Health Inequities in a Conflict Area – An In-Depth Qualitative Study in Assam

Report of a study by the action northeast trust (the ant)
Closing the Gap: Health Equity Research Initiative in India
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Abstract of the Study

Violent conflict is already a major driver of health inequity for many and in the years to come, it is expected to affect most of the poorest and most vulnerable communities in the world, causing much suffering and ill-health.

This study is part of a larger multi-centric study initiated to look at health inequities among tribal populations in India. In Assam, using an in-depth qualitative methodology with ethnographic elements, we focussed on studying the health of tribal communities affected by violent conflicts. We used methods of observation, in-depth interviews, group interviews, key informant interviews, small talks etc.

Six forest villages on the border between India and Bhutan in Chirang District of Assam were selected for the study. Chirang is one of the four districts in BTAD (Bodoland Territorial Areas District) which has experienced 25 years of militant violence and many waves of ethnic conflicts. We studied Bodo and Adivasi populations forcibly displaced by the ethnic conflicts of 1996, 1998 and 2014 but also interviewed non-displaced populations of Nepalis living in the area. To understand the effect of conflict on the health system and health response, we also interviewed multiple health personnel who served in the government health system across the conflict timeline.

Specific questions of research were framed at the beginning of the study which guided our explorations and kept us focussed on the intent of the study through the different stages. The first question examined socio-political changes through the conflict history and how it shaped health and the public health system in a conflict area? And conversely, how does lack of health contribute to conflict? Secondly, we looked at how conflict affects the health of different ethnic groups differentially? If so, how did critical social determinants such as loss of livelihoods, land, housing, culture, safety & security, community mediate to create ill health?
The third question focused on studying the health response of people in conflict and how – individuals and groups intersect with gender, class, ethnicity or religion in a conflict area. We also tried to understand the kind of health seeking pathways adopted by conflict affected communities in the study area and what influences health seeking decisions. Finally, we looked at the role played by government health services and health promoting institutions such as Public Distribution System, Anganwadi Centers, Water, Sanitation and Mid-Day Meal etc. on the health of people in a conflict situation.

Field work was carried out for eight months from June 2016-February 2017 by a team of field researchers, with public health / social work background and with training in qualitative methods of enquiry. A research office with stay facilities was set up for a year in the field area and the field researchers largely camped there through the field work period.

In this study, we find ample evidence of how a functioning public health system was brought down by years of fragility and conflict.Collapsed so badly, even now it lags far behind other districts, struggling to recover in the face of negative perceptions created by the socio-political situation of conflict. An unresponsive public health system is a catastrophe for families completely impoverished by conflict. Irrespective of the ethnic community they belong to, the poor and the marginalised who lead fragile and vulnerable lives in a conflict area are further pushed to the edge after an episode of conflict. For such households, their health, well-being and development gets highly compromised as life after a conflict becomes an intense struggle to merely survive. Without adequate external support, affected families with highly reduced resources find it difficult to cope with this new ecology of ill-health and ill-being.

Disabling poverty which follows close on the heels of a conflict increases risk factors to ill-health significantly while reducing protective factors. This makes vulnerable groups and those with special within the household, like women in general and pregnant women, young girls and young children in particular extremely vulnerable to ill-health and ill-being. Conflict affects the health and well-being of not just the displaced but also non-displaced host communities and the entire area in general. The total collapse of already weak public facilities affects not just the families displaced by conflict but the general populations living
in the conflict affected zones. Apart from the economic balance being affected by the influx of large numbers of displaced families with no livelihood options, another long-term prominent negative fall-out is the ecological effects of conflict. In this study, we see a close relationship between deforestation, falling water table, soil erosion, and human-elephant conflicts and poor well-being and increased vulnerability of the people.

In the absence of an effective and quality public health system, conflict affected populations depend on informal health practitioners like faith healers, herbal medicines and untrained medicine vendors known as ‘pharmacists’. Money, or the lack of it, dictates the health seeking decisions of people. With poor governance becoming the norm in a conflict area, the State seems incapable of managing core social programmes and providing essential services that they are supposed to provide to its citizens. People who have suffered immense loss and are struggling with survival issues find it extremely difficult to fight and demand accountability of the State.

This study calls for going beyond knee-jerk responses and short-term humanitarian relief following a conflict. It recommends the need to develop deep, long term, multi-level and multiagency interventions by government and non-government actors to help reduce vulnerabilities and help affected populations recover their physical, mental and social well-being following conflicts.
Chapter 1

INTRODUCTION TO THE CONTEXT AND BACKGROUND

1.1 Historical Context & Background of Study Area

Since independence in 1947, many of India’s 8 north-eastern states made up of Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura have seen armed conflict and generalised violence. Assam is the most populous of the 8 states and Bodoland in Western Assam is an autonomous region created within Assam for granting some degree of autonomy and self-determination to the largely tribal population of Bodos living in the area. The ‘Bodoland Territorial Areas Districts’ (BTAD) (known as Bodoland) is literally the gateway to the North Eastern Region of India as it borders West Bengal and is the entry to Assam.

With 30-35% population in the area, the Bodos (a recognized scheduled tribe) form a majority of the population and they are known as ‘tribals’ in the area. The rest of the population comprises non ST populations of Adivasis (who are migrants largely from the Chota Nagpur belt, also known as tea-tribes of Assam but not having Scheduled Tribe status in Assam and hence not called ‘tribals’). Bengali Muslims, Koch-Rajbongshis and a few other smaller communities of Nepalis, Garos form the rest of the population. It took a long and violent struggle of over 20 years for the Indian Parliament to create this administrative unit called the BTAD in 2003 under the Special Sixth Schedule of the Constitution of India.

Fig 1.1 Map of BTAD Districts in Assam

![Map of BTAD Districts in Assam](image-url)
Currently, Bodoland comprises of four districts named Baksa, Chirang, Kokrajhar and Udalguri with a total population of around 3.2 million or 31.5 lakhs. With an autonomously elected government called the Bodoland Territorial Council, this administrative unit was created to speed up the economic and social development of the populations living in the area, and especially to protect and promote the rights of the indigenous Bodo people living in the area. Except for Law and Order and Relief and Rehabilitation, 40 departments have been entrusted to the BTC authority to administer which includes health, education, land, agriculture etc.

**Politics of Demography & a Struggle for Self-determination**

The struggle for a Bodo homeland, or ‘Bodoland’ started in the late 1980s, and continued well into the 1990s until 2003, with the signing of the Bodo Accord and the creation of the Bodoland Territorial Council. The agitation emerged largely to resist the cultural hegemony of the ethnic Assamese during the years of the Assam movement. The Bodos demanded separate recognition of their cultural and linguistic heritage, as well as greater opportunities for economic development, which they felt they had been denied to tribals in Assam. Although during the movement this oppression was expressed as one imposed by the Assamese, the Bodos have been disadvantaged from the colonial period, being classified as ‘plains tribes’, which earned them scant protection in comparison to ‘hill tribes’ like the Nagas and Mizos. As a result, the colonial administration did not protect their lands or prevent those of other regions or communities from settling on them.¹

Assam’s history has been particularly important to the discussion of citizenship in India. The Illegal Migrants (Determinations by Tribunals) (IMDT) law passed in 1985, known as the ‘Assam exception’ to India’s citizenship laws was formulated in response to growing unrest, particularly during the Assam movement, against the presence of Bangladeshi immigrants in

Assam. This Act, meant to facilitate deportation of illegal immigrants by setting cut-off dates, was struck down by the Supreme Court in 2005, for being ‘unconstitutional’, and providing a means to Indian citizenship to a particular class of people in Assam, but not in the rest of the country. It was alleged that it encouraged, not discouraged migration, and placed the burden of proof of citizenship on everyone other than the migrant.

These discourses of migration have also seeped into the discourse around citizenship in Bodoland, in particular with regard to the legitimacy of Bengali Muslim inhabitants. In addition, the politics of ethnic homelands effectively creates two categories of citizenship — what Baruah has termed ‘citizens and denizens’. Non-tribal populations in ethnic homelands like the BTAD are denied formal access to land ownership, as well as political representation, leading groups like the Adivasis and Rajbongshis to demand Scheduled Tribe status to avail protective benefits similar to the Bodos. These non-tribal groups are, nonetheless, part of the economy and networks of land ownership, but forced to do so informally.

The Assam Movement, which began after Indian independence and intensified in 1979, was primarily in opposition to the hegemony of Bengali Hindu dominance in educational institutions and jobs, and the relative neglect of Assamese language and culture. While the movement initially targeted the Indian state, it evolved over time to become an ‘anti-foreigner’ agitation, with one of its primary demands being the removal of ‘illegal immigrants’, particularly those having arrived after the creation of Bangladesh in 1971, which, the movement’s leaders pointed out, represented a burden borne disproportionately by Assam in contrast to the rest of India. While the Assam movement emphasized a distinct Assamese identity, it perhaps failed to consider the diverse ethnic groups that comprised this composite identity. It was this perceived dominance of ethnic Assamese Hindu identity that gave rise to the Bodoland movement of the late 1980s, an agitation that mirrored many

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3Ibid., p. 603
of the tactics and symbolic gestures of the Assam movement, but sought to assert a distinct Bodo identity.\textsuperscript{6} However, the presence of other ethnic groups, such as Bengali and Assamese Muslims, Adivasis or tea tribes, Koch Rajbongshis, Nepalis and Bengali Hindus complicates the notion of Bodo identity being defined territorially, through Bodoland. Bodos themselves are not a homogenous group, with many having converted to Christianity during the colonial period, others joining the ‘Brahma’ Hindu sect from the early twentieth century, and yet others practicing the traditional ‘Bathou’ faith, often alongside Hinduism. Despite the potential for cleavages however, politically the group has aligned around a ‘Bodo’ identity, which is not itself without factions that compete to represent the group.

**Tribal Identity & Conflicts**

In some ways, the roots of current conflicts can be traced back to the demand for a separate state of *Udayachal*, by the Plains Tribal Council of Assam in 1967. The movement arose seeking autonomy from an Assamese Hindu identity which, it was alleged, subsumed tribal identity. Two decades later, a new generation of Bodo student leaders emerged with the *All Bodo Students Union (ABSU)*, and the demand for *Udayachal* morphed into one for a separate state called Bodoland.\textsuperscript{7} It has been argued that this itself represented the thwarting of potential plural political identities in the region, as a pan-tribal formation was replaced with the demand for an ethnic homeland for the Bodos,\textsuperscript{8} although others have pointed out that the movement for *Udayachal*, while occasionally incorporating other tribal groups, still did so largely under a Bodo middle-class leadership.\textsuperscript{9} The Bodos demanded separate recognition of their cultural and linguistic identity, as well as greater opportunities for economic development, which they felt they had been denied.

\textsuperscript{6}Baruah, S., 1999. (Baruah, 1999), Philadelphia: University of Pennsylvania Press
In 1993, the Central Government of India struck an interim agreement with the All Bodo Students Union, and the Bodoland Autonomous Council (BAC) was created. The agreement fell through, however, when the central government and Bodo leaders were unable to agree on which villages had more than 50% Bodo population, and thus would be covered by the Council. This gave rise, in the 1990s, to insurgent groups like the Bodoland Liberation Tiger Force (BLTF), the Bodoland Army, and later the National Democratic Front of Bodoland (NDFB), all of which violently campaigned for a separate state, Bodoland. This led to violence and chaos in the form of blasts, general strikes, extortion, but also civil disobedience from by then more moderate groups like the All Bodo Students Union. Insurgent outfits also targeted ethnic groups like the Adivasis in 1996, and the Bengali Muslims in 1993, 1994 and 1998, all of which are remembered by these groups as significant markers in their history in the BTAD.¹⁰

Waves of Ethnic Violence

In May 1996, Bodo militants attacked Adivasi villages in various parts of Western Assam, particularly affecting the districts of Kokrajhar (parts of which are now in present day Chirang district). The riots claimed the lives of about 200 people and forced more than 250,000 to seek shelter in relief camps.¹¹


forest villagers began to return home, they were targeted once again. The aftermath of this violent upheaval also saw the emergence of militant groups among the Adivasi community, the Adivasi Cobra Militants of Assam, the Adivasi National Liberation Army, and the Birsa Commando Force.

In August 2006 more than 54,700 people, mostly Santals and Oraon, were still living in these IDP (internally displaced persons) camps\textsuperscript{12}. These inhabitants are unable to secure much assistance from the state, whether at the central, state or council level. In many instances, their rehabilitation is deemed impossible as it would imply a legitimisation of encroachment of forest lands, as their settlements are not officially classified either as official forest or as revenue villages.\textsuperscript{13}

Less than two years later, May 2014 brought another violent massacre of Bengali Muslims in Baksa district. Incendiary comments made by a BPF MLA and the impending defeat looming before the BPF were widely cited as the causes for the killing of 32 Bengali Muslims in May, allegedly by forest guards in the area.\textsuperscript{14} Most of these were women and children.

In December 2014, 62 Adivasis were massacred by Bodo militants of the National Democratic Front of Bodoland (Songbijit)—the NDFB (S). The attack was supposedly carried out to avenge security operations against the group. By 24 December, following retaliatory attacks against Bodos by Adivasi mobs and police fire to control them, the death toll had risen to 81.\textsuperscript{15} According to official estimates, almost 200,000 people, both from the Bodo and Adivasi communities, were displaced.\textsuperscript{16} People affected were spread across Chirang, Kokrajhar and Sonitpur districts of Assam.

**Politics and Governance**

Despite the signing of the Accord, the transition has been anything but smooth. The first elections for the Bodoland Territorial Council, held in 2005, were marked by violent clashes,

\begin{itemize}
\item \textsuperscript{13}Delhi Solidarity Group (2015), ‘Recent Militant Violence Against Adivasis in Assam: A Fact Finding Report’
\item \textsuperscript{14}‘Camp inmates offer proof’, *The Telegraph*, 8 May 2014.
\item \textsuperscript{15}http://timesofindia.indiatimes.com/india/Assam-violence-Army-chief-vows-to-intensify-operations-against-militants/articleshow/45651729.cms
\item \textsuperscript{16}Delhi Solidarity Group (2015), ‘Recent Militant Violence Against Adivasis in Assam: A Fact Finding Report’
\end{itemize}
as Bodo political leadership was split between the Bodoland Political Front (BPF, led by ex-
militants from the BLT), and the Bodoland Progressive Political Front (BPPF) led by a former
student leader. So far, each subsequent Council election has returned the BPF to power,
though in 2015 this was with an extremely narrow majority. Elections, whether at the
Council, state or national level, have also proved a source of tension and conflict, as well as
represented an arena where inter- and intra-ethnic cleavages were played out. While the
national election in 2014, for instance, represented the rise of the right-wing BJP for most of
India, in the BTAD’s Kokrajhar constituency it remained about intensely local issues. For the
first time in the region’s history, a non-Bodo candidate was elected as Member of
Parliament, as 18 non-Bodo organisations came together in an alliance (called the Ekya
Mancha). For the first time in the history of the BTAD, a non-Bodo, Naba Kumar Sarania,
won the parliamentary seat, defeating both the ruling BPF candidate, as well as the
independent candidate supported by ABSU (who nonetheless had a substantial margin over
the BPF). The election represented both the potential for dynamic expression of ethnic
identities among non-Bodo groups, as well as the split among different Bodo factions that
struggled to outbid one another in an attempt to claim true political representation for the
Bodos.

The state’s approach to conflict in the BTAD has been, as Mahanta has asserted,
‘symptomatic’. He contends that the Bodo Accord was hurriedly drawn up, as a means to
quell the insurgency, but without taking into account the reality of demographics in the
region, or how the rights of all citizens would be encompassed and represented in the BTC.

The links between underdevelopment and conflict areas is well-established in these regions.
A fact-finding report of the December 2014 conflict says, of affected villages:

18 Dutta, A., 2016. The Politics of Complexity in Bodoland: The Interplay of Contentious Politics, the Production of Collective Identities and Elections in Assam. South Asia: Journal of South Asian Studies, 6401(May), pp.1–16
'There was virtually no outreach of the development state in these villages. Even the nearest primary school was more than seven kilometres distant, through the jungles; not surprisingly most children never went to school. There were no ICDS centres for young children, no health worker, and no MGNREGA public works. Almost none of the households had ration cards, and the PDS shop was again seven kilometres distant. We spoke to the local development officers, and it was clear that the first time most had visited the village was after the slaughter. We met in these villages an extremely impoverished people. They owned almost nothing, and had no titles to the small paddy plots which they had cleared and cultivated.'

Analysts like Sripad and Sarma also add a layer of economic analysis to what is the predominantly rural conflict of 2012, arguing that while Muslims continue to be the worst off group in the region generally, their recently improving status could also be a factor fuelling insecurity among Bodos. Udayon Misra traces the origins of current land use and allocation to policies formulated towards the end of the colonial period in Assam, especially regarding the bringing in of non-Assamese labourers, and their subsequent settlement in the region. The colonial regime’s preference for settled agriculture, which was practiced by ‘immigrants’ and more easily facilitated collection of land revenue, over the shifting cultivation practiced by Bodo tribals meant that the Bodos did not receive the protected status their hills tribal counterparts did.

At their core, violent events like the 2012 riots, the massacre of Bengali Muslims in 2014, or the attack on Adivasis in December 2014 are about the struggle over resources, most importantly land, and the notion of citizenship and rights in the BTC. While the state (rightly) comes under fierce criticism from citizens and civil society for failing to maintain humane conditions in relief camps, or providing adequate relief and rehabilitation for victims, it comes under sharp criticism from residents to see its absence in peace building and

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dialogue as a cause for their own inability to participate. As has been pointed out by Barbora, the BTC is not inherently polarized, it more a ‘site of failed interventions’, where the state has failed to recognize the multi-ethnic reality of the region, and to construct a debate that considers the rights of all marginalized people. 24

1.2 Literature review

**Conflict & Health**

Living with conflict and violence is a harsh reality for many people in the world and unfortunately, this harsh reality is touching more and more lives across countries. A World Bank Report of 2011 25 says that “one in four people on the planet i.e. more than 1.5 billion, live in fragile and conflict affected states or in countries with very high levels of criminal violence” which robs them of access to education, public services, and other pathways to prosperity. Pointing out that a civil conflict costs the average developing country roughly 30 years of GDP growth, countries in protracted crisis can fall over 20 percentage points behind in overcoming poverty. It is therefore alarming that the number of global poor living in fragile and conflict states is projected to double by 2030.

A background paper for a UNDP conference on armed violence in Oslo in 2010 says that “conservatively at least 740,000 people are killed, directly or indirectly, by armed violence” It further says that hundreds of thousands more are either injured or suffer psychological trauma; and millions of others live in families and communities that bear the social and economic burden of this violence. Armed violence is one of the top ten causes of death in more than 40 countries worldwide, and is the fourth leading cause of death for people between the ages of 15 and 44. Certain countries in conflict experience particularly elevated levels of violence. (Moyes, April 2010).

Conflicts, besides claiming lives and disrupting livelihoods, also halt delivery of essential services, such as health care and education. Health systems are often devastated in conflicts as health professionals flee, infrastructure is destroyed, and the supply of drugs and

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25 *Conflict, Security, and Development - a World Bank Report 2011*
supplies is halted. Although deaths due to conflict-related violence - so-called *direct mortality* - have fallen in the past 30 years because of the rise in low-intensity conflicts that do not involve large armies or heavy weapons, deaths among non-combatants are on the rise (Margaret E. Kruk a, 2010). These “wars of the third kind”, said to be wars of resistance and also campaigns to politicize the masses whose “loyalty and enthusiasm must sustain a post-war regime” are the prevailing forms of armed conflict today (Pedersen, 2002).

Rather than direct violence, most of the deaths in the conflict zones are caused by fever/malaria, diarrhea, respiratory infection and malnutrition. Also, high morbidity and mortality can persist long after the conflict ends. This “indirect” mortality is also due to the disruption of livelihoods, inadequate food and water supplies, and the destruction of health systems, as well as to continued insecurity (Margaret E. Kruka, 2010). This idea of war “being a development issue and that consequences extend far beyond direct deaths” is also expounded by others (Gates, Hegre, Nygrard, & Strand, 2012).

The World Health Organization Global Burden of Disease Study indicates that war will be the eighth leading cause of death by the year 2020. There were twice as many civilian deaths (34 million) as military deaths (17 million) in World War II (Grundy, Annear, & Mihrshahi, 2008). This can be further distinguished from direct combat deaths and indirect deaths caused by the consequent disease, hunger or lack of care. (Guha-Sapir & D’Aoust, 2010) A large proportion of these deaths were due to the indirect causes related to conflict, including insufficient and unsafe water supplies, non-functional sewage and restricted electric supplies, deteriorating health services with insecure access and the flight of health professionals (Grundy, Annear, & Mihrshahi, 2008). It further leads to forced migration, refugee flows, capital flight and the destruction of society’s infrastructure. Social, political and economic institutions are indelibly harmed. Therefore, war thus creates a development gap between those countries who have experienced armed conflict and those who have not (Gates, Hegre, Nygrard, & Strand, 2012).

It can also cause a wide range of physical, psychological and subsequent social effects (Moyes, 2010). Health is affected through the different phases of conflict. For example, before a conflict, the military expenditures rise and scarce resources are diverted from
health services and medical care (Urdal & Che, 2013). In the Middle East, currently known as “one of the most militarized region in the world”, way back in 1993 itself, 13.91% of the GNP was spend on arms when the world average was 4.7%. Correspondingly, health expenditure was at 2% of the GNP compared to the global average of 4.7% (PV, 2003).

During a conflict, not only do people die or are injured, but the displacement of populations has huge negative health consequences (Murray, King, Lopez, Tomijima, & Krug, 2002). It destroy the agricultural system which causes food shortages (Urdal & Che, 2013) apart from breaking down health systems, social services and increasing the risk of disease transmission exponentially (Murray, King, Lopez, Tomijima, & Krug, 2002). It also weakens society’s capacity of dealing with increasing morbidity and mortality (Urdal & Che, 2013) because as war and conflict progresses the situation deteriorates fast resulting in public health crises. In terms of diseases, we see cholera, dysentery, and nutritional diseases, measles, meningitis and other preventable diseases reaching epidemic if not in pandemic proportions. In their article ‘The unequal burden of war: The effect of armed conflict on the gender gap in life expectancy’, Plumper and Neumayer calls these effects of conflict as “indirect negative consequences” of armed conflict which are often overlooked and under-appreciated (Plumper & Neumayer, 2006).

Unnikrishnan in his article ‘Wars, Conflicts and Militarisation’ says that wars are killing the dream of Health for All and says that the rules of the war and their impacts have also changed. It has become biased against the poor and weaker. It can be from World War I where five percent of the casualties was civilians to World War II where it went up to 50% civilian casualties. In the 1990s, over 32 conflicts in barbaric ways showed that 90% of the casualties were civilians and majority are women and children (PV, 2003). We can see that women and children have become the most vulnerable targets of war and conflicts. Of the 10 countries with the highest under 5 mortality rates seven (Sierra Leone, Angola, Afghanistan, Liberia, Somalia, Guinea Bissau and The Democratic Republic of Congo) are all conflict or immediate post conflict societies (Grundy, Annear, & Mihrshahi, 2008). In a period from 2000 – 2003, 2575 Palestinians have been killed in the year. Out of this, 326 (12.7%) are children below the age of 15 and 1238 (48.1%) are between the age group of 19 to 29 years (PV, 2003). Grundy et al says that women and children are exposed to risk
equally during conflicts both directly as victims of war and the consequences of the conditions created by war (Grundy, Annear, & Mihrshahi, 2008).

Women suffer more severely from the damage to the health and other infrastructure and the wider economic damage as well as from displacement and dislocation during and after conflict. The breakdown of social order and the ensuing brutalization fuels male aggression against women who suffer sexual violence, both from within and outside their domestic household.

The destruction of transport systems, communications and hospitals due to conflict and the associated poverty and insecurity has caused a lot of struggle for women and children. Three of the eight UN Millennium Development Goals (MDGs) relate to improvements in health conditions. Goal 5 is to reduce by three quarters the maternal mortality ratio by 2015, and to achieve universal access to reproductive health. In a mid-term review of the Sub Sahara Africa (SSA) which is also home to a number of conflicts, one in 16 women dies because of complications related to pregnancy and childbirth during her life compared to one in 3,800 in the developed world (Urdal & Che, 2013). Che and Urdal proposed two proximate determinants of maternal health for the observed excess female mortality from armed conflict. First, it is assumed that the availability of obstetrical care is generally much poorer for women in conflict areas therefore increasing the chances of death for every pregnancy and child delivery. According to UNICEF, women die either because they have no access or limited access to health care, or because the quality of care is poor (Urdal & Che, 2013). Women of child bearing age die at home because of post-partum bleeding, denied access to essential health care services. In Cambodia in the mid 1990s, during the final period of hostilities against the remnant Khmer Rouge the mortality rate on the battlefield was equalled by the number of deaths of mothers in Cambodian villages from pregnancy related causes (Grundy, Annear, & Mihrshahi, 2008).

Conflicts also influence the fertility of women and hence their health and well-being. While on the one hand, it has been observed that fertility decreases because of the general increase in violence, psychological stress, wealth uncertainty and poor health. On the other hand, conflict also boosts fertility through what is called an “insurance effect” i.e. As the
future is uncertain, having more children secures the preservation of a minimum level of income (Guha-Sapir & D'Aoust, 2010). Urdal and Che also observe that higher fertility is related to higher levels of insecurity leading to increase in demand for children and hence more children being born. Lack of knowledge and access to reproductive health services also increases number of births (Urdal & Che, 2013). The Studies exploring fertility among conflict affected populations are few but they do point out to complex reproductive behaviors in response to violence and adversity.

That wars affect women adversely is also clear from a 1999 WHO study on Disability Adjusted Life Years (DALYs). The author examined the effects of war by gender, age and different disease categories and found that of the 54 subcategories affected by war, 33 were women. But this needs to be studied more deeply as both men and women have been found to be affected equally in some disease categories. The same has been found for different age groups of boys and girls (Urdal & Che, 2013).

Apart from women, children are also known to experience more of the burden of conflict related deaths (Guha-Sapir & D’Aoust, 2010). The health of children is often compromised in situations of emergencies, armed conflicts, political upheaval and forced migration. Children under five years of age have the highest mortality rates in conflict affected settings (Zwi, Grove, Kelly, Gayer, Jimenez, & Sommefeld, 2006). Infant mortality rises in association with reduced access to health and immunization services, impairment of the basic infrastructure necessary to promote health, poorer nutrition for children and their mothers, and population displacement. During the Ugandan civil war, the infant mortality rate was above 600 per 1000 in certain war affected areas (Zwi, Numbering the dead: Counting the casualties of war). Diarrheal diseases, acute respiratory infections, measles, malaria and severe malnutrition are the most common causes of death in the early phases of conflict related emergencies. In addition, outbreaks of other infectious diseases such as pertussis, typhoid and meningococcal meningitis can contribute to child mortality and morbidity rates (Zwi, Grove, Kelly, Gayer, Jimenez, & Sommefeld, 2006). Lack of resistance to infection, immaturity of the immune system in very young children and immune suppression associated with malnutrition make children especially vulnerable (Banatvala & Zwi, 2000). The occurrence and transmission of these diseases is increased due to the decline in
immunization coverage, population movements and the lack of access to health services. In a case in Northern Uganda, children are forced to leave their villages with their families to seek safety and protection. In this process, they make decisions affecting health every day: where and what to eat, where to sleep, and in what circumstances they can find safety. They decide what to do if their brother or sister has a fever and they decide which health related resources\textsuperscript{26} they should use. They decide whom to talk and whom they must trust (Zwi, Grove, Kelly, Gayer, Jimenez, & Sommefeld, 2006).

The victims of armed violence often have serious mental health problems, including increasing rates of fear, anxiety, fear, depression, post-traumatic stress disorder and suicidal behavior (Moyes, 2010). There is huge psychological stress associated with displacement - both forced and voluntary – which results in grief and loss, social isolation, loss of status, loss of community and, in some settings, acculturation to new environments. Manifestation of such stress includes depression and anxiety, psychosomatic ailments, intra-familial conflict, alcohol abuse and anti-social behavior (Zwi, Numbering the dead: Counting the casualties of war). In the Bosnian and Cambodian conflicts, the rates of depression among refugees reached 14-21% in Bosnia and 68% in Cambodia.

Rates of PTSD (Post-Traumatic Stress Disorder) for Bosnian and Cambodian refugees were 18-53% (Bosnia) and 37% (Cambodia). Conflict leaves a lot fear and insecurity in the minds of people and children. The psychosocial effects of conflict are associated with the loss of a loved one, separation from parents and destruction of homes. Children affected by armed conflict may exhibit both acute and chronic reactions. The most common among acute psychological disturbances is trauma, which is typically associated with problems of flashbacks, nightmares and sleep disturbances, concentration problems, heightened alertness or hyper vigilance and avoidance of people and situations that evoke memories of the traumatic events\textsuperscript{27} (Wessells, 1998).

\textsuperscript{26} Health related resources here refer to traditional healers, clinic nurse, non-governmental organization or government clinic.

\textsuperscript{27} The Graca Machel/UN Study. A global study by the UN General Assembly led by Ms. Graca Machel former First Lady and Secretary of Education of Mozambique.
The long term psychosocial effects of major political conflict and violence have yet to be adequately explored. Many of the youth in South Africa and Palestine have seen violence as the only mechanism for resolving conflict and overcoming adversity, mostly during their childhood. Children seeing their homes burning down or the killing of a family member are bound to be affected. For such individuals, their attitudes towards society, ability to obtain employment or to act as positive role models for their children, to be responsible parents, and to have healthy inter-personal relationships in times of peace, may all be disrupted (Zwi, Numbering the dead: Counting the casualties of war).

