

Research Report

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

A Study by

the ant

(the action northeast trust)

Chirang District, Assam, India

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Chapter 1

Abstract of the Study

Violent conflicts will be one of the main drivers of health inequities among large population of marginalised people and in the years to come, it is expected affect the majority of the poorest and most vulnerable communities in the world, causing much suffering and ill-health.

This study is a 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 largely 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 Districts) which has experienced 25 years of militant violence and many waves of ethnic conflicts. We largely 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 a number of 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 did the lack of health contributed 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 and field researchers largely stayed in the field area during 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 greatly. This makes vulnerable groups and those with special needs within the family, like women in general, pregnant women, young girls and young children 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 most prominent negative fall-out is the long-term ecological effects of conflict and mass displacement of population with no livelihood opportunities. Deforestation, falling water table, soil erosion, and human-elephant conflicts are some of the threats adding to fragility and vulnerability.

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 pharmacists. Money, or the lack of it, dictates the health seeking decisions of people. Poor governance has become the norm in the study area. Essential services that the State is supposed to provide to its citizens are compromised and people living in conflict affected areas find it difficult to demand accountability of a government that seems incapable of managing core social programmes and functions.

This study calls for moving 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 wellbeing following conflicts.

Chapter 2

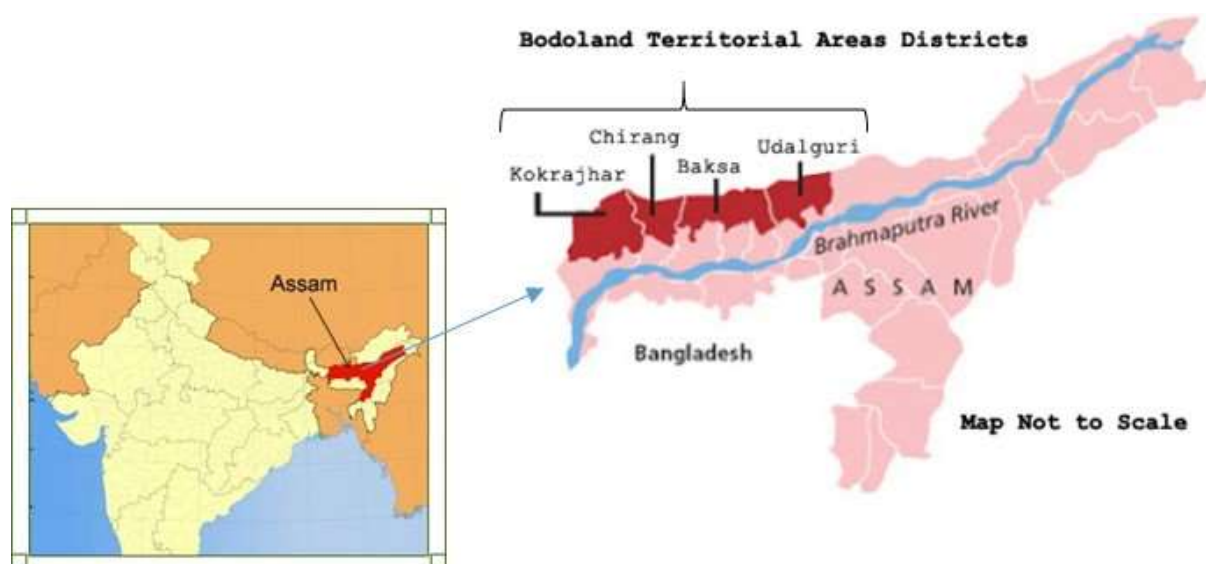
Introduction to the Context & Background

2.1 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 in 2003 to create this administrative unit called the BTAD under the Special Sixth Schedule of the Constitution of India.

Fig 2.1 Map of BTAD Districts in Assam



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.² 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.³ 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'.⁴ 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.⁵

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

¹ Baruah, Sanjib (1999), *India Against Itself: Assam and the Politics of Nationality*, New Delhi: Oxford University Press. See also Goswami, Uddipanna (2014), *Conflict and Reconciliation: The Politics of Ethnicity in Assam*, New Delhi: Routledge.

