Chapter V

Reproductive Labour and Health Care in Adivasi Setting

Introduction:

Previous chapter provided the social and political account of Gujarat in general and Dangs in particular and also focused on adivasi communities of Gujarat. Simultaneously, it underlined the social oppression of adivasis and double subjugation of adivasi women of Dangs. The current chapter attempts to situate adivasi women of Dangs and delineate their health care needs and specific reproductive issues as well as involvement of adivasi women in health care practice. Point to be made here is that there are diverse categories of women make an entry into health sector and the health care needs of women varies depending on their social standing. Concurrently, the stress is on highlighting these health needs in relation to the broader socio-economic conditions, maps the role of the state and discuss what does citizenship mean in the case of adivasi women? In other words, it purports to explain how Indian state includes adivasi women – in the sense that they become the target for family planning, Dai training previously – as well as exclude adivasi women – no substantial health care for pregnant women and no meaningful training for dais – in terms of citizenship. While explaining this, it intends to unearth the problems involved in technocratic, vertical and behaviourial approaches of health services deployed by the state which obscures the everyday realities of adivasi women. Related to this, reproductive labour or traditional medical practice is also compared. Furthermore, it tries to discuss in which way dais in adivasi set up are different from dais from non-adivasi context. This chapter explains the contested work of suvarin (midwife/dais) in the Dangs in south Gujarat in terms of how state de-recognises them at one level and at another level, how suvarins challenge state’s narrative/account. So, here I interrogate seemingly local medical systems and suvarins work in the Dangs as much as the hospital care offered by the state.
Considering the above objectives of the chapter, it is divided into four sections. The first section provides the socio-spatial configuration of *adivasi* villages in Dangs whereas the second section discusses the specific health care needs of *adivasi* women and it’s interlinkages with their socio-political situations and cultural contexts i.e. varied birth practices. The third section deals on the reproductive labour/work and explicate how *dais* legitimize their status when state repudiate their work. Fourth section, diagnoses the role of the state and the relationship between *adivasi* women and state. It is followed by the description of health workers’ movement in Dangs that binds different categories of women as well as tries to capture how different women who were involved in health care questioned state’s initiatives and its divisive agenda.

**Section- I**

**Dangs as Administrative Division:**

Third chapter briefly discussed about the politico-economic condition of Dangs and this chapter deals in-depth the socio-spatial arrangement of the study village. Before moving to the latter point in detail, a short note on the history of Dangs as an administrative district and condition of workers follows. The Dangs district was constituted in 1st May, 1960 and during its inception, it had only one *taluka* (sub-division or administrative division) called ‘Ahwa’. It remained like that for 55 years and in the year 2014, two more *talukas* namely Waghai and Subir came up (Survey Report, Gujarat by Health Department Gandhinagar, 2017). This district is predominantly a rural district as there are 308 villages and the above mentioned *talukas* automatically became small towns. In addition, Saputara is known for housing handicraft business in Dangs; which is also known as a hill station in Gujarat. It is important to point out that these towns are also not well developed towns in terms of possessing infrastructure facilities like decent public transportation system, housing facilities for public servants, well developed concrete roads, etc. Dangs is the only district in Gujarat which does not possess any major industry except the development of Saputara (in terms of construction of bridge) and the surrounding region as a tourist spot. Ironically, even if it lacks basic facilities for the locals, Hindu radicals have slowly for two decades have made their strong footholds in
terms of organizing Kumbh melas in Shabridham, Subir which was unknown to the adivasis. Followed by this, is the construction of Shabri Ma Madir (temple) two kilometres away from Subir and it is now known as ‘Shabaridham’.

**Paradoxical Nature of Gender Equality:**

The total population of Dangs was 228,291 in the year 2011. In terms of sex composition, there are 113,821 males and 114,470 females [Census 2011]. Furthermore, in the age group 0-6 years, the total population is 40,743; while male population is 20,743, female population figure is 20,000. So, according to census data, Dangs has a positive sex ratio unlike rest of the Gujarat. Positive sex ratio is attributed to various factors such as the region consists of predominantly adivasi communities- the total population of Scheduled Tribes (ST) is 216,073 whereas only 992 people are from Scheduled Castes (SC) - where dowry does not overburden the parents to ill-favour a girl child. Thus, practice of female infanticide and foeticide does not exist in this region. Secondly, adivasi households eagerly awaits girl and boy child and thus, there is no gender bias in adivasi household from this angle. Another progressive feature that is prevalent among adivasis of Dangs is that unmarried girls do not face the wrath of the society for being pregnant. As a result, woman is not ostracised for bearing a child/progeny outside of the wedlock and adivasi society prohibits primarily abortion from this ground. Also traditionally, abortion is opposed as it is strongly believed that God would punish if an unborn child or fetus is killed. Nevertheless, recently adivasis of this region have adopted abortion.

However, even if the sex composition is impressive, economic burden is shouldered on women as the Census figure shows. For instance, non-worker population constitutes 40% of the District population i.e. 110,034 non-workers out of 228,291 population in Dangs. Among the working population i.e. 60%, women’s participation in work is higher than the men which is 52,492 males and 57,542 females as per Census 2011[Census 2011]. However, their actual participation in work is not in sync with their wages and their categorisation as “marginal worker”. For instance, in the Census data 2011, women are employed predominantly in agriculture sector and allied sector. However, women are defined as Marginal Workers, Marginal Worker of Cultivator, Marginal Worker of
Agriculture Labourers, Marginal Worker of Household Industries, Marginal Workers of Others, etc. However, men are defined as “main workers”. For instance, men are termed as Main Worker of Household Industries, Main Worker of Others, Marginal Worker of Household Industries (03 Months), and Marginal Worker of Others (03 Months) etc. What does that imply? It denotes that while women actually work more hours than men, their works is subsumed under household income or are given wages not individually but through family income.

The disturbing trend in this context is that while women outnumber men in the work, same importance is not given to them in the realm of education. Even though overall literacy rate is low in this region, men are mostly visible in education compared to women. For instance, total number of literate population is 140,968 and there are 77,314 males and 63,653 female who are literate in Dangs.

**Weak Employment Prospect and Proliferation of Communal Activities:**

Economy of Dangs reveals the state’s discrimination and how the weak policies of the Indian state did not bring any significant benefit to *adivasis* and instead became destitute. This point has been already discussed in detail in the fourth chapter through the legislations such as abolition of Jamindari system, introduction of Indian Forest Act 1878, Criminal Tribes Acts 1871 and poor implementation of the Scheduled Tribes and Other Traditional Forest Dwellers - Recognition of Forest Rights - Act, 2006, which weakened the job prospects of *adivasis* of Dangs. Furthermore, in the Dangs people’s main livelihood work is agriculture. But these activities are solely subjected to monsoon farming and therefore they have to depend on labourer work elsewhere to maintain their family throughout the year. *Adivasi* woman does multitasking. As it was mentioned above; she does agriculture work, labourer work, house work and caretaker of family.

Second important point is that in the Dangs very less people are regular employees in the sense that they are not involved in any public sector which is under state’s regulation and protection. Thus, *adivasis* in general do not have access to any insurance and security
benefits as largely involved in informal economy. Another fact is that adivasis lack any substantial political power i.e. independent decision making to uplift the adivasis, even though adivasis too represent in political parties. They are spread into different political parties like BJP, Congress and JDU. However, they are running the party’s on shrewd lines.

Hardiman (2008) aptly observes that, “In India as a whole, the tribal peoples today make up about 8 per cent of the total of population of over one billion, while in Gujarat they make up almost 15 per cent of the population of 51 million. Their general condition is characterised by poverty, social exclusion, susceptibility to exploitation and poor health. They are, however, an important element within the modern Indian political system, because since independence in 1947, their vote has been decisive in a significant number of state assembly seats. In Gujarat, for example, the tribal vote is crucial in 33 out of a total of 181 state assembly seats (18.23 per cent), which in a tight election may be enough to determine the result. For this and other reasons, different factions of the dominant classes have a strong interest in extending their hegemony over the tribal peoples, and health and healing provides one means towards this end.”

But religious issues affect them quickly. Because many adivasis are also members of RSS and VHP. They spread unrest in Dangs by believing their words. Otherwise Dangi Lok (people) who belong to different religious faiths – Muslim, Christianity and Hindus - have always lived peacefully unlike recently. Peace here not only entails religious harmony but also people’s relationship with the nature. Adivasis remain content with nature and minimum necessities. They use natural things with great care. Because they think that if they would excessivelyuse these natural resources, God will punish them. And that's why they always treat the water, the forest and the land always like their son-daughter or own-relatives. However, successive policies of the Indian state, while in rhetoric was used for the conservation of nature, forest was acquired by non-adivasis and prohibited adivasis from using it for their livelihood. While, simultaneously, major precious plants and properties like timber were extracted by the dominant sections for the business purpose.
Socio-spatial Configuration of Adivasi Villages:

As written in the second chapter, field work was under taken in seven villages of Subir Taluka and the names of the villages include Naktiyahanvat, Badigavantha, Bibupada, Bardipada, Garkhadi, Subir and Harpada. So, it is worth at this juncture to provide a brief socio-economic and caste background of the villages.

The Naktiyahanvat village was constituted before our ancestor. There is a Hanuman Mandir (temple) in outskirt of the village. It is located under the banyan trees. Elder people informed about the nomenclature of the village, “Earlier many ancestors had planned to build an idol of Hanuman. So when a sculptor was making an idol, he blew up Hanuman's nose. So the name of our village has become ‘Naktiyahanvat (nose of Hanuman)’ from ‘Hanvantapada”.

In the village primarily two communities i.e. Bhil and Kunkana live. Earlier, this village was a small and few families lived here. But, now it is a big village as population expanded. As informed by the Anganwadi worker (AWW), this village houses population of 1531 persons, where 770 male and 761 female are enumerated. There are 181 populations, in the age group of 0-6 year’s population and out of them 91 males are and 90 are females. In terms of education, 666 people are literate in the village out of which, males constitute 359 and females constitute 307. Villages have 607 non-worker out of 1531 population and among them there 300 males and 307 females. Out of 477 worker population, 233 are men and 244 are women. As explained earlier, women participate in these in greater number.

Here villager’s main work is agriculture. Every villager hold agricultural land i.e. Bhils and Kunkana both hold the land. Here, Bhil and Kunkana carry out agricultural work. But there are some families who do not have any land. So, they do only labourers work. Some
of these landless labourers are primarily *Ghar-Jamai* (househusbands) or villagers who could not secure land from the state especially during land allotment after the enactment of new Forest Act of 2006. The latter kind of incident occurred when adivasis temporarily migrate to outside and as a result not personally available to do the official processing work. They cultivate in the forest land but forest department and an organisation called ‘*Van Samiti*’ most of the times try to destroy the crop. Besides depending on agriculture for livelihood, villagers migrates other places for labourer work. But Kunkanas are very hard working in agricultural cultivation compared to Bhils. This is due to the fact that Bhil men primarily indulge in drinking daily and do not pay attention to the work. Secondly, since traditionally, Bhil were into hunting, they did not know cultivation; however, slowly they learnt cultivation from Kunkanas. Nevertheless, Bhil women regularly carry out agricultural work for the maintenance of family. There is a school in the villages which offer education between 1 to 8 standards and 7 teachers are employed in the school. In the Dangs public schools (owned by Gujarat Government) mainly provide education in Gujarati language. Whereas in private schools specifically few ones found in the Ahwa and Saputara town provide education in English medium. It is to be marked here that local *adivasis* do not speak in Gujarati in their home and rather converse in Dangi dialect. Furthermore, the areas which are closer to Maharashtra particularly in eastern belt Dangi dialects gets fused with Marathis words. There is a post office which covers seven villages (five villages of the field study and two additional villages called Dumaria and Bilbari).

There are availability of two Anganwadi Centres (AWC) which provide facilities for mother and children. However, AWCs are not run as per the directives scripted by the state and instead these plans remain in the paper. For instance, as per the central government guidelines, each AWC should provide facilities to only 25 children. However, it is observed that two Anganwadi centres catering to the 181 children which is four times higher than the figure given by the guidelines.