Conflict exerts a direct and indirect effect on health and health systems. Many of these effects endure long after the guns have been silenced. Direct effects are broadly related to the impact of military action, and include death, injury, and physical and psychological disability of individuals, including health workers, and the destruction and looting of the health infrastructure, equipment and supplies. Of much greater magnitude, however are the indirect effects of political, economic and social changes, which both underlie conflict and are precipitated by it.

Health systems undergo changes in a changed environment. The government health system also becomes a victim of conflict with the destruction of clinic and health infrastructure, the flight of health professionals, and the interruption of drugs and medical supplies. The health system also suffers even before a conflict as governments redirect their spending from healthcare to military (Kruk, Freedman, Anglin, & Waldman, 2010). In times of conflict, the pre-existing health system tends to get worse, if it is weak. In the revolutionary conflict of Mozambique, Nicaragua and Eritrea, new strategies for health have emerged while in some countries the health system has not been able to adjust to the stresses of war and economic decline. In many cases, there has been a reduction in the availability of health care especially in rural areas where health workers flee the place to go to location where they are more secure, there is no breakdown in supplies of medicines (Macrae, Zwi, & Forsythe, 1995). In the early, 1980s in Mozambique, health workers and clinics were attacked by rebels to destabilize the government (Kruk, Freedman, Anglin, & Waldman, 2010). In Iraq, out of the 34,000 registered doctors in 1990, 20,000 doctors have left since 2003. About
2500 nurses and doctors were killed and some kidnapped in this period (Guha-Sapir & D’Aoust, 2010).

‘It is the Ministries of Defense and not Ministries of Health that makes assessment (necessarily inadequate) of the likely social, population and health outcomes of war’ (Grundy, Annear, & Mihrshahi, 2008). The analyses of war and defense policy are applied from a national security perspective and less from a human security perspective. It is obvious that armed violence can leave victims with pronounced physical, psychological and social disabilities. Inadequate response to these effects can further lead to impaired access to full enjoyment of key social functions, including access to justice, education, economic participation and economic inclusion. In El Salvador, survivors of gun violence have reported their biggest problem is that they cannot work to earn money, provide for their family and care for their children. When individuals, groups or societies experience armed violence, they often suffer reduced access to education and vocational training, and decreased economic opportunities. Adequate policies and practices must be kept in place to ensure that the health impacts of armed violence are not allowed to stop individuals from participating (Moyes, 2010).

Conflict and state fragility are the fundamental drivers of health inequity in conflict affected states. This is starkly illustrated by the International Rescue Committee’s most recent survey in the Democratic Republic of Congo that revealed that mortality rates in conflict areas were two to three times those of non-conflict affected areas (Bornemisza, Kent, Ranson, & Egbert, 2010). It has also been pointed out that while the health effects during specific civil wars are relatively well known, but the general and longer-term impact on health is not much known (Ghobaraha, Paul, & Russett, 2004). Armed conflict between warring states and groups within states have been major causes of ill health and mortality for most of human history. Conflict obviously causes deaths and injuries on the battlefield, but also health consequences from the displacement of populations, the breakdown of health and social services, and the heightened risk of disease transmission. Despite the size of the health consequences, military conflict has not received the same attention from public health research and policy as many other causes of illness and death (Gary King, 2002). In conflict studies and especially trauma related to conflict, one the most startling
observations is that there is a relative absence of studies of the most affected populations in their original locations or countries of origin (Pedersen, 2002). Much of the studies are of displaced populations in the country they have migrated to. This could be perhaps due to the danger and risks of carrying out studies in conflict zones and also the lack of easy access to such populations (Pedersen, 2002).

Health in Conflict Areas of Bodoland

As we saw from the background to this chapter, Assam has been plagued by insurgency and frequent ethnic conflicts. In fact, according to a report prepared by Asian Centre for Human Rights and released in Guwahati in 2015, Assam had the highest conflict induced Internally Displaced Persons in the world during the year 2014. Weak governance and poorly developed systems has seen the state lagging behind other states in development, especially in health indicators. Maternal Mortality Ratio (MMR) in Assam (2010-12) is 328 per 100000 live births, whereas the corresponding national figure is 178. Infant Mortality Rate (IMR) in Assam (2010-12) is 55 per 1000 live births against 42 for the country as a whole. Thus both infant and maternal health status is very poor in Assam compared to All India figures. Both immunisation coverage as well as institutional delivery is also found to be lower. If these are the statistics for the whole of Assam (which includes well governed districts with relatively better functioning systems), then it is very difficult to imagine that the situation is any better in an area – such as Bodoland in Western Assam – which has seen 8 repeated cycles of ethnic conflict in 25 years, apart from the fragility of living in a zone of pervasive militant conflict.

If we look at the NRHM data for Bodoland areas and specially for the district of Chirang (the proposed area of this study), we see these areas are lagging the rest of Assam in what the government considers as important health indictors and for which they have data i.e. MMR, IMR, immunization, institutional deliveries, registration and check-ups of pregnant

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28 SRS, 2001-03, Annual Health Survey 2012-13 & RGI 2010-12
29 Repeated cycles of violence has been defined as “Countries or subnational areas that have seen more than one episode of organized violence for 20–30 years” - Conflict, Security, and Development - a World Bank Report 2011
women etc. Chirang district is also the poorest district in Assam when it comes to the percentage of people having access to potable drinking water, or sanitary latrines or even electricity. Dutta & Baro in a study found that of 257 Bodo households surveyed, in as many as 135 households, there is at least one person who is either blind or crippled or mentally impaired or chronically sick or has more than one such physical or mental disability. Such cases are more in rural areas in comparison to urban (Dutta & Baro, May 2014).

From readings on the link between conflict and health, one can hypothesize that the health of people is worse off when they are affected by conflict than when they are not. We find many NGO reports and studies on the immediate effects, including health impact, following an episode of conflict. For example, in a study carried out in Bodoland, Sinha says that even though the risks and burdens on overall health systems due to armed violence have thus largely remained unknown, yet the adverse consequences of these breakdowns are extremely real. In a field assessment in 2013, following the aftermath of the Kokrajhar ethnic crisis of 2012, he states: “Existing local health system in affected districts was disrupted due to the scale of the problem. This is especially heightened by the need to extend the existing services to new camp populations. This has increased workload of doctors, ANM and ASHA who are working now with patients for whom they do not have medical records or detailed case histories. For instance, in Dhubri District, Bilasipara subdivision, existing sub-PHC is also now fully responsible for extending services to around 4000 internally displaced persons (IDPs) in four camps. This is in addition to the normal workload of the local healthcare workers” (Sinha, 2014).

Similarly, there are reports by Humanitarian Aid Agencies such as Oxfam\textsuperscript{31} or the IAG Report\textsuperscript{32} on the outbreak of diseases, availability of health services and WASH (Water, Sanitation and Hygiene) among the affected populations in relief camps or when conflict affected people return to their villages. Short-term field assessments following conflict is important to know the status and help guide relief action. But in the absence of in-depth studies, it tends to throw up many more questions which need answering. We need a much deeper understanding of the issues at hand to help frame effective policies which can

\textsuperscript{31}Rebuilding Communities in Conflict – Oxfam India’s Humanitarian Response in Assam and Muzaffarnagar

\textsuperscript{32}Joint Needs Assessment report – Assam Conflict 2014 – Inter-Agency group, Guwahati
promote the long-term health and well-being of populations affected by chronic, long-term and repeated cycles of political and ethnic violence.

1.3 Rationale of study / Gaps

Despite the size and seriousness of the health consequences, especially for the poorest and most marginalised populations of the world, violence and conflict have not received enough attention as a public health problem from public health research and policy as much as other causes of morbidity and mortality seem to have. While studies have been done on the effect of wars and high intensity conflict on health and on health systems and services (Ghobarah & others, 2004; Levy & Sidel, 2009; Murray & others, 2009), we do not find many studies on the effects of long-drawn, low-intensity conflicts and repetitive conflicts (which is the predominant type of conflict nowadays). We also do not come across many studies on how chronic low-intensity but persistent fragility with repeated waves of conflict, create health inequities for the populations living in such areas.

Officially, India does not recognise the presence of political conflicts within the country and hence there are few studies done on the effects of conflict and even fewer studies on conflict in the more difficult to access areas of the northeast region. Most studies on conflict done in the northeast region of India tend to be either assessments of the emergency situation following the violence (reports by Oxfam 2012, 2014; Doctors for You 2012, 2014, 2015, Inter-Agency Group 2014; Samrat Sinha 2014) or they monitor the number of IDPs (Internally Displaced Persons). Studies on conflict in Assam largely deal with the sociology and politics of migration, ethnicity and identity (Monirul Hussain 2010; Uddipana Goswami 2013; Mridula Dhekial Phukan 2013; Bonojit Husssain 2012, Hiramoni Das 2015; Pralip Kr. Narzary 2006). There are very few studies on the long-term effects of conflict on development and health of conflict-affected populations. Where health inequities in relation to conflict is studied, most of these are quantitative assessments of the status or study of secondary data on health (Pankaj Kumar Baro & Sumanash Dutta, 2014; Indranee Dutta & Shailly Bawari, 2007). There are almost no in-depth studies which capture the historicity of the conflict and how that affects health care systems and response. There is also a huge gap in research on the long-term health risks and vulnerabilities of those in fragile conflict affected areas. Without this deep understanding, we will not be able to design interventions that help poor, marginalised people, especially those forcibly displaced by conflict, ever to recover and lead healthy lives.
1.4 Process of generating the research objectives & questions

This study was initiated as a part of ‘Closing the gap’ - a five year old initiative of the Achutha Menon Centre for Health Science Studies (AMCHSS), Thiruvananthapuram, Kerala to gather robust evidence that could be used for effective policy action in Health Inequities in India. One of the focus areas being to create an evidence base regarding inequities in tribal health, a call for research was made for a COLLABORATIVE RESEARCH PROJECT ON HEALTH EQUITY AND TRIBAL HEALTH IN INDIA.

the ant responded to the call and was selected as one of the three collaborators for the study. Before the start of the project, a workshop was held for the partners in Trivandrum in February 2016. The objective of the research partners’ workshop was to:

- Provide feedback on the proposals, and facilitate their revision and finalization
- Arrive at a shared conceptual framework, common definitions and methodological approaches
- Plan modalities for implementation of the research studies: setting up advisory groups, reporting requirements, expected outputs and time line, plans for dissemination and advocacy

The workshop led by health researchers, also had research methodology experts as resource persons. It helped us refine and sharpen our research focus, and at the end of the five day workshop – with peer questioning, multiple presentations and iterations, we decided to focus on this topic: Health Inequities In A Conflict Area - An In-Depth Qualitative Study In Assam.

And we came up with four questions of research which guided the study throughout:

1. How have socio-political changes historically shaped health and the public health system in the area? And conversely, how has lack of health contributed to conflict?

2. How does conflict affect health of different ethnic groups differentially? How do critical social determinants such as loss of livelihoods, land, housing, culture, safety & security, community, mediate to create ill health?

3. What are the ways in which different people, individuals and groups, gender, class, ethnicity, religion respond to ill-health in a conflict area?
How do various groups interface with and benefit from government health services and also health promoting institutions such as Public Distribution System, Anganwadi Centers, Water, Sanitation and Mid-Day Meal?

Using a qualitative research methodology with elements of ethnography, data was collected through June 2016 – February 2017. After data analysis, the following is the chapterisation plan for this report:

Chapterisation Plan

Abstract of the Study

Chapter 1 : Introduction to the Context & Background

Chapter 2 : Research Methodology

Chapter 3 : Findings of the Study

3.1 Conflict & the Public Health System in Chirang District

3.2 Well Being & Health of Conflict Affected Tribal Populations

3.3 Health Seeking among Conflict Affected Communities

3.4 Role of State in Responding to and Promoting Health & Well Being of Communities in Conflict

Chapter 4 : Discussion & Conclusion
Chapter 2

Research Methodology

This study followed an in-depth qualitative research methodology in studying the long-term effects of conflict on health and health systems in a conflict affected area in Assam. A major feature of qualitative methods is their ability “to describe and display phenomena as experienced by the study population, in fine-tuned detail and in the study participants' own terms”\textsuperscript{33}. In this study, qualitative methods helped us to understand the experiences, stories, perspectives and events that happened with the population we were studying. It gave us opportunities to go deep into life histories not just of individuals but also of institutions. It gave us the opportunity to “unpack” issues and see what they are about or what lies inside, and to explore how they are understood by those connected with them\textsuperscript{34}.

The Institutional Ethical Committee (IEC) considered the ethical concerns of the research and the methodology and formulated a set of ethical protocols to be followed. Each member of the research team had to individually complete and pass a NIH-web based training on “Protecting Human Research Participants” before the ethical committee gave its clearance. The research tools developed were also okayed by the committee and then only the team could go ahead with data collection. Qualitative methods of data collection – such as in-depth individual interviews, group interviews and observational methods were used to obtain the data. The interviews – where possible – were tape recorded and transcribed. Where it was not possible to record, detailed notes of the same were kept. Timelines, Case studies and life histories were constructed and developed throughout the process of data collection. Detailed date-wise field notes were kept of the small talks, informant interviews observations and photographs by the researchers.


\textsuperscript{34}Same as 33
The following were the questions of research which were formulated to explore and guide the study:

1. How have socio-political changes historically shaped health and the public health system in the area? And conversely, how has lack of health contributed to conflict?
2. How does conflict affect health of different ethnic groups differentially? How do critical social determinants inter-relate to create ill-health? (loss of livelihoods, land, housing, culture, safety & security, community etc.)
3. What are the ways in which different people, individuals and groups, gender, class, ethnicity, religion etc. respond to ill-health in a conflict area?
4. How do various groups interface with and benefit from government health services & also health promoting institutions such as PDS, anganwadi, water, sanitation, MDM?

I. Identification & selection of villages

Initially, the villages selected were within the ant’s intervention villages that were affected by the 1996, 1998 & 2014 conflicts between the Adivasis and the Bodo communities. Since rapport had been built with these villages, we felt this would give us a good starting point for the study. We thus chose displaced populations of various ethnicities who were living deep inside the forest and displaced population settled near the main road. We also took up those newly affected by the recent conflicts on 2014 as well as those who had experienced the older conflicts of 1996 and 1998. It turned out that most of the newly affected population we interviewed had also been affected by the earlier rounds of ethnic conflicts. For some of them, this was the third round of displacement and disruption.

Once we started the interviews, the informants shared stories of their families, friends, and neighbours in other relief camps. We also learnt about villages where people re-settled after the conflict. With this information, we started looking for further information and understanding the differences between these villages and populations of people. Villages and respondents chosen were thus through a snowballing method done with help from our informants. Finally, the villages covered in the study extended beyond Deosri to also cover
areas around Shantipur, Kusumdisa, and Runikhata where populations have re-settled after the conflict. For example, the village of Kusumdisa was later chosen to understand how Bodo families who have fled and returned back to their original villages have fared compared to their fellow villagers who did not return to their original village from the relief camps.

ii. Methodology & Tools Used in the Study

This study used qualitative methods and designs. These methods allowed the respondents and informants to explain their experiences on conflict and health in their own terms. Initially, the researchers started with participatory methods, working with Self Help Groups (SHGs) and holding village group meetings. Different participatory methods such as disease listing, ranking, mapping of health facilities and illness timelines were used with the people to open up and warm up for interviews before going in depth into specific health issues. While the participatory methods initially did help in understanding the overall health status in the villages and in helping the researchers introduce the objectives of the study to the community, we soon found it limiting.

After a few group interviews through meetings in the village, the researchers found that the information we were getting was repetitive and we had hit saturation very early. It was a similar experience with the semi-structured research tool we had formulated for individual interviews. We found the tools limiting deeper explorations into the subject and upon reviewing it with our research advisor, decided to keep the tool aside for a while and first focus on collecting thick “stories of conflict and people’s lives in their own words”. This helped us really understand deeply the context of conflict on health and well-being of people affected by conflict.

a. In-depth interviews were used with conflict displaced individuals of different communities to construct their life-histories/ thick biographies and understand in-depth their experiences with conflict and its effect on their health and well-being. In-depth interviews were also used to interview key informants such as health personnel from the various phases of the conflict timeline, community leaders,
former militant leaders etc. Some of these thick life histories and biographies were used to later construct vulnerability maps, treatment pathways, timelines etc.

b. **Group interviews** were conducted with women’s group regarding women’s health and experiences during conflict. Participatory methods such as drawing of timelines, facilities mapping, disease ranking and mobility maps were used during the group interviews to get the data and verify the information. Group interviews were helpful for respondents who were talking of events which happened a long time ago, like the 1996 conflict displaced respondents. Memories of individuals got jogged while talking in a group and one could also verify accuracy of the information recalled.

c. **Small Talks:** Number of small talks (not formal interviews) with various individuals in the study area like shopkeepers, village elders, patients, carers, staff in the hospitals etc. helped to give a deep understanding of the context and in validating some of the information gathered from other methods such as observations and interviews. Dated, detailed notes for these small talks were kept by the researchers and used during the analysis and in writing the report.

d. **Observations** was also used extensively in this entire research especially in understanding the status of the people, the health seeking behaviour and the health care service providers in the area. For example, the researchers spent hours in the shops and homes of the ‘pharmacists’ and faith healers observing the types of patients, the illnesses and the people they treated. Field notes of the observations were written daily by the researchers and these were filed. Then, it was from observations of the dismal housing conditions, illnesses, unorganised village structure, wife-beating, alcoholism and poor life conditions of one of the long-displaced Bodo villages i.e. Bhurpar Tini-Ali that made us decide to visit their original village of displacement i.e. Kusumdisa and include it as part of the study. Observing and comparing the living conditions of the displaced Bodos with those who returned to their village after displacement gave us strong evidence of how conflict induced displacement lives even 20 years after the incident of violence.
e. **Map construction from Life Histories** was a tool the research team came up with specifically for this study. Oral histories were used to construct various maps and timelines like the conflict timeline, history of the health system, vulnerability maps, illness pathway maps etc. Some of these maps were drawn while the data was being collected and helped point out the gaps in data which the research team then filled up. Then, sharing the health system history map with some of the relevant respondents helped validate the information and sharpen it further. Using diagrams and maps helped the research team present complex phenomenon in a concise manner. The historical context of conflict in the larger socio-economic changes has been analysed through available secondary literature and this too was put in terms of a timeline for easier and clearer understanding.

f. **Photographs & Visuals**: Photographs were taken during field work to highlight the data and information collected through the other means such as interviews. Some of the photographs used were from the archives of NGO (the ant) who were present at the time of the 2014 Bodo-Adivasi conflict in the area. The maps and photographs helped in corroborating the data from the interviews and along with observations, helped in triangulation and presenting the data in a more complete manner.

iii. **Data collection: Experiences and Limitations**
Most of the villages covered in the study fell under the ant’s intervention area where the NGO has been working for almost a decade and is known to the people. Building on the rapport and goodwill already present, the researchers got an easier access to interviewees on the very sensitive topic of ethnic conflict, pain and loss. We could reach out and interview a range of respondents – community members, community and village leaders, teachers, health workers, militant leaders, members of local governance bodies and youth leaders. the ant’s reputation of many years helped open doors and most respondents we contacted for the study were keen meeting the researchers. We got militant leaders willing to share their stories in three-hour long interviews, doctors who served in Shantipur were willing to meet and share their stories to the researchers at any time. The team of researchers was housed in especially rented quarters in the Deosri Nepali Village which belongs to a Deosri Lower Primary School Teacher. This proximity to the villages of the study
ensured that data collection was smooth and fast and we had the flexibility to reach out to different levels of respondents with many opportunities for immersing ourselves into the lives of the people.

The interview place and time were scheduled according to the convenience and availability of the informants and respondents. Most of the interviews were at the houses of informants/respondents. Some of the meetings with community leaders and Community Based Organisation (CBOs) were held at their respective offices.

The process of data collection was very open, flexible and iterative. The research team after two-three interviews would sit together to review data and plan the next lines of questioning. Monthly meetings were held regularly with the research advisor and a bigger review meeting once in three months helped review the progress of the study and make changes if any were required. Each review meeting allowed the researchers to go back to the data, find the gaps, and explore more possibilities of exploration.

**Some Data Collection Sites**

One of the places where the researchers got a lot of information was the Deosri Bazaar where the researchers would hang around. As JL’s field notes of 1/11/2016 describes, “SM is a widow who runs a small shop in Deosri Bazaar selling packaged snacks, toffees and sweets. She also stocks and sells a bit of petrol and diesel brought from across the Bhutan border. Her shop is also popular for a couple of fast food items like instant noodles, fried eggs and tea. One always finds local people sitting in small benches outside her shop, chatting and having some snacks or a cup of tea. Hence, SM thus is well-informed about the local politics and the happenings in the local area”. Since the tea shop owners were always curious about the young new staff of **the ant** residing in

A tea shop in Deosri – one of the sites for data collection
Deosri, they would question the researchers on their projects. As the researchers explained why they were there, people would start sharing bits and pieces of information about various incidents, their opinions, their own personal experiences, stories of their past and how things are now. Some would share their personal problems, while others, who feel responsibility towards the community, would share how difficult and challenging Deosri is and what the future ahead seems for the people.

Sitting and observing in pharmacies in different locations was also advantageous for the researchers. This is where all the local practitioners would share their stories of what kind of patients come to their shop for medicines, who is a regular customer and what kind of illness they treat. “I had visited the pharmacy of Sankar and Raju in Nakkedara. My plan was to talk to Raju regarding the types of illnesses in the area. He has been providing health service in the area since the past 11 years. As I was waiting for him, his wife walked into the pharmacy and told me that her husband would not be coming in today. Though I thought of moving away I decided to spend a little more time observing. In few minutes people started coming to the pharmacy with different illnesses and the whole evening I spent just observing them.” (JM, 09.11.16).

We found that while the pharmacists were quite comfortable with the some of the field researchers, they became totally guarded and very uncomfortable when one of the researchers, a medical doctor went to talk to them. They knew him to be a medical doctor and would not open up.
Challenges of fieldwork

Deosri where most of our field work was located is not an easy terrain, especially during the rains when most of the mud paths are wet and slippery. Being in the Bhutan foothills, the area receives a lot of rain. During the peak monsoon, field work had to be halted for almost a month because researchers could not travel to the villages. Most people are out in their field during the planting and harvesting season and cannot be reached. Then, most of the displaced populations have no land and are thus dependent on the Bhutan side for daily wage labour. The men who go for work to Bhutan leave early morning and return late evening. Meeting some of them was very difficult.

Then, another specific and unexpected fieldwork challenge was the high level of alcohol consumption in the conflict displaced villages. Interviewing people in such villages got a bit tough as people when they were not at work and free to talk to us, would be inebriated. Among the Bodos, only men were found in such state. However, among the Adivasis alcohol consumption in one of the villages in the study was very high among both men and women. Sometimes the responses given were doubtful. To overcome this, we changed the timings of the interviews to early morning but to our surprise many of the respondents were still found
intoxicated in the mornings too. It was a challenge for our field team to keep their own heads steady in some villages where the brewing alcohol fumes hung heavy in the air!

Yet another challenge for the researchers was to manage “expectations from people” as the researchers were seen to be from ‘the ant’ or ‘NGO’. Being in a conflict area where people have received relief materials from NGOs in the past (including from the ant), asking a few questions for the research got people thinking they might receiving something. Researchers faced questions from people such as “what will we get?” “what are you giving us now?” which made it difficult for the researchers to explain their project to people. On the other hand, the researchers also had to face rejections for interviews from people for personal reasons, which were never explained. There were also people who refused to speak to ‘NGOs’ (the proxy for researchers) because they never received anything from them in past.

**Walking the fine line between researcher and activist**

At times, we found ourselves treading a thin line between being researchers and being development workers. It was difficult to remain an objective researcher witnessing people’s struggles and hardships without intervening. There were times during the fieldwork where they were called to act upon certain situations. In one case, one of the researchers during an overnight stay found that a woman was having labour pain and she could not be taken to the state dispensary the next day morning because her family did not have money to pay for the ambulance. The researcher gave money from her own pocket for the ambulance else the woman would have been in danger of a complicated birth. In another case, in one of the displaced villages, researchers found that children, who used to go to school before the conflict had no more school to attend. The researchers had to write to the Executive Director of the ant regarding the situation of the children and got them to start some schooling facilities there.

**iv. Researcher as an Insider and Positionality**

As a researcher, there were also dilemmas about their own positionality. There was a time when one of researchers did couple of interviews with traditional healers. He himself personally never believed in such things and had to struggle not to express his own views show openly in his behaviour. While he tried his best to position himself as an unbiased researcher called to interview, collect data and
write the data as it was but his feelings always contradicted what he was listening to. Gradually, over time he realised the importance of registering all perspectives and not to allow his opinion to shape the process of data collection.

Then, being researchers from the same community had its own set of issues. While being an insider helped in the data collection as one was familiar with the language and could probe deeper issues, it had its flip side. While researching ethnic conflicts, it is not easy remaining totally unbiased about the ‘enemy’ community. Listening to story after story of loss inflicted by the other on ‘one’s own people’ and of their struggle for survival after such losses, did affect the researchers from that community. There were times when one could feel the emotions of anger and awkwardness between the Bodo and Adivasi researchers. It helped for the entire research team to sit and acknowledge the negative feelings and deal with it. This helped normalise the situation and created openness among the research team members.

v. Documentation, Filing and Data Analysis

The in-depth interviews which were recorded in the voice recorder, were transcribed. The first initial transcriptions were stored in their original format and filed accordingly. The transcribed data were later edited and filed as per the village name, given a code number and file name. Transcribing and editing of data was an ongoing process in the field. If there were data gaps which were identified, the team would revert back to the concerned informants/respondents for further clarification.

For small talks and observations, we kept detailed field notes. Most of the field notes give a description of what is happening around on the day of fieldwork and what is observed. The field notes from observations, small talks and interviews were integrated together for analysis. Mapping out the concepts and creating diagrams helped identify data gaps and clarify our own understanding of it.

Analysis was an ongoing process along with data collection. The team held periodic debriefing and review sessions where a highly iterative process was followed to study the data, look at the gaps and Using a combination of instruments such as field notes, memos, short life-histories, various forms of pictorial representations such as photographs and
conceptual maps, which were updated through an iterative process facilitated by periodic sessions of debriefing and brainstorming by the team. At different phases of the study, the team sat together to sift through notes, memos and pictorial representations keeping in mind one research question after another and generated conceptual representations for each of these questions and these were written out as narrative chapters. These were subjected further to rounds of reflection and refinement.

Regular review meetings of the research team were held to review the data, identify gaps and plan out the next steps in the study.

**Limitations of the study**

The subject being so wide, complex, and multi-faceted involving many communities and the time we had for data collection being limited, we really had to resist the temptation to keep going deeper and deeper into every facet. For example, though we really wanted to, we decided not to go beyond the level of State Dispensary Level (PHC) in our in-depth interviews and case studies. We also could not go deep enough into teasing out how different ethnic communities are affected by conflict differently. The research team also had to take a conscious decision not to include the Rajbongshi community, who are one of the non-displaced witnesses of the conflict, in the study due to lack of time. Another limitation we had to deal with was that we did not touch upon the second part of the first question of research i.e. How does lack of health contributes to conflict?

Secondly, language was a limitation for the researchers especially for the Adivasi (Santhali) section. Though we tried very hard, we could not hire a suitable trained and skilled Adivasi researcher to carry out the qualitative interviews. There were no qualified persons within
the community in Deosri and all the others we interviewed from outside the area were hesitant to come and stay in such a conflict-prone and ‘dangerous’ area. It was two months into field work before we could get a Santhali male from a neighbouring district two hours away to come and stay with us and do basic translation from Santhali to English. We feel that if we had got qualified female Santhali researchers, we could have done much deeper interviews with Adivasi women.

**Summary**

This study being a part of a larger initiative to understand health inequities in India, looked at health inequities among tribal communities who have undergone conflict. The qualitative methodology was well suited for the subject since it helped us study the participants' in their ‘own terms’. It helped us ‘unpack’ the many issues related to the collapse of the health system through the eyes of conflict history as well as deeply understand the impact of conflict on people’s health and well-being.

Different qualitative and ethnographic methods of in-depth individual interviews, key-informant interviews, group interviews, observation, small talks and conceptual maps were used to collect data. Most of the in-depth interviews were recorded and transcribed, and detailed field notes were kept of the observations, small talks and key-informant interviews. Analysis was an ongoing process along with data collection, using a combination of instruments such as field notes, memos, various forms of pictorial representations including photographs, maps and diagrams which were updated through an iterative process facilitated by periodic sessions of debriefing and brainstorming by the team.

One of the biggest advantages of the study was that the villages covered in the study fell under the ant’s field intervention area where the NGO has been working for eight years and is known to the people. Building on the rapport and good will already present, the researchers got easy access to interviewees on the sensitive topic of conflict. While being identified with the ant helped build rapport with the respondents, the research team had to deal with the challenges of managing material and other expectations that the community had from NGOs in general and the ant in particular. Then, being development practitioners,
the researchers also had to tread a thin line between research and activism. At times, it was not possible to separate the two roles. The tough terrain and heavy monsoon in the peak of data collection was another challenge for field work.

The main limitations of the study have been that the limited time to cover a subject so wide, complex, and multi-faceted, involving so many communities over different time periods. The research team had to really resist the temptation to keep going deeper and deeper into every facet and focus on the objectives and questions of this research. Not getting a trained researcher who could speak Santhali was another limitation which affected the time taken to collect data. This also affected the depth to which we could go with some of the Adivasi interviews.
Chapter 3

Findings of the Study

3.1 Conflict and its Effects on Health Systems

Health and conflict literature tells us how conflicts, besides claiming lives and disrupting livelihoods also halt delivery of essential services, such as health care and education. Health systems are often devastated in conflicts as health professionals flee, infrastructure is destroyed, and the supply of drugs and supplies is halted [Margaret Kruk, 2010]. But what happens when the conflicts are long-drawn or when they are repetitive? Or when the conflicts are not intensive but cause fragility as they persevere over time and space? What happens to health governance and health systems in such an atmosphere of political fragility? How does conflict and political fragility interact with the health systems?

