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Fending for Themselves – Adivasis, Forest Dwelling Communities and the Devastating Second Wave of COVID-19

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Photo Caption: A Reang woman receives a COVID-19 vaccine dose at Gobindabari village in Chawmanu, near Agartala, in Tripura on Wednesday, May 12, 2021. File Photo: PTI

Fending for Themselves – Adivasis, Forest Dwelling Communities and the Devastating Second Wave of COVID-19

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ABSTRACT

India recognises 104 million of its over 1.2 billion population as Scheduled Tribes. As with the rest of the world, a majority of India's Scheduled Tribes, who comprise the second largest indigenous peoples of the world, are among the poorest of the poor, live in social exclusion, and are often the last touched by the state's welfare tools.

The visitation of the Coronavirus Disease (COVID-19) pandemic since December 31, 2019, further exacerbated the historical exclusion that Adivasis and other forest dwelling communities faced at the hands of governments and the state. As with Indigenous peoples elsewhere, India's counterparts, the Scheduled Tribes, have remained on the margins through the pandemic.

A novel virus, one that had not affected humankind until then, meant developing information and awareness about COVID-19 and studies ascertain that there is a negative direct correlation with spread of awareness and epidemic outbreaks. This Policy Watch by Sushmita, an award-winning journalist and researcher, and Suraj Harsha, an independent researcher and teacher, highlights the lack of communication by the state and unchallenged misinformation regarding the virus with respect to Adivasis and other forest dwelling communities. What makes it worse is that the areas where a substantial population of forest dwelling people live are also geographically remote. This Policy Watch looks into the structural issues such as the withering away of land rights, lack of literacy, failure of government schemes, and other deeper malaises that aggravate the crisis created by the pandemic.

Against this backdrop, this Policy Watch brings out the manner in which the Indian state managed the pandemic like a 'disaster' and elaborates on the response of Forest Dwelling population in 19 districts across 10 States to the pandemic. It is based on interviews conducted with primary sources that worked with the tribal populations and members of the communities affected by the pandemic, as well as secondary sources such as civil society and media reports, Lok Sabha responses, media articles, and government notifications. It reveals how chronic structural, legal, technological, and socio-economic inadequacies came in the way of the delivery of COVID-19 related healthcare services to these communities.

In this context, this Policy Watch also provides a status of the chronic marginalisation of India's most vulnerable population, who are behind the curve in human development indicators and the manner in which they fended for themselves when they were hard-hit during the second wave of the pandemic.

Remedying long-standing issues such as upholding their rights that exist only in the statute book, bridging shortfalls in healthcare provisioning, recognising traditional knowledge systems, and above all, taking political and policy cognisance of the unique conditions that surround India's Scheduled Tribes, are required to redirect India's Scheduled Tribe populations towards the long road to "development".

Keywords: Scheduled Tribes and COVID-19, Adivasis, Forest Dwelling Communities, Scheduled Areas, Forest Rights Act, Nomadic communities, Indigenous peoples, Health, land rights, traditional medicine, ASHA workers, vaccines, pandemic, disease.

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I. ADIVASIS AND FOREST COMMUNITIES IN INDIA – A PORTRAIT OF NEGLECT

India's 104 million Adivasis, listed as Scheduled Tribes (STs) in the Constitution, account for 8.6 per cent of the country's population[1], mostly live in and around forests, and are dependent on them for their survival. Despite constituting a visibly significant proportion of the population, official data reveal the extent to which they remain neglected by government policies and programmes. A detailed answer in the Lok Sabha[2] by the Union Minister for Tribal Affairs, Arjun Munda, on November 18, 2019, provides a portrait of neglect of India's tribes, a majority of whom continue to languish at the margins of society.

Official numbers on India's tribal population need to be seen in the following context: Of the estimated 1,45,000 villages with "more than 25 per cent of tribal population", data on "infrastructure gap" under the Mission *Antyodaya* is available only for 1,17,064 villages. This means that close to 20 per cent, or 27,936 villages, are by the Government's admission off the official radar that monitors "programmes for the development of rural areas"[3]. Some highlights from the data available for the remaining 80 per cent of such villages are presented in Table 1.

[**Note:** The Authors of this Policy Watch use the terms 'Adivasis' and 'forest dwellers', in addition to the administrative classification, Scheduled Tribes, to include communities living in and around forest areas.]

[1] **Government of India. n.d**. *ST Statistical Profile – at a glance* (Table 1), Ministry of Tribal Affairs. [https://tribal.nic.in/downloads/Statistics/Statistics8518.pdf].
[2] **Government of India. 2019**. *Tribal Communities*, Lok Sabha Starred Question, To be answered on November 18, 2019, Ministry of Tribal Affairs. [http://164.100.24.220/loksabhaquestions/annex/172/AS9.pdf].
[3] *Mission Antyodaya* was adopted in the Union Budget 2017-18, as "a convergence and accountability framework aiming to bring optimum use and management of resources allocated by 27 Ministries/ Department of the Government of India under various programmes for the development of rural areas. It is envisaged as a state-led initiative with Gram Panchayats as focal points of convergence efforts." **Source**: [https://missionantyodaya.nic.in/].

Table I: Tribal Dominated Village-wise Infrastructure Gap Analysis — All India (Select indicators)

Village-wise Infrastructure Details	No. of village out of 11,7064 Tribal Dominated Villages	% with access
Availability of Banks in the village	10,945	9.34
All-weather road	77,551	66.25
Availability of PDS	58,068	50.40
Health:		
PHC	3,453	2.95
CHC	7,114	6.10
Sub-centre	18,185	15.53
None	88,295	75.42

Source: Compiled from Lok Sabha Answer, November 8, 2011. MoTA, GoI.

The extent of deprivation faced by STs is evident from data: as many as 75 per cent tribal villages lacked access to healthcare, 51 per cent had no access to the Public Distribution System (PDS) and 52 per cent were not provided with piped water. Of these 1,17,064 "tribal dominated" villages[4], only 3,453 had a primary health centre, 7,114 had a community health centre and 18,185 had a health sub centre, while a total of 88,295 villages had no access to health care. These health-related indicators have a direct bearing on the theme that this Policy Watch addresses.

Health

Even before the pandemic broke out, Adivasis bore a "disproportionate burden" of communicable diseases, including diseases like tuberculosis and malaria. A report by the National Vector Borne Disease Programme points out that,

> "although tribal communities constitute only about eight per cent of the national population, they account for about 30 per cent of all cases of malaria, and as much as 50 per cent of the mortality associated with malaria"[5].

[4] The Lok Sabha Answer describes "tribal dominated" villages as those with tribal population of 25 per cent and above.

[5] **Ministry of Health & Family Welfare. 2018**. "*Tribal Health Report, India*", p. 37. [http://tribalhealthreport.in/full-report/].

Similarly, the prevalence of tuberculosis is higher among indigenous communities among whom the death rate is 703 per population of 100,000 as against a national average of 256. In the case of tuberculosis, a paltry 11 per cent of cases get treated[6].

As reported by the World Bank (2017), India has 0.5 beds per 1,000 people, marginally up from 0.46 in 1960[7]. Of this, only 30 per cent of the beds are for semi-urban and rural areas, which comes to as less as 0.1 beds per 1,000 population with no specific area-wise data. The situation in tribal areas is worse as these are geographically remote. Health infrastructure has always been a lens to measure raging inequalities. The COVID-19 pandemic worsened these disparities creating a healthcare crisis across all sections, including those that could afford expensive medical facilities.

An Expert Committee on Tribal Health, which had also presented its report before the pandemic broke out, was particularly concerned that there was no "comprehensive plan for the development of tribal people, including health at the national level". Pointing out that the tribal population were left to fend for themselves, the *Tribal Health Report – Bridging the gap and a Roadmap for the Future* prepared by this Committee observed:

> "Unfortunately, the MoTA [Ministry of Tribal Affairs] does not lead the other departments in planning for various aspects of tribal development. Similarly, MoHFW [Ministry of Health and Family Welfare] or NHM [National Health Mission] did not actively consider for *[sic]* tribal health. Health of the most vulnerable was left out by both the ministries"[8].

The report also noted that "tribal people face triple burden of diseases"[9]. These were (1) the rampant presence of malnutrition, (2) a disproportionately high incidence of communicable diseases like Malaria and Tuberculosis, and (3) the recent spurt in non-communicable diseases such as cancer, hypertension, and diabetes.

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[6] **Ibid**. p. 38.
[7] **World Health Organization. n.d**. *Hospital beds (per 1,000 people)*, The World Bank. [https://data.worldbank.org/indicator/SH.MED.BEDS.ZS?end=2019&name_desc=false&start=1960&view=map&year=1979].
[8] **Ministry of Health & Family Welfare. 2018**. *Tribal Health Report, India,* p.20. [http://tribalhealthreport.in/].
[9] **Ministry of Tribal Affairs. 2014**. *Tribal Profile at a Glance*. [https://tribal.nic.in/ST/Tribal%20Profile.pdf].

As early as 2014, a report by the MoTA[10] noted that the overall intake of food among the ST population was less than the Recommended Daily Allowances (RDA), a measure of the levels of essential nutrients needed for a healthy person. Stunting and malnutrition was also prevalent with 57 per cent of boys and 52 per cent of girls in the age group of 3-6 years reported as stunted. In the same age group, about 53 per cent of boys and 50 per cent of girls were underweight[11]. Importantly, the report also noted that that 49.6 per cent of STs were "poor" compared with 12 per cent of the total population[12].

The National Family Health Survey-4 (2015-2016), which covered 55,438 Scheduled Tribe households, revealed that only 38.4 per cent households had access to both soap and water for hand washing, while 13.6 per cent used cleansing agents other than soap; 18.4 per cent used only water to wash hands and 19.5 per cent did not use either water or soap[13].

The *Tribal Health Report* also highlighted the severe shortage of healthcare professionals in Adivasi-dominated areas and suggested the need to motivate and train local people, especially Adivasi youth, to join the healthcare workforce. Commenting on the deployment of frontline workers like the ASHAs (Accredited Social Health Activist), the report noted that "no numbers are available as to the density of ASHA workers in tribal areas or the average number of people covered by them" (p.55). It emphasised the potential importance of ASHA workers by pointing out in tribal areas where "public health systems suffer from problems of acceptability", these workers could play "a very crucial role".

Studies also suggest that tribal areas are becoming the "hotspots" for leprosy. A 2022-paper threw the spotlight on the "disproportionate burden of leprosy among tribal populations[14]. Citing a 2019-research paper, it pointed out that not only was the rate of decline of leprosy cases in tribal population "much lower than the non-tribal population" but also that the proportion of new leprosy patients belonging to Adivasi groups increased from 13.3 per cent

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[10] **Ministry of Tribal Affairs. 2014**. *Report of the High Level Committee on Socio-economic, Health and Education Status of Tribal Communities of India,* Government of India, May. p.206
[11] **Ibid**. (Fig. 7.8)
[12] **Ibid**. (Table 5.33)
[13] **International Institute for Population Sciences (IIPS) and ICF. 2017**. *National Family Health Survey (NFHS-4)*, 2015-16: India, Mumbai: IIPS. [http://rchiips.org/nfhs/nfhs-4Reports/India.pdf].
[14] **Sharma, M. *et al.* 2022**. Current situation of leprosy in tribal areas of India in the post-elimination era. In *Indian Journal of Dermatology*, Venerology and Leprology. *Viewpoint* 88 (4);450-451. doi: 10.25259/IJDVL_1380_20. [https://ijdvl.com/current-situation-of-leprosy-in-tribal-areas-of-india-in-the-post-elimination-era/#ref4].

in 2009 to an alarming 18.8 per cent in 2017. The authors of the paper diagnosed the marginalisation of the disease among the tribal population to a wider definitional issue: India witnessed a decrease in the prevalence of leprosy and "most States have achieved the prevalence of less than 1/10,000, the defining feature of 'elimination of a disease as a *public health problem'."* [Emphasis by authors.] However, such an All-India approach tends to overlook subgroups, such as the Adivasis. Providing data from several States (Table II, p.30), the authors express concern that "a substantial reduction in leprosy cases among tribals has remained elusive despite much acclaimed success in other sections of the society." Moreover, as the tribal regions would come under a policy blind spot created by the definition of "elimination of disease as a public health problem", the trend "suggests that leprosy would quickly become more of a disease of the marginalised population living in remote areas"[15]. The policy blind spots are further exacerbated by the ways in which accessibility to health services is made difficult.

Issues of Accessibility: Aadhaar and social security

Since its launch in 2009, Aadhaar, India's unique identification number system, has been pushed by the Union government as a way to streamline welfare schemes and provide access to social security schemes. However, most often it has acted as a barrier rather than a facilitator. For instance, in 2018, 14 starvation deaths were reported mostly of Adivasis from Jharkhand[16]. The issues surrounding digitisation of documents, compulsory requirement for records to be accurate and biometric requirements for disbursement of food and pension seemed to be closely connected with the cause of the deaths. Although the centre maintains that documents like Aadhaar are not mandatory, the situation on ground is at odds with this stated position. Adivasis have been denied various welfare schemes on ground of inadequate documentation and technical glitches. It is also notable how, because of dwindling forests and displacement from their traditional homesteads, Adivasis and forest dwelling communities have been made vulnerable in such a way that not only do they not have their rights recognised but also are dependent on social security schemes for their survival.

[15] **Ibid**.
[16] **Saha, D. 2018**. *Did Aadhaar Glitches Cause Half Of 14 Recent Jharkhand Starvation Deaths?*, IndiaSpend, August 11. [https://www.indiaspend.com/did-aadhaar-glitches-cause-half-of-14-recent-jharkhand-starvation-deaths-73702/].

As per the 2011 census, STs make up 8.6 per cent of the total population, of which more than 90 per cent reside in rural areas, making up 11.3 per cent of the total rural population. However, they account for 20 per cent of Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) workers which is disproportionate with respect to their share in both total population and rural population. Meanwhile, successive cuts in the allocation for MGNREGS in recent Union Budgets will, as representatives of Adivasi civil society organisations state, only amplify the harm and worsen the access to livelihood schemes. It is also important to note that the recent cuts in subsidies across social welfare policies and programmes also included food subsidies.

Contextualising Adivasi, Tribal and Other Traditional Forest Dwellers (OTFD)

This Policy Watch, in addition to describing the situation of the Adivasi communities, takes into account other traditional FDCs whose rights have been established in the Scheduled Tribes and Other Traditional Forest Dwellers (Recognition of Forest Rights) Act, 2006. These communities include Dalits, Bahujans, nomadic, pastoralist and other communities residing in and around forest areas. About 200 million forest dwellers directly depend on forest resources for livelihood in India[17].