Members of *Mahila Mandal* (Women Self-help groups) informed that these AWCs do not provide food and education facilities to all the children of the village. In reality half
of them might be regular and receiving food and other benefits from AWCs and rest join the parents in their work. However, AWC workers record all the children in the paper as well as take these benefits on to themselves in the name of these absentees children. Secondly, these teachers are not regular and do not teach children in substantial sense. Children’s interest in the school is limited especially when the helper of the school calls them to serve Nasta (breakfast). They stay in the vicinity of the school during that period and leave thereafter. If we connect the statement of SHGs with adivasi activists, it resonates. Ishwar Pawar, a tribal who heads South Gujarat's adivasi Vikas Trust that conducted the last survey, said the state government agencies have been manipulating malnutrition figures in the tribal region. He said: "There is a huge gap in reality and the picture the government wants people to believe (cited in Desai 2014)." Even if AWCs are supposed to provide food and vitamin tablets to pregnant women, its service is limited to offering breakfast free of cost. According to the figure given by AWW, there are seven post-delivery women, 20 pregnant women and 34 young girls who obtain cooked food daily.

However, AWC workers have their own rationale for being irregular and Anganwadi worker said, “We are getting very less salary; so we are also doing agriculture work. It is because Anganwadi worker’s salary is not enough for our family. From the four thousand it is not enough to spend for our own children’s education and for the family. It is very difficult for us to survive. This aspect general public would not understand i.e. how to feed the family in this limited salary. No one understands our situation. Government has entrusted various work but do not think about the salary of Anganwadi worker.”

As the quote indicates, demotivation to work primarily arises from the fact of insufficient salary compared to the amount of work. So, this explains not just poor implementation of the public schemes to improve maternal and child health condition but also loop-holes in the structure of the programmes drafted by the Indian state which AWW tried to question. I would return to this point in the third section.
Besides these local *adivasis*, non-*adivasis* like Patels of Gujarat, Patils of Maharashtra, merchant communities (*Baniyas*) of Gujarat are seen here for trade work like wine business, export of precious trees i.e. *sal* (*in scientific literature it is called as shorearobusta*), *sag*, (*Teetona Grandis*)\(^8\) etc for furniture or timber business, etc. and work as moneylender for *adivasis* who borrow loans during their down time from agriculture. It is a known fact that these Patels have nexus with the Forest Department which supposedly aim to conserve and protect these plants and species, however, in reality these dominant sections of people have illegal access to these natural resources while the locals like *adivasis* are denied access to these forest despite the latter using the forest for time immemorial. The Forest Act which exploited the tribals and natural resources, are in fact the extension of colonial law which post-independent Indian state continued it as a weapon for development of tribal areas and indicted the *adivasis*. This point is related to Baxi’s (2005) point that notions of “justice” and “development” in colonial law formations are best paternalistic and at worst accessories to imperial domination. As *adivasis’* source of income dwindles, they borrow money from private money lenders. *Adivasis* mainly use these amount for meeting their family expenses as well as expenses towards staying outside for labourer work. Additionally, some of these money lenders are also contractors *Mukkaddama* (assistant contractor) who make deal with the *adivasis* to work in sugarcane farms. Despite *adivasis* being pennyless, in wine business, it is seen that landless Bhils are the customers while Kunkanas and Patels are involved in liquor business. Bhils are heavily indebted from Patels partially due to their daily consumption of liquor.

The Badigavantha village was constituted six-seven generations ago. In the village primarily two communities, viz. Bhil and Kunkana live. It was revealed during discussion that earlier, only four families lived. But, now their descendants multiplied into fifty families who are residing in the village. Anganwadi worker informed that the village houses population of 327 persons, where 151 males and 176 females are enumerated. In the age group of 0-6 years, there are 43 people and out of which 21 are males and 23 are

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\(^8\)Sag trees are used for the major construction materials for houses, huts, etc.
females. There are 91 people who are literate and among them males constitute 52 and females constitute 39. This village has 99 non-workers (46 males and 53 females) out of 327 populations. In similar vein, more number of women participates in daily wage work compared to men. For instance, out of 96 worker population, 46 are males and 53 are females.

Here villager’s main work is agriculture, cultivation, etc. Source of livelihood is similar to Naktiyahanvat village. There is a school in the village which offers education between 1-5 standards. However, only two teachers are entrusted to teach five classes. But students are extraordinarily high in number. So, how can we expect good quality education for the children? And it is offered in Gujarati medium. Other thing is that, there is one Anganwadi Centre for children. This centre has been established for a decade. What I have observed about the particular AWC is that the living condition of AWC is not good in the sense that many materials (unrelated to AWC) are kept in the room which reduces the space for children to study and play. This AWC came into existence since villagers had demanded for AWC in district Child Development Office at Ahwa. Badigavantha children went earlier to the Anganwadi Centre at Kel which is one kilometre away from this village.

Besides, AWC, an adivasi vanshiwala (medicine man) called ‘Chaurya Lakhubhai’ lives in this village and he is very famous for healing. He provides treatment not only to adivasis but also non-adivasis. People from Maharashtra like Dhulia and Nashik district as well as from Gujarat like Valsad, Surat and Narmada descend to his clinic. Muslims too visit him. His expertise is known in Nasa (veins) and Sandhas (joints). So, now he earns a lot of money in the village. Initially he did not establish a clinic as he started as a wondering doctor who would do door-to-door visit but after he became a famous figure, he started practising from a clinic. However, recently due to demonetisation, he had to face a lot of problem and in fact he lost his earnings since he had accumulated demonetised currency which could not be deposited in bank.
The Bibupada village was constituted many years ago. In this village mainly the Bhil and Kunkana *adivasis* stay. Earlier it used to be a very small village. But, now it is a big village. According to the AWW, the village houses population of 811 persons, where 406 males and 405 females are enumerated. The literate population of the village is counted as 240; where 122 are males and 118 are females. This village has 209 non-workers out of 811 populations and among them 100 are males and 109 females. There are 200 people who are employed and among them 122 are men and 128 are women. In the age group of 0-6 years, population is 122; where there are 62 males and 60 females.

Villagers here are mainly dependent on agriculture. There is one school which provides education from 1<sup>st</sup> to 5<sup>th</sup> standards. This school has three teachers. There is one anganwadi Centre available for children. The first day when I visited the Centre, it was closed. On the second day, when I visited, I met the AWW and she informed that 51 children receive the services of the Centre. It is to be noted that actually the house that was used as AWC had collapsed due to poor construction and heavy cyclone in 2010. After that AWC has been run in the residence of the helper who belonged to the village. AWW worker comes from Vahutia which is 2 kilometres away from this village. 30 pregnant women are recorded to be availing breakfast from the Centre. However, it is observed that most of the women at least 20 of them do not receive breakfast from the Centre as they are preoccupied with their agricultural work in the farm and the timings do not suit them. These women are required to be in the farm land by the early morning (like between 8 a.m. to 9 a.m.), whereas AWC provide breakfast at 10 a.m. to these women. Significantly, breakfast items consist of glass of milk, fruits and snacks which are vital for the health of the pregnant woman.

The Bardipada village was constituted many years ago. In Bardipada village, Bhil, *Mavachi* (they are best known as Gamit in the state record) and Kunkana *adivasis* reside. Mavachis are fisher folk communities who have migrated from Maharashtra and settled here. Since they settled in the village and they were called as “Gamit”. As mentioned earlier, *Mavachis* and Kunkanas prepare wine while Bhils are consumers. Both of these communities are known to have migrated from Maharashtra when the Bhil king brought
them for ploughing and settled agricultural work. It is a known fact that Bhils were not into cultivation. Over the course of time, upward mobility happened in the life course of Kunkanas who were closely associated with Hindu culture and tradition including food habits. However, gradually downward mobility happened in the case of Bhils. As mentioned in the methodology chapter, Kunkanas perceive themselves to be superior compared to the Bhils as they do not eat beef. Since Bhils eat beef, they are treated hierarchically inferior by the Kunkanas. Similarly, Mavachi too eat beef and so, Kunkanas treat them as lower. According to AWW, the village houses population of 619 persons, where 310 male and 309 female are enumerated. Among them only 235 people are literate; where males constitute 120 and females constitute 115. Villages have 181 non-workers out of 619 populations, out of which there are 81 males and 100 females. Worker populations in the village are 171 and among them 99 are males and 72 are females. There are 80 people in the age group of 0-6 years population and 38 are males and 42 are females.

Here, recently a government school has been established in 2014 which provide education to children between 9th to 10th standards. There is also a primary school. Both of these schools provide education in Gujarati language. A point to be noted here is that recently by abiding Government of Gujarat’s policy of establishing a madhyamik school (secondary school) in every 14 kilometres, a secondary school has been established in this village.

The Garkhadi village was constituted by our ancestor. In the village, primarily adivasis like Bhil, Kunkana, Varli and Gamit live. Varlis perceive that though they are inferior to Kunknas, still they are higher than the Gamits and Bhils. For instance, Kunkanas stress that even if they can let their daughter marry with a Varli man, however, they cannot tolerate their daughter marrying a man from Bhil community. According to AWW, the village houses 2122 persons, where 1058 males and 1064 females are enumerated. Among them 1124 people are literate; where males constitute 625 and females constitute 499. In this village, there are 1108 non-worker out of 2122 population and among them 507 are males and 601 are females. Total worker population in this village is 726 and
among them 358 is males and 368 are females. There are 302 children in the age group of 0-6 years and among them 152 are males and 150 are females.

Here villagers’ main work is agriculture. Therefore, they do labourer work for livelihood. Other thing about the village is that there are two Anganwadi Centres which recruited two AWW workers and two helpers to provide services for children. According to Central government’s guidelines, minimum twenty children are required to establish an AWC. Hence, there are two AWCs. 302 children are at present enrolled in the AWCs. And two ASHA workers work in this village, considering the fact that it is a big village. This village also houses a PHC (Primary Health Centre), however, since the infrastructure especially the building for the hospital and residential facilities for the doctors and staffs are not good, no doctors are interested to stay there. They commute-doing up-down from Ahwa daily which basically implies the reduction in their time meant for consultation with the patients. Patients wait for long hours in public hospitals for the arrival of the doctors as well as it also meant that doctors quickly or barely spare few minutes for the discussion with the patients. In these scenarios, how can a PHC offer 24 hours treatment for delivery of a pregnant woman? So, due to lack of quality health service facilities, people go to private clinic mostly.

Here one primary school has been established which offers education for 1-8 standards in Gujarati medium. One new school named “Eklavya Model Residential School” was established by state government which provides education for 9 to 10 standards in Gujarati medium. Before that there was a school named “Ashram Shala” (established by Gujarat Government) which offered education from 1 to 8 standards. This school “Ashram Shala” has now closed. On Saturday haat (weekly market) is held in Garkhadi. Similarly on every Sunday Pipaldahad village holds weekly bajar (market) in which villagers within 20 kilometre radius flock for marketing.

The Subir village was constituted many years ago. In the village, primarily the Bhil, Kunkana, Varli (who primarily have migrated from Maharashtra) and Gamit adivasis live. It is a big village like Garkhadi. Since, Subir was recently made as a Taluka, new
buildings (for housing public offices) and road construction activities are carried out. According to AWW, the village houses population of 3923 persons, where 1899 male and 2024 female are enumerated. There are 2553 literate persons; where males constitute 1628 and females constitute 925. This village has 2529 non-worker out of 3923 population, out of which 1098 are males and 1431 are females. There are 1394 people who are workers and among them 690 are males and 704 are females. In the age group of 0-6 years, there are 933 children and among them 493 are males and 440 are females. Main occupation of the villagers is agriculture. But, people also do labour work like construction work, road work, etc.