Assam has had a three decades long history of political movement and at times violent struggle. This has impacted governance and the public service delivery. But how much of it has impacted the public health system? What kind of impact has it had? How has the political history of unrest, movements and conflict interacted to impact health delivery systems and mechanisms in Assam and also in our study area of Bodoland and Chirang district? And what is the status today? What special interventions need to be designed to better the health of the health systems in the study area? In this chapter, we will explore these questions and through it grapple with the first research question of this study i.e.

*How have socio-political changes historically shaped health and the public health system in the area? And conversely, how has lack of health contributed to conflict?*

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35 Margaret Kruk et al: Rebuilding health systems to improve health and promote state building in post-conflict countries: A theoretical framework and research agenda; Social Science & Medicine 70 (2010) 89–97
3.1.1 Struggles, Conflict & Evolution of the Health System in Assam

Getting a sense of the recent socio-political history of Assam will help us understand how such events impacted governance in general and governance of health systems in Assam and in our research field area.

**Figure 3.1.1 Brief Timeline of Assam’s Political & Conflict Landscape in the last 30 years**

Figure 3.1.1 is a brief timeline of the socio-political history of Assam starting with what is termed as ‘the Assam Agitation’ or the ‘Assam Movement’ believed to be ‘the most stringent mass movement in contemporary Assam’. The anti-government campaign that continued from 1979 to 1985 was started to protest enfranchisement of, who they believe were, illegal immigrants from Bangladesh.³⁶ Led by the AASU (All Assam Students Union), civil society was mobilized to demand for “detection, disenfranchisement and deportation of the foreign nationals”. The initial phase of the movement was marked by wall writings against the government’s exclusionary attitude and call for protest. This instantly saw the assembling of lakhs of people. Mass sit-ins, picketing, satyagraha, strikes and mass signature campaigns, black-outs at night were followed by days and days of Assam bandhs. It is believed that 18 lakh people took an oath to carry out the movement till the “foreigners are ousted”³⁷.

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³⁶ Shodhganga ; Chapter 1: The Assam Movement and the Contest of Citizenship; [http://shodhganga.inflibnet.ac.in/bitstream/10603/33043/11/11_chapter%201.pdf](http://shodhganga.inflibnet.ac.in/bitstream/10603/33043/11/11_chapter%201.pdf)
The Indira Gandhi government at the Centre cracked down on the protesters and in 1980 the army was sent in to control the situation and the press was censored. President’s rule was imposed time and again in the state. There was a complete breakdown of governance, administration and law and order in the state. “The tussle that started as a drive by the indigenous people against the foreigners soon became a greater matter of political crisis and cultural contest. State machinery failed on all accounts; Transportation, Law and Order, Health, Emergency”. [Shodhganga]. After four years of the movement, the Centre decided to forcibly hold elections in Assam in 1983. This was met with violent protests and split the State along ethnic and communal lines with most Assamese protestors boycotting the elections but some tribal and non-Assamese participating in it. The reaction to all this was the hugely violent attack and massacre of over 2000 Bengali Muslims by an indigenous group called the Lalungs (Tiwas) in Nellie (45 kms from Guwahati). Slowly, the support for the movement started waning and Rajiv Gandhi as Prime Minister (following Indira Gandhi’s assassination) began an 18-month long dialogue with the AASU leaders. This led to the signing of the Assam Accord in 1985 and a new government made up of the ex-AASU leaders called Asom Gana Parishad came into power.

Even as the civil movement was going on, a group of Assamese youth in 1979 started a militant group called the ULFA (United Liberation Front of Assam) with an aim to establish a sovereign Assam through armed struggle. ULFA continued to rise as a militant organization rejecting the 1985 Assam Accord and the Government of India classified it as a terrorist organization in 1990. After two decades of violent terrorist activities which peaked in the mid-1990s, the level of violence has come down considerably. The major part of the group has signed a ceasefire agreement and has been undergoing protracted negotiations with the Government. But the years of militant violence badly affected governance of the state and retarded economic development.

In the eyes of Bodos (the largest tribal group in Assam), the Assam Movement turned from an anti-foreigner movement, which they initially supported, to one of “hegemonic
oppression” by the Assamese majority [Sanjib Baruah, 1999]38. This gave rise to the demand for Bodoland where the socio-cultural identity of the Bodos as a race would be protected and their economic and other interests promoted. The Bodo demand was followed by demands for autonomous councils among most of the other tribal communities of the state. That the Bodo movement also turned violently militant added to the state of conflict and fragility that existed in Assam for over two decades since the civil movement ended in 1985.

Socio-Political Changes and the Health System of Assam

Pre-Assam Movement Period: 1970s
In the 1960’s and early 70’s, the health system of Assam was gradually evolving. The three medical colleges and the district hospitals and associated nursing schools were producers of the major healthcare resources of the state. In 1975, the Medical Council of Assam had around 6000 registered medical practitioners but with just a handful of medical colleges in the State, another ten thousand practitioners were only added in 25 years. With few doctors from outside recruited to fill this gap, the demand-supply gap of trained doctors has remained huge, growing bigger in the subsequent years. Earlier, this gap had been filled with two other recognized types of formal medical practitioners in Assam, i.e. Ayurvedic doctors and the LMPs (Licensed Medical Practitioners)39. In fact in the 70’s, most of the recognized allopathic practitioners were LMP doctors but gradually, their numbers came down as the three medical colleges stopped training of such doctors with nothing else to close the demand-supply gap.

Then, the turmoil in Assam state started from 1979 with the Assam Agitation. While the agitation was at its peak in 1983, at the same time India sought to put the National Health Policy in place, trying to integrate all the services of the health systems and focus on a decentralized system with a participatory approach including involvement of civil society organizations and the private sector. Assam seems to have lost out on this health system development that was happening in the rest of India. With bridges burnt, roads blocked and though the health facilities were not specifically
targeted, the breakdown in law and order had an effect on health care services. However, despite this, the health system managed to have doctors recruited apart from increasing other health care personnel in the system. The nursing and other paramedics trainings were also working to churn out the paramedical workforce. The medicine dispenser appointed in the hospitals, erstwhile called compounders, were increasingly being replaced by trained pharmacists, after being awarded with diplomas from a pharmacy institute.

While a bit shaken, the public health system in Assam did not collapse during the Assam Agitation. In fact, it seemed to have recovered sufficiently to provide people with decent health services even in far-flung remote areas, such as in some of the health centres in the Bodo areas even till the start of the Bodoland Movement in the late 1980s. But with globalization, liberalization and privatization in the 1990s being the economic mantra, health spending in India fell sharply bringing down the quality of health care. For the state of Assam, the situation was more serious. With violent militancy ravaging the state, the public health governance weakened further and in many places, health centres collapsed completely and health indicators fell sharply. Even today, Assam reigns the highest in terms of maternal deaths in the country.

3.1.2 Conflict Timeline in Bodoland & Health System in the Study Area

In Chapter 2, we already looked in great depth at the socio-political history of conflict in Bodoland. In this section, we will focus on the intersection of politics and the health system in the area of study. Taking one case study of the Shantipur State Dispensary, which is in our study area, we will try to understand to what extent larger socio-political changes affect or do not affect health service delivery and systems in a conflict affected area. For this section of the study, we conducted many interviews and spoke to a range of people both within the health system and from outside of the system. We spoke to retired doctors who had served in the system earlier and to new doctors who have joined the system afresh. We also spoke to non-formal practitioners of medicine (pharmacists) regarding the health system and to men and women from the community about changes they have seen in the health system over time.
Mapping Health Centres in the Study Area

Six of the villages studied fall under the *Shantipur State Dispensary* (Shantipur SD) which is 14 kms from the border of Bhutan (Gelephu). One of the villages fall under the *Runikhata State Dispensary* (Runikhata SD) which is 18 kms from Shantipur. Both the government health centres cater to villages in a radius of 20-25 kms. The markets of Shantipur and Runikhata also have a number of ‘pharmacists’ (unqualified informal practitioners of allopathic medicines). Theses ‘pharmacists’ are also easily available in smaller market places and are the first care.

**Fig 3.1.2 Map of the Study Area showing State Health Facilities**

Referrals from the State Dispensaries (PHCs or the Primary Health Centres are called State Dispensaries in Assam) are usually to Bongaigaon Town or to Kokrajhar Town which has the Government ‘Civil Hospital’ with 200-bedded facilities. Shantipur SD to Bongaigaon is 40 kms (1.5 hours by road) and to Kokrajhar is 63 kms (around two hours by road). The next referral from the District Hospital to the State Capital, Guwahati. This is 180 kms from Bongaigaon (3.5 hours) and 230 kms (4.5 hours) from Kokrajhar.

In this study, we took the case of one State Dispensary (SD) called Shantipur which serves the study area to see if and how external socio-historical events affect the public health system. We interviewed doctors from across 25 years of history, some of whom had earlier served in this SD. Apart from doctors, we interviewed other health personnel of the health centre and also interviewed community leaders about the hospital over the years. With the data gathered from the interviews, we constructed a historical timeline of the health centre as given in Figure 3.1.2.
**Fig 3.1.2 Shantipur State Dispensary: A Historical Timeline**

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1972</td>
<td>Bodoland Movement (ABSU Andolan Phase I)</td>
</tr>
<tr>
<td>1970s-1980s</td>
<td>Part of a functional health system; no better or worse; part of Greater Goalpara District; regular review meetings in Dhubri both MBBS doctors &amp; also LMPs served here; home visits by doctors; home births in presence of doctors and nurses apart from other informal practitioners; preventive and promotive health activities were there</td>
</tr>
<tr>
<td>1989</td>
<td>Bodoland Autonomous Committee (BAC) Formed</td>
</tr>
<tr>
<td>1993</td>
<td>Armed Militant Violence starts</td>
</tr>
<tr>
<td>1993</td>
<td>Bengali Muslims thrown out of forest villages</td>
</tr>
<tr>
<td>1996</td>
<td>Bodo Adivasis Conflict - I Round</td>
</tr>
<tr>
<td>1998</td>
<td>Bodo Adivasis Conflict - II Round</td>
</tr>
<tr>
<td>2003</td>
<td>Bodo Accord signed - BTC Govt. Formed</td>
</tr>
<tr>
<td>2008</td>
<td>3 rounds of Bodo-Bengali Muslim Conflicts- 2008; 2012; 2014</td>
</tr>
<tr>
<td>2008</td>
<td>Pulse polio programme launched; personnel for that present</td>
</tr>
<tr>
<td>2008</td>
<td>People dependent on informal health practitioners; take treatment from government hospital in Bhutan border of Gelephu charged Rs.2</td>
</tr>
<tr>
<td>2008</td>
<td>Some patients visit Runikhat SD where a Dr. N a Bodo doctor remained till 1996</td>
</tr>
<tr>
<td>2008</td>
<td>Health centre not functional and hence no response during violence &amp; emergency</td>
</tr>
<tr>
<td>2008</td>
<td>Unable to take care of epidemics of cholera etc. in relief camps</td>
</tr>
<tr>
<td>2008</td>
<td>Health centre run by Chowkidar (watchman) who also worked as a private practitioner going for home visits and handling difficult deliveries in the homes</td>
</tr>
<tr>
<td>2008</td>
<td>Bhutan stops services to Indians as cannot handle the crowd</td>
</tr>
<tr>
<td>2008</td>
<td>International NGO MSF (Medicin Sans Frontier) provides free high quality malaria &amp; other treatment &amp; MCH services nearby in Runikhat SD and then Deosri from 2003 to 2007</td>
</tr>
<tr>
<td>2008</td>
<td>NNRM launched in 2007</td>
</tr>
<tr>
<td>2012</td>
<td>2016 one woman MBBS doctor joined; same day angry mobs attacked the health centre after a maternal death by a nurse; the doctor fled and left the government services</td>
</tr>
<tr>
<td>2012</td>
<td>Currently, only 1012 patients a day; for minor illnesses like fever, cough &amp; cold, and some normal deliveries</td>
</tr>
<tr>
<td>2014</td>
<td>In 2016–one woman MBBS doctor joined; same day angry mobs attacked the health centre after a maternal death by a nurse; the doctor fled and left the government services</td>
</tr>
<tr>
<td>2015</td>
<td>Health services during emergency done by external health teams</td>
</tr>
<tr>
<td>2016</td>
<td>2016-17</td>
</tr>
</tbody>
</table>
From Fig 3.1.2, we can draw some inferences regarding the Shantipur State Dispensary:

a. The Shantipur SD started in 1972 and was functioning just as well or badly as the rest of the health system in Assam.
b. It provided medical and other health services to the population around it.
c. Decline of health centres started with qualified non-Bodo doctors fleeing once conflict intensified in the 1990s.
d. Shantipur Health Centre has not recovered since then and is still largely non-functional. It could not even provide basic medical services in emergencies following the repeated conflicts of 1996, 1998, 2012, 2014.

Moving from the experience of this one health centre, let us try and see the larger picture about the health system. For ease of understanding, we have divided the information on the health system into three phases of Pre-Conflict, During Conflict and Post-Conflict.

1. Pre-Conflict Stage & the Health System

Being a part of undivided Assam, the public health system in the Bodoland areas was functional and comparable to most other parts of Assam till 1980s. There were even specialist doctors in rural PHCs such as Bhetagaon and Sidli in Chirang District. Many of the senior doctors we interviewed said they joined the medical services hoping to serve their fellow people, ignoring other career prospects which were easily available at that time.

We interviewed Dr. Sujit Daimary⁴⁰, a Bodo male doctor who worked in different government PHCs for many years and even served in Shantipur Dispensary for four years just prior to the conflict. He says “When I joined the government as a doctor, there were about 11 Dispensaries and 1 PHC in the Sidli Block which used to come under Kokrajhar district. All the PHCs were fully staffed with one MBBS Doctor, two nurses, one pharmacist and one Grade IV staff. The only thing we lacked were vehicles. Before the ABSU andolan, the health system was working quite well. The pay was comfortable, and once a month there was a

⁴⁰All names in this paper have been changed to protect identities of the respondents.
review meeting for all the doctors of the Sidli Block. It was very strict and all the MBBS doctors were expected to attend. There was regular provision of medicines to the hospitals and a truck used to come to Amteka once a month with supplies”.

He mentions the challenges as well and says “Medicine was always in short supply. Where a thousand tablets were required, only five hundred were provided. This could have been due to inability to procure medicines as much as mismanagement. Because of this shortage we had to “ration” the medicines by not prescribing the full course to the patients. In this way, by planning ahead, we could make their stock last a full month. In some ways we are the culprits in creating drug resistance in people”.

Not just the doctors and health personnel but community members also talk about the pre-movement days and how the andolan41 affected all public services in the area, not just of health.

“I was a boy in my middle school, I clearly remember there being a doctor and some nurses in the Shantipur hospital. I even used to see nurses in uniform moving around my village. The doctors and nurses did awareness on alcoholism, family planning like use of contraceptives and operation (sterilization). All these activities and services began to decline during the ABSU andolan. Some years after the andolan, doctors along with treatment facilities and other activities were all gone, neither in the hospital nor in the villages anymore. Most government services (not just health) drastically declined during the andolan” – Nobo Brahma, Bodo Male of around 45 years from Bordangi village; was part of the student’s union and is now a teacher in a government school.

The respondent goes on to describe how during the early days of the andolan which started in 1987 saw massive destruction in government owned infrastructure. “Many schools under Shantipur area were demolished or burnt down. Shantipur High School was burnt, Bordangi LP School was burnt, Simlabagan LP school was demolished. Electric wires were pulled down. Roads and bridges were bombarded. Forest offices were burnt down in several

41 That is what the movement of the Bodos for a separate political homeland is referred to; they also call it the ABSU Andolan since it was spear headed by the student’s union called All Bodo Student’s Union (ABSU).
places. In Bordangi, the forest office was totally burnt down to ashes. The period saw total boycott and destruction of government infrastructure and halted functioning market systems, hospitals and health centres”.

Calling the andolan a ‘mass movement’, Nobo Brahma says that all Bodos – both men and women – took part. He mentions that the non-Bodo government officials were attacked during that period and these attacks had ‘very bad consequences’. Non-tribal government officials used this ‘feeling of insecurity’ as an excuse to get transfers out of Bodo areas. He says Shantipur hospital did not have doctors for a period of 7-8 years after the andolan.

2. The Health System During Conflict

What happens to government health systems and services when violent conflict starts? Most of the health personnel we interviewed in our study had direct experience of conflict and we found that across age, across time and geography, they candidly shared their experiences with us.

Dr. Sujit Daimary, a Bodo doctor was posted at that time as the Medical Officer in Charge in a far-flung State Dispensary says “When the ABSU andolan started, the Amteka and Koila Moila hospitals were burnt and broken. This was done by the people themselves as they did not want the buildings to be used by the security forces as shelter. One paediatrician in Kokrajhar was killed after extortion demands were not fulfilled. Even though no other doctor had been threatened or attacked in any way, a lot of fear prevailed and the Assamese doctors all fled. Even though the Bodo doctors stayed back and gave service, that was not sufficient because most of the doctors at that time were Assamese.

After the violence started, electricity was cut-off (since the poles were destroyed) and I used to conduct deliveries with torchlight. There was no system for sterilization of syringes, except a stove on which water could be boiled. There was also no supply of bandages, or even anaesthesia. I remember one case during the Bodo-Muslim conflict in 1993, a man had been injured with a spade on his head. It was a deep gash and required stitches and I sutured him without any anaesthesia”.

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Interestingly, in the years of militancy and conflict, it was not just the non-Bodo health personnel who felt threatened but tribal Bodo doctors themselves did not seem to have had it any easier. From their interviews and long narrative accounts, it seems that the pressure was on local Bodo doctors was just as great, if not greater.

Dr Gopal Basumatary, a Bodo male doctor was serving as a senior doctor in the government health system at the height of the andolan. He says, “Violence took place in different areas of the district and the doctors stopped coming in. Most of those already posted in different hospitals, left. Only a handful of doctors whose homes were here, stayed back. I was one of them. The whole area was considered to be violence prone and all the public health programmes, including immunization suffered badly. Doctors, including myself were assaulted for trivial reasons, harassed by the public, the police as well as by the administration. They (militants) would come for treatment and we had to treat them. Once, fearing reprisal from the army and police (when forced to treat militants), I complained to my senior about this. This was a mistake and I was harassed a lot after that, even physically attacked. All kinds of false allegations were made against me and I suffered a lot. I regret my decision to be a doctor and serve my people in my own place. I could have done any advanced study in medicine and worked in any medical colleges. But I opted to use my knowledge in the areas where it is needed most, for which I had to repent at the end”.

This sense of pressure on local Bodo doctors was also echoed by Dr. Sujit Daimary who recounts, “In those days (of the disturbance) all of us were picked up at gunpoint and we had to go with them (militants) and treat them. I too was taken. When I applied for a passport about two years later, during police verification they showed a prescription of mine recovered from a guy (militant) and asked me what this was. I told them as many visit the hospital, how could I know if he is a militant or not. The police then asked if they came with guns. I said yes, at times they came with guns. They then asked me why I did not inform them. I replied ‘how could I inform as you (the police) won’t be giving me 24 hours protection. More over your tenure here is for three years only. What after that? I will be here for my whole life and these guys never forget. At least you guys question me, but those guys even don’t question, they just shoot”.

53
The health system following the conflict had collapsed to such an extent that they could not even respond to medical emergencies. In 1996 for instance, no medicines reached the relief camp for 5-6 months following the violence. Due to fear, doctors and other health personnel were hesitant to visit the relief camp. Adivasi respondents who lived in the camp at that time recall that the first medical aid to reach the Adivasi relief camp in Deosri was from Sidli health Centre (some 45 kms away), but they could manage to distribute only one or two tablets to an individual and never carried injections or offered good treatment. Some NGOs also delayed and stepped in 7-8 months after the 1996 conflict. But even they could not do much and most of the health issues remained untouched and unaddressed for a long period of time. The period from 1996-2001 records the highest number of deaths from the relief camp. It is also between these years when cholera broke out resulting in seven to ten deaths in a single day. Medicin Sans Frontier (MSF), an international humanitarian agency working for health care in conflict areas came to address the unattended health crisis in the year 2002. They worked for six years in the conflict affected areas till 2007.

Post-Conflict Phase & the Health System

Though the NRHM (National Rural Health Mission) had already been launched before MSF left the area in 2007, it remained unpopular for long. This was largely because of the crisis with health personnel which remained though there was huge improvement in the collapsed physical infrastructure. Most of the rural hospitals in the research area are even today manned by ayurvedic doctors who have been trained in the traditional Indian system of herbal medicines but are forced to prescribe allopathic drugs in the government hospitals. To deal with the huge shortage of doctors, Assam even experimented with placing a cadre of Rural Health Practitioners42 in the health centres. The hurried decision and implementation, combined with strong opposition of the medical fraternity has created a parallel group of practitioners without recognition from any medical body and with an uncertain future. Naveen Basumatary, an ex-NRHM District Programme Manager was sceptical about the quality of the services offered by these rural practitioners and says, “It is not easy to say

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42The Assam legislature enacted an act by which Rural Health Practitioners (RHPs) were introduced in Assam in 2004 to fill the gap of trained doctors in rural areas. These practitioners were trained for 3 years in the Medical College, Jorhat with the aim to serve the rural areas and then employed by the NRHM on a contractual basis. There are more than 1000 such practitioners in different corners of the state.
whether their (RHPs) presence had helped the system or not. They are almost doing everything, either being compelled or even voluntarily, including private practice, which goes against the law. I feel it is unconstitutional to create separate practitioners to serve separate regions. The government should have rather created a sense of security and safety among the medical fraternity so that more qualified people are willing to come and work in such (disturbed) areas.”

Through our interviews, we find that two prominent and related factors impeding the recovery of the public health system in the study area:

a. Unpopularity of Government Health Centres

Whether it is the Adivasis or the Bodos or Nepalis, the government health centre is not very popular among the people and is not seen to be of much use in its current state. This is clear from various interviews. An Adivasi woman from Mohanpur village in Deosri says, “We need to pay both in our local pharmacies and in the government hospital. But in the local pharmacies, we can get credit. Moreover, they are well behaved and nice to us. Most importantly, they are available for us round the clock, unlike in hospitals where the staff have fixed duty hours.”

This feeling is echoed in group interviews carried out with a group of Adivasi women from Deosri 3 No. village. When asked when they visit the government hospital in Shantipur they said, “For small, small things like cold, cough and small fever of children (we go to hospital). Or if we have no money, we go there. If we go for malaria, they will take blood and then say ‘come tomorrow, come day-after, no medicine etc’. So, we prefer the pharmacy in Shantipur. Nine out of ten women now take to the (government) hospital in Shantipur for delivery. They charge ‘lump-sum’ Rs.500-Rs.800 for normal delivery”.

Sanjay Hembrom, an Adivasi leader of the Deosri Relief Camp said this about the present health facilities, “the first stop for treatment is the Shantipur hospital but there are no medicines available there. The doctor writes the names of the medicines on a slip and they have to be bought at the pharmacy. Those who cannot afford to buy a whole course of medicines buy as many as they can. If this partial course cures them, well and good, else too
bad. Presently, apart from malaria, there is TB, a kind-of swelling in the throat etc. There is no treatment available here, so people go to private hospitals in Bongaigaon. However, most of our people cannot afford check-ups in Bongaigaon”

Currently, not just the Adivasis but the Bodos also prefer government health facilities as is explained by Dr. Sujit Daimary, “Nowadays the Bodos do not visit government doctors very much. This could either be due to affluence, since they can all afford private doctors now, or due to a lack of confidence in the government health system. Each CHC (Community Health Centre) should have at least 7-10 doctors, including specialists, but where are the doctors? Doctors are unwilling to come to BTAD. Even though there is no violence here right now, and there is electricity, there are roads and there are even mobile phones for communication, yet there is an idea of this being a violent place that scares outsiders from coming here. Moreover, there is no social life, and very poor educational facilities for their children”.

b. Paucity of quality & qualified health personnel in conflict areas

With young doctors graduating from medical colleges unwilling to join government services, there is already a shortage of doctors in the public health system of Assam. Add to that a negative perception associated with areas which have experienced conflicts in the past, and the shortage becomes a crisis. Dr. Nath is a senior doctor working in neighbouring Kokrajhar Civil Hospital doubts whether the gap in health personnel can ever be filled, “786 posts of doctors were advertised in the year 2016. But there were fewer applicants than the available posts and even fewer joining in Districts like Kokrajhar and Chirang districts. Only contractual doctors working under NHM would join their posts in such areas”.

Negative perception (may not even be based on facts) regarding the ‘dangerous area’ of Bodoland being a threat to life seems to be a big factor deterring health personnel from joining here. An interview with a fresh, non-Bodo MBBS doctor working in the Runikhata State Dispensary and his colleague, the pharmacist (also a non-Bodo from two districts away) throws light on this fear and apprehension.

JL’s field notes of 14th September 2016 records the interview with this doctor and his colleague.
“Sachit Das is a new MBBS doctor - a Bengali Hindu from Bongaigaon who after completing his medicine from Dibrugarh Medical College has been posted to Runikhata PHC the past 3 months or so. When he heard about his posting in Chirang, he was what he says ‘terrified’ and tried very hard to change his posting from Chirang. He tried all kinds of influence and pressure but could not get his posting changed. He didn’t know what to do and was ready to quit the government job than join in Bodoland ‘to be killed’. Then, a friend of his father gave him the name and phone number of one Bodo person in Runikhata. He felt much more confident and came to see the place. Then, he joined. It has been three months and he says he has had a most pleasant experience and is enjoying being part of this PHC. He has not had any problem and now feels that he was being scared unnecessarily. In his own words, ‘But then one hears so many stories about this place’. Of course, he still does only day duty leaving the night duty to another fellow Bengali pharmacist from Udalguri as he says that with one doctor it is impossible to serve for 24 hours. He emphasised the point that like him, most non-Bodo doctors and their families are petrified on hearing Bodoland and hence do not join. He got a chance to change his perception but others will not even join and so live with and spread the fear to others”.

This interview points out that the threat perception of the doctor is first and foremost, a perception. Like most perceptions, it can be corrected. It took a single contact with one local Bodo person to give confidence to a non-Bodo doctor to overcome his apprehensions and join the hospital. Hence, though the deep sense of fear among non-Bodos from outside the area is real, but it can also be countered. Weak governance in a conflict area and weak law and order encourages people to take law into their own hands. Health personnel also fear aggression and violence becoming standard responses to any incident or interpersonal conflict. This is highlighted in an interview with a non-Bodo man working as the pharmacist in the Runikhata State Dispensary (SD).

JL’s field notes of 14th September 2016: “Raju, the pharmacist at the SD says that as soon as night falls, he starts getting ‘fever’ out of fear as there is no problem during the day as people are well behaved. But as soon as the evening dawns, people start drinking and with that, the level of aggression increases. He claims that he has got threatened and almost
beaten up a couple of times. Even as we were speaking he was also busy getting his applications and documents ready to get posted out of this area. Earlier, he was posted in Amteka State Dispensary and insisted that ‘it was much, much better’. I was rather surprised as Amteka was an exclusive Bodo area which was much more remote than his current posting of Runikhata (next to the busy main road with a diversity of communities). His main reason for finding Amteka ‘safer’ and easier to be in, was that the ABSU (All Bodo Students Union – an influential community based organisation) was close by to keep ‘an eye on things’ and trouble shooting. He also said that the Hospital Management Committee was very active and interested. There, the ABSU and management committee helped take care of issues of ‘daadagiri’ (bullying) but here he felt unsafe as the local people takes no interest in the management of the hospital and they are left to fend on their own”.

The interviews with non-Bodo health personnel serving in remote health centres in conflict zones point out to the crucial role played by local community organisations and local people in dispelling fear and instilling confidence to stay on to serve. Interestingly, it is not just the non-Bodos but also Bodo health personnel who claim they have been victimised by the situation of violence.

We interviewed a Bodo pharmacist working in another health centre from outside the study area but also in the District of Chirang. He also pointed out that the biggest deterrent for the doctors (to join here) is fear about their safety. He says “One of our doctors who served well for many years here was threatened by the militants for not paying their demand. At one time, only the two of us were running the hospital and serving the area, sometimes even beyond our capacities as a doctor and pharmacist. We had to give them the ‘demand money’ as we have been threatened that they might lift our children or other family members. We were not afraid of them, but worried about our families. One day, they went to my child’s school, took him aside and made him to talk to me from their phone. This scared me a lot and there was practically no one to stand beside me. The authority and police are useless to us during such crisis. In fact, they harass us when we give treatment to the militants but we are just doing our duty. I had to hand over all my savings to the militants but that was not all, I was also almost beaten to death. I had serious injuries all over the body, including the neck. All this gave me tremendous mental shock and I had to
take treatment from a psychiatrist in Guwahati. I am from this small town itself yet I was tortured. The doctor serving here is from outside and so naturally, he left”.

These interviews give deep insights into the minds of health personnel serving in conflict areas and how some of their negative perception, fears and apprehensions could be possibly dealt with. Both the factors are closely interlinked i.e. people do not use the public health system because of the poor quality and the quality is poor because of lack of health personnel. And solving the root of the problem would also involve dealing with the fear and the negative perceptions health personnel have about the area and making it attractive for them to join.

Summary

There was a functional public health system in place in Assam in the 1970s and 1980s. The Assam Agitation of 1980-1985 was comparatively short-lived and while it was serious enough to disrupt governance of various systems including the health care system, but it did not derail it. The evidence of this is in the fact that before the Bodo Movement of 1990, there was a working health system in place. There were qualified MBBS doctors and a full team of support staff present in the health centres and people of every community used the services at the health centres. Though there were challenges like shortage of medicines and lack of vehicles, the health system was functional, even reaching out with community programmes right down to the villages.