² Baruah, S., 2009. The Partition's long shadow: the ambiguities of citizenship in Assam, India. *Citizenship Studies*, 13(6), pp.593–606.; Jayal, N.G., 2013. *Citizenship and Its Discontents*, Cambridge, Mass.: Harvard University Press

³ Ibid., p. 603

⁴ Baruah, S., 2005. *Durable disorder : understanding the politics of Northeast India*, Oxford: Oxford University Press

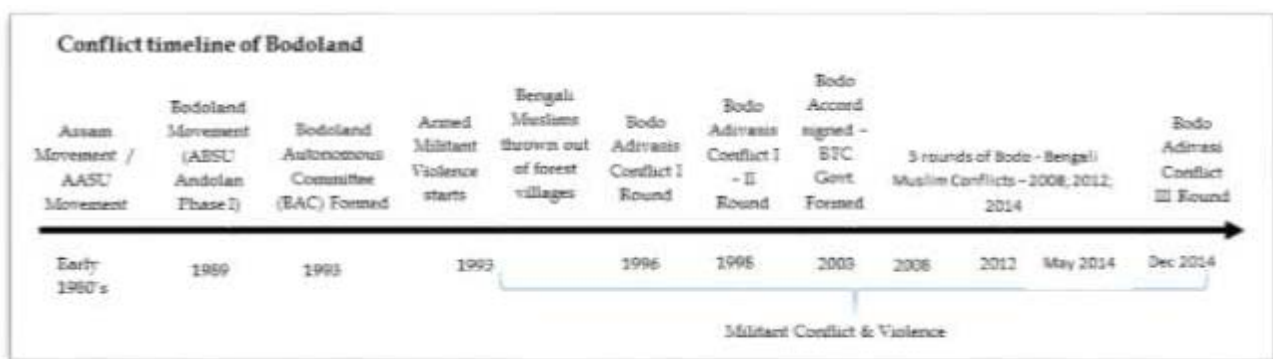
⁵ Baruah, S., 2003. Protective Discrimination and Crisis of Citizenship in North-East India. *Economic and Political Weekly*, 38(17), pp.1624–1626

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 of the tactics and symbolic gestures of the Assam movement, but sought to assert a distinct Bodo identity.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.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,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.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.

Fig 2.2 Conflict Timeline of Bodoland



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

⁶Baruah, S., 1999. (Baruah, 1999), Philadelphia: University of Pennsylvania Press

⁷Baruah, S., 1999. *India against itself : Assam and the politics of nationality*, Philadelphia: University of Pennsylvania Press, pp.-187-88

⁸Barbora, S., 2015. *South Asia: Journal of South Asian Studies*, 38(2), p. 299

⁹Misra, U., 1989. Bodo Stir : Complex Issues , Unattainable Demands. *Economic And Political Weekly*, 24(21), p. 1149

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 In 1998, when these displaced, primarily Adivasi 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 Birsas Commando Force.

In August 2006 more than 54,700 people, mostly Santals and Oraons, were still living in these IDP (internally displaced persons) camps.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.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.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 81.¹⁵ According to official estimates, almost 200,000 people, both from the Bodo and Adivasi communities, were displaced.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, 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.¹⁷ So far, each

¹⁰Goswami, U., 2014. *Conflict and reconciliation : the politics of ethnicity in Assam*, London ; New York ; New Delhi: Routledge

¹¹ Vandekerckhove, N., 2009. "We are Sons of this Soil:" The Endless Battle over Indigenous Homelands in Assam, India. *Critical Asian Studies*, 41(4), pp.523–548.

¹²Vandekerckhove, N. & Suykens, B., 2008. "The Liberation of Bodoland": Tea, Forestry and Tribal Entrapment in Western Assam. *South Asia: Journal of South Asian Studies*, 31(3), pp.450–471

¹³Delhi Solidarity Group (2015), 'Recent Militant Violence Against Adivasis in Assam: A Fact Finding Report'

¹⁴'Camp inmates offer proof', *The Telegraph*, 8 May 2014.

¹⁵<http://timesofindia.indiatimes.com/india/Assam-violence-Army-chief-vows-to-intensify-operations-against-militants/articleshow/45651729.cms>

¹⁶ Delhi Solidarity Group (2015), 'Recent Militant Violence Against Adivasis in Assam: A Fact Finding Report'

¹⁷Saikia, S., 2015. General elections 2014: ethnic outbidding and politics of "homelands" in Assam's Bodoland. *Contemporary South Asia*, 23(2), p. 216

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,¹⁸ 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.¹⁹

The state's approach to conflict in the BTAD has been, as Mahanta has asserted, 'symptomatic'²⁰. 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 on 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:

*'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'*²¹

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.²² 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.²³

¹⁸Dutta, 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

¹⁹Saikia, S., 2015. General elections 2014: ethnic outbidding and politics of "homelands" in Assam's Bodoland. *Contemporary South Asia*, 23(2), pp.211–222.