There is a PHC in this village and compared to Garkhadi, this PHC provides good facility. For instance, there is a maternity hall which provides in-patient facilities. There is a residential doctor who has been practicing in this PHC for the last fifteen years. He originally belongs to Bihar and from Muslim community. There are three nurses who work in this PHC. There is availability of ambulance which is a relief for poor people to commute. But now this PHC got converted into CHC during my field work. This doctor lamented that since the PHC has been developed to CHC, there is a plan to bring in new staff like doctors, nurses, etc. As a result this doctor would be transferred to another PHC in Singhana. There is good school run by missionaries which offer education from standard 1 to 12. Here medium of instruction is offered in English as well as Gujarati. This school charges some nominal amount as fees. In addition, there is a public school for secondary education. There were three AWCs in Subir earlier. However, for the last eight months, one AWC was closed owing to less attendance of children. According to the AWC record, 307 children and 52 pregnant and post-delivery women obtain the services of two AWCs.

The Harpada village was constituted many years ago. In the village, primarily Bhil, Kunkana and Gamit adivasis live. According to AWW, the village houses population of 817 persons, out of which 399 are males and 418 are females. There are 438 people who are literate; where males constitute 227 and females constitute 211. Villages have 357 non-worker persons out of 817 populations, out of which 157 are males and 200, are
females. In terms of working population, it is 259 in number and among them 142 is males and 177 are females. In the age group of 0-6 year, 183 children are available; where 97 are males and 86 are females. There is one public school which offers education from 1 to 5 standards in Gujarati medium. There is one anganwadi centre. Compared to other AWCs, this is relatively better in terms of having enough space and maintains cleanliness and hygiene. However, the number of children who avail the services of AWCs actually is smaller than the number in the paper. AWW worker here informed that this centre provides breakfast to women. Regarding provision of iron and other vitamin tablets, she informed that though they provide these, women do not consume these and instead simply throw. According to my observation, she was right that adivasi women throw it as they fear that these tablets might be made of some poisonous elements especially after coming to know about recent deaths of adivasi women due to sterilisation in Chattisgarh. They perceive that if they would consume those tablets, there would be miscarriage. For adivasi women, state is only interested in controlling their fertility rather than improvement of their health. This information underscores the fact that structural constrains as well as cultural belief disassociate adivasi women to confirm with the public health regimen outlined by the state.

While describing the socio-cultural and economic order of these villages, it is equally important to consider another point which Hardiman (1984) noted. He described about the socio-structural arrangement the villages of Dangs that in the Dangs the ruling chiefs were Bhils and the mass of the peasants being Kunkanas. The tribes of south Gujarat were culturally quite distinct from the Bhils; they were not a mere offshoot of this major tribe. The villages lacked any nucleus for they were without artisans and other specialist castes. In this, the adivasi village provided a marked contrast to many of the so-called ‘traditional’ Indian villages with their hierarchies of Brahman priests, dominant castes, subordinate labouring castes, Vaniya shopkeepers, artisan castes and untouchables. In most adivasi faliyas the members were exclusively of one tribe. They either owned or rented land and they normally possessed their own agricultural implements and draught bullocks (ibid: 200).
In these seven villages, for the last two years, MGNREGA (Mahatma Gandhi National Rural Employment Guarantee Act)\(^9\) schemes have been discontinued as there is no work available at Panchayat (covers six villages). According to an AWC worker, earlier even if adivasis worked under the provision of MNREGA, however, they did not actually work for 100 days. They only worked for twenty–thirty days. To add more problems, even if the actual wage according to Central Government is Rs 120, adivasis in Dangs are paid between Rs 60 to Rs 70.

**Adivasis’ House style:**

In the villages, it is observed during field work that the present house style is different from earlier years. I think it is in the process of development. Because adivasi ancestors lived in the zopdi (cottage) or Chawl\(^{10}\). And they were doing hunting and fishing work for arranging food. But, now work pattern has changed and people are moving towards modernisation be it in economy or in life style or housing structure. So, now they have constructed big houses compared to older times with a lot of struggle. They made houses of big sticks from Sag, Sadal and Sisam trees. They make Bhit (wall) from Int (Brick) and Murumvali safedmatithi (White clay or Soft stone that is in the soil mix). They use Ilayati Kavul (current tubes) in order to make roof of the house. It is Ilayati Kavul (current tubes) they are buying from central Gujarat cities. Earlier adivasi people made Kavul themselves through mud. But now they are not interested in their own Kaval (tubes). So, now they are buying from outside. In the floor they put Chhanthi limpine (dung paint) and decorate the ground through different colours of sand (like white, red and yellow). These colour soils are available locally.

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\(^9\) Mehta, Shepherd, Bhide, Shah and Kumar (2011) wrote that MGNREGA guarantees 100 days of unskilled work at the minimum wage to each household. It was passed unanimously in the Lok Sabha (the lower house of Parliament) on 23 August 2005. It came into force in 200 districts on 2 February 2006 and was extended to an additional 130 districts in 2007-08. The Act was universalised with effect from 1 April 2008 and now covers the entire country. The Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) is not just another wage employment programme. It is legally enforceable, and changes can be initiated only through constitutional amendment. It draws on India’s long experience with wage employment generation schemes (Mehta, Shepherd, Bhide, Shah and Kumar, 2011: 88, 89).

\(^{10}\) A chawl is ‘a row of rooms with either no sanitary conveniences or with community facilities’.
It has been observed that though Central Government and state government offer housing schemes for poor including *adivasis* for affordable housing, there is a gap between scheme and its utilisation. For instance, Indira Awas Yojana (IAY) is offered for BPL (below poverty line) in which economically backward *adivasis* are given money to construct houses. However, they find that amount (Rs 55,000 earlier and now it has increased to Rs 72,000) as insufficient and thus, they put some amount on their own to construct the house. In addition, there is another scheme jointly offered by the state and central government called Sardar Awas Yojana- for APL (Above Poverty Line) card holders in which not only people contribute some amount, panchayat is also mandated to build the house. In this scenario, panchayat gives contract to private parties for construction and as a result poor quality and very small houses are constructed. Consequently, *adivasis* choose not to stay but instead use it for cowshed. *Adivasis* complain that doors made through Sardar Awas Yojana break after few years. It gets dysfunctional after five years. Therefore, *adivasis* construct pucca houses by taking loans from *vaniyas* and other villagers, *Mukkaddam*, etc. and again get exploited by them through high interest rates. Fair price shops are available in these villages where BPL card holders are provided ration at subsidised price. For instance, rice is provided at Rs 3 per K.G., Rs 2 for one kilogram of wheat, Rs 5 for one litre of edible oil, Rs 20 for one litre of kerosene oil etc. However, it is occasionally open and the provisions are of low quality. Furthermore, villagers complain that the actual poor do not avail these facilities because of rampant corruption in these schemes. Another interesting fact is that villagers do not purchase kerosene from the fair price shop as they find it costly.\(^{11}\)

Whereas in the villages mostly *adivasis* like Bhil, Kunkana, Varli, *Mavchi*, Kotvaliya, Kathodiya, etc. live, in the town non-*adivasis* such as Dhodiya patel, SC, *Bhainis* and other mainstream people reside. They are mostly into a regular employment in secretariat, offices like revenue, hospital, transport office, etc. As stated earlier, non-*adivasis* from mainland Gujarat show up here for business purpose to exploit innocent *adivasis* through

\(^{11}\) In the market kerosene oil is sold at Rs 35 to Rs 45 in Dangs. Since *adivasis* find the price of kerosene costly, they only purchase one litre of kerosene from the fair price shop, whereas for each family, government allocates 5 litres of kerosene. In this scenario, ration shop keepers sell these remaining to market at Rs 40 by showing that they have distributed everything to the poor.
private money lending business. It is observed that Baniyas finance Mukkaddam (assistant contractor) as they are involved into money lending business and always aspire to make profit out of the interest amount.

Mukkaddams are mainly adivasis and serve as the leader as well as supervisor and contractor of adivasis who work as labourers in sugar cane firms. More than contractual relationships, the equation between Mukkaddam and adivasi labourers are social. From that angle, adivasi labourers always borrow money from Mukkaddam whenever they are in need like for the marriage or for construction of house, to buy bikes or cell phone, etc. Thus, Mukkaddam lend them money which they originally borrow from financiers or money lenders who are primarily from Patel or Patil community of Maharashtra. Point to be noted here is that since poor adivasis approach generally Mukkaddam, these smart Baniyas directly get hold of the latter so that they do not have to roam around at people’s house for money lending. As mentioned earlier, Mukkaddam is not employed in the sugar cane farms but entrusted contract work in order to bring certain number of individuals for labour work in sugar cane work in Vyara, Bardoli, Valsad and road works in Maharashtra. In this process, in order to bring adivasis for labour work, Mukkaddam generally pays certain advance amount like Rs 1500 per Koyta (pair). Adivasis work mainly in the Gujarat’s sugarcane factory or mills and these mills are owned by Patidars or Patels. Adivasis work for eight months between September to April in every year in these places and earn between Rs 25,000 to Rs 55,000 per Koyta depending on the work performance. Point to be noted here is that these adivasis primarily do cutting work of sugar canes and prior to them small and marginal farmers primarily from OBC communities cultivate sugarcanes and later sell these to mill owners like Patels. Since already adivasis are indebted to Mukkaddam, and again Mukkaddam shave to repay to local money lenders, most of Mukkaddams and labourers come empty hand; after seven to eight months of hard work. In fact, many Mukkaddams and labour workers become indebtorists and defaulters. It generally occurs because of high interest rate – 50%. It was informed that for the loan of Rs 1,000, financiers extract Rs 1500 from these poor in a year. As this description revealed, even if migration became a coping strategy to maintain the family, on the other hand, poor adivasis are trapped into an exploitative chain where
they are heavily indebted. In fact, it is reported that the farmers (non-\textit{adivasis}) too complain against the mill owners since they do not get good price from the mill owners when they sell sugarcane. So from both the sides it is a win-win situation for the Patels and Patils. After demonetisation, the conditions of \textit{adivasis} and farmers became worse because mill owners continued to pay them in old currencies and \textit{adivasis} were not only cheated but also they had to stand in queue in order to deposit their earnings. Interestingly, financiers too made a deal with the \textit{adivasis} to deposit their earnings in their bank account and in return they paid them their daily wages.

Varghese (1999) describes in detail the contract system called \textit{Koyta} during 1990s in the following manner. In the sugarcane fields, the migrants work in gangs. The basic unit of a gang is a \textit{Koyta}. This is a unit of two persons, often, a man and woman, though not necessarily a husband-wife team. They are recruited from the Dangs during the monsoons, and leave after the harvests for the worksite. Both living conditions and labour conditions at the worksite are horrendous. The gang and its head, known as the \textit{Mukkaddam}, are assigned a specified amount of work daily. Payments, far below the legal minimum wages, are made on the basis of each tonne of sugar-cane that the workers cut, strip, bundle and load. In early nineties, at around Rs 33 per tonne, it was far below the legal minimum wages. Instead of wages, regular advances of grain and cash are made to each \textit{Koyta}. Since these advances are small amounts, the \textit{Koyta} also has to take loans in additions from the local shopkeeper. For shelter, each \textit{Koyta} is given a few cane mats and bamboos to make temporary huts, which form their homes till they move to a new site for cutting (ibid: 27). She observes that there is no doubt that the practice of seasonal migration has meant an enormous increase in the workload of the migrants. Work on sugarcane fields is highly labour intensive, and regularly lasts between twelve to fifteen hours daily. This increase in workload is across the sexes: both men and women have to work much harder than they formerly did on their own fields or as wage labourers for the Forest Department. At the same time, the workload of women (who migrate in equal numbers to the men) seems to have increased more than that of the men. As brought out in a vivid description:
“Although the cutting knife is wielded mostly by the men, their helpers, usually the women sometimes take over so that the men may rest. The cleaning, breaking, and bundling of the cane stalks, all very demanding tasks, are handled by the women. While the men drink some water or lay down exhausted during the short break, the women must attend to any infants they may have brought to the field with them, the youngest not yet weaned. On returning to the camp at the end of the day, it is the women again who carry a bundle of wood for the cooking fire on their head, and back in the camp they still have many chores to attend to [such as cooking or washing up while the men rest] (ibid: 27).”