Clearly with conflict, the health system in Bodoland (of which the study area Deosri is a part of) did show a sharp decline. As the movement got violent, public infrastructure, including health centres, schools, electricity, roads and bridges were destroyed to keep the security forces at bay. When militancy followed soon after, non-tribal doctors fled leaving only a few Bodo doctors to manage the health centres. The Bodo doctors who stayed back also did not have it easy in an insecure atmosphere – sandwiched as they were between the militants and the security forces hunting the militants. This was also the period of economic liberalization of the India in the 1990’s when government spending on the social sector including health decreased substantially affecting health services across the country. In
Bodoland, the rise of violent militancy interspersed with waves of ethnic conflicts during that same decade further sounded the death knell of health. It collapsed so badly that the health centres could not even respond to emergencies and epidemics following ethnic conflicts.

Humanitarian non-government organisations like MSF filled a bit of the void of a collapsed public health system in our study area. They gave medical relief to large numbers of completely impoverished conflict affected people in the relief camps and surrounding areas. But when they left in 2007, the high quality of care they provided could not be sustained by a collapsed health system which was just starting to rise with the launch of NRHM in 2005. People suffered greatly again after that.

Physical infrastructure such as buildings and equipment along with some lower level health personnel improved greatly in the health centres after the NRHM came in. But the health centres in the conflict affected areas never got qualified doctors to provide quality services. The negative perceptions about lawlessness and lack of security have sustained long after the conflict and discouraged health personnel from other parts of Assam from serving here in the conflict affected BTAD areas. Some health centers function but with inexperienced part-time doctors (fresh MBBS doctors forced to serve a one year rural posting to qualify for post-graduate studies) or semi-qualified (the 3 year trained Rural Health Practitioners) or even wrongly qualified (like ayurvedic doctors forced to practice allopathic medicine). This has caused people to lose faith on the government health system and is an unpopular choice for treatment. An unresponsive public health system is a catastrophe for families completely impoverished by conflict.

In a conflict-affected area, apart from strong political will backed by resources to get the public health system back on track, we also need a strong civil society to counter the negative perceptions regarding lawlessness and insecurity. Civil society need to proactively reach out to medical students in medical colleges across Assam with positive and reassuring messages, student’s unions, women’s groups, NGOs, intellectuals and community leaders etc. will need to be involved in managing the health centres and keeping it safe and free from violence. A proactive approach needs to be adopted if we are to get back on track a health system derailed by two decades of conflict and fragility.
3.2 Health & Well-being of Conflict Affected Communities

In an area of conflict and fragility, where socio-economic development is severely marred by violence, people tend to lead vulnerable lives. But what happens to their health and well-being when they are affected by repeated bouts of conflict in a highly militarised area? What happens to families when they are forcibly displaced from their homes and have to live in relief camps? How do they cope with the multiple losses and the upheaval in their lives? What happens when they return to their homes? Pedersen in 1996 coined a term called ‘new disease ecology’ which is supposed to arise after a conflict from ‘breakdown of the social fabric, family loss and disruption of daily life, lack of shelter and food shortages, the dismantling of basic services and destruction of the local infrastructure all contribute to extreme forms of suffering and disability’. Duncan explains how this ‘new disease ecology’ has led to countries seeing the ‘re-emergence of infectious diseases and unexpected disease outbreaks i.e. cholera, tuberculosis, malaria, diphtheria, plague, etc.), the emergence of new epidemics i.e., HIV-AIDS, Ebola, Lassa fever, etc. increasing malnutrition and poor health outcomes, and towering rates of mental-illness and behaviour-related conditions. He quotes researchers Desjarlais, Eisenberg, Good, & Kleinman,1995 as also having said this.

In this chapter we try to understand this ‘new disease ecology’, by focussing on unravelling the deep conflict experience in the different ethnic communities of Bodos and Adivasis from 6 villages in the study area. We also try to understand if and how conflict causes vulnerabilities in groups with special needs like pregnant women, single women, young children, adolescent girls etc. This chapter deals with second question of our research, namely:

How does conflict affect health of different ethnic groups differentially? How do critical social determinants such as loss of livelihoods, land, housing, culture, safety & security, community mediate to create ill health?

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Duncan Pedersen, Political violence, ethnic conflict, and contemporary wars: broad implications for health and social well-being; Social Science & Medicine 55 (2002) 175–190
From understanding the experiences deeply, we hope to know what kinds of interventions and support might be required to help families cope and recover from the upheavals caused by conflicts in their lives and remain healthy.

4.2 a. Description of the Study Area
The study areas include Deosri, Koraibari, Mohanpur, North Simlaguri, Bhurpar Balabari and Kusumdisa. These villages are under Sidli block of Chirang district.
Shantipur is a hub for the people living in this area. All the wingers and autos coming from Dadgari and going up to Bongaigaon park here. It is also a hub for institutions like the Government High School where high school children from all the nearby villages study and the All Bodo Students Union (ABSU), and important services like Police Station, State Bank of India Customer Service Point and the State Dispensary. People from Dadgari (border of Bhutan) onwards come for treatment here as it is the first available government facility in the area.

At the State Dispensary, there is one Ayurvedic Doctor who resides in the quarter and is available for treating people.

Shantipur is also one of the biggest markets in this entire area. The market is open daily but the big weekly market is open on Saturday. On Saturday, this market is vibrant with people, vehicles, buyers and sellers as people from all the villages including some distant villages come here. From vegetables, fruits, clothes, shoes, meat, spices, utensils, crafts and medicines, vendors peddle their wares in the weekly market. A range of medicine sellers also peddle their wares - ranging from the ones announcing illnesses and their cures on loud
speakers and attracting customers with colourful banners to ones selling herbal medicines quietly in a corner to those selling modern allopathic pills in the hot sun, on the floor side by side fruit and vegetable vendors.

(L-R) The bridge over the Nijlaguri River goes via Deosri area up to Bhutan gate and the river remains dry on days when there is no rain.

Fig 3.2.3 Displacement Map of the Study Area
The figure above i.e. 3.2.1 show population shifts and upheavals caused by displacement following conflicts. Some of the IDPs travel long distances and after moving from camp to camp, choose to settle down in relief camps and later, in villages far away from their site of displacement. Though some have been able to go back to their original village, many of the displaced families have not been able to return as their lands have now been occupied by the so called ‘enemy’ community and they fear reprisal.

Brief Description of the Study Villages

1. **Deosri RC (Relief Camp)** is one of the relief camps that hosted a huge number of Internally Displaced Persons (IDPs) during the 1996 and 1998 conflict between Bodos and Adivasis. The people who were living in the Deosri relief camps were Adivasis who fled from villages such as Amteka, Baghmara, Shantipur, Nakedara, etc. They fled to Deosri since it had a paramilitary troupe posted and people felt they would be safe there. Called Deosri RC (Relief Camp), most of the 5000 odd original camp inmates moved away in 2006 (after 10 years in the camp) when they got some Rs.10,000 as ‘resettlement’ money. These families have now settled in forests from where they were displaced or in fresh areas. Today, Deosri RC with 46 families living in mud huts looks more like a settled Adivasi village than a relief camp. None of these 46 households have access to toilets, bathrooms, wells and handpumps. Their source of water is the Nijula River flowing nearby. Children attend the Primary School located in Mohanpur and the nearest Health Center is Shantipur State Dispensary, 3.5 Kms away.

2. **Mohanpur Village**: In the year 2005-06, rations were stopped and the IDPs were asked to leave the Deosri RC. Many of the families could not go back to their original place of displacement due to lack of security and so, they moved to village next to the Deosri RC i.e. Mohanpur. There are 127 households with a population of 627 persons in Mohanpur. There is a Lower Primary School inside the village where children from the Deosiri Relief Camp village also come. Water is a In Mohanpur there 10 households with wells and 13 households with handpumps. The nearest health center for them is the Shantipur State Dispensary which is 4 kms away.
3. **Koraibari Village**: Many of the displaced Adivasis living in Deosri RC went back to Koraibari where they were originally from while some others cleared the forest for land. Located 8 kms from Deosri market, there are 160 households with 698 members. Located deep inside the forest, there are only mud paths that lead to Koraibari village. The distance from Koraibari to Shantipur State Dispensary is 12 kms and for small illnesses, patients are taken to the nearest pharmacy at Phulbari village, some four-five kms approximately.

There are no schools, markets or even electricity in Koraibari and people either walk or cycle to Deosri for purchases and other work. Water is a crisis here and the entire 160 households share three wells and a couple of handpumps for drinking water. There is a learning centre for primary school children run by the ant in the village. For schooling beyond Class 5, children must travel a long distance to Deosri or Shantipur and hence, there are many drop-outs in the village.

(top) A house in Koraibari in the middle of the forest and (left) children gathered in front of a school run by the ant, the NGO conducting this study

4. **North Simlaguri** is a Bodo village 11 kms from Shantipur. It is a forest area where the IDPs from the 2014 conflict between the Bodos and Adivasis were relocated after leaving the relief camp. To go to North Simlaguri, one has to take an auto halfway and then people will have to go walking from there to reach their village. There is no electricity in the village because it is in the forest areas.
5. **Kusumdisa No. 2** is a Bodo village with 77 households. The first settlement in the area date back to 1984, 12 years before the first Adivasi-Bodo conflict of 1996. Sameer Boro and his family along with five other families were amongst the first settlers in the village. They migrated in search of land and opportunities to make ends meet. The families of the village are located on either side of the village road which runs north and south extending a distance of nearly 3 Km. Towards the South there is the village called Odalguri, the northern (the Bhutan Hills) and western sides are thick forest which they locally call Kusumdisa 2 No. Forest, and Kusumdisa No.1 serves as the boundary towards the southeast. The land of the village is demarcated into 55 blocks belonging to 55 families from the village. Each family in the village occupies more than 15 bighas$^{44}$ (5 acres) of land. Other families in the village are supposed to be the sons who have moved out of the parent’s home after marriage.

6. **Bhurpar Balabari Village** is across the river Bhur and hence got its name from the river ‘Bhur’ and Balabari means ‘a barren sandy land unfit for irrigation’. It was only in the year 2000 the people started building their homes in the village. The families that are settled here were the displaced populations from the 1996-98 Adivasis and Bodo conflict. These families were informed by the government authorities that compensation would come in cash only if they vacate the market areas. They were thus forced to settle the in lands that were actually prone to soil erosion. After moving out from the relief camps, they were given the compensation amounting to Rs. 10,000 and forced to purchase tin for their roofs from that money. There are 45 families in the village and many of them have to occupy forest lands for irrigation. The nearest market and State Dispensary is Runikatha.

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$^{44}$ Bigha is a measurement of land in Assam with a bigha being around 14,400 square feet i.e. 120 X 120 feet of land or 3.02 bighas of land making up for an acre i.e. 43,560 sq feet.
3.2 b. Effects of Conflict on Health & Well Being

The poor and the marginalised who lead fragile and vulnerable lives get further pushed to the edge after an episode of conflict. For such households, their health, well-being and development get highly compromised as life after a conflict becomes an intense struggle to merely survive. In this chapter, we focus on the health and well-being of those who have experienced conflict – especially those who have been forcibly displaced from their homes.

3.2.1 Fleeing, Forced Displacement & Health in Relief Camps

Our interviews spanned across 6 villages of displaced populations of Adivasis and Bodos. For some of the affected families, this is their third forced displacement in a span of two decades and in this section, we look at suffering from their eyes of those as well as those who have experienced displacement afresh in 2014.

a. Fleeing - the first big disruption

“We returned from the Relief Camp after the 1996 conflict and started living in the village again. But in 1998, there were floods. I was pregnant with my third child and about to deliver any moment. The flood water washed away our grains and some small belongings and our house was about to be washed away. A relative seeing my condition asked us to shift to a safer place. But I was reluctant. Where to go? Also, I was scared there would be elephants in the night. We waited but the flood waters kept rising and the next day my husband moved me and my elder daughter (the second daughter had fallen sick and died after we came back from the relief camp) to a place he found.

It was a house abandoned by the Adivasis from the 1996 conflict. We called our neighbours to help us repair the house which was damaged but still standing. I had made jou (rice wine) in preparation for the birth of the child, and with this we called people to help us repair the house. They cut some fresh thuri (thatch) and fixed the roof. That very night, I delivered my third child, a girl. The Bodo-Santhal conflict had already started again and a day or two later, we had to flee to Tukrajhar Relief Camp. The umbilical code of the new born baby had not

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All names in this report have been changed to protect the identities of the respondents.
yet fallen. I carried her tied on my back with a *gamcha* (woven cloth) and walked all the way to Tukrajhar Relief Camp along with the other villagers”.

- **Anjali Moshahary, Bodo woman in her 40’s living in Burpar Balabari, was displaced in 1996 & 1998 conflicts and did not return to her original village**

“The violence in our village was not intense, so we could flee with our cattle and other essential items. We were the only Bodo family in that part of the village. Our neighbours were all Santals and Rabhas. The people of the village asked us to move out from the house. They painted a scary picture of us possibly getting attacked in the night. So, we fled. We carried whatever we could by loading it on the cycle. We buried some under the soil. The other remaining items were all lost. We had bought some costly wood to make a bed, even that was stolen. They even pulled down our house after looting it. I suspect the Rabhas of stealing our things because they did not flee their homes. The Santhals had all fled and were not even there”.

- **Tara Daimary, Bodo woman, fled the 1996 and 1998 violence, lived in a number of Relief Camps before settling down in Bhurpar Balabari**

“This time (during the 2014), our houses were burnt and we did not carry anything with us. Our *dhaan* (paddy) was also burnt. Our cows, goat and clothes were all left behind. We could not take anything with us. We walked for 3 hours to Deosri. We were very scared when we were moving because we were not sure where the militants were waiting (to kill us). There was no army for protection at that time. When we were in the relief camp, the condition was bad. Rice was very less. The place was dirty and there was smell. There were illnesses all around and going to the doctor was also difficult. We were in the Relief Camp for 6 months this time”.

- **Pratima Murmu; Adivasi woman of around 45 years old; was displaced in 1996 and again in 2014; she lives in Koraibari village**
The voices of the three women respondents, both Bodos and Adivasis, during fleeing gives a sense of intense fear, insecurity, suffering and loss that families suffer when they lose their homes and lives they were used to. When the loss is sudden and completely unexpected, it is a shock for which the families are unprepared. Interviews with both Bodo and Adivasi respondents point out clearly that there was a close social relationship between the two communities prior to the conflicts. Many respondents say that either they got pre-warnings from “friends from the other side” regarding impending attacks or sometimes, even shelter from the opposite side.

“Our family were informed by some Bodos we knew well that ‘some trouble’ is going to break out. ‘You people had better be prepared’, we were told. So, we quickly managed to sell off most of our buffaloes at throwaway prices. We sold a buffalo costing 8-10 thousand for as little as 3000 rupees. But with that money, we managed to buy food the first few months and were better off than others”
- Raman Hasda, Adivasi male of 35 years, currently works as a community organiser with an NGO

“In 2014, it was Winter and we went to cut paddy in the Bodo village and the Bodos there told us not to come back this side because there would be some problem. That some people might come and cut us (the Santhals) up and so, we should stay back in our own village and be alert. So, we came back to the village and we were alert. But we saw the NDFB (Bodo militant group) burning up houses and so we started fleeing through the forest. We were very scared and kept running and did not take anything with us. We threw all our utensils in the jungle”. - Adivasi woman living in Koraibari; she is the village headman’s wife; we found her to be inebriated at 3 p.m. in the afternoon.

Not just the Adivasis, but the Bodos also had also had stories of their close relationship with the other side. That they were completely unprepared is again clear from this account by a Bodo couple now living in Bhurpar Balabari.

Sanjib & Nili’s Story – were displaced from Deosri in 1996; they went back but were again displaced in 1998 and did not go back to their original village.
Sanjib: “I came to Deosri in 1994 just after the Bodo-Bengali Muslim conflict from a village called Patabari which was in the middle of the river. When we moved from Patabari we carried 6 bullock carts of paddy so that the family could eat till the next harvest season. I bought four bighas\textsuperscript{46} of land from a Santhali and another seven bighas from someone else for paddy cultivation. The Santhali from whom I purchased the land was left with no more land and so I asked him to keep living on the land. He worked in my fields and we had such a close relationship that the old man used to call my wife his daughter and address me as his son-in-law.

I also used to go to Bhutan for daily wage labour and one day while returning from there after work, I was told that the Southal Daourou (Santhal attack) had started. On reaching home I first went to check on my Santhal neighbours and was surprised to find their houses empty. They had all fled even before informing our family. We passed that night in complete fear wondering if we would be attacked. Early morning while I was defecating near the river, I suddenly saw huge numbers of Santhals fleeing towards Deosri. The women carried children and bundles of clothes on their backs and the men were pushing bicycles loaded with their things. They were trying to climb the high river bank to reach the Deosri BSF camp which they believed was the safest place for them.

I helped them push their bicycles over the top of the river bank and none of them said a single word when I asked them why they were fleeing. Finally, one familiar face told me that the NDFB militants had burnt their houses and forced them to flee. After all this, I came back home feeling very insecure. I was sure that it was also time for us to prepare to leave the village. I started to first take our paddy to the house of a Nepali neighbour and also started loading some of our household things onto the bullock-cart.

In the middle of all this, the old Santhal man came and told me that we should also run away as their (Santhral) youth have decided to fight back and it would not be possible for the Bodos to stay any longer in the village. After some time, some known Cobras (Adivasi

\textsuperscript{46} In Assam, roughly 3 bighas of land is equal to 1 acre
militants) came to me and asked me to flee. They used to regularly come and drink in our house and we had good relations with them and so they warned me that their people were preparing to attack the Bodos and if we didn’t leave immediately we would be in danger. Since lunch was ready, we decided to first eat. We had just finished eating when a large number of Santhali carrying bow and arrow, knives and spears came and encircled our house.

We fled. I got the servant to avoid the road and lead the bullock-cart through the maize fields. I started to push the loaded bicycle. We met a widow crying trying to carry a big wooden box filled with the dokhonas (traditional dress worn by Bodo women) for her son’s bride-to-be. I broke open the lock and bundled all the dokonas together and loaded it on my bicycle. The Santhals kept shouting at us to leave the place immediately.

I sent away my wife and children along with the others through the river Aie to reach Tukrajhar. My wife tied one son on her back and the other infant on her chest and made the eldest daughter walk. It was dangerous but I stayed back because of the cows which I had left to graze in my Nepali neighbour’s field. After few days, I joined my family in the Tukrajhar Relief Camp. It was so difficult. We had no money and there was no work. I would catch some fish and sell. We spent six months in the Tukrajhar relief camp where my son fell severely ill. Luckily the mission hospital doctor there somehow saved my son.

The administration brought us Bodos back to Deosri where another relief camp was set up. And when the situation improved, we returned to our houses. I had asked one Nepali family to look after our paddy when we fled six months ago. But I got back only one sack of paddy. Rest they ate up.

In 1998 the conflict broke out again. It was very dangerous and we were stuck. The Santhals blocked the road and checked every single vehicle to find and kill Bodos. None of us had money and I only had three rupees in my pocket. I bought paper for one rupee and taking someone’s help, wrote a letter asking the Runikhata Police station and also the ABSU (All Bodo Students Union) to help us. A minibus driver helped carry the letter to them and we were saved.
Escorted by the army, the ABSU boys arrived in Deosri and our villagers were taken in vehicles to Runikatha relief camp. Again, I sent my family ahead while I stayed back to try and protect our village with some other men. But that afternoon I was caught by the army. I was carrying a torch light and wearing a red t-shirt and they suspected me to be a militant causing trouble in the area. They brought me in a jeep along with another friend of mine who was also arrested. Inside the jeep we also discovered a dead body lying in a pool of blood. We recognised the dead body as *pagla* (lunatic) from Laokriguri village. That night I was kept in the army camp and the next day I was taken to the Runikatha police station and then I was sent to Kokrajhar jail”.

**Nili – Sanjib’s wife**

My son kept crying and I was irritated. I did not know that my husband was caught by the army and taken away and perhaps the boy was missing him and crying for him. It was so difficult getting my husband out of jail. My father-in-law made me sell two big oxen for very little money - in that also I got cheated and I was paid even lesser than the agreed amount. To go and see my husband in the jail, I sold three *dokhonas* (traditional clothes worn by Bodo women). Seeing my condition, my in-laws took my children and me in to live with them.

But I had no money and would force the children to walk through paddy fields avoiding the road which went through the market as we had no money to buy anything. My husband used to make fishing nets and there were still some nets which I sold for 20-30 rupees. Since the Bodos could not go to the market in Shantipur, they came and purchased the net from me in the house. With that, they would catch fish and sell.

I took help from one Bodo employee of the Foreigners Check Post in Deosri to get my husband out of jail. The people of that office were very good. They used to hide a lot of Bodos trying to flee from the Santhals. It was not easy (getting my husband out) and took a long time. I had to hide and go through paddy fields to reach this office and get help to write letters and petition for getting my husband out of jail. I even borrowed money from them for this.
One hot day, something seemed to have frightened my baby daughter and she would not stop crying. She kept getting worse, but we had no money and the roads were also not safe to take her to a doctor. So, my mother-in-law took her to an ojha (medicine man) and he advised the child to be given some herb called *jaku muli* which stops the child from crying. I had to carry the child on my back the many trips I made to get my husband released. To keep the child calm, I would carry that herb, mix it with river water and feed the child. I must have over-fed the child this medicine because she became ‘dumb’ and could never talk.

After my husband’s release, we came to live in the Runikatha Relief Camp with the other villagers from our place. From here we moved to Bhurpar Balabari where we bought a small piece of land with the Rs.10,000 we got as compensation. We do not have any relatives. In this new village, we lived together with the people around as our own people. Now I feel anyone in this village is my brother, my sister, my mother and father. We have been living as a family since the days in the relief camp”.

These long narratives of this Bodo couple (Sanjib and Nili) gives us deep insights into the sufferings that the poor undergo following routine violence and conflicts in their lives. Their struggles do not end when the violent episode is over but even 20 years later, they are still coping with the effects of the conflict. Whether it is Bodo or it is Advasi, both seem to have been caught by surprise and it is uncanny how similar the narratives of loss and suffering during a conflict are.

“I am from Kusumdisa... its far from here. We were surrounded by Bodos... with all kinds of weapons, khukris and swords and what not. All were shouting “joi, joi, joi”... Both my father-in-law and mother-in-law were drunk that time. My daughter was just an infant and my mother-in-law took her along with her searching for more liquor from a Bodo village. I ran to search for them and bring them back. One of the Bodo women give the old lady a half
b. Survival and coping with diseases in Relief Camps

- The newly displaced must learn new skills and learn it quickly enough to survive the harsh relief camp conditions.

- Relief camps inmates especially in the older conflicts of 1996 & 1998 were largely left to their own devices to survive or perish.
- **Bodos are better organised and get more support from their community based organisations during the emergency. But like Adivasis, they are also left to recover on their own after the emergency and remain at high risk of ill-health.**

Already 60 years old when he went to live in Deosri Camp in 1996, Dinesh Soren remembers it being nothing like he was ever used to. “All of us are village people and we had never lived so packed together with no space. We could not breathe. We could not eat because of the smell. Where would so many people go? Day time you can go and shit in the open but what about children in the night? Same place we live, cook, shit. The smell was so terrible”. He then said that with rains, the dirt would get mixed with the water and that is when people would fall sick and die. “So many people died. Children, men, women…. 4-5 dead bodies were buried every single day but unlike now where we know (how) to do things, no records were kept at that time”. He estimates at least 1500 people would have died. But not all died of dysentery. “Some people died of having no food”.

- **Dinesh Soren, Adivasi male of 79 years; lives in Koraibari; displaced in conflicts of 1996 and 2014**

“We had no food to eat the first 2-3 days in the camp. In our hunger, we used to look up at the sky – as if the birds above would drop us some food. Food was the biggest problem and there were always fights for food. We survived with kochu (yam) and titha aaloo (bitter potatoes from the jungle). We were scared as it was dangerous going to the jungle too (as there were militants with guns). But what to do? We needed firewood to cook. Children were small. They would cry with hunger. So, we had no choice but go to jungles and riverside near the relief camp…. Even if there was work, it was difficult to go out and work as (we were) so scared”.

- **Women of 3 No. Deosri Village who were forcibly displaced from their homes in the 1996 conflict and many of them lived in the relief camp for over 10 years**
“Some of our family members were a bit smart and knew a bit about ‘the ways of the world’ and so, they chose to live at a higher point right at the edge of the relief camp next to the river. They got some breeze and so, they escaped the stench and the terrible crowding and did not fall sick as much as the others. Only two of our people died of the dysentery but from those living in the midst of the camp, many more died. No one kept records during that time. We did not know how. But nowadays we have leaders and they know how (to keep records)” – Raman Hasda, Adivasi male of 35 years, currently works as a community organiser with an NGO.

Though the Bodos are better organised and get more support from their community based organisations during the emergency. But in our study we find that post the emergency, they are also left to recover on their own and remain at high risk of ill-health.

“When the conflict broke out, the ABSU (The All Bodo Student’s Union) pulled in resources like food and cloth from the Bodo villages which were not affected. They also fed the people in the relief camp and this continued till the ration supplies from the government started coming in. Then, the ABSU also negotiated with the government for security and protection of Bodos, right up to the DC (Deputy Commissioner) level.

Unlike the Bodo relief camps, the Adivasi relief camps were very disorganised. But then, they have always lived like this in an unhygienic and disorganised manner. The Adivasis from the northern side - towards Deosri are also the most uneducated. Even today it is very hard to find an Adivasi graduate person. Without education, one will always lack health and hygiene. Even today, it is this class which is at the bottom of economic development. No doubt they suffered the most losses during the conflict” – Bodo; male; member of Shantipur VCDC
Deadly killers of Children

In a group interview we did with Adivasi women in 3 No. Deosri who had lived in the Deosri relief camp for many years, we came across a number of women whose children had died. 7 out of 10 women who gave birth said that they have lost children. These 10 women had given birth to 41 children, of which only 27 survived and 14 children died. This was in stark contrast to a younger group of Adivasi women in Koraibari we interviewed. They were younger mothers and had not lived in relief camps for very long. Though almost all of them said they had given births at home and not in hospitals, still children have survived. Of the 12-15 women interviewed, only 3-4 said they had ever lost children. Thus, it seems that though conditions in the relief camps are ‘deadly’ for children – fevers, malaria, diarrhoea, pneumonia are killers for bodies already weak and vulnerable. In the relief camps, it seems that women already heavily undernourished, in great stress and receiving almost no care or treatment, find it difficult to ensure child survival and must cope with frequent and multiple child deaths.
A glimpse of Relief Camp life following the 2014 ethnic conflict between Bodos & Adivasis

Makeshift Shelters in Deosri

All the belongings of a displaced Adivasi family in Deosri camp

A Bodo couple displaced and living in tents in 2014

Clamouring for tarpaulin sheets from an NGO – to be used as shelter over their heads in the cold December of 2014

Relief Rice being distributed among the families who have taken shelter in the relief camp

Preparing food in the relief camp
c. **Post-Relief Camp: Health & well-being of conflict affected households**

i. **Complex interaction of Losses leads to Ill-Health & Poor Well-Being**

Does suffering end when the event of violence is over? What happens to families who are forcibly displaced once the violence stops? For how long and in what ways do they suffer? How does suffering affect their health and well-being?

In his section we see how forced displacement leads to a complex web of losses at multiple levels - physical, economic, social, psychological etc. The various losses – which are also critical social determinants of health - interact with one another in different ways that create ill health and retard development of already impoverished and fragile households. The vulnerability of displaced families is best captured in the story of this Bodo couple below who are still trying to piece together their lives after the Bodo-Adivasi conflict of 2014.

**Life Story of Mohan & Rupsi**

Mohan & Rupsi are a Bodo couple now living in North Simlaguri after being displaced in the recent 2014 Bodo-Adivasi conflict. They lost two of their young sons to illnesses after they were displaced and moved to settle in a forest area of North Simlaguri. This is a section from their life history to illustrate post-conflict vulnerabilities of a forcibly displaced family.

Though Mohan likes the new village, the main problem was lack of work and income opportunities. ‘Many of our villagers have migrated to different places for work but even over there, they face discrimination by the employers who often suspect them to be militants as they have no identity proof or other papers’. In this new place he has been allocated around 9 bighas (3 acres) of land, but he could not cultivate it since being jungle land, it has to first be cleaned and readied for cultivation using a tractor, something that he could not afford. So, though he gets only half the produce he had to give it away for share-cropping. Even building a small shelter was a problem “as the village is cut-off from other villages and not part of them (so no one comes to help). There are no work opportunities here. The Shantipur market is at a distance of more than 11 kms from this place. No four wheelers can come to this village and the one way for us to survive was to collect firewood
and sell it in Shantipur market.” Along with selling firewood, they also try to catch fish, dry it and sell it in Shanipur market. During agricultural seasons, they hope some daily wage labour will help ease the burden. Mohan before the conflict who used to drink once a week (with friends when he got his payment from Bhutan for labour work) now drinks every single day.

