *Focused group discussion*: The Focussed Group Discussions (FGD) with the tribal, as well as non-tribal women were ensued to assess the problems they face in accessing health services, cause of these problems, and possible solutions. Focused group discussions are group interviews where a moderator guides the interview while a small group discusses the topic that the interviewer raises. The FGD was aided by an FGD guide *(See FGD guide enclosed as Annexure 2)*

- *Participatory visual techniques*: These included venn/*chapatti* diagrams to facilitate a comparative assessment of health service providers (government and private service providers). A participatory visual technique like venn/*chapatti* diagram is a visual depiction of key institutions, organisations and individuals and their relationship with the local community or other groups. The techniques were used to indicate the degree of importance attached to a health related institutions and service providers functional at the village level. Big circles were drawn to represent 'most important' organisation and smaller circles indicating 'less important' organisation as perceived by the participants. A chart paper and markers were used to execute the activity. Many women who could not speak were able to transcend their thoughts through this activity. It helped the research team to facilitate a comparative assessment of health service providers (government and private service providers).

Figure 2.2: Venn Diagrams of Health Service Providers



Venn diagram denoting the most important and least important health service at the village level

- *Community Ranking of Educational services***:** A simple community ranking tool was used to assist in the tribal women's collective assessment of educational services on selected educational indicators. The indicators included aspects like: regularity and accessibility of teachers and students; infrastructure availability (toilets, playground, electricity, water, classroom condition TLMs, Books for SC/ST, Table and chairs, seating arrangements, status of the school building); monitoring and evaluation (visit by the DEO, teachers meeting, Parents meeting, discussions at Panchayat level) etc. (*See community ranking tool enclosed as Annexure 2*)

- *In-depth semi structured Interviews*: In-depth semi structured Interviews of 1-2 women in each sample village were done to assess the status of education and health in their family, the problem faced in accessing the health and educational related services in their village, and the possible solutions for better access and quality of both education and health related services. The interviews were aided by an Interview guide (*See interview guide enclosed as Annexure 2*)

- *Semi Structured Interviews*: These were taken by members of the SMC, VHSC, Service Providers and NGO staff, to know about the status, barriers, challenges and suggestions for better access and quality of the services.The interviews were aided by an Interview guide*(See interview guide enclosed as Annexure 2)*

(The data collection tools are enclosed as Annexure 2)

2.2.3 Data Collection Framework and Tools

The focus of inquiryvaried from each category of respondents.

- *Tribal Women*: With tribal women the research focus was to get the women's critical perceptions of the status of health services; challenges faced in accessing timely & quality health services; the perceived as well as the real causes of these problems; and alternate sources of health services accessed by the women. In addition exploration of possible solutions and future course of action was also an important area of collective inquiry.

- *Non-Tribal Women*: The research focus here was to assess the health profile of the villages and get their views on the status of health services, problems faced in accessing health services and possible solutions to the problems.

- *Service Providers of health services*: The research thrust was to capture their perception on issues related to provision of health services to the tribal women. It included their assessment of the status of health services provided (i.e. Quality, timeliness, responsiveness of staff, convergence among different departments); the perceived

problems faced by women in accessing health services; the underlined reasons for these barriers; and suggestions for addressing these barriers.

2.3.4. Data Collection Visits

Date collection was undertaken during the October 2012 – February 2013 period.

- *Exploratory visit*: An exploratory study was done during October 2012, with the aim was to identify the partners in the two districts, to select sample blocks and the sample villages in those blocks. It further included discussions with the tribal women in two villages (covering both the districts) to include them in the identification of the critical issues related to health, education and entitlement issues, which would help in framing the focus of inquiry. In addition this visit was also helpful in collectively identifying the participatory research methods which would be useful in ensuring active participation of the women in the data collection and data analysis process.

- *Data Collection field visits to Dumka and Jamtara*: For the participatory data collection two visits each was made to each of the 10 intervening villages. The data collection visits were done in two phases. The first phase was done in December 6-19, 2012, and the second phase was done during February, 8-24, 2013. In each phase sample villages of both the districts were covered. During the first phase the focus was on assessing the access to health services (under NRHM), while in the second phase the focus was on assessing access to primary education (under SSA) and entitlements like Ration card, BPL cards and Aadhar cards.

- *Sharing of draft findings with the community women*: In keeping with the participatory research nature of the research, the draft findings were shared with the respondent group at the village level during April 13- 16, 2013 in both Dumka and Jamtara. This helped in triangulating the findings with the community, and also instilling a feeling of ownership with the community over the research process. Discussion on follow up action at the village and panchayat level was initiated through these visits.

2.3.5 Data Analysis

Data analysis has primarily been qualitative in nature. The first level of data analysis was done at the level of the respondents, especially at the level of the tribal women, wherein deeper analysis of the barriers to the current status of services and the possible solutions to the same was undertaken by the women (as service users), the service providers, as well as by the intermediary community based structures like the SMC and the VHSC.

The second level analysis was undertaken at the level of the researchers, wherein the qualitative trends were drawn out, and triangulated with the rich data available to the

researchers. Analysis of data was done from the focussed group discussions, interviews, social mapping process, Venn/chappati diagrams, transect walks were undertaken within a broad study framework, keeping the research objectives in mind. Though qualitative analysis at the level of individual respondent was not undertaken, the focussed group discussions were taken as a unit to facilitate village level picture and also to facilitate inter district comparative analysis.

CHAPTER 3

ACCESS TO DEVELOPMENT SERVICES IN DUMKA DISTRICT

3.1 HEALTH SERVICES

- **3.1.1 HEALTH PROBLEMS SHARED BY TRIBAL WOMEN**
- **3.1.2 AVAILABILITY AND ACCESS TO HEALTH SERVICE PROVIDERS**
- **3.1.3 QUALITY OF HEALTH SERVICES**
- **3.1.4 DETAIL ASSESSMENT OF PERFORMANCE OF SERVICE PROVIDERS**
- **3.1.5 ENGAGEMENT OF COMMUNITY IN HEALTH SERVICE DELIVERY**
- **3.1.6 SERVICE PROVIDERS PERSPECTIVE**

3.2 EDUCATIONAL SERVICES

- **3.2.1 PRIMARY EDUCATION STATUS**
- **3.2.2AVAILABILITY AND ACCESS TO EDUCATION SERVICE PROVIDERS**
- **3.2.3 QUALITY OF EDUCATION SERVICES**
- **3.2.4 ENGAGEMENT OF COMMUNITY IN EDUCATION SERVICE DELIVERY**
- **3.2.5 SERVICE PROVIDERS PERSPECTIVE**
- **3.2.6 MONITORING AND EVALUATION**

3.3 SELECT ENTITLEMENTS

- **3.3.1 ACCESS TO ENTITLEMENTS**
- **3.3.2EASE OF GETTING ENTITLEMENTS**
- **3.3.3. SATISFACTION WITH THE PROVISIONS RECEIVED**

CHAPTER 3:

This chapter provides an overview of the status of primary health care (maternal and child health), primary education and other select entitlements in select villages of Dumka district, as shared by tribal women. It captures the tribal women's perceptions about availability, accessibility and quality of health and education services and other entitlements received by them. It further highlights the community engagement in health service delivery and the government service providers' perspectives on issues related to access and quality of the chosen development services.

3.1 HEALTH SERVICES

The Health indicators of Dumka district with respect to Jharkhand and India as a whole are provided in the table below.

Table 3.1: Health Indicators[4]

Indicator	Dumka
Crude Birth Rate (CBR) (SRS 2009)	25.8
Crude Death Rate (CDR) (SRS 2009)	7.1
Infant Mortality Rate(IMR) (SRS 2009)	46
Maternal Morbity Rate (MMR) (SRS 2009)	312

Source: http://210.212.20.93:8082/jrhms/DHAP.aspx

These indicators are derived in the *District Health Action Plan* of Dumka District for the year 2011-12.

As per existing norms one Health Sub Centre (HSC) is planned for every 5000 population and for tribal areas the 3000 population, one Primary Health Centre (PHC) for every 30,000 population and for tribal area 20,000 population one CHC (Community Health Centre) for every 1,20,000 population. For tribal areas the norm is one CHC per 80,000 populations. The current scenario of the services available in Dumka, as per District Health Action Plan 2011-12 is as follows:

[4] As per the Annual Health Survey, 2010-2011 the IMR of Jharkhand is 41, as compared to India's IMR of 53.Further the MMR of Jharkhand is 278, as compared to MMR of India, which is 212.

Table 3.2: Health Facilities in Dumka district

Sl. No.	Type of Units	No. of Units
1.	Sadar Hospital	1
2.	Referral Hospital	2
3.	Primary Health Centre	10
4.	Addl. Primary Health Centre	34
5.	Health Sub – Centre	-
6.	Family Welfare Centre	2
7.	Maternity & Child Health Centre	0
8.	District T.B. Centre	0

Source: http://210.212.20.93:8082/jrhms/DHAP.aspx

Apart from health functionaries such as doctors, medical officers, paramedics staff, nurses, and compounders several other types of workers/volunteers such as AWWs, NGOs are playing vital role in the proper functioning of the district health system. (Jharkhand Rural Health Mission Society, 2013)

3.1.1 HEALTH PROBLEMS SHARED BY TRIBAL WOMEN

The focused group discussions (FGD) with tribal women were conducted in which approxiamately 10-15 women participated from all the sample villages. The opinions of majority of women were taken into account.

Table 3.3: Health Problems in Dumka district

Health Problems	Number of Focussed Group Discussions where the problem was highlighted
Varied types of body pain	5
Irregular Menstrual Cycle	5
TB	5
White Discharge	4
Anemia/ Weakness	3
Cold and Cough	3
Asthma	3
Malaria	3
Kalazar (Black Fever)	3
Jaundice	2
Falaria	1

The data reveals that in 5 FGDs women faced health problems like TB, irregular menses and body pain. In 4 FGDs, the women complained about irregular white vaginal discharge. Women in 3 FGDs reported suffering from Kalazar (Black fever), malaria, asthma, cold and cough, and anemia. Jaundice was reported in two FGDs and filariasis in one FGD.

Personal interviews of women suffering from various diseases were interviewed. Following is the case of Suhagani Dehari of Jiathar village who is suffering from irregular menstrual cycle for past 5 years.

Voices of Tribal women

Sughani Dehari aged 40 belongs to a Mal Paharia Tribe, she has three children and a husband who is a farmer by occupation. She is working as a cook in Government Tribal School. I think my health is poor as I haven't got my menses for the past 5 years." She suffers from persistent white discharge and constant body pain which disrupts her day-to-day activities. When she went to the hospital, the doctor shared that she has reached menopause. This worried her, as her present age is 35. She did not approach the doctor after that.

Rabnidevi got married at the age of 20 and migrated to the Upper Murgathali village. She has two children a daughter who is 3 years old and a son who is 5 years old. She was busy with her household stuff when we first met her. She complained about severe body pain and back ache due to which she is unable to work in the field with her husband.

3.1.2 AVAILABILITY AND ACCESS TO HEALTH SERVICES

Health service infrastructure and service providers are the two main pillars for health service delivery. The third pillar is the community institution – bridging the gap between the service provider and the service users. In this study the community institution identified is the Village Health Committee, stipulated under NRHM.

A) Availability, Accessibility and Effectiveness of Heath Infrastructure/Institutions

During the FGDs, a number of institutional health services were enumerated by women at village, neighborhood and block levels.

The discussion in the FGD was on assessing the a*vailability of the physical infrastructure and its approximate distance from the tribal tola.*[5]

Table 3.4: Health service infrastructure availability and access (kms) matrix of Dumka district

Availability of Heath Facility	Upar Murgathali	Jiathar	Antipur	Sagbaheri	Amgachi
Village level					
Primary Health Sub centre (SHC) available within range	Not available (Census 2011). Paharia health centre also available.	Not available (Census 2011)	Not available (Census 2011)	Not available (Census 2011)	Not available (Census 2011)
Primary health centre (PHC) available within range	Between 5 Kms and 10 Kms (census 2011)	Not available. Between 8 to 10 kms in Ghasipur panchayat.	Not available. 5 km away in Kathijoria village.	Not available Between 5 Kms and 10 Kms (census 2011)	Between 5 Kms and 10 Kms (Census 2011)
Aganwadi Centre within tola range	Available in the Mal paharia tola (uphill) within 1km as well in the Santhali tola within 1km.	Not available in the Santhali tola (2kms). But available in Christian Santhai tola withi n 0.5 km.	Not available in the village. Available in other village between 5-6 kms.	Available. But is running in Anganwadi worker's house. It is near (0.5 km) the Christian santhali tola but 1kms away for santhai tola.	Available within 1km.
Mobile Health Unit (MHU) Awareness and frequency	Not aware	Not aware	Not aware	Not aware	Not aware
Mamta Vahan Service Awareness and frequency	Available. But reaches only till Hat Murgathali (down hill).	Available on call. But no numbers displayed in the village.	Available on call. But no numbers displayed in the village.	Available on call. But no numbers displayed in the village.	Available on call. But no numbers displayed in the village.
At Block level					
Dumka Hospital	Available at the Block. Between 5 Kms and 10 Kms from the tribal tola.	Available at the Block. More than 10 Kms from the tribal tola.	Available at the Block. Between 5 Kms and 10 Kms from the tribal tola.	Available at the Block. Between 5 Kms and 10 from the tribal tola.	Available at the Block. More than 10 Kms from the tribal tola.
Private Clinics in Dumka	Available but not accessed (FGD)	Available between 5 Kms and 10 Kms from the tribal tola.	Available Between 5 Kms and 10 Kms from the tribal tola.	Available but not accessed (FGD)	Not available

[5]Hamlets are called tolas in Dumka. .A tola can comprise of a homogeneous group like Santhali tola, Christian tola, Yadav tola, Mohali tola, or Muslim tola. There are no visible physical boundaries. They all stay in close proximity.

Summary Findings:

- *Sub Health Centre (SHC) and Primary Health Centre (PHC)***:** The most accessible health service institution was the SHC, which the women can reach by walk, but was available only in one village. The other 4 villages have PHCs, with most beyond 5 kms to 10 kms, so the women cannot go there by foot. The access to the PHC thus is an issue in the select villages.

- *Community Health Centre***:** In all the 5 villages, the more specialized Health Centre's located at the block and district headquarter level are accessible by motorable road, approximately 5-15 kms from the villages.

- *Anganwadi Centre:* Available in 4 villages, at an approximate distance of 1 km from the Santhali tola. There is no anganwadi in Antipur village.

- *Private Clinics*: Available at block and district headquarters levels. There are more private health clinics in Dumka than in Jamtara.

- *Mamta Vahan***:** Women from 4 villages mentioned that the Mamta Vahan is a very important vehicle that helps connect tribal women to the hospital in Dumka for delivery of babies. However, a number of women did share the problem of the Mamta Vahan not reaching the village, and the non-availability of other emergency services like ambulances. In one village that is uppar murgathali the Mamta Vahan service was not available, as the village is built uphill and has no motorable road. The condition gets worse during the rainy season.

Voices of Tribal Women

Difficulty in reaching the governmenthospital: "I don't know how to drive a vehicle. I can visit the hospital only when my husband is at home and he can take me on his motorbike. We don't go to the PHC before going to the hospital as they don't have the required medicines and they refer us to the government hospital most of the time anyway. It doesn't make sense to go to PHC when we know that they will refer us to the government hospital. Also, the distance between the government hospitals in Dumka headquarter and the PHC is the same (8 kms), so we prefer going to the hospital. The Mamta Vahan never visits our village. I have not seen any ambulance either despite our village being near the main road. We commute to Dumka by bus. Their frequency is good." – **Sona Hemrom, Jiathar**

The only conveyance she has is a cycle; there is no means of transport to take her to the hospital. Even the Mamta Vahan doesn't come to her village as the road is not metaled. It is particularly difficult during the rainy season when the area is flooded. She shared that, "We carry the pregnant women on cot down hill and then walk up till the main road in order to access the service of mamta vahan". – **Sughani Dehari, Uppar Murgathali**

Indu Devi aged 40, resides in Jagarbane village of Dumka Block for past 10 years. When asked does she know what a mamtavahan she said is, "I don't know what mamtavahan is."

B) Availability and Accessibility of Service Providers/Human Resources

During the FDGs the women were asked to list out the health functionaries at village, neighborhood and block levels. Their availability and accessibility was assessed from the *residence of the health functionary* and *frequency of visits by them to the village.*

At village level, women spoke about the presence of the Auxiliary Nurse Midwife (ANM), Anganwadi Worker (AWW), Sahiya/ASHA (Accredited Social Health Activist), traditional healers and quacks ("jholawala doctor"). At block and district levels they mentioned government doctors, and in some cases private doctors.

Table 3.5: Health service provider availability and access matrix of Dumka district

Availablility of service providers	Upar Murgathali	Jiather	Antipur	Sagbaheri	Amgachi
State Providers					
ANM	Compounder of paharia centre resides within the village. ANM visit anganwadi once in a month.	Anganwadi not available in the santhali tola but available in the mission tola. ANM visits 1st Saturday of every month.	No anganwadi but the ANM of nearby village visits the village for immunization of women and children. ANM doesn't reside in the village.	ANM of Kodokhicha village visit's sagbaheri village anganwadi once in a month. ANM doesn't reside in the village.	Visits once in a month
Government Doctors	Doctor visits the paharia health centre twice a month and charges Rs 200 per visit.	Doctors not available in the PHC which is 8kms away from the santhali tola.	Available only at the Community Health Centre, which is 5 kms away	Not available in the kodokhicha PHC.	available at the Community Health Centre which is more than 10 kms away or at the Trust Hospital which is also more than 15 kms away
Sahiya (ASHA)	One Sahiya available. She is Santhali	One Sahiya available within the tola from Santhali tribe.	One Sahiya available within the Mohali Tola. Sahiya is from the Yadav community	One Sahiya available within the Christian tola. She is santhali	One Sahiya available away from santhali tola, She is a muslim
AWW	One AWW available at village level in the house of anaganwadi worker. AWW resides at in the village.	No anganwadi within the tola therefore the AWW also doesn't reside in the snthali tola. She resides in the mission tola.	No AWW	Anagnwadi run in the house of the anganwadi worker. She resides in the mission tola.	AWW available. She is Muslim AWW resides in the muslim tola.
Non State Providers					
Jholawala /Quack/RMP	available, comes to the village atleast twice a day	available, come daily to the village	available, come daily to village	available, comes come daily to village	available, come daily to village
Traditional Healers	Available	available	available	available	available
Private doctors	Private doctors only available at the block level.	Private doctors only available at the block level.	Private doctors only available at the block level.	Private doctors only available at the block level.	Private doctors only available at the block level.

Summary Findings:

- *ANM*: In all 5 villages the ANM visits the designated villages at least once a month. In Uppar Murgathali the compounder at Paharia PHC resides within the village and is thus available and accessible at all times. In Jiathar, there is no anganwadi in the Santhali tola but is available in the Mission (Christian Santhali) tola. The ANM visits jiathar village on the first Saturday of every month. In Antipur, an anganwadi is not available but the ANM of a nearby village visits the village to immunize women and children. The ANM of Kodokhicha village visits the anganwadi in Sagbaheri village once a month and in Amgachi to the ANM visits once a month.

Weekly Schedule of ANM

Ms Ruth Tudu is the ANM of Kodokhicha PHC. She has seven villages under her jurisdiction for immunization of women and children. This includes the sample village of Sagbaheri in this report. The schedule followed by her is as follows:

Schedule of ANM, Sagbaheri	
Monday	In Kodokhicha PHC attending the patient. It is 5 kms away from the Sagbaheri village
Tuesday	Meeting at the block level
Wednesday	Meeting at block level
Thursday	Visit one of the seven villages
Friday	In PHC attending the patient
Saturday	Visit one of the seven villages

- *Sahiya:* Sahiyas are available in all 5 sample villages. However, accessibility is hampered due to community dynamics. As there persist unrest between the *Mohali* and *Yadav* community. For example, in Antipur, there is a Sahiya available within the *Mohali* tola but as she is from the Yadav community (a minority community), most women from other communities do not avail of her services.

- *Anganwadi worker*: AWW was not found in 2 villages. In the other 3 villages, she resides in the village, so is easily accessible.

- *Government doctors*: Available to all the 5 sample villages at the Community Health Centers, this is between 5 and 15 kms away. Except for Uppar Murgathali where the doctors visit the Paharia Health Centre twice a month and charge Rs 200 per visit, in none of the other village doctors are available nor do they visit the SHCs or the PHCs. In Amgachi, doctors are available at the Community Health Centre at Kathikund

block, which is more than 10 kms away or at the Trust Hospital which is more than 15 kms away.

- *Non-state providers*: The "jholawala doctor" (quack) is available in all the villages. They usually visit each household/ family in the village twice a day in the morning and in the evening. The service of traditional healer was also available in all the 5 villages. Private Doctors were available only at the district headquarter level.

3.1.3 QUALITY OF HEALTH SERVICES

In order to assess the effectiveness of the physical and human infrastructure related to health services, the Venn diagram/chappati diagram was used as a participatory method to generate responses from the tribal women. The size of the circle drawn by the women indicated the degree of importance attached to the institution or individual by the community. Big circles represent 'most important' organization/individual and smaller circles indicate 'less important' institutions or individual, as perceived by the women.

A) Quality of Health Infrastructure/Institutions

This was assessed based on the following two indicators generated in consultation with the women:

- *Importance of and visit to the institution for health related service*
- *Satisfied with the services of the Institution*

Table 3.6: Health infrastructure quality matrix of Dumka district

Quality of Health Infrastructure	Upar Murgathali	Jiather	Antipur	Sagberi	Amgachi
Institutions					
SHC	Most important & Satisfied.	Not Available	Not Available	Not Available	Not Available
PHC	Not important PHC not visited by women. Problem Faced: Lack of transport.	Not important. PHC not visited by women Problems faced: 8 km away; they don't believe in curability of the medicines provided in the PHC; the doctor is and ANM are not present in the PHC.	Not important. PHC not visited by women Problems faced : 5 km away ; irregular staff not,	Not important. PHC not visited by women Problems faced: 8 kms away, most time closed, ANM only staff, appropriate medicines not available	Not important. PHC not visited by women. Problems faced: Shortage of medicines, far off, irregular ANM attendance
Anganwadi Centre	Less Important for medicines. Most important	Less Important for medicines. Most important for 0-6	Not Available	Less Important for medicines. Most important	Less Important for medicines. Most

	for 0-6 children.	children.		for 0-6 children.	important for 0-6 children.
Mobile Health Unit	Not shared in the FGD	Not shared in the FGD	Not shared in the FGD	Not shared in the FGD	Not shared in the FGD
Mamta Vahan	Most important for pregnant women	Most important for pregnant women	Most important for pregnant women	Most important for pregnant women	Most important for pregnant women
At Block					
Dumka Hospital	Most important& Satisfied, but want better facilities, and also regular access to Mamta Vahan to their village(chk if DC)	Less important & Not satisfied, as medicines not available, give expired medicines not have infrastructure facility likexray machiene, sonography machines, (chk if DC)	Most important & Satisfied with the gov hospital (chk if DC)	Less important & not very satisfied; feel the cost of medicines is high (chk if DC)	Less important Satisfied with the CHC in Kathikund. As it is near.
Private Clinics	Less important	Most important &Satisfied with the service, but the cost of treatment is an concenrn	Most important.	Not important. As cannot afford the treatment.	Not important As cannot afford the treatment.

Summary Findings:

- *SHC*: In Uppar Murgathali where the SHC is available (Paharia Health Centre), women perceived it as a health care service. In that village women were satisfied with the available health Infrastructure.

- *PHC*: In the remaining 4 villages where an SHC is not available, the PHC was not perceived as very important nor was it approached for providing health care service. In these villages the women were not satisfied with the health infrastructure available. The reasons given by the women for not visiting the PHC included: persistent shortage of medicines, poor quality and expired medicines, no emergency service, unsuitable timings and lack of transport to reach the PHC.

- *Anganwadi***:** In the 4 villages where the anganwadi was available, women perceived it as not important nor did they approach it for accessing health care service like medicines for minor and major ailments. They used it *more for immunization of pregnant women and nutrition for children in the 0-6 age group.* In 3 villages the women were dissatisfied with the anganwadi health infrastructure available (due to no proper building, lack of proper ventilation and open space).

- *Mamta Vahan***:** Mamta Vahan was considered the most important, especially for pregnant women. In all 5 villages, the Mamta Vahan reached when required yet

Uppar Murgathali the vehicle reached only till hat murgathali (downhill santhali tola) and in Antipur the vehicle reached till motorable road is constructed. The service became inaccessible for pregnant women especially in the tolas with scattered population due to the topography and lack of motorable road.

- *CHC*: The CHC was not perceived as very important nor approached for providing health care service by the women in all 5 villages.
- *District Hospital*: Women from 2 villages did not perceive it as important and did not approach it. In 2 other villages, the women were dissatisfied with this health infrastructure and the services provided. Only in one village the women chose the hospital at the district headquarter over the services provided by jholawala doctors.

The primary reasons shared by the women for not approaching the government hospital were lack of transport facility to the town where it was located other reasons include: Need for an educated escort, inhibition due to being illiterate, less educated, or less aware, inability to drive any vehicle, offensive attitude of government staff towards tribal women, long queues for medicines that can be bought from private hospitals, one or multiple days' wage loss, husbands uninterested and apathetic towards the health of their wives, lack of trust in the quality and effectiveness of government, general discontent among the people towards the government hospital for not being effective and corruption.

Mismatch between the work schedule of tribal women and PHC

"The timings of PHCs are from 10 am to 1 pm. We work in field at that time" A women shared in FGD. The work schedule of tribal women is as follows:

Tribal Woman's Work Schedule	
4:00 am	Wake up get ready;
5:00 am	besmear the soil on floor and walls;
6:00 to 9:00 am	cook food and send children off to school and other household work;
10:00 am	Go to field and do work;
4:00 pm	Return back from field;
5:00 pm	Cooking and resting for some time;
6:00 pm	Going to fetch water;
9:00 pm	Serving food to family;
10:00 pm	Washing utensils ;
11:00 pm	Sleep

Voices of Tribal Women

UshaDevi, aged 20, married at the age of 14 is staying in the village since then. She was preparing a bamboo basket when we approached her. She share that she is getting white discharge daily and she is very upset about this. She considered her health to be fair. She said, "I don't feel good about myself, I always feel irritated, I don't have proper cloths to use daily for stopping the discharge." when asked did she ever went to the hospital she said," I approached the Traditional healer and never went to the government hospital." Why? She said, "I don't feel comfortable to share about my problem with a male doctor. There is no female doctor with whom I can share. Not only that whenever I went to the government hospital they don't talk to us well, they behave in a very unfriendly manner with us. Most of the time they refer us to private hospitals which I can't afford.They only give us Saline (glucose) for any time of health related problems we face. I believe if a doctor does my check up and diagnose about my problem I will get well soon." During our conservation it was observed that Usha was getting up to spit the Saliva. She looked very pale and weak. She was pausing to take a breath after every statement she as making. She might be suffering from some major problem than what she is was sharing or thinks she is suffering from.

Brahaspati Devi (Antipur) aged 50 while she was working in her field and shared about her experiences with government hospital. While sharing about her problem she disclosed that she suffered from leprosy which is now cured. Yet she suffers from weakness and severe body pain. She said *"I went to the government hospital for treating my leprosy but I was referred to a private hospital for buying the medicines. Thus it was very burdensome for me bearing the cost of medicines. I find the government hospital to be ok in terms of its service delivery. Though we get the medicines for free but as I am a farmer and mother of two children I don't have enough time to visit the government hospital again and again. For taking the medicines we have to stand in a long queue and spend an entire day for taking the medicines. We can't afford to lose a day without wages. This is the reason why we prefer taking the medicines from Suresh (JholawalaDr) He visits our village daily on the bike at 10 am. He talks to us well and we get the medicines at our door steps."*

- *Private Hospital*: In 3 village women perceived it as not important and did not approach it for providing health care service. There was however satisfaction with the infrastructure and facility available. The cost of the service was a concern, not the quality. However, in cases where the women did access the private hospital, such as in Antipur village, they perceived it as value for money. In 2 villages it was considered important as many women shared in the FGDs that when they have

wasted much money on getting treated by the jholawala and government doctors but ultimately they got treated by the private doctor only. Thus now no one wastes money on approaching the jholawala and the government they directly got the private doctor.

B) Performance of Service Providers

The performance of the service providers was assessed by studying:

- *The extent to which the service provider was approached by the tribal women* and
- *Extent of satisfaction of the tribal women with the services*

Table 3.7: Health service provider's performance matrix of Dumka district

	Upar Murgathali	Jiathar	Antipur	Sagberi	Amgachi
Service Providers/ Institutions (approached most)					
ANM	Less important for medical purpose. Role only restricted to immunization Satisfied as she visits the village and conducts the immunization.	Not important Satisfied with the service as the ANM of mission tola (Ms Asha Jha) also visits the village on 1st Saturday of every month.	Less important as the ANM visits only during the polio apart from regular immunization days. Satisfied even though the village doesn't have a anganwadi the ANM and 'active Sahiya	Less importance The ANM. She visits once a week (vaccination for pregnant and lactating mothers and children) Satisfied as she is regular and does good work	Less importance to the ANM.(All pregnant women have been immunized) Satisfied with the immunization work.
Sahiya	Less Important. Dissatisfaction with her performance. limited role to escort women	Less Important. Dissatisfaction with her performance. Role limited to escorting pregnant women	Less Important. Dissatisfaction with her performance.	Less Important. Dissatisfaction with her performance.	Less importance by majority of the respondents for sahiya. – Dissatisfaction with her performance.
AWW	Less Important. Not approached by many women for health related problem. But those who approach her are satisfied	No Aganwadi in the santhali tola. Not satisfied with the AWW of mission tola	No Aganwadi in village. Not satisfied as the women demanded for an anganwadi in their won tola.	Less Important. Satisfield with the AWW.	Less important. Not satisfied with the
Jholawala /Quack/	Less important as approached by few women for	Less important as approached by few women	Most important as Approached by most women	Most important women for minor ailments	Most important as approached

RMP	minor ailments. Satisfied with their performance	for minor ailments Not very satisfied	for minor ailments Satisfied with the performance	Not satisfied,	by most women for minor ailments Satisfied
Traditional Healers	Less important but approached for specific problems Satisfied for the kind of services provided.	Less important Satisfied by the traditional healer treatment	Less important Satisfied with the Jadi booti doctor	No such service available	Less important Not shared in the FGD.

Summary Findings

- *Auxiliary Nurse Midwife*: In all the 5 villages, the ANM was not perceived as very important for providing health care service. In all the 5 villages, women were satisfied with the limited services (immunization and vaccination) provided by the ANM.

- *Sahiya*: In all 5 villages, the Sahiya was not perceived as very important for providing health care service. In all the 5 villages, women were dissatisfied with the service (*unaware about her holistic role, tribal and caste identity acts as a barrier*).

- *Aganwadi Worker*: In 3 villages where the AWW is available, their role is not perceived as very important for providing health care service. In 3 villages, however, women were dissatisfied with the services (particularly due to *discriminatory practices by the AWW)*

- *Government Doctors*: In 2 villages women perceived them as not important for providing health care service. In 2 villages the women were dissatisfied with the services provided by the government doctors.

- *Private Doctors*: In 2 village women perceived them as not important for providing health care service. In 3 villages, the women had concerns about the cost of the services, as they were considered very expensive.

- *"Jholawala Doctors"*: In 2 villages they are perceived as not very important for providing health care service. In 2 villages, women were dissatisfied with their services (*medicines not effective, they charge money, etc.)*

- *Traditional Healers*: In 4 villages, they were perceived as not very important for providing health care service. In 2 villages, women were dissatisfied with their services.

Voices of Tribal Women

Rabnidevi (Uppar Murgathali) When asked did she ever got treated herself by a doctor. She said, "I only believe the traditional healer. I approach Doctor (compounder in the sub centre) only when I am not able to bear the pain." She is not happy with the service provided by the traditional healer as she feels uneasy and change in behavior after taking the medicines. But there is not other alternative.

3.1.4 ASSESSMENT OF PERFORMANCE OF SERVICE PROVIDERS

(a) Auxiliary Nurse Midwife:

- *Role*:As per the Ministry of Women and Child Development,the major responsibilities of the ANM are in relation to maternal and child health, family planning, medical termination of pregnancy, nutrition, carrying out universal program on immunization, training of *dais*, treating communicable diseases, record keeping of vital events, treatment of minor ailments, and ICDS team activities.

- *Preference and satisfaction*: Less preference is given to the ANM for availing medical services. She is seen as a person coming to the village for immunization of pregnant women and children. Across all thevillage women were satisfied with the role of the ANM.

- *Reasons for satisfaction and dissatisfaction*: In Uppar Murgathali, the compounder (of the Paharia Health Centre) resides in the village and can be accessed anytime; in Jiathar, though the Santhali tola does not have an anganwadi, the ANM (Ms Asha Jha) conducts immunization for the women and children of the Santhali tola; in Antipur the village doesn't have an anganwadi but the ANM and the AWW of a nearby village immunize the women and children and also visits the village on polio days; in Sagbaheri the ANM (Ms Ruth Tudu) has a fixed schedule to visit the seven villages under her jurisdiction. Women were satisfied with her work and regularity and in Amgachi also women were satisfied with the ANM.

- *Convergence gap:* Though women did not overtly mention their dissatisfaction with the ANM, the fact is that her service (as perceived by the women) is limited to her role in immunization. The ANM is mandated to work along with the Sahiya/ASHA worker but in none of the villages did the women mention any other work done by the ANM (apart from immunization).

(b)Sahiya:

- *Role*: One of the key components of the National Rural Health Mission (NRHM) is to provide every village in the country with a trained female community health activist (Sahiya/ASHA) selected from the village itself and accountable to it. Sahiyas will be trained to work as an interface between the community and the public health system.

- *Preference and satisfaction*: Sahiyas are available in all the 5 villages. In 4 of the 5 villages, most women did not approach the Sahiya for availing health services. Those who did, did so only for reproductive health related services, primarily as an escort for institutional delivery either in the district hospital or the nearest Community Health Centre.

- *Reasons for dissatisfaction*: The reasons for low accessibility towards the Sahiya include lack of awareness about her expected role, limited stock of medicines, poor communication and relationship building skills, representing minority community and not Santhal community, and no alternative available if Sahiya herself is pregnant.