She pointed out that, given the hostility of both men and women to hard and intensive wage labour; it is interesting that the Dangis have not responded to the strenuous sugarcane-field work with the same irregularity that characterised their work for the Forest Department. One reason for this could be the subsistence imperative. But a more specific explanation for the phenomenon can be found in the role of the Mukkaddam, or the male head of the gang. The Mukkaddams (who are Dangis) are appointed informally by the large non-Dangi contractors who undertake to supply labour for the sugarcane fields and factories. The Mukkaddams are told to hire and bring to the contractors a specified number of labourers to form a gang. They are paid an amount in advance by the contractors to ensure that the specified number turns up. It is the Mukkaddam who then hires labourers to form his gang. He pays the prospective labourers a portion of the advance. Most Mukkaddams are slightly better-off than those they hire; sometimes, however, they are almost as poor. Occasionally, the Mukkaddams hold senior positions in local patriarchal kinship hierarchies and hire junior kin as part of the gang; at other times, the gangs are hired informally amongst those whom the Mukkaddams know (ibid: 27).

Furthermore, she argues that the Mukkaddam does not only play a role in hiring; he is the head of the gang in the sugarcane fields, and it is he who gives direct orders to the kaytas (meaning Koytas) in his gang. Those whom he hires (usually the man in each kayta) are those over whom he has either economic or social superiority (or both) within the local context. To refuse to turn up for work after accepting wages, or to not work well on the fields, is thus not merely to ignore an outside contractor. For the men, it would involving
the local village and social hierarchy. For the women, in addition to this, there is the patriarchal system within the household itself which has to be defied. Again, once the koyta starts working, the system is geared to ensure that they cannot leave easily. The advances they are paid do not even cover their subsistence - as we noted, they have to take additional loans from the shopkeeper (on security provided again by the Mukkaddam). They are paid for their work only at the end of the season. This strategy ensures their compliance throughout the season. For the women, the situation is doubly difficult. Even the regular advances are made to the men in the koyta, who exercise control over the women as husbands, brothers or, less commonly, fathers. The practice of seasonal migration has definitely led to the transformation of cultivation practices. Several of the preparatory tasks in the pre-monsoon period, such as the making of seedbeds, have to be carried out either at the last minute, or by older kin-members who have stayed at home. Also, the migrants on returning home quite exhausted after the seven months of intensive work, are not willing to put in much labour into cultivation. Indeed, in some cases, migrants even lease out their land to neighbouring Koknis (meaning Kunkanas), often belonging to the medium land holders. Thus, for the migrants, the importance of cultivation is declining. But cultivation is still perceived as very important, which is one of the main reasons the migrant Dangis give for returning to their villages just before the monsoons commence. This is the period when most intensive agricultural tasks have to be undertaken. The food crops that are sown continue to provide a means of subsistence for the household for a significant portion of the year in Dangs even now (ibid: 28).

In the constitution of the teams for seasonal migration, women's labour power has been central. But here it is no longer a question of women working individually as wage labourers. A Koyta almost invariably consists of a man and woman. Here, then, the old peasant household was working as a unit in the wage labour market. At the same time, the wages of the Koyta are paid to the male member of the unit: women have thus become not just individual wage labourers but an essential part of a wage labour unit over which the male member of the Koyta has greater control. Thus, women are far from being 'free labour' (ibid: 28-29).
The motive behind describing the Koyta system is not merely exploitative work system but also its connection with the reproductive vulnerability when women do heavy physical labour and experience early pregnancy as discussed in the previous chapter. On one hand, marriage and migration are the coping mechanism to overcome economic crisis or distress when state is in retreat, on the other hand adivasis and mainly women are caught into double bind - work burden and lack of quality maternal facility. Their suffering is exacerbated by insufficient nutrition and early pregnancy. These insights were revealed through the discussion with the members of Payal Sakhi Mandal, Naktyahanvat as well as by a missionary doctor which has been elaborated in the subsequent section. Another thing which I have observed that since women are malnourished and do heavy work, their body structure is very thin. So, poverty and insufficient income are the important factors as far as reproductive health of the adivasi women is concerned the reason.

Additionally, marriage in the teenage followed by pregnancy brings another ominous result for health. Because in this circumstance, age of the mother becomes very young this invites the risk for delivery. This facet was discussed by a worker called “K” in ICDS programme who previously worked as a sex worker, “Being a mother at a young age, she is prone to many infectious diseases. It is because, she is not so aware of these issues at this age. So, early marriages are very dangerous for every woman and in principle, they should be discouraged. But in the society people get married soon after seeing the economic situation. It is due to the fact that they only bother about how to feed the family during that time. They know what the rules of government are. That is why we should give more attention to education in this area. And the government is especially needed to provide facilities for it. At the same time, it becomes very important to make available employment opportunities for those people.”

**Differential Distribution of Public Health services:**

In the whole district, there is one district Hospital located in Ahwa and there is no availability of sub-divisional hospital. However, despite the availability of District
Hospital, it was revealed during the field study that it does not have caesarean facility for pregnant women. Besides these, there are three CHCs [Community Health Centre], ten PHCs [Primary Health Centre], sixty eight SBs [Sub-Centre], one MHU [Medical Health Unit] and one MMU [Mobile Medical Unit]. The names of PHCs established in Dangs are in Gadhvi, Pimpri, Samgahan, Galkund Garkhadi, Pipaldahad, Singana, Jhawda, Kalibel and Sakarpatal (Health Survey Report dated 01-12-2016). In the Dangs during my field work, it was observed that even if three-tier health system exists in Dangs, at the same time, facilities like doctors, equipment and services are negligible as seen in the case of Garkhadi PHC. Each PHC should supervise five sub-centres but in these PHCs, there are only three sub-centres. Doctors are frequently transferred as there is no proper facility for residence. Similarly, these centres do not provide 24 hours service. Doctors are only available from 10 a.m. to 4 p.m. They provide excuse of attending meeting and other important things for their absence. So, people go to the private hospitals or private traditional practitioners. Because they have no time for wasting time in order to avail treatmet from public health centres by waiting for the doctor’s arrival.

Noting this, Qadeer (2016) writes that “Primary Health Care was identified soon after independence and following the Bhole committee recommendation to aim at equal health care to all; the rural health care infrastructure was designed as a three-tier system: sub-centres (SC), primary health centres and community health centres, which was meant for populations of 5,000, 30,000 and 120,000, respectively. Although these facilities were meant to provide high-quality services in public health, they failed to do so due to lack of health care professionals; either this section of the staff could not be recruited or they did not turn up for duty after being appointed. There is lack of an successful infrastructure in rural areas and a medical education based on colonial vision of medicine that alienated medical tablets and public health failed to inspire doctors to work in PHCs though their

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12 This is a new PHC and was formed in 2014.
13 Galkund PHC was shifted from Saputara when PHC at Saputara got upgraded into CHC since 11th February, 2015. PHC at Galkund was established on 6th of June 2016.
14 PHC at Singana was shifted from Subir as the latter PHC was upgraded into CHC on February 11, 11-2015. Later PHC at Singana was established on June 14, 2016.
15 PHC at Jhavda was established on June 30, 2016.
numbers continued to rise as private medical schools expanded and further undermined public health component of medical education. Attentiveness in cities and out relocation characterized this set of personnel. This scarcity of employees in rural areas created a vast gap between needs and availability of public sector providers. People depended upon private providers from different systems of healing such as AYUSH and folk medicine, and the fastest growing among these were the informal allopathic practitioners. This trend was more in the well off areas as compared to other relatively poor areas where profits are difficult in private practice (ibid: 591).”

Section-II

This section discusses the specific health care needs of adivasi women and it is interlinked with their socio-political situations and cultural contexts i.e. varied birth practices. As discussed in the earlier section, most of the adivasi women are malnourished and it is problematic as they do heavy work without sufficient and nutritious food and rest. So their public health requirement is nutritious food and self sufficiency in food.

Problem of Malnourishment and Its Risk for Deliveries:

The missionary doctor from Subir said,

“The pregnant women in Dangs suffer from– Pneumonia, High B.P., and Less Hemoglobin etc. So, pregnant woman should be aware of their own situation always. During pregnancy, check up of the body should be done through the good doctor but not from a fake doctor. And this check-up is important particularly when the woman is pregnant for less than three to six weeks time. This is how you will know particularly own health awareness. That is protecting pregnant woman from dangerous diseases.”
The above information from the doctor point out the problem of malnourishment which creates risk for delivery as well as de-regulation of the medical practitioners, namely the proliferation of fake doctors which puts adivasi women into danger.

She too succinctly linked the problem of malnutrition with structural inequality

“Poverty is main problem in the Dangs for nutrition. They are eating Nagli’s roti (Ragi’s chapatti) and chili chutney only. They are not taking fruits, milk etc. Agriculture has not earned the perennial vegetables. So, they use most of dry things as well as Dal, pulse, rice, etc. Particularly, summer and Monsoon seasons are very difficult for them! That time they eat always dry food. If these women are outside of Dangs while doing labour work they are also not eating nutritious food. For example, while doing labour work in sugarcane farms and other work; they have no time to mind about their health and take rest because they have to work day and night without break since they primarily migrate to earn money”.

As these examples elucidated, job insecurity and insufficient income leads to malnutrition which is again an important risk factor during delivery for migrant woman workers. Additionally, women who stay in Dangs and do agriculture too skip nutritious food like milk and fruits and iron-tablets as timings of AWC are incongruous with their work timing as well as due to their cultural beliefs. On the other hand, institutionalization of delivery is done in an instrumental and technocratic manner which isolates the living conditions of the adivasis.

Unlike Brahminical society, where there is a tradition of women eating in the end i.e. after feeding the elders and children and consuming the left-over food, adivasi society does not make a discrimination in food intake between men and women. Men and women eat together and consume same amount of food irrespective of their pregnancy or illness. So, there is no gender discrimination in terms of food intake. Instead, their malnourishment lies in the work pattern and economic structure of the region. It is commonly seen that when women come to field for cultivation, they just take chapattis (a thin pancake of unleavened wholemeal bread cooked on a griddle) in their hand and chew
and eat while they carry tiffin for their family members on their head. They have their lunch while walking as they do not want to waste their time for taking a special break for lunch.

Secondly, even if adivasis struggled to have nutritious food from their earning, still they can expect from the benevolent state to provide them welfare benefits like food (cooked food) or ration. As narrated in the first section, even if there are schemes offered by the state to get ration, these benefits often do not reach the really needy people. Proper identification of the poor is not done meticulously and as a result, dominant sections hijak the public services and real needy are excluded from it.

This is best narrated by S a suvarin who remarked, “Garib Melas are organised by the government. But for whose benefit it is held? I have never been part of these melas. In my knowledge, no one gets any benefit even if they visit these melas. The people who are members of these programmes always use the government's scheme. It is visible everywhere. And well of people always take advantage of the plans. Nobody asks the poor. If he gets it somehow, then he eats. Otherwise, he goes hungry to bed. Who is asking poor? This is our life. Who wants to beg the government? Sarkarna thagana dhandha aas dusara kahi nahi (Government only cheats people nothing else)”. (S did not receive any training in modern delivery as she was furious to travel by vehicle especially bus as she feels nauseous.)

Mander (2009) in this connection writes, “The right to enough and assured good in order to live an active and healthy life with dignity is, in principle, also an essential component of the fundamental right to life, because life itself is impossible without food. Yet, state authorities are conventionally not held responsible when a person loses his or her life because he or she cannot access sufficient food for survival in the same way as a person who dies because the state directly takes his or her life without resorting to due process of law. The death of a citizen by starvation is seen a moral failure of the state, but rarely as one that entails direct punishable criminal or even civil liability of public authorities who
were charged with the responsibility to ensure that every man, woman, and child, in their jurisdictions, have access to sufficient food for their survival with dignity (ibid: 235).

Additionally, S continued,

“Now everyone needs money. It is because; the Government has introduced mobile phones in rural areas. So, now poor villagers have access to mobile phones. However, without providing basic facilities like road, education, etc government is promoting mobile phone services. Therefore, we are facing more problems in the adivasi society. Since youth have access to mobile phone, they spend time in talking. They become bankrupt by paying phone bills. And given the limited income they have, the entire income is spent on by paying phone bills instead of spending income on food. So you would see, youth migrating to city when they become penniless so that they can pay mobile bills. They do not care about spending the earnings on food. I think government system and private companies are to plunder poor people.”