Figure 3.2.4 shows that the ecology of vulnerability which Mohan & Rupsi already existed in before the conflict is made that much more fragile after the conflict – one that impacts their bodies, the choices they can or cannot make, their health and well-being as a family. Before the conflict, their two sons were born in the government hospital which meant they had the money and agency to decide for what they saw as safer childbirth practices. It was after the conflict that their two young sons died because they could not afford good treatment. It was after the conflict that Rupsi had to send her two young daughters away to work as maidservants. It is ironic that by sending her second daughter, a 13 year old girl to work meant money for a safe childbirth for the mother but exposure of the daughter to risks of abuse and trafficking.
Hence, after the conflict, what become protective factors for health of the mother are negative risk factors of ill-health and ill-being for the daughter. JM, a researcher in this study was present on the day when the mahajan (rich owner) came to negotiate taking away the daughter to work in his house. JM’s field notes of 24/8/2016 say “the girl kept looking at me desperately hoping I would do something to prevent this. At one point she cried out ‘I don’t want to be a ruwanti (maidservant) anymore’. But the mother was desperate. The previous day, she had gone around the entire village asking for a loan to send her daughter to school but no one gave her a loan. Almost on the verge of giving birth to another child, she feels she cannot take the burden of her daughter’s schooling. Rupsi’s desperation is clear as she is sending her daughter away even after knowing how her neighbour’s 13-year daughter, also sent away to work as a maidservant after the conflict, was sexually abused by the 60 year old mahajan in whose house she was working and the police had even arrested him for that”.

ii. Conflict & Vulnerable Populations within the Household

Disabling poverty which follows close on the heels of a conflict, especially for families who have been forcibly displaced, often gets played on the bodies of the most vulnerable members of the household, like women and children. Faced with survival issues even after they return from the relief camp, there are no resources left to cope with even minor illnesses. In the absence of any health support – government or non-government, small illnesses turn into health catastrophes for women and children. In this section, let us examine how conflict plays out itself in the health and well-being of women, young girls and children.

a. Women: Embodying Vulnerability & Suffering

Taking one thick biography of Rashmi Narzary, a survivor of the recent 2014 Adivasi-Bodo conflict, let examine how a conflict episode affects the risks of ill-health in lives of women. Rashmi’s post-conflict narrative will be followed by an attempt to map out the protective and risk-factors in her life.
Life History of Rashmi Narzary

Rashmi Narzary, a Bodo woman is originally from Nijlaguri village and presently living in North Simlaguri which is a distance of 12 kms from the main market and from the government dispensary of Shantipur. She presently has three daughters and one son. The Bodo-Adivasi conflict of 2014 saw her life turn upside down.

Counting Losses of 2014 Conflict

Her husband was a daily wage labourer and they had no land for cultivation. On 24th December, 2014 he went for daily wage labour in a nearby village called Nangdorbari. Fighting broke out between Bodos and Adivasis and her husband went missing. The people from Nijlaguri relief camps along with the army went searching around the place where he was working but unfortunately they could not find his body. She says “santhals cut my husband”. The search team confirmed his death when they discovered his clothes and shoes scattered at some distance from where he worked that particular day. But they never found the body.

Rashmi and her family fled their village and went to live in Nijlaguri LP School Relief Camp where they stayed for a month. It was tough living in the camp and all she got to eat was some rice, dal and potatoes given as relief by the government. Her health deteriorated as a month before the conflict, she had delivered a baby girl. She remained in the relief camp as she was told that she could get compensation for her losses only if she remained in the relief camp. But she got nothing and was denied any compensation because her husband’s dead body was never recovered. “While I lived in the relief camps with all the losses and emotions, all that I received was the tent, rice, dal and sympathies of people around.”

Even as she was reconciling herself with her husband’s death, the infant daughter also died in the relief camp. “One day, the baby started to cry since morning, yelling and kicking her legs with great pain. Some NGO people helped take the baby to Kajalgaon civil hospital but she did not survive and died the same day”. Rashmi feels that some dyna (witch) is involved in taking away her daughter from her as she says “many people in the camp would come and see and kiss the baby because she was so cute and they felt pity as she had no father. One of them must have been a dyna and killed my daughter.”
Settling into a new place

Rashmi had a very difficult time because of the mysterious disappearance of her husband and the death of her baby. She still had to look after her three other children, two daughters and a son. “Although we had small quarrels over family issues, I was never worried when my husband was alive. I used to work hand in hand with him to keep the family going. Even when I was pregnant I used to go for work to help my husband. We used to go and collect firewood in the forest and sometimes in the river. Together we brought back the firewood for selling in Shantipur market”. Her brother, a farmer advised her to move to North Simlaguri (where he also lived in a nearby village) and she also felt the need of getting some land for the future of her son.

“My sister and I were the first to come to North Simlaguri as soon as I heard that there would be a land distribution here (for families affected by the violence). I was allotted 8 bighas of land.” She feels that land in North Simlaguri was not distributed equally but still it was land she got but now she feels insecure as the previous year, the ‘phakras’ (armed militants) had come asking the new families to move out of this land. She feels insecure as “once more they (militants) send us a notice, we will have to move out even if the forest people (the forest department) allows us to stay”.

In the beginning of her stay in North Simlaguri, Rashmi was supported by her brother who gave her some rice. She went to catch fish and collected wild vegetables and sold them in the market. “My husband’s family could not support us because they themselves had nothing”. She also had to spend two thousand rupees for one of the closing rituals of her dead husband recently. Their ‘house’ was built in one day. The tin roof was brought from her previous house in Nijlaguri and she made walls from the plastic tirpal (sheet) which she received from some NGOs. “I did not receive any compensation because my husband’s body was not recovered while other families who incurred loss of lives or injuries received huge compensation even up to 5 lakhs. I did not even receive the compensation amount of 50,000 rupees as my house in Nijlaguri was neither destroyed nor burnt during the conflict. I just received some help in cash from some NGOs.”
Rashmi now earns through hazira (daily wage labour). She also has a kitchen garden from where she is able to sell the produce in order to purchase other essentials. “My previous house in Nijlaguri was better. I planted some chillies and maitha (sour leaves) in the present village (North Simlaguri) but some insects destroyed it. In the previous year (2015) I had given out our land for mustard cultivation to others and got 500 rupees as rent for the year.”

When she does not find any hazira, she goes to the river where she catches small fish, crabs and snails and sells them in Shantipur market – 12 kms away. She recently tried a new business i.e. purchase vegetables from other villagers to resell in Shantipur market. “It gives me a slightly better earning but the effort and time is extreme for me. I have to go early in the morning in search of vegetables, by noon I come back home to prepare lunch and then leave for Shantipur daily market to occupy my place for selling the vegetables. I take the last vehicle from Shantipur that goes towards our village. By the time I reached back home its 7.30 pm. I have to walk for about 3 km after getting down from the vehicle to reach our village since there is no vehicle that goes till the village”.

In her earlier village, she used to supplement her income with brewing and selling rice beer. Now she has not been able to invest any money for brewing rice beer and she is also not sure if it will sell in this new place.

“We hardly cook meat in the house nowadays. We are not vegetarians but I am unable to buy meat with my little earnings.” Almost all the profit she makes from selling vegetables in Shantipur is just enough for her transportation and to buy rice. “I earn a maximum of ₹150 in a day. I buy 5kg of rice for ₹110, twenty rupees goes for the travel and ten rupees for salt and other essentials.” She often is in debt with the Shantipur shopkeepers. Comparing the shopkeepers of Shantipur with shopkeepers in her earlier village of Nijlaguri, she says “The Nijlaguri shopkeepers were never bothered if I bought things from their shop on credit but in Shantipur I have often been shooed away”. She currently has a debt of 60 rupees – 20 to another vegetable vendor she took money from, 10 rupees in one pharmacy for some medicines she took, 10 rupees to a neighbour and 20 to the auto rickshaw driver. She hopes
to clear the credit in a few days and is careful about visiting familiar shops to win the trust of the shopkeepers from whom she can get help during emergencies.

The family eats twice a day, once in the morning and once in the night. Whenever she feels tired she is reminded of the fact that the family would go hungry if she did not go out for work, and hence she never takes any off days from her work. “We have not been able to have a satisfactory meal since the day my husband went missing.”

**Life in the present village**

She does not get any PDS rations in the present village (North Simlaguri) though in the previous village she got ration rice 4 times. She has a job card which she submitted to the VCDC as she was told that on giving the ration card, she would get paid cash now.

“When we fall sick, we go to Shantipur (government hospital). The children never fell so seriously ill till date so I have not needed to take them outside except to Shantipur.” She feels lucky that “with two-three tablets they (the children) are fine”. When anyone in the family falls ill, the daughter sends the money and if not, Rashmi manages somehow. She also goes to a place where there are NGO workers and if she asks, they will give her medicines. In Shantipur she gets some treatment for typhoid and malaria. Though their earlier village Nijlaguri was much easier to get to the hospital but she is here with the hope that her son will have land in the future. But “if there is no chance of getting land here at all, then I am ready to move back to my old village”.

*Photos of North Simlaguri Village* where the displaced Bodo families now live post the 2014 conflict; they have not been able to build their houses and still live under plastic sheets
Rashmi was a member of a village Self Help Group (SHG) back in Nijlaguri. Their SHG used to spend a portion of group funds to purchase pork during the week-long Bwisagu (April Harvest Festival) festival. The meat was equally divided among the group members. “I remember that I received around 2 ½ kg of pork every year during the Bwisagu festival. My husband and I together used to borrow money from the SHG during emergencies. It was a good source to borrow money because it charged less interest from the group members.” Rashmi is still a member of the Nijlaguri SHG but her association with the group has diminished because of the distance. “I also have very little time to spare to be involve in its activities because I am busy working the whole day. I have failed to attend the meetings of the groups many times so I had to pay fine to the group. I am actually unable to pay those fines because I have money enough just to be spent on food.”

“We could not celebrate the Bwisagu festival of 2015 because of the conflict in 2014. My experiences were too bitter to go for enjoyment.” Like the people of Kombla Mondir, Rashmi was living in the Nijlaguri relief camp during the 2015 Bwisagu festival season. The people were rendered helpless as they had lost all their harvest and livestock during the conflict. Above all, living in the relief camp with all the sorrows and grievances they did not have any reasons for celebration. “All we could do was to grieve over our losses and watch the nearby villages enjoying Bwisagu festivities.”

“Even after the people resettled in North Simlaguri we were not in a position to afford to celebrate Bwisagu of 2016. The wounds of 2014 conflict are not yet healed; the people were still struggling to build their homes in their new village. We had nothing to harvest, the spring had no difference for us, it was too early for the villagers around to involve into these newly settled group of people living near their village for the festival.”

Rashmi and her neighbours decided that they would be celebrating the forthcoming baisagu festival (harvest festival) of 2017. They feel that they would gain some stability by then and
they would be in a position for the festival. Rashmi’s neighbours, in their previous village i.e. Kombla Mondir used to even invite the Santhals and would even go and dance in the Santhals house as a sign of friendship and inter-relationship. All that is over now.

In above, we see the number of risk factors to ill-health having increased greatly for the respondent after the conflict. With the protective factors decreasing, the vulnerabilities are high, not just for Rashmi but also for her children. Young girls having lost education are at a huge risk of being sent away to work – increasing their chances of being abused or trafficked.
We thus see that in Rashmi’s life, daily survival becomes a big challenge after a conflict, especially if the household has been forcibly displaced. Women such as Rashmi bear a huge burden of suffering. Adivasi women interviewed also talk about suffering and how that affects their body. It is as if their suffering has got embodied. Chitaa Soren, an Adivasi woman talks about her health and her body after the 1996 conflict.

Whether it is Bodo or Adivasi, conflict creates immense suffering in women. The women are able to link their experience of pain and suffering with their ill-health. They seem to understand how pain and suffering has got ‘embodied’ and become a part of their present existence.

“Our health while in relief camp was very poor – can give it only one out of ten points as we were very weak. But even now, we are not in good health... it is only half of what it should be. Women are not healthy as (there is) fighting in the household, illnesses, problems getting food, pain during our periods, difficulties in child birth ... also every two-three years, women keep getting pregnant and having babies. (We feel) unhealthy as we are not getting enough food.... The head spins, we feel weakness. Nowadays we are unable to work as much as we used to do earlier (before the conflict)”.

After her daughter’s death and her husband’s killing, she now had her baby daughter to look after. Her in-laws were living separately in the camp and could not help her. She had a really difficult time in the relief camp for two years. “My daughter and I often went hungry as going for work in the houses of the nearby Nepalis – even if there was work - was difficult because my daughter was so small. But luckily, both the mother and the daughter did not suffer from any major illnesses in these two years.” She brewed alcohol with the little rice she received as relief rations in the camp and sold the alcohol to get more money to buy rice so that they could eat regularly - **Chitaa Soren, Adivasi women; displaced in 1996; young daughter died and husband killed by militants; lived 10 years in relief camp; displaced again in 2014**
**Women’s Mental Stress after Conflict & Coping**

It is not just the physical burden of loss that women suffer but the mental burden also ‘wear’ out their bodies. Women respondents we interviewed link their bodies being weak and unhealthy to many things – prominent among them being mental stress resulting from tension after the conflict. Food insecurity, fights in the house, wife-beating and alcoholism are some of the stressors.

By examining some of these stressors in women’s lives, we understand what they are called to cope with after a conflict and how it must be affecting their bodies.

“What tensions do men face? As long they have food to eat and can sleep with their wives – what tension will they have? But a woman has to manage everything – manage the money, household needs... food. We worry that there is no money in the house and worry where to get the money from....” - Adivasi Woman; 3 No. Deosri Village; lived in the Deosri Relief Camp for over ten years from 1996-2005

**Post-Conflict Alcoholism as a Major Stressor in Women’s Lives**

Women talk about the rise of alcoholism and wife-beating after the conflict. In our fieldwork, we also observed that drinking and disharmony was much more among still displaced villages compared to non-displaced or returned villages. But while men externalised the stress and coped with it – albeit with negative consequences for their families and themselves – how would women have coped? Is it that women’s poorer health is a result of their bodies internalising the stress or “embodying their social ecologies” as embodiment theorists would call it.
“In our earlier village before the ‘gondogol’ (conflict), out of 10 families, one or two had drinking problem .... (They were) those who were poor and struggled and did ‘hazira’ (daily wage labour). But those who had land and work and money did not drink like this. We were busy. All this ‘bottle problem’ started when we came to the relief camp. The men started showing more bahaduri [recklessness]. Used to get relief rice which they would sell and also cash which they would buy alcohol with.

What we drink now is also different ... it is a water type. Earlier, we made wine with rice in our own house. We used to drink one or two cups for festivals and some occasions. There was no fighting like we now have. Almost no fighting. We had enough food, we had land, money, proper house to stay (so no need to drink). But now, they start drinking and don’t stop till the end (till they are totally drunk)”.

“Women do not drink and fight like the men. Only a very few (women) do this. Like those who make and sell alcohol or those who go to Bhutan to work.... They drink a bit. Only one or two (women) create problems and start fights in the house but finally, they too end up getting beaten by the husband”

—from a group interview with Adivasi women of 3 No. Deosri village

Adivasi women’s views on the problems of alcoholism among men after the conflict is echoed by community leaders. Two prominent community leaders we spoke to had this to say:

“Alcohol consumption changed hugely after our displacement. Earlier, only during parabs (festivals) we drank. In the conflict, people lost everything they had. They became ‘heartbroken’ and lost all hope of ever recovering. So, to forget their loss, they started drinking. Also, we had sufficient earlier...of land, cattle...enough food. (there was) no need to work for others. We had more than enough to keep us busy. In the camp, nothing to do whole day. And so, people drank. Our people had no money and would sell ‘relief rice’ (rice got as relief from the government) to buy alcohol or they would barter one kilo of rice for one
bottle of alcohol. Women also started drinking in the camps. The relief committee members tried to control alcoholism and imposed punishment. They made people crawl all the way on their knees, get them to eat salt as punishment etc. But that did not help”

- Ganesh Hasda, Adivasi male of 45 years; he is a practitioner of allopathic medicine and has a small ‘pharmacy’ in Deosri; though untrained, highly regarded by the Adivasi community for his services in saving lives of people in the relief camps following the 1996 and 1998 conflicts.

“I feel that for us Adivasis, alcoholism & poor education has been the worst fall-outs of the conflict. Earlier in the village, we used to take alcohol only during parab (festivals) or once a week on bazaar days. People would drink just a little bit but this became regular once they started living in the relief camp. Earlier, women drank a little bit only during festival time but now for every ten men who drink, we find three women also drinking. And after drinking, arguments and then fights break out. Earlier we used to make the alcohol at home and that was not harmful, but now we buy and they use ‘bad medicines’ for making alcohol. It ferments very fast in just two-three days and is not good for health. In my village, many people have spoilt their eyes. Earlier, we had heard some people getting night-blindness but nowadays, because of this alcohol, people’s eye-sight is gone. Our organisation (Cobra) tried to stop alcoholism many times. We have beaten a lot of people and even destroyed their pots and driven the sellers away, but failed. They (the sellers) come back because there are customers. Nowadays, we cannot beat because people in fact put an ulta (opposite) case on us if we beat”.

- Anil Hasda, Adivasi male; founder and now commander of one of the Adivasi militant outfits in Deosri. The group is under a cease fire pact with the government, but they are still called on to arbitrate in community matters.
b. Young Adolescent Girls: Vulnerable survivors of Conflict

Along with women, we find that young adolescent girls, whether Bodos or Adivasis, become extremely vulnerable after conflict episodes as they drop out of school and are sent out to work, increasing the risks of getting abused or trafficked.

Chitta Soren – Adivasi woman living in Koraibari; lived in relief camps in 1996-2005 and again in 2014

Five years ago after returning from the relief camp (roughly around 2010), her second daughter went to work as a house maid in Gelengphu, Bhutan with her cousin sister. She and her cousin sister were working in a Nepali house there. Her husband Barku used to go and collect the payments from the master for whom the daughter was working. One day the two sisters shifted to another family for work. While working there, the cousin sister eloped with a boy from a neighbouring village also working in Gelenphu. After few days when the parents went to collect money from the master’s house they were told that the girl had run away. Chitaa and her husband looked for the daughter everywhere in Gelephu but could not find her anywhere. Chitaa enquired about their daughter from the cousin sister who was working together. The cousin sister told Chitaa that their daughter was still in the master’s house when she had ran away. Chitaa informed BIRSA (one of the armed militant groups of the Adivasis) about the case of her missing daughter but till date nothing has been done and there has been no news of her. It is 5-6 years since then.

With the first daughter dead (her daughter died in pregnancy after returning back from relief camp in 2015) and the second one lost, Chitaa’s third daughter (the eldest child from the second husband) has now gone out to work as a maidservant in Arunachal Pradesh.
She went in the month of March 2016 with her friend from the village. After 6 months, the friend returned informing them that their daughter would be returning home the following year i.e. in March 2017. Chitaa is waiting. She does not have any contact with her daughter nor does the daughter send them any money. She says that she and her husband had advised the daughter against going outside for work but the daughter still went. She is not sure if she will return home.

**Rupsi Narzary – Bodo woman, displaced in 2014 violence**

After her first husband died, Rupsi had sent her eldest daughter away to work as a maidservant. The little money she got from there was helpful and it was one less mouth to feed. But the second daughter Sonima was a huge help in the house. When her mother remarried and had two sons, Sonima helped look after them while her mother went out for work. She also attended middle school in Shantipur, something she loved to do. But after the conflict there was no way for her to go to school. The family was in no state to send her to school now 11 kms away and she had to stop schooling.

Sonima is now 13 years old and the NGO working in their village promised they would help get her admitted into a government bridge school where school drop-outs like her could get free studies and stay. But Rupsi is worried as she has tried but has not been able to come up with the money required to buy her clothes and essentials needed to send her there, “I would be the sole person responsible for taking care of the expenditure of my daughter. Yesterday I had gone to a nearby village to borrow some money for her expenses but I failed to get any. I am now carrying another child and it is eight months. I foresee problems that I would have to face if my daughter goes to school. Right now I am not in a position to take added responsibilities because I have only a few days before I give birth to another child.”

Sonima (13 years) and her friend Naani (also of the same age) were taken away by a mahajan (rich owner) to work in his house. Sonima’s main job is to be a companion to the master’s daughter and drop and pick her up from school. She would be paid Rs.1300 a month for this. Her friend would be preparing meals for the master’s brother and his family who lived close by. She would be paid Rs.1500 a month. Both of them were promised that
they would get to meet each other often. Rupsi got an advance payment of Rs.1500 for her daughter.

This money was a huge help 10 days later when the time came for delivering her baby. They had planned for a home birth – as they had no money to go to the government hospital. Before the conflict, both her sons had been born in the government hospital but this time, they just did not have the money to spend. But the labour went on for many hours and finally, unsure and coaxed on by others, they called the 108 ambulance and moved Rupsi to the Shantipur State Dispensary. After some hours, Rupsi gave birth to a girl. The ambulance charged Rs.300 one way and the hospital nurses and doctors took a lump sum amount of Rs.1000. They were thankful for the money got from the daughter’s mahajan some days ago.

In case after case, young girls are seen coming to the rescue of their impoverished households displaced after a conflict. In the absence of external financial and other supports, it is indeed ironic that in poor households, the daughters’ increased vulnerabilities is responsible for decreasing vulnerabilities of their families. In the case of Rupsi and her daughter Sonima above, the absence of free delivery in the government hospital increased the mother’s vulnerability which was ironically reduced by money got from her daughter’s labour (sic).

“None of my children are going to school at present,” says Rashmi. Her eldest daughter who is 15 years old is working as a house maid. She studied till class II. She started working when she was very young, “ever since she started to wear a dokhona” (the traditional dress of Bodos). She does not know how much she earns now but reckons it must have increased from the 2000 rupees she earlier got. Whenever her daughter sends her money, she buys some 20 Kgs of rice for the month. Once in a while she also gets a thousand or two as extra money from her daughter. Recently, her second daughter has also left home to work as a house maid to help her mother and sister maintain the family.

While still in the relief camp, Rashmi’s eight year old son was taken by a group of people to study in a residential school called Bhag Raja Ashram in the neighbouring Baksa District. Rashmi was already sad with the death of her husband and missed her son terribly and so
during one of the vacations, “when the other parents from the village went to pick their sons from the school I went with them and brought him back and never sent him back to the school again”. He does not go to school now because there is no school in North Simlaguri.

- Rashmi, North Simlaguri, Bodo widow; husband killed in 2014 riots

c. Children: the youngest survivors of conflict

In the earlier section, we saw how young girls after a conflict lose their education, become child workers and become extremely vulnerable and at risk of abuse. But not just young girls, children in general suffer grave consequences of conflict. Their loss and suffering is greater because apart from being innocent victims of war, they also do not have a language to express what is happening to them. With survival being the sole aim of families after a conflict, children’s mental, emotional and social development is of no priority.

Evan Kisku is a 33 year old Adivasi man now living in Mohanpur. He was a young boy when they fled to the Desori relief camp in 1996. His story gives us an idea of conflict from the eyes of a 12 year old child.

Evan Kisku was a 12-year old cowherd in a Bodo family when the conflict broke out in 1996. His uncle was also a servant in that household. Evan’s job was to take the cattle early morning to the fields and graze it. He would be back by 12 noon and get his lunch. Even now he remembers with great fondness the Bodo family he worked for, “they loved me so much as their own son. I was never given breakfast with plain curry. But only if there is good curry like pork or chicken, then only I would be given. Else, I would have rice with milk. I never had to ask for my food but was given as much as I wanted to eat. I was also never scolded. I became very healthy and fat”.

On the day the conflict broke out, Evan says that he was “really lucky” because that day, he brought the cattle to graze in the Adivasi side of the village since there was more space. He was in his own house having lunch when the fighting started. The Bodo owner told his uncle to look for him quickly, otherwise the boy would get killed. Running here and there, his uncle was relieved to find Evan safe in his own house. Bodos were burning down the houses of the Santhals and he asked them to flee.
Evan fled with his mother and three brothers. “We could bring nothing, only what we wore. I had a pant and shirt on my body and an umbrella which I got from the Bodo’s house”. When they reached Deosri, he remembers the Nepalis there being cruel to them. “They were not allowing us to hide in their houses and not even giving us a bamboo for making our shelter. Our people were not allowed to go near their houses to collect dried branches and leaves for fuel. They kept shouting and chasing us away”.

Evan’s father and the other men stayed back and tried to protect their houses from getting burnt down. They succeeded for a short while but “the Bodos kept coming in large numbers and it was getting dark, so they also fled to the camp. They were chased and fired on till they reached the river here in Deosri”. Evan says that the Bodos fired all over the place and “we saw fire in the sky like we had never seen before”.

Many people from all over Deosri came and started staying in the camp. “We had no food and water to drink. It was so crowded with five-six families living under one tent. Many people died in the camp, may be because of gas and the so soric [bad smell]. There was no space even for sleeping. We were like dead bodies lying on the ground without any cloth. People started dying, worse than animals. Daily, 10 to 12 people died in the camp. The cemetery South of Swapan’s house became full. Diarrhea could have affected people because we could not go far for our needs. Like animals, people used to urinate and shit here and there. There was no water for washing. All around the camp, there was bir (big jungle). It was very dangerous (for us) to enter the jungle because the Bodos were coming till here. We lived like this for two years in the camp. In 1998 we were attacked again”.

The government gave 10,000 rupees to each family, stopped the relief rations and asked them to move out of the camps. “It was difficult moving back to our village and so before shifting out, we started making huts in our villages. It hardly lasted for a week. These huts we made were burnt by the Bodos and so, we stayed backed in the Relief Camp. The government had to give us rations again”. 

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Evan says that before he came to the camp, he was not interested in studies. And even here, there was no atmosphere for studying but he pestered his father to enrol him into the camp ‘school’ (which were actually classes held in the veranda of a building). “The same place was used for distributing rations and also for running the classes for children and so, was always crowded with people and we could hardly study”. But after he got the taste of reading and writing, he got interested and though he had no clothes to wear, he attended classes regularly, sometimes dressed only in a gamocha (loin cloth worn around the waist). Somehow he managed to complete his primary school and started middle school in Shantipur (4 kms away). But it was not easy.

“Growing up as a young boy in the camp was tough. I have had some very bad experiences. In the camp, the number in my family increased and my younger brother and three sisters were born there. Among them, one died. I was the second in the family and food was our biggest problem. We did not see such aakal (drought). There was shortage of food, water, cloth and shelter. We all cried out of hunger. One day it was raining and we were all taking shelter under one umbrella. We were hungry. My mother was pained so much that she went around begging for a bit of rice. I don’t know where she managed to get 250 grams of rice from, but she cooked dak mandi (watery rice) for us with it. No one could help us as all families and my relatives were in the same situation”.

Before the conflict, Evan does not remember his father ever doing daily wage labour or selling firewood. But once in the camp, he used to sell or exchange firewood for rice. “We were so poor and in such a situation, I could not think of school and stopped then. I had to stand on my own feet”. Apart from poverty, young men were also need to guard the Relief Camp during the night and could not sleep at night. Later, some militant groups like the Birsa Commando Force (BCF) and Adivasi Cobra Militants of Assam (popularly known as Cobra) also emerged in the Relief Camps.

Evan says, “Out of hunger they used to do some illegal acts but boys like us of 15 to 18 years would get picked up from the camps and put into jail. I was also picked up and taken to the Kokrajhar jail. Once caught, they used to kick and beat us anywhere they wished. CRPF jawans (soldiers of the Central Reserve Police Force) were doing all this. They were like
devils. Very much greedy for young women too. We could not let our young women go out alone for anything. But some of our own people also became like that. Young men became wild”.

In the camp, Evan got married while he was just 15 to an even younger girl. They had children almost a year later and Evan regrets he could not bring up his children properly as he was a child himself! He was not even 20 years old and though he “did not belong to any of the groups”, he was caught and jailed on suspicion of being a militant. There were six or seven of them from Deosri and many more others from the other camps. He is thankful they were not beaten while in jail but there was not enough to eat even there. They were released after six months as they were innocent.

He regrets that the relief camp environment totally destroyed the childhood of children. There was no space for games, the education environment was totally destroyed. Children were not taken care of by their parents, “children were like sheep, gathered in one place. They were not cleaned and stayed without clothes. No good food for the children and the health of the children was not good at all. But there was a school teacher named Ganesh who knew some allopathic medicines and started practicing in the camp. He helped a good number of people and saved their lives with whatever little he knew”.

Even today, Evan is concerned about the future of his people. He feels there is a “cold war” going on between the Bodos and the Adivasis even today. Though he talks to his Bodo friends, he is not “free with them”. He feels bad because they should be working together to improve education and other things and not fighting each other. He also feels bad that “the government is also not supporting us properly to grow a healthy life”. His dream is to see at least five to six students passing the Class 10 exams every year from among the Adivasis. But most are unable to do that and he feels sad to see so many young Adivasi children dropping out of school and leaving home for earning, “they go to Kerala, Chennai, Bangalore…. I feel so bad and worried about our children, whether they will also become the same as we are today”. He is hopeful that one day the Adivasis will also overcome all these challenges and be able to develop. But is worried “if the fighting goes on like this, then not possible for any development to take place for only peace can help us to develop”.
But for another Adivasi boy, displacement actually had one positive fallout i.e. education. “If I was at home I would have most probably not gotten to study because I would have had to look after the cows and do cultivation”. At the relief camp, he got a chance to take admission and later go on to complete his Class 10 which he says, “has bettered his life and also changed his mentality”.

- Biswajeet Murmu; 30 year old Adivasi man; was also a cowherd of 8-9 years old when he went to live in the relief camp; studied till his first year B.A; became a student leader and is now the Secretary of the Deosri VCDC (Village Council Development Committee)

3.2.1 Conflict & Its effects on Non-Displaced Host Populations

Effect of Conflict on Host Population of Nepalis in Deosri

Those who experience conflict directly bear the brunt of its effects – deaths, displacement, many levels of loss, ill-health etc. But even others in the vicinity who may not have been displaced or directly undergone loss, are also affected. In this study, we looked at the effects of conflict on the health and well-being of the Nepali community. The Nepalis have been settled in the Deosri forest area for years and have been “witness” to the violence and political upheaval in the area. Before they knew it, Nepalis turned into the “host” community when violence between the Bodos and the Adivasis erupted in 1996 and thousands of Adivasis landed up and started living in relief camps, literally in their backyard.

A UN Refugee Agency (UHCR) document\(^4^7\) on impact of refugees on host population state “The presence of refugees, and demands on the already severely strained economy, services and infrastructure add to the extreme hardship affecting the local populations. In many instances, refugees become an added impediment to, or risk jeopardizing, the development efforts of the host country”.