(c) Anganwadi Worker:

- *Role:* As per the Ministry of Women and Child Development, the responsibilities of the AWW include guiding the Sahiya/ASHA in performing health and integrated services such as organizing health day once/twice a month at the anganwadi and orienting women on health related issues such as the importance of nutritious food, personal hygiene, care during pregnancy, importance of immunization, etc. The AWW is the depot holder for drug kits and issues it to the Sahiya/ASHA. The drugs can be replaced through the AWW as well. Sahiyas/ASHAssupport the AWW in mobilizing pregnant and lactating women and infants for distributing nutrition supplements. She also takes the initiative in bringing beneficiaries from the village on specific days of immunization, health checkups/health days, etc., Toanganwadi.

- *Preference and satisfaction*: No preference was given to the AWW in relation to seeking health related benefits by women of all the 5 villages. The anganwadi was perceived as a centre only meant for children of 0-6 years of age where they play and have their midday meal. In 3 villages women were satisfied with the work of the anganwadi either in their village or outside their own tola. However, in Angachi village, discrimination (quantity of the meal given to Santhali children are less than that given to Muslim children) and prejudice in the form of untouchability was practiced by the AWW towards the Santhali children.

- *Reasons for satisfaction and dissatisfaction:* In 3 villages, women were satisfied with the anganwadi. In both Upper Murgathali and Sagbaheri, women were satisfied with the anganwadi but in both the villages the anganwadi is run in the house of the AWW. Thus there is need to have a separate anganwadi building. In Amgachi women were not satisfied with the anganwadi due to the practice of untouchability by the AWW towards Santhali children.

(d) *Jholawala* Doctors:

- *Role:* In all villages, most women were aware of the role oftheunqualified medical practitioner or "*jholawala doctor*".

- *Preference and satisfaction:* In 3 villages' majority of the women used the service of these quacks. Further, the women were satisfied with the service while in 2 villages the women were dissatisfied.

- *Reasons for satisfaction*: The underlying reason for their preference to use the service of jholawala doctors was due to the fact that the quakes were available and accessible in all the villages. The quacks are very organized in their functioning. The quacks regularly visit the villages (twice a day). They usually visit the village in the morning and in the evening. They all had motorcycles which increased their mobility and the number of households they covered on a daily basis. The quacks have a good relationship with all the households in the villages. They personally visit each household. Quacks are considered affordable as he takes payment in installments which relieves the women from paying a high one-time cost. Further, the quacks are available during an emergency.

- *Reasons for dissatisfaction*: On the other hand, the reasons for dissatisfaction with the service of jholawala doctors were the poor quality of medicines and paid medicines. It was also observed that with the availability of sub-health centers within 3 villages the dependence on the jholawala doctors (non-state provider) reduced.

(e) Traditional Healers:

- *Role*: Person resides in the village or nearby village providing treatment for ailments like snakebite, infertility, etc.

- *Preference and satisfaction:* In 4 villages, the women perceived them less importance for health related problems, both minor and major. However the trustability factor is higher incomparision to the government service providers.

- *Reasons for satisfaction and dissatisfaction:* In Antipur and Jiathar, women approach the traditional healer for irregular menses and the problem of white discharge. Many women also approach him for infertility related issues. The tribal women trust the traditional healer as they are old established institutions, reside in the village, speak understand their native language, and minimal fees charged.

3.1.5 COMMUNITY ENGAGEMENT IN HEALTH SERVICE DELIVERY

- In none of the 5 villages women were aware of the Village Health and Sanitation Committee (VHSC), nor were the VHSC members active in undertaking their duties. The VHSC members were not aware that they were members of the VHSC committee.

Villages	Status of VHSC
Uppar Murgathali	Present, but unaware about their role and work
Jiathar	Present, but unaware about their role and work
Andipur	Not present
Sagbaheri	Not presentas no one knew about who is the *jal sahiya* ther village.
Amgachi	Present but Not aware

- The majority of the women were not very aware about the services provided to them under NRHM. Few women did have an understanding of the benefits under Jannani Surkasha Yojna.

- In none of the 5 villages women were aware that maternal and child health as an issue was discussed in the panchayat meetings. The main reason is that gram sabhas are not conducted at the village level. In no sample village women or community were aware about PESA Act (Panchayat Extension to Schedule Area Act). No wall writing about the members of VHSC in any of the sample villages.

3.1.6 SERVICE PROVIDERS' PERSPECTIVE

(a) Auxiliary Nurse Midwife:

Insights on Services:

- *Key health problems*: The key health related problems were malaria, brain malaria, *kalazar* (Blackfever), diarrhea, anemia and weakness in Uppar Murgathali and Sagbaheri; pneumonia, jaundice, anemia, high Infant Mortality Rate and Child Mortality Rate in Jiathar; and malaria, typhoid, irregular menses and white discharge in Amgachi.

- *Tribal and Non-Tribal Differences*: The ANMs did not perceive any major difference in terms of accessing the services provided by the ANM among tribal and non-tribal. In Uppar Murgathali, the compounder, Motilal Giri, at Paharia Health Centre said, *"We do not discriminate between the Santhali and Pahraia while giving health services."* In Sagbaheri, the ANM, Ruth Tudu, from Kodokhicha PHC said, *"Christians Santhali women are more verbal about their problems than the Santhali women."* In Amgachi, the ANM, Shobha Kumari, at Kathikund Community Health Centre, said, *"Both Santhal and OBC women come for institutional deliveries."*

- *Status of Service*: In all 5 villages, the ANM provided the services. Three villages were located on the road and the Mamta Vahan reached their village. In Uppar Murgathali medicines are provided once a year as per the norm for the paharia health centres.

Problems faced in performing mandated role:

- *No delivery related facilities in the PHC*: In Uppar Murgathali the compounder expressed the need for building delivery related facilities in the PHC itself as the village is on a hill and the Mamta Vahan service does not reach the village in time. Pregnant women are carried on a cot down the hill and then transferred to the Mamta Vahan. As a result, there are high chances of casualties.

- *Aversion towards institutional deliveries*: In Sagbaheri, the ANM shared the problem of women not coming for institutional deliveries. Pregnant women neither approached the PHC nor the anganwadi (for immunization) till the sixth or seventh month of their pregnancy. This makes the immunization largely ineffective. On an average, almost every tribal woman hides her pregnancy.

- *Naxalism Impact*: The ANM of Kathikund CHC shared, "*TheNaxals call the doctor and ANM anytime for medical treatment and we have to go. There is no public transport from the Pusaldi village to Kathikund. All the Sahiyas working at the village level are well aware about the Naxal problem. Personally, The ANM fears going to the*

Amgachi village since the confrontation between the police and the people has occurred."

(b) Sahiya:

Insights on Services:

- Key health problems shared by the Sahiyas were malnutrition among children, TB, asthma and kalazar.

- *Tribal and Non-Tribal Differences*: There are no major differences in accessing health services among tribal and non-tribal women except in Amgachi village where the Sahiya shared that Santhal women access health service less in comparison to Muslim women. In Sagbaheri village, the Christian Santhali women access the services more than Santhali women.

- *Status of Service*: In all 5 villages, the Sahiya only performed the role of taking the pregnant women for institutional deliveries.

Problems faced in performing mandated role:

- *Community mobilization*: In Uppar Murgathali, the Sahiya, Bhanudevi, shared: *"Whenever I conduct a meeting, the men in the community do not allow me to conduct the meeting. They do not allow women to get together and discuss."*

- *No boarding and lodging in hospitals*: All the Sahiyas across the 5 villages faced the problem of lack of adequate restroom facilities in the hospital. When they bring the women for delivery, the pregnant women get a bed but the Sahiya has no place to rest. This is particularly felt when the Sahiya brings the patient to the hospital at night.

- *No honorarium*: The Sahiya in Amgachi raised the issue of being given a fixed honorarium for all the services being provided by her. She currently gets paid only for the delivery related work done by her. But apart from deliveries, the Sahiya also has to conduct meetings on health related issues in the community.

- *Cycles to commute*: Though the Sahiyas are provided cycles to help commuting to the nearest PHC, the villages that are far away from the PHC/CHC are difficult to reach on cycles due to the terrain. Also, in many places the cycle was not distributed to the Sahiya.

- *Stratified community***:** In Antipur, the Santhali population outnumbers the Yadavs in the village. But the Sahiya is from the Yadav community. There was a tension in the

FGD when the majority of the women blamed the Sahiya for not performing her role properly.

(c) Anganwadi Worker:

Insights on Services:

- *Tribal and Non-Tribal Differences*: The AWW did not perceive any major difference in accessing health services by tribal and non-tribal women, except in Sagbaheri village where the AWW, Bilati Hasda, shared: *"Santhal women access health services less in comparison to Christian Santhali women. Because the Christian Santhali women are organized, Church conducts health camps for the them, their children get sponsored for continuing their education such is not the case with Santhali women who are unorganized, illiterate, and confined to merely performing household"*

- *Status of Service***:** The AWW is present in 4 villages. In all 4 anganwadis non-formal education classes were not being conducted. The anganwadi primarily engaged only in two types of services: immunization of women and children and serving midday meals to the children.

Problems faced in performing mandated role:

- *Decreased ration quantity*: In Uppar Murgathali the AWW shared that the quantity of ration had decreased over a period of time. This was affecting the meals being given to the children.

- *Lack of own building*: In Sagbaheri, the anganwadi is built in the house of the AWW. The AWW expressed the need for a separate building for the anganwadi, as she is not able to conduct the non-formal education classes for children aged 5 to 6 years from the current premises.

- *Delayed salary*: The AWW in Sagbaheri faced the problem of delayed salary payment.

- *Lack of play way material for mentally and physically challenged children*: In Jiathar, the AWW shared that there are two children in the Santhali Christian tola who are physically challenged and in the Santhali tola there is one child who is mentally challenged. Though the school and the angwanwadi are open for these children but the teachers and the AWC are neither well equipped nor well trained to work with such children with special needs. The AWW, Martha Murmu, of Santhali Christian tola said, *"There is need to also focus on the handicapped and mentally challenged children of the village as they might be enrolled but not much attention is given to their development."*

3.2 EDUCATIONAL SERVICES

3.2.1. PRIMARY EDUCATIONAL STATUS

Table 3.8: Primary Educational Status of Dumka district

OPTION OF SCHOOL In all the 5 villages regular school going children only accessed the government run primary or welfare department run paharia schools	**ENROLLMENT** In all 5 villages most children of 6-14 years of age were enrolled in SSA run government primary, upper primary and middle school. Upper murgathali did not have an SSA run primary school in their village so the children were enrolled in a Special School for Paharia Children (both for Girls and Boys) or SSA run upper primary school in other panchayat whcih was 3 kms downhill.
ATTENDANCE AND REGULARITY In all 5 villages, irregular attendance of many students in the schools was evident	**DROPOUT** In all 5 villages high dropout of children shared by a large number of parents. The girls dropped out mainly after primary due to family constrains, infrastructural and cultural barriers
PERCEIVED LEARNING LEVELS In all 5 villages most parents rated learning level as low as most of the children had poor reading and writing skills both in Hindi and English which their illiterate parents could also understand	**SATISFACTION WITH SCHOOL-QUALITY AND INFRASTRUCTURE** Only in 1 village parents were satisfied with the government school in the village

3.2.2 AVAILABILITY AND ACCESS TO EDUCATION SERVICES PROVIDERS

Education infrastructure and service providers are the two main pillars for education service delivery. The third pillar is a community institution to bridge the gap between the service provider and the service users – in the case of this study it was identified as the School Management Committee (SMC) stipulated under Sarva Shiksha Abhiyan (SSA).

A) Availability and Accessibility of Education Infrastructure

An important indicator of access to schools for children was the presence of a school in close proximity of the villages, and more specifically the *tola* where the tribal women resided. The focus was more on children in the age group of 6-14 yrs.

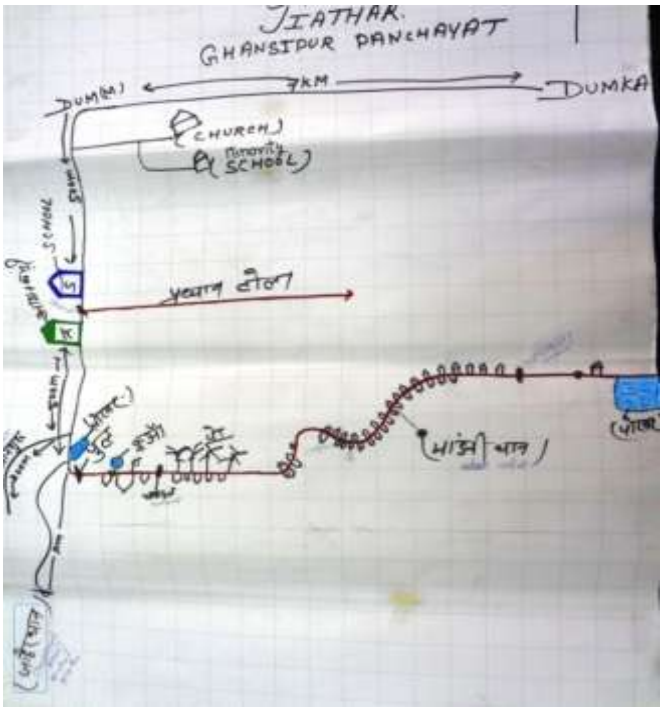
Table 3.9: Availability and access to education infrastructure of Dumka district

Education Infrastructure	Upar Murgathali	Jiather	Antipur	Sagberi	Amgachi
Availability and approx. Distance from tribal Tola					
Distance from the nearest town (in kilometer(s)	8	12	5	7	36
Bus transport facility available within the range	Between 5 Kms and 10 Kms (census 2011)	More than 10 kms(census 2011)	Within 5kms (census 2011)	Between 5 Kms and 10 Kms (census 2011)	More than 10 kms (census 2011)
Primary government school	No government school within 1 km range in the village for the Paharia children . Only paharia boarding school for boys (1/2 km away) and girls (secluded and 3 kms uphill). Another school- at a distance of more than 3 kms in chandrapore panchayat	Primary Government School Located in the Christian tola School beyond 1 km from the santhal tola	Primary Government School Available within 1km the village.	Primary Government School within 1 km of the tribal tola	Middle Government School within 1 km of the tribal tola
Government Middle school	Between 5 Kms and 10 Kms (census 2011)	Within 5 Kms (census 2011)	Between 5 Kms and 10 Kms (census 2011)	Within 5kms (Cenus 2011)	Within 1kms
Private school	No private school near the village	Children sent to private school in Ghasipur (5kms)	No private school near the village	Children sent to private school in Ghasipur (7kms)	No private school near the village

Summary Findings:

- *Primary Government School*: In 3 villages the primary school was available within 1 km of range of the villages. In 2 villages, the primary schools were beyond 1 km range of the village. In Uppar Murgathali, apart from the paharia boarding school, an upper primary school was available in 3 kms range of the village. The Paharia School for girls near the uppar murgathali is up on a hill, secluded and the path to the school is lonely and inconvenient. The local paharia girls either do not go to the school or get admitted to the boarding school if they wish to study. In Jiathar, the primary school is located in the Christian tola more than 1 km (by road) from the Santhali tola. (Map below)

Figure 3.1: Sketch of Jiather Village



Sketchof Jiathar Village, where children walk more than 1 km to attend school

- *Government Middle School*: In 3 villages the school was between 5 and 10 kms from the centre of the village. In another 2 villages it was within 5 kms from the village.

- *Private School*: In 3 villages there were no private schools. Only Jiathar and Sagbaheri had access to private schools, wherein the few parents send their children to a private school in Gahsipur panchayat which was approximately 5 kms from Jiathar and 7 kms from Sagbaheri.

- *Availability of bus transport facility*: In 3 villages, bus transport facility was available between 5 and 10 kms which could be accessed by walking to the main road or

reaching there by personal vehicle. Whereas in 2 villages the bus transport facility was more than 10 kms which was difficult to access by walk and more for families who did not have any kind of personal vehicle.

B) Availability and Accessibility of Education Service Providers

Table 3.10: Availabity and access to education service providers of Dumka district

Teacher Availability	Upar Murgathali	Jiather	Antipur	Sagberi	Amgachi
Available : Number and Residence					
Government Teachers	Available: 3 in chandrapore	Available: 1	Available: 1 (but never comes to school)	Available: SSA: 1 Minority school 4	Available: 1
Total Children enrolled	147 (SSA School in chandrapore	50	40	131 (Minority school)	322
Number: (Teacher–student ratio)	1:21	1:25	1:20	1:30	1:54
Residence	In Dumka (SSA govt. Teacher) Paharia school (overnight in shifts)	In Dumka	In Dumka	In Dumka	In Kathikund
Para Teacher	4 para teachers SSA school chandrapore	1 para teacher Other village-Golpur (1km)	2 para teacher	No Para teacher	5 para teachers
Residence	Within school in paharia special school and in SSA school para teachers resided in Dumka town	Another village-Golpur (1km)	Within village	No para teacher	1 within village and another 4 from nearby village
Women teachers available	2 women teachers (1 head teacher) Paharia School:Female teacher and male teacher for both the schools accordingly	No woman teacher in school	1 govt teacher (always absent due to tension between para an govt teacher)	There is only one teacher who is a woman	one para woman teacher

Summary Findings:

- *Government Teachers:* Government teachers were available in all the sample schools. However the number varies from 1 to 3 government teachers as per the enrollment of children and the population of the village. In all the villages, the teacher had to travel from Dumka to reach the school. The need for recruiting more teachers was expressed by the Pradhan of Sagbaheri village.

- *Student Teacher Ratio*: On average the student teacher ratio was within the RTE norm, which is 1 teacher for 35 students in the upper primary school.

- *Government Teachers' Residence***:** All the teachers recruited under the SSA primary or upper school were residing in the nearby town and commuted daily to the village. In the paharia boarding school, the teachers stayed in the school overnight with the children in shifts.

- *Para Teachers*: The term 'para teachers' have been a generic term applied to all teachers appointed on contract basis often under varying service conditions in terms of emoluments and qualification requirements. In Dumka, para teachers are recruited on an ad-hoc basis and their main role is to support the government teacher mainly in translating the Hindi or English lessons into Santhali or any local language. In 4 schools para teachers were available, their number ranging from 1 to 5. Most of the para teachers were residents of the sample villages and thus were easily available.

- In general, gender balance of teachers was low with fewer women teachers in comparison to male teachers. In all 5 villages, male teachers outnumbered female teachers. In one village there were no women teachers.

PERCEIVED QUALITY OF EDUCATION SERVICES

A) Performance of Service Providers

The performance of service providers was assessed by studying the perception of tribal women on the following indicators:

- *Overall satisfaction with teachers*
- *Teacher regularity and punctuality*
- *Teacher behaviour towards children*

Table 3.11: Satisfaction with role and performance of service providers of Dumka district

Women Perceptions on performance of service provider	Upar Murgathali	Jiather	Antipur	Sagberi	Amgachi
• *Overall satisfaction with Teachers* • *Teacher Regularity and punctuality* • *Teacher behavior towards children*					
Satisfaction with Government Teachers	In general women not satisfied with the absence of school in the village. Even though they are satisfied with both the schools (Paharia and Chadeapore)	Majority of women not satisfied. (*irregularity of teacher, poor infrastructure of school)*	majority of women not satisfied. (para teacher are running the school after they had a tension with the govt teacher. Quality of teaching is poor)	majority the women were not satisfied. *(Only one teacher)*	Not Satisfied (Only one para teacher and no government teacher)
Satisfaction with Para Teachers	Not Satisfied as no para teacher stays in the village	Majority not satisfied with the performance.	Majority not satisfied with the performance	no para teacher	Majority satisfied with the para teacher performance
Govt Teacher Regularity and punctuality	Regular	Not regular and not on time	irregular and not very punctual.	Irregular	Regular and Puntual (who teacher or para teacher)
Para Teacher Regularity and punctuality	Regular and Puntual (Both Schools)	Not regular and not on time	irregular and not very punctual. The para teachers open the school late	No para teacher	Regular and Puntual (who teacher or para teacher)
Teacher Behaviour towards children – physical or mental harassment	Majority of women were satisfied.	Majority of women satisfied.	Majority of women satisfied.	Majority of women satisfied.	Majority of women satisfied.

Summary Findings:

- *Satisfaction with Government Teachers*: In 4 villages, the majority of the women were dissatisfied with the government teachers' role and performance and in one village (Uppar Murgathali) they were not satisfied with the absence of SSA run government primary school in their tale. Women complained of teachers not following the scheduled

time frame and leaving before time (in Antipur); irregularity of teacher attendance and poor infrastructure in the school were the major concerns in Jiathar village. In Sagbaheri the women demanded recruitment of more than one teacher and improvement in the quality of teaching. In Antipur, the children bear the brunt of the tension between the para and government teacher as the para teacher opens the school late and sends the children home early.

Rift between para and government teacher

In Antipur village discrepancy in the salaries of para (Rs 5000) and government teachers (Rs 40000) is an issue with the para teacher. All the para teachers of the district sat on strike against this injustice. Also in Antipur village the para teachers chased away the head teacher (as told by women in the FGD). The para teacher feels that they invest equal time and energy and are always available in the school, yet the government teachers are paid more. This is one reason for the only government teacher not to come to school. – ***shared in FGD by women***

- *Satisfaction with Para Teachers*: Of the 4 villages where para teachers were available, only in one village were the women satisfied with the para teacher mainly because the para teacher was from their own community and they could interact with him/her in their own language. However, in 2 villages (Jiathar and Antipur) the women were dissatisfied with the para teachers. In Antipur, the majority said that the para teacher living in the village is not very useful to them as there are two para teachers who have formed an alliance against the government teacher who never visits the school. This has a negative effect on the children's learning. In Jiathar, the para teacher lives in another tola and thus does not interact with the parents. In Sagbaheri, there was no para teacher.

- *Regularity of Government Teachers*: In 3 villages, regularity and attendance of government teachers was an area of concern. In Jiathar, the teachers either do not come to school or open the school very late. Although in Uppar Murgathali there is no government school, but the community people observe the teacher of Paharia School who is regular.

- *Regularity of Para Teachers*: In 2 villages, the para teacher was perceived by women to not be very regular.

- *Behavior of Teachers*: In all the 5 villages the behavior of teachers towards children was amicable. No incidence of rude and aggressive behavior, mental or physical harassment, physical punishment, or detention was reported by the women.

- *No extracurricular activities*:In none of the schools did teachers take the children out for a picnic. In majority of the schools, there were no extracurricular activities.

B) Quality of Infrastructure

Table 3.12: Quality of education infrastructure and facility of Dumka district

Quality Indicators	Upar Murgathali	Jiather	Antipur	Sagberi	Amgachi
• ***Condition: Good-not good*** • ***Cleanliness: Clean-not clean*** • ***Infrastructure availability: Available as per norm***					
School building condition	The Paharia school for girls and SSA school building was in good condition.	poor condition	good condition. It however did not not have a boundary wall.	good condition,.	good condition,
Cleanliness	The Paharia boarding school building clean	Cleanliness not maintained.	Cleanliness not maintained	clean	cleanliness not maintained
Infrastructure availability for students					
Chairs, tables, dari, blackboards	In the Paharia girls boarding school building all the classrooms were well equipped for the students.	No daris for children of class 1-V. blackboards available	The classrooms had dari for 1-5 Blackboard available	Dari for 1-5	Dari for 1-5 and table and chairs for class 8th onwards, blackboards available
Tiolets availability and cleanlines	Toilets available seperatly for girls and boys.	Toilets available but in poor condition	Toilets available but in poor condition	Toilets available but in poor condition	Toilets available but in poor condition
Play ground,electricity, water availability	*No Playground* *No Electricty* Drinking water source available- in all the three school(Paharia girls and boys and SSA upper primary school)	No Playground No electricity Drinking water source available	No Playground No electricity Drinking water source available	No Playground No electricity Drinking water source available	Playground available No electricity Drinking water source available

✍Summary Findings:

- *Condition of School Building*: In 4 out of the 5 villages the condition of the school building was good, with a pucca structure. In Jiathar the condition of the building was not good.

- *School cleanliness*: Only in 2 schools the tribal parents were satisfied with the level of cleanliness in the school. In Jiathar, the classrooms were being used to store husk and wheat; Antipur had opened sewage lines while in Amgachi cleanliness was an area of great concern for the tribal women.

- *Infrastructure Availability for Students*: Across the government schools present in the 5 sample villages, in 4 schools *dhurries* (carpets) were available for children to sit on in classes 1 to 5. In Jiathar, the children either sat on the floor or on their rucksacks. The blackboards were available in all the schools, but were not in very good condition. Toilets were available in all the 5 schools; however separate toilets for girls were available only in the Uppar Murguthali boarding school. Other amenities like electricity were not available in any school. A playground was available only in one school, and drinking water was available from hand pumps in all the 5 sample schools.

C) Quality of Educational Entitlements

Table 3.13: Satisfaction with educational entitlements received in Dumka district

Quality Indicators	Upar Murgathali	Jiather	Antipur	Sagberi	Amgachi
Quality: good or poor Provision as per norms					
Quality of Midday Meal(MDM)	The girls of the Paharai boarding school shared that the MDM received by them was good, and that they get different food daily. Good for SSA School even	The tribal women parents shared that no MDM was served in the school.	Majority of the women were not satisfied with the quality of MDM	Majority of tribal parents were not satisfied with the quality of MDM provided	Majority of tribal parents were not satisfied with the quality of MDM
Timely and accurate provision of scholarships - ie scholarship, free books, uniforms	Good as they get all the benefits from the government and the girls looked satisfied with the provisions Timely dispersal of entitlements in SSA schools also	The tribal women respondents mentioned receiving the stipend and books last year.	The tribal women respondents mentioned receiving free books.	The tribal women respondents mentioned children getting books and stipend	Children getting books and stipend

✍Summary Findings:

- *Midday Meal Quality***:** As per the ICDS scheme, midday meal (MDM) norms in Jharkhand[6]are 3 kg dry food per student per month. In 3 of the 5 villages, the tribal women were not satisfied with the MDM quality. In Jaithar there was great concern about the MDM not being served in the school; in Amgachi there were concerns vis-à-vis theMDM quality; and in Antipur there was concern that the MDM was not being served regularly to the children.

- *Entitlements*: The SSA (Jharkhand) state rules regarding entitlements due to tribal children is in the process of being notified. As per our findings, in 4 schools free text books were available, while scholarship and stipend were available only in 2 schools**.** This was an area of concern for the parents of primary school children. In Jiathar village, the women complained about stipend not being distributed for the last one year.

Voice of Tribal Woman

Aladi Tudu is a resident of Jiathar village. She has a son and two daughters. One of her daughters, Roopsona, is mentally challenged. Roopsona goes to the school in the village but not on a regular basis. Reason that stops special children like Roopsona attending the school is lack of a friendly and, learning environment to teach the differently abled children lke her.

3.2.4 COMMUNITY ENGAGEMENT IN EDUCATION SERVICE DELIVERY

✍Summary Findings:

- In all the 5 villages parents were never informed about student progress, they were never invited to school events and functions and they were never engaged in School Management Committee (SMC) tasks. The basic connect between teachers and parents were missing. Teacher and parent meetings were not held in 4 villages.

Voice of Village Pradhan

"Children don't go to school, as for classes 1 to 5 there is only one teacher. She comes to the school on alternate days. Children of classes 1 to 3 get admitted to class 5 without being eligible. I as a pradhan cannot complain against the teacher nor can the SMC as the primary school is the only option for schooling in the village. I suggest more teachers be recruited and the quality of teaching should improve." – ***Munshi Hasda, Pradhan, Sagbaheri village***

- None of the women in the 5 villages were aware about the PESA Act, the RTE Act, or the provisions under SSA. In 4 villages the SMC chairpersons were aware about the RTE Act and enumerated few provisions they remembered after attending the RTE workshop which had been conducted at the block level.

- In all the 5 villages SMCs had been constituted. There were 16 members of the committees. In most of the villages since the formation of the SMC, meetings had been conducted only twice in a year with meager participation from the community/members who are parents. Most of the members were not aware of even being part of the SMC.

- No woman in any of the 5 villages was aware that education as an issue was discussed in the panchayat meetings. The main reason is that gram sabhas are not conducted at the village level. In no sample village the women or the community were aware about the PESA Act.

3.2.5 SERVICE PROVIDERS' PERSPECTIVE

The service providers were interviewed during visits to the primary schools located within the village. If there were no primary schools, either the middle school or the upgraded primary school (with only the para teacher) was taken into consideration. Apart from formally interacting with the teacher, we also informally interacted with the children, asking them about their likes and dislikes and the schooling system. This was necessary as most teachers were of the opinion that children only come to school for the MDM. But when we interacted with the children, they said they come to school to study.

(a) Government and Para Teachers

The problems faced by the staff are:

- *Lack of Basic Amenities*: In 5 villages, the school building was in a working condition. In 4 villages, non-maintenance of the toilets, playgrounds, classrooms, benches, *dari*, blackboards, charts, cupboards and other teaching-learning materials was an issue of concern for the teachers. The 5 sample schools had their own school building which is why they were at an advantage as they could spend the development fund given under RTE for school maintenance. The biggest constraint faced was the lack of classrooms that leads to implementing the multi-grade classroom system.

- *Multi-grade Classrooms*: In all 5 sample villages the schools had multi-grade classrooms. In a multi-grade classroom pre-primary children sit on dhurries together with higher class children who sit on chairs and benches. The multi-grade classroom system along with less teaching staff was presented as one of the reasons for

deteriorating standards of quality of teaching. Another reason for the poor quality of teaching was the engagement of teachers in non-teaching work.

- *Time Consuming Non-teaching Work*: In Antipur, the teachers shared the problem of serving the MDM to the children. The para teacher, Vinod Tudu, said, *"Ideally, as per the rule, each day an egg should be served to the children but the government has only allocated Rs 3 per child per day. We are not able to manage the variety of meals and quality in MDM with such a low budget."* In the other 4 villages, no problem with regard to non-teaching work was shared.

- *Dropout and Attendance***:** The dropout rate among girls was high mainly due to early marriage, and household and field related work. On the other hand, the scheme for distribution of cycles to girls, which is meant to increase the enrollment and participation of the girl child, is turning out to be unsuccessful as most of the time the head teachers take the signatures of the girls without giving them the cycles. The children are irregular in attending the school mainly due to household chores and field related work as delegated by the parents and absenteeism of school teachers, poor quality of teaching.

- *Santhali Vs Hindi***:** Santhali is the *lingua Franca* but Hindi is the official language of Dumka district. This contradiction hampers the learning of the children. To overcome this problem, para teachers have been appointed who translate the Hindi lessons into Santhali. Yet, the gap between teaching and understanding remains. We received a whole gamut of responses from the parents and teachers speaking for and against Hindi as the medium of instruction.

- *Displeasure Towards RTE Provisions*: Almost all the teachers we interviewed showed their displeasure towards three provisions of RTE: prohibition of physical punishment, introduction of the grading system as against the exam and not to fail any child. Rajeev Ranjan Shah, a government teacher in Jiathar, said, *"The grading system has culled out the fear towards exams and studies in children. Also the teachers are prohibited to use a stick, cannot beat but must inculcate fear if the children create a nuisance in class or come to school without doing their homework. I am a teacher because my teacher punished me with a stick if I misbehaved or overlooked my homework."*

- *Training and Capacity Building of Teachers***:** In all 5 sample villages teachers expressed the felt need for training and capacity building specifically on methods and tools of teaching.

- *Permanent Vs Contractual Teachers*: In Antipur, the discrepancy in the salaries of para (Rs 5000) and government teachers (Rs 40000) is an issue with the para teachers going on strike. The para teacher feels that they invest equal time and energy and are always available in the school, yet why then are government teachers paid more?

(b) School Management Committee

The School Management Committee (SMC) as the name suggests is an oversight committee formed in 12 to 16 members from the village community under section 21 of the RTE Act. In the Central Model Rules, the composition suggested is as follows: Three-fourth (75%) members of the SMC from parents/guardians. Of these, 50% will be women. Weaker sections will be represented in the SMC in proportion to their population in the village. Rest one-fourth (25%) will be as follows: 1/3rd local authorities; 1/3rd school teachers; 1/3rd academicians/students. However, the SMCs face many problems.

- *Helplessness of SMCs*: It should be noted that the SMC is required to function as a body that is vigilant towards education related issues in the community. But in all the villages we visited, the chairpersons felt depressed and helpless as they were unable to perform their ideal duties. The major problem they faced was in conducting monthly meetings.

- *Poor community participation*: Parents and guardian more often do not turn up for the meetings. Though most of them complained about the poor quality of teaching and MDM in the FGDs, they do not make use of the SMC as a tool in their hands to bring about positive change in their village. In Sagbaheri, meetings had been conducted many times but no one came to the meeting. This is the main cause of concern for the SMC chairperson.

- *Parents' illiteracy and ignorance*: In Antipur, parents are illiterate and they do not realize the importance of education for their children. This devalues the status of education. In Sagbaheri, lack of the responsible attitude of the parents towards their children's education was shared as a problem.

c) Block and District Officials

Voice of Governmental Officials

Singhasan Kumari, District Gender Co-ordinator, Dumka**: "***The enrollment of girls is more in pre-primary and primary but as they finish primary schooling they tend to drop out mainly because of household work and early marriage."*

Vijay Kumar Soni, Block Development Officer, Dumka and Shikaripara**: "***The main problems faced by the people are high dropout rate among girls, non-availability of qualified teachers at school level, and recurrent power cuts."*

3.2.6 INTERNAL MONITORING SYSTEM AND AWARENESS OF STAFF ON RTE

In all the 5 villages the Block Education Officer visits the schools. Teacher and parent meetings were not conducted in 4 villages. In 4 villages the SMC chairpersons were aware about the RTE Act and enumerated a few provisions they remembered after attending the RTE workshop which had been conducted at the block level.

3.3 SELECT ENTITLEMENTS

3.3.1 ACCESS TO ENTITLEMENTS

In all, 7 women interviewed explained about the status of bank accounts, availability of ration cards, the problems associated with accessing ration cards and the status of aadhar cards. From the interviews conducted data reveals that the:

Summary Findings:

Bank Account: Only one woman of the 7 interviewed had a bank account. In the other 6 villages in fact, no woman possessed a bank account.

Awareness about BPL, Aadhar Card, Ration Card: Out of the 7 women interviewed, the majority were not aware about ration cards, its usefulness and procedure to apply. On the other hand, 3 out of the 7 women were aware about the Aadhar card as their identification was being carried out. Four women were aware about the Aadhar card but not about its usefulness or the reason for which their data had been collected.