Thus far these examples elucidated that job insecurity and unequal work burden causes malnutrition which is in turn important risk factor during delivery as well as weak functioning of the Food Security Programmes (FSP). On the other hand, reproductive health programmes carried out by the state does not attract these adivasis due to multifarious reasons. This also points out to short sightedness of the economic planning of the India state which promotes consumerism even among the poor and this further reduced their chance of spending on food. This highlights the connection between poverty and food deprivation and consequently malnourishment.

**Poor Road Facility Makes Hospital Delivery a Risky Affair:**

It was revealed during the field work that dais offer services at the door-steps of the adivasis whereas to avail delivery services at public hospitals, poor adivasis have to struggle with the bad road. G who is a traditional birth attendant as well as received training in mid-wifery services in modern health systems said,
“Suvarin’s work involves assisting pregnant women in good delivery when she is called upon ‘Suvarin sarvar karala khas karini petvali benna ghar jaha. Fakt pudli var ti suvarinna ghar tapas karala yeh...tibhi to tila bes hava tava jah. Nahi to suvarinla bolvi leta tesni ja ghar.’ (So, she always goes to pregnant woman’s house for treatment. Pregnant woman first goes to suvarin’s house for check up.) Means, pregnant women go there to find out whether they are pregnant or not with certainty. Sometimes women do not visit us personally for check-up; instead they call us to their house for confirmation of their pregnancy. There is a big difference in our way of service delivery and services provided through government (means state) like in order to receive delivery from government health care centre, pregnant women have to visit the hospital whereas if they want to do their delivery by us, we reach at their doorsteps. So the former method is very bad for pregnant woman. Because the road facility is not good in Dangs like the road is very narrow and slippery as the area is surrounded by mountains and hills. Besides that since these are not concrete roads, vehicles passing through the roads generates dusts; everywhere in the atmosphere. In this condition, what is the use of taking pregnant woman for delivery in the hospital at Ahwa (District Hospital)?”

G continued,

“Despite being useful for delivery, government has criminalised our work. However, people have not stopped their relationship with us. Even if government has banned us, most of the pregnant women approach us for birth services. You should be asking why? It is because they are not providing really good facility to pregnant woman like the suvarins. This work has been continuing from our ancestors. We are not cheating our people; while on other side government have cheated adivasi people and pregnant woman in the health scheme. It is not good for adivasis’ health. Government always thought of and target for their agenda and does not pay attention to adivasis health in really. It is so, because if state genuinely cares for adivasis then first they would have understood the condition of adivasis and their particular needs.”
As the quotes pointed out *suvarin* legitimised her work while discrediting the approach of the state especially family planning scheme. As mentioned earlier, *adivasi* women too avoid and suspect vitamin tablets offered to pregnant women due to the state’s preoccupation of reproductive restraints among the deprived sections. This particular statement resembled with Pinto (2006)’s observation in rural UP among *Dalit* women. She argues that “On the one hand, in state family planning programmes, local agents closely monitor reproduction, recording not only pregnancies and births, but also contraceptive use and, by extension, sexuality. The intimate quality of *Dalit* women’s relationship to – and knowledge of – the bodily lives of women in the village is replaced by the broad surveillance of the state, as *Dalit* women themselves become objects of surveillance. For *Dalit* women, biomedicine beckons with promises of health, while institutions repel with a range of threats. A mother of six tells me she has withheld vaccinations from her children because ‘needles don’t suit us’, referring both to what are felt to be the heating properties of western medicine and to the threat that the needles and drugs of official institutions offer marginalized people. Others tell me that birth is just friendlier, easier, better in the village. Others fear the large scope of ‘operations’ – caesarians and forced (or surreptitious) sterilization. Others have more extreme fears: if they need an abortion, or a labour-induction, it is better that it comes from known local (usually uncertified) hands, than hospitals where people suspect, as one woman told me, ‘they put poison in the needle for the poor people’. Thus, there is a conflict between social and health requirements of *adivasi* women, cultural beliefs and practices and the kind of health services provided by the state.

It is important to note an interesting observation of the public health care facilities available in Dangs. For Badigavantha village population, technically the Naktyahanvat sub-centre should provide health care including deliveries. However, in my observation I have never seen an ANM to be functional and doing deliveries in its stipulated constituencies. Besides ANM, sometimes or very rarely I have seen a Malaria Health worker in the sub-centre. So the alternative option is to reach to the nearest PHC in Garkhadi which is seven kilometres away from this village. However, this is also not a
conducive option as it is a well-known fact that doctor is almost absent in the PHC or leaves early since there is no residential facility available for the doctors. The quarters that are available in the premise of District Hospital are in dilapidated condition and thus doctors refrain from staying there. Additionally, it lacks basic facilities like water, vehicle or phone facility there. Regarding this, a non-resident doctor M Brevealed, “In this situation how can we stay here? I lived here for week and spend week time in tensions my wife was not ready to stay here with me. So, how can I provide good treatment to people in the area? I think, I would have been better if I had to change it. I do not want to stay here. Because no facilities here”. So sub-centre and PHCs are almost dysfunctional for providing reproductive health services.

News papers too reported about the dismal state of public health care especially Janani Shishu Suraksha Karyakram (Safe Motherhood and Child Scheme and henceforth JSSK)\textsuperscript{16}. For instance, Nair, (2016) wrote by reporting about the CAG’s assessment of JSSK scheme in Gujarat,

“The CAG also found shortcomings in storage of drugs, availability of blood, supply of free diet and diagnostic facilities being provided under the Janani Shishu Suraksha Karyakram (JSSK) scheme. Laying bare the poor condition of the healthcare system in Gujarat, the Comptroller and Auditor General of India (CAG) in a report, tabled in the Assembly Friday, stated that the maternal mortality rate (MMR) is on the rise in the state in the past three years. It also pointed out instances where women were found being transported in a “chakhra rickshaw (a vehicle for carrying goods)” after a caesarean section. In its report on “General and Social Sector”, the country’s top audit watchdog stated that among 15 big states, Gujarat stood at a lowly 11\textsuperscript{th} position “in terms of percentage of reduction of maternal death” between 2004-13. While MMR in neighbouring Maharashtra (which ranked 1) reduced by 49 per cent, in Gujarat it came down by 30 percent. Between 2013-16, however, MMR in Gujarat rose. “The state had achieved success in reducing infant mortality rate (IMR) and neonatal mortality rate

\textsuperscript{16}This scheme was launched by Government of India on 1\textsuperscript{st} June, 2011 to motivate mothers for institutional delivery.
(NMR). However, the MMR changed unfavourably from 72 in the year 2013-14 to 80 in 2014-15 and finally to 85 in 2015-16. Considering the pace and direction of “In the three test-checked districts, the MMR was higher than the state average i.e Valsad (94), Dahod (93) and Surat (89),” It added, while auditing the Government of India’s Janani Shishu Suraksha Karyakram (JSSK) scheme that was focussed on reducing MMR, NMR and NMR in the states. The CAG stated that the implementation of the scheme in Gujarat was “fraught with many deficiencies and gaps”. The auditor stated that despite Gujarat having 1,763 ambulances and 256 khilkhilat vans (used for free drop-back facility for post natal care of mother and infants since 2012), only 33 per cent of the beneficiaries were provided with free transportation. In Latipur, the CAG observed transportation being provided to pregnant women through chakhra — a special rickshaw designed for carriage of goods in rural areas — upon a payment of Rs 250 per woman. “Transportation of women after delivery especially after caesarean section in Chakhra rickshaw was highly risky for the fresh stitches of operation due to constant vibrations,” it said. The report also pointed out that against a target of converting 50 per cent of the Primary Health Centres (PHCs) into round-the-clock centres by 2010, the Gujarat government could operationalise only 323 out of the 1,334 PHCs in the state as round-the-clock PHCs (as on August 2016). “Resultantly, audit could not ensure healthcare facilities for pregnant women at door step as intended in the scheme,” the report stated. Even in the operational round-the-clock PHCs, the CAG found inadequate facilities like lack of labour room, new born care centres, ambulances, ultra sonography tests, operation theatres and drop-back facilities. The auditor also found that the in 60 per cent of the cases the mother and the new born baby were discharged before 48 hours of delivery and were thus “deprived of post delivery treatment which could cause complications for both.” The CAG also found shortcomings in storage of drugs, availability of blood, supply of free diet and diagnostic facilities being provided under the JSSK scheme.”

These facets indicate the failure and poor implementation of JSSK scheme and thus it signals the weak state of public health programmes. In this connection, it is worthwhile to
elaborate on the specific cultural practices of adivasis related to reproduction which is fraught with modern universal practices of reproduction.

**Specificity of Birthing Practices and Traditional Reproductive Labour:**

Jeffery et al (1988) write that birthing practices are cultural specific rather than universal. In line of this, this study too describes varied cultural practices associated with birthing. One of the significant aspects of birthing in Indian context is the association of *dai*- lower caste woman for assisting deliveries. However, in *adivi* context, *dai’s* (*suvarin’s* as called in Dangi) work varies in the sense that whereas in non-*adivi* or caste set up, it is primarily women from lower caste are involved, in *adivi* society, they do not belong to any specific caste. So a principle of ascription does not apply. Additionally, men are also involved in birthing service. An elder man explained about how reproductive labour work differs from non-*adivi* Brahminical tradition to *adivi* tradition,

“In the *adivi* society men are also seen in doing delivery work; but women do these worksmore than men. For instance, Badgyabhai Kayachyabhai Bhoie at Malga, Ityabhai Maharubhai Gangada in Vahutiya and Mahdyubhai Sabdyabhai Pawar, Mahryabhai Bagul in Naktiyahanvat are all male suvarans. But, everybody is not interested in the same work. It works like this. We do not have any hierarchy of work or assign differnce; work is work. Each person is free to choose his work. I never took modern medicine in my life. I used only our local Vakhad-Vansi (Ayurvedic medicine). I have never fallen ill; I need to take local medicines. We get sick later each time we swallow medicine (implying modern); we need to take medicine only when we fear about death. Otherwise, we do not take medicine. I need to take the medicine man’s fear of death. Otherwise, no one will eat the medicine.’’

R, a man who also assists women in delivery discussed about why *suvarins* work is valued, “I am happy to work as a *Suvarin*, because I like doing it; my mom also did this work and I learnt it from her. My mother advised me, ‘*Tula pati ti kam kar*; *bayku ani goho Na kam alag nahi aha*. *Tula gam to kam karja*; *dusarana aayaksi nok*. *Khaskari tuna man bolil tikam kar*; *dusrana dabanma ini kam pasand noko karasi* (Do any kind of
work you want to do. Do not differentiate between men's and women's work. Do whatever you want to do; but do not waste time thinking about others or do not be influenced by others! If you are interested in any work you do freely, without listening to anyone).’ Most people themselves do not do work but give advice to others. And in this way I chose to do this work in my mind. And now I am still doing this work. I'm also a Bhagat. But I have no problem. Suvarin's work is very big. There can be no big job compare to suvarin job! Because, the suvarin brings new creatures in this world. There can be no big news other than this. I have never believed that this work is of a woman. And the same thing is that my mummy struck me with a spell before. Sometime we both have gone for attending delivery work. She was the main suvarin and I did assistant work with her.”

The above illustration indicated how birthing practices differ culturally. In Brahminical tradition which is based on hierarchy and purity and pollution, reproductive labour and women are placed at the bottom of hierarchy. Therefore, though giving birth is crucial for the maintenance of family, reproductive labour especially cleaning of the body is handed over to lower caste women as cutting umbilical cord and touching blood are considered as defiling as pointed by Pinto (2006) and Kumar (2002). However, among the Bhils of Dangs, women who are involved in these works are highly respected as well as there is no gender bias in carrying these activities as notion of purity and pollution does not exist here. These differences are attributed to the egalitarian nature of adivasi society.

