



Adivasis

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Tribal groups or Adivasis are considered to be the earliest inhabitants of India. The term Adivasi is commonly translated as ‘indigenous people’ or ‘original inhabitants’, and literally means ‘Adi or earliest time’, and ‘vasi or resident of’. The state and discourse in India, however, reject the term “indigenous peoples”, as it is considered “divisive, undermining the unity of the Indian nation” (Ghurye in Chopra 1988). The government instead recognizes most Adivasis under the Constitutional term “Scheduled Tribes” derived from a schedule in the Constitution Order of 1950. While the Order declared 212 tribes located in 14 states as Adivasis, the Government of India today identifies 533 tribes. To many therefore, any aggregate analysis of Adivasis is meaningless because it cannot capture the uniqueness that defines tribal groups.

Scheduled Tribes are often conflated with Scheduled Castes in the development literature, although they are completely different social categories. The former do not strictly fall within the caste hierarchy, and have distinct (often considered non-Hindu) cultural and religious practices and social mores. Also, they do not face ritual exclusion, say in the form of untouchability, as do the Scheduled Castes or ‘Dalits’². But when exclusion is defined more broadly in terms of being “prevent(ed) . . . from entering or participating” or “being considered or accepted” (Encarta online edition), Adivasis fit squarely within the conception of excluded people. The major difference in the

development status of the SCs and Adivasis is that while the former lived among but were segregated socially and ritually from the mainstream and from upper caste groups, the latter were isolated physically, and hence socially (Béteille, 1991).

While India is widely considered a success story in terms of growth and poverty reduction, Adivasis in 2004–05 were 20 years behind the average. The poverty headcount index for Scheduled Tribes fell by 31 percent between 1983 and 2004–05. In comparison, poverty fell by about 35 percent among the Scheduled Castes and by 40 percent at an all-India level (table 1). The relatively slower decline in poverty among Adivasis means that they are increasingly concentrated in the poorest deciles. Comprising about 8 percent of India’s population, Adivasis accounted for a fourth of the population living in the poorest wealth decile in 2005. More worryingly, in states with high tribal populations (more than 10 percent of the state’s total population), Adivasi households exhibited poverty rates that were higher than the rates across the nation as a whole in 2004–05. In the state of Orissa, for instance, almost 75 percent of Adivasi households fell below the official poverty line.

These findings need to be nuanced considering the highly unequal results across states and by urban/rural residence. In states where the Adivasis are a majority (such as in the north-east) and where they have gained from education, their status is different from the status of Adivasis living as marginalized minorities in the interior reaches of the central or western states. We also find intra-group variation in poverty for Adivasis over time. Growth Incidence Curves that we calculated in rural and urban areas indicate that expenditures among Adivasis grew more rapidly at the higher end of the expenditure distribution than in the lower end. This was particularly true in urban areas, and may in part be explained by particularly large income gains among those with access to and benefits from reserved jobs. This result may also explain why poverty rates among STs in urban areas have fallen relatively quickly.

1 This brief is based on a chapter in the forthcoming volume, *Poverty and Social Exclusion in India*. It is not a formal publication of the World Bank. It is circulated to encourage thought and discussion, and its use and citation should take this into account. Maitreyi Bordia Das is Lead Specialist in the Social Development Department of the Sustainable Development Network in Washington DC. Soumya Kapoor Mehta is an independent consultant in New Delhi.

2 For the purposes of the graphs and the tables in this note, we use the term SC/ST as these are standard administrative/survey categories. In the text though, we use the self-preferred terms i.e. Dalits and Adivasis (or tribals) interchangeably with SCs and STs respectively.