Further, while the category of Scheduled Tribes is mostly an administrative one, many people in India belonging to various tribes have self-identified as Adivasis. Some have also argued that the word Adivasis does not adequately represent all the communities[18]. However, for the purposes of writing this Policy Watch we have used the terminology of Adivasis and forest dwellers, which, in our opinion, include the communities living in and around forest areas. This is also a widely used terminology in the context of forest rights and rights recognition processes.

Institutional framework on land and forest rights

Decades of rising state control over resources has alienated several Adivasi and forest communities from forest and land resources with which their lives were intertwined across

[17] **CFR-LA. 2016**. *Promise and Performance: Ten Years of the Forest Rights Act in India.* Citizens' *Report on Promise and Performance of The Scheduled Tribes and Other Traditional Forest Dwellers (Recognition of Forest Rights) Act, 2006, after 10 years of its Enactment.* December 2016. Produced as part of Community Forest Rights-Learning and Advocacy Process (CFRLA), India, 2016 (www.cfrla.org.in).

[18] **Bijoy, C.R. 2003**. The Adivasis of India A History of Discrimination, Conflict and Resistance" in *PUCL Bulletin*, February, and **Burman, Roy, J. J. 2009**. *Adivasi: A Contentious Term to denote Tribes as Indigenous Peoples of India*, Mainstream Weekly, Vol XLVII, No 32, July 25. [https://www.mainstreamweekly.net/article1537.html].

several generations. What were considered as commons for centuries have been broken into various legal categories of forests with differentiated access for different categories of people[19]. Colonial forest policies continued after independence, disenfranchising Adivasi communities from those forests that they had protected, conserved and made fertile through their labour. Several policy measures, like the New Forest Policy, 1988, left room for interpretation and misinterpretation of Adivasis' rights over their resources. In 1990, the concept of Joint Forest Management (JFM) came into the official vocabulary in many States through a circular, "Involving of Village Communities and Voluntary Agencies in the Regeneration of Degraded Forests", by the Ministry of Environment and Forests (MoEF)[20].

As of October 2001, 27 out of 28 States in India had issued JFM orders specifying their respective bases for working in partnership with local villagers, and 14.25 million hectares of forest land (18 per cent of total forest area) was already being officially protected by roughly 62,890 village organisations under JFM[21]. However, the JFMs turned into an exploitative institution as, in many cases, the villagers' cattle grazing land was also brought under JFMs. Some States like Odisha (then Orissa) extended it to revenue lands under the Revenue Departments. In Uttarakhand, the JFM aspired to bring community managed forests with legal standing under the JFM[22].

Sarin, Et al. (2003) point out that the provisions of the Panchayats (Extension to the Scheduled Areas) Act, 1996, (PESA) was a "more radical constitutional and legislative mandate for devolution of local self-governance in Schedule V (tribal majority) areas". They point out that the Act made Gram Sabhas "competent to safeguard and preserve the traditions and customs of the people, their cultural identity, community resources etc". Although these village-level bodies comprising "all adult voters of a self-defined community" could "approve the plans, programmes and projects for its social and economic development before their implementation, besides having ownership of minor forest produce within its area either directly or through the Gram Panchayat", the authors held out the caution that the Act was "riddled with ambiguities" and was open to misinterpretations.

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[19] **Sarin, M. *et al.* 2003.** Devolution as a Threat to Democratic Decision-making in Forestry? Findings from three States in India, ***Oversees Development Institute,*** **London. [https://www.cifor.org/knowledge/publication/1189/].**

[20] **Government of India. 1990**. The Circular Concerning Joint Forest Management, Ministry of Environment and Forests, June 1. Source: Food and Agriculture Organization of the United Nations, FAOLEX Database. [http://extwprlegs1.fao.org/docs/pdf/ind21949.pdf].

[21] **Sarin, M. *et al.* 2003.** Op. cit.

[22] **Ibid**.

> "The PESA effectively mandates community-based forest management by Gram Sabhas in tribal majority areas. This is in contrast with JFM, which establishes new village committees under Forest Department supervision to manage forest lands. Forest Department and administrative officers assert that PESA does not apply to the management of nationalised forest lands. Mobilised tribal communities, on the other hand, insist that their community resources include forest areas they have traditionally used but which have been taken over by the state over the past few decades"[23].

In this socio-political context, the FRA, for the first time, clearly defined the rights of the communities without leaving any space for ambiguities. The FRA is a unique piece of legislation recognising Individual Forest Rights (IFRs), Community Forest Resource rights (CFRs), through which Gram Sabhas (primary body of the Indian local self-governance system called the Panchayati Raj) or other village institutions have the right "to protect, regenerate, conserve or manage any community forest resource which they have been traditionally protecting and conserving for sustainable use" (Section 3(1)(i) of the FRA). It focuses primarily on recognising people's pre-existing rights on their land while establishing almost no conditions regarding forest management.

A study on the impact of the pandemic on Adivasis and similarly vulnerable populations concludes by noting the following:

> "A vast majority of forest and other ecosystem dependent communities in India still do not have secured rights and access to the forests and other ecosystems and, therefore, are vulnerable to social, political, economic and ecological distress, consequently exacerbating the already existing vulnerability. The bare minimum estimated potential forest area over which Community Forest Resource (CFR) rights can be recognised in India (excluding five northeastern States and J&K) is approximately 85.6 million acres (34.6 million ha). Rights of more than 200 million Scheduled Tribes (STs) and Other Traditional Forest Dwellers (OTFDs) in over 1,70,000 villages are estimated to get recognised under FRA. However, by 2016, only three per cent of the minimum potential of CFR rights could be achieved"[24].

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[23] **Ibid**. p. 6

[24] **Vikalp Sangam and CFR-LA, 2020**. *Community Forest Rights and the Pandemic: Gram Sabhas Lead the Way* - Volume 2 of the Extraordinary Work of 'Ordinary People – Beyond Pandemics and Lockdowns' Series and Bulletin 5 of COVID 19 & Forest Rights, Vikalp Sangam Core Group, Pune, October, p.32.

This Policy Watch aims to understand the impact of the second wave of COVID-19 in Scheduled Areas where Adivasis and forest dwelling people live. It looks at aspects of health and structural issues that impacted effective intervention in some of these areas. The Policy Watch also tries to apply a lens of land and forest rights and tries to understand the interplay of these issues when it comes to service delivery in moments of crisis and thereby lays grounds for further research and policy interventions.

II. COVID-19: THE SECOND WAVE

Adivasi and forest dwelling communities (FDCs) were not on the frontiers during the first wave of the COVID-19 visitation[25]. The first wave of the pandemic swept large parts of metropolitan India and then moved slowly to the rural areas, and from cities such as Mumbai and Delhi to States such as Odisha, Jharkhand, and Chhattisgarh that have significant population of Adivasi and FDCs. By mid-2020, the pandemic had clearly moved from metros to the districts. For instance, States in the Northeast experienced the first wave in July 2020. This trend was picked up by media reports. India Today, on July 23, 2020, while reporting that there was a "relative decline of the share of India's metros in the pandemic", also pointed out that there was an

> "… explosion in cases across the countryside. Cases are now reported in all but 11 districts, and the median Indian district has between 100 and 500 cases. For a country whose biggest cities struggled to contain the disease and keep hospital admissions at manageable levels, the high rates of infections in other districts, particularly in rural areas, will be a cause for concern"[26].

Similarly, the second wave reached its peak across States, cities and rural areas at different periods. This meant that the first as well as the second waves had different trajectories for different regions. Thus, the solution of abrupt lockdown for the first wave had differing impacts on people and their perspective towards COVID-19. For many, it also meant suffering for a longer period of time and this fuelled the existing distrust in the government.

Despite warnings from epidemiologists, public health experts, researchers, virologists, and immunologists that the pandemic was not over[27] (after the first wave), that better data was needed, and precautionary measures warranted, several political rallies and large gatherings

[25] In the absence of mainstream media reportage and overwhelmed information channels, it is hard to assess accurately the initial impact, especially on health of Adivasi and forest dwelling communities, during the first wave.

[26] **Rukmini, S. 2020**. *How coronavirus pandemic has moved beyond India's big cities*, India Today, July 23. [https://www.indiatoday.in/india/story/how-coronavirus-pandemic-has-moved-beyond-india-s-big-cities-1703760-2020-07-23].

[27] **Padma, T.V. 2021**. *Indian Government should heed its scientists on Covid*, Nature, April 30. [https://www.nature.com/articles/d41586-021-01140-6#:~:text=Researchers%20have%20spoken%20out%20against,Policymakers%20must%20listen.&text=The%20world%20stands%20aghast%20at%20the%20COVID%2D19%20crisis%20in%20India].

were held around February-March 2021 when Assam, West Bengal, Kerala, Tamil Nadu, and Puducherry went to polls. This apart, about nine million people attended the Kumbh Mela between April 1, 2021 and April 17, 2021 in Haridwar, Uttarakhand. As per reports, Uttarakhand witnessed a 1,800-per cent rise in COVID-19 cases and a similar exponential rise was witnessed in many different places[28]. An already strained public healthcare delivery system came under tremendous pressure. It did not have the infrastructure to deal with the sheer numbers. Acute shortage of beds to treat the sick and a massive lack of oxygen supply across the country threw the state apparatus out of gear. Although the agony of patients in urban areas was captured by mainstream media and social media channels, there was very little credible news from the hinterlands.

On May 11, 2021, the WHO classified the B.1.617 variant of the Coronavirus as a 'variant of global concern'[29]. The second wave of COVID-19 proved to be devastating due to increased transmissibility owing to the highly infectious manifestation of the B.1.617 variant and its severe impact on the younger population. There was a sharp surge in daily positivity rates from 1.62 per cent on March 1, 2021 to 20 per cent by May 31, 2021[30]. The resources in this phase depleted quicker and the situation became serious very soon with hospitals not having enough beds, life-saving drugs and apparatus, and uninterrupted oxygen supply. The second wave caused as many as 20 million infections in India by late-May of 2021. The death toll in India after the two waves roughly stood at four million, with about 2.4 million deaths taking place during the second wave[31,32]. Several studies published later highlighted a likely massive undercounting of the actual deaths by official sources.

As India does not have national all-cause-mortality (ACM) data, the World Health Organization, the United Nation's public health agency, extrapolated numbers from other

[28] **Ellis-Petersen, H and Hassan, A. 2021**. *Kumbh Mela: How a superspreader festival seeded Covid across India*, The Guardian, May 30. [https://www.theguardian.com/world/2021/may/30/kumbh-mela-how-a-superspreader-festival-seeded-covid-across-india].
[29] **Nebehay, S and Farge, E. 2021**. *WHO classifies India variant being of global concern*, Reuters, May 10. [https://www.reuters.com/business/healthcare-pharmaceuticals/who-designates-india-variant-being-global-concern-2021-05-10/].
[30] **Kumar, S. 2021**. Second wave of COVID-19: Emergency situation in India, Journal of Travel Medicine, Oxford Academic (oup.com), *Journal of Travel Medicine-Oxford Academic,* May 25.
[31] **Mordani, Sneha. 2021.** *2nd Covid wave was India's worst tragedy since Partition, saw up to 49 lakh excess deaths: Report*, Indiatoday.in, July 21. [https://www.indiatoday.in/coronavirus-outbreak/story/2nd-covid-wave-was-india-worst-tragedy-since-partition-saw-up-to-49-lakh-excess-deaths-1830894-2021-07-21].
[32] **Bhattacharya, A. 2021**. *Covid-19: Second wave cases cross 2cr, nearly 2/3rd of total infections*, The Times of India, July 19. [https://timesofindia.indiatimes.com/india/covid-19-second-wave-cases-cross-2cr-nearly-2/3rd-of-total-infections/articleshow/84539120.cms].

available data implying the sub-regional data from 17 Indian States. The WHO has estimated that India's excess death toll was 4.7 million, making it the country hardest hit by COVID-19[33]. These numbers gave rise to a controversy between the WHO and the Government of India, over the methodology as the data given by the global organisation "were either reported officially or obtained by journalists who filed Right to Information queries and accessed Civil Registration System (CRS) data in different States"[34]. This analysis by columnist, Dilip D'Souza pointed out that there were States in which

> "the CRS data showed large gaps between CRS-registered deaths for previous years and deaths for pandemic months, as well as a large gap between reported COVID-19 deaths and observed mortality"[35].

During the second wave, the black fungus disease or mucormycosis was reported in patients with diabetes and COVID-19. A peculiar problem during this wave was the deterioration of even people who seemed to be recovering, and sudden drop in oxygen levels. Symptoms in this wave included difficulties in breathing, loss of appetite, vomiting, stomach pain, hearing loss, extreme weakness and lethargy, dry mouth, headache, diarrhoea, and loss of taste and smell[36].

The reported COVID-19 numbers "miss those who died without testing, they're contingent on the country correctly defining COVID-19 as the cause-of-death and they miss the increases in other deaths that are related to the pandemic leading to overwhelmed health systems or patients avoiding care", complicating the process of pinning down the excess mortality[37].

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[33] **Das, S, and Mampatta, S. 2022**. *India Covid death toll highest in world, says WHO as govt rejects report*, Business Standard, May 6. [https://www.business-standard.com/article/current-affairs/4-7-mn-died-of-covid-in-india-ten-times-more-than-govt-figure-who-122050501193_1.html].

[34] **D'Souza. D. 2022**. *You must understand the methodology*, Mint, May 27. [https://www.livemint.com/opinion/columns/you-must-understand-the-methodology-11653596282521.html].

[35] **Ibid**.

[36] **Medanta. 2021**. *Covid 2nd Wave: What are the new symptoms?*, May 22. [https://www.medanta.org/patient-education-blog/covid-2nd-wave-what-are-the-new-symptoms-1/#:~:text=Loss%20of%20appetite%2C%20vomiting%2C%20stomach,infection%20in%20the%20second%20wave].

[37] **World Health Organization. 2022**. *Methods for estimating the excess mortality associated with the COVID-19 pandemic*. [https://www.who.int/publications/m/item/methods-for-estimating-the-excess-mortality-associatedwith-the-covid-19-pandemic].

A study on mortality trends across 90 municipalities in Gujarat, published in the *PLOS Online Global Public Health* journal,[38] states that during the pandemic,

> "The vast majority of these excess deaths likely represent direct deaths from COVID-19, in the absence of any other known catastrophe. A small percentage of these would include deaths from the indirect impact of the pandemic, and from causes unrelated to the pandemic."