A male assistant of a suvarin called H said, “I am not a suvarin. But I am working as assistant suvarin in our society. Ma suvarin pan banishakat pan ma to Gadha-Bhagat ahu. Ani ma mota-motadungaramaeyelgufamasirini puja karu. Bani ma suvarinnakam karat nahi (But I have become a suvarin too. As I am a Gadha-Bhagat. And I worship den in the mountains, so, I am not primarily working as a suvarin). Therefore, people called me always to attend delivery at the pregnant woman’s house. So, I always work as an assistant. It is not bad! If husband can wash clothes of women, then what is the problem if they do delivery work and clean? But Bhagat is like God for our society.
Because, sick people always visit Bhagat (male healer) for recovery. So, he should not do suvarin work.”

He also said, “Hospital delivery is always good. But why are woman’s Lajja (honour) not considered while conducting deliveries in the hospitals. They bare the woman for delivery in front of others. But, every pregnant woman should not be brought to hospital. If the case is complicated, then she should be provided hospital treatment. Why they (ASHA workers) bring everyone to hospital is to do with maintaining record of governmental work. However, adivasi society always cared for delivery woman and their honour (Lajja). They do not give respect to pregnant women in the hospital. I heard that, when pregnant women cry during delivery time, nurses get angry on her; that is not good. May be doctors and nurses think that since these adivasi woman come from mofussil, these women cry loudly due to labour pain. However, pain varies according to individual. Some feel more pain whereas, other feel little less. This should not be perceived as a problem. What I have seen in the hospital that doctors provide injection to women in order to reduce the labour pain when women cry loudly. This is not good for them. They (hospital staff) only think of doing their duty and do not take proper care of adivasi woman. There is no water in the hospital. So, why do they take delivery woman to hospital? Our home is good for the better delivery in the society. I think government inducted ASHA workers in order to discontinue the suvarin work! Now, suvarin’s earnings are taken over by ASHA workers as earlier people would give some token amount or grain or any other thing they have.

As the quote showed, the assistant suvarin does the delivery work which is basically related on cleaning, however, since he is attached to the traditional male health practitioners, -bhagat, his position is ambivalent. Second point to be noted down here is that though gender hierarchy is absent in terms of reproductive labour at the same time, a distinction is maintained between some male practitioners - Bhagat who provide all kinds of care and healing except delivery, and suvarin – a woman who is expert in delivery. Thirdly, the cultural differences observed between delivery at home and hospital. For instance, according to adivasis, conducting delivery in hospital is considered as a public
space. For *adivasis*, deliveries at the hospitals are conducted in general ward, which implies in the view of the public. It is considered as a public space by comparing their own cultural field. For instance, in *adivasi* set-up, during the time of deliveries, women gather in a group and form a circle and try to cover the actual delivery process from the view of the general public by putting clothes and sari and men are exempted from seeing it. So, women remain in *purdah* (veil) in traditional birthing and honour of the women is protected whereas from *adivasis’* point of view women’s honour is violated in public hospital as anyone can see these. Similarly, in hospital set-up, there is requirement of a certain bodily dispossession i.e. crying in the low voice. This aspect *adivasis* take it as offensive as they think that they are derided by hospital staff for not behaving like a “civilized/city type” individual. These two facets points to the notion of modern hospital care which is always thought as generic phenomena and therefore taken for granted, needs scrutiny as it actually upset the cultural processes of *adivasis*. So besides considering apathetic and insufficient care and poor facilities available at the public health care set-up, cultural issues too should be taken into account which actual pre-empt them to visit hospital. Fourthly, *suvarin* discredited hospital delivery on certain grounds i.e. use of injection and lack of water facility though he acknowledged that hospital care is needed during complication which the next respondent discusses.

In addition, respondents spoke about how *suvarin’s* work is valued and respected in *adivasi* society and how some of the rituals associated with birthing are affected as a result of hospitalisation of delivery.

S said, “A midwife gets respect in our society. It is very encouraging for midwives and therefore they enjoy doing their work. She is always ready for her work. Taking women for hospital delivery is very good but government does not take proper care. There is no water in the Hospital for bathing women and infants after delivery. There is no warm water too. Because I went to the hospital many times and brought many women for their delivery, that’s why I’m telling you! At primary level some health workers are good. They are providing good service. For instance, they are frequently caretaking women after some days; ask about their health conditions and carefully give treatment advice too. But
many health workers work for money. Nowadays, people are becoming very selfish and thus they do not work properly. But, some people are very good; they work properly. We are also doing midwifery properly; therefore we do not mishandle any pregnancy related work.”

As the quote captured, bathing the infant is a cultural tradition and unavailability of water facility in the public hospital also demotivates *adivasis*. Thus, this insight depicts the way hospital delivery affects some of the cultural practices related to birthing.

**Presence of Unlicensed Doctors:**

In a social climate, where there is income inequity and severe joblessness which belittle the chance of proper nutritious food, *adivasi* women’s health is equally endangered by the insufficient public health facilities. Simultaneously, their own specific cultural practices are disrupted while attending hospital delivery. It is again compounded by the proliferation of private health practitioners as discussed by missionary doctors.

Dr. J. who is a gynaecologist in a missionary hospital in Subir narrated, “*In the Dangs most deliveries are done in their own houses. These home deliveries are done by suvarins and these numbers are more than institution [hospital] deliveries. Our Davakhanu (clinic) is private (run by missionary which is primarily non-profit hospital, however, it charges from patients not exorbitantly but nominal amount), so few patients come here. Those people who are from well of families, come here for treatment. Recently, these women have started going to hospital (state) because government is giving money to delivery woman and those who bring them are also receiving money. The latter are ASHA or suvarin (Dais) both receive money. They (adivasi women) are going to the government hospital primarily for money but they do not receive any good health service. The government gives them attractive incentives therefore they go there. If government would stop providing financial incentive for delivery, people would just stop coming for hospital delivery. But if people need good delivery service they come here. Because private hospital take care of the patients properly. So, some people go to the private*
clinic for good health. Since two years I am seeing a rise in institutional delivery; because of government scheme for delivery and ASHA workers.”

She continued, “Our sister’s go village to village for the out reaches work. And found out the prevalence of different type of diseases in the village. For example, Leprosy, T.B., Typhoid, Malaria, Diabetes, Paralysis, Jaundice and Sickle shell etc. They explain to them (villagers) about the treatment and guide people about the availability of the treatment centre. We always give more attention to the health problems but people do not visit us. People are not serious about their health. Health is the sole reason for leading a happy life. So, everybody should be aware always in life. So, this message was spread among grassroots people. Yet in the village fake doctors (those who provide medical care without having proper license and degree) have strong hold on the people. They arrive in the villages during weekly market and provide medical services. So we are aware of them. But adivasis are not aware that these doctors are not safe for their health. They are doing business here rather than providing good health care to locals. Thus, we explain the villagers that, ‘They are not certified doctors; so always be aware of them. Please visit the large hospitals and doctors holding degree. Be aware of the false and bearing the false expenses from fake doctors.’ We detected four cancer patients through our camp. But our sisters observed that, local people in Dangs believed bhagat (local god man) more than the hospital doctor. They do not come quickly for treatment to the hospital. These area people when they go out (either for work or for health care) they feel they have come to a different world!”

As the excerpt goes, the missionary gynaecologist acknowledged the work of suvarins while simultaneously cautioning about hygiene and preparedness for emergency case, “It does not matter if the delivery is undertaken at home. Women also need to have more feminine care during delivery. But the woman will not face any difficulty, if the doctor does the check up three to six times when she becomes pregnant (prior to delivery). Midwife should know about hygiene. Already at the time of delivery at home, all the responsibility of preparation is done by midwife sister. Because I have seen blood during
labour pain, so she should be prepared for an emergency vehicle. And woman should be treated quickly."

This quote threw light on several issues involved in rational delivery in Dangs society. Missionary doctor cautioned the prevalence of unlicensed doctors which indicated the fault lines of state medical regulation. It also brought to the light of the vulnerability of adivasis in general in the hands of fake doctors. Equally, like suvarins, she also discredited the delivery at public hospital on certain grounds even if she endorsed hospital delivery by mobilizing adivasi women through financial incentives. Thirdly, even if she acknowledged the work of suvarins in difficult social conditions where the reach of rational care is a distant reality, like Indian state, she also doubted and indicted suvarins with regard to “cleanliness”. It is ironical that even if adivasis are known to be maintaining hygiene (as remaked by Bang and Bang), missionary doctor pinpointed suvarins from the ground of hygiene. So colonial moorings are also evident in missionary health workers. Fourthly, like traditional practitioners, missionary doctors too emphasised the aspect of healing. In this connection Hardiman (2008) too argued that alternative forms of healing in South Gujarat is competed between indigenous medical practitioners like dais and Bhagats on one end and Christian faith healing on the other where the latter too stress on spirituality.

Section-III

Contested Nature of Reproductive Labour:

The previous section dealt on the structural constrains faced by adivasis while receiving hospital care, the role of poverty, insufficient income and unemployment in exacerbating malnourishment as well as cultural practices of adivasis that are disrupted while going for hospital care. This section deals on the reproductive labour/work and explicate how dais legitimize their status when state continuously disdain dais’s service. Historically, Dai training has been controversial issues as sometimes dais was included in training and at other time, they were banned. Recently, as part of universalisition of health care through a flagship programme called NRHM (National Rural Health Mission) in 2005, dais were
replaced steadily by ASHAs (Accredited Social Helath Activists) whose main job is to register pregnant women and encourage them to seek institutionalised care at government facilities (Devraj 2017). Point to be noted here is that state not only indict suvarins but also monitor the reproduction and sexuality of adivasi women as it was discussed earlier. Furthermore, adivasi women are alienated from public health institutions as the observation note of PHCs and sub-centre revealed.

S discussed about the wrath and humiliation inflicted by state authorities against suvarins for continuing home deliveries, “Once an ASHA worker[S] told me that she needs to bring pregnant woman to the hospital. This message is sent by the doctor for me to convey everyone in the village. Because if we do deliveries at home, there would be the provision of injection and medicine. ASHA worker told me, ‘Home delivery is not safe. So sir (doctor) told me that every pregnant woman should be delivered at the hospital only. These things are good for pregnant woman.’ Then I told her, ‘You talk in government language, why, because you take money for every case; we understand that some people speak in the voice of government. However, some people are always fighting against government system because their scheme only lies in paper and not really translated into the reality. So, they do not provide good facility for poor people. If health facility is well then why poor people visit private hospital for health treatment?’”

R a male suvarin of Bardipada who did not receive any training in modern delivery service countered state’s account of suvarin for not maintaining hygiene, “Now Government is doing delivery work that is good; but government alleges that suvarins are not aware of hygiene. If they are aware then why they are not going to labour worker’s place to do delivery. We also anticipate that dangerous situation which can happen at any time and take the delivery woman to hospital during emergency. It is also our responsibility; because she is member of our society.”

As these two quotes showed, dais not only justified their service but also expanded the faultlines of government programmes. Dais too also speaks about how radical reforms are not brought in health services outlined by the state. Secondly, it also points out that
how *dais* too acknowledge their limitation and speak in the language of coordination and paternship, between modern health care and traditional practice instead of being completely hospital to it. However, it is ironical that *dais* are always registered in the health programmes as being “backward” and fixed to traditional practice. Marginalisation of *dais* are actually the antecedents of British colonial times and has continued to contemporary India through policies drawn up by colonial moorings, caste and class bias.

**Delegitimiziation of Dai Training and Competition Between Dais and ASHAs**

Alienation of *dais* not only entails replacement of them by ASHAs but also when they were included in primary health care in the past, trainings were provided in such a way that it could not enhance the stereotypical image of *dais*.

Recollecting the experience of *Dai* training in the past, a trained *suvarin* called “S” replied, “This training was scheduled for two days. But they did not teach much except cleanliness. Most of the time they were asking us to sing and dance. Our collectivisation was punctured when the training was stopped. Another thing that was discontinued was that government has stopped giving delivery kit to us also. The government had provided trained *suvarin* these kits for delivery earlier. Now, government wants us to bring delivery woman to the Hospital. And here, government in order to do this work appointed ASHA workers to do advertisement of their scheme. So, government has brought to our work a full stop. However, we were useful for our society prior to government (hospital care), but government has brought *suvarins* livelihood to the end. But, government people never work properly. Because we are not work only for money; but we work and help our society. We do not expect money from people. They want to give money when they happy. We never demanded money from our people for delivery work. It is our responsibility; because it was done customarily and we only carried over our ancestors’ work. So it is not our job. But now government gave people to different scheme in order to lure adivasi women; they are not giving full of attention for adivasi health in the Dangs. So why they did not do all the arrangements so far for health. Why do people have to go away for treatment, leaving our district? Truly outstanding if they would concentrate on how remove people out of poverty, we are also part of the tribal group.
But who is interested to hear adivasi woman’s voice? If we keep mum it is better. Government also wants it.”