Entitlements in the 5 villages:

- Yellow card (Antodaya card): Identified by 2 women.
- Red card (BPL): Identified by 3 women.
- Orange card (BPL ration card): Identified by no women.
- Green card (APL): Identified by no women.
- Aadhar card process initiated in 3 out of the 5 villages.

3.3.2EASE OF GETTING ENTITLEMENTS

✍Summary Findings:

Difficulty in Opening a Bank Account: All 7women shared the difficulty and apathy in opening a bank account. First, they lacked any kind of identification proof and other collaterals required to open an account and, secondly, all the women were poor with meager family income and limited to no savings. Thirdly, they believed in household savings over savings in a bank.

Problems Related to Getting BPL, Ration and Aadhar Cards Made: The problems they face are mainly in getting the BPL cards from the block level. Once the identification has been completed by a designated person at the village level, there is no one to communicate with at the block level regarding the eligibility or non-eligibility of a family for the BPL card. This keeps the beneficiaries unaware about the procedure to be followed at the block level.

The majority of the women did not face difficulty in getting their ration cards made. The only problem shared was to possess a red card that encompasses all the entitlements such as rice, kerosene and salt.

No woman faced any kind of difficulty in getting the Aadhar card made. Identification of the majority of the women had been completed but they were unaware about the use and benefits of possessing an Aadhar card.

3.3.3. SATISFACTION WITH THE PROVISIONS RECEIVED

✍Summary Findings:

- *Provisions Received Under Ration Card*: The yellow card holder gets rice and kerosene; the red card holder gets rice, kerosene and salt; the green card holder comes in the APL category so they are entitled only to kerosene. The orange card holders are the BPL ration card holders. Identified as belonging to the BPL category, they also get all the three entitled services (rice, kerosene, salt). Families who had either yellow or green cards wanted to avail the benefit under the red cards as it provided all entitlements.

- *Satisfaction with the Ease and Quality of the Ration Card Provisions*: Majority of the women was not satisfied with the services provided especially in terms of BPL and ration cards.

3.3.4 SERVICE PROVIDERS' PERSPECTIVES

Dominant Phrases: Pradhan/Ward Members

Voices of village representatives

Uppar Murgathali*: "Maximum people do not have ration cards despite being below poverty line. Block level officials have assured us that in the new survey those who are eligible will get the ration card."*

Jiathar: *"Ration cards are not accessible to everyone. Only the influential have access to all the benefits such as BPL cards, Indira Awas Yojana, ration card, etc."*

Sagbaheri: *"Maximum numbers of people have no ration cards. No Aadhar cards either."*

Angachi: "*Majority in the community don't have a ration card."* [While we were conducting interviews, many villagers came with their voter cards and other cards thinking we were collecting information regarding BPL families. The need for ration/BPL cards was apparent from their behavior and the poor living conditions.

CHAPTER 4

ACCESS TO DEVELOPMENT SERVICES IN JAMTARA DISTRICT

4.1 HEALTH SERVICES

- **4.1.1 HEALTH PROBLEMS SHARED BY TRIBAL WOMEN**
- **4.1.2AVAILABILITY AND ACCESS TO HEALTH SERVICE PROVIDERS**
- **4.1.3 PERCEIVED QUALITY OF HEALTH SERVICES**
- **4.1.4 DETAIL ASSESSMENT OF PERFORMANCE OF SERVICE PROVIDERS**
- **4.1.5 ENGAGEMENT OF COMMUNITY IN HEALTH SERVICE DELIVERY**
- **4.1.6 SERVICE PROVIDERS PERSPECTIVE**

4.2 EDUCATIONAL SERVICES

- **4.2.1 PRIMARY EDUCATION STATUS**
- **4.2.2AVAILABILITY AND ACCESS TO EDUCATION SERVICE PROVIDERS**
- **4.2.3 PERCEIVED QUALITY OF EDUCATION SERVICES**
- **4.2.4 ENGAGEMENT OF COMMUNITY IN EDUCATION SERVICE DELIVERY**
- **4.2.5 SERVICE PROVIDERS PERSPECTIVE**
- **4.2.6 MONITORING AND EVALUATION**

4.3 SELECT ENTITLEMENTS

- **4.3.1 ACCESS TO ENTITLEMENTS**
- **4.3.2EASE OF GETTING ENTITLEMENTS**
- **4.3.3. SATISFACTION WITH THE PROVISIONS RECEIVED**

CHAPTER 4

This chapter provides an overview of the status of primary health care (maternal and child health), primary education and other entitlements in select villages of Jamtara district, as shared by tribal women. It captures the tribal women's perceptions about the availability, access and quality of health, education and entitlements received by them. It further highlights the community engagement in health service delivery and the government service providers' perspectives on issues related to access and quality of these select development services.

4.1 HEALTH SERVICES

Table below indicates the Health indicators of Jamtara district with respect to Jharkhand and India as a whole.

Table 4.1: Health Indicators[7]

Indicator	Jamtara
Crude Birth Rate (CBR) (SRS 2009)	25.8
Crude Death Rate (CDR) (SRS 2009)	7.1
Infant Mortality Rate(IMR) (SRS 2009)	46
Maternal Morbity Rate (MMR) (SRS 2009)	371

Source: http://210.212.20.93:8082/jrhms/DHAP.aspx

These indicators are derived in the District Health Action Plan of Jamtara District for the year 2011-12.

As per existing norms one HSC is planned for every 5000 population and for tribal areas the 3000 population, one PHC for every 30,000 population and for tribal area 20,000 population one CHC for every 1, 20,000 population. For tribal areas the norm is one CHC per 80,000 populations.

[7] As per the Annual Health Survey, 2010-2011 the IMR of Jharkhand is 41, as compared to India's IMR of 53.Further the MMR of Jharkhand is 278, as compared to MMR of India, which is 212.

To ensure one progress of any district, it is important to ensure that its people are healthy and have round the clock easy access to adequate health infrastructure. Currently 4 CHCs, 15 PHCs and 132 HSCs are functioning in the district. District hospital is located at Jamtara block. So there is need of CHC here. The block wise details included in the District Health Action Plan of Jamtara District for the year 2011-12, are as follows:

Table 4.2: Health Facilities in Jamtara District

Sl.	Public Health Facility Available	Number of Facility	Number of Beds
1.	District Hospital	1	30
2.	SDH	0	0
3.	Referral Hospital	1	6
4	Community Health Centre	4	120
5	Primary Health Centre	15	60
6	Health Sub Centre	132	0

Source: http://210.212.20.93:8082/jrhms/DHAP.aspx

Apart from health functionaries such as doctors, medical officers, paramedics staff, nurses, and compounders several other types of workers/volunteers such as AWWs, NGOs are playing vital role in the proper functioning of the district health system. (Jharkhand Rural Health Mission Society, 2013)

4.1.1 HEALTH PROBLEMS SHARED BY TRIBAL WOMEN

The focused group discussions (FGD) with tribal women were conducted in which approxiamately 10-15 women participated from all the sample villages. The opinions of majority of women were taken into account.

Table 4.3: Health Problem Shared by Tribal Women in Jamtara district

Health Problems	Number of FGD where the problem was highlighted
Body pain etc	5
Irregular menses	4
White Discharge	4
Anemia/Weakness	4
TB	3
Falaria	2
Cold & Cough	2
Leprosy	1
Dirrhoea	1
Jaundice	1

In the focused group discussions (FGDs), women disclosed about undergoing numerous body pains such as leg pain, stomach ache, back pain, shoulder pain, headaches. All of these are considered minor health problems but was shared as a persistent problem in all the 5 FGDs. Apart from body pains women from 4 FGDs complained about irregular menses, white vaginal discharge and anemia. Cases of TB patients were reported in 3 FGD. Cases of filariasis and cold and cough were reported in 2 villages. Cases of women suffering from leprosy, diarrhea and jaundice were reported in one village.

Personal interviews of women suffering from above mentioned ailments were conducted by making home visits or physically going to the place of work to know about the realcausee ofsuffragee. Mentioned below is the case of Chato Marmu of Asanchuma village who is suffering from TB for past 7 years without any treatment. The disease doesn't only takea toil on her health but also on her social functioning. The other case is of Lalita Tudu who is not only suffering from filariasis but also the isolation from the community activities.

Case 1: Chato Marmu

Chato Murmu is a 14 year old girl living in Asanchuma village with her mother and grandmother. She is a student of class 8. She has been suffering from TB for the past 7 years. Her father died of TB. This is a cause of concern for her mother who herself is struggling with the problem of irregular menses and white discharge. Chato's mother (late 40's) just wants her daughter to be treated so that she can live a healthy life. Chatu considers her health to be poor as she is not able to concentrate on her studies. She feels weak and cannot participate in sports. Due to TB and weakness she faces problems in her menstrual cycle as well.

Chatu said, "We treated our father at the government hospital for a long time. The dosage prescribed by the doctors was given to him as per the schedule. Yet my father's condition deteriorated. The medicines provided were ineffective. We were partly to blame as TB treatment requires on-time DOTs treatment. If you miss one dose, the entire cycle lapses. But we neither had thefacility to go to the hospital nor the money to buy medicines."

When we asked Chatu if she had approached the nearest health centre to get treated*, she said, "We went to the PHC many times but there was no medicine available in the PHC or with the Sahiya. I can't go to Jamtara alone, which is why my illness is becoming worse day by day."*

Unhappy with the early demise of her father and the widespread prevalence of TB, Chato suggested that the Sahiya should become very active in the village, especially with regardsto the issue of TB. She also suggested there should be appropriate medicines in the SHC so that the trust which has been lost can be regained, and the people who approach the "jholawala doctors" (quacks) begin to approach the authentic government functionaries.

Case 2: Lalita Tudu

In Chandradeepa village we met Lalita Tudu (45). As she came out of her house, she was coughing and showed us her stomach and legs whcih were swollen due to Filariasis disease. She is ungergoing treatment by a government doctor, but couldn't continue her treatment as she doesn't have enough money to buy medicines.

Her husband is a labourer, they don't posses any land, nor do they have a BPL card. She couldn't converse much due to her racking cough, but she did express her discontent with the non availability of doctors at the village level and difficult access to the medical services provided by government at the district level. As we went to meet her in her place except for the Sahiya, and feld staff no one from the community entered her house. She feels isolated from the community acitvities.

4.1.2 AVAILABILITY OF AND ACCESS TO HEALTH SERVICES

Health service infrastructure and health service providers are the two main pillars for health service delivery. The third pillar is the community institution which bridges the gap between the service provider and service users – in the case of this study it was identified as the Village Health and Sanitation Committee stipulated under the National Rural Health Mission (NRHM).

A) Availability of and Access to Health Infrastructure/Institutions

During the FGDs, a number of health functionaries and institutional health services were identified by the women at village, neighborhood and district levels.

At village level, the majority of the women in the FGDs were aware of the sub health centre (SHC), primary health centre (PHC) (where available). Further, most were aware of the community health centre (CHC) at the block level and the government hospitals at district level. Few mentioned the availability of private hospitals.

Table 4.4: Health service infrastructure availability and access matrix of Jamtara district

Availability of heath facility	Asanchuma	Chandradeepa	Niltaha	Rupaidi	Chirudi
Village level					
Primary Health Sub centre (SHC) available	Not available	Available within the the village. (0.5 kms)	Not available.	SHC within 0.5 km range	Not available

within range					
Primary health centre (PHC) available within range	Between 5 Kms and 10 Kms (Census 2011)	More than 10 Kms (Census 2011)	More than 10 Kms (Census 2011)	With in 5 Kms (Census 2011)	More than 10 Kms (Census 2011)
Aganwadi Centre	Available within the the village(0.5 kms)	Available within the the village. (1 km)	Available Within 0.5 kms for the Bengali tola and 1km for the santhali tola.	Available within the the village. (0.5 kms)	Available within the the village. (0.5 kms)
Mobile Health Van (MHV)	Not shared	MHV available once a month	Not shared	Not shared	Not shared
Mamta Vahan	Available whenever called. Mamta Vahan Call centre number displayed on community walls	Available whenever called. Mamta Vahan Call centre number displayed on community walls	Available whenever called. Mamta Vahan Call centre number displayed on community walls	Available whenever called. Mamta Vahan Call centre number displayed on community walls	Available whenever called. Mamta Vahan Call centre number displayed on community walls
Block level					
Jamtara Hospital	Between 5 Kms and 10 (Census 2011) Kms Can be accessed using local transport.	More than 10 Kms (Census 2011) Can be accessed using local transport.	More than 10 Kms (Census 2011) Can be accessed, using local transport.	With in 5 Kms (Census 2011) Can be accessed using local transport.	More than 10 Kms (Census 2011) Can be accessed, using local transport.
Private Clinics in Jamtara	Available but not accessed (FGD)	Available but not accessed (FGD)	Available but not accessed (FGD)	Available but not accessed (FGD)	Available but not accessed (FGD)

Summary Findings:

- *Sub Health Centers*: Out of 5 villages, SHCs were existing within 2 villages (Chandradeepa and Rupaidi).

- *Primary Health Centers*: In 3 out of 5 villages PHCs were available in more than 10 kms of the radius of the village. In Asanchuma village it was located between 5-10 kms and in Rupaidi it was available within 5 kms of the radius of the village.

- *Anganwadicenters*: Anganwadis were available in 4 villages within 0.5 km radius of each village.

- *Mobile Health Van*: Reference to the mobile health van was made in only 1 village. In another 4 villages the women did not share about accessing the service of health van.

- *Mamta Vahan***:** Mamta Vahan was available whenever required. In each village the Mamtaphone call centre number was prominently displayed on the community walls, PHC wall and on the wall of Sahiya's house. Other essential contact details like civil surgeon's number, Crematroy van number, Total number of Sahiya's in the village, ANM's contact details, Ambulance number, police station number etc. were also part of the wall writing. The picture depicted is the wall writing of chandradeepa village's health and Sanitation committee.

- *District Hospital***:** In the entire 5 village the district hospital can be accessed by using public transport. However in 3 villages in the district hospital is located more than 10 kms away from the village. And in 2 villages the district is located between 5-10 kms from the village.

- *Private Clinics***:** The private clinics were located in the district headquarter, jamtara. The number of private practitionerswas lesser in Jamtara than Dumka. It was found that women in none of the villages approached private clinics for any kind of treatment.

B) Availability and Accessibility of Service Providers/Human Resources

At the village level, women shared their perceptions about the Auxiliary Nurse Midwife (ANM), Aganwadi Worker (AWW), *Sahiya*/ASHA (Accredited Social Health Activist), traditional healers and quacks ("*jholawala* doctor"). At the block and district levels they mentioned government doctors, and in some cases private doctors.

Table 4.5: Health service provider availability and access matrix of Jamtara district

Availability of service providers	Asanchuma	Chandradeepa	Niltaha	Rupaidi	Chirudi
State Providers					
ANM **Visit**	Resides within the village. Once in a month	Resides within the village Once in a month	Service available Once in a month	Service available Once in a month	Service available Once in a month
Government Doctors	Available only at the Jamtara Hospital Can be accessed using local transport.	Available only at the Jamtara Hospital Can be accessed using local transport.	Available only at the Jamtara Hospital Can be accessed using local transport.	Available only at the Jamtara Hospital Can be accessed using local transport.	Available at the Community Health Centre, which is more than kms away or at the Trust Hospital which is also more than 15 kms away.
Sahiya (ASHA)	One Sahiya available. She is a Santhali	One Sahiya available. She is a Santhali	One Sahiya available. She is a Santhali	One Sahiya available. She is a Santhali	One Sahiya available. She is a muslim
AWW	Available withn the village and accessible by every tola.	Available withn the village and accessible by every tola.	Available withn the village and accessible by both Bengali and Santhali tola. But the Santhali need their own Anganwadi in their tola	Available	Available. The whole village is divided into four tolas: Masjid tola (Anganwadi; no Sahiya) Sasiya Bitha (Anganwadi and Sahiya), karbal pahari (No Sahiya and No Anganwadi) Kudrata (Both Sahiya and Anganwadi)
Jholawala / Quack/RMP	available, comes to the village atleast twice a day	available, come daily to village	available, come daily to village	available, comes come daily to village	available, come daily to village
Traditional Healers and	Available	Not available	Available	Available	Available
Private doctors	Private doctors only available at the block level.	Private doctors only available at the block level.	Private doctors only available at the block level.	Private doctors only available at the block level.	Private doctors only available at the block level.

Summary Findings:

- *Auxiliary Nurse Midwife*: The services of the ANM are available in all the 5 villages. In 2 villages the ANM resides within the village.

- *Sahiya:* In all the 5 villages Sahiyas are available and reside in the village.

- *Anganwadi Worker*: In all the 5 villages, AWWs are available and reside in the village. However, in 2 villages there was demand for having a mini anganwadi in their own *Tola*.[8] In Nildaha, the Santhali tola stays away from the Bengali tola. Also, the practice of untouchability is prevalent among the community. The Santhali women shared an incidence of discrimination practiced in distributing food to Santhali children by the AWW who belongs to MuslimTola.

- *Government Doctors*: Government doctors are available only at the district hospital in Jamtara which is located 5 to 15 kms away from the sample villages and is accessible by local public transport.

- *Private Doctors*: For all 5 villages, private doctors are accessible at the block headquarters which is 5-15 kms away.

- *Jholawala Doctors*: The most accessible service is the "*jholawala* doctor" (quack) who is available in all the 5 villages. He doesn't reside in the village but visits the villages at least twice a day. The case of Mirodi Hemrom mentioned below depicts the faith tribal women have about the services of *jholawala* doctors as he the first person who comes to their mind at the time of crisis.

- *Traditional Healers* available in 4 villages. The traditional healing as an art is practiced by the majority of people. As the region falls near the tropic of cancer

The case illustration mentioned below is of Mirodi Hemrom who is suffering from piles problem. She narrates her experience about how the jholwala doctor (quack) response to the emergency situation and came to the village late night. His promptness helped in saving her husbands life.

[8]Hamlets are called tolas in Jamtara. A tola can comprise of a homogeneous group, like Bengalis or Santhalis. There is no visible physical boundary that exists between the hamlets. They are all in close proximity.

Case 1: Mirodi Hemrom

Mirodi Hemrom, 38, is a Santhali woman with two children. Her husband is a farmer and works as a labourer. She came to the village at the age of 18 when she got married. She suffers from piles and occasional white discharge. She considers her health to be fair except for the piles problem.

The two health related service she avails are the jholawala doctor (quack) and the SHC. Her first preference is the jholawala doctor because she has less faith in the medicines given at the SHC. She only approaches the SHC when there is a major health problem in the family. She lost faith in the medicines given in government institutions when her husband got diarrhea. She said, "On day at 2 am my husband suddenly woke up from sleep in great pain. We all were very worried as he was panting and appeared very pale. At that crisis time the only person that came to mind was the jholawala doctor. At 3 am in morning he came immediately to our house put glucose to my husband. A total of 7 bottles of glucose was instilled in his body. He said my husband was in a critical condition. If I hadn't called him, my husband would have died. The one who helps you in your critical moments is a real friend. The SHC was closed the next day as it was Sunday; Sahiyas don't give saline so I did not contact her. The hospital in Jamtara is too far away; his condition would have worsened by the time we would have reached the hospital. It's not that we are not happy with the service provided by the SHC. The quality of medicines provided are good, it's free of cost and accessibility is high. But the services are time bound, limited to few diseases and ailments, there is only one ANM who has to visit other SHCs as well. No doctor has ever visited the SHC. These are the reasons why we are not comfortable using the government services."

4.1.3 PERCEIVED QUALITY OF HEALTH SERVICES

A) Quality of Health Infrastructure/Institutions

The following two indicators, generated in consultation with the women, were used to assess perceived quality of health services among the tribal women:

- *Importance of and visit to the institution for health related service*
- *Satisfied with the services of the institution*

Table 4.6: Health infrastructure quality matrix of Jamtara district

Quality of Health Infrastructure	Asanchuma	Chandradeepa	Niltaha	Rupaidi	Chirudi
Instititions					
SHC	Most Approached	Most Approached	No SHC in the village and the nearest one is (chandradeepa) away from the village.	Less approached	No Subcentre in the village the nearest is the PHV which is mortahn 10 kms
PHC	Not near the village thus Not approached	Not near the village thus Not approached	Not near the village thus Not approached	Not near the village thus Not approached	Most approached
Community Centre	No reference in the FGD	No reference in the FGD	No reference in the FGD	No reference in the FGD	No reference in the FGD
Private Hospital	Not approached	Not approached	Less approached	Most approached	Not approached
Aganwadi Centre	Not approached for medical assistance The centre was in good condition.	Not approached for medical assistance The centre lacked basic amenities such as water, electricity, daries for children.	Not approached for medical assistance The centre has all the basic amenities	Not approached for medical assistance The centre was attached to the school and had all the basic amenities.	Not approached for medical assistance The Anganwadi was built in the house of the AWW.

Summary Findings:

- *Sub Health Centre*: In the 2 villages where an SHC is available, women perceived it as important and approached it to avail of its service and were satisfied with the health infrastructure (availability of medicines, etc.). The SHC was not available in 3 villages (Nildaha, Rupaidi and Chirudi).

- *Primary Health Centre:* In the 3 villages where the PHC was not available, the PHC was neither perceived as a very important health institution nor women approached it for seeking health care service.

  In 4 villages the tribal women were not satisfied with the health infrastructure available. The reasons provided for not visiting the PHC included persistent shortage

of medicines, poor quality and expired medicines, no emergency service, unsuitable timings and lack of transport.

- *Anganwadi*: In all 5 villages women perceived it as not important and did not approach it for providing health care services (like medicines for minor and major ailments). In 2 villages the women were dissatisfied with the health infrastructure available at the anganwadi (basic amenities like a light not available, not well equipped, etc.)

- *Community Health Centre*: In all 5 villages the CHC was not perceived as very important nor approached for providing health care service. For a majority of villages, the government hospital is more than 10 kms away from the village. This is one reason for the increased dependence of women on the immediately available health service providers like "*jholawala* doctors". The prominent reasons shared by women for not being able to approach the government hospitals were lack of transport facility to reach the CHC, need for an educated escort, inability to drive any vehicle, offensive attitude of government staff towards tribal women, standing in long queues for medicines that can be bought from private hospitals, one or multiple days' wage loss, inhibition of being illiterate, less educated, less aware women, husbands uninterested and apathetic towards the health of their wives, lack of trust in the quality and effectiveness of government, general discontenttowards the government hospital for not being effective, and corruption.

- *District Hospital*: In all 5 villages women perceived it as important and approached it for seeking health care service. In all 5 villages the women were satisfied with the health infrastructure available and the services provided in the district hospital.

- *Private Hospital*: In 4 village women perceived it as not important nor approached it for seeking health care service. The exception was Rupaidi village where women went to the private hospital only when the quacks failed to treat them.

B) Performance of Service Providers

The performance of the service providers was assessed by studying:

- *The extent to which the service provider had been approached by the tribal women*
- *Extent of satisfaction of the tribal women with the services*

Table 4 .7: Health service provider's performance matrix of Jamtara district

	Asanchuma	Chandradeepa	Niltaha	Rupaidi	Chirudi
Service Providers & Institutions (Approached most by women)					
ANM	Not approached for medical purpose by a majority of the respondents. Limited role perceived by women	Approached and Satisfied: She is active, available most of the time in PHC and conducts monthly meetings with the Sahiya on reproductive health of women.	Not approached for medical purpose by a majority of the respondents. Limited role perceived by women	Not approached for medical purposes. Satisfied with the ANM's work in relation to immunization	Approached but Not Satisfied :(ANM of PHC) charges money from the pregnant women. Cases of corruption reported by women in relation to Janini Surakshaa Yojana
Sahiya	Approached for reproductive health related services and contraception. Dissatisfied	Approached for medicines. She conducts the monthly meeting with women and works in close coordination with the ANM. Satisfied	Approached but dissatisfied No stock of medicines with the Sahiya. She delivered a child herself so is not able to perform the job of Sahiya.	Approached for reproductive health related services and contraception. Satisfied	Approached for reproductive health related services and contraception. Sahiya has a limited role in assisting the ANM for community moblization and escorting pregnant women
AWW	Not approached for medical purpose. Satisfied with the limited role performed by her towards the 0-6 children and MDM.	Not approached for medical purpose. Satisfied: The work done is satisfactory but the he only fault which we observed in the ananwadi was the lack of proper infrastructure, water, electricity facility in the AW.	Not approached for medical purpose. Not satisfied: There is no anganwadi in the santhali Tola Women demanded a mini anganwadi in their own Tola	Not approached for medical purpose. Not satisfied: Not well equipped	Not approached for medical purpose. Not satisfied: Women demanded a mini anganwadi in theior own tola.
Jholawala /Quack/RMP	Most Approached and Satisfied with their performance	Approached and dissatisfied	Most Approached and satisfied as Easy& Cost effective	Most approached and satisfied as coming to the village daily for past	Most Approached and satisfied Easy& Cost effective

				15 years.	
Traditional Healers	Less Approached but Satisfied as their forefathers also applied guide but when they were bitten by a snake. So they are also following the same habit.	Less approached and Satisfied (Old people practice the use of jadi boti for healing purposes)	Low Preference Satisfied Trust	Less approached Satisfied: Trust: Women mainly approach the the Jadibooti wala with regards to snake bite, insect bite, infertility problem, marital problem etc. The behind approaching him is they don't have any service in the village with regard to solving marital problem.	Less approached

Summary Findings:

- *Auxiliary Nurse Midwife*: In 3 villages, the ANM was not perceived as very important for providing health care service. In one village women were dissatisfied with the services (pregnant women had to pay money to avail the service).

- *Sahiya*: In all the sample villages, the Sahiya was not perceived as very important for providing health care service. In 3 village women were dissatisfied with the services (unaware about role, tribal and caste identity as a barrier).

- *Anganwadi worker*: The AWW is available in all 5 villages but the AWW's role was not perceived as very important for providing health care service. In 3 villages, women were dissatisfied with the services (discriminatory practices by AWW).

- *Government Doctors*: Women in all 5 villages perceived them as important for providing health care service and all of them were satisfied with the service provided.

- *Private Doctors*: In 4villages the women perceived them as not important for providing health care service.

- *Jholawala Doctors*: Only one village perceived them as not very important for providing health care service. In 1 of the village, women were dissatisfied with their services (medicines not effective, charge money, etc.)

- *Traditional Healers*: In all 5 villages the traditional healer was not perceived as very important for providing health care service for minor and major ailments. The traditional healer was consulted for incidents like snake bites, etc.

4.1.4 ASSESSMENT OF PERFORMANCE OF MULTIPLE SERVICE PROVIDERS

(a) Auxiliary Nurse Midwife

- The service of the ANM was available in all the villages. In 2 villages, the ANM resided within the village which made the women access the ANM in the SHC more in comparison to the other villages. In 3 villages the ANM was not approached for any medical treatment and women only underwent the immunization service provided by the ANM.

- *Reasons for satisfaction and dissatisfaction:* In 2 villages, women were satisfied with the role of the ANM as she wasregularlyr in conducting immunization in theanganwadiicenterss. However, in 3 villages the women were not satisfied due to a limited role in terms of immunization, corruption at the PHC, and lack of availability of ANM in the SHC as they have a monthly schedule to follow.

> ***Corruption as impediment***
>
> *In one PHC the ANM was reported to have engaged in corrupt activities under the Jannini Suraksha Yojana. Women said that the ANM conducts delivery of children at their houses and pockets the money allocated for institutional deliveries. People have reported against her to the civil surgeon but he has not taken any action.*

(b) Anganwadi Worker

- Across all 5 villages, no woman approached the AWW for seeking medical services. She was perceived as a person merely responsible for the functioning of the anganwadi in the village and to take care of children between ages 0 and 6.

- *Reasons for satisfaction and dissatisfaction*: In 2 villages the women were satisfied with the work done by the AWW in their village. In Chandradeepa, the women were satisfied with the work but we observed the anganwadi lacked basic facilities like water, electricity and adequate light (it was dark and dingy). In 3 village women were

not satisfied with the AWW. In Nildaha, the women demanded a mini anganwadi for the children of the Santhali tola due to the untouchability practiced by the Bengali community towards the Santhal community which was manifested in less food being given to the Santhali children. Also, the AWW does not visit the Santhali tola. In Chirudi, the village is densely populated and divided into four tolas. The anganwadi is available in 3 tolas. Thus the women of pradhan tola want a mini anganwadi in the tola which currently has no anganwadi. The nearest anganwadi from the tola is 1.5 kms away and far from the highway road. The parents either have to escort the children till the anganwadi or if children are left to go alone then the parents fear of accident. This ultimately leads to children not being sent to the anganwadi.

(c) Sahiya

- In all the 5 villagesthe Sahiya was approached by the women. Though the role of the Sahiya is that of being a health activist at the village level, none of the women were aware of the Sahiya's comprehensive role. In 4 villages, women approached the Sahiya only for reproductive health related services like escorting pregnant women for delivery. Only in one village was she approached for medicines for minor ailments. In 2 village women were satisfied with the Sahiya. In the other 3 villages, women were dissatisfied.

- *Reasons for satisfaction and dissatisfaction*: In Asnachuma, the Sahiya was present in the FGD and the women questioned her for not conducting awareness meetings. Sahiyasto face constraints, like in Nildaha. While talking to the Sahiya, her husband kept a watchful eye on us. When she wanted to show us her uniform and the medical box she got from the PHC, he raised his voice and asked her to go inside. How can a Sahiya conduct home visits, part of her mandated role, when male domination in society is still so prevalent? In Chirudi, the Santhali women were dissatisfied with the Sahiya as she discriminates against them and does not visit their community often.

(d) Non-State Providers

- In 4 villageswomen approached quacks the most and were satisfied with the service provided, primarily because he was cost effective and easily accessible (he visits the community daily). The women can pay in installments too and can seek his advice over the phone. Only in 1 village, the women were dissatisfied with the services of jholawalas as the village has a SHC.

Sub Health Centre in Chandradeepa village where the ANM, Ms Ester Das, attendsto her patients

- *Reasons for satisfaction and dissatisfaction*: In 4 villages, the women were satisfied with the service of the quacks primarily because he is available at all times to attend to the emergencies and he conducts home visits. Quacks also build relationships with the patients, which increases their confidence in him.

Jholawala doctors prompt responses at the time of crisis

In **Asanchuma**, a man suffered severe stomach ache at 4 am. His family called up the "jholawala doctor" on his mobile. He came immediately and took the patient to the hospital. He was the first person whom they thought of at this time of distress. His emergency visit charges (early in the morning or late at night) are Rs 100 plus petrol expenses. Quacks are also known to deliver babies.

In **Rupaidi** the women shared that the quack has been coming to their village for the past 15 years on a daily basis. He approaches every family in the village. This building of a relationship with every family in the community is very strong in comparision to any other health functionary.

By and large the community people perceive the Sahiya's role to be limited, primarily responsible for pregnant women, not as a health activist. Shift of trust from the quacks to the Sahiya will take time.

(e) Traditional Healers

In all the 5 villages the women approached traditional healers, but less frequently than they approached other health functionaries. The women were satisfied with the services provided by the traditional healer.

4.1.5 COMMUNITY ENGAGEMENT IN HEALTH SERVICE DELIVERY

- *Village Health and Sanitation Committee***:** In all 5 villages, the VHSC has been formed but women were not aware of its existence, the members and its role in only 2 villages.In 2 villages, the VHSC had put up posters. Wall writing with NRHM details were also found in 2 villages.

Villages	Status
Chandradeepa	Formed; few women aware
Nildaha	Formed; few women aware
Asanchua	Formed; women not aware
Rupaidi	Formed; women not aware
Chirudi	Formed; women not aware

Wall writing by the Health and Sanitation Committee, Asanchua

- Majority of the women were not very aware of the provisions available to them under NRHM. Few women did have an understanding of the benefits under Jannani Surkasha Yojna.

- In none of the 5 villages were the women aware that maternal and child health as issues were discussed in panchyat meetings. The main reason is that gram sabhas are not conducted at the village level. In no sample village were the women or the community aware of PESA (Panchayat Extension to Schedule Area) Act.

4.1.6 SERVICE PROVIDERS' PERSPECTIVE

(a)Auxilliary Nurse Midwife

Insights on Services:

- *Key health problems*: As per the ANMs, the key health problems were TB, AIDS, and leprosy in Chandradeepa; anemia and TB in Chirudi.

- *Tribal and Non-Tribal Difference*: No major difference existed in terms of accessing the services provided in the anganwadi by tribal and non-tribal women. In Chandradeepa

the ANM shared that non-tribals women (Bengali women) are more aware about contraception than tribal women. Santhali women do not come out openly seeking information on contraception.

- *Status of Service*: The ANM provided servicein all 5 villages. Of the 5 villages, 3 were located on the road and could also avail of the Mamta Vahan servicce.

Problems faced in performing mandated role:

- *Naxalism impact*: Narayanpur block is known for the Naxal problem. The ANM, Ms Sililiya Lakada, shared, *"The Naxals do not disturb the health and education related activities as government services are the only services reaching them. But to work in such a situation is challenging."*

- *Shortage of staff*: In Chandradeepa, the ANM shared the problem of acute shortage of staff in the PHC. She is the only one available at the PHC and has to perform all the administrative duties as well.

(b) Sahiya

Insights on Services:

- *Key health problems* shared by the Sahiyas were TB, leprosy and anemia in Chandradeepa; Filariasis and white discharge in Nildaha; and Filariasis in Rupaidi.

- *Tribal and Non-Tribal Difference*: Out of the 5 villages, in 2 villages the Sahiyas perceive a difference in the behavior of tribal and non-tribal women. (Mentioned above)

- *Status of Service*: Sahiyas are available in all the 5 villages. In Chandradeepa, the Sahiya informed us of the corruption prevalent in the District Hospital of Jamtara. She has to pay a bribe to the staff to get the patient discharged from the hospital. The hospital staff charges bribe between Rs 200 to Rs 500. This is a matter of concern for her. She also shared with us the heartening fact that after the appointment of Sahiyas in every village the number of institutional deliveries has gone up. In Nildaha, the Sahiya conducts a monthly meeting with women and the Mamta Vahan service is prompt. In Rupaidi, the SHC has two ANMs and it opens regularly from 10 am to 1 pm. The irony is that the people perceive the "jholawala doctor" to be a government doctor. In Chirudi, the Sahiya shared that she likes her work but when she is required to stay in the hospital for 2-3 days with no arrangements to overnight stay, it becomes difficult for her to manage. If the Sahiya takes the patient to a private hospital, she does not get reimbursed for the institutional delivery. Lastly the Sahiya shared that Muslim women do not feel comfortable opting for tubectomy. All these factors culminated together makes the job of Sahiya difficult to perform.