An investigation done by Reporters Collective, a collective of journalists working on politics and governance, found that 3,59,496 more people died than in a normal year in Rajasthan, Jharkhand, and Andhra Pradesh where governments claimed that only 28,609 persons had died of COVID-19[39]. All this pointed to the fact that the second wave was deadlier, that there was a massive under-counting of deaths, and that the symptoms and impacts had a spiralling and long-lasting effect.

Of direct relevance to this Policy Watch is the missed opportunity presented by the late onset of the pandemic in rural and tribal India. In June 2021, a group of civil society activists wrote to the Union Government expressing caution that the "Covid-19 spread which was sparse during the first wave has increased its severity and spread this year compounded with poor or non-existent health service"[40]. By then, media reports had pointed out that as many as 21 particularly vulnerable tribal groups (PVTGs) had reported Covid infections[41].

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[38] **Acosta, R. J. *et al.* 2022**. *All-cause excess mortality across 90 municipalities in Gujarat, India, during the COVID-19 pandemic* (March 2020-April 2021), *PLOS Global Public Health* 2(8). [https://doi.org/10.1371/journal.pgph.0000824].

[39] **the reporters' collective. 2022.** "9. The Reporters' Collective subsequently partnered with @101reporters to file RTIs across India to get similar death records data for entire country. Our team found: 3,59,496 more people died than in a normal year in just 3 states where govts claimed only 28,609 died of Covid." August 18. 9.00 am. Tweet. [https://twitter.com/reporters_co/status/1560106747682926592?s=20&t=ZJccoJF7VbvI5gmMMEi9mw].

[40] **The New Indian Express. 2021**. [Online] *Address crisis in tribal areas due to Covid-19: Civil society group to Centre*, June 5. [https://www.newindianexpress.com/nation/2021/jun/05/address-crisis-in-tribal-areas-due-to-covid-19-civil-society-group-to-centre-2312209.html].

[41] 21 tribal communities across eight different PVTGs including two from the secluded Bonda in Odisha have tested positive. **Barik, S. 2021**. *Coronavirus | 21 members of vulnerable tribes infected in Odisha*, The Hindu, May 14. Members of the Dongria Kondh, Kutia Kondha Didiya, and Saura tribes have also tested positive, see **Pal, S. 2021**. *COVID-19: Increasing Cases Reported Among Vulnerable Tribal Communities in Central India*, NewsClick, May 19. [https://www.newsclick.in/COVID-19-Increasing-Cases-Reported-Among-Vulnerable-Tribal-Communities-Central-India].
Upadhyay, P. 2021. *Tribals in Palghar frustrated with Maharashtra govt's Covid mismanagement*, India Today, May 12. [https://www.indiatoday.in/coronavirus-outbreak/story/maharashtra-govt-palghar-covid-mismanagement-tribal-belt-corona-cases-deaths-1801837-2021-05-12]. Government's Covid-19 mismanagement at tribal belts in Maharashtra's Palghar frustrates locals - Coronavirus Outbreak News (indiatoday.in)

The Adivasi and FDCs were more severely impacted during this wave due to several reasons, first and foremost being a lack of assessment of the impact of the first wave on these communities. The government did not maintain any demographic data, and its response to most questions regarding the communities, migrant workers or health workers remained that it did not have the required data[42].

The June 2021 letter, (in which the first author of this Policy Watch was also a signatory) flagged several issues. They pointed out that the

> "lack of effective accessible health care facilities due to the terrain and distances, lack of information on precautionary measures to prevent infection and their transmission, absence of testing facilities, basic equipment like oximeters, transport, medicines, and the capacity to deal with emergencies compounded the crisis. These were only available at the far away district headquarters which were themselves taxed beyond their capacity"[43].

Drawing the political leadership's attention to the livelihood-related challenges and their impact on the pandemic-triggered health crisis, the letter pointed out that "as many as 87 per cent of the Adivasis" were forest dependent and that the collection, transportation and sales of Minor Forest Produce "were affected by the lockdown".

> "State procurement and special measures to address livelihood and food security were largely absent or ineffective. Other calamities such as cyclones, forest fires and untimely rains further pushed them to severe distress. Social security schemes such as MGNREGS, too, are sparsely implemented in Adivasi areas."

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[42] **Sushmita and Godavar. 2020**. *Data dark governance in the age of Aadhaar*, The New Indian Express, September 29. [https://www.newindianexpress.com/opinions/2020/sep/29/data-dark-governance-in-the-age-of-aadhaar-2203305.html].

[43] **Countercurrents.org. 2021**. *Covid-19, lock down and health crisis in Adivasi areas*, [Letter to Shri Arjun Munda, Minister of Tribal Affairs, Government of India]. [https://countercurrents.org/2021/06/covid-19-lock-down-and-health-crisis-in-adivasi-areas/].

Moreover, with regard to 'Protected Areas'

> "the Ministry of Environment, Forest and Climate Change (MoEFCC) repeated its advisory to the forest department to restrict entry of Adivasis into the forests, particularly National Parks/Sanctuaries/Tiger Reserves. They happen to be the most isolated and vulnerable people and the advisory ended up immediately affecting about 3 to 4 million people living in and around protected areas, mostly PVTGs, and nomadic and pastoral communities, among others. Needless to say, this further legitimised the antagonism of the forest department field staff towards the forest dwellers"[44]

[44] **Ibid.**

III. APPROACH TO THE STUDY

The relevance and need for qualitative methodologies in understanding relatively new phenomena has been further affirmed in the past few decades or so. As has been said, "The aim of qualitative research is not to reduce the complexity by breaking it down into variables but rather increase the complexity by including the context"[45]. Here people whose lives are to be studied, are selected based on their relevance to the research and are not selected for constructing a "statistically representative sample of the general population". The principles of openness[46] in such research implies that the researcher must suspend all *a priori* information. This is particularly useful in situations when a phenomenon — new and previously not studied — throws up multiple areas of impact or study.

Qualitative, as well as exploratory and action-based methodologies, offer an epistemological approach and tools to address the multiple dimensions of any new social phenomena as well as place the focus on the need to understand the subjective experiences. This allows researchers space where they are not just looking at what is in front of them but are also open to what comes up as the process evolves.

To this end, the onset of COVID-19 has radically impacted research methodology, especially ones which require fieldwork. Some pre-COVID-19 concerns, such as climate change and health, resurfaced. Some of these include the need to decarbonise, as well as to be able to conduct field surveys in the time of a pandemic where social distancing has become a question of survival. Further, the pandemic exposed in full relief the challenges faced by researchers to reach respondents in remote areas. As pointed out by scientists, one of the main changes required in how field work is conducted involves finding alternative modes of interaction that require less travel[47].

[45] **Flick, U. 2009.** *An Introduction to Qualitative Research*. Sage, ISBN 978-1-84787-323-1.
[46] **Hoffmann-Riem, C. 1980**. "Die Sozialforschung einer interpretativen Soziologie: Der Datengewinn", *Kolner Zeitschriftfiir Soziologie und Sozialpsychologie*, [The social research of an interpretative sociology: The data gain. *Cologne Journal for Sociology and Social Psychology*] 32:339—372.
[47] **Scerri, E.M.L *et al.* 2020.** Field-based sciences must transform in response to COVID-19, *Nat Ecol Evol* **4**, 1571–1574 (2020).[https://www.nature.com/articles/s41559-020-01317-8].

The social concern on the other hand is the inaccessibility to marginalised people who are geographically at the margins and the social distance is vast to cover[48,49]. Additionally, in many institutions, doctoral research is finding new ways to adapt to this change, requiring the search for new tools, methods and in the words of some, "resilience necessary to face momentary adversities"[50].

Against the backdrop of a confluence of such external factors, it becomes crucial to deploy a mix of best methods available. Further, COVID-19 being a new phenomenon, and the areas that we wanted to study being inter-disciplinary (for instance, the issues of a global pandemic, health and land rights), it became even more crucial to be innovative in our approach. We chose the respondents by random sampling, but with a specific background in interacting with the indigenous communities, as well as their own experiences of working on issues of land and forest rights, as well as development schemes. To this extent, our respondents demonstrated an understanding that is only possible through long understanding and engagement with some of these issues. Most of the respondents' engagements has remained multi-dimensional, spanning, but not limited to, forest rights, human rights, employment schemes, nutrition, food, health, and gender.

For the purpose of this Policy Watch, we have addressed the issue of ascertaining the impact that the second COVID-19 pandemic had on the Adivasi and the forest dwelling population in several parts of the country (barring the Northeast). Our approach has been to provide, through primary and secondary sources close to the ground, a ringside view of the manner in which a selection of the most vulnerable sections of society — the Adivasis and forest dwellers — coped (or did not) with the pandemic.

The study explores the impact of COVID-19 on the lives of Adivasi and FDCs and state responses to the pandemic, especially in the areas that have a sizable population of Adivasi and FDCs. As the aim of the study was to understand the impact that the government response had on the lives and livelihood of the ST population, the approach to the field study was to reach out to representatives of civil society activists, some of whom were members of the

[48] **Will, G. *et al.* 2020**. COVID-19 lockdown during field work, *Survey Research Methods*, *14*(2), 247-252. [https://ojs.ub.uni-konstanz.de/srm/article/view/7753].
[49] **Favilla, K.*, and Pita, T. 2020***. *"When will fieldwork open up again?" Beginning a project in pandemic times*, *Fennia - International Journal of Geography*, *198*(1-2), 230–233. [https://fennia.journal.fi/article/view/99203].
[50] **Ibid.**

affected communities themselves and who, in turn, were monitoring the ground situation on a regular basis, as well as were directly involved in relief measures.

It is important to understand the context in which the study was conducted: Firstly, the pandemic affected all sections of society, including, at various times, the authors themselves; and secondly, the lockdowns placed constraints on the authors by the lack of direct physical access to respondents. However, the same was made possible through telephonic and messaging correspondences.

The second wave of the COVID-19 pandemic hit India during mid-March 2021. By April, we received several updates from civil society organisations, village representatives, leaders and activists about people dying from 'COVID-19-like symptoms'.

> "People are dying of cough and cold. All the doctors in the area have refused to see patients with COVID-19 like symptoms," Shrikant Nirala, the *Mukhiya* (village head) of Gondalpura village in Jharkhand's Barkagaon Block told us. "Public hospitals are functioning, but they are at a distance of 10-15 kms from the village."

Anybody with a "heart-chest problem" [co-morbidity] quickly gets serious and is dying in the absence of basic medical advice. To highlight the grim situation, researchers, activists, and members of forest rights groups wrote to MoTA[51]. They said, "COVID-19 spread which was sparse [in tribal-dominated areas] during the first wave has increased its severity and spread this year compounded with poor or non-existent health service."

As anecdotal evidence started mounting from many areas, we also set Google alerts with the keywords such as Adivasis, Tribal, COVID-19, rural, health, livelihood etc. to track news reports coming in every day between the months of April and July. The numbers of cases and positivity rates in Scheduled Areas during the days between mid-May and the first week of August were actively tracked. All the areas that were tracked showed the spread of

[51] **Express News Service. 2021**. *Address crisis in tribal areas due to Covid-19: Civil Society groups to Centre*, The New Indian Express, June 5. [https://www.newindianexpress.com/nation/2021/jun/05/address-crisis-in-tribal-areas-due-to-covid-19-civil-society-group-to-centre-2312209.html].

COVID-19, with some villages showing positivity rates as high as 75, for example in Niyamagiri Hills in Odisha[52].

Keeping in mind the restrictions on movements that were still in place, we conducted telephonic interviews (semi-structured and open) with representatives of civil society organisations and activists on the field. The semi-structured interview schedule allowed space for the respondents to share their thoughts and experiences while working with the affected people during the COVID-19 pandemic. We interviewed 12 civil society representatives working in the Scheduled Areas of the States of Uttarakhand, Himachal Pradesh, Uttar Pradesh, Bihar, Jharkhand, Chhattisgarh, Karnataka, Gujarat and Maharashtra. These States have significant number of Adivasi population and also have scheduled districts where other traditional FDCs reside.

Table II: **Population of Adivasis in the States Represented by the Respondents in the Study**

State	Population of Adivasis
Odisha	95,90,756
Maharashtra	1,05,10,213
Chhattisgarh	78,22,902
Gujarat	89,17,174
Jharkhand	86,45,042
Karnataka	42,48,987
Uttar Pradesh	11,34,273
Himachal Pradesh	3,92,126
Uttarakhand	2,91,903

Source: Census 2011.

It's important to note that these activists had a background and rapport with the communities. They had a long history of engaging with issues related to forest rights implementation, rights recognition processes, land rights and were well connected to several villages and gram panchayats in their area of functioning or operation.

Some of them were also engaged in COVID-19 related relief work on the ground. The relief work included conducting surveys, distributing ration and disaster-related help. On many occasions, it was difficult to get through to them in one call; hence we made several follow up calls. We prepared a questionnaire with questions on themes such as health, forest-based and

[52] **Barik, S. 2021**. *80 of Odisha tribal group test positive*, The Hindu, May 21. [https://www.thehindu.com/news/national/other-states/80-of-odisha-tribal-group-test-positive/article34618129.ece].

other livelihood, schemes, food, nutrition etc. We rarely interrupted the flow of their sharing as we thought it was important to receive this first level of information to inform our study as no such studies had been conducted so far.

It was also critical for us to acknowledge that some of the respondents were sick themselves. One of them informed us that he lost his sister to COVID-19.

We also referred government notifications, relevant studies and reports, media articles, Lok Sabha responses, secondary sources, social media etc. for the purpose of our study and while drafting this article.

Our respondents were spread across the following specific districts:

Table III: **Districts covered by the Respondents.**

State	**Districts**
Odisha	Mayurbhanj, Deogarh, Sambalpur
Maharashtra	Murbad, Shahpur, Thane
Chhattisgarh	Bilaspur, Balod, Raipur, Mahasamund
Gujarat	Not available
Jharkhand	Latehar, Palamu
Karnataka	Mysore, Kodagu
Uttar Pradesh	Sonbhadra
Himachal Pradesh	Palampur, Simla
Uttarakhand	Nainital
Bihar	Kaimur

Note: The coverage by the respondents included information gathering and relief work during COVID-19.

Our findings and observations can be used to conduct further research as well as inform policy measures especially in times of a crisis.

Ethical considerations: We have kept the names of most of our respondents confidential in order to ensure their safety. Further, it was not advisable to get into close proximity with community members simply for research purposes as that would have led to further endangerment of the respondents.