While discussing about the dai training, the respondent too brought out how dais maintain certain ethicality such as pursuit of care and health is more important than the pursuit of profit or money. They view that in the hospital set-up, there is an inverse relationship in the sense that pursuit of profit is prioritized over pursuit of care despite it being free of cost. The above quote and the subsequent statements also reflected how competition between dais and ASHAs starts in the process of recruiting ASHAs for mobilising women for hospital delivery. It is interesting that suvarins too emphasise on tackling poverty than compensating for institutionalisation of delivery. The interesting aspect is to see how respondents have deconstructed the image of suvarin being irresponsible and materialistic as well as delegitimized the health care provided by the state.

I, a suvarin who has received training in modern delivery said, “Even if suvarins’ works is not on the paper (prohibited by the state and state does not recognise their reproductive labour), she provides full attention to the patients…. I never heard suvarin demanding money from the delivery women. I have never demanded money from any pregnant woman. If they have money, then they give it to suvarin for their satisfaction. But sometimes if they do not have, then they donot give. Suvarin never wanted to do this work by expecting money; because it is the society that gives her respect for doing delivery, she gets the motivation. It is not comparable to money. I think it is not important in my view. I am not continuing suvarin’s work. Because, here senior suvarin is present. People give her first priority. But in the emergency I am ready to offer my service for people; when they call I am ready for their work; at any time (day and night)”.

This quotes though not explicit but captured how dais while privileging their work tried to pinpoint their differences with ASHAs especially on the latter’s materialistic approach. In addition, many suvarins complained during the interview that even if they bring women to the hospital for delivery, they are not paid by hospital. Nevertheless, hospital
authorities have asked suvarins to keep a note on the number of deliveries done at home and no of deliveries they have brought to the hospitals. In this situation, suvarins approach ASHAs to record these on their (suvarins’) behalf since they are illiterate. According to suvarin, ASHAs do not include these cases by taking advantage of their educational limitations. Thus, these incentives are pocketed by ASHA workers.

J a suvarin said, “Really there should be research on the health conditions of adivasi women and accordingly social schemes (health) should be devised for adivasi women. It is the first work to be done by the government (state); but they are not doing that way. They think about us in the lines of city people (urban people) and bring the scheme and facilities for every people in their terms. This is not fair for every Gujarat’s people. Because every people’s needs and demand are different. In the Dangs the hospital has been established for many years old. But why still there is unavailability of basic facilities now. What is a problem in the Dangs? Why are not good facilities here? For example, lack of instruments, lack of good Doctors, good ANMs, good health staff, good work, and good facilities inside in the hospital. While basic facilities like caesarean facilities unavailable in tertiary level hospitals like District Hospital then think about how to provide good quality care in small health centre (meaning sub- centre) is big question mark for state?”

As the quote explains, the respondent highlighted notonly insufficnet facilities availbale at public hospitals but also how, hospitals function typically from the lens of city dwellers. I think this statement is linked to the previous argument of hospital delivey by adivasis leads to the disruption of their own cultural practices.Respondents also discussed about the unsafe delivery that are practiced in public health care set up:

G a suvarin said, “They cut the vagina of delivery woman. They want to do the delivery fast and do not have patience to wait for the labour pain, it’s not fair. My patient told it to me. Once I brought the delivery woman to hospital in the ambulance. We travelled around 10 k.m. and she was ready for delivery. Then I told malaria health worker and ambulance to keep it aside. I suggested him that I can do a good delivery. Then I told
malaria health work to return home. But he never believed me and took the pregnant woman to Ahwa hospital for delivery. I went to my house and the pregnant woman’s mother accompanied her to the hospital. She informed me that her vagina was cut in the hospital. When she returned home, I visited her house and she told me. I think this is very dangerous, because I have already carried out delivery of woman. How can they cut her vagina? It is unbecoming of good treatment in the hospital! So, how can pregnant woman go there for good delivery?”

Similarly, another suvarin S who is not trained in modern delivery too discussed about the incident with the malaria worker 17, “A government health worker was called upon to for delivery. His name was Somnathbhai (malaria health worker). He was from our village, but he was still learning to become a health worker later. But what happened was that the infant came out but the Var (placenta) was still inside and people became nervous about this. So, local people called me during the panic situation. He saw the case and got frightened. A government health worker was also present. I rushed to that place and looked into the matter. Everyone said, “You please save the woman.” Health worker also said me; “Oh! Auntie we were depending on you only. Then I gathered courage and inserted my hand into the vagina and took placenta out slowly. Then the health worker praised me a lot!”

These lackadaisical attitude and unethical practices which are common sight at public hospitals notonly demotivate poor adivasis butalso validates the position of dais. Kutty (2010) writes regarding the curative services offered in public health centres, “While it is true that health planning does involve offering curative services to the people, these services are badly administered through a weak infrastructure (ibid: 236).”

Even though economic incentives are provided for medicalization of delivery, still demand of dais are intact and district hospital report (showed in the second chapter) too supports the fact.

17 This is to be noted that prior to the induction of ASHAs in delivery work, malaria workers in Malaria control programmes were entrusted the responsibility in the villages as part of community care.
Section-IV

After looking at the conflict between ASHAs and dais which is created by the state as well as structural inequality that creates the situation of malnutrition and cultural differences related to birthing practices, it is worthwhile to examine the role of the state and the relationship between adivasi women and state. Additionally, a description of health workers’ movement in Dangs is provided to unravel its divisive agenda and so too the subversion of adivasis women.

Women Health Workers’ Movement:

On one hand, a huge responsibility and work load is entrusted on the frontline workers or lower rung workers while Indian State gears up for universalisation of health care and especially safe delivery. On the other hand, the footloose workers who deliver these programmes face lot of difficulty and get demotivated by insufficient salary. In addition, suvarins or traditional birth attendants who received training in modern delivery till recently were angst about discontinuation of their training and de-recognition and repudiation of their work by the state government. Thus, both these facets create outrage against the Indian state. On the other hand, the inadequacies or failure of public health service brings discontent among the adivasis which help the traditional health practitioners to legitimise their status. An interlinking point made by Anagnost (1995) in the case of reproductive care economy that “birth-control work lends itself to this theme of consuming labour. It is acknowledged as the most difficult task of local government and is referred to as “the number one difficulty” it is a therefore a perfect medium through which the party can represent to the masses its spirit of self-sacrifice and commitment to the national good. But this theme of consuming labour takes on specific images in the case of birth-policy workers, who are usually women. Not only do they give up their health, youth, and even their personal safety to the demands of this labour, the economic welfare of their households (ibid: 33).”
So here women health workers’ protest has been described in detail. By discussing about the protest organised by suvarins in the midst of dai training programme, the whole attempt is to depict how state de-recognises dai’s work as work in the lieu of voluntarism and how dais press for recognition of their work and entitlement for salary.

S, a suvarin said, “We (many suvarins) have gone many times for training (on deliveries) to Dang Swarajya Ashram Shala (DSAS)\textsuperscript{18} in Ahwa,Dangs. Once, we were all (Dangisuvarins) together for midwife training at Dangs Swarajya Ashram Shala, Ahwa. This happened seven to eight years back. The training was the full day affair from 11 a.m. to 4 p.m. Since all suvarins from the Dangs called for training, we could know each other and came up with a plan to meet the District Collector to report about our common problem. All of us decided to meet Collector Ben (she is a woman collector). So we had gone to discuss about the meagre salary of midwives with collector on the same day of the programme. Our organiser ‘Deepshila Trust’ stopped us from going and meeting the Collector. But, all suvarins decided to meet her and convey her about our issues. We thought we should see how she responding and wanted to listen to her once is. So, we went to collector office’s court in order to meet the collector ben. We spoke to the police and took permission to meet her. He (Police) did not give permission to meet Collector. So we decided that all of us would just do a sitting (protest) in front of Collector’s court and would not budge. Meanwhile, the Collector went there for some work and saw us from far. When collector saw us she asked the police man who was standing beside her, ‘Why are these women gathered here?’ Then police replied, ‘Madam, they wanted to meet you!’ She replied, ‘Oh! …Okay, I can meet them after sometime!’ Later she found out about our organisers and our organisers called us to return to the training place. And informed us that the Collector would come to meet us in DSAS hall. Then she met us in the afternoon at DSAS hall. She asked us, ‘Tell me, what you want from me?’ We told her, ‘we are all suvarins in the Dangs and we want a fixed salary for our work; because, we also work for 24 hours in a day which is more than that of a government doctor.’ Later she answered, ‘This decision is in the hand of government. It is not in my hand. So, I

\textsuperscript{18}It is a Gandhian Organisation works on tribal welfare and mainly the developmental programmes are supported by the state government. This Organisation is about 70 years old.
would send your message to the higher authorities in, Gandhinagar. The Government would take decision, okay?”

This particular suvarin’s statement revealed their outrage against the state especially dai offering training in a very peripheral and cosmetic manner while simultaneously blaming them for not maintaining cleanliness and hygene. As discussed already by Hodges (2006) that Dai training schemes for midwives brought stigma and the latter are lamented and indicted during colonial era. It also depicted their collectivisation spirit to interrogate the state and demand for the provision of salary through showcasing workload as well as payment differences that are observed between doctors and mid-wives. Pinto (2006) too makes a similar observation that portrayal of dais as dirty, ignorant and superstitious enabled one of the functions of the colonial institutionalization of women’s medical care: blaming dais and ‘traditional’ practices for a range of social and physical ills. As 19th century colonial writing shifted from representing the dai as ‘the appropriate person to assist in childbirth’ to ‘the symbol of superstition and dogged resistance to change,’ abolition of dais became a goal of women’s organizations and elite society. Low-caste women became the anti-thesis of modernity. During this period the first dai-trainings were held, beginning a long history in which one of the primary ways Dalit women were linked to the state was through dai-training (ibid:5-6/10). Additionally, she also discussed how during training dai even if the dias raised critical questions these questions were overlooked, “In the course of one of my early meetings with Rakesh’s mother (a dai), she became engaged in a heated argument with the supervisor for a large-scale state family planning scheme. She asked forcefully if there would be a tankhah for her services in her community, and listed expenses that went into her training. The supervisor said with some disdain, ‘Those days are over. You can’t always demand money from the government.’ It was her duty, he said, to get a ‘fixed rate’ from clients. (As I later learned, many clients pay trained post-partum workers less than previous jajmani payments, either assuming they are receiving government wages, or saving remuneration for those who deliver babies and are more highly regarded by institutional programmes.) The supervisor turned to me. ‘These women can’t go on expecting the government to do everything for them. They must learn to collect money for them, to not
be dependent. There are some people who just repeat the same thing over and over again, Sitaram, Sitaram, demanding something from the government; these women are like that they are just parrots (ibid: 6/10, 7/10).” She continues to argue that, even trainings advancing respect for ‘traditional knowledge’ focus overwhelmingly on cleanliness, reiterating the matter at the core of concepts of ‘untouchability’. While hygiene is a crucial issue for reproductive health and matters such as tetanus no small concern, it is worth noting that the bulk of efforts promoting cleanliness are aimed at Dalit and lower caste and class women. In everyday interactions in villages, such frameworks underscore many caste Hindu women’s stereotypes of Dalits as unclean, providing politically legitimate language for divisive sentiments (ibid: 6/10).