\(^4^7\) UNHCR Social and economic impact of large refugee populations on host developing countriesSocial and economic impact of large refugee populations on host developing countries; EC/47/SC/CRP.7; By: UNHCR Standing Committee  |  6 January 1997; http://www.unhcr.org/excom/standcom/3ae68d0e10/social-economic-impact-large-refugee-populations-host-developing-countries.html
What has this meant for the host Nepali community? To what extent a disruption of this nature affect the lives, health and well-being of those who are caught up in the cross-fire? How much can non-partisan parties escape the effects of violence and conflict and how do they cope? Also, are there any positive fall-outs of conflict on host communities? In this study, we interviewed a number of people from the Nepali community in Deosri and also from Shantipur area. They included community leaders, pharmacists, traditional healers, ordinary men and women, youth etc. Hanging around the tea shop and markets and taking part in festivals and NGO organised events, we also had a lot of opportunity to closely observe the relationship between the Nepali community and others in the area. The house we rented in Deosri belonged to a Nepali and generally, because of our long presence in the area, the Nepalis seemed to trust us and opened up to us.

**Effect of Conflict on Health of Non-Displaced Host Population**

1.  **The Economic Impact of Conflict on Nepalis**

The economic impact of displaced populations on host communities seem to be well-recorded as the same UNHCR document goes on to say, “From the moment of arrival, refugees compete with the local citizens for scarce resources such as land, water, housing, food and medical services. Over time, their presence leads to more substantial demands on natural resources, education and health facilities, energy, transportation, social services and employment. They may cause inflationary pressures on prices and depress wages. In some instances, they can significantly alter the flow of goods and services within the society as a whole and their presence may have implications for the host country’s balance of payment and undermine structural adjustment initiatives”.48

Many of the Nepali respondents we interviewed seemed to believe their economic development suffered because of the sudden influx of Adivasis in the area. Some also spoke about the general situation of militancy and conflict and how it victimised them.

48 Same as 1 above
“We (Nepalis) helped the Adivasis a lot when they came here. From my own house we gave them rice to eat. I would go and check on them at night in the school building, where they were staying, to see if they had eaten or not. I did not like it if the children were crying, so I did all I could. We gave them not only rice, but also wood to burn and cook the rice on”. However, he feels that sharing their personal supplies with the Adivasis did not affect the Nepali community badly. They only helped out in the beginning, when the crisis descended suddenly. “After that the Adivasis moved to the relief camp, they started working in the fields and stabilized their situation, so the Nepali community did not have to help out any more. But it did however cause other difficulties – with the relief camp located between our village and fields, we found it difficult to go to our fields to work”. Many of the Adivasis sought work in the fields of the Nepalis, but they too found it difficult to leave the camp and go out into the fields. “Thora sa bhi bahar jayega to Bodo aadmi maar dega (if they even stepped out a little bit, they would get killed by the Bodos)”. For about 5-6 years, the fields lay uncultivated. The Nepalis grew maize, mustard, vegetables, etc. in their kitchen gardens and courtyards and at times, it was so difficult that they themselves had to buy rice to eat.

- Rohit Chetri (Nepali Male, 45 years, Hindu, lives in Deosri)

“The situation of the Adivasis had an effect on the Nepali community as well. The government was unable to supply anything at short notice, so the Nepalis gave them food and clothes. Sometimes there were night-time thefts as well – fruit and tamul (betel nut) would be stolen. But what to do? These people had nowhere to go, they could not go back to their work, they could not go elsewhere to look for food because they feared being attacked. The Nepali Basti was the only option close at hand, so they all went there. The Nepalis could not object”.

“If an entire village comes to the relief camp then it will affect the neighbouring village as well. The arrival of the Adivasi community caused some problems for the Nepalis. I used to attend the Deosri Primary School at that time, and during the day there were cars passing by on the main road next to the school. I saw with his own eyes Adivasis beating up some Bodo people who had been passing by in a car. I also saw people bringing in guns and carbon at night. Yet, we (the Nepali community) continued to help them. We gave them
employment because we were in a position to do so. Many Adivasi people used to beg and
the Nepalis would provide for them as well”.

- Amit Gurung (Nepali Buddhist Male, 28 years; lives in Deosri, works as community
  mobiliser in an NGO)

That the Nepali hosts found it difficult not to blame the ‘guests’ forced upon them is evident
in the conversation we had with a Nepali woman leader in Deosri.

“Hamara gaon Chirang district mein sabse gareeb hai (our village is the poorest in Chirang
District)”. SM attributes the poverty of the village to the coming of the Adivasis. She says
they would go from house to house asking for food, and would steal if they weren’t given
any. They took fruits from trees, goat kids, “batane mein bhi mushkil hai (it is even difficult
to say it)”, SM whispers. “When Kokrajhar district was made, the Bodos started entering,
saying it is their district. They got into fights with the Muslims as well as the Adivasis. Had
they (the Adivasis) lived in their own villages, they would have been able to eat from their
fields, or at least have the fruit from trees in their villages. But since they were being
attacked, they left behind everything, including their clothes
and fled. When they came to
Deosri, they created a burden on our resources. Even now, within their community, they are
not very well-off. Only ten or fifteen families have money”. - Mansi Chetri (Nepali Hindu
widow; 50 years; small shopkeeper in local market, looked upon by Nepali women as their
leader).

2. Health Impact of Conflict on the Nepali Community

a. Conflict caused illnesses among non-displaced host populations like the Nepalis

Diseases which broke out amongst the displaced Adivasis in the relief camps affected the
Nepalis too. They were hit when cholera epidemic broke out in the nearby Adivasi relief
camp but being relatively well-off, they seemed to have afforded treatment faster in private
facilities and hence could save many lives.

“People would have 3-4 ‘blood dysentery’ and then die. 16 – 17 Nepalis died within one
week. In the relief camp (of the Adivasis), many more died. 7 - 8 of them in a single family
used to die. There was no medical support at that time. MSF came only much later. There
was only one pharmacist who used to bring medicine from Sidli. There have been no incidents of blood dysentery apart from that time. When MSF came, they made handpumps in all houses, distributed phenyl and also the relief camp shifted” Suraj Pradhan (Nepali Hindu Male; 39 years; lives in Deosri; leader of community)

“In the relief camp, about 30-35 people would get fever in a day. Infection travelled fast and many of the Nepalis fell ill too. However, we (the Nepali community) have been relatively more prosperous, so we could go and get themselves treated in a good hospital, which saved our lives. Earlier, we would go to Bhutan for treatment at a Bhutanese government hospital. There they got good medicines. But three-wheeler autos were banned in Bhutan, so going there became difficult. Those in Deosri who could afford it, used to go to Bhutan. But now people from Assam have been banned from going to Bhutan for treatment. Now everyone has to go to Shantipur”.

He also recalls that during the conflict, dysentery in the relief camp was so bad that entire families would die at a time. “Houses would be locked and empty” he says and because of the severity, the infection spread to the Nepali Basti and many people were badly affected. Initially there was not much help available, but later on the dispensary (government) started giving medicines for dysentery. “After the conflict, an NGO came here to treat malaria and dysentery. They gave good medicines and many people got cured”.

Rohit Chetri (Nepali Male, 45 years, Hindu, lives in Deosri)

b. The Health Care System during Conflict & Impact on Nepalis

“After 1998 conflict, people had just started settling down, when there was a small incident in 1999. The CRPF commander was killed and one Adivasi man was attacked. This led to a revenge attack from the Adivasi side. They attacked with bow and arrow and killed many people. I saw with my own eyes one man who was running being cut down from behind. He ran a few more steps before falling down and dying. I saw how the blood spewed out. It became very unsafe for the Bodo doctor and compounder in the dispensary. We tried to protect them. ‘Kisi ko toilet mein tala maar diya (we locked some of them inside the toilet), and like this we kept them safe. Bahut [emphasis his] dar lagta tha. Aisa danger tha. (We were very frightened. It was that kind of danger)” AG said he saw these things with his own
eyes and that was why he was scared. He said that though the Nepali community did not fear an attack upon itself, because of all the help they were extending, they feared being caught in the cross-fire. After this incident, for some time there was no doctor in the dispensary. It became very difficult for the people to avail treatment. They had to make do with only the compounder”.

- Amit Gurung (Nepali Buddhist Male, 26 years; lives in Deosri, works as community mobiliser in NGO)

“Nowadays there are cars, ambulances, bikes and many other modes of transport. It is now much easier to take someone to hospital. During the conflict, sometimes people in medical emergencies would be transported in police vehicles, but many others died due to the difficulties of transport. The journey in itself was difficult. There would be incidences of violence along the way. Besides, the only good dispensary in the area was in Kashikotra, but the bridge to Kashikotra had been blown up. It was difficult to go to Sidli as well. The bridge there was broken and vehicles could not cross. It took three to four months to construct a wooden bridge, and many people opposed the building of it. A police complaint had to be filed and the police had to come and stand guard over the bridge so it could be completed” - N5-Babita Pradhan (BP, Nepali Hindu woman, 63 years, lives in Deosri)

“Before 1996, there used to be very little dysentery, but there was malaria and TB. Treatment used to be available at the Shantipur dispensary, but many people practiced herbal medicines at home for minor illnesses like jaundice. Pharmacies were not easily available those days, so allopathic medicines were anyway difficult to come across. The doctor did not sit regularly at the government dispensary, but a compounder used to be available. Medicines for malaria were available at the dispensary, but for TB people would go to Kokrajhar”.

“Also earlier, people used to go to Kokrajhar or Bongaigaon for treatment. They could either hire a car or take a winger. There were sometimes dacoit attacks on wingers. It was not possible to go at a good speed either, because the road was broken. Those who received injuries during the conflict also went to Kokrajhar or Bongaigaon for stitches and bandage but everyone used to travel in great fear. Today, if anybody needs stitches, they go to the
local pharmacy”. - **Amit Gurung (Nepali Buddhist Male, 26 years; lives in Deosri, works as community mobiliser in NGO)**

c. **Stress, Tension and Fear**

There was fear, insecurity and mental stress caused by the conflict on the host populations of Nepalis too.

“Life during the conflict years was one of constant fear. Even a firecracker during a festival would scare people – they would think it was a gunshot or a bomb attack. There was an incident when the Deosri market had caught fire at night. My family and me gathered up all their belonging and got ready to leave. Even the slightest things would scare us in those days. People feared going out of the house. Once when a friend and I had gone to graze our cattle by the Aie river, we saw the Bodos and Adivasis attacking each other….. one side there was ‘teer dhanush’ (bow and arrows) and the one side ‘goli’ (bullets). We could not even run, because we would have been in danger. So we watched through the entire episode”. **Amit Gurung (Nepali Buddhist Male, 26 years; lives in Deosri, works as community mobiliser in NGO)**

3. **Social Impact of Conflict on Host Community**

In small, remote, rural areas such as Deosri, the sudden influx of thousands of conflict displaced Adivasis could hardly have gone unnoticed. The UNHCR paper mentions that if the refugees are from the same cultural and linguistic group as the local population, there is often identification with and sympathy for their situation. But different ethnicity, however, can be a basis for problems. Even if traditional animosities may not exist between groups, failures in communication and understanding caused by language and/or culture can form serious barriers. In some cases, the presence of one (ethnic) group of refugees may affect ethnic balances within the local population and exacerbate conflicts.49

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49 UNHCR Social and economic impact of large refugee populations on host developing countriesSocial and economic impact of large refugee populations on host developing countries; EC/47/SC/CRP.7; By: UNHCR Standing Committee | 6 January 1997; http://www.unhcr.org/excom/standcom/3ae68d0e10/social-economic-impact-large-refugee-populations-host-developing-countries.html
The host community may also complain about displaced refugees adding to security problems in general and rise of crime, theft, murder etc. They are also blamed for other social problems such as prostitution and alcoholism. While true to some extent, as enforced idleness and poverty within a refugee camp may cause an escalation of such tendencies, especially if there are groups of young men who are not meaningfully occupied. On the other hand, refugees, as an “out” group, can be blamed for all untoward activities.

“The Bodo-Adivasi violence affected the Nepali community the most. These people’s violence happened and kept repeating. But we are the original settlers in this place and we have suffered. When they came and stayed in the relief camps, we could not grow our income anymore. Whatever is grown in the fields, these people would take away. We could not sell our own betel nut, it was all stolen by the Adivasis. I had gone to college in Bijni Town and when I returned in 1997, I found a relief camp near my village. Huge influx of Adivasi to Deosri cost us Nepalese to constantly lose our livestock and field produces to the relief camp people. We could not harvest our makai (maize), they would take it away. Betel nut they would take away. Could not keep good goats for income even cows…. We could not keep anything outside, they would take it away. But we could not say anything to them because they are in the relief (camp). We also had to guard our cattle during the night against them (Adivasi). I had to discontinue my college education and return home to guard the cattle because my father was alone in the house as my eldest brother had already moved separately after he married”. Suraj Pradhan (Nepali Hindu Male; 39 years; lives in Desori; leader of community)

Suraj also says that the NDFB (one of the factions of the Bodo militants) used to put tremendous pressure on the Gorkha community for “donations”. He added that if they did not pay up, people were killed. Though nobody was killed in Deosri, but such happenings were common and he himself ended up paying over Rs. 15,000 in all these years.

“The relations between the Adivasis and the Nepali communities have always been cordial. They (Adivasis) came here seeking our help as it was in our ‘bharosa’ (trust) they came here. We helped the Adivasis in all ways possible - giving them rice, clothes, whatever they needed. I would feel bad when the children cried, so I gave them whatever I could. I was
also asked to help the Adivasis in the relief camp in obtaining ration. All of them were illiterate – not one among them was educated, all blank slates! Hence, they were unable to write applications for release of ration and were not aware of the procedure of getting rice released or whom to contact. So they approached me and as the Headman I helped them in obtaining their rations for well over three years”.

- **Kamal Pradhan (Nepali Male, 63, headman of the village during the conflict period)**

“For the past few years Durga Pooja and Kali Pooja have been huge events in Deosri. There is music and dancing, fireworks, a goat sacrifice, and much enjoyment. During the conflict years the celebrations had been subdued to the point of being non-existent. Till 2008-09 everyone was very upset. Every once in a while there were reports of violence that would cause panic among the Adivasis. This would affect Nepali festivities too. If everyone’s mind is not at peace, then how can it be? Nepalis and Adivasis celebrate their festivals together. In fact, traditionally, it was the Adivasis who played the drums at Nepali events. So if the Adivasis were not celebrating, it was difficult for us Nepalis to do so”.

- **Babita Pradhan (Nepali Hindu woman, 63 years, lives in Deosri)**

“Prior to the conflict, relations between Nepalis, Bodos and Adivasis were very good. We went to the same markets, worked together on dams, celebrated Dussehra together, went to each other’s festivals, weddings, parties, etc. Now, once again, relationships are like that. But during the conflict, the Adivasis and Bodos fell completely foul of each other. Dono ko milane wala hum Gorkha log hi tha (the Gorkhas were the ones who brought both of them together). The Gorkhas would counsel both communities to not be violent, live together peacefully, conduct ‘Shanti Committees’, hold meetings with the SP, DC, etc. But the worst things for us Nepalis who are the original settlers of the area is when a person who came to Deosri displaced by the conflict of 1996 (and came here) much later has the power to issue us VCDC certificate certifying that we belong and live in this area!”.

- **Suraj Pradhan (Nepali Hindu Male; 39 years; lives in Desori; leader of community)**
“In my conversation with Sh. KP today, and Sh. RC yesterday, I noticed that they have a patronising but cordial (sort of paternalistic) attitude towards the Adivasi community. They see themselves (the Nepali community) as the provider and protector of the Adivasis who came to their village for refuge”. (PR, field notes 11-6-2016)

3.2.3 Ecological Health Effects of Conflict & Displacement

We are seeing a big impact that conflict and displacement has had on the ecology of the Deosri area. This is important to understand because it has started telling on the health and quality of life of people in the area – not just of the displaced populations but on other communities as well and on all forms of life there.

“The forest department was very strict during the 1970s and the years following that. During those days people were restricted from entering the forest. If anyone was caught going into the forest with an axe or a knife, it was considered a threat and the forest department took strict action against such persons.

But once the ABSU Andolan started (in the late 1980’s), there was a rapid increase in population of the area and the same forest where local people were not allowed in, was opened for settlement and we saw large scale migration to the forest lands. In the 70s, one could easily spot sight of tigers and deer’s and bears in the vicinity. Today the forest cover is fallen beyond limits and we can spot such animals only in our dreams. Earlier, there was very less population, hence less illnesses. Increase in population because of new migration gave unprecedented increase of illnesses. After the ABSU Andolan, from the year 1996 there has been increase in number of illnesses for the next ten years. I had the highest number of patients in my pharmacy since the Bodo and Adivasi conflict till the year 2007”.

– Badal Chetri, Nepali pharmacist practicing in Deosri market
“When we reached the house of the headman of Koraibari village at around 11 a.m., there was some tension as two elephants had come the previous night and eaten away one big patch of maize the family had planted just across the stream from their house. They had kept vigil after dinner and had heard the elephants at around 10 p.m. and had chased them away. But when they did not return even after two hours, the family slept. The men were sleeping in a semi-open shed and with the rains pelting down the tin roof and drowning out all noise, they did not hear the elephants return. This morning when they woke up, they found the entire patch of maize crop which had just ripened and almost ready for harvesting, all gone. Suraj had planted hybrid maize seeds this time and each plant had sprouted two maize cobs which were all big and full of ears of corn. We visited the patch and estimated around 300 plants had been destroyed by the elephants that night and even if they sold each at a minimum of Rs. 5 each, they would have lost 3000 rupees of corn in one night. Already the elephants in previous visits had uprooted and eaten a lot of the simla aloo (tapioca) behind the house.

Hence, the family was tense as there was one more patch of corn just in front of the house which needed one more week for harvesting. The whole day was spent in pregnant suspense if the elephants would again come in the night. As we waited for dinner to get ready, I sat with Suraj Mardi and Raman in the tin shed talking about the conflict of 1996 and their return from the Deosri camp to Koraibari. We had to really shout as there was huge storm raging and we could hardly hear ourselves in the rain. With sprays of water getting us wet, yet we talked. And time and again, we would all shine our torches in the dark

Treatment or elephants?
“I am called to visit patients (in their homes) any time, even at night…. Few weeks ago, I was asked to go to Koraibari at 10.30 p.m. I refused to go because of danger of attack by elephants but they pleaded and forced me to go. I was so scared and tense as it was so silent and scary in the jungle. We were lucky we did not cross the paths of any elephants that night. Now whatever happens, I have sworn I will never ever do this again. It is too risky”.
– Ganesh Hasda, Adivasi pharmacist practising in Deosri
towards the maize patch and keep a look-out for the elephants. But we could hardly see through the sheets of pouring water.

As soon as the rains let up a bit, I heard a loud thump sound and asked Raman what that was. He startled and told me that it was the elephant hitting its trunk on the ground! Suraj ran towards the maize patch and all the other family members also ran excitedly – some with torches and some without. I remained with the youngest boys in the shed watching in fear and awe. The two elephants – probably of the previous night – had come yet again and were eating away at the fresh match of maize even as we spoke. Making loud noises and shining their torches, they managed to get the elephants away from the patch. But only for them to lumber to the back of the house towards the fields of simla aloo (tapioca)! Even I joined in the excitement of elephant chasing this time as we ran towards the back of the house. The elephants disappeared into the nearby jungle in the commotion. We could hear them snort from time to time but could not see them in the dark.

Sometime after our dinner, they crossed over back to their own side of the jungle and did not return again that night! But till we slept (and perhaps even long after that), I could spot Suraj going to and fro from the maize patch in the front of the house to the tapioca fields at the back, shining his torch, trying to spot and chase away the elephants. Early morning, he was up at 5 a.m. and by the time we woke up, he had already gone fishing in the dong (water canal) and brought back around half a kilo of small sized fish for lunch. The family was sad and upset this morning too. The entire maize they planted this year has been eaten up by the elephants. They know the elephants will return when they plant paddy too. Wherever I went to in Koraibari and whoever I met was talking about the elephant problem. It was obvious that people were agitated, worried and getting very little sleep because of this. Last year the elephants killed two people in their village and this year too one has been killed. Not just in villages like Koraibari in the middle of the forest but this year, the elephant raids on human crops and habitation has come all the way to villages near the Deosri market. The Nepali and Rajbongshi villages close to the main road have also been raided. Apart from maize and tapioca, elephants have acquired a taste for home-grown pineapples too and entire patches of pineapples right inside people’s backyards have been finished.
And it is not just the elephants. Much else is pushing an already fragile ecology to almost breaking point. With no clear rehabilitation policy of where to settle people who have lost their homes in conflict, coupled with weak forest governance, more and more families are bound to settle here after clearing forests. Every afternoon right from 2 p.m. onwards, we see hundreds of cycle loads of firewood from freshly cut trees being taken out of the forest and sold in the markets. Each cycle load sells for 300-400 rupees in the market. While many are conflict affected families selling firewood for a living, some wood-cutters come from as far as Bengtol and Runikhata (15-20 kms away).

With the forest cover disappearing, the rivers that flow from Bhutan have also gone wild. Soil erosion is threatening the very existence of the entire Deosri area. All communities – Nepalis, Rajbongshis, Adivasis, Bodos – lost large tracts of land to soil erosion last year. A few days ago I was taken to see this destruction and was really alarmed when Sanjay Hembrom, one of the Adivasi leaders told me that he alone lost 20 bighas (8-9 acres) of agricultural land last year. The Nepalis who keep cattle in gumtis (large cattle farms in the middle of the river with hundreds of heads of cattle) have had to shift all of it out. The entire Rajbongshi village of Aie Powali is also threatened – 4 houses were washed away in the floods and erosion this year. Deosri somehow feels like an ecological time-bomb waiting to burst”.

Tree stumps dot fresh agricultural land as forests are cleared by dwellers – largely families displaced by conflict in search of land to settle.

Trees cut and bicycle load of firewood taken out from the forests every day.
Summary

The poor and the marginalised who already lead fragile and vulnerable lives in a conflict area are further pushed to the edge after an episode of conflict. For such households, their health, well-being and development gets highly compromised as life after a conflict becomes an intense struggle to merely survive. Without adequate external support, affected families with highly reduced resources find it difficult to cope with this new ecology of ill-health and ill-being.

In the study we see that irrespective of the ethnic community, conflict is an extremely life disrupting event especially when forced to flee one’s home. While Bodos are better organised and get more support from their community based organisations during the fleeing and emergency, they like the Adivasis are left to recover on their own after the emergency and remain at high risk of ill-health. The forcibly displaced who have experienced loss of every kind need a lot of support but they were left to their own devices to survive or perish, especially in the older conflicts of 1996 & 1998. While other kinds of losses have a greater chance to get addressed, loss of relationship and trust is one of the earliest losses is an ethnic conflict and very few address this loss.

For the forcibly displaced, disabling poverty follows close on the heels of a conflict. We see in the many life histories of families and by mapping post conflict vulnerabilities, that a complex web of losses at multiple levels - physical, economic, social, psychological etc. interact with one another to create ill health and retard development of already impoverished and fragile households. We also see that risk factors to ill-health increase significantly while protective factors decrease making the affected households and especially populations of women, young girls, children extremely vulnerable with few resources to cope and remain healthy.

Women remain highly vulnerable to ill-health and ill-being long after the episode of conflict. The stress and tension of survival seems to get embodied in their bodies and even gets passed on to the next generation – as seen in the ill-health of women and also ill-health and deaths of children following a conflict. Alcoholism amongst men with its attendant problems
has increased greatly after conflict and so, while most men externalise and cope with the loss by taking to self-destructive habits like alcohol, women seem to absorb and internalise the stress and tension into their bodies. Young girls after a conflict remain vulnerable. Many of them lose their education, become child workers and become extremely vulnerable and at risk of abuse. As adults get preoccupied with survival after a conflict, the education and development of children takes a backseat. Children face malnutrition, ill-health, deaths, loss of education and loss of development apart from mental trauma, fear and insecurity.

Conflicts cause upheaval not only in the lives of those who have experienced violence directly through losses or displacement but also to those who have been just exposed to conflict by their presence, like the Nepali community in our study. As the host community to the Adivasi IDPs in Deosri, they also claim to have experienced economic loss and also loss of lives because of epidemics. Caught between the two communities in conflict, they have had to negotiate and balance delicate social relationships. The loss of health infrastructure and weakening of the health systems and also general governance also affected their access to health and other essential services. Then, pressure on natural resources and destruction of the ecology (tree felling, soil erosion, floods, falling water table, human-elephant conflicts etc.) because of conflict displaced populations affects lives, livelihoods and the very existence of all in the conflict area.

To help conflict-affected populations negotiate an acceptable quality of health and well-being, we would need a long-term, multi-agency, multi-layered approach which goes beyond addressing emergencies, reduces vulnerabilities and focuses on long-term and sustainable recovery.
3.3 Health Seeking among Conflict Affected Communities

Introduction
How do conflict survivors with hugely depleted resources and left extremely vulnerable (as seen in the previous chapter 3.2) cope with illness and disease after a conflict? What treatments do people resort to when the public health system is collapsed and so weakened following conflict? In this chapter, we try to understand the coping and health seeking behaviour among conflict survivors. We try to map the landscape of formal and informal, government and non-government health providers following conflicts and the role played by each of these in the wake of conflict and how these interact with each other. During our study, we found that people accessed four types of health service providers following the conflict:

- **a. Traditional Healers**
  - Faith healers (called deosigiri, gonokhi etc. who are exorcists who get rid of the evil eye)
  - Ojha (could practice a bit of faith healing but also gives herbal medicines)
  - Kobiraj (generally administers herbal medicines but used interchangeably with ojha)

- **b. Pharmacies - unqualified practitioners of modern medicines**
  - Local markets
  - Reputed practitioners consulted as experts for treating certain illnesses like malaria or pneumonia etc.

- **c. NGOs**
  - Medicins Sans Frontieres (MSF)
  - Missionaries

- **d. Government Hospitals**

In our study, we found that dependence on informal health care providers is very high as the public health system is unable to respond to health needs of people in conflict areas.
Informal health practitioners such as traditional healers, pharmacist and NGOs take over the role of health care providers in an area where there is lack of government health care. The informal health care providers have established an understanding and a relationship with people and people can reach out to them for any illnesses. Let us examine each of the non-formal health care providers in depth and see how the families affected by conflict interact with them.

3.3 a. Traditional healers

Traditional healers also known locally as ‘Ojha’, ‘Ojha Guru’ or ‘Kobiraj’ are practitioners who have been curing people either by offering pujas (ritual worship) & sacrifices or herbal medicines. Giving jungle roots, herbs and jadibuti (herbal medicines) is a very common form of traditional healing for any kind of illness. People approach the traditional healers for illnesses such as malaria, jaundice, diarrhoea, abdomen pain, dysentery, typhoid, broken limbs & hands, snake bite, menstrual problems, black magic, family problems etc.

Different traditional healers have their own way of diagnosing illnesses, preparing and giving medicines. Not every illness is treated by offering pujas or giving herbal medicines. Niranjan Narzary a traditional healer said “I treat fever by collecting herbal medicines and making a paste. The paste is put on the forehead to bring down the temperature. The jahrinai (getting rid of evil spirit) is done by checking the symptoms and based on the symptoms I perform the jahrinai. I particularly do the jhar for twisted ankle and broken limbs. I also do it for those persons possess by evil spirits.” There are other set of traditional healers who pray and meditate to find out people’s illnesses and problems. Chandra Murmu, a traditional healer from Deosri said, “Doctors do blood test to find the illness a person is suffering from, but I meditate and diagnose the disease...also in the meditation, I am able to see what medicine is needed to treat the illness.”
Lohit, a 25-year old faith healer has patients who come to him for serious cases and illnesses as well as those having problems with the Gods. “The serious patients that come to me are the ones that are bed ridden and on whom doctors and ojha’s medicines have not worked. When a person contracts multiple illness, it is very difficult to get them healed”.

Interviews with different traditional healers have led us to understand that prior to the conflict in 1996 the people were dependent on traditional healers or on herbal home remedies. Some households living deep in forest areas got introduced to modern only when they were displaced to the relief camp. They now have a mix of plethora of treatment seeing practices. Many even after being introduced to modern medicines also visit a traditional healer. Only traditional healers are consulted for certain illnesses, like jaundice, snake bites and bone setting. They are also preferred if people are not satisfied with the medical treatment, especially if it is a prolonged illness.

Badal Tudu is a 70 year Adivasi healer from Koraibari village. A follower of Bajrang religion (form of Hinduism), he reached Koraibari 3 years before the conflict of 1996 in search of land. When the conflict broke out he lived in Deosiri Relief Camp for years and continued his practice which he had started back in his previous village. Both his parents were traditional healers and he learned from them. He says “People come to me if doctor’s medicines fail to help them recover. I give herbal medicines and offer puja for healing the patients. Some of the illnesses that I have been able to cure are-Tuberculosis, pneumonia, typhoid, jaundice, malaria, abdomen pain, swollen body, menstrual disorders, diarrhoea, wounds, paralysis, etc. Before the 1996 conflict people from Koraibari suffered from malaria and diarrhoea. In those days the villagers were largely dependent on herbal medicines and traditional faith healings. The ojhas used to treat malaria by seeing the symptoms such as shivering.

In the 1996 relief camp I treated many people who were suffering from diarrhoea and wounds. In the camp my first patient was a woman who suffered from diarrhoea. When the women recovered the others realised that my treatment was good. Thereafter many started to come to me for the same. Many people in the relief camp who could not avail proper treatment died from diarrhoea. I could not treat all the suffering people because I could not collect the herbs and roots from the forest because of the conflict. I do not charge any fees
for my treatment. People pay me according to their wish. The highest I was paid till today is 1500 rupees and the minimum I have received is 50 rupees”.