Further, online interactions also have several limitations and challenges, including concerns about sharing information as well as reduced sense of anonymity when compared with a face-to-face personal interview.

IV. COVID-19 SERVICES – DELIVERY, LIMITS, AND POLICY BLIND SPOTS

Individual health, inevitably, is linked to the overall health and other conditions — social, economic, and political — of that society. In the case of India's tribal populations, which are "at the bottom of the Human Development Index in India"[53], the healthcare gap is wide.

The *Report of the Expert Committee on Tribal Health*, a 2018 publication by the Union Ministry of Health and Family Welfare, brought out the gulf between India's tribal and non-tribal peoples:

> The tribal people in India form a heterogenous group — there is huge diversity not just in their cultures and lifestyle, but also in their socioeconomic and health conditions. The differences persist across regions but also between groups in the same region and between members of the same community who live in tribal areas and those who live outside it. Yet, the one commonality among tribal communities in India is that they have poorer health indicators, greater burden of morbidity and mortality, and very limited access to healthcare services[54].

The state's healthcare interventions for tribal populations should be seen against this complex backdrop of a non-homogenous group of population that bear a disproportionate burden of diseases and deaths.

India's public healthcare structure has three layers — the Sub Centre (SC), the Primary Health Centre (PHC), and the Community Health Centre (CHC). The breakup of the number of these public healthcare centres is provided in the following table.

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[53] **Santhakumar, V and Mishra, S. n.d.** *A Better Life for the Scheduled Tribes: Lessons from Gadchiroli, Maharashtra*, Azim Premji University. [https://practiceconnect.azimpremjiuniversity.edu.in/a-better-life-for-the-scheduled-tribes/].

[54] **Government of India. 2018**. *Tribal Health in India: Bridging the Gap and a Roadmap for the Future,* Report of the Expert Committee on Tribal Health, Ministry of Health and Family Welfare, New Delhi. p.23.

Table IV: **Number of Health Centres in Tribal Areas**

Sub centre	Number of Sub Centres in Tribal Areas	Number of Primary Health Centres	Number of Primary Health Centres in Tribal Areas	Number of Community Health Centres	Number of Community Health Centres in Tribal Areas
1,57,819	26,351 (16.69%)	30,579	3,966 (12.96%)	5,951	975 (16.38%)

Source: Compiled from Rural Health Statistics, 2021.

Although the numbers look impressive compared with the 8.61 per cent of the tribal population, a closer look points to shortfalls in all three segments of the public healthcare delivery system. According to the Rural Health Statistics 2020-21[55], the mid-year tribal population on July 1, 2022, is 10,05,79,297. There is a shortage of 8,503 Sub Centres, 1,464 Primary Health Centres, and 347 Community Health Centres. Shortfalls have also been reported in various categories of personnel, from health workers to specialists in these areas to varying degrees (although some States report surpluses in some categories). In brief, the tribal areas were already faced with shortage of medical services when the pandemic descended on India.

A backbone of the health service delivery system is the primary healthcare. Primary healthcare was understood as

> "healthcare that is affordable and acceptable to everyone and comprised the preventive, promotive, curative and rehabilitative aspects of health and an integrated and comprehensive approach to development of health services"[56].

In the field of public health, the declaration of Alma-Ata on Primary Health Care in 1978, was a milestone that guided the path for establishing effective primary health care in member countries, including India. The declaration provided a holistic understanding of health in

[55] **Government of India. n.d.** *Rural Health Statistics: National Health Mission: 2020-21*, Ministry of Health and Family Welfare**. [**https://main.mohfw.gov.in/sites/default/files/rhs20-21_1.pdf].

[56] **Sodani, P. R and Sharma K. 2012**. Strengthening primary level health service delivery: lessons from a state in India, *J Family Med Prim Care*, July 1(2):127-31.[https://www.researchgate.net/profile/Prahlad-Sodani/publication/259986935_Strengthening_Primary_Level_Health_Service_Delivery_Lessons_from_a_State_in_India/links/0c96051c42a769f97e000000/Strengthening-Primary-Level-Health-Service-Delivery-Lessons-from-a-State-in-India.pdf].

which health is viewed as an integral part of the socioeconomic development of a country. This declaration specifies that,

> "primary health care should include at least education concerning prevailing health problems and methods of identifying, preventing, and controlling them; promotion of food supply and proper nutrition, and adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and promotion of mental health and provision of essential drugs"[57].

This chapter looks at the aspects of service delivery that were found to be either not working or hampered, thereby impacting the general access and reach of various services like testing, vaccination, PDS, MGNREGS etc.

While there is a general mistrust on the public health system among people in India[58], it is severe among Adivasis and forest communities due to several reasons, one being the stigmatisation and/or hostile treatment that they face[59,60]. This was one of the reasons that their access to healthcare during the COVID-19 pandemic was curtailed.

The existing mistrust proved an impediment in accessing the service(s). A respondent from Maharashtra said: "Under grave circumstances, we preferred private doctors. The state-run rural hospitals act as referral hospitals, i.e., they refer almost all cases to bigger hospitals (in cities)." She added that the health system was focused on COVID-19 implying that the

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[57] **World Health Organization. 1978.** *Declaration of Alma-Ata*, International Conference on Primary Health Care, Alma-Ata, USSR, September 6-12. (Section VIII. Para. 3) [https://cdn.who.int/media/docs/default-source/documents/almaata-declaration-en.pdf?sfvrsn=7b3c2167_2].

[58] **Kane, S and Calnan, M. 2017**. Erosion of trust in the medical profession in India: time for doctors to act, *Int J Health Policy Manag,* Jan 1, 6(1):5–8. [doi:10.15171/ijhpm.2016.143]. [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5193507/].

[59] **Indigenous Women's Network, India**. Situation of Indigenous Peoples and Rights to health, *OHCHR*.org, Submission to UN Human Rights UN Expert Mechanism on the Rights of Indigenous Peoples. [https://www.ohchr.org/sites/default/files/Documents/Issues/IPeoples/EMRIP/Health/IndigenousWomenNetworkIndia.pdf].

[60] **George, M.S. *et al.* 2020**. "Everything is provided free, but they are still hesitant to access healthcare services": why does the indigenous community in Attapadi, Kerala continue to experience poor access to healthcare?, *Int J Equity Health,* **19,** 105, June 26. [https://doi.org/10.1186/s12939-020-01216-1].

treatment for other diseases took a backseat during the time. "The neglected areas and illnesses have further been neglected."

However, there are many facets to the aspect of service delivery, with food, nutrition, job security being some of them. Respondents in Karnataka said that when it came to food, the Integrated Tribal Development Authority (ITDA) did distribute food packets, but "only distributing food won't solve the problem."

An important step towards response and recovery is also being able to sell their forest products in the markets. Here, many civil society representatives have advocated a Minimum Support Price (MSP) for the Minor Forest Produce (MFP) scheme[61]. However, the respondents said:

> "This year they collected honey, but they cannot sell it, some they sold it locally, but for a very low price. Government can fix an MSP and procure it. That will be the greatest help rather than just distributing food or dry kits. Some donors are giving dry food kits which is not a long-term solution. The government is not procuring on MSP."

It was clear that the procurement of MFPs would have provided the communities with substantial income and support. However, as this structure is not yet functional in many places, it could not be utilised.

A report titled, *Confronting the Pandemic: Response and Recovery for Dalit and Adivasi students*[62] prepared by the National Campaign on Dalit Human Rights (NCDHR) pointed out that out of the surveyed students during the pandemic, 22 per cent Dalit and 29 per cent Adivasi students were forced to take up employment in addition to their courses. A matter of distress is that the largest block of such work taken (48 per cent) was manual labour. Additionally, closing down of university spaces blocked social mobility and resources for Dalit and Adivasi women. The study also revealed that 21 per cent of women respondents were forced to take

[61] The Scheme for MSP for MFP and development of value chain was started by the Ministry of Tribal Affairs (MoTA) in the FY 2013-14 with an objective of providing a fair price to MFP gatherers, enhancing their income level and ensuring sustainable harvesting of MFPs. The objective of the MSP for MFP scheme is to establish a framework for ensuring fair prices for the tribal gatherers, primary processing, storage, transportation etc. while ensuring the sustainability of the resource base.

[62] **Roy, Catherine Rhea. 2021**. "Confronting the Pandemic: Response and Recovery for Dalit and Adivasi Students" *National Campaign on Dalit Human Rights (NCDHR).*

up employment during COVID-19. Elsewhere, Kasi & Saha, 2021, have elaborated further on the plight of Adivasi youth across information, livelihood, healthcare and food[63].

ASHA workers as important agents of health services

In 2005, the ASHA programme was launched with an intention to fulfil the gap of trained health professionals, especially in areas facing relative deprivation. They were conceived as a set of volunteers with no fixed remuneration but working on an honorarium basis. Since the start of COVID-19, ASHA workers put their lives in line without receiving necessary technical and logistical support[64].

In reality, ASHA workers have come to play a huge role in the lives of Forest Dwelling Groups who have also been prone to diseases and pandemics, with government schemes seldom reaching them. In the months after COVID-19 was declared a health emergency, ASHA workers were enlisted by the central government for tasks such as contact tracing and collecting COVID-19-related information. They were also involved in a multitude of other tasks such as distributing rations. In Adivasi-dominated areas, one ASHA worker is expected to cater to around 700 people, which often spills over to close to 1,000 people. They are responsible for activities like identifying and registering new pregnancies, births, and deaths; identifying, managing, and referring disease cases; supporting health services through home visits; conducting first-aid and immunisation sessions; and maintaining data and participating in community health planning[65]. During COVID-19, the ASHA workers played the role of key frontline defenders and the link between flailing health systems in Scheduled Areas and the FDCs.

Apart from additional tasks, the ASHA workers were overwhelmed by the sheer number of villages they had to cater to, in the absence of any other immediate support. A respondent from Gujarat, on June 25, 2021, when the second wave was on, said:

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[63] **Kasi, E. and Saha, A. 2021**. Pushed to the Margins: The Crisis Among Tribal Youth in India During COVID-19, *Critical Sociology,* February 24, Vol 47, Issue 4 - 5. [https://doi.org/10.1177/0896920521994195].
[64] **Sushmita. 2020**. *India's community health workers undermined in the struggle to reach the most marginalised*, The Thirdpole, December 18. [https://www.thethirdpole.net/en/livelihoods/indias-community-health-workers-undermined-in-struggle-to-reach-most-marginalised/].
[65] **Ibid.**

> "There was one ASHA worker assigned for three villages. The organisation [with whom respondent was attached] provided thermal gun and oximeter to all ASHA workers in the villages covered by us. Additionally, our organisation also provided emergency release of funds for oxygen cylinders at the request of the people and ASHA workers. At present, since the CoWIN portal[66] is not accessible, ASHA workers along with nurses and *anganwadi* workers have been going from village to village setting up regular camps as per the vaccine stock. They have also provided walk-in vaccines at the PHC, CHC, and DHC levels among other places."

COVID-19 Testing

States fumbled with testing as COVID-19's second wave peaked. Testing was the key to check the spread of the virus. It was impossible to get an accurate picture without testing, which needed to be a step ahead of transmission to prevent the spread. However, it was revealed that though the number of tests were being increased, mostly in urban centres, that still was not enough. Further, almost all the Tribal Areas/Scheduled Areas faced issues of access, and respondents reported the absence of village-to-village or door-to-door testing. A respondent from Maharashtra said, "In the cases where there would be [testing], the samples would be sent to the cities. Sometimes the results never arrived."

The distance of testing centres from the villages and tribal hamlets was one of the major reasons why the villagers were not able to get tested. There were inordinate delays in reporting cases after samples were collected. Adequate information about testing and how it could save others in the communities from getting infected did not reach these areas. There were apprehensions about false positives. A respondent from Himachal Pradesh said:

> "People in the rural areas were apprehensive about getting themselves tested and falling prey to 'false positive' outcomes, and hence needed to be persuaded to take RT-PCR tests. Stories of obvious cases not getting detected added to the unreliability of the tests. I wouldn't even call them a myth because this was

[66] The COVID-19 Vaccine Intelligence System (CoWIN), an internet portal, a joint initiative of the Union ministries of Health and Family Welfare, and Electronics and Information Technology (MoHFW and MeITY, respectively), was launched on December 23, 2020, "to effectively roll out and scale up the mechanism for COVID Vaccine Distribution System, nationally". Source: Press Information Bureau [https://pib.gov.in/PressReleasePage.aspx?PRID=1683001].

> the reality. These are gaps that the Health Ministry failed to respond to in time."

It was difficult to ascertain the reasons for COVID-19-related deaths, especially in Scheduled Areas. Govabhai, a respondent from Gujarat, said:

> "Some villages have had fewer deaths and many others have at least 50 per cent positive rates but one cannot claim that it is because of COVID-19 since there were no RT-PCR tests done. When someone fell extremely sick and only after home remedies failed to work, they would go to the local PHC about 10-12 km away only to be told to buy a Rapid Antigen Test (RAT) kit from a private pharmacy, which had no official record of the results of the test. The result could either be positive or negative and the patient was sent home nonetheless."

The RAT was not as sensitive as molecular tests and was more effective only in the first few days of the infection when the viral load was higher. This meant that many sections were left without a proper diagnosis, even after all the hardships faced in procuring the kits.

The findings of our study also pointed towards not only structural deficiencies, but also indications of corruption and misappropriation at even smaller levels that thwarted access to testing facilities. Merely providing testing kits was not adequate; the people were to be provided with the necessary support at every step by informing them about the need to get tested, dispelling myths related to isolation, and stressing on physical distancing.