Problems faced in performing mandated role:

- *No boarding and lodging in hospitals*: All the Sahiyas across 5 villages face the problem of lack of adequate rest rooms in the hospital. The pregnant woman gets a bed when she is admitted to delivering the baby, but the Sahiya has no place to sleep or relax. This is a greater felt need when the patient is brought to the hospital at night.

- *Cycles to commute*: Though the Sahiyas are provided cycles for commuting to the nearest PHC, it becomes difficult to reach those villages that are far away from the PHC by cycle. Also, in some cases, the cycle had not been distributed to the Sahiya. The task is still in process.

- *Corruption*: The Sahiya in Chandradeepa village shared about the abrupt denial of service to pregnant women by ANM if the Sahiya doesn't manage to pay her the bribe. In Chirudi village, the Sahiya shared that the ANM advises the pregnant women not to bring along the Sahiya, so that the ANM gets Sahiyya's honorarium and the pregnant women takes her amount (Rs 1400) as prescribed in the *Janini Suraksha Yojana*.

- *Mobility*: Across all 5 villages, no Sahiya explicitly shared any problems faced because of their husbands or other family members. But in Chandradeepa the Sahiya shared that in her opinion the mobility and freedom to work at Sahiya enjoys depends on the support she gets from the family.

- *IEC Material*: InRupaidi the Sahiya shared that the tribal women do not understand the posters displayed on the walls of the anganwadi as they are illiterate.

- *Lack of Self-help Groups (SHG)***:** In Rupiadi, the Sahiya shared that women in SHGs are more active than women who are not associated with any SHG. Also it is easier for the Sahiya or any functionary to approach an SHG than going to each woman independently in order to arrange a meeting or awareness generation sessions.

(c) Anganwadi Worker

Insights on Services:

- *Tribal and Non-Tribal Difference*: Only in Nildaha, the AWW shared that as the parents of Santhali children are also illiterate which is why they are not able to give help their children in doing school homework. On the other hand children of non-tribal families, in comparison, get better guidance.

- *Status of Service*: The AWW is available in 4 villages.Non-formal education classes are not conducted in any of the anganwadis. The anganwadi is primarily engaged in

providing two services – immunization of women and children and serving midday meals to the children.

Problems faced in performing mandated role:

- *Delayed salary*: In Chandradeepa, the AWW shared the problem of delays in receiving her salary.

- *Immunization*: In Chirudi and Nildaha the AWW shared the problems they face mainly with regards to delivery of their work. The one major problems faced by them is conducting immunization which includes mobilization of women and convincing the parents to bring their children for immunization and awarness generation among male towards the importance of women health

- ***Voice of Service Providers***

  *"I have to cover 8 villages of Udalbani panchayat (Udalbani, Jhaghargoda, Asanchua, Amlachatar, Udalbani, Bhaganapada, Dhanbad, Kanidi, and Budhipada) in one month along with other administrative work. I don't have time to sit in the health centre."***– Jaimala Kumari, 45**

  *"The doctor has never visited the SHC, due to which I find it difficult to administer medicines. The doctor has visited the village only during a health camp."***– Ester Das, 27, ANM, Chandradeepa**

  *"The business of the jholawala doctor is getting affected because of the institution of Sahiya. The jholawalas sell medicines like vegetables, going door to door."***– Sililiya Lakada, ANM in PHC**

4.2 EDUCATION

4.2.1 PRIMARY EDUCATION STATUS

Table 4.8: Educational status of Jamtara district

OPTION OF SCHOOL In all the 5 villages regular school going children only accessed the government primary schools.	**ENROLLMENT** In all 5 villages most children of 6-14 years of age were enrolled in SSA run government primary, upper primary and middle school.
ATTENDANCE AND REGULARITY In all 5 villages, irregular attendance of many students in the schools was evident.	**DROPOUT** In all 5 villages high dropout of children shared by a large number of parents. The girls dropped out mainly after primary. Reasons being househol chores, early marriage, no middle school, poor family background.
PERCEIVED LEARNING LEVELS In all 5 villages most parents rated learning level as low as most of the children had poor reading and writing skills both in Hindi and English which their illiterate parents could also understand.	**SATISFACTION WITH SCHOOL-QUALITY AND INFRASTRUCTURE** In all the 5 village parents were not satisfied with the SSA schools.

4.2.2 AVAILABILITY AND ACCESS TO EDUCATION SERVICES PROVIDERS

Education service infrastructure and education service providers are the two main pillars for education service delivery. The third pillar is a community institution bridging the gap between the service provider and the service users – in the case of this study this has been identified as the School Management Committee (SMC) stipulated under Sarva Shiksha Abhiyan (SSA).

A) Availability of and Access to Education Infrastructure

An important indicator to analyse access to schools by children was the presence of a school in close proximity to the village, more specifically the *tola* where the tribal women resided. The focus was on children between the age group of 6 to 14 years.

Table 4.9: Availability and access to education infrastructure of Jamtara district

Education Infrastructure	Asanchuma	Chandradeepa	Niltaha	Rupaidip	Chirudi
Availability and approx. distance from tribal tola					
Distance from the nearest town (in kilometer(s)	9	10 Kms from Mihijam	12	8	19
Bus transport facility available within the range	Between 5kms to 10 kms (Census 2011)	More than 10 kms (Census 2011)	More than 10 kms (Census 2011)	Between 5kms to 10 kms (Census 2011)	Between 5kms to 10kms (Census 2011)
Primary government school	Primary Government School within 1 km of the tribal tola	Primary Government School within 1.5 km of the tribal tola	Primary Government School within 1 km of the tribal tola	Primary Government School within 1 km of the tribal tola	Primary Government School within 1 km of the tribal tola
Government Middle school	Available (with 1 kms)	Available (with 1.5 kms)	Not available	Not available	Available (with 5 kms)
Private school	No private school near the village	No private school near the village	No private school near the village	No private school near the village	No private school near the village

Summary Findings:

- *Government Primary School*: In 4 villages, the primary school is located within 1 km of range of the village. In one village, the primary schools are beyond 1 km. Chandradeep covers an area of 648 hectares, which is why the children have to walk for more than 1 km to reach the school.

Figure 4.1 Social Sketch of Chandradeepa village.

The black line with arrow indicates the distance children travel to reach the school.

- *Government Middle School*: In 3 villages, the school was within 5 km. In the other 2 villages there was no middle school which was accessible.

- *Private Schools*: There were no private schools in any of the sample villages.

- *Distance from the nearest town:* The average distance of each village from the nearest town Jamtara is approximately 11 kms.

- *Bus transport facility***:** In 3 villages, buses are available between 5 and 10 kms from their village whereas in 2 villages buses are available more than 10 kms away from their respective villages.

B) Availability and Accessibility of Education Service Providers

Table 4.10: Availability and access to education service providers of Jamtara district

Teacher Availability	Asanchuma	Chandradeepa	Niltaha	Rupaidip	Chirudi
• *Available : Number and residence*					
Government Teachers	5 govt teachers	2 Government Teachers	2 governments	2 Govt Teacher	Visited two schools. As in the village only an **upgraded primary school** is available in which **300 children** are enrolled, one para teacher & no government teachers are recruited. Therefore we visited a **middle school** which was accessed by most of the children of the village. Total children enrolled **442 (G=216; B-226)**
Total Children enrolled	Total children enrolled: 234	Total children enrolled: 271	Total children enrolled: 147	otal children enrolled: 126	TSR: 74:1
Number: (Teacher – student ratio)	1:40	39:1	29:1	42:1	
Residence	In Jamtara	In Jamtara	In Jamtara	In Jamtara	Residence govt teacher: In Jamtara
Para Teacher	1 para teacher;	1 Para teacher	3 para teachers	1 Para teacher	1 para teacher in upgraded school and
Women teachers available	No woman teacher in school	No woman teacher in school	No woman teacher.	one para woman teacher	one para woman teacher
Residence :	NA	NA	NA	In village	In village

Summary Findings:

- *Government Teachers*: Government teachers were available in all the sample schools except in chirudi village where an upgraded primary school exists with only a para teacher as a staff. The number of government teachers recruited varied from 2 to 5 as per the enrollment of children and the population of the village. In all the schools the government teacher had to travel from Jamtara to reach the school. In the Chirudi village as there was an upgraded primary school available so we visited a middle school of the nearby Panchayat where most of the children from the village go for schooling.

- *Student-Teacher Ratio*: In 4 sample villages the student-teacher ratio was more than the RTE norm, which is 1 teacher for 35 students in the upper primary school. Only in one village, Nildaha, the student-teacher ratio was 1:29 which is within the RTE norm. In all other village the student teacher ration was high. (See table Annexure 4)

- *Residence of Government Teachers*:All the teachers in the primary or upper school schools recruited under SSA resided in Jamtara (the nearest town) and commuted daily to the villages.

- *Para Teachers*: The term 'para teachers' is a generic term to characterize all teachers appointed on contract basis (often under varying service conditions in terms of emoluments and qualification requirements). In Jamtara, para teachers are recruited on an ad-hoc basis and their main role is to support the government teacher in translating the Hind or English lessons into Santhali or any local language. Para teachers were available in all 5 schools, their number ranging from 1 to 3. Most of them were residents of the sample village and thus were easily available.

- In general, the gender balance is low withfewr women teachers. In all 5 villages male teachers outnumbered the female teachers. In Rupaidi and Chirudi villages, the para teachers were female and resided within the village.

Voices of Teachers

"The SMC members are labourers. It is difficult to make them sit for long hours.There is a sense of detachment among parents and teachers which should be improved."

– Vijay Kumar Singh, Head Teacher

"More girls are going in for higher education than boys" – ***Chandramuni Soren, para teacher***

4.2.3. PERCEIVED QUALITY OF EDUCATION SERVICES

A) Performance of Service Providers

Performance of service providers was assessed by studying the perception of tribal women on the following indicators:

- *Overall satisfaction with teachers*
- *Teacher regularity and punctuality*
- *Teacher behavior towards children*

Table 4.11 : Satisfaction with role and performance of service providers of Jamtara district

Women Perceptions on performance of service provider	Asanchuma	Chandradeepa	Niltaha	Rupaidip	Chirudi
	• ***Overall satisfaction with Teachers*** • ***Teacher Regularity and punctuality*** • ***Teacher behavior towards children***				
Satisfaction with Government Teachers	Majority not satisfied. *(Governenment teacher working as drawing dispersal officer due to wchih quality gets hampered; school building on grazing land)*	Majority not satisfied. (*school building on grazing land and in very bad condiction; children of 1st to 5th sit on varanda as the classroom is dark and dingy and wall are weak)*	Majority not satisfied. *(Quality of teaching; Irregularity of teacher; Undue focus on Hindi lang and not on other sub like maths and english; No SMC)*	Majority not satisfied (poor teaching)	Majority not satisfied (mostly due to teachers apathetic attitude and not because of the lack of services)
Satisfaction with Para Teachers	Satisfied as stay in village and accessible	Majority not satisfied with the performance.	Majority (Santhali tola women) not satisfied with the as the para teachers (Language constrain and untouchability)	Satisfied as she stayes in the village and understands santhali language.	Majority not satisfied with the performance
Govt Teacher Regularity and punctuality	The teachers are regular in coming to school. However the community shared that the teacher are always seen reading newspapers. They are not satisfied with the education	Regular	Regular except for one government teacher who doesn't come to school regularly	Regular. But the head teacher doesn't come to school	Regular
Para Teacher Regularity and punctuality	Regular and Puntual	Regular and Puntual	Regular and Puntual	Regular and Puntual	Regular and Puntual
Teacher Behaviour towards children – physical or mental harassment	Majority of women were satisfied. (*No such incident was reported by the girls)*	Majority of women satisfied. (*The teacher did not take refuge to phyisical punishment any a time)*	Majority of women satisfied. (*No such case of harressment reported by the women in FGD)*	Majority of women satisfied. *(Such an insident was never reported)*	Majority of women satisfied. (*never such a case is registered)*

Summary Findings:

- *Satisfaction with Government Teachers*: In all 5 villages majority of the women were dissatisfied with the government teachers' role and performance. In Asanchuma village dissatisfied with the government teachers' role and performance. In Nildaha village, poor quality of teaching; the irregular attendance of the teacher; undue focus on Hindi and not enough on other subjects like Maths and English; and no SMC meetings are reasons for dissatisfaction of the women with the school.In Rupaidi and Chirudi, poor teaching and apathetic attitude of teachers are the major reasons for dissatisfaction. In Asanchuma village the government teacher is also deputed as a Drawing Dispersal Officer due to which he is caught up in administrative work/non teaching work (population census, cattle census, loan disbursement, election duty etc) more than teaching work. The engagement of head teacher and other government teachers in the non teaching work is one of the reasons for deteriorating quality of education. The school is built on grazing land[9] which is owned by community people. The school doesn't have any land of their own in the village. In Chandradeepa village the school is also built on grazing land which is owned by the community and is in a very bad condition. Children in classes 1 to 5 sit on the veranda as the classroom is dark and dingy and the walls are weak.

- *Satisfaction with Para Teachers*: In 2 villages the women were satisfied with the para teachers as they were from their own community and were hence more accessible. However, in 3 villages (Chandradeep, Nildaha and Chirudi) the women were not satisfied with the para teachers' performance. In Nildaha, para teachers belong to the Bengali community and reside in the Bengali tola. The Santhali women reported that the Bengali community practices untouchability against the Santhali community and the para teacher was hence viewed as unfriendly.

- *Regularity of Government Teachers*: In all 5 villages the government teachers were regular. However, in Asanchuma the women complained of teachers seen reading newspapers; they were not satisfied with the kind of education being provided to their children in the school. In Nildaha, one government teacher does not come to school regularly. In Rupaidi, the head teacher comes to the school once a month.

- *Regularity of Para Teachers*: In all 5 villages the para teacher was perceived as regular and punctual.

[9] Grazing land is a part of land which is owned by the community. If a government school is built on a grazing lands owned by the community the school is not authorised to do any kind of infrastructural repair work.

- *Behavior of teachers*: In all the 5 villages the behavior of teachers towards children was amicable. No incidence of rude or aggressive behavior, mental or physical harassment, physical punishment, or detention was reported by the women.

- *No extra curricular activities*: In none of the schools do the teachers take the children on a picnic. In the majority of the schools there were no extra curricular activities.

B) Quality of Infrastructure

Table 4.12: Quality ofeducation infrastructure and facility of Jamtara district

Quality Indicators	Asanchuma	Chandradeepa	Niltaha	Rupaidip	Chirudi
• ***Condition: Good-not good*** • ***Cleanliness: Clean-not clean*** • ***Infrastructure availability: Available as per norm***					
School building condition	Poor condition. The school building is on grazing land and in a very bad condition. Even the SMC cannot spend any fund to repait the building.	Poor condition and built on grazing land	good condition	Good and own building	Good condition,
Cleanliness	Clean	Cleanliness not maintained. (grazing land)	cleanliness maintained	Clean.	Clean
Infrastructure availability for students					
Chairs, tables, [10]dari, blackboards	Pre primary children sit on dari and children in class 8th sit on benches. Blackboard available	No daris for children of class 1-V. blackboards available	The classrooms had dari for 1-5 *and table and chairs for class 8th onwards* Blackboard available	Dari for 1-5 and blackboards available	Dari for 1-5 and table and chairs for class 8th onwards, blackboards available
Tiolets availability and cleanlines	Toilets available but Same for girls and boys and in bad condition	Toilets available but in poor condition Separate for girls and boys	No toilets	Separate Toilets in poor miserable condition	Toilets available but in poor condition Toilets for girls in worst condition
Play ground,electricity, water availability	*No Playground Electricty available*	No Playground No Electricty Drinking water	No Playground No Electricty Drinking water	No Playground No Electricty	Playground available No Electricty

	Drinking water source available	source available	source available	Drinking water source available	Drinking water source available

Summary Findings:

- *Condition of School Building*: In 3 out of 5 villages the condition of the school building was good, with a pucca building. In Asanchuma and Chandradeepa the condition of the building is poor. The school building is built on grazing land owned by the community. Even the SMC cannot spend any funds to repair the building.

- *School Cleanliness*: In 4 schools the tribal parents were satisfied with the school's cleanliness. In Chandradeepa, cleanliness was an issue as the school building is in a dilapidated condition.

- *Infrastructure Availability for Students*: Across the government schools in the 5 sample villages, in 3 schools dhurries were available for children between classes 1 and 5. In 2 villages (Chandradeepa and Chirudi) there was no dhurrie available for the children of classes 1 to 5 to sit on. As a result, the children sat on the bare floor or on their rucksacks. The blackboards were available in all the schools, but were not in a very good condition. Toilets were available in 3 sample villages. However, a separate toilet for girls was available only in the Rupaidi. No toilet facility was available in the school in Nildaha. Other amenities, like electricity, were not available in any school. There was a playground only in one school. Drinking water was available from handpumps in all the 5 sample schools.

C) Quality of Educational Entitlements

Table 4.13: Satisfaction with educational entitlements received of Jamtara district

Quality Indicators	Asanchuma	Chandradeepa	Niltaha	Rupaidip	Chirudi
Quality: good or poor Provision as per norms					
Quality of Midday Meal(MDM)	Good: They change the meal on a daily basis	Poor as same meal quite often	Poor as half of the meal goes waste which is thrown later on	Majority of tribal parents was not satisfied with the quality of MDM provided (same)	Poor No MDM running for past two months.

Timely and accurate provision of scholarships - ie scholarship, free books, uniforms	Poor: As girls are not getting the cycles Books and stipend given as per minimum required attendance	Poor as teachers get the signature done on Rs 180 but only give Rs 150 to the students Books and stipend given as per minimum required attendance	Very Good according to the teachers but as told by the women in FGD they pay less (Rs 150) than the stipulated amount (Rs 180) Books and stipend given as per minimum required attendance	The tribal women respondents mentioned children getting books	Only Books

Summary Findings:

- *Midday meal quality*: As per the ICDS midday meal (MDM) norms in Jharkhand,[11] there is 3 kg dry food per student per month. In 4 of the 5 villages, the tribal women were not satisfied with the MDM quality as it was poor and repetitive. In Asanchuma the MDM was good as they changed the meal daily and followed the schedule.

- *Entitlements*: The SSA state rules (Jharkhand) related to the entitlements due to tribal children is in the process of being notified. In all 5 schools free text books were available, while scholarships and stipends were available only in 3 schools**.** This was an area of concern for the parents of primary school children. In 2 village women complained about the stipend not being distributed. Of the 3 schools where stipend was being distributed, the women complained about children getting less than the stipulated amount in 2 schools. The women were unaware of the reasons behind teachers engaging in such a practice.

4.2.4 COMMUNITY ENGAGEMENT IN EDUCATION SERVICE DELIVERY

Summary Findings:

- In all the 5 villages parents are never informed about student progress, are never invited to school events and functions and are never engaged in SMC tasks. The basic connect between teachers and parentsis missing. Teacher and parent meetings are held in 2 villages.

- In none of the 5 villages women were aware of the PESA Act, the RTE Act, or the provisions under SSA.

[11] http://mdm.nic.in/Files/PAB/PAB-2011-12/AWPB%20Appraisal%20Notes/JHARKHAND.pdf

- SMCs were formed in all the 5 villages. There were 16 members of the committee. In most of the villages the SMC had met for meetings only twice in a year since being formed, with meager participation from the community/members who are parents. Most of the members were not aware of even being part of the SMC.

- In none of the 5 villages were the women aware that education as an issue was discussed in the panchyat meetings. The main reason is that gram sabhas are not conducted at the village level. In none of the sample villages were women or the community aware about the PESA Act.

4.2.5 SERVICE PROVIDERS' PERSPECTIVE

Education service providers are the SMC chairperson and members, primary school teachers (both government and para teachers), the Pradhan (traditional headman), and the mukhiya (elected village representative under panchayati raj). Service providers were interviewed by visiting the primary schools established within a village. If there were no primary schools, either the middle school or the upgraded primary schools (with only the para teacher) were visited. Apart from formally interacting with the teacher, we informally interacted with the children as well, asking about their likes and dislikes and the schooling system. This was necessary as most of the teachers were of the opinion that children came to school only to avail of the MDM. But when we interacted with the children, they said they came to school to study. The irony is that the quality of both MDM and teaching is poor, ultimately resulting in lower enrollments in schools.

(a) Government and Para Teachers

- *Lack of basic amenities*: Two of the schools are not run in their own school building; rather they are built on grazing land. This leads to non-maintenance of toilets, playgrounds, classrooms, benches, dhurries, blackboards, charts, cupboards and other teaching-learning material. The school that had their own school building were at an advantage as they could spend the development fund given under RTE for school maintenance. The biggest constraint faced was the fewest number of classrooms leading to multi-grade classroom system.

- *Multigrade Classrooms*: Almost all the schools we visited had multi-grade classrooms. In a multi-grade classroom, pre-primary children sit on dhurries along withchildren of higher classes, who sit on chairs and benches. The multi-grade classroom system along with less teaching staff were presented as the main reasons for deteriorating standards of teaching quality. Another reason given for poor quality of teaching was engagement of the teacher in non-teaching work.

- *Dropout and Attendance*: Majority of the teachersshared ignorance, illiteracy, and poverty of people as prominent reasons for the high dropout rate among children.

- *Teacher-Student Ratio*: The teacher-student ratio in Jamtara is very high in the majority of the schools. This was shared as a cause for concern by teachers.

- *Displeasure towards RTE Provisions*: Almost all the teachers we interviewed showed their displeasure towards three RTE provisions: prohibition of physical punishment, introduction of the grading system after the exam and not to fail any child.

- *Training and Capacity Building of Teachers*: Most teachers expressed the felt need for training and capacity building specifically on the methods and tools for teaching. Apart from this, teachers also suggested changes in the present syllabus mainly in terms of making it more interesting for children and incorporating examples from their own state. In Rupaidi, para teachers who faced the problem of retaining children's attention for long hours shared the need for training and capacity building.

- *No Gram Sabhas*: The lack of proper functioning of the gram sabhas was also a concern shared by teachers for not being able to perform their role efficiently. As under the RTE provisions the Pradhan/ mukhiya is responsible to monitor the educational activities in their village. But in case of all the sample villages visited most of the pradhans were not conducting gram sabhas. This led to lack of accountability byteachers towards the Pradhan. Ultimately hampering the education as a whole in their village.

- *Non-teaching Work*: Most government teachers instead of focusing on the development of the child engage in time consuming non-teaching work like population census, cattle census, MDM accounting, income tax, loan disbursement and sanctioning of leave. The head teacher in Asanchuma village also acts as the drawing dispersal officer. In Nildaha, the teachers shared that government teachers are overburdened with administrative work that consumes most of their time and affects the quality of teaching.

(b) School Management Committee

The SMC, as the name suggests, is an oversight committee formed in 12 to 16 members from the community under section 21 of the RTE Act. In the Central Model Rules, the composition suggested is as follows: Three-fourths (75%) members from parents/ guardians. Of these, 50% to be women. Weaker sections will be represented in the SMC in proportion to their population in the village. Rest one-fourth (25%) will be: 1/3rd local authorities;

1/3rd school teachers; 1/3rd academicians/students. However, the SMCs face numerous problems.

Helplessness of SMCs: It should be noted that the SMC is required to function as a body that is vigilant towards education related issues in the community. But in all the villages we visited the SMC chairpersons were depressed and helpless as they were unable to perform their assigned role. The major problem they faced was in terms of teachers not listening to their complaints.

Poor Community Participation: The SMC is a body composed of 12 to 16 members but hardly any parents and guardians attend the meetings. Though most of them in the FGDs complained about the poor quality of teaching and MDM, they do not utilize the SMC as a tool in their hands to bring about positive change in their village.

Voice of SMC chairpersons

*In **Nildaha village** the SMC chairperson looked uncertain about the work he is supposed to do. He has sent in his resignation because ideally he is supposed to manage and monitor various aspects related to the functioning of the school but when he actually filed a complaint against the government teacher he was stopped by the other teachers and has never got any response from the block and district officials.*

*In **Rupaidi,** the major problem faced by the school and the SMC is that the head teacher/government teacher has not been coming to the school for the past 7 to 8 years; yet she has not been penalised by any authority. This reduces the number of teachers available in the school and the teacher-student ratio increases.*

*In **Asanchuma village**, the chairperson said that he had not visited the school in quite a while as on 26th January the teachers deliberately chose a different menu for children and a different one for themselves. They gave poor snacks to children and ordered good snacks for themselves. Seeing this discrimination the SMC chairperson has refused to attend any meeting. This is affecting the SMC meeting schedule.*

4.2.6 INTERNAL MONITORING SYSTEM AND AWARENESS OF STAFF ON RTE

- In all the 5 villages the Block Education Officer visits the schools. Teacher meetings were conducted in 3 villages. Parent-teacher meetings were conducted in 2 villages.

- In 4 villages the SMC chairpersons were aware of the RTE Act and enumerated a few provisions they remembered after attending the RTE workshop which was conducted at the block level. Teachers in Chandradeepa and Rupaidi were aware about the provisions of RTE even though they had not attended any training. They found three days' training to be a sheer waste of time.

4.2 SELECT ENTITLEMENTS

In all, 5 women were interviewed for knowing about the details of theirthe entitlements received by them.

4.3.1 ACCESS TO ENTITLEMENTS

✍***Summary Findings*:**

Bank account: Majority had no bank account (only one woman had a bank account). In 4 villages, no woman in the entire village possessed a bank account.

Awareness about the Benefits of BPL, Aadhar Card, Ration Card: All the women interviewed were aware about these cards. With regards to aadhar card the women were unaware about the usefulness.

Entitlements available:

- Yellow Card (Antodaya card): Held by 2 women.
- Red Card (BPL): Held by one woman.
- Orange card (BPL ration card): Held by no women.
- Green Card (APL): Held by one woman
- Aadhar card: Process had been initiated in all 5 villages, but only in 3 villages did the women possess the card.

4.3.2 EASE OF GETTING ENTITLEMENTS

✍**Summary Findings:**

Difficulties in Opening a Bank Account: All 5 women shared how difficult it was to open a bank account. First, they lack any kind of identification proof and other collaterals required to open the account and, second, all the women we met were poor with meager family income and hardly any savings. Thirdly, they believed in household savings over bank savings.

Problems Related to Getting BPL, Ration and Aadhar Cards: Three women shared the difficulties they faced in getting these cards made. They applied but did not receive any information from the block level regarding their status. They asked the Pradhan of their

village, but this too was not helpful as the Pradhan works in Jamtara and has little time to follow up. None of the women shared information about problems in getting the other card made.

4.3.3. SATISFACTION WITH THE PROVISIONS RECEIVED

Summary Findings:

Provisions Received under Ration Card: The yellow card holder gets rice and kerosene; the red card holder gets rice, kerosene oil and salt; the green card holder comes in the APL category so they are entitled only to kerosene. The orange card holders are BPL ration card holders who also get all three provisions (rice, kerosene and salt).

Satisfaction with the Ease and Quality of the Ration Card Provisions: Majority of the womenwas not satisfiedd with the services provided, especially in terms of BPL and ration cards.

Voices of women seeking entitlements

Narayani Soren from Chandradeepa village possesses no bank account as she doesn't have sufficient income. All she has is a BPL number and an Aadhar card. She complained about the pradhan not having time to take action regarding non-receipt of her BPL card. Her only suggestion was to engage women in some income generating activities.

Parvati Soren from Rupaidi village has a green ration card under which she is eligible only for kerosene. Her identification for the Aadhar card has been completed. She suggested making women aware about the benefits of the Aadhar card and other welfare schemes which are designed especially for poor women.

Shivdhan Tudu of Nildaha village demanded ration dealers be located in the village itself as this will help monitor them and check the corruption which the dealers engage in (they write they have given 35 kg rice on the ration card but only give 30 kg in hand).

CHAPTER 5

COMPARATIVE ASSESSMENT OF DEVELOPMENT SERVICES IN DUMKA AND JAMTARA

5.1 CONTEXT OF DUMKA AND JAMTARA

5.2 ACCESS TO AND QUALITY OF HEALTH SERVICES

- **5.2.1 AVAILABILITY OF AND ACCESS TO HEALTH SERVICES**
- **5.2.2 QUALITY OF HEALTH SERVICES**
- **5.2.3 ENGAGEMENT OF COMMUNITY IN HEALTH SERVICE DELIVERY**
- **5.2.4 PERCEPTIONS OF SERVICE PROVIDERS ON THEIR PERFORMANCE**

5.3 ACCESS TO AND QUALITY OF EDUCATIONAL SERVICES

- **5.3.1AVAILABILITY OF AND ACCESS TO EDUCATIONAL SERVICES**
- **5.3.2 QUALITY OF EDUCATIONAL SERVICES**
- **5.3.3 SCHOOL'S ENGAGEMENT WITH PARENTS**
- **5.3.4 PERCEPTIONS OF SERVICE PROVIDERS ON THEIR PERFORMANCE**

5.4 ACCESS TO AND QUALITY OF ENTITLMENTS

5.5 INSIGHTS ON IMPACT OF UNREST ON SERVICE DELIVERY FOR TRIBAL WOMEN

CHAPTER 5

5.1 CONTEXT OF DUMKA AND JAMTARA

In Chapter 1 demographic detail of Dumka and Jamtara district has been provided. The key features have been summarized in the table below:

Table 5.1 Comparative Context of Dumka and Jamtara Districts

Context	Dumka	Jamtara
No. of blocks	10	6
Population *(2011 Census)*	13,21,096	7,90,207
Scheduled Tribe population (*2011 Census)*	5, 71,077 (43.21%)	2, 40,489(30.4%)
Terrain	More hilly and rocky	Lower altitude
Forest cover	30% of area is under forest cover	11% of the area is under forest cover
Left Wing Extremism(*South Asia Terrorism Portal, 2012)*	Highly affected	Moderately affected
Sex ratio (*females per 1000 males*) *(2011 Census)*	962	958
Maternal mortality (*maternal deaths per 100,000 live births*) (*SRS 2009***)**	312	371
Literacy (*2011 Census***)**	62.54	63.73
Retention rate at primary level (*District Report Card, 2011-12)*	51.5	54.3
Learning levels (*ASER ,2012)* • Children (Std I-II) who can read letters, words or more • Children (Std I-II) who can recognise numbers (1-9) or more	 59.4% 63.9%	 63.4% 69.1%

Comparative assessments of both the districts reflect the following findings:

Dumka is older and a bigger district than Jamtara: The district of Dumka is the sub-capital of Jharkhand since 2000. Dumka is one of the oldest districts of Jharkhand state under Santhal Parganas.Jamtara was formed on 26 April 2001 by carving out four blocks from Dumka district.There are 10 blocks under Dumka sub-division, while Jamtara comprises 6 blocks.

Dumka has a higher population. As per 2011 Census, Dumka and Jamtara have a total population of 13,21,442 and 7,91,042 respectively, which constitutes 4% and 2.39% of the total population of Jharkhand.

Dumka has a larger tribal population. In Dumka, 43.21% of the population belonging to Scheduled Tribes (ST) while in Jamtara 30.4% of the population are ST. Compared to Jamtara, Dumka also has more primitive tribes like the Mal Pahadia, Pahariya.

Dumka has more difficult terrain: Dumka has predominantly undulating terrain, with high ridges and valleys bounded by mountains and rivers. Nearly 30% of Dumka are under forest cover, as compared to about 11% in Jamtara.[12] With hard rocks underground, fertility of soil is poor due to extensive erosion, acidic character and low retaining capacity.Jamtara is located at a lower altitude of Chhotanagpur plateau.

Dumka is more affected by Naxal activities: Though both districts are unrest affected according to the South Asian terrorism Portal, basing its analysis on trends through 2011, Dumka has been identified as "highly affected" and Jamtara as "moderately affected" by Left Wing Extremism. (South Asia Terrorism Portal, 2012)

On key maternal health indicators, Dumka ranks better than Jamtara. The sex ratio in Dumka stood at 962 per 1000 males which are higher than the sex ratio of Jamtara, at 958 per 1000 males. As per the *District Health Action Plan 2011-2012*, Jamtara has a higher maternal mortality rate at 371, compared to Dumka's 312 maternal deaths per 100,000 live births.

On key education indicators, Jamtara ranks better than Dumka.Jamtara fares marginally better than Dumka in total literacy as well as male and female literacy, as per 2011 census. Jamtara fares marginally better than Dumka on retention rates at the primary level, 54.3 rates as compared to Dumka's 51.5.**(**NUEPA, 2013).Further, on learning levels, Jamtara performs better than Dumka as per ASER 2012.

The following sections undertake a comparative assessment of the salient findings around the status of service delivery provisions and the views of the service providers based on the 10 villages in the sample study. As the sample was small and purposive, and the nature of the study was exploratory, the emerging trends should not be taken to reflect the situation in the entire district.

[12]http://www.sameti.org/Soil_Inventory/Jamtara_Soil_Analysis.pdf

5.2 ACCESS TO AND QUALITY OF HEALTH SERVICES

5.2.1 AVAILABILITY OF AND ACCESS TO HEALTH SERVICES

To compare Dumka and Jamtara district on the availability and access to health services it would be useful to first revisit the health infrastructure availability, as described in detail in Chapter 4 and 5.