Traditional healers are not just men but a number of healers in the area of study are also women, especially those faith healers who perform rituals to exorcise the evil eye/ evil spirit from a person’s body. Mansi is one such female Bodo Deosigiri (exorcist) from Gasagaon village. She says that when families come to her after they have spent a lot of money on ojhas, doctors and medicines and are still not recovering. She explains that when the family gods and goddesses are displeased with the family they cannot be cured with medicines, either modern or herbal. She then directs the family to do the required rituals and offerings to appease the Gods and only when this is done, the patients are advised to visit the doctors again as only then will the medicines work.
Traditional Healers at work

A signboard of a traditional healer giving the rates of various types of services offered; the English Translation is given alongside.

Established 2015
Notice Board

- Open from 9.00am-12.00 noon (Patients seen between this time).
- Open the following days: Tuesday, Thursday and Saturday.
- Those entering the altar should come along with the following: incense sticks; betel nut; other essentials.
- Slipper and mobile phones prohibited inside and around the altar.
- Non-veg food and drinks prohibited before entering the altar.
- None other than a family member can be present while communicating with the deosigiri (gonoki) in the altar.
- Contribution of 11 rupees on first entering the altar.
- Cost for an amulet= Rs. 501
- Cost for gastric medicine= Rs. 101
- Purification of family from evil powers/possession= Rs.201
- Leg massage medicine= Rs. 101
- To revive goddess of luck for the family: Rs. 251
- 80 pieces of betel nut and betel leaves to get rid of an evil eye.

A Bodo patient consults the deosigiri (gonoki) who is lying down in a trance in

An Adivasi man comes to consult an Adivasi ojha to find out if his wife will have a safe

3.3  b. ‘Pharmacy’ in Village markets

Locally called ‘pharmacy’, these untrained, self-taught and non-licensed practitioners of modern medicines has become the first line treatment choice of poor families in the study area. Most of the pharmacists have learnt from observation and apprenticing with other pharmacists and they give medicines for most illnesses, apart from administering saline, injections and conducting malaria tests. Having got used to modern medicine but due to the poorly functioning government health centres and non-availability of medicines, there is a
high dependence of people on these pharmacists. Some of the pharmacists were the sole health care providers during the periods of conflict and having won the trust and confidence of the people, continue practising till date.

Ganesh Hasda is a 40 year old Adivasi male who runs a pharmacy in the Deosri Relief Camp. He says he learnt the trade from his uncle and started treating patients when he was just 15-16 years in the Deosri Relief Camp. People acknowledge him as saving more lives during the cholera outbreak than the government or anyone else. He says “When the conflict broke out in 1996 and Adivasis moved into the relief camp, they were scared to go out for medical treatment. They were also falling seriously ill with diarrhoea but received very little health care. At that time, many of my relatives urged me to come to the relief camp and provide medicines. So, I moved along with my family into the relief camp. I bought my first stock of medicines with my own money, and thereafter reinvested all the income I generated from selling medicines in the relief camp in buying more supplies. When the need to administer saline drips arose, I saw how they were doing it at the Shantipur pharmacy and

“We hesitate to go to the Shantipur hospital because it is too expensive, and besides the doctor just writes the name of medicines on a slip and sends us to the pharmacy. So, we might as well go to the pharmacy straightaway, why go to the hospital?
- Lucy and Mary, Adivasi women from Mohanpur village.
started performing that task as well. According to me, people prefer medicines and when they do not get well, then they go to the ojha [traditional healer]”

This corroborates the views of the traditional healers who also say that people visit them if they are not cured by modern medicines. Patients have their own reasons for preferring pharmacies over the government health centres which also dispenses modern medicines. Amba Tudu, an Adivasi woman from Mohanpur Village say, “We need to pay both in our local pharmacies and the government hospital. But in the local pharmacies, we can get credit. Moreover, they (the pharmacists) are well behaved and nice to us and also available to us all the time, unlike in hospitals when the staff have fixed duty hours and not available otherwise.”

Use of modern medicine is linked to the conflict and the Adivasi respondents say that only after the conflict that they came across modern medication and treatment for illnesses like malaria which is rampant in the area. “During those days, people were not aware or have never heard of the word ‘malaria’. In cases of shivering and high temperature, people opted for ojha for its treatment. In Santali language, the word rabang ruea denotes a type of illness which has symptoms identical to malaria. This illness reached its peak in the morning and evening hours, during the day time symptoms remain un-noticed. The traditional method of healing/treatment for rabang ruea was using the yellow coloured insects nest found in the maze plants. Rabang ruea disappeared with burning smoke of the insect nest. The whole villagers practiced this as home remedy for recovery from rabang ruea.

When we came to live in Deosri Relief Camp in 1996, we learnt that rabang ruea was known by a different name. Doctors coming to the Relief Camp called it as malaria. Over the years rabang ruea/malaria cases has been consistently increasing. It was rampant during our stay in the relief camp. The traditional practiced method of healing from rabang ruea has decreased over the years. Today the villagers visit pharmacies or hospitals for medication”.

*Suraj Mardi, male, Adivasi, Koraibari*
Rajib and Sankar are two pharmacists who share a pharmacy in the local market. Sankar has been providing health service in the area since the past 11 years and tells me that the most common illnesses in the area are malaria, typhoid, itches (skin allergies) and gastric. I spent an afternoon watching Rajib, Sankar’s pharmacist partner treat many different patients. Five patients—three men and two women—came for painkiller tablets. Then, an Adivasi man from Korabari came to buy medicines for his wife suffering from severe pain because she had delivered a baby in the house that morning. Rajib gave him two tablets worth 10 rupees for the pain. Then, another two persons were suffering from fever and one person from continuous headache. There were three cases of malaria. One woman approached him for skin infection medicines and a newly married woman bought a medicine in private from him and does not want to reveal. Another woman came to buy medicines for her child who is having skin infection. A mother of a 17 year old girl came to get medicines from him because her daughter cannot get up from bed. The medicine taken before did not work so her mother takes medicines for typhoid today. There were a lot of blood tests also done of patients today. He saw a total of 18 patients today.

3.3 c. Role of NGOs in Health care in Conflict

The public health system already weakened by violent militancy could not respond to the humanitarian crisis when the conflict broke out in 1996 and 1998. This gap was filled by various non-government actors. The church first provided some amount of medical relief services during the height of the conflict but largely, people in Deosri and its surrounding areas were left to survive with their own devices. One of the most significant contribution to health services post the conflict was made by an international NGO called Medicins Sans Frontier or MSF who arrived in Bongaigaon to serve the people affected by conflict. MSF’s role was highly recognised and remembered by the people till today for the service they provided during the emergency period especially in tackling malaria. People remember them as ‘The NGO’ who was there after the 1996 conflict.

Of that period and the role of MSF, one of the pharmacists from Bordangi says “There was huge rise in the number of malaria cases by 1996 i.e. the conflict period. Government health centres and the few pharmacies of the area were just inadequate to address this rising
problem. I suspect malaria spread such abnormally because people gathered in huge numbers in the relief camp. When MSF came to tackle malaria it could control its increase to a large extent but one could see huge numbers of malaria cases even after five years of their intervention.”

We interviewed Dr. Rajiv Das in Delhi. He was a part of the MSF team in Bongaigaon from 2003-2007 giving his services as a medical doctor. He said that MSF began its work in Assam in 2001 in the Baksa district, but shifted to Runikhata and Deosri in 2003. These areas were selected in keeping with MSF’s mission statement of helping those who ‘lack healthcare due to conflict’. He came to Runikhata in 2003 as well. The Runikhata dispensary was lying abandoned and MSF took over that building. Most local health centres were not functioning at that time since health workers were afraid. MSF did recruit two local nurses. Thereafter, they expanded into Shantipur since the malaria situation was very severe there. The Runikhata and Shantipur clinics were in the dispensary buildings while the Deosri clinic was in the LP school building. There was no infrastructure whatsoever in the dispensaries when the MSF team opened their clinics. They had to bring in everything from beds to lab equipment. MSF also recruited Community Health Workers (CHW) from the local population and trained them as per their existing knowledge levels and skill sets. For example, those who could read and write were given registry work. There were five CHWs in Runikhata, three in Deosri and two in Shantipur.

MSF treated patients free of cost but they only ran OPD clinics, with a labour room. For surgeries, caesarean deliveries and serious cases, until 2003, patients were transferred to a private hospital where they had a tie-up and MSF paid the costs. When the Kokrajhar District Hospital became functional, serious patients were transferred there. MSF also established malaria labs where they trained local individuals how to check blood samples for malaria.

Dr. Das said that the MSF team was always made to feel welcome by the community and never felt any opposition, neither from the local population, nor from the militant groups, nor from the security forces. He feels this may be because of their policy of providing treatment to one and all, without discrimination or bias. “Throughout our stay in Runikhata,
Deosri and Chirang, the common people were not concerned with fighting but more caught up with the struggle to survive”. He mentioned more than once that in the waiting rooms of MSF clinics, members of all communities would sit together, wait together, discuss each other’s symptoms, enquire about each other’s children’s well-being. Since the patients were seated on first-come first-served basis, there was no grouping together of a particular community, nor any preference or bias. Even militants, police and CRPF men sat together with the common people while waiting for a check-up”.

Apart from medical services, MSF also looked at water and sanitation. “They checked the drinking water consumed by the people living in the camp. They tested the well water for germs and other water borne diseases and helped disinfect the wells. They also installed hand pumps and dug well water in order control water borne diseases. Prior to this the camp people were dependent on the river to collect their drinking water”.

- Raman Hasda, Adivasi male working as a community worker in an NGO in Deosri

MSF served in the area for five years from 2002 to 2007, leaving when some of amount of peace and stability had returned. It was also just when the nascent National Rural Health Mission (NRHM) programme was being launched and MSF even signed an MOU with the State hoping that the government would be able to take over the services they started. But it was a long shot in the dark. The government health services never replaced the high quality of care and services that MSF had established and people had gotten used to. While undoubtedly MSF did a very good job in saving lives and filling critical gaps in government health services left broken by the conflict, it has its critics, even within the community.

Noren is a Bodo teacher in his late 40’s from the Deosri area who was witness to the years of unrest and conflict. Appreciating MSF for their role, he says “Their major focus was on malaria and many lives could be saved from malaria because of MSF, but their medicines were very strong and of high dosage. When they left after their project ended in the year 2007 our malaria medicines did little good to help malaria recover”. This feeling is also echoed by some of the Nepali leaders in the area. “I heard that MSF is from America. They used very high dose of medicines on our people but still, it helped address the health crisis of the period”. Another Nepali community leader though appreciative of the malaria
services during the emergency was less kind in saying “All the mental patients from the area are because of MSF’s medicines. They introduced new high dose medicines like Larithar to help patients quickly recover from malaria. Though malaria was subdued and was under control during their five years project, it once again turned out to be the major problem after they left this place. Only this time (after they left) malaria was even getting worse because medicines from the local pharmacies and government health care centres could not cure malaria anymore. The available medicines were of inferior quality and it no more helped in treating malaria”.

3.3 d. Understanding treatment pathways of households in conflict areas

In our study, we found that all communities in the study area, Bodo, Adivasi and Nepalis use a mix of treatment services. Irrespective of the community they come from, people use only traditional healers for a few illnesses like jaundice or conditions like dislocations and snake bites. They also use some home remedies and herbs for small illnesses. But apart from that, belief in modern medicine is quite prevalent and the choice of treatment is most times dependent on the ‘purchasing capacity’ of the family.

An interview with Mansi Chetri, a Nepali shop-keeper in Deosri gives an insight into the treatment seeking behaviour of people in the study area. Mansi lives with her son and his wife in Deosri. The daughter-in-law gave birth to a baby girl recently and she says that the baby was born at home and was quite okay till the 11th day of birth. That day they had the ‘naamkaran’ (naming ceremony) and had invited many people. “Such a crowd”, she says, “who knows who has cast what kind of an evil eye? Also, when the punjikaran (horoscope) was consulted, the priest said that there is dadi-poti grihuh (grandmother and grand-daughter’s stars were clashing)”. She says that from that night onwards, the baby would not stop crying and started ‘withering’. “We call it ‘monkey bimari’ where the child starts shrinking and becoming skin and bones. She just would not stop crying. We first took her to the ‘child specialist doctor’ in Kokrajhar. He gave medicines but it did not help. Then, we started taking her from one ojha to another to ‘jhado’ (remove evil eye) as it was evil eye and she needed to be rid of it”. Sometimes, they were so desperate when the baby just would not stop crying even for a minute that they would even rush her to an ojha in the middle of the night.
“Someone told us about a famous ojha in Panbari near Bijni (over 70 kms away). We got the number and I called him up and explained to him our problem. He said that he would prepare a special ‘tabiz’ (amulet) for the baby. We took a vehicle and went all the way to Chapaguri and he met us there. We paid him 1000 rupees for the tabiz. It was waste. No effect. Yet another time we paid Rs.500 to buy another “tabiz” made up of silkworm cocoon and that also did not work”. They had already spent over 22 thousand rupees on the child and didn’t know what to do. “Finally, it was a Bamun (Brahman) ojha in Gurubasha (around 25 kms away), a Nepali, who had seven sessions of evil eye removal or ‘jhado’ before the child became okay when she was one month four days old. This ojha was paid 101-103 rupees for each session and Rs.350 for the tabiz (amulet). For almost a month, no one slept or ate properly. Now, the child is okay and not need to go to a doctor”.

Mansi is considered relatively well-off as she has a small business and good income apart from having a small family. Hence, she first went for specialised medical treatment. For most of the poor families in the study area, using the services of pharmacists or local healers is the only option they can afford.

**Poverty Vs. Culture in Treatment Seeking Behaviour**

In our study we see a difference in the way Adivasis seek modern medical treatment vis-à-vis the Bodos and the Nepalis. Though one thing emerges clearly – that in most cases it is the level of affluence and affordability that decide the treatment pathways of households in the study area. The Adivasis delay in seeking modern allopathic treatment for most illnesses because they cannot afford to buy medicines and hence they wait for the last moment.

Rajib Mushahary, a popular Bodo male pharmacist practicing in a village market; has both Adivasi and Bodo clients. Of the Adivasis, he says, “They usually delay in coming for check-up. When a person first falls ill he/she is first given some tablets which they buy from the pharmacy. The family keeps waiting for better results at least for two days. When the person does not improve, then only they are brought to the pharmacy. Often when a person is found to be shivering and having high temperature, the person is treated with malaria and typhoid injections even without blood tests. People try to avoid the expense of conducting
the tests. Many Adivasis do not complete the malaria treatment course. When they feel better with just one injection, the person stops the course. On many occasions people cannot complete the course because they do not have the money for the injections”.

We have also found belief in faith healing – prayers, sacrifices and rituals – to higher among Hindu Adivasi villages than among the Christian Adivasi families. Christians prefer to go to the doctor and pharmacist while the Hindu Adivasis access both modern medicines and traditional healers. Chandra Murmu is a Hindi Adivasi ojha. He says, “Though the Christians Adivasis claim that they use only modern medicines, a few of them come to us secretly when they are not recovering with medicines or their prayers. Some ojhas do not treat the Christians but I do not have any discrimination and treat all the people.”

Suraj Mardi, an Adivasi male village leader of Koraibari village shares, “I fractured my wrist two months ago. I first consulted Ganesh a pharmacist in lower Deosiri. I paid 55 rupees for each injection and spent a total of 700 rupees as he also gave me some of tablets. As the number of injections increased, the pain got worse. When I realised that the injections were not doing any good to my hand, I started performing the prayers & offerings (puja-path) and applying herbal medicines. In our village, no one with broken limbs is taken to hospital for X-ray or treatment but is treated in the village itself. Depending on the nature of fracture, it takes its own time for recovery. In another incident, an old man was taken to Shantipur hospital in a bullock-cart. Doctor from the hospital referred him to town hospitals. The family did not have any cash and had nothing to sell to raise cash. Even Santosh (An Adivasi pharmacist in Shantipur) pharmacy was closed that day. The family returned after purchasing few tablets from the pharmacy which did little help to recover. On return, all the villagers gathered in the house of the old man and offered puja. He recovered after and till date, is healthy and fine.”
### 3.3.1 Matrix of Health Facilities Availability

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Village</th>
<th>Community</th>
<th>Nearest Government Health Centre</th>
<th>Distance to Govt. Health Centre</th>
<th>Do Health Personnel stay at Health Center?</th>
<th>ASHA Worker available or not</th>
<th>Number of Pharmacies in the village</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bhurpar Balabari</td>
<td>Bodo</td>
<td>Runikhata</td>
<td>1 Km</td>
<td>MBBS doctor visits but does not stay; some health personnel stay on campus</td>
<td>Available</td>
<td>11-12 (approx) in Runikhata Bazaar</td>
</tr>
<tr>
<td>2</td>
<td>Kusung Dwisa No. 2</td>
<td>Bodo</td>
<td>Shantipur</td>
<td>10 Km</td>
<td>Ayurvedic doctor stays on campus but remains in his room most of the time; 2 nurses are posted but do not stay</td>
<td>Available</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>North Simlaguri</td>
<td>Bodo</td>
<td></td>
<td>14 Km</td>
<td></td>
<td>Not Available</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>Deosri RC</td>
<td>Adivasi</td>
<td></td>
<td>3.5 Km</td>
<td></td>
<td>Available</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>Mohanpur</td>
<td>Adivasi</td>
<td></td>
<td>4 Km</td>
<td></td>
<td>Available</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Koraibari</td>
<td>Adivasi</td>
<td></td>
<td>12 Km</td>
<td>Deliveries are conducted against payment ranging from 500-800 rupees; patients complain most medicines have to be bought from outside against prescription</td>
<td>Available</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Nepali Basti</td>
<td>Nepali</td>
<td></td>
<td>4 Km</td>
<td></td>
<td>Available</td>
<td>2</td>
</tr>
</tbody>
</table>

From Fig 3.3.1, we see that in the villages we have studied, access to quality government health facilities remain poor. Six of the seven villages studied depend on Shantipur State Dispensary for services. Earlier, in Section 3.1 (page 35), we saw how weak the services of Shantipur Dispensary have remained after years of conflict. Unavailability and accessible health care system coupled with economic impoverishment of the families is responsible for
the kind of treatment choices conflict affected families resort to. People spent a lot of money on the travel to dispensaries and hospitals. Being very poor, the money that they have is not enough for treatment and medicines. The lack of money makes people withdraw from medical treatment early.

Suraj Mardi, an Adivasi village leader from Koraibari Village explains why all women in Koraibari have home births, “Families from Koraibari prefer home delivery to delivery in hospital. When a woman first experiences pain and it is night time, it is impossible to call for an ambulance. Before mobile phones began to come to the village it was very hard to coordinate between the Asha and ambulance to go for institutional delivery. Even today network coverage is very poor and very difficult to make or receive calls. The Asha’s house is three kms from our village and with wild elephants moving around, it is very scary. So, the children are born at home. During the Summer, it is impossible for an ambulance or jeep to enter the village because of the bad road condition though the distance between the village and the main road is just five kms. Once, we called an ambulance in the night and it reached the village only in the morning. For serious cases, families use a bullock cart to take mothers for delivery”.

**Poverty & Treatment Pathways of two conflict affected families**

From the life-histories of two families, we study the treatment pathways of two families whose family members have falling sick after the conflict. Their desperate attempts of these poor, resource starved families to save their family members shows how poverty after a conflict delays treatment and turns a common episode of illness into health catastrophes leading to death. The first case is of Mohan and Rupsi, a Bodo couple displaced in the 2014 violence. After staying six months in the Relief Camp, they moved to North Simlaguri. We have already studied this household’s vulnerability profile in Chapter 3.2 (Page 58). In this section, we look at their treatment seeking efforts for their two young sons of 3 ½ and 2 ½ years and the outcome of their efforts.
Fig 3.3.2 above shows

The next case history of Binod and Lakhi Tudu, an Adivasi couple living in Koraibari shows the how the struggle for basic healthcare is a catastrophe for conflict affected families newly impoverished by conflict struggle.

Binod married Lakhi when she was just 15 years old and they fled to the Deosri relief camp in the 1996 conflict. Of the three children Lakhi gave birth to while in the relief camp for 10 years, only the eldest girl called Sarna survived. They went to live in Koraibari village in forest land next to the Bhutan border, Lakhi and her family again had to flee in the recent 2014 Bodo-Adivasi conflict. This time they lived only for 6 months in the relief camp. Though they managed to save a few of their cattle, they lost over 200 kilos of harvested paddy and their house and all belongings had been burnt to cinders. When the government stopped all rations and support to the relief camp inmates, they were forced to return to their village. Lakhi’s 15-year-old daughter Sarna had gotten married a year before the 2014 violence. Left with nothing, the new couple survived with doing daily wage labour in Bhutan. She and her husband also fled to the relief camp but returned from there to live with her parents. Sarna was 2 months pregnant when they returned from the camp.
Figure 3.3.3 shows how poverty after a conflict negatively affects health-seeking behavior of an affected household leading to ill-health and death. In Lakhi’s life-history, all three children she gave birth to, died after two rounds of conflict. Ironically, one died trying to give birth herself as seen in Figure 3.3.3. This life-history also points out that women embody the accumulated marginalizations and inequalities of their life circumstances which is further accentuated by conflict and this embodiment is even “inter-generational” [Nancy Krieger, 2010]. In situations of conflict and fragility, negative life events are so acute that recovery from it becomes very difficult. With no support from either government or non-government agencies after a conflict, minor illnesses end up as health catastrophes. Within
six months of their return to their forest village from the relief camp in May 2016, nine young children and two women (one of them is Sarna in Figure 3.2.3) of Koraibari Village died in a ‘malaria epidemic’. The health department carried out malaria detection and treatment camps after the deaths. But that stopped after the public outcry over the deaths ended.

Summary

All communities in the study area, Bodo, Adivasi and Nepalis use a mix of treatment services. Irrespective of the community they come from, people use only traditional healers for a few illnesses like jaundice or conditions like dislocations and snake bites. They also use some home remedies and herbs for small illnesses. But apart from that, belief in modern medicine is quite prevalent and the choice of treatment is most times dependent on the ‘purchasing capacity’ of the family.

Traditional healers and pharmacists in the days to come will continue to be health providers in the absence of a good health care system. The traditional healers and pharmacists are within the reach of people. Besides, traditional healers give mental and emotional succour to people. In the long run, ambulance services need to be improved because most of the IDPs live in areas which are very far from the main road. If these services are active then it will cut down the cost of travel for people.

With conflict comes displacement and various losses which affect the daily lives of people. Treatment seeking behaviour of people is also determined by economic factors. If there is enough money then people do not have to worry about reaching out for treatment.
3.4 Role of State Promoting Health & Well Being of Communities in Conflict Areas

In this study, we raise a difficult question of whose responsibility is it to look to the well-being of forcefully displaced families following conflicts? Conflicts occur primarily because of a break-down in law and order, whose maintenance is the prime responsibility of the State. Hence, when families get forcibly displaced because of a failure of the State, then can the State be absolved of caring for the welfare and well-being of such people?

50 The UN Guiding Principles on Internally Displaced Persons (IDPs) says, “IDPs are persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized state border.” It is interesting that India does not officially acknowledge the presence of IDPs due to internal conflict and the Indian government has repeatedly expressed reservations in international fora about the UN Guiding Principles on Internal Displacement, which it sees as infringing its national sovereignty. India has no national IDP policy targeting conflict induced IDPs, and the responsibility for IDP assistance and protection is frequently delegated to the state governments. 51 In fact, the recent *National Relief and Rehabilitation Policy 2007* talks about rehabilitating people displaced due to developmental projects, but it does not talk about conflict-induced displacement.

The Assam Government on its part passed an act called the *Disaster Management Act, 2005* which guides government response to disasters. The *Assam Disaster Management Manual, 2015* 52 lays out detailed response to disasters but most of these pertain to natural disasters such as floods and earthquakes. In fact, man-made disasters (of which conflict is one) is mentioned only in passing in the manual. But conflicts, especially ethnic conflicts that have

50 Johanna Lokhande, Centre For Social Justice, Ahmedabad; posted in “Counterview” on May 23, 2013; https://counterview1.files.wordpress.com/2013/05/assam.jpg
52 Assam Disaster Management Manual, 2015; Revenue & Disaster Management Department, Government of Assam
major elements of social breakdown, disharmony, fear, insecurity and aggression may not lend itself to management like natural disasters. Also, the displacement following the disaster is sometimes long term or even permanent, as is seen in many of the villages and families in this study.

It is seen that most of the time, following displacements after disasters, government agencies try to force the families to return to their villages as soon as possible. While this is desirable as it helps restore a sense of normalcy and helps families move on with their lives, in ethnic conflicts the situation is more challenging. The physical insecurity and fear of attack makes it difficult for victims of ethnic conflicts to return to their village immediately. Sometimes, those families who have lost a lot of material goods have no resources left to start life. If the government delays in providing sufficient compensation and there is also no support from non-government agencies, they are unable to go back. The response to conflicts thus need to be tailored to this context and not automatically be clubbed with responses to natural disasters.

Let us look at some of the important aspects of government response in FCAS areas and how it promotes the health and well-being of people living in such areas.

a. Governance in a Fragile Conflict Affected Area

It is the government’s role and responsibility to look after the welfare of its citizens and provide for services that promote the health and well-being of people living within its boundaries. But the government can only deliver such services where the governance structures and processes are in place and it functions as how it is supposed to function. So, in Fragile Conflict Affected States (FCAS), a question we need to ask ourselves is, ‘Is conflict the result of poor governance or is poor governance the result of conflict?’ It is a very difficult question to answer and even seemingly pointless for those struggling with the day-to-day reality of living in such areas. The reality is that essential services that the State is supposed to provide to its citizens are compromised, there is low accountability to citizens and the government seems incapable of managing core social programmes and functions [Kruk, 2010].
In this light, the areas under study suffer from a triple jeopardy of governance. Apart from bearing witness to two and a half decades of fragility and conflict, it is in a border area suffering from the neglect that most border areas suffer. Thirdly, most of the communities are viewed as ‘illegal occupiers’ of forest land and hence, their entitlements as full citizens seem to be suspect.

The field notes of junior researcher JM on 21-9-2016 about North Simlaguri; a Bodo Village displaced in the 2014 conflict refers to the loss of entitlements of conflict affected families of Kombla Mandir. ‘While in Kombla Mondir too (their original village from where they got displaced in the 2014 conflict) the villagers never got much in terms of government service, schemes and programmes. But the villagers were in the process of making their ration cards and they told me that the headman in Kombla Mondir had asked for a treat from them and each family collected Rs. 20 to buy alcohol. They were assured that all the families would be getting their ration cards but even today, only one person in the present village (North Simlaguri) has a ration card. No one else has a ration card’.

If the state of the physical infrastructure of government building (from where governance takes place) is an indication of the state of governance in the area, then the office of the VCDC (Village Council Development Committee, akin to a Panchayat in non-scheduled areas) in Deosri speaks volumes. The VCDC ‘office’ functions out of the veranda of what was earlier the ‘forest office’. This run-down building is multi-functional, earlier it was the school, distribution point of relief materials during conflicts, Anganwadi centre (early childhood centre); immunisation point etc. An interview with a VCDC member in the “office” is revealing about the state of local governance in the area.

“Deosri VCDC has 1236 households under it, with 6800 population. As VCDC members, we are expected to do all the work of the government – like implementing all the schemes, selecting the beneficiaries, carry out the NREGA (National Rural Employment Guarantee

53The autonomous Bodoland government when formed in 2003 rejected Panchayats as the local governance structure and have a separate structure in place. VCDCs is the Panchayat equivalent in the BTAD areas. But they are nominated and not elected. Women’s reservation and other rules governing panchayats do not apply to VCDCs.
Act) work, issue certificates to people etc. but we have to do it with no support. For example, there is no salary for any of the VCDC members, not even money for fuel for vehicles or even stationery like paper and pen! There is so much of paper work to be done. They keep asking for reports and for data which we have to send. Nowadays everything is computerised and so all the data has-to- be really up to date. We do not even have a computer. The VCDC Chairman’s brother has a personal laptop and he helps us put in all the data. The Chairman pays him a little bit for it. The PD-DRDA (Project Director- District Rural Development Agency) pays me Rs.4500 a month for my work as VCDC Secretary and that too we get only once in six months or so. I manage because my elder brother is a farmer and he supports the family.

For all this work, we need at least 2-3 full time salaried persons and one accountant cum data entry person who knows computer. We should get Rs.15,000 salary for there is a lot of work to do. I hear in Bengal, they get Rs.12,000 for the kind of work that I do here in the VCDC. We do not get income even from selling VCDC certificates here (because very few people require it). The Chairman got 1000 pieces printed at his own cost. We charge Rs.20 for the certificate with only Chairman signature and Rs.30 if it needs to be countersigned by BDO as we need fuel and other expenses if we need to go all the way to Sidli Block office to get it signed. If at least certificates would have been sold, we would have been happy as at least some money for our tea would have come from this”.

Biswajeet Murmu; Adivasi; VCDC member of Deosri.
The Deosri VCDC Office in the Veranda

Overall, we observe that the level of development in the villages under Deosri VCDC are worse off than villages under Shantipur VCDC. There are roads and other infrastructure such as schools and health centres in Shantipur. Then, there are also more government schemes implemented there than under Deosri VCDC. A Bodo VCDC member from Shantipur had this explanation to give,

“There are forest revenue villages and then forest encroached villages. Under the Forest Rights Act, families living as encroachers are not entitled to any services. If today some services reach them (Deosri VCDC), it is purely on the ground of humanity (and not an entitlement). Most of the villages under Deosri are encroached villages. Earlier, no development works could be done in these areas and today, it is the money of BTC and DRDA that is being spent for development in these areas. There are technical difficulties in the implementation of schemes and services in an encroach area”.