²⁰Mahanta, N.G., 2013. Politics of space and violence in bodoland. *Economic and Political Weekly*, 48(23)

²¹Delhi Solidarity Group (2015), 'Recent Militant Violence Against Adivasis in Assam: A Fact Finding Report', p.4.

²²Motiram, S. & Sarma, N., 2014. The Tragedy of Identity: Reflections on Violent Social Conflict in Western Assam. *Economic and Political Weekly*, 49(11), p. 50.^[1]_{SEP}

²³Misra, U., 2012. Bodoland: The Burden of History. *Economic and Political Weekly*, 47(37), pp.36–42.

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 peacebuilding and 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 takes into account the rights of all marginalized people.²⁴

2.2 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 2011²⁵ 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 states 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 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, a majority of deaths in the conflict zones are caused by fever/ malaria, diarrhea, respiratory infection and malnutrition. Also high morbidity and mortality

²⁴ Barbora, Sanjay (2012), 'Identity of a recurring conflict', *The Hindu*, 31 July 2012.

²⁵ *Conflict, Security, and Development - a World Bank Report 2011*

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. Kruk a, 2010). This idea of war “being a development issue and that consequences extend far beyond direct deaths” is also expounded by others (Gates, Hegre, Nygard, & 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, Nygard, & 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 destroys agricultural system that 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 to 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 seen in the World War I, 5 percent of the casualties was civilians, World War II it went up to 50 percent. In the 1990s, over 32 conflicts in barbaric ways showed that 90 percent 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 of less than 3 years, 2575 Palestinians have been killed in the year 2000 to 2003. 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 woman die 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 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 have an effect on the fertility of women and hence her 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 either 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 data 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 5 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 immunosuppression 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 resources²⁶ 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 result 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 percent in Bosnia and 68 percent in Cambodia.

Rates of PTSD (Post-Traumatic Stress Disorder) for Bosnian and Cambodian refugees were 18-53 percent (Bosnia) and 37 percent 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

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

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.²⁷ (Wessells, 1998)

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 is 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 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 away their spending from healthcare to military. (Kruk, Freedman, Anglin, & Waldman, 2010) In times of conflicts, the pre-existing health system tends to get worsen 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 and no breakdown in supplies of medicines (Macrae, Zwi, & Forsythe, 1995). In the early, 1980s in Mozambique, health workers and clinics were attacked by the 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 and population -health outcomes of war." (Grundy, Annear, & Mahrshahi, 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 experienced armed

²⁷The 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

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 as a whole 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 whole²⁸. 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 this is the state 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 cycles²⁹ of ethnic conflict in 25 years, apart from the fragility of living in a zone of pervasive militant conflict.

²⁸SRS, 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*

If we look at the NRHM data³⁰ for Bodoland areas and specially for the District of Chirang (the proposed area of this study), we see these areas lagging behind the rest of Assam in what the government considers as important health indicators and for which they have data i.e. MMR, IMR, immunization, institutional deliveries, registration and check-ups of pregnant 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 sub-division, existing sub-PHC is also now fully responsible for extending services to around 4000 internally displaced persons (IDPs) in 4 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 ³¹ or the IAG Report 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 much deeper understanding of the issues at hand to help frame effective policies which can promote the long-term health and well-being of populations affected by chronic, long-term and repeated cycles of political and ethnic violence.

2.3 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

³⁰Chirang District Factsheet: Maternal and Child Health Indicator (2013-14 & 2014-15) HMIS Provisional data – 2014-2015 – data from NRHM, Chirang

³¹Rebuilding Communities in Conflict – Oxfam India's Humanitarian Response in Assam and Muzaffarnagar

³²Joint Needs Assessment report – Assam Conflict 2014 – Inter-Agency group, Guwahati

of wars and high intensity conflict on health & on health systems and services (Ghobarah & others, 2004; Levy & Sidel, 2009; Murray & others, 2009) we do not find much of studies on 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 Hussain 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 long term health risks and vulnerabilities of those in fragile conflict affected areas. Without this deep understanding, we will not be design interventions that help poor marginalised people, especially those forcibly displaced by conflict ever recover and lead healthy lives.