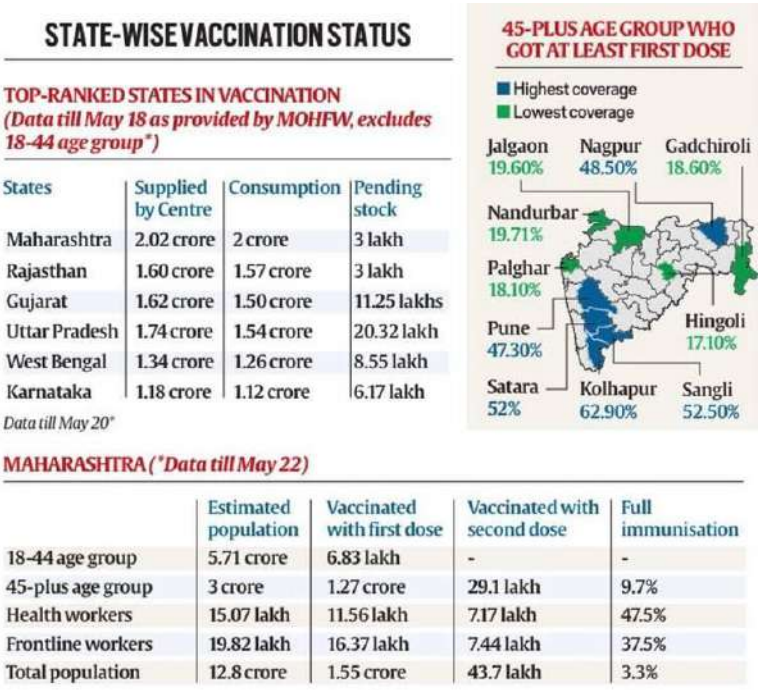
COVID-19 Vaccination

The vaccination drive was announced in India on January 16, 2021. The vaccination coverage had been patchy in Scheduled Areas and had been marred by the lack of either access to the internet or availability of smart phones. Adivasi-dominated districts kept reporting significantly lower vaccine coverage[67] compared with other districts even by June 2021, several months after vaccination had already started.

[67] **Iyer, K. 2021**. Remote Tribal Villages Show How to Fight Vaccine Disparity, *IndiaSpend*, June 8.

While several reports predicted that with the then rate of vaccination, it may take up to 8.7 years to vaccinate the whole population, it was likely that for forest dwelling communities this time period would be stretched further. A report published in The Indian Express highlighted the vaccine disparity and showed how tribal and rural districts were falling behind. Some of the districts that were most vulnerable to COVID-19 had the lowest vaccine coverage by the third week of May 2021[68].

Image 1: Figures showing extent of vaccination till May 18, 2022



STATE-WISE VACCINATION STATUS

TOP-RANKED STATES IN VACCINATION
(Data till May 18 as provided by MOHFW, excludes 18-44 age group)*

States	Supplied by Centre	Consumption	Pending stock
Maharashtra	2.02 crore	2 crore	3 lakh
Rajasthan	1.60 crore	1.57 crore	3 lakh
Gujarat	1.62 crore	1.50 crore	11.25 lakhs
Uttar Pradesh	1.74 crore	1.54 crore	20.32 lakh
West Bengal	1.34 crore	1.26 crore	8.55 lakh
Karnataka	1.18 crore	1.12 crore	6.17 lakh

Data till May 20

45-PLUS AGE GROUP WHO GOT AT LEAST FIRST DOSE

Highest coverage
Lowest coverage

Jalgaon 19.60%
Nagpur 48.50%
Gadchiroli 18.60%
Nandurbar 19.71%
Palghar 18.10%
Pune 47.30%
Hingoli 17.10%
Satara 52%
Kolhapur 62.90%
Sangli 52.50%

MAHARASHTRA (*Data till May 22)

	Estimated population	Vaccinated with first dose	Vaccinated with second dose	Full immunisation
18-44 age group	5.71 crore	6.83 lakh	-	-
45-plus age group	3 crore	1.27 crore	29.1 lakh	9.7%
Health workers	15.07 lakh	11.56 lakh	7.17 lakh	47.5%
Frontline workers	19.82 lakh	16.37 lakh	7.44 lakh	37.5%
Total population	12.8 crore	1.55 crore	43.7 lakh	3.3%

Source: The Indian Express, May 23, 2021.[69]

Another report[70] published in November 2021, showed that of the 48 districts where the first-dose coverage was yet to reach the half-way mark, 24 districts had more than 50 per cent Adivasi population. There was a serious lack of effort[71] in extending vaccination coverage.

[https://www.indiaspend.com/covid-19/remote-tribal-village-shows-how-to-fight-vaccine-hesitancy-753840#:~:text=Skepticism%20about%20Covid%2D19%20vaccination,with%20longstanding%20low%20immunisation%20coverage].

[68] **Barnagarwala, T. 2021**. *Vaccine Disparity: How tribal and rural districts are falling behind; Districts most vulnerable to Covid have vaccinated the least*, Indian Express, May 23. [https://indianexpress.com/article/cities/mumbai/vaccine-disparity-how-tribal-rural-districts-are-falling-behind-districts-most-vulnerable-to-covid-have-vaccinated-the-least-7326226/].

[69] **Ibid**.

[70] **Barnagarwala, T. 2021**. *Why Covid-19 vaccination coverage lags behind in several of India's tribal majority districts*, Scroll.in, November 16. [https://scroll.in/article/1010621/why-covid-19-vaccination-coverage-lags-behind-in-several-of-indias-tribal-majority-districts].

[71] **Barnagarwala, T. 2021**. *Vaccine Disparity: How tribal and rural districts are falling behind; Districts most vulnerable to Covid have vaccinated the least*, Indian Express, May 23.

Due to the absence of post-vaccination care and changing guidelines, such as who would be eligible for the vaccine, there was uncertainty over the issue of vaccination itself. Many areas saw uneven distribution of vaccines. For instance, while some areas received these in bulk, they did not know how to use them or did not have enough healthcare professionals to administer them. Despite erratic supply of vaccines in many areas,[72] respondents informed us that in some areas there was oversupply of vaccines and medications.

The pressure that was created during the months of March and April 2021 (the second year of the pandemic) to vaccinate people also eased down[73,74]. Although reports do highlight the aspect of vaccine hesitancy, a deeper look into why this happened or what were the precise concerns of the communities remained missing.

The vaccine drive for civilians started with the age group of 60^{+} years across India, with each State being allotted a certain number of vaccines. The CoWIN portal was reported to be slow on the first day. By June 2021, the respondents said that only two per cent of the population in the rural tribal areas like Murbad and Shahpur in Maharashtra had been vaccinated despite the availability of vaccines in villages across these areas. The reason for this, according to the respondent, was that there were limited or no effort by the government to spread awareness in the tribal areas. In densely populated regions like Mumbai, the vaccine demand was extremely high with daily slots filled within minutes. Since vaccine was not easily available in Mumbai, one peculiar case that the respondent mentioned was that of people travelling from Mumbai to the villages to get vaccinated. As vaccine distribution was linked to technology (CoWIN portal), its failure in rural areas meant inaccessibility to vaccines for the rural population. And since the access to vaccines did not have any other guidelines except age, people with cars in Mumbai thronged those areas.

A respondent from Jharkhand said that there was strong "opposition [to the vaccines] in the villages". He added, "Because of the unpreparedness of the government and the longstanding

[https://indianexpress.com/article/cities/mumbai/vaccine-disparity-how-tribal-rural-districts-are-falling-behind-districts-most-vulnerable-to-covid-have-vaccinated-the-least-7326226/].

[72] Abhay Bang in the Scroll report.

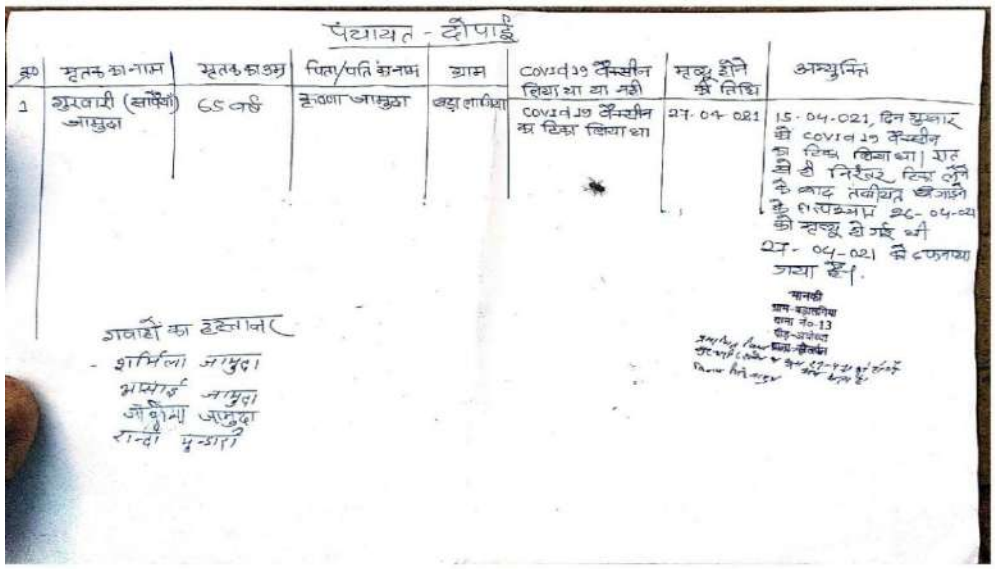
[73] Although the pandemic is named COVID-19, the suffix, 19 refers to the year in which the first reported case of the pandemic surfaced. The WHO declared COVID-19 as a pandemic on March 11, 2020.

[74] **Barnagarwala, T. 2021**. *Why Covid-19 vaccination coverage lags behind in several of India's tribal majority districts*, *Scroll.in*, November 16, [https://scroll.in/article/1010621/why-covid-19-vaccination-coverage-lags-behind-in-several-of-indias-tribal-majority-districts].

apathy of the doctors and medical practitioners towards Adivasi and Tribal people, the net result is that people are refusing to take vaccines."

In the absence of necessary support from the government agencies, fear and ignorance gripped these areas where people are already apprehensive of modern medicines. Not only this, but they also were often stigmatised in hospitals and by doctors, reducing their belief even further.

Image 2: Page from the record book of Jharkhand Janadhikar Mahasabha



Picture description: A death recorded by the Jharkhand-based civil society organisation, Jharkhand Janadhikar Mahasabha, after a person was vaccinated in Jharkhand. It says that 65-year-old Gurwari Jamuda was administered COVID-19 vaccine on 15.04.2021, after which she was constantly unwell and finally passed away on 26.04.2021. She was cremated on 27.04.2021.

Other vulnerable groups such as pastoralists and nomads faced more vulnerability and exclusion. In many villages where the *Van Gujjars*, a transhumance group from Uttarakhand, dwelled, there was a disconnect between the state machinery and the tribal populations as the vaccination camps were held in fewer villages. A respondent from Uttarakhand said, "Though the people here aren't avoiding vaccination, they can only receive it if the camps are set up in their areas." In this case, it was because of the nature of the transhumance of the *Van Gujjars*, who move seasonally between hills and lowlands with their livestock for herding or grazing. Moreover, the regular non-COVID-19 vaccination drives, too, were affected. A respondent from Chhattisgarh said that even the regular vaccination for women and children did not take place.

The reasons were not too uncommon in many parts of tribal India: Lack of information and frequent changes in government notifications made it harder for the communities to accept the vaccines. When it came to COVID-19 vaccine hesitancy, there were a few additional strands. The first was the worsening of the prevailing distrust in the government and their medical staff. A respondent from Maharashtra said: "The existing distrust in the healthcare system has further been deepened. It would be difficult to get their trust back on healthcare post-pandemic." Secondly, it was reported by some respondents that some doctors and medical professionals in these areas were not able to deliver adequate information to the forest dwellers about the vaccine's efficacy. A respondent from Gujarat said: "Tribal people were updated with the discourse and distrust in vaccines even by medical professionals". Thirdly, limited or no awareness of COVID-19 and the vaccine, especially in their regional and local language, also greatly limited the vaccine's reach.

The fourth factor that affected access to vaccines was the absence of vaccination camps and the uneven distribution of vaccines. Some of them also experienced the debilitating side effects of the vaccine that made them feel that the vaccine is intended for harm. Further, the government's decision to change the gap between the two doses did not help either. Moreover, excessive irrelevant allopathic medicines — as many as 17 — were prescribed at health centres (PHC, CHC, DHCs) in the absence of doctors and trained nurses, which led to more complications.

V. INFORMATION, AWARENESS, AND THE DIGITAL DIVIDE

One of the most important developments in Economics was the redefining of 'poverty', based on the contributions led by Nobel Laureate, Amartya Sen, by shifting it "from a unidimensional (income) to a multidimensional perspective, resulting in a more comprehensive picture of poverty"[75]. This resulted in a better understanding of not only the extent of poverty but also the several contributory factors, thereby giving policy makers the tools to move people out of chronic poverty. In the Indian context, the study of poverty is far from complete without a disaggregated look at castes and tribes.

Against this backdrop, to better understand the manner in which the Scheduled Tribes confronted the COVID-19 pandemic and the factors that impacted their access to information, etc., we first provide the extent of deprivation that this section of the population faces. Pradhan et al (2022) bring out the extent of multiple deprivations faced by the Scheduled Tribes of India in their study to "assess the differential in multidimensional poverty amongst social groups in India"[76]. Their key finding was that the "STs have dramatically higher rate of deprivation in all the indicators[77] compared with other social groups" and that they

> "contribute a significantly higher amount of the national Multidimensional Poverty Index (MPI), around double their population share, whilst the Scheduled Castes contribute around 1.25 times their population share. Other Backward Classes (OBCs) and Other contributions, on the other hand, are lower than their population proportions."[78]

[75] **Tanwar, N. Hooda, E., et al. 2019**. Assessment of Aspect Based Multidimensional Poverty in Urban Haryana, *Economic Affairs,* 65(2), 407-415. Cited in *Uneven burden of multidimensional poverty in India: A caste based analysis*, by Itishree Pradhan, Binayak Kandapan, and Jalandhar Pradhan. PLoS ONE 17(7): e0271806: [https://doi.org/10.1371/journal.pone.0271806].

[76] **Pradhan, I, Kandapan, K, et. al. 2022**. *Uneven burden of multidimensional poverty in India: A caste based analysis*, PLoS ONE 17(7): e0271806. [https://doi.org/10.1371/journal.pone.0271806].

[77] The study, which adopted the NITI Aayog approach to multidimensional poverty, was based on analysing 12 indicators under three categories: Health (3 indicators), Education (2) and Standard of Living (7).

[78] **Ibid**.

The following Table brings out the extent of deprivation faced by India's Scheduled Tribes as computed by Pradhan et al.

Table V: Percentage of people deprived in each indicator of the MPI by social groups in India

Dimension	Indicator	SC	ST	OBC	Others	Total
Health	Nutrition	44.2	**50.4**	41.6	33.4	40.8
	Child & Adolescent Mortality	3.1	**3.0**	2.9	2.2	2.8
	Maternal Health	21.7	**25.6**	21.5	15.8	20.4
Education	Years of Schooling	16.3	**23.0**	13.1	8.8	13.5
	School Attendance	7.4	**11.0**	6.3	4.5	6.5
Standard of Living	Cooking fuel	67.1	**83.2**	57.6	44.0	58.3
	Sanitation	62.3	**74.3**	51.8	36.2	51.9
	Drinking water	14.1	**28.7**	13.8	11.4	14.6
	Electricity	14.7	**17.6**	12.9	6.9	12.1
	Housing	53.1	**70.7**	44.1	33.2	45.5
	Assets	16.1	**29.9**	12.0	9.8	13..9
	Bank Assets	10.8	**14.1**	8.7	8.8	9.7

Source: Pradhan, et al. (2022)

While Pradhan, et al. bring out the multidimensional poverty index and present the conditions of the Scheduled Tribes compared with other social groups, the TRH also contributed significantly to helping researchers and policymakers understand the extent to which India's tribal peoples have been deprived of even basic healthcare.