– Bodo male; Shantipur VCDC member

We found this argument repeated by most government officials we interviewed regarding lack of health, education and non/poor implementation of different development schemes in the Deosri villages. But how much of basis does this oft repeated argument hold to deny
citizens their basic rights and entitlements to government welfare measures? A 33-year old Adivasi male respondent in our study displaced from Koraibari and now works as a mobiliser in an NGO questions, “the government does not give us facilities since we are forest encroachers and illegal in their eyes. Then, how come they have no problem in taking our votes during elections? How come we get recognized as citizens only then and not otherwise?”. Without clear policies and guidelines regarding status of forest dwellers, some of the most vulnerable populations in dire need will remain without essential services that is supposed to be provided by the government.

b. Status of Rehabilitation Policies in Conflict Areas

Many of the families in the study area live in forest land because they have not been properly rehabilitated after their displacement following various ethnic conflicts. Hence, the rights of forest dwellers in fragile conflict affected areas in Assam is closely linked to the rehabilitation policies of Internally Displaced Persons (IDPs).

“In Assam, group discussions with IDPs revealed that in 1996, the camps were packed beyond capacity, with as many as 20,000 crowded in just one of them. Only in the initial few weeks the government provided essential items like, oil, clothes, lamps, water pump etc. Subsequently, the relief would boil down to rice and dal. Even during the latest Assam violence in 2012, the government provided rice and dal, and some nutrients to pregnant mothers and new-borns. After the recent 2012 violence, despite severe cold in Assam, the IDPs at the Sakkipara camp were not provided with warm clothes. The situation was the same with the IDPs at West Gumurgaon and Rangjohra”. [CSJ Report, 2013]

If the relief rations were inadequate while the IDPs were in the relief camps, the rehabilitation and resettlement policy, packages, schemes were even more opaque. Rabindra Murmu, an Adivasi man of 33 years who never went back to his village and has settled around Deosri Relief Camp says this of families displaced by the 1996 conflict living in Deosri Relief Camp, “By the end of 2004, the government announced compensation of

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54 CSJ (Centre for Social Justice, Ahmedabad); REPORT of A STUDY ON INTERNALLY DISPLACED PERSONS OF INDIA MAPPING AND CITIZENSHIP RIGHTS; http://www.centreforsocialjustice.net/wp-content/uploads/2015/12/A_Study_on_Internally_Displaced_Persons_of_India.pdf
Rs.10,000 following which the families had to leave the relief camp. Hearing the amount, Adivasi families from the camp strongly decided that they would not leave the camp if they were not compensated for their losses incurred as a result of the conflict. During the election campaigns, different (political) parties make promises to their issues of rehabilitation, compensation and other entitlements. But, all these promises have never come true even till date. Different Adivasi organisations have submitted memorandums and appeals to all the leaders. We have even maintained photocopies of all the memorandums and applications we have submitted to different political leaders and other government authorities”.

c. Status of Health Promoting Schemes in Study area

Health is not just about medical services when people are ill but also a range of essential services that the State is supposed to provide for the welfare and well-being of its citizens. There are many welfare services for the poor in India but the most important health related services include subsidised rations for the poor, guaranteeing work which leads to food security like the MGNREGA (Mahatma Gandhi National Rural Employment Guarantee Act) guaranteeing 100 days of work to every family. Then, there are childhood nutrition and education schemes and also compulsory Mid-Day meals for children in primary schools. Apart from that, the Public Health Engineering Department (PHED) of the government is supposed to provide water and sanitation facilities to the people.
### Fig 3.4.1: Matrix of Government Facilities Available in Villages of Study

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Village</th>
<th>Community</th>
<th>No. of Households</th>
<th>ICDS/Anganwadi working?</th>
<th>Government Primary School Available?</th>
<th>School Mid-day Meal Available?</th>
<th>Piped Water Supply</th>
<th>No. of Latrines in Village</th>
<th>MGNREGA Job Card Holders</th>
<th>Distance from nearest health center (Km)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bhurpar Balabari</td>
<td>Bodo</td>
<td>59</td>
<td>Yes</td>
<td>Irregular</td>
<td>No</td>
<td>3</td>
<td>40</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Kusung Dwisa No. 2</td>
<td>Bodo</td>
<td>77</td>
<td>Defunct</td>
<td>No</td>
<td>No</td>
<td>0</td>
<td>77</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>3</td>
<td>North Simlaguri</td>
<td>Bodo</td>
<td>9</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>2</td>
<td>0</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>4</td>
<td>Deosri Relief Camp</td>
<td>Adivasi</td>
<td>46</td>
<td>Defunct</td>
<td>Yes</td>
<td>Regular</td>
<td>No</td>
<td>46</td>
<td>3.5</td>
<td>3.5</td>
</tr>
<tr>
<td>5</td>
<td>Mohanpur</td>
<td>Adivasi</td>
<td>127</td>
<td>Defunct</td>
<td>Yes</td>
<td>Regular</td>
<td>No</td>
<td>127</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>Koraibari</td>
<td>Adivasi</td>
<td>160</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>0</td>
<td>85</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>7</td>
<td>Nepali Basti</td>
<td>Nepali</td>
<td>185</td>
<td>Yes</td>
<td>Regular</td>
<td>No</td>
<td>185</td>
<td>185</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

Deosri VCDC has 1236 households under it, with 6800 population. Fig 3.4.1 can be taken as a small sample to show the status of essential government services provided in the villages under the area of study. Let us look at each of the welfare services in detail.

**a. Access to Government Health centres**

Except for Bhurpar Balabari which is close to the Runikhata State Dispensary, all the other six villages access the Shantipur State Dispensary. The distance from the nearest government health centre is an average of 6.5 km with some being right next to the hospital. Both Koraibari and North Simlaguri (the most affected villages in the recent 2014 conflict and hence by far the most vulnerable) are as far as 12 km away. We have already seen that even where access is there, the quality of services in the Government State Dispensaries is highly inadequate and hence for those who need it, it is not of much use. We saw this in the cases we highlighted to show treatment seeking pathways (pages 95-98). We saw how the government health system failed the conflict affected families in dire need leading to the deaths of the most vulnerable i.e. two small children and a young pregnant woman.
b. PDS & MGNREGA

With loss of land, agriculture and work, nutrition security worsens after a conflict, rendering the affected families vulnerable to malnourishment and illnesses. For such families, the food security net which has been ripped apart needs supporting till the affected families are able to gain their balance and find livelihoods which is sufficient to give them needed nutrition and maintain their health. Either work should be made available to them so that they can earn and buy their food or subsidised / free food grains be made available to the conflict affected families so that their nutrition levels are maintained.

In India, the PDS System (Public Distribution System which gives subsidised food grains to poor families; also called the Food Security Act) and the MGNREGA (Mahatma Gandhi National Rural Employment Guarantee Act guaranteeing 100 days of work to every family) are two critical schemes which tries to ensure food security for the poor. Where these schemes are well implemented, the nutrition security net of the poor are significantly strengthened. Important for poor families in any situation, these schemes become critical after a disaster when families have suffered multiple losses and are extremely vulnerable to illness and ill-being.

The Assam Disaster Management Manual, 2015 guides the government’s policy on provision of relief following disasters. The Food and Civil Supplies Department is supposed to be in-charge of giving relief supplies following a disaster. Though the guidelines do not specify the quantity or duration of food that is to be provided as relief rations following a disaster, the local Food and Civil Supplies Department stock and supply around a week to two week’s supply of relief rations. Without proper guidelines, most of the time food grains given as relief are arbitrary, infrequent and insufficient. Under special circumstances, usually requiring a court order following strong demands and protests (such as in the relief camps following the 1996 Bodo-Adivasi conflict), the government could provide free food grains (known as ‘relief’ by people) for longer periods. For example, the inmates of the Deosri relief camp received one kg rice per head per month for almost 10 years following the 1996 conflict. Although it was meagre and insufficient for their needs, it was critical in keeping many families from starvation when they were most vulnerable. It also shows that the government can make special provisions for providing food rations when it is needed.
In the study area, we found both these schemes – PDS and MGNREGA - doing very poorly. Most of the IDPs do not have BPL (Below Poverty Line) ration cards which entitles them to highly subsidised / free food grains. For example, of the 59 households in Bhurapara Balabari (a village with Bodo IDPs), only 5-6 of the households have BPL ration cards. Only one of the nine families in North Simlaguri have ration cards of any kind and of the 160 Adivasi households in Koraibari, only 24-25 families have BPL ration cards. The PDS system is already very weak and irregular and without ration cards, the poor families cannot avail of food subsidy even in this leaky system.

Compared to the food scheme which though irregular and leaky still exists, the work guarantee scheme of MGNREGA is even worse. Though most of the households in villages we have studied have NREGA ‘job cards’ (registration required for getting work under this scheme), there is no work. Adivasi women in a group discussion we had in Mohanpur village say that there is no proper NREGA work for the past two years. They say that only a few people get ‘job card’ work (that is what the MGNREGA work is locally referred to) a couple of days in a year. Most of the work under this scheme is for making village roads but those who need work do not get it. Even if they get, they do not get the money or get it after many months. They complained that some people in their village who worked six months ago have still not got paid.

Biswaajeet Murmu, an Adivasi VCDC member of Deosri blame the people for their unwillingness to work under this scheme. He says, “People here are not willing to do NREGA work. For one road we built, only 15 people turned up to work. No one trusts that they will get paid as earlier, money to the labourers was not paid even after two or three months (if they were paid at all). Now systems are much better, and their wages are deposited into their accounts within 15 days of completing the work but it was very, very difficult earlier. Also, labourers need the money immediately after working and keep enquiring if their money is deposited. Another problem is that the bank is so far away from here. It is in Kokrajhar and Bongaigaon (40-50 km away) and it will cost them Rs.200 for one trip just to withdraw their wages. So, who would want to go to bank to withdraw money? For us (the VCDC), we need NREGA work for if there is some NREGA work, we put in three-
four job cards extra and take that as payment for our expenses. If we cannot pay the VCDC members for their work, we can at least reimburse their expenses. If not, how do we function?”.

The poor performance of these two flagship government programmes for ensuring food security has further increased the vulnerability of the poorest families affected by conflicts in the study area.

c. ICDS Programme

While the health of the entire household is adversely affected by food insecurity following a conflict, vulnerable populations with special needs such as young children, pregnant women, lactating mothers and adolescent girls take a harder hit.

In all the villages we studied, irrespective of communities, the government’s flagship ICDS (Integrated Child Development Scheme) which provides for early childhood health, supplementary nutrition and education (also popularly known as Anganwadi centres) do not function in the area. Under this scheme, pregnant & lactating mothers and adolescent girls are also given supplementary rations but no functioning ICDS centres means none of this is also given.

“In 2008, with the help of the ant (an NGO working there), a team from Delhi, including the Child Rights Commissioner visited the Deosri area and our people complained to her. After this, a few more ICDS centres were opened. It ran for two years but again stopped in 2010 and has remained defunct since then. The anganwadi worker and the helper are never to be seen in the centres. The distribution of cereals and other supplements have stopped. Children have stopped coming for the 7-9 am classes because there is no teacher present in the centre. I have filed two RTI (Right to Information) applications and found that sanctions and supplies were given regularly for all the centres. But this does not reach the ICDS centres because it is misappropriated in between”.

— Raman Hasda; 35 years old Adivasi Male working as a field mobiliser in an NGO
Figure 3.4.2: Effect of Non-Functional ICDS in Study Area

Figure 3.4.2 above shows how illness and possible deaths of vulnerable populations with special needs is linked to poor nutrition. From Figure 3.4.1 we see that not one of the seven villages in the study had a functioning ICDS centre which shows the complete collapse of the programme in the area. Failure of a supplementary nutrition programme in a conflict area is failure to prevent malnutrition of the neediest populations and their possible deaths. Could the illnesses and subsequent deaths of Mohan & Rupsi’s children and the young pregnant woman (Sarna) that we saw in earlier sections (Pages 95-98) been prevented? Had there been a good supplementary nutrition programme, perhaps we could have kept their bodies from weakening and falling ill?

d. **Government Schools & Mid-Day meals**

From the earlier chapter (pages 67-69), we saw how non-availability of schools after a conflict play a vital role in determining if students, especially girl students, drop out of school and start working as maidservants and becoming vulnerable to abuse and exploitation. The matrix in Figure 3.4.1 (Page 102) shows that three of the four villages we studied did not even have primary schools in the village. When primary education itself is not present, it becomes even more challenging for children from these conflict-affected villages to access secondary schools and high schools.
While availability of schools prevent child labour as children are kept in schools, government schools (till Class 8) are also supposed to provide a cooked, hot mid-day meal for the students. This again would go a long way to help children from poor families maintain their nutrition and remain healthy. In our study area, we find only two of the schools attended by the children of three villages i.e Deosri Relief Camp, Mohanpur and Nepali Basti have regular mid-day meals whereas young children from 4 villages do not get any mid-day meals.

“Money for the mid-day meal comes but at the implementation level there are lots of corruption. The regular meal comprises of rice, dal, one or two pieces of potato. They do not follow the menu given under the MDM scheme. The only time when they (children) are given good meal is after the half yearly examination and annual exams. This is the only time they get meat. Mid-day meal in the school is not up to the mark” – Kishor Gurung, Nepali male teacher at a primary school in Deosri

e. Water & Sanitation Facilities

There is no water supplied by the government in any of the villages we studied. Villagers depend on their own water sources like handpumps, public wells or small streams and rivulets. Humanitarian organisations have helped provide some wells and handpumps in affected villages following the 2014 conflict.

“When our family first came to settle in Koraibari, the nearest drinking water facility was in Deosiri, 12 km away. Like the other men from the village, I too would fetch the water only two times in the entire day. People then mostly used earthen pots which would often break but I was lucky to have steel one. It was easier in Summer because we could collect water from the stream. When the stream water dried up in the dry season of Winter, we would reach till Deosri bridge (Nijula bridge), wandering everywhere looking for water.
The first well in the village was dug in the year 2005 (around 25-26 rings used) after we returned from the relief camp. All the villagers got together to dig it after our neighbouring villages stopped us from taking water from their wells as their wells too dry up in Winter. We then dug another well this side of the village as that was so far away and after the conflict we were scared to go far from the house in the night. Then, when the army left (they set up camp to guard us when we returned to our village after the 2014 conflict), we petitioned them to leave behind the diesel engine and water pump for us. Each household contributes money for buying the diesel to run the pump but now this is also out of order and we are unable to repair it. Then, an NGO gave us another hand-pump in the Northern side of the village after the 2014 conflict but that is also spoilt now”.

- **Suraj Mardi, village headman of Koraibari Adivasi village**

All the villages practice open defecation i.e. Except for Nepali Basti where all households say they have some toilet facilities (though some of them could be temporary pit latrines and may be not sanitary latrines). It is interesting that there are only the Nepalis have toilets in their home whereas the others do not. The Nepali village has not been displaced before and that could be a possible reason why they are relatively well-off and can afford sanitary latrine. The headman of Koraibari village says he does not remember the PHED department people ever visiting their village.

**Summary**

In general, we see that Fragile Conflict Affected Areas suffer from poor governance. Essential services that the State is supposed to provide to its citizens are compromised and people living in such areas find it difficult to demand accountability of a government that
seems incapable of managing core social programmes and functions. As a result, people do not get the entitlements they are supposed to get. The National Relief and Rehabilitation Policy 2007 does not even talk about conflict induced displacement. Hence, it has no policy provisions for such people. States are left to respond on their own and the response is very inadequate and arbitrary.

Affected populations having experienced material, emotional, socio-relational losses are at their most vulnerable state. They need extra support and services to help them cope and not fall prey to further ill-health and ill-being. But the State fails and people are left to survive or perish on their own. Schemes like subsidised food grains and work guarantees are critical for dealing with poverty induced hunger following a conflict but they do not work well.

Children’s nutritional programmes like ICDS scheme are critical for maintaining the nutritional levels of children, pregnant women, lactating mothers and adolescent girls after a conflict. Education and regular provision of mid-day meals can prevent children from dropping out of school and needing to migrate and start working. It can also maintain children’s nutritional levels and prevent illnesses and deaths of children. Water and sanitation is much neglected in forest villages where IDPs have settled after a conflict. Unavailability of clean water coupled with poor sanitation practices makes people susceptible to diarrheal diseases and death.

Conflicts occur primarily because of a break-down in law and order, whose maintenance is the prime responsibility of the State. When families are forcibly displaced because of a failure of the State, it must take responsibility for the welfare of such populations rendered extremely vulnerable. First and foremost, the Indian government which denies the existence of conflict induced IDPs must recognise its existence and develop a good and clear policy on relief, resettlement and rehabilitation of such persons. Special services and schemes must be developed for ensuring food and nutritional security, health services, schooling and children’s health is protected following a conflict.
Chapter 4
Discussion & Conclusion

There was a functional public health system in place in Assam in the 1970s and 1980s. The Assam Agitation of 1980-1985 was comparatively short-lived and while it did disrupt governance of various systems including the health care system, yet it did not derail it. The evidence of this is that before the Bodo Andolan of 1990, there was a working health system in place. There were qualified MBBS doctors and a full team of support staff present in the government health centres even in remote places and outreach programmes even reached people’s doorsteps in the villages. There is also evidence that every community used the services at the government health centres even though there were severe challenges like shortage of medicines and lack of vehicles.

Clearly with conflict, the health system in Bodoland (of which the study area Deosri is a part of) showed a sharp decline. As the movement got violent, public infrastructure, including health centres, schools, electricity, roads and bridges were destroyed to keep the security forces at bay. When militancy followed soon after, non-tribal doctors fled leaving only a few Bodo doctors to manage the health centres. The Bodo doctors who stayed back also did not have it easy in an insecure atmosphere – sandwiched as they were between the militants and the security forces hunting the militants. This was also the same period of liberalization of the 90’s in India when government spending on the social sector including health decreased substantially affecting health services across the country. In Bodoland, the rise of violent militancy interspersed with waves of ethnic conflicts during that same decade further sounded the death knell of the health system. It collapsed so badly that the health centres could not even respond to emergencies and epidemics following ethnic conflicts.

Humanitarian non-government organisations like MSF filled a bit of the void left by a collapsed public health system in our study area. They gave medical relief to large numbers of completely impoverished conflict affected people in the relief camps and surrounding areas. But when they left in 2007, the high quality of care they provided could not be
sustained by a collapsed health system which was just starting to rise with the launch of NRHM in 2005. People suffered greatly again after that.

Buildings, equipment and other physical infrastructure along with some lower level health personnel improved greatly in the health centres after the NRHM came in. But the health centres in the conflict affected areas never got qualified doctors to provide quality services. The negative perceptions about lawlessness and lack of security has sustained long after the conflict and discouraged health personnel from other parts of Assam from serving here in the conflict affected BTAD areas. Some health centers function but with either unexperienced part-time doctors (fresh MBBS doctors forced to serve a one year rural posting to qualify for post-graduate studies) or semi-qualified (the three year trained Rural Health Practitioners) or even wrongly qualified (like ayurvedic doctors made to practice allopathic medicine). This has caused people to lose faith in the government health system and is an unpopular choice for treatment. An unresponsive public health system is a catastrophe for families completely impoverished by conflict.

In a conflict-affected area, apart from strong political will, backed by resources to get the public health system back on track, we also need a strong civil society to counter the negative perceptions regarding lawlessness and insecurity. Apart from proactively reaching out to medical students in medical colleges across Assam with positive and reassuring messages, student’s unions, women’s groups, NGOs, intellectuals and community leaders etc. will need to be involved in managing the health centres and keeping it safe and free from violence. A proactive approach needs to be adopted if we are to get back on track a health system collapsed by two decades of conflict and fragility.

The poor and the marginalised who lead fragile and vulnerable lives are further pushed to the edge after an episode of conflict. For such households, their health, well-being and development gets highly compromised as life after a conflict becomes an intense struggle to merely survive. Without adequate external support, affected families with highly reduced resources find it difficult to cope with this new ecology of ill-health and ill-being.
In the study we see that irrespective of the ethnic community, conflict is an extremely life disrupting event especially when forced to flee one’s home. While Bodos are better organised and get more support from their community based organisations during the fleeing and emergency, they like the Adivasis are left to recover on their own after the emergency and remain at high risk of ill-health. The forcibly displaced who have experienced loss of every kind need a lot of support but they were left to their own devices to survive or perish, especially in the older conflicts of 1996 & 1998. While other kinds of losses have a greater chance to get addressed, loss of relationship and trust is one of the earliest losses is an ethnic conflict and very few address this loss.

For the forcibly displaced, disabling poverty follows close on the heels of a conflict. We see in the many life histories of families and by mapping post conflict vulnerabilities, that a complex web of losses at multiple levels - physical, economic, social, psychological etc. interact with one another in different ways to create ill health and retard development of already impoverished and fragile households. We also see that risk factors to ill-health increase significantly while protective factors decrease making the affected households and especially vulnerable populations of women, young girls, children extremely vulnerable with few resources to cope and remain healthy.

Women remain highly vulnerable to ill-health and ill-being long after the episode of conflict. The stress and tension of survival seems to get internalised in their bodies and even gets passed on to the next generation – as seen in the ill-health of women and also ill-health and deaths of children following a conflict. Alcoholism amongst men with its attendant problems increased greatly after conflict and so, while most men externalise and cope with the loss by taking to self-destructive habits like alcohol, women seem to absorb and internalise the stress and tension into their bodies. Young girls after a conflict remain vulnerable. Many of them lose their education, become child workers and become extremely vulnerable and at risk of abuse. As adults get pre-occupied with survival after a conflict, the education and development of children takes a backseat. Children face malnutrition, ill-health, death, loss of education and loss of development apart from mental trauma, fear and insecurity.
Conflicts cause upheaval not only in the lives of those who have experienced violence directly through losses or displacement but also to those who have been exposed to conflict by their presence, like the Nepali community in our study. As the host community to the Adivasi IDPs in Deosri, they also claim to have experienced economic loss and also loss of lives because of epidemics. Caught between the two communities in conflict, they have had to negotiate and balance delicate social relationships. The loss of health infrastructure and weakening of the health system and poor governance also affected their access to health and other essential services. Then, pressure on natural resources and destruction of the ecology (tree felling, soil erosion, floods, falling water table, human -elephant conflicts etc.) because of conflict displaced populations affects lives, livelihoods and the very existence of all in the conflict area.

To help conflict affected populations negotiate an acceptable quality of health and well-being, we would need a long-term, multi-agency, multi-layered approach which goes beyond addressing emergencies, reduces vulnerabilities and focuses on long-term and sustainable recovery.

Traditional healers and pharmacists in the days to come will continue to be health providers in the absence of a good health care system. The traditional healers and pharmacists are within the reach of people. The traditional healers besides playing a role of giving herbal medicines and offering pujas also look up to the traditional healers for a mental satisfaction. People feel satisfied with the service that these informal health practitioners render. In the long run, the ambulance services needs to be improve because most of the IDPs live in areas which are very far from the main road. If these services are active then it will cut down the cost of travel of people.

With conflict comes displacement and various losses which affect the daily lives of people. Treatment seeking behaviour of the people is also determined by economic factors. If there is enough money then people do not have to worry about reaching out for treatment.

In general, Fragile Conflict Affected Areas suffer from poor governance. Essential services that the State is supposed to provide to its citizens are compromised and people living in
such areas find it difficult to demand accountability of a government that seems incapable of managing core social programmes and functions. As a result, people do not get the entitlements they are supposed to get. The National Relief and Rehabilitation Policy 2007 does not even talk about conflict induced displacement. Hence, it has no policy provisions for such persons. States are left to respond on their own and the response is very inadequate and arbitrary.

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Children’s nutritional programmes like ICDS are critical for maintaining the nutritional levels of children, pregnant women, lactating mothers and adolescent girls after a conflict. Education and regular provision of mid-day meals can prevent children from dropping out of school and needing to migrate and start working. It can also maintain children’s nutritional levels and prevent illnesses and deaths.

Water and sanitation is much neglected in forest villages where IDPs have settled after a conflict. Unavailability of clean water coupled with poor sanitation practices makes people susceptible to diarrheal diseases and death.

Firstly, the Indian government must recognise the existence of conflict induced IDPs in India and then develop a good and clear policy on relief, resettlement and rehabilitation of such persons. The role of the Central and State government needs to be made clear for persons affected by conflict. Special services and schemes have to be developed for ensuring food and nutritional security, health services, schooling and children’s health is protected following a conflict.
Studies on people’s health affected by conflict need to move beyond assessments of the physical health or maternal health service available immediately following conflict. Affected populations, especially the forcibly displaced, already weakened by poverty and fragility become much more and remain vulnerable even years after a conflict episode. In this study we see how very complex, indirect and non-linear risk-factors such as loss of income, distance from market, loss of access to health services, mental tension, alcoholism, loss of schooling, young girls sent out to work etc. intersect to create ecologies of ill-health, morbidity and mortality for women and their families long after the incidents of violence. From some of the stories of women, we see how the increase in risk factors of ill-health hugely outweigh the protective factors following conflict & displacement. The illness pathways of not just women but also their family members are so intrinsically linked to poverty and loss arising out of conflict that one cannot divorce the illness from the social ecology leading to it. Hence, malaria deaths after a conflict cannot be blamed only on the malaria parasite without linking in some way to the ecology of increased vulnerability and decreased protective factors.

In the absence of a functioning government health system to support people’s health and respond to ill-health, the bodies of poor, tribal, conflict-displaced women get ‘worn out’ as they struggle to deal with and negotiate the multiple negative risk factors after a conflict. With their own coping resources having been greatly compromised, conflict affected women and their families need external help and support to recover from the fragility they are exposed to. While alcoholism, picking up fights and domestic violence seem to be popular ways men tend to cope with severe survival stress, it compounds the stress and tension already faced by women, further decreasing their well-being.

If we really want to help affected households recover their physical, mental and social wellbeing following conflicts, we need to move beyond knee-jerk responses and short-term humanitarian relief during or just following a conflict. Interventions by government and non-government actors must be deep and long term addressing the multiple and complex factors risk factors of ill-health. First and foremost, the government must be held accountable for developing conflict response policies that focus on vulnerability reduction and complete recovery. In a conflict risk area, community preparedness and resilience to
disasters need to be built up. To reduce hunger and food insecurity, both government and non-government agencies need to focus on making ‘food for work’ and ‘cash for work’ programmes available for affected families which should be for longer durations of at least a year or more following a conflict.

Health services need to be made available beyond the relief camp i.e. when returnees go back to their villages. Mobile and door-step health services will help take care of small illnesses and prevent health catastrophes. Education should not be disrupted or should be restored as soon as possible and scholarships for girls be made available. This is critical for protecting the health, rights and safety of young girls. If women are to be healthy and happy, men need to be given work to do and also taught how to manage their stress to keep them away from alcohol and wife-beating. Finally, forming and building up strong women’s collectives after a conflict would rebuild social support and solidarity for women and help them recover. Only multiple, multi-layered, deep and long-term strategies can help those affected to recover and be healthy after life-disrupting events such as conflict and forced displacement.
References


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## Annexure

### IDP Interview Schedule

<table>
<thead>
<tr>
<th>Respondent’s Profile</th>
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<tbody>
<tr>
<td>1. Name of respondent:</td>
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<td>2. Village:</td>
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<tr>
<td>3. Name of respondent’s husband/wife:</td>
</tr>
<tr>
<td>4. Male/ female :</td>
</tr>
<tr>
<td>5. Age:</td>
</tr>
<tr>
<td>6. Community &amp; Religion:</td>
</tr>
<tr>
<td>7. How many members are there in your family?</td>
</tr>
<tr>
<td>8. How many children do you have? How old are they? What do they do?</td>
</tr>
<tr>
<td>9. What is your occupation? How long have you been doing this work? What all did you do before? Why did you change?</td>
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<tr>
<td>10. Who else in your family earns? What do they do?</td>
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<table>
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<tr>
<th>History of Displacement &amp; Conflict</th>
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<tr>
<td><strong>History of Displacement</strong></td>
</tr>
<tr>
<td>11. How long have you been living in your current village?</td>
</tr>
<tr>
<td>12. Were you born and brought up here? If not, from where?</td>
</tr>
<tr>
<td>13. Where all did you live before coming here?</td>
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<tr>
<td>14. If we had to draw a line to show the history of where all you lived from the time of your birth .... Can you please tell us? (researcher here uses the <strong>timeline</strong> method and chronologically maps out the migration history of respondent.... covering the following questions).</td>
</tr>
<tr>
<td>a. <em>Where were you born? Where all did you live after that?</em></td>
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<tr>
<td>b. <em>Why did you move? How many times was it because of conflict?</em></td>
</tr>
<tr>
<td>c. <em>Who all in your family moved with you?</em></td>
</tr>
<tr>
<td>d. <em>Did you return to your original village? Why? Why Not?</em></td>
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<tr>
<td>e. <em>The land where you stated in your original village, who did it belong to?</em></td>
</tr>
<tr>
<td>f. <em>The land where you are currently staying, who does that belong to?</em></td>
</tr>
</tbody>
</table>
g. What all did you lose every time you have moved because of conflict?

Experience of Relief Camps

15. Have you ever stayed in the relief camps? Why did you come to the relief camps?
   How often it was because of conflict?
   a. Which all relief camps have you lived in? How long did you did you stay in the relief camps? *(get the information in chronological order..... may be in the form of another time line)*
   b. What was life like in the relief camps in the beginning?
   c. What did you do for food, water and stay while in the camp?
   d. What did you do for money? What income sources did you have?

Livelihood & other loss

16. What were your income sources before moving to the camp? How did it get affected?
17. What all in your life got disturbed by your moving to the camp? Allow for responses and then researcher could prompt details of how each was affected - property, children, work, health, food, relationships, mental peace etc.

Relationships with others

18. When you moved from your original village, did the other families move with you?
   Where did they go? Did you keep in touch with them? What happened to all of them? Who do you miss the most from your original village? Why?
19. How was your relationship with the other communities around you before the conflict? Which were the communities you were closest to? *(the researcher at this stage could map out using venn diagramme method/ mobility mapping)*
20. How was the social life in the village where you lived earlier before the conflict?
   How has it changed now? e.g. Festivals, celebrations like marriages, deaths, cultural and religious customs etc.