Table 5.2 : Access to health infrastructure

Health Infrastructure	Dumka-5 villages	Jamtara- 5 villages
• ***Availability and approx. distance from tribal tola***		
SHC	Paharia Health Centre available in 1 village; approx distance: within 1 km	SHC available in 2 villages; approx distance: within 1 km
PHC	Available to 5 villages; approximate distance within 5-10 kms	Available to 5 villages; approximate distance between 5-10 kms
CHC	Available; approximate; distance between 5- 15 kms	Available :approx. distance between 5-15 kms
District Hospital	Available at Dist HQ: approximate distance more than 10 kms	Available at Dist HQ: approximate distance more than 10 kms
AWC	Available in 4 villages; approximate distance within 1 km	Available in 5 villages; approximate distance within 1 km
Private Clinic	Available at block and district level	Available at block and dist level
Mamta Vahan	Access to 4 villages;frequency of visit:on call	Access to all 5 villages; frequency of visit:on call
Transport availability	Easy public transport accessibility is a issue in few villages	More readily accessible public transport in most Jamtara villages as they are more closer to the roads

Table 5.3: Access to health service providers

Health Service Providers	Dumka-5 villages	Jamtara- 5 villages
• ***Available : Frequency of visits and residence***		
ANM	In all 5 villages visits once a month and does not reside in the village	In all 5 villages visits once a month. In 2 villages ANM resides in the village
Sahiya	Available in all 5 villages and resides in the village	Available in all 5 villages and resides in the village
AAW	Available in 3 villages and resides in the village.	Available in 5 villages and resides in the village.
Doctor	Available to 5 villages at the Community Health Centres, this is between 5-15 kms away. Doctor visit the Paharai Health Centre twice a month and charge Rs 200 In 1 village available at Trust Hospital, this is 15 kms away.	Available to 5 villages at the Community Health Centre, this is between 5-15 kms away.
Private Doctor	For all 5 villages available at the block level, which is between 5-15.kms away. Presence of greater number of private doctors	For all 5 villages available at the block level, this is 5-15 kms away.
Jholawala	Available in all 5 villages, comes to the village at least twice a day	Available in all 5 villages, comes to the village at least twice a day
Traditional healer	Available in all 5 villages	Available in all 4 villages

Comparative Assessment

Building on the above tables, it will then be useful to compare both the districts, as attempted in the table below:

Table 5.4: Comparative assessment of availability of and access to health services

Indicators	Commonality	Differences
Access to Health Infrastructure	• In the entire villages Health infrastructure was available at the village (SHC, PHC), block (CHC) and district levels, as per the government norms of distance fromthe village.	• In Jamtara, SHC available in 2 villages, while in Dumka only 1 village had the Paharia Health Centre at the village level. • Transport facility is more readily accessible in Jamtara, while it is a problem in remote areas in the more

		hilly regions of Dumka. The Mamta Vahan is not able to reach some inaccessible villages. • Greater awareness about Mamta Vahan in Jamtara than in Dumka.
Access to Health Service Providers	• ANM visits once a month in all the villages • Sahiya was available and resides in the village, in all the villages • Government doctors available at CHC, and private doctors available at block level • "Jholawala doctors" (quacks) and traditional healers available in all villages	• ANMs in 2 villages stay in Jamtara; (while in non village in Dumka ANM stays at the village level • AWWs stay in all 5 villages in Jamtara; while AWWs stay in 3 villages in Dumka • The government doctor visits the Paharia Health Centre twice a month in Dumka; no doctor visits the SHC in Jamtara • More private doctors available in Dumka block headquarters than in Jamtara

Jamtara has comparatively *better access to health infrastructure* in the form of availability of SHCs and better government transport facility. One of the underlying reasons for poor access in Dumka is that some of the sample villages were less accessible due to the hilly terrain.

There is *comparatively greater and regular access to village health service providers* like the ANM and AWW in Jamtara, as in nearly all the sample villages the ANM and AWW resides in the village itself. One assumption could be that less condition of unrest in Jamtara as compared to Dumka makes it more conducive for service providers to stay in the village and hence be more accessible. However, availability of the doctor twice a month in the Paharia Health Centre in Dumka while no doctor visited the SHC in Jamtara reflects the benefits and effective implementation of the Jharkhand Welfare department's special schemes primitive tribes.

5.2.2 QUALITY OF HEALTH SERVICES

To compare Dumka and Jamtara district on the quality of health services it would be useful to first revisit the information provided in detail in Chapter 4 and 5.

Table 5.5: Utilisation and satisfaction with health institutions

Health Infrastructure	Dumka-5 villages	Jamtara- 5 villages
• ***Perceived importance and approached as provider of health service by tribal women*** • ***Satisfaction with the Infrastructure and services of the Institution)***		
SHC	In 1 village where SHC available (Paharia Health Centre), women perceived/approached it as important by providing health care service. In that village women were satisfied with their Health Infrastructure available	In 2 village where SHC available, women perceived it as important and was approached by providing health care service. In the 2 village women were satisfied with their Health Infrastructure available (ie *medicines availability*)
PHC	In the 4 villages where SHC not available, PHC was not perceived as very important nor approached for providing health care service. In all 4 villages the women were not satisfied with the Health Infrastructure available(*lack of medicines, irregular staff*)	In the 3 villages where SHC not available, PHC was not perceived as very important nor approached for providing health care service. In all 4 villages the women were not satisfied with the Health Infrastructure available(*lack of medicines, irregular staff, no transport, no emergency service)*
CHC	In all 5 villages CHC not perceived as very important nor approached for providing health care service.	In all 5 villages CHC not perceived as very important nor approached for providing health care service
DH	In 2 villages women perceived it as not important nor approached for providing health care service. In 2 villages the women were dissatisfied with the Health Infrastructure available and the services provided.	In all 5 villages women perceived it as important and approached it for providing health care service. In all 5 villages the women were satisfied with the Health Infrastructure available and the services provided by them.
Private Clinic	In 2 villages women perceived it as not important and not approached for providing health care service. In 3 villages there was satisfaction with the infrastructure and facility available in the private clinics.	In 4 villages women perceived it as not important nor approached it for providing health care service.
AWC	In 4 villages where AWC was available women perceived it as not important nor approached for providing health care service like medicines for minor and major ailments. (*more for immunisation of pregnant women and nutrition for 0-6 children)* In 3 villages the women were dissatisfied	In 5 villages women perceived it as not important nor approached for providing health care services like medicines for minor and major ailments. In 2 villages the women were dissatisfied with the Health Infrastructure available

	with the Health Infrastructure available (*i.e. no proper building, lack of proper ventilation, open space)*	(*I.e. basic amenities not available, like light, not well equipped etc.*)

Table 5.6: Utilisation of services and satisfaction with performance

Health Service Providers	Dumka-5 villages	Jamtara- 5 villages
• ***Perceived importance and approaching provider of health service by tribal women*** • ***Satisfaction of the tribal women with their services***		
ANM	In all the 5 villages not perceived as very important for providing health care service. In all the 5 villages women were satisfied with their limited services (*immunisation and vaccination).*	In 3 villages not perceived as very important for providing health care service. In 1 village women were dissatisfied with their services (*charging money from pregnant women*).
Sahiya	In 5 villages not perceived as very important for providing health care service. In all the 5 villages women were dissatisfied with their services (unaware *about role, tribal and caste identity as barrier*).	In 5 villages not perceived as very important for providing health care service. In 3 villages women were dissatisfied with their services (unaware *about role, tribal and caste identity as barrier*).
AAW	In 3 villages where Aganwadi worker was available, AAW's role not perceived as very important for providing health care service. In 3 villages however women were dissatisfied with their services(*discriminatory practices by AWW)*	In 5 villages where Aganwadi worker was available, AAW's role not perceived as very important for providing health care service. In 3 villages however women were dissatisfied with their services(*discriminatory practices by AWW)*
Government Doctor	In 2 villages women perceived them as not important for providing health care service. In 2 villages the women were dissatisfied with the Health services provided.	In all 5 villages women perceived them as important for providing health care service. In all 5 villages the women were satisfied with the Health services provided by them.
Private Doctor	In 2 villages women perceived it as not important for providing health care service. In 3 villages the women there were concerns about the cost of the services being very high.	In 4 villages women perceived it as not important for providing health care service.

Jholawala	In 2 villages not perceived as very important for providing health care service. In 2 villages women were dissatisfied with their services (*medicines not effective, charge money)*	In 1 village not perceived as very important for providing health care service. In1 villages women were dissatisfied with their services (*medicines not effective, charge money)*
Traditional Healer	In 4 villages not perceived as very important for providing health care service. In 2 villages women were dissatisfied with their services.	In 5 villages not perceived as very important for providing health care service for minor and major ailments. (*More for snake bites etc*.)

Comparative Assessment:

Building on the above table, it will then be useful to compare both the districts, as attempted in the table below:

Table 5.7: Comparative assessment of quality of health services

Indicators	Commonality	Differences
Women's Satisfaction with Health Infrastructure	• In villages where SHC was not available, the PHC was not perceived as important, nor approached much • Most women of all the villages not satisfied with the facility and service available in the PHC • In all the villages CHC not perceived as important, nor approached much • In all the villages where anganwadi was available, it was not perceived as a very important institution for accessing health	• The importance and use of SHC is more in Jamtara • Comparatively more women are satisfied with the SHC services in Jamtara • In Jamtara, the importance and use of the district hospital and satisfaction with its infrastructure and services is more • In Jamtara, there is greater satisfaction with anganwadi infrastructure and facilities • In Dumka, the importance and use of private clinics is more
Women's Satisfaction with Performance of Service Providers	• In majority of the villages the "jholawala doctor's" role is perceived as important by the tribal women and majority were satisfied with the service • In majority of the villages tribal women were satisfied with the ANM's services of immunisation • In most villages, majority of the tribal women did not perceive the anganwadi as important and majority were not satisfied with its service	• Greater importance, usage and satisfaction of tribal women with government doctor services was evident in Jamtara • Greater importance and utilisation of ANM services by tribal women was evident in Jamtara • Greater satisfaction with the Sahiya's role was evident in Jamtara • Greater importance and use of services of private doctors by tribal women in Dumka

	• In most villages, majority of the tribal women did not perceive the traditional healer as important	

The findings reflect that in Jamtara the tribal women had *greater satisfaction with state health infrastructure*, especially with the SHC and district hospital. Conversely, the tribal women in Dumka approached the private clinics more and perceived it as most important.

This trend is further reinforced with the finding that the women in Jamtara were *more satisfied with government service providers* like doctors and Sahiyas as opposed to perceived preference of private doctors in Dumka. A plausible reason for this could be better and regular performance of the government service providers due to safer and more conducive work environment in Jamtara compared to the more hostile and unrest-ridden environment in Dumka. This would also contribute to and strengthen the existing trust deficit in Dumka.

5.2.3 ENGAGEMENT OF COMMUNITY IN HEALTH SERVICE DELIVERY

An overall trend in all the 10 villages was low engagement of the community, especially women, in health service delivery. The lack of awareness of women about VHSC and on discussing health issues in the gram sabha is indicative of this trend.

However, more *women were aware about VHSC* in villages of *Jamtara the* and better government communication strategies is one of the underlying reasons for this.

Table 5.8: Engagement of community in health service delivery

	Dumka	Jamtara
Women aware about VHSC	In all 5 villages women not aware about VHSC	In 3 villages women not aware about VHSC. In 2 villages however women were aware and posters on VHSC were available.
Health issues discussed in Gram Sabha	Gram Sabha not regularly held, and health issues not find prominence in the discussion	Gram Sabha not regularly held, and health issues not find prominence in the discussion

5.2.4 PERCEPTIONS OF SERVICE PROVIDERS ON THEIR PERFORMANCE

In both the districts the health service providers shared a number of common problems which they faced in effectively performing their roles. This included issues related to lack of awareness among tribal women inadequate and ill-equipped physical infrastructure, inadequate communication facilities, work overload, insufficient support infrastructure, inadequate capacity building and information support.

In addition, service delivery staff like ANMs and doctors in Dumka mentioned fear of travelling to Naxal affected areas, affecting availability of services to tribal women.

Table 5.9: Perceptions of health service providers

Service Providers	Dumka	Jamtara
ANM	• No delivery related facilities in the PHC/SHC • Aversion towards,institutional deliveries among tribal women • Mental fear towards naxals	• Mental fear towards naxals • Shortage of staff
SAHIYA	• Community mobilization a challenge • No boarding and lodging in hospitals • No honorarium • No cycles to commute • Stratified community	• No boarding and lodging in hospitals • No Cycles to commute • Corruption • Mobility dependent upon family • Lack of IEC Material • No SHG
AWW	• Decreased ration quantity • Lack of own AWC • Delayed Salary • Lack of play way material for mentally and physically challenged children	• Delayed Salary: • Immunization a tough task

5.3 ACCESS TO AND QUALITY OF EDUCATIONAL SERVICES

5.3.1 AVAILABILITY OF AND ACCESS TO EDUCATIONAL SERVICES

To compare Dumka and Jamtara district on the availability and access to education services it would be useful to first revisit the education infrastructure availability, as described in detail in Chapter 4 and 5.

Table 5.10: Availability and access to education infrastructure

Education Infrastructure	Dumka	Jamtara
Availability and approx. distance from tribal tola (within 1 km, within 5 km, within 10 km)		
Primary government school	Available to 4 villages; approx. distance within 1 kms In 1 village Paharia boarding school in 1 village within 3 kms	Available to all 5. villages; approx. distance within 1 kms
Private	Available to 2 villages; approx.	Not available to any of the 5 villages;

primary school	distance within 5-7 kms; children are set there	
Government Middle school	Available to all 5 villages; approx distance within 10 kms	Available to 3 villages; approx distance within 1 kms
Government transport facility	Easy public transport accessibility is a issue in few villages Within 5 km:1 school Within 5-10 km:2 schools More than 10km:2 schools	Easy public transport accessibility is a issue in few villages Within 5 km: Within 5-10 km:3 schools More than 10km:2 schools

Table 5.11: Availabity and access to education service providers

Service Provider	Dumka-5 villages	Jamtara-5 villages
• ***Available : Number and residence***		
Government Teachers	Approx 1 government teacher available in all 5 villages. In all 5 villages teacher resides at block level.	Approx 2-5 government teachers available in all 5 villages. In all 5 villages teacher teacher resides at block level
Para Teacher	Between 1-5 para teachers available in all 4 villages. In 2 cases para teacher resides in the village. No para teacher in one school.	1 para teacher available in 4 villages, while 1 para teacher available in 1 village. In all 5 villages resides in the village.
Women teachers available	Average 1 Women teacher available in 4 schools.	In 3 schools no women teachers available.
Teacher-student ratio	Average: 1:30	Average: 1: 40

Comparative Assessment:

Building on the above table, it will then be useful to compare both the districts, as attempted in the table below:

Table 5.12: Comparative assessment of availability of and access to educational services

Indicators	Commonality	Differences
Access to Education Infrastructure	• Government primary school was available within 1 km in almost all sample villages	• Dumka has a government middle school accessible to all the 5 sample villages, while in Jamtara it was accessible to 3 villages. • In Dumka, 2 villages have private schools between 5-7 kms where children did go, while in Jamtara no private school was available close to the sample villages.

Access to Education Service Providers	• In majority of the sample villages, there is availability of government teachers, para teachers and female teachers. In most sample schools, the teacher-student ratio is between 1:30 and does not exceed 1:40.	• In Jamtara, there is availability of more government teachers (2-5 teachers) In Dumka there is availability of more para teachers (1-5 teachers); in Jamtara the average is 1 para teacher. • In Dumka, however, of the available para teachers, in 1 village the para teacher did not reside in the village. • In Dumka, there is better availability of female teachers (4 schools have at least 1 female teacher); while in Jamtara 3 schools no female teacher was available.

Dumka had better access to private school facilities and also had a Paharia government boarding school in the village where a primary government school was not available.

Interestingly, in *Jamtara therewerea greater number of government teachers available*, while in *Dumka there were greater availability of para teachers and also women teachers*. One possible reason could be that the perceived unrest acted as a deterrent to teachers working in Dumka, and the gap in service was being addressed not only through more para teachers but also through the private schools. Having more female teachers, which includes both government and para teachers, is a positive trend.

5.3.2. QUALITY OF EDUCATIONAL SERVICES

To compare Dumka and Jamtara district on the quality of education services it would be useful to first revisit the quality of the educational services, as described in detail in Chapter 4 and 5.

Table 5.13 Qualities of education infrastructure and facility

	Dumka	Jamtara
• ***Condition*** • ***Cleanliness: Clean*** • ***Infrastructure availability: Available as per norm***		
School building condition	In 1 villages the schools available were not in good condition (pucca)	In 2 villages the schools available were not in good condition (pucca)(*iepoor condition, built on grazing land)*
Cleanliness	In 3 villages the schools were not clean	In all 5 villages the schools were clean
Infrastructure availability for students		
Chairs, tables, dari, blackboards	In 1schools *daris* were not available till class V In all schools blackboards were	In 1 schools *daris* were not available till class V In all schools blackboards were available

	available	
Tiolets availability and cleanlines	In all 5 schools Toilets were available till class V In 5 schools Toilets were not clean	In all 5 schools Toilets were available till class V In 5 schools Toilets were not clean
Play ground,electricity, water availability	In 5 schools play ground was not available In all 5 schools water was available In all 5 school electricity was not available	In 5 schools play ground was not available In all 5 schools water was available In all 5 schools electricity was not available

Table 5:14 Satisfactions with educational entitlements received

	Dumka	Jamtara
	• ***Quality: satisfied or not satisfied*** • ***Provision as per norms: satisfied or not satisfied***	
Quality of Midday Meal(MDM)	In 4 villages, majority of women were not satisfied with the MDM quality(regular mdm not available, children sent back to get MDM, not cooked properly) In 1 village, no MDM available	In 4 villages, majority of women were not satisfied with the MDM quality (poor quality, no variety) In one village no MDM running for past 2 months
Timely and accurate provision of scholarships - ie scholarship, free books, uniforms	In all 5 village, majority of women were satisfied with the books provision In 1 villages, majority of women were not satisfied with the stipend provision	In all 5 villages, majority of women were satisfied with the books provision In 4 villages, majority of women were not satisfied with the stipend provision (ie *not receive stipend, receive less stipend than stipulated*)

Table 5.15.Satisfaction with role and performance of service providers

	Dumka	Jamtara
	• ***Overall satisfaction with Teachers*** • ***Teacher Regularity and punctuality*** • ***Teacher behavior towards children***	
Satisfaction with Government Teachers	In all 5 villages, majority of women not satisfied with government teacher performance(irregularity, poor infrastructure, quality of teaching poor, tension between teacher and para teacher)	In all 5 villages, majority of women not satisfied with government teacher performance (i.e. poor infrastructure, poor teaching, teaching in hindi language etc.)

Satisfaction with Para Teachers	In 4 villages where para teacher available, in 3 villages majority of women not satisfied with para teacher performance (not teach properly, not stay in village)	In 3 villages, majority of women not satisfied with para teacher performance(poor quality teraching, para teacher Bengali thus discriminates against santhali children)
Govt Teacher Regularity and punctuality	In 3 villages, majority of women perceived the teacher as not regular	In 5 villages, majority of women perceived the teacher as regular
Para Teacher Regularity and punctuality	In available 4 villages,in 2 villages majority of women perceived the para teacher as not regular	In 5 villages, majority of women perceived the para teacher as regular
Teacher Behaviour towards children – physical or mental harassment	In 5 villages, majority of women satisfied with government teacher behaviour towards children (no case of mental or physical harassment by teacher reported)	In 5 villages, majority of women not satisfied with government teacher behaviour towards children (no case of mental or physical harassment by teacher reported)

Comparative Assessment:

Building on the above table, it will then be useful to compare both the districts, as attempted in the table below:

Table 5.16: Comparative assessment of quality of educational services

Indicators	Commonality	Differences
Women's Satisfaction with Education Infrastructure	• The majority of school buildings is in good condition, have theories and blackboards available, water and toilets • In all the 10 schools, however, the toilets are not well maintained, there are no separate toilets for girls and they do not have electricity and a playground.	• The schools in Jamtara are cleaner

Women's Satisfaction with Entitlements received	• In majority of the schools, tribal women were not satisfied with the midday meal being provided • The children in all the 10 primary government schools had received their textbooks.	• In Dumka, in all 5 villages women mentioned the ST children receiving the government stipend • In Jamtara, 2 women mentioned not receiving the stipend, and 2 women had concerns about the corrupt practices regarding release of the stipend
Women's Satisfaction with Performance of Service Providers	• In all 10 villages majority of the women were not satisfied with the government teachers. • In all the 10 villages, there was no case of physical or mental harassment of children by the teachers.	• In Jamtara, regularity and punctuality of government and para teachers was better

In Jamtara, regularity and punctuality of government and para teachers was perceived to be better than in Dumka. Further, schools in Jamtara were cleaner. An underlying reason could be irregularity of staff in Dumka due to the unrest. The tribal women of Dumka, however, were more satisfied regarding dispersal of stipends to ST children.

5.3.3 SCHOOL'S ENGAGEMENT WITH PARENTS

An overall trend in all the 10 villages was low engagement of the community, especially the women, in education service delivery. The low awareness among women *about SMC, PESA and Right to Education provisions, and lack of education issues being discussed in the gram Sabhaare indicative of this trend.*

Table 5.17: Engagement of community in education service delivery

	Dumka	Jamtara
Women aware about SMC	In all 5 villages women not aware about SMC	In all 5 villages women not aware about SMC
Parent –Teacher meeting held	In none of the 5 villages the meetings with parents were held.	In 2 villages meetings with parents were held.
Education issues discussed in Gram Sabha	Gram Sabha not regularly held, and education issues not find prominence in the discussion	Gram Sabha not regularly held, and education issues not find prominence in the discussion
Understanding about PESA	In all 5 villages women not aware	In all 5 villages women not aware
Understanding about RTI	In all 5 villages women not aware	In all 5 villages women not aware

5.3.4 PERCEPTIONS OF SERVICE PROVIDERS ON THEIR PERFORMANCE

In both districts the education service providers shared a number of common problems faced in effectively performing their roles. This included issues related to lack of awareness among tribal women, inadequate and ill-equipped physical Infrastructure, inadequate communication facilities, work overload, delays in salary being paid and dissatisfaction with disparities in pay between government teachers and para teachers.

Table 5.18: Perception of education service providers

Service Providers	Dumka-5 villages	Jamtara- 5 villages
Teachers	• Shortage of staff, • No timely payment of salary, • Non-teaching work (MDM) consumes more time • No punishment for the students who are irregular or absent, • No Recreational facilities • No basic amenities like electricity, water and toilets • Lesser enrollment of Santhali children. Due to engagement in household and field related work. *FGD member: The quality of teaching gets hampered as the teacher student ratio is very bad. Most of the time teachers are engaged in other type of administrative work.*	• Time consuming non-teaching work *(Population census, Cattle Census, Mid-day meal accounting, Income Tax, Loan disbursement and sanctioning of leave etc.)* • High teacher student ratio • Displeasure towards RTE provisions –Grading system • Non-teaching work (MDM) consumes more time and affects quality of work. *"The quality of teaching gets hampered due to high teacher student ratio and continuous engagement in the administrative work"*- Manoj Kumar Mandal, Para Teacher, Bakhudi Middle School
Para teachers	• Lack of cleanliness; • Low Salary of para teachers; • Low budget allocated for MDM per day per child. • Male teachers outnumber women teachers. ***Teresa Kisku para school teachers, Middle school Amgachi,*** *"My parents taught me so I am capable to teach. I feel more women teachers should be recruited to increase the enrolment of girls."*	• Need for capacity building for creative teaching methods. *"I find it difficult to retain the attention of children for such longer hours. When should be taught some methods and techniques to make children sit and study for longer hours."****Chandramuni Soren, Para Teacher, Rupaidi***
SMC	• To conduct meeting as no one participates in the meeting. • Meetings were conducted many times but no one came for the	• Miniscule or no participation of SMC members • Miserable condition of toilets.

	meeting this is the main cause of concern for the SMC chairperson *My child is enrolled in school for past two years but he doesn't know how to read and write hindi as well as English alphabets. I have conducted meetings many times but no one participates-* ***Khana Tudu, SMC Pressident, Sagbaheri***	• Tribal children fail in competitive exams (navodaya vidhyalaya) • High dropout among the girl child; • No parents come for the SMC meeting • No disciplinary action taken against the head teacher for not attending the school. *"The government officers who come to visit the school are only interested in the attendance of teachers, children and regularity of MDM they are not concerned about other problems teachers, students and SMC are undergoing. They don't talk to any of the community people while they are inspecting the school*" **Lal Kumar Jha, Nildaha**

5.4 ACCESS TO AND QUALITY OF ENTITLMENTS

To compare Dumka and Jamtara district on the access and quality of entitlement, it would help to revisit the entitlement data, as described in detail in Chapter 4 and 5.

Table 5.19: Access to and quality of entitlments

Access to entitlements	**Dumka (*7 women interviewed*)**	**Jamtara (*5 women interviewed*)**
Bank account	• 1 woman has a bank account	• 1 woman has a bank account
Awareness about benefits of BPL, Aadhar and Ration Cards	• Majority not aware about ration cards and its usefulness • 3 women were aware about the Aadhar card and its usefulness	• Majority (5 women) were aware about ration cards and its usefulness • 3 women were aware about Aadhar card and its usefulness
Entitlements available	• Yellow card (Antodaya card): 2 women. • Red card (BPL): 3 women • Orange card (BPL ration card): No women • Green card (APL): No women • Aadhar card process initiated in 3 out of 5 sample villages	• Yellow Card (Antodaya card): 2 women • Red Card (BPL): 1 woman • Orange card (BPL ration card): No women • Green card (APL): 1woman • Aadhar card process initiated in all 5 villages

Entitlements in whose names	• No women mentioned that in the village the ration card is in the name of women	• 1 woman mentioned that ration card was in her name. • 2 women mentioned that ration card was in husband's name

Comparative Assessment:

Data available from the interviews of 12 tribal women that women of both districts fare similarly vis-a-vis bank accounts, awareness and access to entitlements.

Table 5.20: Ease of getting entitlement

Ease of getting entitlements	**Dumka (*7 women interviewed*)**	**Jamtara (*5 women interviewed*)**
Difficulties in opening bank account	• All women shared difficulty in opening a bank account	• All women shared difficulty in opening a bank account
Problems related to getting BPL, Ration, and Aadhar Cards Made	• Most women shared difficulty in getting BPL card made • Majority did not face difficulty in getting ration card made • No women shared difficulty in getting Aadhar card made	• Women shared difficulty in getting BPL card made • Women shared difficulty in getting ration card made • No women shared any difficulty in getting Aadhar card made

Comparative Assessment:

From the data available all the women in both districts faced difficulties in getting these entitlements.

Table 5.21: Satisfaction with the provisions

Satisfaction with the provisions received	**Dumka (*7 women interviewed*)**	**Jamtara (*5 women interviewed*)**
Provisions Received Under Ration Card	• Rice and kerosene oil received by as per entitlements by the women possessing a ration card	• Rice and kerosene oil received by as per entitlements by the women possessing a ration card
Satisfaction with the Ease and Quality of the Rations	• Majority women not satisfied	• Majority women not satisfied

Comparative Assessment:

From the data available, all the women in both districts were not satisfied with the ease and quality of the provisions available against the ration card.

5.5 INSIGHTS ON IMPACT OF UNREST ON SERVICE DELIVERY FOR TRIBAL WOMEN

On the basis of the comparative analysis, some insights can be drawn on the impact of the ongoing Naxal activities on the access and quality of development services.

Access to and availability of physical infrastructure

- *Access to government transport facilities like Mamta Vahan is more difficult in districts with hilly terrains and dense forests.* These districts also have a higher incidence of Naxal/Maoist activities.This trend was evident in the study, with tribal women in Dumka facing more problems in accessing the Mamta Vahan.

- *Availability of private service infrastructure at the village level is better in districts and blocks with greater unrest incidences.* This trend was evident with more villages in Dumka having private schools at the village level. This can be attributed to the fact that for private service providers' service outreach and profit margin overrides the perception of fear and insecurity of the staff. Further, ineffectiveness of the state service infrastructure creates a viable demand for their service.

Access to and availability of service providers

- *Access to government service providers at village level is relatively more difficult in the district and blocks with greater unrest incidences due to fear and insecurity.* This is supported by the findings that there was comparatively greater and more regular access to village health service providers like ANM, AWW and government teachers in Jamtara than in Dumka. In Dumka the unrest environment is a possible contributing factor affecting service providers like ANM and teachers residing in the village, or to commute daily to the villages to work.

Quality of physical infrastructure

- *There is higher dissatisfaction among tribal women with the state enabled service infrastructure in higher unrest areas*. The findings reflect that in Jamtara tribal women had greater satisfaction with state health infrastructure, especially with the SHC and district hospital. Women in Dumka accessed and approached private clinics more and perceived them as more important in health service delivery. In Jamtara schools are cleaner. A reason for this could be irregularity of the staff in Dumka.

- *The perceived preference for private service infrastructure and providers is higher in district with relatively higher unrest.*The findings reflect that more women in Dumka perceive private clinic as well as private doctors as important. Similarly, more parents send their children to private schools in Dumka than in Jamtara. This trend thus reflects greater incidence of declining trust, as well as dissatisfaction of tribal communities with state delivery systems in unrest regions.

Quality of service providers

- *There is higher dissatisfaction with the performance of state service providers in higher unrest areas***.** This trend is reinforced by the finding that women in Jamtara were more satisfied with government service providers like doctors and Sahiyas. In Dumka, there was a greater preference for private doctors. In Jamtara the regularity and punctuality of government and para teachers was perceived to be better than in Dumka. A plausible reason for the better and regular performance of government service providers could be a safer work environment in Jamtara

- *In difficult and inaccessible areas, village level state para workers like the Sahiya, AWW and para teachers become very important* as they are from the community and more accessible. Also, the role of the "jholawala doctor" to treat minor ailments is also seen as very significant in the rural service delivery mechanism.

- *More effective performance of targeted government development initiatives for primitive tribes.* The population of primitive tribes like the Mal Paharai is more in Dumka district TheJharkhand welfare department thus has special schemes targeted at these primitive tribes. A doctor visited the Paharia Health Centre twice a month as compared to no visit by a doctor to the SHC in Jamtara. The benefit and effective implementation these schemes are evident by the perception of greater satisfaction with the Paharia government boarding school in the villages and the Paharia Health Centre, as compared to other development institutions and services in Dumka district.

CHAPTER 6

BARRIERS IN ACCESSING DEVELOPMENT SERVICES

6.1 BARRIERS PERCEIVED BY TRIBAL WOMEN

6.1.1 COMMUNITY BARRIERS

6.1.2 DELIVERY SYSTEM BARRIERS

6.1.3 BARRIERS DUE TO UNREST

6.2 BARRIERS PERCEIVED BY SERVICE PROVIDERS

6.2.1 COMMUNITY BARRIERS

6.2.2 DELIVERY SYSTEM BARRIERS

6.2.3 BARRIERS DUE TO UNREST

6.2.4 BARRIERS DUE TO POOR GOVERNANCE

6.3 CONCLUSIONS

CHAPTER 6

The study analysed the barriers to service delivery experienced by tribal women based on their perceptions as well as those of service providers. The barriers identified to support findings of other studies (Rana and Das, 2004; Jha and Jhingran, 2005; Rani, Ghosh and Saran, 2007; Arvind, 2008) which have explored access and quality of different development services by tribal women of Jharkhand and other marginalized areas.

6.1 BARRIERS PERCEIVED BY TRIBAL WOMEN

Participatory methods were used to help tribal women collectively reflect on the current status of access and quality of basic services – health (with a focus on maternal and child health), primary education and entitlements of BPL, ration and other cards. They were also facilitated, individually and collectively, to critically analyze the perceived barriers which obstructed the timely and quality delivery of these services.

The barriers identified by the tribal women have been grouped under the following heads:

- *Community barriers*
- *Delivery system barriers*
- *Barriers due to unrest*

6.1.1 COMMUNITY BARRIERS

- ***Socio-cultural dimension***: The inadequacy of awareness among a number of tribal women about the need for immunization, contraception, benefits of institutional delivery and opening of bank accounts prevented them from readily accessing the services of the state delivery system. Some traditional beliefs (not being able to work in the fields after an operation, or not bringing their children for immunization if they are crying, or that the child will get fever on being immunized) also created obstacles to accessing government and private institutions service delivery systems.

  Existing discrimination and tension within the tribal community and between tribes and non-tribes of the same village were another barrier identified by the tribal women. In Amgachi, the underlying tension between the Muslim and Santhali communities resulted in the Muslim AWW not providing equal nutrition to the non-Muslim children, thus acting as a barrier to Santhali children accessing anganwadi services. Similarly, in Jamtara, there was discrimination and untouchability practiced among the Bengali and Santhal communities, with the latter being treated as inferior. This again impacted their access to health services.

- ***Economic dimension*****:** Poverty was seen as an important barrier to women accessing quality educational and health services. For example, women were forced to migrate to other states due to unavailability of jobs. Migration thus impacted children who then did not attend school regularly, led to also human trafficking and losing one or multiple days' wages impacted access to the government hospital at the block/district level. Poverty is also one of the causes for more girls dropping out of school after the primary stage.

- ***Information dimension***: A number of women mentioned that they were not aware of the different development schemes available to them, such as the different central and state development schemes in health and education (NRHM, ICDS, SSA, etc.) And of provisions/entitlements in acts like PESA, RTE and Right to Information.

- ***Education dimension***: Women felt their illiteracy impacted the provision of adequate support to their children. It also impacted their accessibility to government hospitals as they hesitated to interact with the doctors and other hospital staff.

- ***Gender dimension***: Santhals follow the patrilineality system, where an individual belongs to his or her father's lineage. In that context in most cases women shared that they did not go to the government hospital alone and needed a male escort. In cases where the woman's husband was uninterested and apathetic towards her health, the woman's health was affected. In most cases the bank account and ration card was in the name of the husband, and many women shared that they did not have a say in key household decisions. Mostly male members of the family were seen sitting idle at home, with women being were primary bread earners. Husbands however took their money forcefully and spend the money in alcohol. This sharply demonstrates the position of women in the household and the vulnerabilities shared by them.

  Customs like early marriage, which were earlier not part of the tribal cultural milieu, have further sharpened the gender divide with girl children being married off at an early age, thus being forced to leave their study incomplete. This is becoming a significant barrier to their access to educational and health services. There were also incidences narrated of preference for sons, leading to multiple pregnancies. Girl children dropping out after primary school is yet another indication of gender based discrimination, with the girl child being constrained to play the gender determined roles of taking care of the household and siblings.

  The other discrimination practiced against tribal women is the *Dayan Pratha* (witchcraft). The Ojhas, Sokhas, Bhagats and other influential people brand a female member of a particular family as a *dain* (witch) who is said to be responsible for the illness, calamities and deaths in the community. The real motive of the killers is to grab the property or to settle personal scores with the victims. They brand the female

member as doing so that they are able to muster the support of the co-villagers in torturing and killing the victims. The innocent villagers believe that the woman is responsible for the illness, death, drought and despair that overwhelm their lives. (National Commission for Women, 2013)

- ***Confidence dimension***: Though not overtly articulated, lack of confidence and space to take decisions on accessing health, education and economic services do act as barriers to women raising complaints about teacher irregularity, or lack of medicines in the SHC/PHC, in attending SMC meetings or raising these issues in gram sabhas.

  The women mentioned being "afraid to complain" and being "silent observers". In Jiathar, while conducting the FGD, the majority of women shared instance of the rude and unfriendly attitude they face when they go to the government hospital at the block level. This inhibits them from going to the government hospital and they thus needed an educated escort to go with them.