Access to facilities, either provided by the state or the markets, is an important indicator for economic and social progress. Often tribal populations live away from mainstream habitats.

Not only are Scheduled Areas remotely located, only 31 per cent of the Adivasi households there owned a cellphone[79]. Further, only a little over 50 per cent of the Indian population own a smartphone[80]. And, internet connectivity in rural areas is weaker and erratic than in urban centres. The tech solutions offered during the pandemic, such as the CoWIN portal for registration for vaccines, did not work well among the people.

[79] **Shah, S. 2016**. *#MissionCashless: Few use mobiles, fewer know what mobile is, in Adivasi belts of Madhya Pradesh*, Scroll.in, December 23. [https://scroll.in/article/824882/missioncashless-few-use-mobiles-fewer-know-what-internet-is-in-adivasi-belts-of-madhya-pradesh].

[80] **PTI. 2022**. *India to have 1 billion smartphone users by 2026: Deloitte report*, Business Standard, February 22. [https://www.business-standard.com/article/current-affairs/india-to-have-1-billion-smartphone-users-by-2026-deloitte-report-122022200996_1.html].

Although the reasons for spread of the pandemic to the tribal areas can be attributed to the increased and inevitable mobility between the urban and rural centres, an equitable access to technology could have helped in eliminating many challenges faced by Adivasi and forest dwelling persons. However, technology only worked to feed and exacerbate the existing structural gaps.

All respondents we spoke to claimed a lack of awareness and misinformation about COVID-19 and, more importantly, the vaccine.

The information available was largely in English or Hindi. This acted as a barrier in the reach of any kind of information to people. In another analysis on response by various governments, we went through the official websites of all the districts in Jharkhand and found that none of the websites had banners/campaigns in languages other than Hindi and English. Jharkhand has more than 20 languages (10 regional and 10 *Janjatiya* [tribal] languages as per the notification dated February 18, 2022, by Department of Personnel, Administrative Reforms and Rajbhasha)[81] spoken in the State with 26 per cent tribal population, 91 per cent of them living in rural areas.

Most awareness programmes were led by civil society organisations. Here, women from Self-Help Groups (SHGs) also played an important role.

A respondent from Jharkhand said that it was difficult to bust myths around the vaccine. In areas where the vaccination took place through [Christian] missionary institutions, the situation was better as people turned up for vaccination. But such a support or awareness mechanisms were not available in many areas. They added,

> "Even the *Sahiyya and didis* [ASHA workers] have failed to address [the myths around vaccine]. People had many questions, such as whether vaccines could be taken by a diabetic or a person with high blood pressure."

[81] **ANI. 2022**. Jharkhand government rolled back Bhojpuri and Magahi as regional languages from Bokaro and Dhanbad districts; issues new notification of district-wise regional languages, *Twitter*, February 19. [https://twitter.com/ANI/status/1494846706567245825/photo/1].

Even in districts and States that reported overall high vaccination coverage, the cumulative numbers did not reflect the ground realities of the tribal populations as these numbers were skewed towards urban centres. While urban areas of a particular district or State did have a high number of vaccine coverage, the rural areas in some cases had as less as two per cent vaccine coverage. Rumours[82] such as the 'vaccine causing impotency' were also rife in some areas.

In a situation of lack of awareness, vaccine hesitancy and being already overstretched, at many places, the ASHA workers were further "burdened" with the responsibility to ensure that information about vaccination schedules was communicated to people in remote rural areas, a respondent from Himachal Pradesh said, adding, "They were also burdened with the task to ensure awareness about testing for infection as that remained low even as cases went up." While ASHA workers were tasked with several additional tasks, adequate training was not provided to them. Even basic health equipment that which is taken for granted in an urban setting, such as the thermometer, were not provided to them. The respondent added:

> "So, while ASHA workers were given responsibility to communicate about the efficacy of tests and side effects of vaccines, no one took the responsibility to equip them with what it takes to deliver on their goals. For example, I live only 13 kms away from a *tehsil,* yet there was no thermometer at the health centres, and as you'd assume there were no oximeter as well. We tried sharing oximeters, and we found that the practitioners had no idea about using one. We advocated the need for training as well as focused on removing the social stigma against getting tested."

In addition to such issues that were reflective of shortfalls at the ground level, in some areas, the tribal population faced another kind of man-made deprivation. This came in the form of an exploitative mechanism wherein the privileged, even if they were not residents of the areas, were able to access the vaccines that were meant for rural, specifically Adivasi areas.

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[82] **Kulkarni, S. 2021**. *Covid-19 is just another problem in Palghar's Adivasi villages*, The Wire, May 13. [https://thewire.in/health/covid-19-is-just-another-problem-in-palghars-adivasi-villages].

More than the technology, its design and implementation failed the most marginalised people in India (Dhorajiwala, 2020)[83].

Even in States such as Jharkhand, where the State governments came up with their own applications, these still lacked the cognisance of local solutions.

The importance of official (and also community-centric) channels can't be overemphasised in a moment of crisis. In the past epidemics, alert systems worked to prevent and restrict further spread of the disease. A robust system of communication also acts as a deterrent for spread of misinformation. Our experience showed that largely, these channels remained absent, despite some infrastructure being available, boiling down to a question of lack of initiative from the officials in ground and apathy of the leadership.

An absence or lack of functioning of these channels led to the continuation and prevalence of fear and myths when there was a space for these to be dispelled easily. In some cases, these affected the reach, even when access was there. In other cases, these caused fear that became more pronounced or ingrained as time passed and will impact future responses as well.

A systematic channel between the MoTA, the State Tribal Welfare Departments and district-level officials would have helped. The Block-level officers could have made lists of hamlets in each Block, get the Gram Sabha to nominate persons who would be contacted over mobile phones. Basic information required to assess the COVID-19 situation, such as the needs, services available and other related determining factors could have been prepared by the Block officials along with Gram Sabha members[84].

[83] **Dhorajiwala, S. 2020**. *Who Is Responsible When Technology Fails the Marginalised?*, EPW Engage, Vol. 55, Issue No. 21, May 23, 2020.

[84] Inputs from CR Bijoy, who works on natural resource governance.

VI. RESPONSE TO THE COVID-19 PANDEMIC

This chapter is divided into two parts — one that highlights the state response and the other that documents the responses from the civil society. Given the multiplicity of interventions that are possible by, and in many instances expected of, the state, we focus on some of the responses that directly impacted and threatened the health of Adivasis and forest dwellers.

On April 30, 2021, the MoEFCC issued an advisory that restricted the access of forest dwellers and Adivasis to protected forests, despite protests and opposition to a similar advisory issued on April 6, 2020, during the first wave. The stated reason for such advisories was to prevent "human-wildlife transmission of disease"[85] despite there being no scientific evidence behind this. This made things extremely difficult for these communities. This advisory would have immediately impacted about "3 to 4 million people living in and around the protected areas"[86]. These were mostly Adivasi communities, including Particularly Vulnerable Tribal Groups, nomadic, and pastoral communities, among others who are most dependent on the natural resources within and around the protected areas for their livelihoods.

Although the Union Ministry of Home Affairs on March 24, 2020, had directed District Magistrates to implement containment measures (MHA, 2020), the government officials who were responsible for the implementation of these measures were unavailable to address the concerns of the people. A respondent from Uttar Pradesh confirmed,

> "All the officers, DMs, and collectors said that they work online but they are not available on call. We tried every day to resolve situations of relief and violence, but they always avoided talking with us."

For the second wave, there were no guidelines issued by the Union Government on containment measures. Rather, it directed States and UTs to contain the virus as per their own respective guidelines that were operational within their boundaries. For instance, in Uttar

[85] **ANI. 2020**. *MoEF & CC sends letter to States/UTs advising immediate restriction on human-animal interaction*, Business Standard, April 6. [https://www.business-standard.com/article/news-ani/moef-cc-sends-letter-to-states-uts-advising-immediate-restriction-on-human-animal-interaction-120040601598_1.html].
[86] Countercurrents.org. Op. cit.

Pradesh, there was no institutional quarantine as on April 5, 2021, with a few exceptions for international travellers. Uttar Pradesh reached its peak during the second wave on April 27, 2021.

In September 2020, the MoTA said in a press release that it had constituted a 'COVID response team', which formulated a COVID-19 pandemic response plan for Scheduled Tribe livelihood and health and asked States/UTs to utilise the funds from State TSP (Tribal Sub Plan)[87]. Steps suggested in the TSP included ensuring supply of ration, provision of community kitchen, support towards creation of isolation/quarantine facilities, and self-employment training and bank linkage, among others. Evidence from the ground suggested that the supply of food was mostly interrupted throughout the lockdown in the States of Jharkhand, Chhattisgarh, and Karnataka. A contrast was seen in *Van Gujjars* in Uttarakhand who were forced to survive in very difficult conditions.

The MoTA also developed the Swasthya Portal (swasthya.tribal.gov.in), wherein data on health infrastructure and manpower gaps from Ministry of Health and Family Welfare, Ministry of Women and Child Development and from districts were captured. Recognising the need to strengthen community-based services and primary-level health infrastructure in peri-urban, rural, and tribal areas, the Ministry of Health & Family Welfare issued a detailed standard operating procedure (SOP) outlining the containment and clinical management practices to be put in place[88]. The National Human Rights Commission issued a short advisory on ensuring vaccination, medical kits and other issues prevailing during COVID-19 keeping in line with its objectives under the Human Rights Act, 1993[89]. Ground reports from the States of Chhattisgarh, Jharkhand, and Karnataka, however, suggest that the people mainly depended on traditional medicines as PHCs lacked the basic infrastructure to provide the requisite care. The government was able to do little or nothing to dispel their fears over the efficacy/side-effects of the vaccines, resulting in depriving people from the benefits of vaccination.

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[87] **Ministry of Tribal Affairs. 2020**. *Press Release: Steps taken by Government to support tribal communities during Covid-19 pandemic*, Press Information Bureau, September 17. [https://pib.gov.in/PressReleasePage.aspx?PRID=1655632].

[88] **Ministry of Health & Family Welfare. 2021**. SOP on COVID-19 Containment & Management in Peri-urban, Rural & Tribal areas, *MOHFW.gov.in*, May 16. [https://www.mohfw.gov.in/pdf/SOPonCOVID19Containment&ManagementinPeriurbanRural&tribalareas.pdf].

[89] **National Human Rights Commission. 2021**. Advisory on protection of Human Rights of the Particularly Vulnerable Tribal Groups (PVTGs) amid Covid-19, *NHRC.nic*.in, June 3. [https://nhrc.nic.in/sites/default/files/NHRC%20Human%20Rights%20Advisory%20for%20PVTGs%20amid%20Covid-19.pdf].

On November 29, 2021, Renuka Singh Saruta, Minister of State for Tribal Affairs, in response to a Lok Sabha question on the impact of COVID-19 on Adivasis, said that COVID-19 was being treated as a 'disaster' and that it had coordinated with the Ministry of Health and State Tribal Affairs departments to take steps to curtail the prevalence of COVID-19. The minister also said that the department had not maintained data on the impact of COVID-19 based on demographics and social indicators.

This implied that the Union government had no assessment of the extent of impact of COVID-19 on Adivasis and FDCs. Even the death counts were not maintained on the basis of demography, making it almost impossible to really assess the situation of the vulnerable communities.

Further, it seemed like the central government simply offloaded its responsibilities on State governments at a time when the first wave had already caused significant distress, especially on the aspect of health and livelihood. The period between the two waves, roughly extending to about three to four months, could have been utilised by the State governments to prepare for the waves and put in place significant measures (at the least, in the short term, better preparation of quarantine centres, rapid vaccination and awareness campaigns, building up testing centres, preparation of hospital beds, other regulations regarding community spread, social distancing, masking etc.) that could have prevented the distress that was experienced in these areas.

Across States, the respondents reported that Gram Sabha meetings were stopped by the local authorities, and many important decisions could not be made, nor a virtual platform pushed for them to be able to have these meetings. In many areas, the process of recognition of their rights under the FRA was stopped completely since meetings of the Gram Sabha could not take place. Further, processes related to field verification of filed claims could not take place. Meetings of SDLC and DLC (District Level Committees) to decide on pending FRA claims, could not take place either.

Many activists working in the States alleged that there was inadequate support and coordination between the governments of non-BJP ruled States and the Union government. On May 13, 2021, Jharkhand Janadhikar Mahasabha, a Jharkhand-based platform of civil

society organisations, highlighted[90] how there were 2.3 crore adults in the State and that by then only 3.4 lakh vaccinations had taken place, the main reason being inadequate number of vaccines provided by the centre to the State.

Response of Civil Society

Civil society organisations have often played an important role in bridging the gap between the government and the people and that it is understood that non-governmental organisations are instrumental in promoting CFR rights-based programmes across India. Despite recent studies showing mixed results on the role of NGOs in community forest resource management[91,92] during COVID-19, civil society organisations showed remarkable initiatives intervening not only on issues of rights recognition and forest-based livelihoods, but also providing support for health-based services and food and nutrition.

NGOs and other Civil Society Organisations (CSOs), despite their limitations, intervened at every possible concern and issues of Adivasi and FDCs. They assisted in vaccine advocacy and debunked various misinformation that reached the people. However, the civil society respondents also highlighted that they had to divert their resources to other COVID-19-related work. For instance, if an NGO had undertaken research and advocacy in ecology in Adivasi and forest dwelling areas, during the first and second waves, they were ensuring the disbursal of food and ration for the residents of the area while the pandemic had also impacted the ecology and forests. This implies that the NGOs and civil society organisations had to move their focus away from their primary fields or areas of work and undertake relief-related operations to fill the gap created by the absence of local- and State-level institutions.