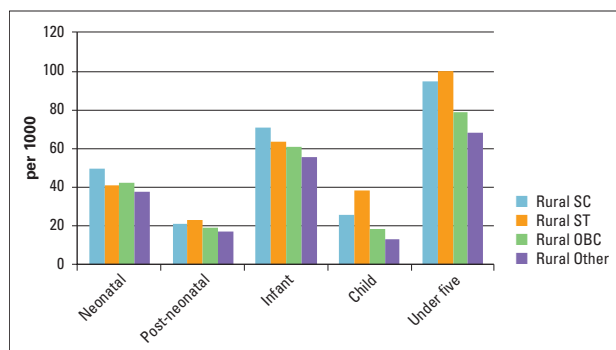
Table 1: Poverty Rates: Adivasis are 20 years behind the average population
Population below the poverty line, %

Location, social group	A. 1983	1993–94	B. 2004–05	% change (A, B)
Rural				
ST	63.9	50.2	44.7	–30
SC	59.0	48.2	37.1	–37
Others	40.8	31.2	22.7	–44
All	46.5	36.8	28.1	–40
Urban				
ST	55.3	43.0	34.3	–38
SC	55.8	50.9	40.9	–27
Others	39.9	29.4	22.7	–43
All	42.3	32.8	25.8	–39
Total				
ST	63.3	49.6	43.8	–31
SC	58.4	48.7	37.9	–35
Others	40.5	30.7	22.7	–44
All	45.6	35.8	27.5	–40

Source: Staff estimates based on Schedule 1.0 of the respective NSS rounds and official poverty line; table 1.1 in report

While Adivasis saw significant gains in health indicators, some of which improved at rates that were more rapid than the average, a stark marker of tribal deprivation is excess child mortality. Under-five mortality rates among tribal children remain startlingly high (at about 96 deaths per 1,000 live births in 2005 compared with 74 among all children). An average Indian child has a 25 percent lower likelihood of dying under the age of five compared to an Adivasi child. In rural areas, where the majority of Adivasi children live, they made up about 11 percent of all births but 23 percent of all deaths in the five years preceding the

Figure 1: Rural Adivasi Children: Lower Risk of Dying at Birth, but Greater Risk by Age 5



Source: Staff calculations based on 2005 NFHS data; figure 1.1 in report

National Family Health Survey (NFHS) 2005/6.

The analysis for the India Poverty and Social Exclusion Report (Das et al, 2010) has three clear findings. First, a disproportionately high number of child deaths are concentrated among Adivasis, especially in the 1–5 age group and in those states and districts where there is a high concentration of Adivasis. Any effort to reduce child mortality in the aggregate will have to focus more squarely on lowering mortality among the Adivasis. Second, the gap in mortality between Adivasi children and the rest appears after the age of one. In fact, before the age of one, tribal children face more or less similar odds of dying as other children (figure 1).

However, these odds significantly reverse later. This calls for a shift in attention from infant mortality or in general under-five mortality to factors that cause a wedge between tribal children and the rest between the ages of one and five. Third, the analysis goes contrary to the conventional narrative of poverty being the primary factor driving differences between mortality outcomes, because even after controlling for wealth quintiles, the effect of being Adivasi stays robust. This indicates that belonging to the Adivasi community disadvantages children in other ways as well.

Malnutrition among Indian children has remained stubborn to poverty reduction and programmatic intervention. But Adivasi children show even worse levels of malnutrition. The gap between the Adivasi and non-Adivasi children in severe stunting and in wasting³ appears within the first 10 months of birth and persists—with some variation throughout early childhood. The rise in severe wasting among Adivasi children during the first 10 months of life is particularly alarming. Microstudies on food insecurity among Adivasi households provide a contextual picture of the causes of chronic malnutrition.

³ Stunting reflects long-term effects of malnutrition; while wasting measures the current nutritional status of the child, i.e. his/her food intake immediately prior to the survey.

Child deaths among Adivasis have led to frequent public outcry. Public interest law suits have been filed on behalf of families that lost their children⁴, and state governments have been repeatedly directed by the courts to take remedial action. Governments have undoubtedly become more vigilant on this issue than they were before, but solutions are still ad hoc and in crisis-mode. For instance, during an emergency large numbers of medical personnel are deployed to the vulnerable areas, but in normal times absenteeism of doctors is endemic in rural and especially tribal areas. Additionally, poor registration of births and deaths has meant frequent haggling over the real numbers of deaths/children affected.

Are tribal children more likely to become sick as they grow older, and, so, more of them die? The answer is no. Contrary to expectations, tribal children do not get diarrhea or respiratory disease more often than other children, although they are more malnourished. But when they do get sick, tribal children are much less likely than other children to receive medical assistance. For instance, only 56 percent of Scheduled Tribe children were taken to a health facility for treatment of fever and cough in 2005 compared with 67 percent of non-Scheduled Tribe children. Mothers of tribal children are also less likely to obtain antenatal or prenatal care from doctors or have an institutional delivery.