- ***Trust dimension***: The lack of trust in government institutions and service providers is an important perceived barrier, especially in areas more prone to unrest. There was also evidence of lack of trust among the tribal women in the government service delivery mechanism. This was evident in their statements about the medicines in the SHC and PHC not being effective to treat their ailments, the poor capacity of the Sahiyas and para teachers, or the corrupt practices of the ANM. The lack of trust was implicit in many cases where the tribal women trusted the "jholawala doctor" (quack) more for minor ailments than the ANM or the government doctor.

6.1.2 DELIVERY SYSTEM BARRIERS

- ***Resource constraints and system inefficiency leading to inadequate and ill-equipped physical infrastructure***: A number of women mentionedlack of or inadequate provision of infrastructure (as per the relevant scheme and program) as a significant barrier to accessing that service. The physical infrastructure included availability of buildings (SHC, PHC, primary school, pucca anganwadi, PDS shop). In many cases, absence or inadequate availability of relevant facilities and amenities like playground and functional toilets in primary schools, beds and relevant medicines in SHCs and PHCs, and absence of toilets in anganwadis were shared as reasons why the women did not use those services.

- ***Poor maintenance of physical infrastructure***: Apart from lack of physical infrastructure, poor maintenance of the physical infrastructure (dirty linen in the PHC/SHC, unclean classrooms) was also a deterrent for many tribal women. For example, although the PHC

is 5 kms from Jiathar village and the district hospital is 8 kms away, women prefer travelling the longer distance to the hospital as there is no full time staff in the PHC nor does it have stock of relevant medicines.

- ***Inadequate communication***:In inaccessible villages and villages which are far away from services like the Community Health Centre, government hospital and government middle school, the lack of metalled roads and regular public transport was another important barrier. Though the Mamta Vahan was considered a good initiative of the government to provide support to pregnant women, in hilly areas like in Uppar Murgathali its access was restricted. Further, lack of other transport means also restricted access of tribal women to health service delivery.

- ***Procedural Barriers***- These included issues like the timing of the SHC and PHC being opened not suiting the tribal women. The SHC and PHC are opened only during10 am - 1.00 pm, which is also the time in which the tribal women are occupied in their household and livelihood aspects. The fact that medium of teaching in the primary school is Hindi, also adversely impacts the learning levels of the tribal children, who are more conversant with their tribal dialect. The local para teachers are only partially successful to bridge this language gap. This affects the motivation of the child to come to school regularly.

- ***Inadequate and ineffective human Infrastructure***: In addition to inadequate and poorly maintained physical infrastructure, non-availability of adequate number of staff in the health, education and administrative machinery was shared as an underlying reason for many women not accessing and using these services regularly. The lack of stipulated teachers in government primary schools and doctors in the Community Health Centers resulted in long queues at the hospital and students playing during school hours as there was only one government teacher to teach multiple classes.

- ***Behavior of service provider***: In many instances women mentioned not accessing government health and education services due to the rude behavior of the government health staff and government teachers. In addition, irregularity and indifferent attitude of the teachers and ANM, the corrupt practices of the ration shop owner and the mukhiya when making BPL cards, and the discriminatory practices of the AWW all contributed to creating an environment of distrust among the tribal communities.

- ***Ineffective system of parent engagement***: The ineffective system of engaging with the tribal communities by the health and education service providers is another barrier. It includes the ineffective functioning of the SMCs and VHSCs, lack of visits by the teachers to the homes of the students, and non-invitation of parents to school functions. This impacted the trust between the state institutions and the tribal communities, especially the women.

6.1.3 BARRIERS DUE TO UNREST

Discussions with tribal and non-tribal women in Naxal affected blocks in both districts, as well as the comparative analysis between Dumka and Jamtara districts, reveals that the unrest or insecure environment does affect delivery of government services like health and education to a certain extent. The underlying reason was fear on part of the service providers to go to these villages, rather than fear on the part of the users to avail these services.

The tribal women shared that the environment of fear and insecurity was affecting the residence of ANMs and teachers in the villages, and also prevented some of the ANMs from coming to their villages in the evenings and at night.

None of the tribal women however shared that they felt afraid to go the SHC or PHC, or send their children to school fearing the Naxals. None of the women, individually or in groups, shared any incident where the Naxals stopped tribal women and men from accessing government health and education services or receiving their economic entitlements such as rations. In some cases, the tribal women shared being more fearful of the police and their interrogation. In Amgachi village, where an encounter between the police and the Naxals had taken place a few years back, the tribal women and men shared that the government service providers are apathetic to the problems of the village, and they were not trusted by the police, with the later visiting them regularly to interrogate.

6.2 PERCEIVED BARRIERS BY SERVICE PROVIDERS

With the help of semi-structured interviews, a chosen sample of government health, education and entitlement service providers at village, block and district levels provided their insights about access to and quality of services, and the barriers they perceived in ensuring the same, especially to tribal women. The responses at the block and district levels help understand the situation beyond the 10 sample villages.

The barriers identified by the service providers can be grouped under the following heads:

- *Community barriers*
- *Delivery system barriers*
- *Barriers due to unrest*
- *Barriers due to poor governance*

6.2.1. COMMUNITY BARRIERS

- ***Socio-cultural dimension***: These related to the socio-cultural context of the tribal women. It included the health service providers' own language barrier in not being able to communicate with the tribes in Santhali, a fact highlighted by the District Education Officer of Jamtara. Traditional beliefs and practices – of tribal women hiding their pregnancies, not using contraceptives, using traditional health practices to treat ailments and for post-natal care, use of *dhatura* plant leaves for any kind of body pain or applying chopped leaves of the brandy plant to warm the body of a newborn child and mother, and not preferring institutional deliveries – were shared as obstacles by a number of ANM and Sahiyas. Intake of *Mahua and madha* traditionally by tribal men and women was also perceived as potential barriers to accessing services. As one Pradhan stated: "Use of Mahua *cripples them both mentally and physically to engage in any kind of productive work, and to access development services."*

  Discriminatory practices within the villages in the form of untouchability wasrecognized as a barrier by the service providers too. Child Development Program Officer (CDPO) Jamtara highlighted that prejudice and discrimination in the form of untouchability among the Bengali and Santhal communities was affecting the use of government services by the tribal communities. A teacher in a school in Chirudhi stated that an increasing number of Muslim children in the school have affected regular attendance of Santhali children.

- ***Economic dimension***: Economic barriers were also articulated by some education service providers. According to some teachers, abject poverty drives most families migrate or engage their children in work, thus impacting the regularity of attendance of the child in school. During the harvest season, the need for additional hands in the fields also affects the attendance of children.

- ***Information dimension***: A number of service providers such as DC of Dumka district and CDPO of Jamtaramentioned lack of information about government schemes and legislation as a significant barrier.

  "The main problems that have blocked the development of this area are illiteracy among masses and lack of knowledge of various legislation to assert their rights." – Munni Hasda, Zilla Parshad Member, Jamtara

- ***Education dimension***: Few service providers, at village, block and district levels, mentioned illiteracy of the tribal women and parents as a key structural barrier. The underlying rationale given by some service providers was that illiteracy was the reason for sub-optimal use of the health and education services of the government. According to one teacher, illiterate parents cannot provide guidance to their children at home.

Another teacher mentioned that parents send their children to school to get the midday meal, and not to educate their children.

- ***Gender dimension*:** The barriers evident due to gender inequality and gender discrimination within homes, communities and institutions was mentioned by only a few service providers. The Sahiya of one village mentioned that fewer women participate in village meetings and men do not allow women to attend awareness generation meetings. In Antipur, a teacher also shared the impact of early marriage on girl child education. Gender constraints also impact the functioning of the service providers at the village level. For example, the Sahiya of Nildaha village, Kalpana Mandal, wanted to show the researcher team the medical aid box, bag and the outfit she received after she became a Sahiya. Her husband, however, thought there was no need for this and sternly asked her to go inside.

- ***Trust dimension*:** The trust deficit between the tribal communities and the service providers was mentioned by few village level service providers like the Sahiya. The Sahiya of one village mentioned that there was a perception among the community that she gets a lot of money and materials which she is reluctant to distribute. She shared the lack of trust and disrespect towards the institution of the Sahiya in comparison to the traditional healer and "jholawala doctor". The presence of the community based organizations was negligible in the filed, and there was a sense of lack of trust between the NGOs and the Government Officials.

6.2.2. DELIVERY SYSTEM BARRIERS

- ***Resource constraints and system inefficiency leading to inadequate and ill-equipped physical Infrastructure*:** Similar to the barriers perceived by the tribal women, a number of service providers also mentionedlack of or inadequate provision of infrastructure (as per the relevant scheme and program) as a significant barrier to service access. These included lack of buildings, toilets, playgrounds, beds, medicines, medical kits, baby weighing scales, materials/aids for Nutrition and Health Education (NHED) and delays in supply of items for supplementary nutrition.

  CDPO Jamtara mentioned lack of anganwadi buildings which curtailed proper functioning of the centre, a view which was echoed by District Social Welfare Officer (DSWO) Jamtara, who also highlighted that ill-equipped anganwadis affect the effective implementation of the ICDS program. In three villages (Chirudi, Antipur, Nildaha), a need for mini anganwadis was raised by the majority of the women in the FGDs.

- ***Inadequate communication facilities***: Lack of adequate transportation facilities for women in inaccessible areas and for ANMs was shared as another important barrier in

two cases. The ANM of Uppar Murgathali stated that the Mamta Vahan cannot reach the village due to the topography. As a result, pregnant women are taken lying on a cot down the hill to the road where the Mamta Vahan awaits (a distance of 1 km).

- ***Inadequate and ineffective human infrastructure***:A large number of service providers highlighted barriers related to human infrastructure. They have been classified as:

  Less staff and work overload: The deployment of less than required staff in the education and health services, especially at the level of the SHC and PHC and government schools, was seen as putting extra pressure on existing human resources, thus affecting their performance. Similarly, dual charges by officials like the DSWO, and election duties to be performed by Block Development Officers (BDOs) were also mentioned as constraints by the service providers.

  In Jiathar, a teacher mentioned that the majority of their time was engaged in providing the midday meal and other administrative work, thus affecting their teaching responsibility. The ANM highlighted managing the PHC single-handedly and meeting targets due to shortage of doctors at the PHCs (the doctors come only when there is a health camp or in the mobile health van).

  Salary delay and dissatisfaction: Delayed compensation to service providers like teachers and AWWs and the salary discrepancy between government teachers and para teachers affects the motivation of the service providers to effectively play their roles. In Jaithar, it was shared that the government teachers had not received their salaries for the last three months.Delayed compensation was also a complaint shared by the AWWs, with most of the AWWs interviewed saying that their salaries were pending for two to three months.

  In Anthipur, teachers shared that the discrepancy in the salaries of para teachers (Rs 5000) and government teachers (Rs 40000) had created dissatisfaction among the para teachers, who had gone on strike. The para teachers feel that they invest equal time and energy and are always available in the school; then why do government teachers get paid more?

  Insufficient support infrastructure: Lack of support infrastructure also negatively affects motivation and performance of service providers. Views shared included lack of rest rooms or food allowance from government hospitals for Sahiyas escorting pregnant women to the hospital and in some cases non-availability of cycles for Sahiyas.

  Inadequate capacity building and information support: Lack of adequate pre-service and in service training of village level workers like para teachers, Sahiyas and AWWs was shared as a constraint by some service providers. Lack of relevant knowledge and skills to effectively play their mandated roles resulted in ineffective performance.

- **Inappropriate behavior of service providers**: This component was mentioned only by one or two senior level service providers. It was shared that the lack of understanding of the language and sensitivity to the cultural context of the tribal communities created a barrier between the tribal women and service providers. This was highlighted by CDPO Jamtara as the reason affecting performance of ANM and teachers. According to DEO Jamtara, inadequate interaction of teachers with parents needs to be addressed. One Sahiya also mentioned the corrupt behavior of some health staff in government hospitals.

- **Ineffective system of parent engagement**: This was also raised as a barrier by the service providers, similar to that raised by the tribal women. DEO Jamtara highlighted that SMCs do not perform their role properly at the village level. According to District Gender Coordinator (DGC) Dumka, there was less to no participation in the SMC meetings conducted at the village level. Sahiyas highlighted that reproductive health training, especially the use of contraceptives, was not very effective imparted to the tribal women. It was shared by teachers that there was a poor interaction of parents with teachers, women did not participate in SMC meetings and the SMCs were not functional.

6.2.3. BARRIERS DUE TO UNREST

Interviews with government service providers in the Naxal affected blocks in both districts revealed that the environment of unrest or insecurity did to some extent affect the delivery of government services like health and education.

Despite the recognition that Naxals have not hurt or stopped any health and education services, the perceived environment of unrest, fear and insecurity serves as a deterrent for village level service providers like ANMs and teachers from taking up residence within the village, a case highlighted well in the comparative analysis of Dumka and Jamtara districts. Further, it also impacted the availability of ANMs or doctors in the unrest sensitive regions after dark.

One doctor in the Community Health Centre at Kathikund stated candidly that the impact of the confrontation between the police and Naxals a few years ago in Amgachi village has resulted in health staff following the 10 am to 3 pm office timings strictly. ANMs in these unrest areas try to avoid commuting during night or late evening. He mentioned that the health staffhas to be very cautious about their behavior with the patients who come for treatment, as there is an implicit fear that they may be Naxals. BDO Dumka highlighted the need fordoctors to visit villages, especially in villages which are hard to reach and infested with Naxalites.

The Civil Surgeon of Dumka however mentioned that health service providers are not affected or attacked by Naxals as these services benefit the families of the Naxals as well.

Nonetheless, visiting Naxal affected regions does prove to be de-motivating for village level staff like ANMs. This fact was supported by one of the ANMs of Kathikund block of Dumka district when she mentioned that hilly terrain and remote areas with Naxals create an underlying fear of working in the villages of this block. Doctors and ANMs have received calls from the Naxals to deliver medicines for members of the cadre or their families, but the Naxals did not harm them.

The ANM at Chirudi PHC, which is under Naraynpur block and is affected by Naxal activities, has a residence within the PHC compound. She mentioned that Naxal leaders have taken her to their villages to facilitate childbirth and deal with health related emergencies; however they have not harmed her, as they are aware of her commitment to her work and the villages.

4. BARRIERS DUE TO POOR GOVERNANCE

The Jharkhand Panchayat elections were held in 2010, a decade after the formation of the state. The capacity and performance of the recently elected Panchayat members however leaves a lot to be desired. Issues of ineffective functioning and corrupt practices of Panchayat members were shared by the respondents, including the traditional pradhans. Further it was seen that the elected women representatives were also not aware about various aspects of the functioning. They were not aware about the schemes, legal rights of women, mechanism of the fund flow, etc. There was also negligible presence of the women in the Gram Sabha meetings .In addition, the PESA, 1996 Act provisions were not effectively operational on the ground. A large number of service providers and nearly none of the tribal and non-tribal women were aware of PESA provisions.

The lack of effective functioning of panchayati raj institutions at the village level and inactive gram sabhas is leading to unsuccessful village level planning, inadequate discussion on and inequitable implementation of development programs and schemes, and lack of accountability of service providers to the gram Sabha and elected Panchayat members. These barriers to effective governance affect service delivery.

Ineffective local self-governance was mentioned as a significant barrier by the traditional pradhans. They mentioned that gram sabhas were not held, in the absence of which many issues such as selection of beneficiaries for welfare cards, discussion on schemes, etc., were not addressed or debated. The elected mukhiya does not play an active role; the traditional Pradhan has a role limited to collecting land revenue and submitting it to the revenue department. Zilla Parishad Chairperson, Jamtara mentioned that the attitude of government functionaries towards panchayati raj institutions is unhelpful and discouraging. Further, the elected Panchayat representatives at each level are unaware of the provisions of PESA, which gives a central role to the gram Sabha in the development of villages and hamlets.

The perceived unrest between the traditional pradhans and the elected panchayat representatives supports studies which detail the tension between the traditional leadership structure involving hereditary, non-elected headmen (pradhans) and the elected panchayat system, especially as the traditional system was patriarchal and feudal and women were not allowed to hold positions of political power (Sunder, 2005).

In the absence of active Panchayat members, with special focus on electing women, and an empowered gram Sabha, effective village level planning based on the expressed needs of the community, demand for timely and quality development services in the community, and pressure on different service providers to be accountable and respond to the demands of the community will not occur.

6.3 CONCLUSIONS

The table below attempts to provide a comparative picture of the perceived barriers, building on the voices of both the tribal women as service users and government service providers.

	Tribal women's perspective	**Service provider's perspective**
1.Community System Barriers		
Socio-cultural barrier (awareness)	Yes	Yes *(greater emphasis*)
Economic barrier	Yes	Yes
Information barrier	Yes	Yes
Education barrier	Yes	Yes
Gender barrier	Yes	Yes
Confidence barrier	Yes	
Trust barrier	Yes	Yes
2 Delivery System Barriers		
Physical infrastructure	Yes	Yes
Communication facility	Yes	Yes
Human infrastructure	Yes	Yes *(greater emphasis)*
Behaviour of service providers	Yes *(greater emphasis)*	Yes
System of community engagement	Yes	Yes
3 Barriers due to unrest	Yes	Yes *(greater emphasis)*
4. Barriers due to poor Governance		Yes

Commonly perceived barriers: From the table we can conclude that there are some barriers which are perceived as significantly by both service users and service providers. Within barriers, however, the emphasis variation between the two sets of respondents. Thus different service providers perceive existing cultural barriers of the tribal communities and human infrastructure barriers within their departments as much more significant. For the

tribal women, the behavior of the service provider held greater importance as a barrier to accessing a service. The commonly articulated barriers need to be studied in greater detail and ways to address them need to be prioritized.

Differently perceived barriers: There are some barriers which were articulated by only one set of respondents. These include convergence and local governance deficit barriers which were articulated by service providers and the lack of self-confidence perceived by the tribal women.

Comparative assessment: In general, barriers are perceived by the tribal women using the individual lens, while the institutional lens is used more by service providers. Both these lenses are important to find appropriate and sustainable solutions to reduce or remove these barriers.

CHAPTER 7: CONCLUSIONS AND RECOMMENDATIONS

7.1. STATUS OF DEVELOPMENT SERVICES FOR TRIBAL WOMEN

7.1.1 GENERAL TRENDS

7.1.2 COMPARATIVE ANALYSIS: IMPACT OF UNREST ON ACCESS AND QUALITY OF SERVICES

7.2. BARRIERS TO SERVICES

7.2.1 BARRIERS AT THE LEVEL OF THE COMMUNITY

7.2.2 BARRIERS AT THE LEVEL OF THE SERVICE DELIVERY SYSTEM

7.2.3 BARRIERS DUE TO EXISTING UNREST

7.2.4 BARRIERS DUE TO POOR GOVERNANCE

7.3. RECOMMENDATIONS

7.3.1 CAPACITY ENHANCEMENT OF TRIBAL WOMEN

7.3.2 SENSITISATION OF TRIBAL COMMUNITY

7.3.3 STRENGTHENING SYSTEM TO ADDRESS INFRASTRUCTURE DEFICIT

7.3.4 CAPACITY ENHANCEMENT OF SERVICE PROVIDERS

7.3.5 STRENGTHENING SUPPORT SYSTEMS FOR SERVICE PROVIDERS

7.3.6 STRENGTHENING ENGAGEMENT WITH TRIBAL COMMUNITY

7.3.7 STRENGTHENING LOCAL GOVERNANCE IN TRIBAL COMMUNITIES

7.3.8 STRENGTHENING INTERNAL AND EXTERNAL MONITORING SYSTEMS

7.3.9 STRENTHENING CONVERGENCE FOR EFFECTIVE DELIVERY

7.3.10 STRATEGIES TO PREVENT UNREST

7.3.11 SUMMARY RECOMMENDATIONS

7.4 CONCLUSIONS

CHAPTER 7

7.1. STATUS OF DEVELOPMENT SERVICES FOR TRIBAL WOMEN

7.1.1 GENERAL TRENDS

The status of development services for tribal women across the 10 sample villages, covering both Dumka and Jamtara districts, is as follows:

Availability of and Access to Services

- In majority of the villages *physical infrastructure is available* at the village level, such as sub health centre, primary health centre, government primary school, and *anganwadi* centre. The physical infrastructure at the village level is primarily a government infrastructure in both health and education services, with private clinics available at the block level. Private primary schools were available in only 2 villages.

- In majority of the villages'*access to village level physical infrastructure* (health and educational buildings) was within walking distance, as these institutions are available within 5 kms from the tribal *tolas*. For accessing block and district level facilities, ready availability of transport facilities is an issue of concern for most villages, especially for the more inaccessible villages. *Mamta Vahan* was accessible in most of the 10 villages.

- In a majority of the villages the *village level availability of government service providers* like Auxiliary Nurse Midwife (ANM), *Sahiya*, anganwadiworkers (AWW) was as per the program mandate. In case of primary government teachers, however, the numbers were lower than the mandated requirement. The staff deficit however was being overcome by recruitment of para teachers, who are paid a lower salary than the government teachers.

- The tribal women had reasonableease of*access to the government village level service providers* like ANM, *Sahiya*, AWW, teachers and para teachers, in the ten sample villages. In most villages the service provider resided in the village, e.g., *Sahiya*, AWW and the para teachers, which aided accessibility. The ANMs in most cases visited the villages at least once a month, as mandated, and in 2 cases the ANM stayed in the village. The village level service providers could thus be approached whenever needed. The access to doctors however was not as easy, as doctors were primarily found only at the block and district levels.

Quality of Services

- In majority of the villages the *tribal women were not very satisfied with the quality of the village level physical infrastructure and development facilities, particularly* SHCs, PHCs, and primary schools. In the case of *anganwadis*, however, in 5 out of the 10 villages majority of the women were satisfied with the facility. Reasons for dissatisfaction with the development facilities included poor medical equipment in the SHC and PHC; lack of electricity and playground, and poor maintenance of toilets in the schools; and absence of basic amenities and learning material in anganwadis.

- In majority of the villages, a large number of *tribal women expressed dissatisfaction with the performance of the government service providers* like *Sahiya* (*dissatisfaction in 8 villages*), AWW (*dissatisfaction in 6 villages*), teacher (*dissatisfaction in 10 villages*) and para teachers (*dissatisfaction in 6 villages)*. Concerns included their lack of regularity, limited capacity to undertake their mandated roles, their lack of commitment to their role, corruption and at times a discriminatory attitude of AWWs and Sahiyas towards tribal communities. Interestingly, in majority of the villages the tribal women were satisfied with the performance of the ANM in undertaking her mandated role, and the performance of government doctors, when the latter were approached.

- In all the 10 villages *"jholawala doctors" (quacks/unregistered medical professionals)* were available and were considered important by most tribal women of 7 villages. Most of the women were satisfied with their services. This could be attributed to their ease of accessibility and their rapport-building behavior which inculcated trust among the tribal women. Interestingly, in the majority of villages, traditional healers were not perceived as important in addressing minor and major health ailments of the women.

- In both the districts, *access to select government entitlements* was poor. The majority of the 12 *women interviewed did not have a bank account* in their name. Most women however did have access to one of the economic entitlement cards (APL, BPL, ration and *Antyodaya* card). A positive finding is that the process for identification to get an *Aadhar* card had been initiated in all the sample villages. In both the districts, *the performance of the PDS centre was also an area of concern for the women.*

Community Engagement with Services

- In both districts the performance of the *sectoral community committees* like the School Management Committee (SMC) and the Village Health and Sanitation Committee (VHSC) was poor, with large number of women not being aware of their existence. These

community institutions were thus not effectively playing the role of bridging the gap between the service providers and the service users.

- Engagement of the larger *community in ensuring quality delivery of education and health services* was also found to be poor, with development issues not being discussed in panchayat meetings, the gram sabha not being held regularly, etc.

- In both the districts, the tribal women had *very little awareness of the different development schemes* (such as *Sarva Shiksha Abhiyan*) operational in the districts. There was awareness of the *Jannani Surksha Yojna* and the midday meal (MDM) scheme. They were not aware aboutthe Right to Education Act, 2009 and the PESA Act, 1996.

7.1.2 COMPARATIVE ANALYSIS: IMPACT OF UNREST ON ACCESS AND QUALITY OF SERVICES

The research undertook a comparative assessment betweenthe service delivery status of the sample tribal women in Dumka and Jamtara district, with Dumka hasa higher incidence of Naxal/Maoist activities. The finding reflects the following insights on impact of unrest on service delivery:

Access to and availability of physical infrastructure

- *Access to government transport facilities like Mamta Vahan is more difficult in the district with inaccessible hilly terrains and forests.* These are unfortunately also districts which tend to have a higher incidence of Naxal /Maoist activities.This trend was evident in the study. Dumka has more hilly terrain and is more densely forested than Jamtara. Accessibility to the *Mamta Vahan* for tribal women in Dumka was comparatively more of a problem than in Jamtara.

- *Availability of private service infrastructure at the village level is better in the district and blocks with greater unrest incidences, as compared to other district.* The gaps in the state service infrastructure create a viable demand for private services. More villages in Dumka had private schools at the village level in comparison to Jamtara where none of the sample villages had any private schools. This can be attributed to the fact that for private service providers, the profit to be made by providing the service overrides the perception of fear and security staff.

Access to and availability of service providers

- *Access to government service providers at village level is relatively more difficult in the district and blocks with greater unrest incidences due to a higher perception of fear and insecurity.* This is supported by the findings that there was comparatively greater and

more regular access to village health service providers like the ANM, AWW and government teachers in Jamtara than in Dumka. An underlying reason could be that in Dumka the unrest environment is more intense contributing to fear and resistance of service providers like ANM and teachers to live in the village, or to commute daily to these villages for work.

Quality of Physical Infrastructure

- *There is higher dissatisfaction among tribal women in the state enabled service infrastructure in areas with higher unrest*. The findings reflect that in Jamtara the tribal women have greater satisfaction with the state health infrastructure, especially with the SHC and the district hospital than the tribal women of Dumka district. Interestingly the private clinics were approached more and perceived as more important in Dumka, than in Jamtara. Further it was also found that the schools in Jamtara were better maintained than the school buildings in Dumka. One underlying reason for this could be an irregularity of attendance of education staff in Dumka due to higher unrest.

- *The perceived preference for private service infrastructure and providers by tribal women is greater in the relatively higher unrest district, Dumka.* The women of Dumka approached and considered private clinics more important. Similarly more parents sent their children to private schools in Dumka than in Jamtara. This trend thus reflects greater decline in trust as well as dissatisfaction of tribal communities with the state delivery systems -- a consequence of and a reason for the unrest.

Quality of service providers

- *There is a higher dissatisfaction of tribal women with the performance of the state service providers in areas of higher unrest***.** Tribal women in Jamtara were more satisfied with government service providers like government doctors and *Sahiyas*, while the perceived performance of private doctors was more satisfactory for the women in Dumka. In Jamtara, regularity and punctuality of government and para teachers was perceived to be better than in Dumka. Further it was also found that the Jamtara schools were cleaner than the Dumka schools. A plausible reason for this could be better and regular performance of the government service providers due to more safe and conducive work environment in Jamtara, as compared to Dumka.

- *In difficult and inaccessible areas, village level state para workers like the Sahiya, AWW and para teachers become very important* as they are from the community. Also, the role of the "*jholawala doctor*" to treat minor ailments is also seen as very significant in the rural service delivery mechanism.

- *More effective performance of targeted government development initiatives for primitive tribes, whose population resides more in unrest affected districts like Dumka.* The population of primitive tribes like the Mal Paharai is more in Dumka district due to the hilly terrain and enhanced forest cover. Dumka thus has special schemes of the Jharkhand Welfare department targeted at the Primitive tribes. The benefit and effective implementation of Jharkhand Welfare department's scheme is evident by perception of greater satisfaction of tribal service users in the Paharia government boarding school in the villages and the Paharia Health Centre in Dumka district, as compared to the other development institutions. The doctor is available twice a month in the Paharia health centre. By contrast, in Jamtara, no government doctor visits the SHC.

7.2. BARRIERS TO ACCESSING SERVICES

Interestingly there was commonality on a number of perceived barriers identified by the tribal women and the service providers. They highlighted both community level barriers and delivery system related barriers. The service users, service providers and the service intermediaries identified four sets of key barriers:

- *Barriers at the level of the individual and community*
- *Barriers at the level of the delivery system*
- *Barriers due to the unrest context*
- *Barriers due to poor governance*

7.2.1 BARRIERS AT THE LEVEL OF THE INDIVIDUAL AND COMMUNITY:

- *Socio-cultural barriers*: These include issues like traditional beliefs in cures for certain ailments and lack of acceptance about the need for immunization, contraception, the benefits of institutional delivery, and of putting savings in a bank. Existing discrimination and unrest within the tribal community and between the tribes and non-tribes of the same village were another barrier identified by the tribal women.

- *Economic barriers:* Poverty was seen as an important barrier to women accessing quality educational and health services. For example, migration impacted children who then do not attend school regularly, and losing one or multiple days' wages impacted access to the government hospital at the block/district level. Poverty is also one of the causes for more girls dropping out of school after the primary stage.

- *Information barriers*: These include lack of awareness of different central and state development schemes in health and education (like NRHM, ICDS, SSA, etc.) And of provisions/entitlements in acts like PESA and RTI.

- *Education barriers***:** Illiteracy impacted the provision of adequate support to their children. It also impacted tribal women's accessibility to government hospitals as they hesitated to interact with the doctors and other hospital staff.

- *Gender barriers:* Patrilineality system, where an individual belongs to his or her father's lineage, restricted decision making and mobility among women. Not sending girl children to school to get additional household help and gender discriminatory practices like early marriage, which earlier were not part of the tribal culture, and witchcraft practices were also perceived as barriers for women to access development services.

- *Confidence dimension*: Though not overtly articulated, lack of confidence and space to take decisions on accessing health, education and economic services acted as a barrier to women raising complaints about teacher irregularity or lack of medicines in the SHC/PHC, in attending SMC meetings or raising these issues in gram sabhas.

- *Trust barriers*: The lack of trust in government institutions and service providers is an important perceived barrier, especially in areas more prone to unrest. There was also evidence of greater trust in the "*jholawala* doctor".

7.2.2. BARRIERS AT THE LEVEL OF SERVICE DELIVERY SYSTEM

- *Physical infrastructure barriers*: These include lack of health equipments and shortage of medicines in the government delivery system (SHCs/PHCs); ill equipped anganwadicenters; lack of basic facilities like electricity, playgrounds and separate toilets for girls in schools. Further, inadequate transport facilities in inaccessible areas created barriers for health service providers like ANMs from reaching remote villages.

- *Human Infrastructure barriers*: These include fewer *staff* at the level of the sub and primary health centers; *delayed compensation* to teachers and AWWs and the salary discrepancy between government teachers and para teachers which affects motivation; l*ack of* supporting facilities like rest rooms in government hospitals or food allowance for Sahiyas escorting pregnant women to the hospital for institutional deliveries, non-availability of cycles for *Sahiyas*; and inadequate capacity building of teachers, para teachers and Sahiyas. Issues of language (emphasis on Hindi in schools and doctors not understanding the tribal dialect) also create barriers in accessing the service.

- *Behavioural barriers*: These included rude as well as indifferent attitude of the health government staff and government teachers towards tribals; irregular attendance of teachers and ANMs; corrupt practices by some teachers, ANMs, ration shop owners and pradhans; and discrimination against tribals by the AWWs.

- *Procedural Barriers*- These included issues like the timing of the SHC and PHC not suiting the tribal women. The SHC and PHC are opened during 10 am -1.00 pm, which is also the time in which the tribal women are occupied in their household and livelihood aspects. The fact that medium of teaching in the primary school is Hindi, also adversely impacts the learning levels of the tribal children, who are more conversant with their tribal dialect. The local para teachers are only partially successful to bridge this language gap. This affects the motivation of the child to come to school regularly.

- *A poor community engagement*: The system of engaging with the tribal communities by the health and education service providers is ineffective. SMC meetings are not held regularly, there is a lack of awareness of the role and members of the VHSC in the community, and teachers do not invite parents to the school for important functions.

7.2.3 BARRIERS DUE TO EXISTING UNREST

The findings have shown that there were no reported incidences, by the communities as well as the service providers, where Naxal/Maoist had directly targeted or obstructed of health and educational welfare services of the government.

The preliminary findings however has shown that in districts with higher incidence of Naxal activities, there was a greater incidence of fear and insecurity among the service providers, especially those external to the community but working at the grassroots. This was thus affecting the movement of ANMs to remote villages during evenings and nights, and also preventing ANMs and teachers to take residence near the village. This situation was aggravated due to lack of regular transport facility to reach these villages. In cases where recent Naxal activities were evident, an environment of distrust existed among the state and the tribal communities.

The unrest context was seen as affecting the access and regularity of the service providers, their attitude towards the tribal communities, as well as the motivation of the service provider to perform their mandated duties effectively. This could be one of the underlined reasons for the research findings that in the higher disturbed district areas there was higher dissatisfaction of tribal women in the state enabled service infrastructure and with the performance of the state service providers .Further the perceived preference for private service infrastructure and providers, by tribal women, was also higher in the relatively higher disturbed district of Dumka.

7.2.4 BARRIERS DUE TO POOR GOVERNANCE

The lack of effective functioning PRIs at the village level and inactive *Gram Sabha* were leading to ineffective village level planning on development issues, inadequate discussion on these issues in the community, inequitable implementation of development programs and schemes, and lack of accountability of service providers to the gram Sabha and elected Panchayat members. These barriers adversely impact the quality of the development services being provided.

7.3. RECOMMENDATIONS

As identified by the study, a number of barriers exist at the individual level, as well as within the family, community and government system. Sensitivity to these constraints in formulating strategies to improve the availability and accessibility of development services is required. This will help make the primary health care system more effective to carry out its role of preventive, curative and rehabilitative health, the education system to ensure not only enrollment, but also retention, transition and enhanced learning outcomes, and the public distribution system to meet the nutritional needs of the tribal communities.

The recommendations are aimed at the policy makers and decision makers of the line ministries and departments dealing with issues of women development and empowerment; the key policy makers and planners of India, as well as the staff of NMEW. They are aimed to ensure that development benefits reach the disadvantaged sections of society in an equitable, affordable and timely manner , and the circle of vulnerability that tribal women face is conclusively broken.

RECOMMENDATIONS FOR LINE MINSTISTRIES AND DEPARTMENTS

7.3.1 CAPACITY ENHANCEMENT OF TRIBAL WOMEN

A number of barriers which exist within the tribal women, as well as within the family and social cultural context, in which they exist, have been highlighted by the study. Sensitivity to these constraints and strategies to address them would important to facilitate access to of development services by them. Some key interventions include:

Raise awareness of the significance of the available development schemes and services*:* Sensitisation of tribal women needs to be inbuilt part of every development interventions, wherein the importance of education, health and economic aspects are undertaken in an integrated and culturally sensitive manner, building on the tribal communities existing best practices and local knowledge .