With no sight of the official machinery and the near absence of local government, the Adivasi and forest dwelling groups, in response, took various measures at a local or the village

[90] **Jharkhand Janadhikar Mahasabha. 2021**. *Twitter* https://bit.ly/3JYuRL8 URL last accessed on May 13, 2022 [Translation: The State needs a total of 4.6 crore vaccines, but so far only 3.4 lakh people have been vaccinated because the union government hasn't assured the availability of vaccines. The government should wake up from its slumber and should immediately ensure that universal vaccination is provided. Mahasabha's appeal to @HemantSorenJMM government…]

[91] **Barnes, C and Van Laerhoven F. 2015**. *Making It Last? Analysing the Role of NGO Interventions in the Development of Institutions for Durable Collective Action in Indian Community Forestry*, Environmental Science & Policy, November, Vol 53, Part B, pp. 192–205. [https://www.sciencedirect.com/science/article/abs/pii/S1462901114001245?via%3Dihub].

[92] **Baruah, M. 2011.** *Joint Forest Management (JFM) and Role of NGOs: Cases from Rajasthan, India*, Syracuse University, Syracuse, New York. [http://iasc2011.fes.org.in/papers/docs/206/ submission/original/206.pdf].

(Gram Panchayat) level, for instance, barricading the borders of the village to restrict the spread of the virus and allotting space for quarantining.

Civil society members, in some cases, were able to make some arrangements. In Gujarat, a collective of civil society members was able to get Adivasi migrant workers back to States like Jharkhand and Odisha after liaising with the State government, Ministry of Railways and ensuring every migrant worker was aware of the scheduled train and boarding station. A respondent from Gujarat says:

> "A lot of resources were utilised in doing this work as every time the Ministry agreed to schedule a train, we only had less than 24 hours to call more than 1,500 migrant workers to ensure they board the train, were fed for the journey and being tested on return."

Pointing out that there was a "top-down management model rather than a participatory approach", a report[93] published by the Voluntary Health Association of India drew from India's own experiences in fighting Ebola and eradication of Small Pox and emphasises the "dire need to reinforce participation of the local communities and their stakeholders (NGOs, CBOs)" as they "can augment the government's efforts in public education, care and support of the patients as well as their families." Most importantly, such organisations "can also act as a 'Weather Station', updating the district administration on various developments".

[93] **Voluntary Health Association of India. 2021**. *COVID-19 Global and National Response – Lessons for the Future.* (A report by the Independent Commission on Development & Health in India), New Delhi. pp. 168-169.

VII. INDIGENOUS HEALTH SYSTEMS

One of the constant paradoxes of society is the coexistence of the modern with the traditional. In the field of healthcare, the WHO estimates that around 80 per cent of the world's population use traditional medicine. There is, however, a caveat: the lack of reliable data.

> "Around 80 per cent of the world's population is estimated to use traditional medicine. To date, 170 of the 194 WHO Member States have reported the use of traditional medicine, and their governments have asked for WHO's support in creating a body of reliable evidence and data on traditional medicine practices and products"[94].

The WHO's strategy document for traditional medicine defines Traditional Medicine (TM) as

> "the sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness" [95].

Variously described as 'people's knowledge', 'ethno-science', and 'agro ecology'[96], such knowledge, which is not restricted to medicine, is passed on through generations by word of mouth and is dynamic. According to Daes,

> "The heritage of indigenous peoples is comprised of [*sic*] all objects, sites and knowledge the nature or use of which has been transmitted from generation to generation, and which is regarded as pertaining to a particular people or its territory. The heritage of an indigenous people also includes objects,

[94] **World Health Organization. 2022**. *WHO establishes the Global Centre for Traditional Medicine in India*, News Release. Geneva, March 25. [https://www.who.int/news/item/25-03-2022-who-establishes-the-global-centre-for-traditional-medicine-in-india].
[95] **World Health Organization. 2013**. *WHO Traditional Medicine Strategy: 2014-2023*, Geneva. p.15. [https://apps.who.int/iris/rest/bitstreams/434690/retrieve].
[96] **Kumar, K. A. 2010.** *Local Knowledge and Agricultural Sustainability: A Case Study of Pradhan Tribe in Adilabad District.* Centre for Economic and Social Studies, Begumpet, Hyderabad.

knowledge and literary or artistic works which may be created in the future based upon its heritage"[97].

Such knowledge has been an essential component of survival of the indigenous communities.

Despite the side-lining of traditional medicine systems, an attitudinal shift in how these are perceived is observed. Many countries are practicing traditional medicines alongside modern medicines[98]. Many recent experiences suggest that indigenous communities have, over many years, developed strong traditional medicine systems, which are used not only by the indigenous people but also by the rural population in the surrounding areas.

The reasons why communities resort to using these medicines are not one but many, including cultural beliefs, isolation, inaccessibility to modern healthcare, forest dependence, proven relevance of the medicines etc. Studies have suggested that more than 25,000 formulations are used in traditional medicines. These are usually available in their locality and, at least, one or more people know the medicinal value of the herbs and plants in the region[99]. The reasons for the popularity of traditional methods could be availability, acceptability, and affordability.

During the course of the study, all the respondents from 10 States indicated how the FDCs fell back on their indigenous medicines during the COVID-19 period, especially during the second wave. They used these to boost their immunities, as well as to treat milder issues like fever, cough etc. Several reported drinking *kadha* — a potion made of various plant leaves such as *tulsi, neem, giloy* or similar decoctions. Apart from easy availability of such a form of medicine, it was the lack of access to the more mainstream avenues that made people feel that it was better to rely on these. The extent of effectiveness of indigenous medicines in the face of a newly evolving virus needed further investigation. But it was clear to us that this form of

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[97] **Daes, E-I. 1995**. *Protection of the heritage of indigenous people.* Final report of the Special Rapporteur, Mrs. Erica-Irene Daes, in conformity with Sub commission resolution 1993/44 and decision 1994/105 of the Commission on Human Rights. United Nations Economic and Social Council., June 21, p. 10.

[98] **World Health Organization [WHO].1978.** Declaration of Alma Ata: international conference on primary health care, Alma Ata, USSR, 6–12 September 1978, [cited 2020 May 9]. [https://apps.who.int/iris/handle/10665/39228].

[99] **Sen, S and Chakraborty R. 2017.** Revival, modernization and integration of Indian traditional herbal medicine in clinical practice: importance, challenges and future, *J Tradit Complement Med.* 2017; 7(2): 234-44. doi: 10.1016/j.jtcme.2016.05.006.

Patra, J.K, *et al.* (Eds). 2019. *Ethnopharmacology and biodiversity of medicinal plants*, Palm Bay, Florida, FL: Apple Academic Press; 2019.

traditional knowledge would need to be incorporated into any form of western medicine or system that are being introduced or are being engaged in these areas. To this extent, the Forest Rights Act and the Biodiversity Act in India, together, recognise and protect the people's rights over their traditional knowledge systems.

A respondent from Jharkhand said:

> "A large number of people who had all the symptoms of COVID-19 somehow managed to survive because of their traditional medicine. What we have found out [is] that traditional medicine is certainly very useful in increasing your immunity."

He also highlighted issues of wrong and excessive [allopathic] medication, ultimately pointing towards the apathy and indifference with which the indigenous people are treated by mainstream health systems.

Another respondent from Odisha said, "People use traditional medication like juice made out of leaves and herbs such as *Chattian chali* (in Odia) with *haladianichali* (in Odia) and juice of *goiso* leaves with honey."

In India, indigenous communities have guarded traditional knowledge systems for centuries. But most of these streams are not codified and are sustained mainly through oral traditions[100,101]. Research in Kerala's Wayanad analysed the consequence of forest policies since independence and found that changes in property rights that the policies brought about had "far reaching" adverse implications for sustenance of the traditional body of knowledge and its distribution in the community. This impacts the quality and availability of raw materials that are used in the material practice. Since much of the knowledge is not codified, the authors argued that the issue of intellectual property rights surrounding traditional knowledge could

[100] **Sen, S and Chakraborty, R. 2015**. Toward the integration and advancement of herbal medicine: a focus on traditional Indian medicine, *Botanics*, Volume 2015: 5, pp.33-44. doi: 10.2147/BTAT.S66308.
[101] **Sudha, P.S. 2018.** *Interface between traditional knowledge (TK) and human rights in realizing right to health and health care–an Indian perspective*, Peace Human Rights Governance, 2018; 2(3): 331-45. doi: 10.14658/pupj-phrg-2018-3-3.

not ignore the issues arising out of changes in physical property rights that the forest policies brought about[102].

Despite their proven relevance, traditional practices were entirely avoided in the country's first National Healthcare Policy prepared by the Bhore Committee in 1946. In later years, other committees attempted to correct this. The Mudaliar Committee made recommendations for integrating modern medicines with the traditional medicines. However, western medicine had achieved significant influence by then. In this, the Expert Committee on Tribal Health (*Bridging the Gaps* report), pointed out that a contentious but important issue when it comes to indigenous healthcare was to see ways to accommodate the indigenous medical system without compromising the scientific principles and methods.

Further, in the Twelfth Five Year Plan, certain provisions related to tribal health, mainly highlighting the need for evolving a new strategy that combines Indigenous tribal medicine with other medical systems, was given shape. The Plan called for a systematic effort to document the traditional tribal knowledge of medicinal/herbal plants, standardise the information, and recognise it as an independent system of medicines and emphasised on the role of indigenous healers.

In 2006, the Draft National Tribal Policy proposed a targeted strategy aimed at addressing the specific problems faced by indigenous people with respect to health and medical care. This included enhancing access to modern healthcare by developing new systems and institutions and a synthesis of Indian systems of medicine. However, another concern was of overexploitation and use of medicinal plants by commercial or outside entities. Land and forest degradation have impacted the availability and growth of these plants. Kanchi Kohli and Manju Menon, while talking about India's Biodiversity Act, say, "…access itself can be disenfranchising for both local communities and weak governments. Access may also go against the tenets of conservation and sustainable use, and, in such instances, a sharing of benefits may be deceptive".

[102] **Deepak, V.K. and Bhaduri, S. 2015**. Forest Policies and Tribal Traditional Medicinal Practices: A Perspective from India, *Asia and the World Economy*, May, pp.261-282.

VIII. RECOGNITION OF RIGHTS AND COPING IN CRISIS

Forests being central to the lives of Adivasi, Tribal, and Forest Dwelling groups, the rights of these groups are recognised by the Scheduled Tribes and Other Traditional Forest Dwellers (Recognition of Forest Rights) Act, also known as the Forest Rights Act, or FRA. The FRA recognises Individual Forest Rights (IFRs) and Community Forest Resource rights (CFRs). These rights enable the use and access to forest land and resources; community forest resource rights to use, manage, and govern forests within the traditional boundaries of villages; empowerment of right-holders and the "Gram Sabha", which comprises all adults of a village, for the conservation and protection of forests, wildlife and biodiversity, and their natural and cultural heritage. A report[103] prepared by practitioners on forest rights, *Promise and Performance*, estimated that about 20 crore Adivasis and forest dwellers living in 1,70,000 villages can benefit from the FRA. The World Bank estimates the number of forest dependent communities at about 275 million[104].

Importantly, the FRA, for the first time, recognised community, community resource and individual rights over forest land which included the right to hold, live and cultivate on these lands and ownership over minor forest produce. Section 3(1)(k) of the Act also recognised, for the first time, the "forest rights of Forest dwelling Scheduled Tribes and other traditional forest dwellers", the "right of access to biodiversity and community rights to intellectual property and traditional knowledge related to forest biodiversity and cultural diversity"[105].

Further, the Indigenous and local communities, who either grow biological resources or have traditional knowledge of these resources, have been recognised as beneficiaries under the Biodiversity Act 2002[106].

[103] **CFR-LA, 2016**. *Promise and Performance: Ten Years of the Forest Rights Act in India.* Citizens' *Report on Promise and Performance of The Scheduled Tribes and Other Traditional Forest Dwellers (Recognition of Forest Rights) Act, 2006, after 10 years of its Enactment.* December 2016. Produced as part of Community Forest Rights-Learning and Advocacy Process (CFRLA), India, 2016. (www.cfrla.org.in).
[104] **World Bank. 2006**. *India - India's total forest income has potential to increase to US$2 billion per annum in 2020, says World Bank report*, April 3. [http://web.worldbank.org/archive/website01291/WEB/0__C-254.HTM].
[105] **Ministry of Tribal Affairs and United Nations Development Programme, India. 2014**. *Forest Rights Act, 2006: Act, Rules and Regulations*, pp. 3-4. [https://tribal.nic.in/downloads/FRA/FRAActnRulesBook.pdf].
[106] **Tandon, M. 2020**. [Commentary] India's Biological Diversity Act finally shows progress after NGT order, Mongabay. [https://india.mongabay.com/2020/06/commentary-indias-biological-diversity-act-finally-shows-progress-due-to-ngt/].

In some areas where forests had been cleared, communities were compelled to engage in construction and manual work and had no recourse to any livelihood support. The sale of minor forest produce was impacted.

Secure and sustainable livelihoods can not only prevent or act as a safety net against/in crisis situations, but also are crucial to reducing the intensity or probability of spread of the disease itself.

Yet, according to a 2016 study[107], only three per cent of the minimum potential of CFR rights could be achieved. In February 2020, the MoTA constituted a special committee for Community Forest Rights[108], which was summoned repeatedly for recommendations during the lockdown to combat the spread of the pandemic. The manner in which the pandemic played out brought to light the vital connection that indigenous and forest communities played in conserving a balanced and healthy forest ecosystem and, therefore, the legal recognition of CFR was very urgent and important.

A report titled "*Community Forest Rights & the Pandemic: Gram Sabhas Lead the Way*"[109], jointly published by CFR-LA and Vikalp Sangam in 2020, brought to light numerous case studies from the first wave of the pandemic that demonstrated how tenure security, in particular legal recognition of community forest rights as per the FRA, is linked to greater community governance, autonomy, and ability to be resilient in the face of a crisis. In times of a pandemic and lockdown, the right to manage one's own territory, which includes community, health, and food systems, as well as protecting and conserving the forest, is fundamental.

The examples in this document are from Maharashtra, West Bengal, Karnataka, Gujarat, Madhya Pradesh, Chhattisgarh, and Odisha where Gram Sabhas exercised their CFR during

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[107] **CFR-LA. 2016**. *Promise and Performance: Ten Years of the Forest Rights Act in India, Citizens' Report on Promise and Performance of The Scheduled Tribes and Other Traditional Forest Dwellers (Recognition of Forest Rights) Act, 2006, after 10 years of its Enactment.* December 2016. Produced as part of Community Forest Rights-Learning and Advocacy Process (CFRLA), India, 2016. (www.cfrla.org.in).
[https://rightsandresources.org/wp-content/uploads/2017/11/India-Promise-and-Performance-National-Report_CFRLA_2016.pdf (cfrla.org.in)].