Discontent with the Indian state does not only come from the suvarins, ASHA workers and AWW too had their own difficulties to share. Let’s see how ASHAs describe their work and their relationship with the state

N an ASHA worker of Garkhadi said, “ASHA worker’s work is very challenging and dangerous. Any time they can call me for delivery of the woman (i.e. to accompany the delivery woman to PHC or Hospital). We have to be always ready and prepared in our own mind for going anywhere (PHC or CHC or Sub-centre) pregnant woman’s family wants us to take. It is also a service for people of our society. But our salary is very less and they give us case based salary (she meant incentives). The amount is not enough for me, because I have four children; and the expenses for studies are increasing day by day. So, how can we manage? We also doother work to meet the additional expenditure of our family. Our village houses a PHC. So, the doctors always call me to work in the PHC. There is no salary but they assign lots of work. Like, village survey, government suddenly announced that we have to attend so and so programme like Mamata day and Polio day etc., attention of pregnant woman and sterilization,. It is different from the government assigning work to different and primary health centres. I’m very tired. And let’s leave the idea of doing this work. We must have a salary according to our work. But who can explain to the government! Our ASHA worker women are also tired now.”
Another ASHA worker called S of Naktiyahanvat said, “In our work, only a successful delivery is at the hospital is not the only task. In addition, we have to submit the identity cards like Voter ID card or AADHAR or ration card as the proof that the pregnant woman is the eligible person to avail these facilities as well as payment of Rs 2,000 for the first delivery. However, most of the adivasis women do not have these documents except some Christian women. I try to explain them about the requirement of these documents at their house but they do not listen. So on their behalf; I put my own money to issue identity cards. However, they do not pay me back after they receive the cards. So, later on I changed my strategy and when they payment is done to the woman for delivery I first pocket the amount that is spent for issuance of ID cards and rest of the amount I return. However, during that time, delivery women complain and think that I have siphoned off their money. I have always fulfilled my duty. Even though I have a very happy family, I am always tensed because of the nature of the work and accusations. I do my work with all my heart. Whether people will give respect or not is their own problem, and not mine. I am not satisfied with my salary; because the salary is very less. We all [ASHA Workers] hope that since our Union (ASHA workers of Gujarat) demanded the government for the provision of fixed salary, in course of time Government would listen to us. Therefore I am not leaving this job. But, my husband is pressurising me to leave the job as our salary is based on the number of pregnant women we bring to for hospital delivery. Since I am doing this work which consumes much time, he on the other hand expects me to help him in agricultural work (agricultural field is in Maharashtra). So I have to traverse between these two worlds. Somedays when my spouse asks me to do agricultural work, I get panic and visit field in the wee hours. By 10 a.m. I get tensed about the possibility of complain or inspection. So, my husband drops me at the village. But I will not resign from this job, because I hope that it will get permanent.”

The above narration highlighted the complex life world of ASHA worker and the difficulties of implementing institutional deliveries with lots of documentation that she is expected to do. Compared to suvarins, ASHAs have to do additional works like monitoring and registering the details of the case as well as help women in issuing valid ID cards as failing these involves loss of payments. On the other hand, when ASHAs put
their own money and reduce the compensation amount to delivery women, their relationship with pregnant woman becomes strained. Similarly, as the respondent said she has triple burden, her own family burden, her husband expects her to join him in agricultural work and then working as ASHA worker and dealing with pregnerat women on one side and hospital staff and authorities on the other. In simple terms, it can be said that this is how state creates conflict between different kinds of adivasi women depending on the situation.

Additionally, poor functioning of ICDs were also reported in the news paper by revealing the findings of the CAGs. Desai, (2014) writes,

“The organisations, which conducted the malnutrition surveys, point that “There is a strong link between the state of the anganwadis and the extent of malnutrition in the state. At least three different surveys have debunked the Gujarat Government's claim of having effectively combated malnutrition and revealed that as many as 94 per cent children in the tribal regions of the state stretching right from Ambaji in the north to the Dangs in the south are stunted or undernourished.

CAG said that 1.87 crore people had been deprived of the benefits of the ICDS scheme to promote holistic development of children, expectant and lactating mothers and adolescent girls. The state needs 75,000 Anganwadi centres but only 67 per cent are running. The organisations, which conducted the malnutrition surveys, point that there is a strong link between the state of the Anganwadis and the extent of malnutrition in the state. The first survey by the Surat based Centre for Social Studies (CSS) found malnutrition levels in 849 children to be as high as 94 per cent. The children were in the age group of five years to 15 years and live in 20 villages of tribal-dominated Dediapada taluka (tehsil) of Narmada district in South Gujarat. A cursory look shows that the public health machinery has not reached many parts of this region. The reasons for malnutrition are that most children cannot access the mid-day meal scheme and the Anganwadis are in a pathetic state. Another study carried out by Child Rights and You (CRY) among 249 Anganwadis in 17districts across the tribal belt, a whopping 65 per cent have no or very
poor toilet facilities, 34 per cent lack working weighing scales to gauge a child's nutrition levels, 28 per cent are bereft of a regular health checkup and 30 per cent do not have utensils to prepare and serve food to children.”

Combing with the failure of state in combating malnutrition through ICDS is difficulties faced by AWWs in running the existing number of ICDS. So, AWWs are also involved in uprising. Even Anganwadi workers are unhappy with their salary. K, an Anganwadi worker at Badinagavntha criticised, “Even if our job is not permanent but, government entrusts us many works. Because we are working in grassroots level. The government made better schemes - have given the books to us outlining how to take care of babies, nutrition, charts depicting the kinds of foods to be provided, there are videos, etc but did not do right implementation in the area such as in order to provide nutritious food to babies, we have to spend from our salary. There is a separate budget for these things. But first we have to spend and later on it is reimbursed to us. How improvements can come in the area? We are doing good work but are not given good payment by the government. We are on contractual job but are expected to do a lot. While people who are on permanent position are not doing good work, they expect this from us. They work less and draw more payment. While grassroots workers are over-burdened with work they are given a paltry amount as salary. Is that women empowerment? If we will get good job then we will leave this job. Why to hold on to that job? I think government is playing politics by not improving the poor woman’s situation. Our case is the point of illustration. Government does not want poor people to live a good life. Because our union [Anganwadi woman’s union group] have been fighting for many years for the hike in salary. Therefore government does not agree or do not hear any good news for us. We are doing without any passion in this work. If I find any other job later I will leave this job soon.”

Even if this respondent dicussed about the struggles of AWWs and raising specific issues to be addressed by state through forming union, she too discussed about the challenges AWW movement faces, “Every AWC worker wants her salary to be increased, and however, they are too scared to join Anganwadi worker movement. They provide excuse
about the family problem and skip the meeting organised by AWC Union. But I attend. Our demand besides making our job regular and hike in payment is that they should fix the salary of AWC to Rs 5,000 and should not pay it according to the qualification of the AWC. I am paid Rs 4,500 and recently it got increased to Rs 5,000 since I have done my M.A. and B.A. in Education. However, others who have been working for 15-20 years and experienced but have less education compared to me, they are paid less compared to me.”

Regarding the Anganwadi’s movement against the Guajrat state, she said, “There was a meeting organised by the Anganwadi workers in Navsari district two years back. I was supposed to attend but could not attend it. My own child was ill and therefore I could not go. But I came to know that four five leaders of Anganwadi were arrested in order to suppress our movement. Government is not interested in making us permanent employee. If we demand about regular appointment or pay hike, then Anganwadi women are arrested and imprisoned. Is this the step of women empowerment of the Government of Gujarat? Another else, what to us do?”

These instances also threw some light on the ASHA worker’s and AWW movement in the state. Point to be noted here is that though state had tried creating division/hierarchy among the suvarins and ASHA workers and AWWs, by repudiating suvarins and including the latter groups, these women irrespective of the recognition of the state, do not have major conflict. The appreciation of suvarins about ASHA and AWWs’ work while at the same time pinpointing the higher officials shows the deeper awareness of the social situation by the suvarins. So their insight is not an isolated story. It is to be noted that on March 07 and 08, more than a thousand social activists including Anganwadi and ASHA workers were detained across Gujarat in an all women’s rally to mark International Women’s Day was cancelled and several workers were detained or put under house arrest (Dhar 2017). This indicates not just suppression of women from marginalized backgrounds by state but equally the subversion tactics deployed by these women. These are manifested through questioning and highlighting the facultlines of public health programmes. Interestingly, these experiences of ASHAs, AWWs and
Suvarins brings a point that state entrusts subaltern women these vital talks by labelling these as “service” “voluntary” instead of “work” especially in the era of neo-liberalisation where state is in retreat. Additionally, it gears up for democratisation of health care in a cosmetic manner that it creates a whole lot of chaos and confusion. At the same time these marginalised sections of women too do not become docile actors but fight back. Importantly, in challenging the state, their articulation is not merely modern vs. recalcitrant actors. Rather, they express their willingness to be included in modern health care services. At another level, what it all boils down to is that reconciliation does not take place between public health care and cultural practices. Also, Suvarins’ arguments are not just their but also somewhere expresses the sentiments of adivasi community at large.

**Summary:**

This chapter described the specific social location of adivasi women of Dangs and delineated their health care needs and specific reproductive issues as well as involvement of adivasi women in health practice. Concurrently, the stress is on highlighting these health needs in relation to the broader socio-economic structure and maps the role of the state and discuss what does citizenship mean in the case of adivasi women? Related to this, reproductive labour work or traditional medical practice is also looked at. Furthermore, it tried to discuss in which way Suvarins in adivasi set up are different from dais from non-adivasi context and explained the contested work of Suvarin in the Dangs in south Gujarat in terms of how state derecognises them at one level and at another level, how Suvarins challenge state’s narrative/account. So, here I interrogated seemingly local medicine systems and Suvarins work in the Dangs.

In this direction, the first section provided the socio-spatial configuration of adivasi villages in Dangs. It described how villages lacks basic facilities for the locals such as good roads, good houses, dismal functioning of AWCs, Mid-Day Meals, MGNREGA, Indira Awaas Yojana, etc, hierarchy and differential social status as well as economic standing among adivasis between Bhils and Gamit in one end and Kunkanas in another, slow penetration of Hindu radicals in terms of organizing Kumbh melas in Shabridham,
Subir which was unknown to the *adivasis* and disturbed the peaceful coexistence of plural religious communities like Christians, Muslims and Hindus. Furthermore, it highlighted that even if the sex composition is impressive, economic burden is shouldered on women. However, their actual participation in work is not in sync with their wages and their categorisation as “worker”. In addition, it argues that while women actually work more hours than men, their works is subsumed under household income or are given wages not individually but through family income especially under *Koyta* system. Work burden among *adivasis* women is compounded with poor functioning of public health care creates risk conditions for their maternal health. The striking fact is that in the whole district, there is one district Hospital which does not have even caesarean facility for pregnant women.

The second section discussed the specific health care needs of *adivasi* women and it’s interlinkages with their socio-political situations and cultural context i.e. varied birth practices. It highlighted that most of the *adivasi* women are malnourished and it is problematic as they do heavy work without sufficient food and rest. So their public health requirement is nutritious food and self sufficiency in food. However, *adivasi* women neglect these due to thosocial-circumstance underwhich they work. It also discussed about varied cultural practices related to birthing and how some of the practices related to hospital delivery as well as state’s involvement with population control programme demotivated many to avoid medicalization of birthing. It showed through field insights that delivery at hospitals disrupts the cultural practices of the *adivasis*.

The third section dealt on the reproductive labour/work and explicated how *dais* legitimized their status when state repudiates their work. It is done primarily by highlighting the negligence of the health workers appointed by the state. While going deeper into the difficult questions raised by *suvarin*, the idea was to encapsulate how traditional health practitioners claim their legitimacy by pinpointing the state’s failure to provide public health services. Fourth section, diagnosed the role of the state and the relationship between *adivasi* women and state. It is followed by the description of women health workers’ movement in Dangs that binds different categories of women as well as tries to capture how different women who were involved in health care, questioned state’s
initiatives and its divisive agenda. The experiences of ASHAs, AWWs and *suvarins* brings a point that state entrusted subaltern women these vital talks by labelling these as “service” “voluntary” instead of “work” especially in the era of neo-liberalisation where state is in retreat. This also helped the state to make their work as contractual and incentive based, so that they cannot demand for regular position. At the same time these marginalised sections of women too did not become docile actors but fought back. Therefore, they started claiming their entitlements that is to consider it as “work” and thus, “permanent position”.