To fulfil their and their family's basic needs of education, health and livelihood, tribal women need to be sensitized to the need to avail the development services being provided.

Awareness of diseases such as TB, AIDS, jaundice and seeking timely medical attention, and recognition of the need for reproductive and child health issues and the role of service providers in meeting these needs would be an important intervention. The positive as well as the negative impacts of some of their traditional health practices also needs to be discussed with them.

In addition to raising awareness of tribal women, efforts and communication strategies should be developed to reach their spouses and other adult family members so that recognition of the need to pay attention to health and education is built at the family level. Awareness about social ills like early marriage, which are not part of their tribal tradition, also needs to be strengthened. Awareness generation can be done using multiple creative and culturally appropriate measures like mobilization and sectoral awareness drives and camps for the tribal women; structured trainings, exposure visits, and on-going support to women's collectives; and encouraging and promoting women members to community institutions like SMCs, VHSCs and Panchayats. Cultural sensitivity and respect for their traditional practices should be an integral part of capacity strengthening interventions.

Improve access to timely and regular information: IEC material prepared to communicate government programs should be in the local language, with use of creative and culturally appropriate pictorial as well as audio visual material to overcome the barrier of illiteracy. The material should be widely distributed and prominently displayed. Village level service providers can be deployed and citizen committees like SMCs and VHSCs can be motivated to enhance the reach of the information. During the study there was an interesting suggestion of distributing mobile phones to women in inaccessible areas, compiling information on all schemes for the tribal community and making it accessible at the village Panchayat. Further village level information resource centre can be established to provide updated information on development schemes, like the *Poorna Shakti Kendras*. The *Poorna Shakti Kendra* (PSK), Ahimsa Messenger can be implemented in the district to create awareness regarding schemes, their rights, child marriage, domestic violence etc and also by linking the eligible women with existing government schemes and programmes.

Strengthen women's control over decisions**:** While ensuring access to quality services to fulfill basic needs is important, the capacities of tribal women should be strengthened to enable them to gain confidence and address gender inequality issues and strive for decision making space within their homes and the community. There is a need for development programs to design mobilisation and capacity building strategies whereby a tribal woman's decision making capacity vis-a-vis social and economic issues is strengthened. Involvement of women in peer groups like self-help groups will assist in helping women draw strength from their peers and gain confidence to take decisions.

7.3.2 SENSITISATION OF TRIBAL COMMUNITY

Sensitisation of the tribal community to demand timely and quality services: The tribal community, with special focus on tribal women, needs to be made aware of their political role and rights as active participants of the gram sabha, and of social legislations like PESA, RTI and Forest Rights Act. Further they should be encouraged to attend gram sabha meetings and raise issues related to education, health and social entitlements. Awareness generation and gramsabha mobilisation campaigns is an important strategy to ensure the same. Further sectoral community collectives like the SMC and the VHSC can also play an active role to mobilize the community on sectoral as well social accountability issues.

7.3.3 ADDRESSING SYSTEMIC BLOCKADES IN THE DELIVERY SYSTEM

The current study highlighted a number of systemic blockages which obstruct the effective performance of government service providers. These include lack of and poorly maintained physical infrastructure, less staff, delayed compensation, lack of supporting facilities and inadequate capacity building support. Strategies which target removing these barriers include:

Better availability of physical infrastructure and facilities**:** Availability of adequate *physical infrastructure* which is accessible and well equipped is essential to ensure effective service delivery in remote areas. Financial commitments under the relevant line department and sectoral programmes need to be made and implemented in a timely and effective manner to bridge the identified gaps in availability of health centres, schools and *anganwadis*. Further procedural reforms and budgetary allocations needs to made in the concerned line departments to address gaps in basic service facilities like beds for patients and pregnant women, medicines and basic medical equipment in SHCs and PHCs; *dhurries*, educational material, water and electricity in anganwadis, playgrounds and toilets in schools; and better roads to aid mamta vahans to reach remote villages. Further, *repair and maintenance* of existing physical infrastructure should be ensured.

In addition mobilisation of additional resources and financial commitments to meet the bottom-up requests from the community and grassroots service providers for a*dditional infrastructure* (as captured in the current research) is necessary. Requests from different stakeholders included: a boundary wall in the SHC, facility for institutional delivery at the nearest PHC, separate room for Sahiyas in the CHC and district hospitals, mini aganwadi for 250-300 population, additional residential schools for tribal children, evening schools, emergency transport facilities to take pregnant women to the hospital (beyond mamta vahan); phone call service for health queries, etc.

Strengthening the system to provide adequate human infrastructure for service delivery**:** The identified human resource gaps in the sectoral programs need to be bridged at the earliest. For example, studies have shown that only one trained health care provider,

including a doctor with any degree, is available per every 16 villages in Jharkhand (Jharkhand Rural Health Mission Society, 2013). In the current study some key human infrastructure requirements include recruitment of more doctors, more ANMs in PHCs, filling up government teacher vacancies, additional para teachers in schools; cleaning staff in schools, etc.

Strengthening inbuilt mechanism of bottom-up planning in each sectoral program: In order to capture the gaps in physical and human infrastructure, it is very essential that each sectoral program facilitates bottom-up planning with active involvement of the community, *gram sabha*, service providers, elected PRI representatives at each level, and the relevant standing committee of the Panchayats. In NRHM and SSA, this institutional space for bottom-up planning exists and needs to be effectively implemented.

Procedural Reforms: In addition procedural reforms to facilitate community centred measures like changing the timings of the SHC/PHC to suit the needs of the tribal women, incorporating provision of teaching in tribal dialect in primary schools etc. It would also go a long way to bridge the distance between the tribal women and communities and the service providers.

7.3.4 CAPACITY ENHANCEMENT OF SERVICE PROVIDERS

All the service providers need to effectively perform their mandated responsibilities .They need to be armed with the necessary knowledge, skills, commitment, motivation and attitude to work under difficult and challenging conditions. The capacity building intervention should be designed and implemented in a participatory manner, with inbuilt follow up and hand holding support.

Capacity enhancement of village level para workers - technical and behavioral training: In each of the sectoral schemes like ICDS, NRHM and SSA, capacity building elements are clearly articulated and need to be implemented in a more effective manner. Special attention is needed to undertake and monitor effective pre-service and ongoing technical capacity building of village level workers like the *Sahiya*, AWW and para teachers, as in the absence of adequate qualified technical human resources at the village level, the role of these para workers gains immense significance.

Training of village level workers should include not only technical *sectoral information* directly relevant to their mandated role, but also the *behavior and attitude* required to engage effectively with the communities they are directly working in (i.e., Overcoming bias and prejudices). They should also be given basic training to address unrest issues , and build and support lasting institutional partnerships for development effectiveness. In addition, there should be sufficient written and visual material for these para workers to effectively carry out their work in the community. Communicating in their folk art forms can be considered to establish links with the community. A brief compendium of central and

state specific schemes in local language to be provided to the block and village level functionaries through State Resource Centre for Women (SRCW).

Capacity enhancement of village level technical service providers - cultural sensitivity: *For* Teachers, ANMs, doctors and other trained technical service providers, there is a need to have capacity building intervention where along with the sectoral issues, sensitivity to *tribal culture and gender issues and recognition of the importance and ways of facilitating women's participation* in development programs is strengthened.

7.3.5 STRENGTHENING SUPPORT SYSTEMS FOR SERVICE PROVIDERS

Ensuring provision of mandated benefits as well as incentives for service providers: There is an urgent need to ensure that the staff, especially those working at the village level in difficult and insecure conditions, receive their salaries and other mandated facilities and support in a timely manner. This is very essential to keep them motivated to perform their duties efficiently. It will also check the inclination to resort to corrupt practices .Procedural reforms as well as administrative efficiency is required to streamline the provision of mandated and additional benefits.

In the study ensuring the provision of the following mandated benefits were identified: regular payment of salary to AWWs; provision of transport support to village level workers; Sahiyas to receive honorarium for other service provided, beyond the reproductive health related services (i.e., for community mobilization for immunization, conducting meetings with women).

Strengthen or create grievance redressal mechanisms for the staff: The staff grievance redressal mechanism under different sectoral programmes needs to be established or strengthened at different levels to ensure prompt redressal of complaints.

7.3.6 STRENGTHEN ENGAGEMENT WITH TRIBAL COMMUNITY

The trust deficit between the tribal communities and the government service providers is another barrier which impacts effective reach of development services to the tribal communities. The study has shown this deficit is more evident in districts and blocks where Naxal inflicted unrest exists. It is thus essential to have structured measures to build an environment of mutual trust and respect.

***Strengthening community engagement of service providers*:** In order to effectively address the service needs of tribal communities, it is important that the government service providers strengthen their engagement with the tribal community, with special focus on women. For example, a small measure like more frequent home visits by teachers to inform parents and guardians (especially the women) about the educational progress of the child and invite them to school functions will go a long way in building this environment of trust. Similarly, ANMs and doctors should also regularly hold meetings and regular health camps

with the community, especially in remote, inaccessible areas. The access strategy of the "*jholawala* doctor" is a building block for developing a relationship based on trust. Effective monitoring of the implementation of these process need to be undertaken on a regular basis.

Enhancing capacity of the sectoral community committees: There is need to activate and strengthen the SMCs and the VHSCs, as they are mechanisms to bridge the gap between the government and the community. The mandated role of the SMC and the VHSC include awareness generation among the communities about the relevance of the services, participating in developing sectoral plan with active participation of the community, representing the voices of the marginalized communities with the government service providers, holding the service providers accountable by undertaking monitoring interventions, presenting the service status to the gram sabha etc. These provisions just need to be effectively implemented. The inbuilt provisions of strengthening their capacity needs to implemented and monitored on an ongoing basis.

7.3.7 STRENGTHEN LOCAL GOVERNANCE IN TRIBAL COMMUNITIES

In areas which come under PESA an active and empowered gram Sabha, supported by a strong Panchayat can play a pivotal role in ensuring service delivery and in addressing the grievances of the tribal communities in a peaceful and democratic manner. A cross sectoral programs, efforts are required to ensure that there are inbuilt strategies to strengthen and engage the gram Sabha in every stage of the program planning, implementation and monitoring, as per the mandate of PESA. Further, each sectoral program also needs to strengthen the capacity of recently elected PRI members at each level, especially the *mukhiya* and elected women members, and engage them actively in the management of sectoral programs. In addition, training and exposure for the *pradhans* and *mukhiya* on PESA and Panchatyati Raj Act must be undertaken. There is also need for forging effective coordination between the traditional governance system of the tribal communities and the newly constituted elected local governance system.

During the study the need to strengthen Panchayats as an important step to ensure effective service delivery, build an environment of trust and ameliorate unrest was highlighted by a number of stakeholders which included the BDOs of Dumka and Jamtara, District Gender Coordinator, Dumka, Programme Officer MNREGA, Dist Planning officer, Zilla Panchayat chair and Zill Panchayat member, Jamtara, and District Commissioner Jamtara. According to DC Jamtara, *Gram Sabha's* should be conducted, and *people and community at large* are the *change agents can be instrumental in generating community responses and make things change*. In addition training and exposure for the pradhans and mukhiya on PESA and Panchatyati Raj Institution need to be strengthened. Awareness training to women elected representative on government schemes, acts, policies especially

for women, their rights (Legal, Social, Political etc) child marriage, domestic violence etc should be provided.

7.3.8 STRENGTHENING INTERNAL AND EXTERNAL MONITORING SYSTEMS

In order to address issues related to the gaps in the service delivery, there is need to strengthen the internal as well as the social monitoring mechanisms of the development programmes.

***Strengthening internal systems**:* The existing internal monitoring and information system of sectoral schemes and programs like NRHM, ICDS and SSA need to be effectively implemented. Each of these schemes has rigorous internal monitoring systems in place, which include monitoring visits (by CDPO and ICDS supervisor, by BEOs, by POs, etc.) Review meetings, and reporting processes need to be undertaken in a timely and rigorous manner.

Strengthening social monitoring process: There is a need to strengthen *monitoring by the sectoral community committees like SMC and VHSC, as well as the community*. Under both SSA and NRHM mechanisms for community based monitoring exist, which need to be strengthened. Relevant standing committees of Panchayats also need to be supported to play their monitoring role more proactively. Within these committees it is very essential to have a special focus on women representatives, so that their voices can be represented well.

As Dumka and Jamtara are PESA areas, it is essential that the mandated *role of Gramsabha to monitor* effective implementation of economic and social development programs should be strengthened, and the monitoring by the sectoral community committees is done in coordination with the gramsabha meetings. Further there is a need to create interface opportunities like *gramsabha* meetings at the village level or Panchayat level meetings or multistakeholder dialogues wherein the line department staff, the Panchayat, the women representatives and the community members can sit together and discuss the monitoring results or the grievances and problems faced by the women and other community members.

RECOMMENDATIONS FOR NATIONAL MISSION FOR EMPOWERMENT OF WOMEN

7.3.9 CONVERGENCE FOR EFFECTIVE SERVICE DELIVERY FOR TRIBAL WOMEN

All service providers have been working but in vertical silos and thus there is lack of convergent approach at all levels especially at the block & district level which further limits the access of services to women. Thus, an important strategy related to strengthening and reforming the service delivery system is ensuring convergence among the different line departments and the private service providers. Enhanced and improved connectivity, communication and coordination of basic services, sharing of resources and working

towards a common goal between government departments and other institutions will also be an effective measure to build a peaceful and secure environment.

Convergence is needed at the level of policy making, planning and framing of programs down to implementation and review. It thus includes multi-party, multi-level and multi-institutional processes.

(a)Potential areas of sectoral convergence: Emerging insights

Building on the study findings, this section highlights potential areas of convergence and two possible convergence strategies for the future, keeping the tribal women's needs and issues in the centre. A number of suggestions were received from the respondents during the study to address the issues of inadequate and poor quality physical and human infrastructure. These have also been included in this section.

(i) Convergence between NRHM, ICDS and Panchayat initiatives on maternal and child health issues**:** There is need for better coordination between the NRHM, ICDS and Panchayat initiatives, falling under the domain of three different Ministries, inorder to ensure effective delivery of maternal and child health related services.

At the programme design level both these initiatives have specified ways of coordination between their grassroots functionaries. NRHM provides that the ANMs will have the support of 4 to 5 Sahiyas and AWWs in discharging her duties and the role as envisaged in the mission. This is reinforced in the ICDS program guidelines, wherein the AWW has to assist the ANM in identifying the target group for immunization and health checkups. The ANM's monthly visit for immunization of pregnant and lactating mothers at the anganwadi centre is an important convergence initiative which needs to be strengthened.As per Ministry of Women and Child Development, the AWW's identification of sick or malnourished children and referring them to the PHC or its sub-centre, and the ANM and AWW working in close coordination to facilitate nutrition and health education among tribal women of 15 to 45 age group will go a long way in ensuring effective impact.

In addition to the specified coordination measures, there is also need for greater coordination between *the Sahiya and AWW*, as both are based on the community level, and for both health of women and children is an important focus. The Sahiya can support the AWW by ensuring pregnant women come for immunization, and in turn the provision of an anganwadi in each village has the potential to provide an additional infrastructural resource for the Sahiya.

(ii)Convergence between Education, Health, ICDS and panchayat interventions on education and health initiatives*:* The three main service institutions at the village level are the primary school, the Sub Health Centre and the anganwadi. The common focus of all the three institutions is children and their mothers. This is an important collaborative factor

which can assist the three institutions, as well as the panchayat representatives belonging to different ministries to work in close coordination.

There is potential to strengthen coordination between the *primary school and the anganwadi as* non-formal education to children between the ages of 0 to 6 years is supposed to be provided in the anganwadi. Visits by primary school teachers to the anganwadi and visits by the AWW to the school will help enhance learning methods in the anganwadi. It will also help in strengthening the accountability of the AWW in performing her role of providing non-formal education to young children.

Health camps for young children by the health service providers can be organized in coordination with the primary school in the village to increase coverage.

(iii) Coordination of state tribal welfare schemes with the centrally sponsored schemes: Programmes like SSA,NRHM, and Jannani Surksha Yojana can be tied in effectively with a multitude of very relevant schemes of the state welfare department for ST children, such the bicycle distribution scheme; supply of uniform to SC and ST girl students; construction of hostels for SC, ST, OBC and minority children; ashram/Eklavya schools for ST students in Jamtara ; Mid-day meal scheme for students of paharia primitive tribes in Dumka ; health centres for paharias in Dumka and ayurvedic health centre scheme for STs.

(iv) Better coordination with private service providers: Exploring options for better synergy with private players like private schools and traditional healers, especially in disturbed areas, will help address the human infrastructure gaps to some extent.

(b)Potential strategies to ensure convergence on the above specified areas

(i) Strengthening commitment and institutional mechanisms for convergence: Implications for NMEW

For effective convergence at the grassroots level, commitment and mechanisms at the level of different national ministries, and their state level department are necessary. The National Mission for Empowerment of Women (NMEW), could take lead in generating this commitment and making systemic changes, at the national, state and district level.

For effective convergence at the grassroots level, it is essential that there is commitment and willingness at the level of the *different national ministries*, as well as *their state level departments,* cutting across the narrow sectoral lines and mandates. The National Mission for Empowerment of Women (NMEW), with its mandate to strengthen inter-sector convergence and facilitate the process of coordinating all the women welfare and socio-economic development programmes across ministries and departments, could take the lead in generating this commitment and making systemic changes. This would include convergenece among related departments like: Social welfare,Women and Child Development department; Social Welfare department; Department of PR & NREP; Tribal

Welfare department;Jharkhand Education Project Council; Department of Health & Family Welfare; Jharkhand Rural Health Mission Society; Food, Public Distribution & Consumer Affairs; and Dept of Rural Development

M*echanisms* that can build and strengthen systems that will assist in ensuring convergence of different sectoral programmes for women at the village, panchayat, block and district levels can include:

- *Joint convergence meetings at national, state and district level for policy framing and designing integrated implementation strategies***.** Members need to be designated from the relevant ministries and departments to attend these meetings, with preferably fixed dates for these meetings.

- *Assigning responsibilities within the sectoral departments for different convergence avenues, especially from district level and below***.** It would help to have designated staff as "Convergence Focal Points" in each of the concerned departments .This will ensure that the accountability for ensuring convergence is entrusted to designated individuals, who will also represent their department's views and perspective in the convergence planning and review meetings.

- *Design multi-sectoral and integrated capacity building programs for service providers, at national, state and district level especially those working at the grassroots*. These capacity building programmes will provide opportunity for the government staff of different line departments to participate in joint learning programmes, undertand the significance of and mechanism for convergence at each level of programme management. This would include convergenece at the level of planning programmes, implementing the programmes, as well as in monitoring and evaluation of the programmes. For example greater coordination between the sectoral line departments, the tribal welfare department, the department of women and child development and the department of panchayats will help in developing a more comprehensive capacity building strategy for the tribal women, as well as for the para workers.

  The awareness generation and structured training modules of different line department sectoral programs should include both sectoral awareness generation and training on gender equality and political empowerment. Identifying experts from within the government, and also from NGOs and other development actors to design and implement such capacity building modules will be a huge contribution to ensure effective convergenece, espcially on services which have a bearing on women's needs and priorities.

- *Strengthening Joint Inter departmental planning and monitoring mechanisms***:** There should be special focus on undertaking integrated planning approach at the district level

by building on integrated micro level plans from both urban and rural areas through the already established institution of District Planning Committees. In addition to the decentralised and comprehensive district planning interventions, there is need to ensure that the integrated plans are implemented in a coordinated manner. For that the grassroots functionaries of the departments dealing with interrelated services, as well as the panchayat elected representatives need to work in close coordination. For example this would include ANM, sahiya and AWW, as well as teachers, ANMs and AWW working in closer coordination with each other. This requires mechanisms to ensure better joint planning of the work of these staff and its effective implementation and monitoring at the field level.

Joint monthly meetings at the District, Block and Panchayat level, coordinated by the CEO and BDO office, in collaboration with Zilla Panchayat and Panchayat Samiti,can be one mechanism to ensure this coordination among the functionaries of the line departments responsible for interrelated services, as well as with the panchayati raj elected representatives . In addition d*esigning common reporting mechanisms and undertaking joint monitoring and review of the integrated service provisions*, will assist the convergenece machinery to be implemented in an effective manner. Here again it would help to identify relevant experts to undertake this challenging task.It could include exploring IT technology which would eneable actors across sectors and locations to work on an integrated planning, monitoring and evaluation system.

- *Enhanced communication and connectivity* among the departments, and panchayat representatives at the district, block and panchayat level would go a long way to enhance coordination between the different line departments and the panchayati raj interventions. This could be enabled via better egovernance mechanisms, information sharing meetings, inter departmental coordination committees etc.

- *Convergence of interdepartmental information:* The National Resource Centre for Women, under the National Mission for Empowerment of Women (NMEW), has been set up to function as a National Convergence Centre for all schemes and programs for women. It acts as a central repository of knowledge, information, research and data on all gender related issues and is the main body servicing the National and State Mission Authority.The effective implementation of its convergence model of *Poorna Shakti Kendra*, which has provision for convergence and facilitation centersin the district, block and village level, will facilitate the convergence of information at each level.

(ii) Strengthening bottom up convergence efforts in Tribal Areas

A bottom-up approach of convergence is recommended in order to ensure an effective and sustainable model of convergence, especially in the context of the Vth Schedule for tribal areas and districts like Dumka and Jamtara.

Recognizing Gram Sabha as the fulcrum of convergence (as mandated under PESA, 1996 Act): The building block of the convergence model should be the gram Sabha**,** which under the Panchayat Extension to Scheduled Areas (PESA), 1996 Act, has a central role in ensuring the social and economic development of a village. Under this Act, the gram sabha's key powers include approve plans, programmes and projects for social and economic development; identify or select persons as beneficiaries under poverty alleviation and other programmes; give certification of utilisation of funds by the panchayat; exercise control over institutions and functionaries in all social sectors; and have control over local plans and resources for such plans including tribal sub-plans. These provisions, if implemented in their true spirit, will facilitate the convergence of different development services at the village level.

Engage with the gram sabha in all sectoral programs: An important strategy can be to ensure that in each of the sectoral programs, especially in the tribal regions, *gram sabha* engagement is integral to program delivery. This will ensure that need-based plans and community accountability mechanisms are strengthened for all development services, irrespective of the line departments they are being provided through. Better convergence between the line departments and the department of panchayati raj and department of women and child development can facilitate grams Sabha mobilization and their activation, with special focus on women's active participation.

Collaboration between panchayati raj institutions and the sectoral community committees in all sectoral programs: *Panchayati raj institutions* as *constitutionally (formally) recognized* bodies are mandated to promote and implement a wide range of economic and social development programs. Their responsibilities include working on an integrated approach of development, with emphasis on community participation and long-term sustainability. The devolution of power and authority and focus on women's participation is a major breakthrough. In practice, however, opportunities and capacities are not available to convert designated roles into action.

In order to strengthen collaboration between panchayati raj institutions and sectoral committees, structured mechanisms to facilitate community participation should be included in the project plan and strategy. In the case of NRHM and SSA, the provisions for collaboration with panchayati raj members exist. These need to be strengthened, especially in the case of developing village health plans and school health plans.

Designing bottom-up integrated planning to ensure convergence in the tribal areas: Comprehensive District Planning (CDP) has been proposed in 250 districts identified under the Backward Regions Grant Fund (BRGF) by the Ministry of Panchayati Raj, Government of India and the Planning Commission. Under CDP, a district vision with a development perspective over the next 10-15 years has to be prepared in a participatory manner. The building block of the district vision is micro planning and visioning at the gram Panchayat and urban local body level.

This integrated planning process at the gram Sabha level, approved by the gram Sabha and village Panchayat, and consolidated at the block and finally at the district level by the District Planning Committee is an available convergence tool that should be effectively used.It will ensure effective sharing of financial as well as human resources among the different depratnts Active involvement of local elected bodies at each level needs to be inbuilt.

RECOMMENDATIONS FOR POLICY MAKERS , PLANNERS AND GOVT OF JHARKHAND

7.3.10 Evolving strategy for the State to prevent unrest

The Government of India has embarked upon an integrated approach to deal with Left Wing Extremism (also know as Naxalism). It includes addressing issues of security, development, administration and public perception in areas affected by the Maoist/Naxal activities. (Ministry of Home Affairs, 2012)

There is a need for greater unrest sensitivity among policy makers and program planners while planning and implementing development initiatives in disturbed areas, so as to prevent violent unrest incidences. The study findings support the thinking that the State Government's efforts to maintain law and order on issues related to Left Wing Extremism need to go hand in hand with *serious efforts and commitment to effectively implement the large number of central and state supported development schemes.* This should be done with the participation of the *gram sabha* and Panchayats at each level, so that development and governance issues are effectively addressed. Ensuring development benefits reach the needy in a timely, quality, equitable and affordable manner will go a long way in dealing with issues that aggravate the present disturbing situation in the region serve as a unrest preventive step, and assist in building an environment of trust and peace.

Policy pressure and administrative will to effectively implement the Panchayats (Extension to Scheduled Areas) Act (PESA), as well as the Scheduled Tribes and Other Traditional Forest Dwellers (Recognition of Forest Rights) Act, 2006 is another effective, and sustainable strategy to counter naxalism and build an environment of peace, development and prosperity in the tribal regions of Jharkhand

7.3.11 SUMMARY OF RECOMMENDATIONS

The table below attempts to summarise the key recommendations and how they attempt to address some of the perceived barriers encountered by the tribal women, obstructing their access to timely and quality service provisions.

Perceived Barriers	Key Recommendations
A. Individual and Community level Barriers	
Socio-cultural,economic and educational barrier	• *Using multiple and culturally appropriate approaches to raise awareness on significance of development schemes, among women and their spouses, with due recognition of their existing best practices and local knowledge.* • *Sensitisation and mobilisation of the tribal community to demand timely and quality services,by becoming aware of their political roles and rights as gram sabha members, and being informed about social legislations like PESA 1996, RTE 2009 and Forest Rights Act 2006*. • *Strengthening convergence to ensure integrated awareness generation strategies*
Information barrier	• *Strengthening access to timely and regular information on development services through: culturally appropriate and creative IEC material ; strategic use of village level staff and sectoral citizen committee members; and through establishment of village level information resource centre* • *Strengthening convergence for effective information dissemination*
Gender barrier	• *Designing capacity building and mobilisation strategies, across sectoral programmes, to strengthen women's control over decisions related to the development services* • *Strengthening convergence for integrated capacity building for tribal women*
B. Service Delivery System Barriers	
Physical Infrastructure barrier	• *Financial commitments and its effective implementation by concerned line departments and sectoral programs, to bridge the identified gaps in availability of health centers, schools and anganwadis.* • *Procedural reforms and budgetary allocations in the concerned line departments : to address gaps in basic service facilities(beds, medicines, educational material etc) ; to ensure repairs and maintenance of existing physical infrastructure; and to meet the bottom-up requests for additional infrastructure* • *Strengthening inbuilt mechanism of bottom-up planning in each*

	sectoral program with active involvement of the community, gram sabha, service providers, elected PRI representatives at each level, and the relevant standing committee of the panchayats. • *Strengthening convergence for optimal utilisation of development physical infrastructure across sectoral programmes*
Human Infrastructure and Behaviour barrier	• *Advocating for State Government's efforts to bridge the identified human resource gaps in the sectoral programs,like ensuring availability of adequate doctors, ANMs, teachers,at the earliest.* • *Ensuring provision of mandated benefits, as well as incentives for service providers and strengthening grievance redressal mechanisms for the staff through procedural reforms, as well as administrative efficiency.* • *Capacity enhancement of village level para workers through provision of effective pre-service, and ongoing technical as well as behavioural andunrest addressal capacity building.* • *Capacity enhancement of village level technical service providers on sectoral issues, as well as ensuring sensitivity to tribal culture and gender issues.* • *Strengthening inbuilt mechanism of bottom-up planning in each sectoral program with active involvement of the community, gram sabha, service providers, elected PRI representatives at each level, and the relevant standing committee of the Panchayats.* • *Strengthening convergence for optimal utilisation of human infrastructure across sectoral programmes, integrated capacity building and for effective bottom up planning*
Procedural barrier	• *Procedural reforms to include community centred measures like changing the timings of the SHC/PHC to suit the needs of the tribal women, incorporating provision of teaching in tribal dialect in primary schools etc.*
Community Engagement and Trust deficit barrier	• *Ensuring greater engagement of government service providers with the tribal community, with special focus on women, and undertaking effective monitoring of the implementation of these process.* • *Activating and strengthening the sectoral community committees like SMCs and the VHSCs, to bridge the gap between the government and the community, and undertaking effective monitoring of the implementation of these process .* • *Strengthening convergence for integrated capacity building*

	programmes across sectors
C. Barriers due to unrest	• *Ensuring greater unrest sensitivity among policy makers and program planners while planning and implementing development initiatives in unrest affected areas.* • *Balancing State Government's efforts to maintain law and order on issues related to Left Wing Extremism with serious efforts and commitment to effectively implement the central and state supported development schemes.* • *Generating policy pressure and strengthening administrative will to effectively implement the Panchayats (Extension to Scheduled Areas) Act (PESA), as well as the Scheduled Tribes and Other Traditional Forest Dwellers (Recognition of Forest Rights) Act, 2006* • Strengthening convergence efforts for effective service delivery
D. Barriers due to poor governance	• *Building strategies across sectoral programs to: strengthen and engage the gram sabha in every stage of the program management, as per the mandate of PESA; and strengthening the capacity of recently elected PRI member at each level, and engaging them actively in the management of sectoral programs* • *Ensuring effective implementation of existing internal monitoring and information system of sectoral schemes and programs like NRHM, ICDS and SSA.* • *Strengthening monitoring by the gramsabha, sectoral community committees like SMC and VHSC, as well as the community and creating interface opportunities like gramsabha meetings or multi stakeholder dialogues.* • *Designing bottom up convergence efforts in the tribal areas for effective service delivery*

7.4 CONCLUSIONS

This participatory research intervention in 10 tribal villages of Dumka and Jamtara district has helped in collectively exploring the multiple vulnerabilities faced by tribal women in these difficult and disturbing areas .Their vulnerabilities are a result of their poor economic and education status, their tribal and gender identities, and living in a hostile geopolitical as well as socio-political environment. The study has shown how multiple vulnerabilities work in tandem with the systemic, capacity and context barriers of service providers to deny access of timely and quality development services to tribal women, and thereby creating a viscous circle of vulnerability.

The participatory nature of the research has facilitated both the tribal women and the service providers to explore multiple, integrated solutions to address the multi-level barriers, and helped think of possible ways forward to break the viscious circle of vulnerability. The study findings reiterate the need for serious efforts and commitment of the government to effectively implement the different development schemes for the tribal communities and tribal women.

The recommendations for policy makers and bureaucrats across sectors are aimed to break the circle of vulnerability that tribal women individually and collectively face, andshow a way forward so that development benefits truly reach the disadvantaged in a timely, quality, equitable and affordable manner.

REFERENCES

- Adhikari, A. & Bhatia. K. (2010). NREGA wage payments: can we bank on the banks? *Economic and Political Weekly*, 45(01), 30-37.

- Andotra, N. & Gupta, P. (2008). *Elementary education and Sarva Shiksha Abhiyan.* New Delhi: Anmol Publications Pvt. Ltd.

- Arjjumend, H.(2005). *Inquiry into tribal self governance in Santal Parganas* .Retrieved on December 6,2012 from http://www.grassroots.org.in/catalogue/ inquiry%20into%20tsg%20in%20sp%20jhar%20-%20gi,%20git%20study.pdf

- Arvind, G. R. (2008). *The state, local community and participatory governance practices: prospects of change*. World Academy of Science, Engineering and Technology 44 2008 (Online). Retrieved on March 6, 2012, from http://www. waset.org/journals/waset/v44/v44-116.pdf

- ASER (2012). *Annual status of education report, (Rural) 2012, Provisional*. Retrieved on May 2, 2013 fromhttp://img.asercentre.org/docs/Publications/ ASER%20Reports/ ASER_2012/DPT_2012/aser2012districttablesapril42013-allstates.pdf

- ASER (2012). *Annual status of education report, (Rural) 2012 District Performance Table, provisional.* Retrieved on May 2, 2013 from http://img.asercentre.org/docs/Publications/ ASER%20Reports/ASER_2012/DPT_2012/aser2012districttablesapril42013-allstates.pdf

- Banerjee, A. et al. (2007). Can information campaigns raise awareness and local participation in primary education? *Economic and Political Weekly,* 42 (15), 1365-1372.

- Barnes, L. (2007). Women's experience of childbirth in rural Jharkhand, *Economic and Political Weekly, 42* (48),62-70.

- Barua, A. & Apte, H. (2007) .Quality of abortion care: perspectives of clients and providers in Jharkhand, *Economic and Political Weekly*, 42 (48), 71-80.

- Basu, A.M.(1990). Cultural influences on healthcare: two regional groups in India. *Studies in Family Planning*, 21(5),pp 275-86.

- Bharat, S., Patkar, A. & Thomas, D. (2003). *Mainstreaming equity and access into there productive and child health programme.* London: Department for International Development (DFID) Health Systems Resource Centre.

- Bhatti, B. (2012). Aadhaar enabled payments for NREGA workers, *Economic and Political Weekly*, 47(49), 16-19.

- Bhatia. B, Drèze.J. (2006). Employment guarantee in Jharkhand: ground realities. *Economic and Political Weekly*, 41(29), 1-5.

- Bhattacharjea, S. &Ramachandran,V. (2009). Attend to primary school teachers! *Economic and Political Weekly,* 44(31).

- Bloom, S., S.,D. Wypij & Gupta, M. D.(2001). Dimensions of women's autonomy and the influence of maternal healthcare utilisation in a north Indian city. *Demography,* 38(1), 67-68 .

- District Administration Dumka. (2013). *Dumka at a glance.* Retrieved on May 2, 2013 from http://164.100.150.8/dumka/

- Drèze, J. & Goyal, A. (2003). Future of mid-day meals. *Economic and Political Weekly,* 38 (44), 4673-4683.

- Dreze, J. and Kingdon, G. (2001). School participation in rural India. *Review of Development Economics,* 5 (1), 1-33.

- Ekka, P. (2003). *Tribal movements – a study of social change*. Pathalgaon, Jashpur: Tribal Research and Documentation Centre.