Poor access to health facilities for tribals is not just an issue of low demand for services as medical practitioners frequently say. There are serious issues of supply as well. In most states in India, Scheduled Tribes live in physically isolated hamlets, in remote regions and districts and in hilly and forested areas with poorly staffed health centers. Limited coverage of all-weather roads makes transportation in emergencies virtually impossible, even if health centers were attended by medical personnel. Migration of tribals during the lean season to cities and towns makes the task of health surveillance for antenatal care or immunization or growth monitoring of children even more difficult. There is also a deep-rooted cultural chasm and mistrust between the largely nontribal health providers and tribal residents. While administrators realize the value of recruiting local residents as field level medical personnel, it is often impossible to find even secondary educated tribal women who can fill

the positions of nurses or female health workers. As a result the positions either remain vacant or are filled by non-tribal, non-resident providers.

There have been a number of successful initiatives in both the nongovernmental and the public sectors to improve access to services in many tribal areas.⁵ Studies from around the world suggest that the adaptation of health services to the culture of the beneficiaries (for instance, by recognizing the importance of traditional medicine) leads to better outcomes. Yet, the most well known efforts have often been small, resource-intensive ones, making scaling-up a challenge.

Mortality outcomes for tribal children in India need to be looked at in the light of larger changes experienced by Scheduled Tribes, especially in the past two or three decades. Land and forests are the mainstay of tribal livelihoods but the relationship of tribals to land is not restricted merely to subsistence cultivation. It extends to their dependence on natural resources for livelihoods and for food security. Over time, the average landholding has declined more rapidly among Adivasis than among other groups. This reflects the ‘alienation’ of Adivasis from their traditional lands largely through displacement (by infrastructure projects) or fraudulent private transactions. The government’s 10th Five-Year Plan noted that between 1951 and 1990, 21.3 million people were displaced; 40 percent of them—or 8.5 million—were tribal people. This alienation explains, to a large extent, the poor outcomes among tribals. The loss of control over their *jal, jungle, and zameen* (water, forest, and land) has alienated Adivasis from public schemes, affected their traditional food practices and forced them to migrate to cities to work under harsh conditions.

Physical remoteness and smaller numbers have gone together with political isolation and low voice in decision making for the Scheduled Tribes. There have been measures to assure defacto autonomy and self-rule to Adivasis, but implementation has been patchy. The Indian government’s response to vulnerability among Scheduled Tribes has been proactive and has included a mix of constitutional and budgetary instruments. Both the Panchayat Extension

⁴ See for instance, Sheela Barse v/s State of Maharashtra 1993

⁵ In the remote tribal areas of Gadchiroli (Maharashtra), the Society for Education Action and Research in Community Health, for example, is an international success story in maternal and neonatal health.

to Scheduled Areas Act (PESA) and the Tribal Rights Act fundamentally question the power relations between Adivasi and non-Adivasi areas and purport to transfer greater power to the former. In particular, PESA attempts to give special powers to tribal gram sabhas (village assemblies) to enhance tribal voice on issues related to mining leases and infrastructure development in tribal areas. It is also unique in that it is in consonance with customary laws and, rather than on revenue villages, it focuses on tribal hamlets on the basis of culture. However, it is widely believed that these wide-reaching legislations have not been implemented in spirit.

Protest movements among tribal groups have a long history. Spontaneous uprisings against the state occurred before the British period, and each such conflagration was an assertion of the cultural and political identity of tribals, as well as a claim on natural resources. A Planning Commission report links movements since independence and the recent militancy squarely with the underdevelopment of Scheduled Tribes (Government of India 2008). There is growing recognition among policymakers that increasing militancy in tribal areas is not merely a “law and order” problem (Singh, 2009). Instead the causes lie in the marginalization—spatial, economic and political—that tribal groups have experienced over years. Addressing the development needs of tribal groups will be central

to attaining India’s goal of shared growth. More discussion of tribal aspirations and problems from their point of view is needed, rather than an examination of such issues through the lens of policy makers, the bureaucracy, or the civil society.

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