[108] **Kukreti, I. 2020**. Tribal affairs ministry constitutes committee on CFR guidelines under FRA, *Down To Earth*, March 03. [https://www.downtoearth.org.in/news/forests/tribal-affairs-ministry-constitutes-committee-on-cfr-guidelines-under-fra-69572].

[109] **Vikalp Sangam and CFR-LA. 2020.** *Community Forest Rights and the Pandemic: Gram Sabhas Lead the Way.* October. [https://rightsandresources.org/wp-content/uploads/2020/10/CFR-and-the-Pandemic_GS-Lead-the-Way-Vol.2_Oct.2020.pdf].

the lockdown to various positive outcomes. These outcomes include: quick and contextual responses by the Gram Sabhas, lessened distress out-migration, greater support for livelihood options, including ecological livelihood[110] options, healthy and diverse ecosystem, including agroforestry systems, resilient forest conservation systems leading to good water and soil conditions, support for the most marginalised communities (migrant workers or families in distress), women's participation and leadership resulting in better management of systems, long-term cluster level plans, collective organisations as statutory bodies such as Community Forest Resource Management Committees (CFRMCs), as well as other productive bodies such as FPOs or Large Area Multi-Purpose Cooperative Societies (LAMPS), and employment generation at the level of the Gram Sabhas.

During the COVID-19 national and State lockdowns, the Gram Sabha meetings could not take place in most areas. In a few areas where there was mobilisation for rights or rights had been recognised, people were able to devise their own local solutions for responding to the crisis. Many of the people who returned and had rights over their land could access the safety net provided by the nearby forests in the form of medicinal plants or for consumption.

Further, we too could get the visibility on aspects of health because there was a certain ground level awareness on rights, which helped in the civil society representatives knowing the situation on the ground. In the recent past, struggle for implementation of CFR rights under FRA in various states have also emerged as a "long drawn people's struggle for control of forests than a bureaucratic process".

During the second wave, in the cases where people had rights over their lands and could exercise significant autonomy, it was observed that their health and capacity to face the pandemic was improved. A respondent from Uttar Pradesh said:

[110] **Gadgil, M. 2020**. *An alternative jobs and skills strategy for India*, Hindustan Times, September 17. [https://www.hindustantimes.com/analysis/an-alternative-jobs-and-skill-strategy-for-india/story-wkgAv5EE5jHmVfEZf6KirJ.html].

> "…it has been seen that in Sonbhadra of UP, women have a claim for their lands as well as farming collectively and fighting for their rights with police and forest department. Through this, women are self-sustained in terms of their livelihood and help other communities by contributing paddy or rice to them. They fed the migrant labourers who came from different states after lockdown and distributed paddy to their families."

The respondent further maintained,

> "If they are not able to do agriculture, they are not able to eat, then how will their immune system be strong? How can they fight with any diseases? They suffer from other diseases like typhoid and diarrhoea. No facilities and allowance for these conditions. People stand on the verge of starvation."

The dependence on traditional and Indigenous medicines and knowledge by the Adivasi and forest dwelling communities to fight the pandemic cannot be overstated. The social, psychological, spiritual connection with these proved an important coping and fall-back mechanism for many communities.

Protecting FDCs' rights to resources will protect their right to produce knowledge from the natural resources and will serve to promote, preserve, and evolve knowledge from natural resources around the forested areas. This will also serve as a motivation for communities to prevent the decline of resources.

IX. SUMMARY

The pandemic and lockdown measures had severely impacted the marginalised communities in India, which is set to become one of the worst impacted countries in the world as per a WHO report[111]. The lockdown measures during subsequent waves have caused loss of livelihoods and employment, food insecurity and distress in various facets of life.

Adivasi and FDCs in India have faced loss over their traditional ecosystems exacerbated by lack of access, use, and management and conservation rights.

Uneven and inequitable development policies have led to the displacement of FDCs, mainly Adivasis and other traditional forest dwellers from their homestead. Expansion of extractive industries and policies encouraging them, have meant the loss of traditional ecosystems of these communities — something on which they are dependent for their everyday needs. This, combined with patchy implementation of job guarantee schemes like MGNREGS, has made the communities more vulnerable and have compelled communities to migrate from their traditional homes causing an enormous economic, social, and ecological crisis.

The management/governance of first and second wave affected Adivasi and FDCs differently yet impacting them during both episodes. The first wave witnessed an authoritarian lockdown, which led to loss of jobs, rights, livelihood, dignity, food, and education with no promise of healthcare protection and safety.

> "Certain pre-existing conditions in tribal areas, such as lack of basic healthcare facilities, healthcare professionals, information and awareness, and breakdown of traditional health care systems, among others, created greater difficulties and made Scheduled Areas more susceptible to the pandemic" [112].

[111] **D'Souza, D. 2022**. *WHO's right about covid numbers?*, Mint (livemint.com), May 12. [https://www.livemint.com/opinion/columns/whos-right-about-covid-numbers-11652376232691.html].
[112] **CFR-LA. 2020**. COVID Lockdown impact on tribals and forest dwellers_4th May (fra.org.in), *fra.org.in*, May, Report submitted to MoTA.

It has been seen that vulnerable and marginalised communities suffer more in the event of an epidemic or pandemic. While conducting our research, we observed that a sound healthcare cannot be provided or imagined unless aspects like livelihood, food and nutrition, certainty of a place to live, fall-back options in case of disaster, a functioning public distribution system, job guarantee, and rights to cultivate and nourish own land are ensured. We also see the close linkages between the problems and fallouts of this situation with how certain development policies are being designed. A health crisis like COVID-19 has somehow brought more awareness about how our worlds are inter-connected. And yet, even the pandemic is experienced differently by different people and different sections. The second wave saw even the financially affluent struggling for oxygen cylinders and hospital beds. It cannot be denied that India was among the hardest hit.

Barrier measures[113] are already weak in Adivasi and forest communities as only a fraction have access to clean water, good sanitation and soaps. In the Union Budget for 2022-23, the Centre only allocated Rs. 89,265.12 crore (or 2.26 per cent of the total expenditure) for Scheduled Tribes who constitute 8.6 per cent of the population: an allocation that is evidently disproportionate to the population of STs in the country. As per the Multidimensional Poverty Index published by UNDP and Oxford Poverty and Human Development Initiative, five out of six multidimensionally poor people in India are from tribes or oppressed castes. The Schedule Tribes group is the poorest with more than 50 per cent of the population living in multidimensional poverty, followed by Scheduled Castes groups at 33.3 per cent and Other Backward Classes at 27.2 per cent[114].

During the second wave, lack of autonomy in accessing health resources, discrimination and stigmatisation faced at formal institutions, precarities created due to lack of access to traditional medicines and resorting to external channels for procurement and management of livelihoods, restrictions on entering into forests, absence of reporting from media outlets, a disconnect with technology and social media platforms, lack of understanding of available directives in local and regional languages and the absence of creative means to reach local populace, mismanagement of available resources — all these played a role in worsening the

[113] **Bourdelais, P. 2021**. *The Covid-19 Pandemic in Historical perspective*, Social Science Open Access Repository (SSOAR), *Historical Social Research, Supplement*, pp.302-315. [https://doi.org/10.12759/hsr.suppl.33.2021.302-315].

[114] **PTI. 2021**. *In India, 5 out of 6 multidimensionally poor are from lower tribes or castes: UN report*, The New Indian Express, October 7. [https://www.newindianexpress.com/nation/2021/oct/07/in-india-5-out-of-6-multidimensionally-poor-are-from-lower-tribes-or-castes-un-report-2368917.html].

situation of already vulnerable communities during the COVID-19 and exposed them to a health and livelihoods crisis of catastrophic proportion.

"The first wave barely affected [adivasi] people in terms of COVID-19. However, in the second wave, villages close to towns and cities were the worst affected," said another respondent from Jharkhand. He further added, "Relief work by the government and civil society was more organised in the first wave unlike the second wave." A respondent from Odisha also echoed the situation in Jharkhand: "In the first wave, villages close to the forest or forest villages were the least affected, but this time [second wave] the COVID-19 infection has been reported from even the remote countryside in the forest area as well." Adivasi and Forest dwelling groups took several measures both in the first and second waves to fill the gap left behind by the absence of central and State governments. For instance, in some villages in Gujarat, the Adivasis dug up roads at the borders of their village to restrict entries and exits.

Respondents from Odisha, Jharkhand, and Uttarakhand affirmed that the local government with the help of Adivasis made quarantine facilities, food and relief measures available in the first wave. However, in the second wave, containment and welfare measures were uneven, limited and, at many places, absent, especially when cases were found even in the most remote areas. A respondent from Odisha stated, "Last year [first wave, 2020], migrant workers stayed for 15 days quarantine in the Panchayat and got tested." For the second wave [2021], he said, "They adopted home quarantine and did not test if they had no symptoms." Another respondent from Odisha said, "When the migrant workers returned [during the first wave], they had to stay at the Panchayat Bhavan arranged by the Sarpanch as the isolation or quarantine centre for them. They got minimum facilities such as food and healthcare at the centre. This year [2021], there were no quarantine centres. When migrant workers returned to the village, they had to stay in home isolation or home quarantine."

Across India, schools and other community centres were transformed to quarantine centres during the first wave as was directed by the Ministry of Home Affairs. In Uttarakhand, during the first wave in 2020, Adivasi migrant workers who returned were kept in quarantine centres made outside the villages wherein the Gram Pradhan was given the responsibility and budget to run the facilities.

The respondent from Uttarakhand elaborated:

> "The schools and community centres during the first wave were turned into makeshift quarantine centres and if a person got infected and was not sent to the centre, police intervened and transferred them to the quarantine centres. But this year [2021], everything changed; the government did not pay any attention. The Gram Pradhans were informed that they should make arrangements to create COVID-19 quarantine centres but neither financial allocation nor facilities were provided. Therefore, quarantine centres came up in places where people had enough awareness, or else the Gram Pradhans did not invest time on it."

The lack of exercise of urgency by the government (local and national) and bureaucrats further led to the deeper penetration of COVID-19 into the most remote areas. Respondents from all states affirm lack of preparedness, awareness and medical staff with the existing dysfunctional healthcare infrastructure. The respondent from Uttarakhand continued:

> "This time [second wave] since the government did not try to make any infrastructure available to the people after the first wave, people and the administration thought that the Corona [sic.] is now gone and we are free to move around; no problem is there."

An important aspect emerging from our study was that government agencies can no longer afford to look at the issue of healthcare for marginalised communities like Adivasis and forest dwellers in isolation from other grave issues that they face, and in order for a national and State level effective response to the situation of pandemic, one cannot overlook the structural problems. Despite this knowledge, an early warning system was largely missing in most states, irrespective of the political party in power. The extent of impact of issues related to health spiralled down to other aspects of their lives where they could not go for seasonal forest products' collections, could not access the forests for medicinal plants etc. The streamlining of healthcare, appointment of community members as also the linkages between the traditional and modern medicine systems could have gone a long way in dealing with the crisis.

Rather than experiencing the state as a facilitator, they found the state coming across as an obliterator. For instance, a respondent from Karnataka's Nagarhole, where the *Jenu Kurubas* reside, reported of violence just before the second wave. In a protest, they organised asking to expedite the recognition of their rights under the FRA. They were assured of the process moving forward if they withdrew the protests. However, the forest department removed their coffee plantations and charged them with grievous offences under the Indian Penal Code. Incidents such as these exposed the communities to great risk in the face of the pandemic.

Similarly, respondents in Gujarat were protesting against the Statue of Unity and had been slapped with false cases. Many of the members from Bhil community also reported of fatal infection in the villages surrounding the Statue, but the lack of testing and data collection and subsequent lack of information also led to fragmented information about COVID-19 related deaths[115]. Respondents in UP and Bihar also reported of violence by forest department. In some areas, afforestation drives carried out without prior information to the communities led to a situation of conflict.

This points to a situation that in a moment of crisis, when the communities should have enjoyed autonomy and would have been encouraged and facilitated to plan effective local level responses, they were managing a threadbare existence, no different from how they've survived so far, and further being pushed to the margins.

It also became clearer that traditional and indigenous solutions gave them great physical as well as emotional strength. This coupled with the security over their lands added an extra level of safety. In situations where people's rights were yet to be recognised, many had no option but to return to the cities.

Legislations such as the Forest Rights Act and the Panchayat Extension to Scheduled Areas Act provide opportunities for communities to protect and tend to their traditional knowledge, even intellectual property rights, in preserving these resources. The Act, if implemented correctly, has tremendous potential to even prevent development related displacement and migration.

[115] **Pal, S. 2021**. *Covid-19: Increasing cases reported among Vulnerable Tribal groups in India*, Newclick, May 19. [https://www.newsclick.in/COVID-19-Increasing-Cases-Reported-Among-Vulnerable-Tribal-Communities-Central-India].

A report published by ATREE (Ashoka Trust for Research in Ecology and the Environment) in October 2020 estimated that 60,000 villages have the potential to claim CFR area under the FRA over an area of ~1,83,000 square km in four states (Maharashtra, Jharkhand, Chhattisgarh and MP). This will potentially benefit the livelihoods of ~6.26 crore people, including ~2.36 crore people belonging to Scheduled Tribes and ~0.66 crore people belonging to Scheduled Castes across these four States[116]. As per a citizens' Promise and Performance of Forest Rights Act report, which spanned the 10 years of the Act being in force, only three per cent of Community Forest Resource (CFR) rights could be achieved, despite the potential forest area for the recognition of these rights being as large as 85.6 million acres.

Moreover, as the *Community Forest Rights* & *the Pandemic* report emphasises:

> Lack of tenure security has emerged as one of the major reasons for the vulnerable situation of the communities. Additionally, in most areas, the lockdown had seriously affected the livelihoods of the local communities. Nearly 100 million forest dwellers depended on various kinds of forest produce for food, shelter, medicines and cash income. The collection season for these, however, is mainly in the months from April to June which coincided exactly with the lockdown[117].

It strongly emerges from our research that issues of healthcare can be addressed in a better and more structured manner if land rights are recognised for Adivasi and forest dwelling people.

[116] **Lele, S, Khare, A, & Mokashi, S. 2020**. *Estimating and mapping CFR potential for Madhya Pradesh, Chhattisgarh, Jharkhand and Maharashtra*, Centre for Environment & Development, ATREE, Bengaluru, October. [https://www.atree.org/sites/default/files/reports/CFR_Potential_Mapping_Report_compressed.pdf].
[117] Vikas Sankalp and FR-LA. Op. Cit.

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