- Government of Jharkhand. (2013). *Introduction. Profile of Jharkhand* .Retrieved on May 15, 2013 from http://jharkhand.gov.in/New_Depts/healt/Web%20Site/HEALTH%20WEBSITE/html/INTRODUCTION.html

- Government of Jharkhand. (2013) .*Official website of the Government of Jharkhand.* Retrieved on May 2, 2013 from http://jharkhand.gov.in/AboutState_fr.html

- Government of Jharkhand.(2013).*Schemes.*Retrieved on May 2, 2013 from http://jharkhand.gov.in/schemes.html

- Govinda, R. & Diwan, R. (Ed.) (2008). *Community participation and empowerment in primary education*. New Delhi: Sage Publications India Pvt. Ltd.

- Intrahealth International Incorporated (2008) .*Role of Village Health Committees in improving health and nutritional outcomes.* Retrieved from http://www.intrahealth.org/~intrahea/files/media/maternal-neonatal-and-childrens-healthfamily-planning/ER_Brief_VHC%204.pdf

- Jha, J. & Jhingran, D. (2005). *Elementary education for the poorest and other deprived groups. The real challenges of universalisation*. Delhi: Manohar Publishers and Distributors.
- Jharkhand Rural Health Mission Society. (2013).*District health action plan. Year 2011-2012* .Retrieved on May 14, 2013 from http://210.212.20.93:8082/jrhms/DHAP.aspx
- Jharkhand Rural Health Mission Society. (2012). *Mobile medical unit* .Retrieved on Nov 17, 2012 from http://210.212.20.93:8082/jrhms/Mobile_Unit.aspx
- Kumar.K, Priyam. M, &Saxena. S. (2001). Looking beyond the smokescreen. *Economic and Political Weekly*, 36(07), 560-568.
- Kumar, R. (1997). Land Rights of the Santali women. In Rao, N & Rurup, L (Ed.) *A Just Right: Women's ownership of Natural Resources and Livelihood Security*. New Delhi: Friedrich Ebert Stiftung.
- Ministry of Home Affaires. (2012). *Outcome budget ,2011-2012* .Retrieved on April 4, 2012 from http://mha.nic.in/pdfs/OB%28E%292011-12.pdf
- Ministry of Human Resource Development. (2011).*PAB-MDM meeting to consider and approve AWP+ B 2011-12 .State-Jharkhand.*Retrieved on December 1, 2012 from http://mdm.nic.in/Files/PAB/PAB-2011-12/AWPB%20Appraisal%20Notes/JHARKHAND.pdf
- Ministry of Human Resource Development. (2011). *Sarva Shiksha Abhiyan. Framework for Implementation. Based on Right of children to free and compulsory education act, 2009*. New Delhi: Department of School Education and Literacy.
- Ministry of Law and Justice. (Legislative Department). (2009). *The right of children to free and compulsory education act, 2009*. Retrieved on November 4, 2012 from http://ssa.nic.in/quality-of-education/right-of-children-to-free-and-compulsory - education-act-2009.
- Ministry of Women and Child Development. (2013). *Integrated child development scheme (ICDS*). Retreived on March 10, 2013 from http://wcd.nic.in/icds/icdsteam.aspx
- Narayanan, H. (2011). Women's health, population control and collective action, *Economic and Political Weekly,* 46(08), 39-48.
- National Commission for Women. (2003). *Gender Profile–Jharkhand*. Retrieved on November 2, 2012 from http://ncw.nic.in/pdfreports/Gender%20Profile-Jharkhand.pdf
- National Mission for Empowerment of Women. (2013). *About the Mission*. Retrieved on Nov 15, 2012 from http://www.nmew.gov.in/index.php

- National Rural Health Mission (2011) *District health action plan. 2011-2012. District Jamtara.* Department of Health and Family Welfare. Government of Jharkhand. Retrieved on August 24, 2013 from http://210.212.20.93:8082/jrhms/DHAP.aspx

- National Rural Health Mission. *Framework for Implementation. 2005-2012* .Retrieved on October 1, 2012 from http://nrhm.gov.in/about-nrhm/nrhm-framework-for-implementation.html

- NUEPA (2013 a). *District elementary education report card, 2011-12*. Retrieved on May 1, 2013 from http://www.dise.in/Downloads/Publications/Publications%202011-12/DRC% 202011-12.pdf

- NUEPA (2013 b). *Elementary Education in India, Progress towards UEE, Flash Statistics. 2011-2012* Retrieved on August 23, 2013 from *http://www.dise.in/Downloads/Publications/ Publications%202011-12/Flash%202011-12.pdf*

- PRIA (2001). *Purna saksharata abhiyan aur buniyadi siksha ke sath uska sambandh: Dumka, Jharkhand, ek addhyayan*, New Delhi : PRIA

- PRIA. (2005-6). *Role of Panchayat in primary education. A report*. Delhi: PRIA.

- Rao, N (2001).Enhancing women's mobilisation in a forest economy.Transport and gender relations in the Santal Parganas, Jharkhand .*Indian Journal of Gender Studies* .8 (271).

- Office of the Deputy Commissioner, Jamtara.(2013) *Official website of District Jamtara.*Retrieved on May 2, 2013 from http://jamtara.nic.in/

- Office of the Registrar General & Census Commissioner. (2012). *Annual Health Survey Bulletin, 2010-2011, Jharkhand.* Retrieved on May 2, 2013 from http://censusindia.gov.in/ vital_statistics/AHSBulletins/files/05-Jharkhand_AHS_Bulletin__23x36_.pdf

- Paul, S. (2003). Hashiye se hukumat tak. In Sudhi Paul and Ranendra (Ed.), *Panchayati Raj - Hashiye Se Hukumat Tak*. Panchkula: Adhaar Publication.

- PESA, 1996. *The Provision of the Panchayats (Extension to the Scheduled Area) Act , 1996*. Retrieved on October 15, 2012 from http://www.tribal.nic.in/writereaddata/ linkimages/pesa6636533023.pdf

- PRIA (2004).*Tribal self rule in Jharkhand. Implications of Jharkhand Panchayati Raj Adhiniyam, 2001 in Scheduled Area*. New Delhi: Society for Participatory Research in Asia.

- Press Information Bureau, Government of India. (2010). *Integrated steps for Naxal affected districts*. Retrieved on April 2, 2012 from *http://pib.nic.in/newsite/erelease.aspx? relid=66917.*

- Ramachandran, V. (2009). Right to Education Act: A Comment, *Economic and Political Weekly*, 44(28), 155-157.

- Ramachandran, V. (2005) .Why school teachers are demotivated and disheartened. *Economic and Political Weekly*, 40 (21), 2141-2144.

- Rana.K & Das. S (2004) Primary Education in Jharkhand, *Economic and Political Weekly*, 39 (11), 1172-1178.

- Rana, L. & Rao,N.(1996) .Gross Injustice.*The Hindustan Times*, October 17.

- Rani, S., Ghosh, S &Sharan, M. (2007). Maternal healthcare seeking among tribal adolescent girls in Jharkhand, *Economic and Political Weekly*, 42(48), 56-61.

- Sarva Siksha Abhiyan. *Framework of implementation* (Draft 16.12.2010) Retrieved on January 15, 2011 from http://ssa.nic.in/framework-docs/Draft1.

- Singh ,K.S (1990). *Tribes of India*. New Delhi: Oxford University Press.

- South Asia Terrorism Portal (2012) *Jharkhand assessment 2012* Retrieved on April 2, 2012 from http://www.satp.org/satporgtp/countries/india/maoist/Assessment/2012/Jharkhand.htm South Asia Terrorism Portal

- The Registrar General & Census Commissioner. (2012). *Primary data abstract data highlights -2011* (India). Retrieved on May 1, 2013 from *http://www.censusindia.gov.in/2011census/ hlo/pca_highlights/pe_data.html*

Websites

- http://jharkhand.gov.in

- http://jamtara.nic.in

- http://164.100.150.8/dumka

- http:www.censusindia.gov.in

- http://wcd.nic.in

- http://mha.nic.in

- http://www.nmew.gov.in

- http://nrhm.gov.in

- http://mohfw.nic.in

- http:www.ssa.nic.in

- http:www.neipa.org
- http://education.nic.in
- http://www.dise.in
- http://www.schoolreportcards.in
- http://www.asercentre.org
- http://www.satp.org

ANNEXURE 1

LIST OF BLOCK AND DISTRICT OFFICIALS INTERVIEWED FOR STUDY

Sl. No.	Level	Name of the Officials	Department
Dumka			
1	Deputy Commissioner	Mr Harsh Mangla	District Headquarter
2	District Welfare Officer, Dumka	Mr. Sukumar Modak	Welfare
3	Project Officer	Mr Chandrashekar Pandey	MNERGA
4	District Planning Officer	Mr. Desh Kumar Gautam	Planning
5	Sr DOTS Supervisor	Mr. Arvind Kumar	NRHM
6	District Gender Coordinator	Ms. Singhasan Kumari	Education
7	Block Development Officer	Vijay Kumar Soni	Block Level
8	Zilla Parshad Member	Munni Hasda	Zilla Parishad
9	Special Paharia Officer	Mr Om Prakash	Welfare
10	Doctor	Dr O.P Kesari	Community Health Centre
Jamtara			
1	Deputy Commissioner	Chandra Shekhar	District Headquarter
2	Block Development Officer	Raj Mahesh Saram	Block Level
3	Dist. Social Welfare Officer	Anmol Kumar	Welfare Department
4	Civil Surgeon	V.K Shah	Department of Health
5	CDPO	Rita Basera	ICDS
6	District Education Officer	Siavar Prasad	Department of Education
7	Chairperson	Pushpa Soren	Zilla Parishad

ANNEXURE 2

DATA COLLECTION INSTRUMENTS

GUIDE FOR FOCUSSED GROUP DISCUSSION WITH TRIBAL WOMEN AND NON TRIBAL WOMEN ON HEALTH ISSUES

Number of FGD members: **Village:** **Hamlet** **Tribe:**	
Warm Up Conversation	
(Some warm up conversation ; the social mapping exercise before this group discussion may help in that; ask about their names,family etc. Explain to them the purpose of this group discussion, how it will help helping them collectively analyse their health issues and problems and explore ways to address these problems)	
Current status of health and health service providers	
	What specific health problems are faced by you all? (*elaborate)*
	Who all do you approach to address these health problems?.
(Can start listing the names of ALL the institution or individual on piece of paper. Mark women in the middle of the flip chart. As the women will be illiterate you can use drawing figures to depict each institution /individual)	
	Which institution /individual do you approach most when you or your family falls ill or needs medical assistance ? (*make that name the bigger circle and closer to the women)*
	After that who do you approach ? (*reduce the size of the circle, and the distance so on*)
	For what services do you approach each of the Circles-(starting from the Bigger circle)*(list them down)?*
	Why do you approach them for these services ? (*probe them for their reasons; ie why do they approach the "jhola wala doctor" or the traditional healer ?*)
	Are you happy with the service provided by each of the institutions? (*probe further-quality, effectiveness, cost, ease etc*)?
	If not, what are your reasons for not being satisfied? /challenges faced in accessing timely & quality health services?
	Why do you not approach some of the institutions or individuals for medical services? */the perceived as well as real causes of these problems;*
(probe them for their reasons- ie if they do not go to the health sub centre, why do they not go there? What hinders their access to that service- is it concern for own safety, is it gender roles,is it non	

availability of the medical staff, is it bad behaviour of the staff, is it due to lack of trust;)	
	What are some other problems faced in accessing health services of the government ? *(probe them… encourage them to give some concrete examples)*
Prevalence of Unrest and its effect on access to health service [13]	
	In the last one or two years has there been any incidence of unrest or violence in your village? If yes, please describe.
	Do you feel more fearful or less in comparison to earlier years? (*Probe further on the underlined reasons, with reference to any possible unrest in the village)*
	What makes you feel safe while choosing a health service in your neighbourhood?
	Do you fear going to a PHC alone? Does anyone accompany you to the PHC? (Personal anecdotes)
Awareness about Panchayat Extension to Scheduled Areas (PESA)-1996 *?*	
	Are you aware about the PESA, 1996 act?
	If yes what are the provisions and rights provide under the act for the Tribal communities of Scheduled 5 areas of Jharkhand?
Future Expectations and Suggestions *(exploration of possible solutions and future course of action)*	
	In future what kind of health services should reach you and your village (from government and other sources)? (*nature, quality, timing etc*)
	What needs to change/improve in all the identified institutions and individual dealing with health services ?

[13] Questions to be asked seeing the groups comfort in speaking about these sensitive issues in public

IN DEPTH SEMI STRUCTURED INTERVIEW SCHEDULE FOR TRIBAL WOMEN ON HEALTH

(Note: Take the consent of the person before interviewing and explain the purpose of the interview)

I. GENERAL INFORMATION

Name of the Interviewee	
Age	
Tribe	
No of family members	
Name of the head of the household	
Occupation of your Husband	
Number of children	
How long you have been living in the village/ town	□Less than 5 years; □5-10 Years; □ More than 10 years; □Entire Life

II. FAMILY HISTORY/ A FAMILY TREE

Relative	**Current Age**	**Current Health status or any past health related problem**
Husband		
Daughter		
Son		
Mother in Law		
Father in Law		
Sister/s in Law		
Brother/s in Law		
Any other		

III. HEALTH STATUS, ACCESS TO HEALTH (QUALITY AND TIMELY SERVICE)

Q. What was your age of marriage? (Other related information)
Q. Do you consider your health to be: □Excellent □Good □Fair □Poor
Q. What are the major health problems you face?
Q. What are the various health services available near the village □Sub Centre; □Primary Health Centre; □Community Health Centre; □Traditional Health care ; □Any other please mention
Q. Where do you mainly go for health related problems (Institution and on Individuals) □Sub Centre; □Primary Health Centre; □Community Health Centre; □Traditional Health care □Any other please mention
Q. Why do you approach them for these services ? (*probe them for their reasons; ie why do they approach the "jhola wala doctor" or the traditional healer ?*)
Q. Are you happy with the service provided by the above mentioned institutions or individuals? (*probe further-quality, effectiveness, cost, ease etc*)?
Q. If not, what are your reasons for not being satisfied? /challenges faced in accessing timely & quality health services?
Q. Why do you not approach some of the institutions or individuals for medical services?(*probe forthe perceived as well as real causes of these problems);*

Q. What are some other problems faced in accessing health services of the government ? *(probe them… encourage them to give some concrete examples)*

Q. **Health Service availability**

Services	Target Group	Service Provided by	Is the service available Yes or No? if no why?
Supplementary Nutrition	Children below 6 years: Pregnant & Lactating Mother (P&LM)	Anganwadi Worker and Anganwadi Helper	
Immunization*	Children below 6 years: Pregnant & Lactating Mother (P&LM)	ANM/MO	
Health Check-up*	Children below 6 years: Pregnant & Lactating Mother (P&LM)	ANM/MO/AWW	
Referral Services	Children below 6 years: Pregnant & Lactating Mother (P&LM)	AWW/ANM/MO	
Pre-School Education	Children 3-6 years	AWW	
Nutrition & Health Education	Women (15-45 years)	AWW/ANM/MO	

Q. Do you have a Village Health & Sanitation Committee (VHC) in your village?

Q. Do you have a village health plan made with the support of ANM, Sahiya, AWW and Self Help Groups?

Q. Does you gram sabha select/ appoints a Sahiya worker or anyone in the similar capacity in your village?

Q. What kind of roles Sahiya worker performs in your village? Are you satisfisfied with her performance?(*ie carries a health tool kit; takes preganant women for institutional delivery etc?)*

Q What kind of roles ANM performs in your village in terms of Health Care? Are you satisfisfied with the performance?

Q What kind of roles Aganwadi worker performs in your village in terms of Health Care? Are you satisfisfied with the performance?

Q What kind of roles Panchayats, esp Sarpanch performs in your village in terms of Health Care? Are you satisfied with the performance?

Q. Any other relevant information

IV.PREVALENCE OF UNREST AND ITS EFFECT ON ACCESS TO HEALTH SERVICE

Q In the last one or two years has there been any incidence of unrest or violence in your village? If yes, please describe.
Q. Do you feel more fearful or less in comparison to earlier years? (*Probe further on th underlined reasons, with reference to any possible unrest in the village)*
Q. What makes you feel safe while choosing a health service in your neighborhood?
Q. Do you fear going to a PHC alone? Does anyone accompany you to the PHC? Do you carry anything for your own protection or self defense (Personal anecdotes)
Q. Do you see any inter-generational change in the kind of health services available to you today and also in terms of the unrest.?
Q. Are the local health practitioners from among the community or they are from outside. Please elaborate

V. SUGGESTIONS:

Q. What you would like to suggest for a better health and living conditions?
Q. What is your expectation from the government specifically regarding better access to quality health services?
Q. What is your expectation from Panchayats specifically regarding better access to quality health services?
Q. What is your expectation from Civil society organizations specifically regarding better access to quality health services?
Q.What is your expectation from other Private health providers (incl traditional health care provider) specifically regarding better access to quality health services?

Interview Schedule

(GOVERNMENT AND INTERMEDIARY ORGANISATIONS ON HEALTH ISSUES)

Name of Respondent: **Village:** **Sex:** **Age:** **Tribe:** **Designation:**	
SN	**Questions-Semi structured**
	What specific health problems are faced by the tribal women ? (elaborate)
	What specific health problems are faced by the non tribal women ? (elaborate; any difference between tribal and non tribal women ? if yes, what could be the possible reason)
	What is the status of health services provided to tribal and non tribal women (i.e. *who all provide, quality, timeliness, responsiveness of staff, convergence among different departments*);
	What are the problems faced by tribal women in accessing health services from all these institutions ?
	What could be the underlined reasons for these barriers? (*trace the reasons from the women and the institution side,assess the safety dimension also*)
	What are the problems faced by non tribal women in accessing health services?
	What could be the underlined reasons for these barriers?
	What are the problems faced by your institutions to deliver health service (*ie staff attitude, safety, mobility etc*)
	What are the problems faced by other institutions to deliver health service (*ie staff attitude, safety, mobility etc*)
	Is there any comparative advantage the private providers have over their State counterparts in providing health services ? If Yes, what could be the possible reason?(ie *issue of trust, comfort, accessibility, perceptions)*
	What are your suggestions for addressing health barriers for tribal women?.
	What efforts can be made to facilitate convergence among other government line departments to address these barriers?
	How will you contribute to undertake follow up action of the research?.
	Any other comments?

VILLAGE AND COMMUNITY PROFILE[14]

I. VILLAGE PROFILE

<table>
<tr><td>Name of the village</td><td></td></tr>
<tr><td>Name of the Panchayat</td><td></td></tr>
<tr><td>Name of the District</td><td></td></tr>
<tr><td>Accessibility</td><td>□On road □Away from the Road (up to 5km) □Interior (more than 5 kms)</td></tr>
<tr><td>Village Population and Religion</td><td>
<table>
<tr><td>Village population</td><td>Male / Female / Children</td><td>Religion Practiced</td></tr>
<tr><td>Tribals</td><td></td><td></td></tr>
<tr><td>Non Tribals</td><td></td><td></td></tr>
<tr><td>Backward Castes</td><td></td><td></td></tr>
<tr><td>Others</td><td></td><td></td></tr>
<tr><td>Total population</td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>Language Spoken</td><td></td></tr>
<tr><td>Community cohesiveness factor:
Explain in terms of High /_ /Medium/_ / Low /_/
Describe with examples occasions/activities the communities participate/contribute together</td><td></td></tr>
<tr><td>Main sources of Livelihood</td><td></td></tr>
<tr><td>What is the average income level of the village? (Income per year) How would you describe the welfare status of the village?</td><td></td></tr>
</table>

II. COMMUNITY PROFILE

Name of Tribal Community	No of Families	Main Occupation	With Nos
Tribal 1			
Tribal 2			
Tribal 3			
Tribal 4			
Non Tribals			
Backward Castes			
Others			

[14] Data to be collected from the Social Map exercise as well as discussion with the Sarpanch and key people in the community

GUIDE FOR FOCUSSED GROUP DISCUSSION WITH TRIBAL WOMEN -

ON EDUCATION AND ENTITLEMENT ISSUES

Number of FGD members: **Village:** **Hamlet** **Tribe:**	
Warm Up Conversation	
(Some warm up conversation; etc. Explain to them the purpose of this group discussion, how it will help them collectively analyse the educational and entitlement issue and explore ways to address problems related to these issues)	
Current status of Education and Education service providers	
	How many children do you have ? (Male / Female-Capture average trend)
	Are all your children between 6-14 yrs of age enrolled in school ? (Male/Female-Capture average trend). If not, what is the reason?
	Do all your children (6-14 yrs) go to school? (Male/Female -Capture average trend). If not, what is the reason?
	Which school do your children go to ? (Male/Female-Capture average trend) • Government • Private • Others
	Do they all go to school regularly? (Male/Female-capture average trend).
	Have any of your children between 6-14 yrs of age dropped out of school?) Male/Female - Capture average trend).If yes, what is the reason?
	Does your child/ children in class 6-14 yrs enjoy going to school?*(Capture the general trend)*
	What do they like in School?
	What problems do they face in school?
	What kind of Role of Panchayts, esp Sarpanch performs in your village in terms of provision of Education.? Are you satisfied with that performance**?**
SEE ANNEXURE 1 FOR GROUP RATING OF THE EDUCATION SERVICE PROVISION. (You can use stones/flowers/leaves /local material to facilitate this Rating exercise).	
	Overall are you satisfied with the educational provisions available to your children ? • If yes, what are the reasons? (list out) (*probe further- encourage them to give some concrete examples)*

	• If not, what are the reasons?(list out) (*probe further- encourage them to give some concrete examples)*
Current status of Select Entitlements	
	Do you have **Bank Account** in your Name? If yes then where? • With Bank • SHG • Post office • Cooperatives • Others
	If not, then what were the difficulties in getting the Bank Account made ?
	Does anyone in your family have a bank account? If yes then where • With Bank • SHG • Post office • Cooperatives • Others
	Are you aware about the following and about the benefits from the following entitlements. • Ration Card • BPL Card • Aadhar Card If yes, specify the benefits?
	Do you or your family have a Ration Card? It is in whose name?
	What problems did you face in getting the Ration card made?
	During the last month what provisions you or your family have bought from the Ration shop using the Ration Card? • Rice • Wheat • Kerosene • Sugar • Others
	Did you have any problem getting the provisions using the Ration Card? If yes specify what were they? (quality, access) Are they linked to your being a women?
	Do you or your family have a BPL Card? If no, what difficulty did you face in getting the BPL card made? Are they linked to your being a women?
	Do you have an Aadhar Card? If no, what difficulty did you have in getting the Aadhar Card made? Are they linked to your being a women?
Prevalence of unrest and its effect on access to education service and other entitlements [15]	
	In the last one or two years has there been any incidence of unrest or violence in your village? If yes, please describe.

[15] Questions to be asked seeing the groups comfort in speaking about these sensitive issues in public

	Do you as a women feel more fearful or less in comparison to earlier years? (*Probe further on the underlined reasons, with reference to any possible unrest in the village)*
	What are the safety concerns for your children? (especially girl children)
	Do you prefer sending your children to school which are closer to your home? Do you feel safe sending your children, esp girl children to government school ? Does anyone accompany them to the School? (Personal anecdotes)
	Do you feel safe visiting the government school ? Does anyone accompany you to the School? (Personal anecdotes)
	. Do you see any inter-generational change in the kind of educational services available today (especially for girl children) and also in terms of the unrest.?
	Do you feel that the unrest situation is making access to basic entitlements difficult? Explain? Are women more vulnerable ?
Awareness about Right to Education Act, 2009 ?	
	Are you aware about the RTE, 2009 act?
	If yes what are the provisions and rights provide under the act for the Children (6-14 yrs of age)?
Future Expectations and Suggestions *(exploration of possible solutions and future course of action)*	
	What needs to change/improve in all the government and also private schools to provide effective educational service to your children ?
	What role can Panchayats play to ensure effective education services for your children?
	What role can CSOs play to ensure effective education services for your children?
	What role can Community play to ensure effective education services for your children?
	What should government do to ensure easy access to entitlements like BPL card, ration card, Aadhar Card, especially for Tribal women?
	What should panchayat do to ensure easy access to entitlements like BPL card, ration card, Aadhar Card, especially for Tribal women?
	What should CSOs do to ensure easy access to entitlements like BPL card, ration card, Aadhar Card?
	What should the Community do to ensure easy access to entitlements like BPL card, ration card, Aadhar Card, especially for Tribal women?
	Any other Comments?

GROUP RATING MATRIX FOR TRIBAL WOMEN

Rate the government school on the following heads. Give reasons

1. Availability and quality of Infrastructure and Facilities

Pictoral	***Very Good***	***OK***	***Poor***	***Reasons for the rating***
Access to school (transport/proximity)				
Special provisions for girl children				
Are the classrooms of well-equipped for the students?-(*chairs, tables, dari, ventilation, blackboard)*				
School building				
Cleanliness of school				
Midday Meal quality				
Provision of entitlements-ie scholarship, free books(as per SSA, Jharkhand norm for Tribal children)-timeliness, total amount				

2. Role and Performance of Government Education service providers : Head Teacher, Teacher

Pictoral	***Very Good***	***OK***	***Poor***	***Reasons for the Rating***
Teacher living in proximity				
Teachers Attendance and Regularity				
Composition of Teachers (ie presence of women teachers; Presence of tribal teachers				
Teacher Behaviour towards students- (how relate with girls, boys etc –rude, aggressive, mental or physical harassment, physical punishment, detention)				
Equal treatment of Boys and Girls				
Teacher Behaviour towards parents (open, communicative,				

Teacher ‘s teaching style (strict,creative,participatory)				
Extra curricular activities				
Quality of teaching				

3. School’s Engagement of Parents

Pictoral	***Very Good***	***OK***	***Poor***	***Reasons for the Rating***
Parents Informed about Student Progress				
Parents invited to school events and functions				
Parents engaged in school management aspects-ie active School management committee				

SEMI STRUCTURED INTERVIEW SCHEDULE FOR TRIBAL WOMEN ON TRIBAL CHILDREN EDUCATION AND ENTITLEMENT ISSUES

(Note: Take the consent of the person before interviewing and explain the purpose of the interview)

I. GENERAL INFORMATION

Name of the Interviewee	
Age	
Tribe	
No of family members	
Name of the head of the household	
Occupation of your Husband	
Number of children	
How long you have been living in the village/ town	□Less than 5 years; □5-10 Years; □ More than 10 years; □Entire Life
Educational Qualification-own	
Educational Qualification-spouce	

II. Background Information: Parents

Head	Number of Boys	Number of Girls
• Total Number of children		
• 6-14 yrs going to school		
• 6-14 yrs old who are not enrolled		
• Reason for not enrolling the children between 6-14 years	1. Heath Reason: 2. Economic reasons- Economic reasons- child help in fields, unable to financially support child's education 3. Household duty reason 4. Child not interested 5. Migration of parents 6. Any other	1. Heath Reason: 2. Economic reasons- Economic reasons- child help in fields, unable to financially support child's education 3. Household duty reason 4. Child not interested 5. Migration of parents 6. Any other
• 6-14 yrs old who have dropped out from school		
• Reason for dropout of the child	1. Heath Reason: 2. Economic reasons-child help in fields, unable to financially support child's education 3. Household duty reason 4. Child not interested 5. Migration of parents 6. Any other	1. Heath Reason: 2. Economic reasons-child help in fields, unable to financially support child's education 3. Household duty reason 4. Child not interested 5. Migration of parents 6. Any other

III. ***Current status of Education and Education service providers***

	How many children do you have ? (Male / Female)
	Are all your children between 6-14yrs of age enrolled in school ? (Male/Female)If not, what is the reason?
	Do all your children (6-14yrs) go to school? (Male/Female)If not, what is the reason?
	Which school do your children go to ? (Male/Female) • Government • Private • Others
	Do they all go to school regularly? (Male/Female).
	Have any of your children between 6-14 yrs of age dropped out of school? (Male/Female) If yes, what is the reason?
	Does your child/ children in class 6-14 yrs enjoy going to school?
	What do they like in school? *(List out or tick what they mention)* • Academic : studies, teachers, books • Infrastructure related-classroom, playground • Friends related- • Extra-curricular activities-games, plays • Any other
	What problems do they face in school*? (List out or tick what they mention)* • Poor Teaching • Irregular teacher presence • Discriminatory Teacher Attitude • Discriminatory Peer Attitude • Lack of Infrastructure-toilets;drinking water • Poor midday meal quality • Delay in receiving SC children entitlements • Made to sweep the classrooms
	What kind of Role of Panchayts, esp Sarpanch performs in your village in terms of provision of Education.? Are you satisfied with that performance**?**
SEE ANNEXURE 1 FOR RATING OF THE EDUCATION SERVICE PROVISION. You can use stones/flowers/leaves /local material to facilitate this Rating exercise.	
	Overall are you satisfied with the educational provisions available to your children ?

	• If yes, what are the reasons? (list out) (*probe further- encourage them to give some concrete examples)*
	• If not, what are the reasons? (list out) (*probe further- encourage them to give some concrete examples)*
Current status of Select Entitlements	
	Do you have **Bank Account** in your Name?If yes then where? • With Bank • SHG • Post office • Cooperatives • Others
	If not, then what were the difficulties in getting the Bank Account made ?
	Does anyone in your family have a bank account? If yes then where • With Bank • SHG • Post office • Cooperatives • Others
	Are you aware about the following and about the benefits from the following entitlements. • Ration Card • BPL Card • Aadhar Card If yes, specify the benefits?
	Do you or your family have a Ration Card? It is in whose name?
	What problems did you face in getting the Ration card made?
	During the last month what provisions you or your family have bought from the Ration shop using the Ration Card? • Rice • Wheat • Keroscene • Sugar • Others
	Did you have any problem getting the provisions using the Ration Card? If yes specify what were they?(quality, access) Are they linked to your being a women?

	Do you or your family have a BPL Card? If no, what difficulty did you face in getting the BPL card made? Are they linked to your being a women?
	Do you have an Aadhar Card? If no, what difficulty did you have in getting the Aadhar Card made? Are they linked to your being a women?
Prevalence of unrest and its effect on access to health service and other entitlements[16]	
	In the last one or two years has there been any incidence of unrest or violence in your village? If yes, please describe.
	Do you as a women feel more fearful or less in comparison to earlier years? (*Probe further on the underlined reasons, with reference to any possible unrest in the village)*
	What are the safety concerns for your children? (especially girl children)
	Do you prefer sending your children to school which are closer to your home? Do you feel safe sending your children, esp girl children to government school ? Does anyone accompany them to the School? (Personal anecdotes)
	Do you feel safe visiting the government school ? Does anyone accompany you to the School? (Personal anecdotes)
	Do you see any inter-generational change in the kind of educational services available today (especially for girl children) and also in terms of the unrest.?
	Do you feel that the unrest situation is making access to basic entitlements difficult? Explain? Are women more vulnerable ?
Awareness about Right to Education, 2009, Act?	
	Are you aware about the RTE, 2009 act?
	If yes what are the provisions and rights provide under the act for the Children (6-14 yrs of age)?
Future Expectations and Suggestions *(exploration of possible solutions and future course of action)*	
	What needs to change/improve in all the government and also private schools to provide effective educational service to your children ?
	What role can Panchayats play to ensure effective education services for your children?
	What role can CSOs play to ensure effective education services for your children?
	What role can Community play to ensure effective education services for your children?
	What should government do to ensure easy access to entitlements like BPL card, ration card, Aadhar Card, especially for Tribal women?

[16] Questions to be asked seeing the groups comfort in speaking about these sensitive issues in public

	What should panchayat do to ensure easy access to entitlements like BPL card, ration card, Aadhar Card, especially for Tribal women?
	What should CSOs do to ensure easy access to entitlements like BPL card, ration card, Aadhar Card?
	What should the Community do to ensure easy access to entitlements like BPL card, ration card, Aadhar Card, especially for Tribal women?
	Any other Comments?

Interview Schedule

(GOVERNMENT SERVICE PROVIDERS OF EDUCATION, SCHOOL MANAGEMENT COMMITTEE MEMBERS AND INTERMEDIARY ORGANISATIONS)

Name of Respondent: **Village:** **Sex:** **Age:** **Tribe:** **Designation:**	
SN	**Questions-Semi structured**
	What are the specific problems related to education of tribal children, esp girl children (between 6-14 years of age)? (elaborate)
	What is the status of education services provided to tribal children (between 6-14 years of age)? (i.e. *who all provide, quality, timeliness, responsiveness of staff, convergence among different departments*);
	What are the problems faced by tribal children, especially girl children (between 6-14 years of age)? in accessing quality education services from the prevalent educational institutions .
	What could be the underlined reasons for these barriers? (*trace the reasons from the women and the institution side,assess the safety dimension also*)
	What are the problems faced by your institutions to deliver educational service (*ie staff attitude, safety, mobility,parent attitude etc*)
	What are the problems faced by other institutions to deliver educational service (*ie staff attitude, safety, mobility,parent attitude etc*)
	Is there any comparative advantage the private providers have over their State counterparts in providing educational services ? If Yes, what could be the possible reason?(ie *issue of trust, comfort, accessibility, perceptions)*
	What are your suggestions for addressing educational barriers for tribal children, esp girl children?.
	What efforts can be made to facilitate convergence among other government line departments to address these barriers?
	How will you contribute to undertake follow up action of the research?.
	Any other comments?

Interview Schedule

(GOVERNMENT SERVICE PROVIDERS OF ENTITLEMENTS AND INTERMEDIARY ORGANISATIONS)

Name of Respondent: **Village:** **Sex:** **Age:** **Tribe:** **Designation:**	
SN	**Questions-Semi structured**
	What is the status of access to entitlements like Ration card, BPL card, Aadhar card to tribal women? (i.e. *who all provide, quality, timeliness, responsiveness of staff, convergence among different departments*);
	What are the specific problems related to access to entitlements like Ration card, BPL card, Aadhat card of tribal women ? (elaborate)
	What could be the underlined reasons for these barriers? (*trace the reasons from the women and the institution side,assess the safety dimension also*)
	What are the problems faced by your institutions to these entitlements (*ie staff attitude, safety, mobility etc*)
	What are the problems faced by other institutions to deliver these entitlements (*ie staff attitude, safety, mobility etc*)
	What are your suggestions for addressing these barriers for tribal women ?.
	What efforts can be made to facilitate convergence among other government line departments to address these barriers?
	How will you contribute to undertake follow up action of the research?.
	Any other comments?