2.4 Process of generating the research objectives & questions

This study was initiated as a part of “Closing the gap” - a 5 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 and 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 and also had research methodology experts as resource persons, helped us refine and sharpen our research focus and at the end of the 5 days 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 4 questions of research which guided the study throughout:

1. How has 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 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?
4. 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

Chapter 1 : Abstract of the Study

Chapter 2 :Introduction to the Context & Background

Chapter 3 :Research Methodology

Chapter 4 :Findings of the Study

4.1 *Conflict & the Public Health System in Chirang District*

4.2 *Well Being & Health of Conflict Affected Tribal Populations*

4.3 *Health Seeking among Conflict Affected Communities*

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

Chapter 5 :Discussion & Conclusion

Chapter 3

Research Methodology

This study followed an in-depth qualitative research methodology with elements of ethnography 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”.³³In 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 in depth into life histories not just of individuals but also of institutions. It gave us the opportunity “to 'unpack' issues, to see what they are about or what lies inside, and to explore how they are understood by those connected with them”.³⁴

The Institutional Ethical Committee (IEC) considered the ethical concerns of the research and also the methodology and formulated a set of ethical protocols to be followed. Each member of the research team had to individually complete 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. Different methods of individual interviews, group interviews, observational methods were used to obtain data. The data was collected some recorded and some were written notes. The recorded data were transcribed. Case studies and Life histories were developed throughout the process of data collection. Detailed date-wise field notes were kept of the small talks, informant interviews and observations by the researchers.

The following were the questions of research which formulated to explore and guide the study: How has socio-political changes historically shaped health and the public health system in the area? And conversely, how has lack of health contributed to conflict?

1. 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.)
2. What are the ways in which different people, individuals and groups, gender, class, ethnicity, religion etc. respond to ill-health in a conflict area?
3. How do various groups interface with and benefit from government health services & also health promoting institutions such as PDS, anganwadi, water, sanitation, MDM?

Identification & selection of villages

³³Jane Ritchie & Jane Lewis, **QUALITATIVE RESEARCH PRACTICE: A Guide for Social Science Students and Researchers**, Sage Publications [2003]

³⁴Same as 33

Initially, the villages selected were within the ant's intervention villages that were affected by the 1996-98 & 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 also 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 also respondents chosen was 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 the original village from the relief camps.

Study tools

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.

In-depth interviews were conducted with respondents to learn their life-histories and understand in-depth about their lives, and their experiences with conflict and health. This method was also applied in cases of health personnel, community based organisation leaders, former militant leaders, and community leaders. Additionally, group interviews were conducted with women's group regarding women's health and experiences during conflict. Participatory methods were also used during the group interviews to get the group

involved. Observation was also used in this entire research especially in understanding the health seeking behaviour of people and the health care service providers in the area.

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 eight years and known to the people. Building on the rapport and good will already present, the researchers got an easier access to interviewees on the sensitive topic of conflict. We could reach out and interview a range of respondents – community members, community and village leaders, teachers, health workers, militant leaders, local governance body members and youth leaders. The ant's reputation of many years helped open the doors and most respondents we contacted for the study were very open to meet the researchers for any interview. 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 flexibility to reach out to different levels of respondents.

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 data, find the gaps, and explore more possibilities of exploration.

Some Spaces of data Collection

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



A tea shop in Deosri – one of the sites for data collection

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 young new ant staff residing in 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 the pharmacies in different locations was also advantageous for the researchers 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 & 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, Nakedara Pharmacy.) 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, the 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 found. 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 returns 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. For this, most of the interviews were scheduled in the morning. 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 just 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 of the cases, 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 village, researchers found that the 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.

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. He knew that as a researcher he should not have such strong opinions but he found it difficult to avoid. 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 personal opinion to shape the process of data collection.

Being researchers from the same community was good for the data collection in terms of language and communication. However, we found that 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 community” 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.

Documentation, Filing and Data Analysis

The 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, small talks interviews were integrated together for analysis. We used different types of maps and diagrams for a clarifying the data and our own understanding of it.

Analysis was an ongoing process along with data collection, using a combination of instruments such as field notes, memos, short life-histories, various forms of pictorial representations including 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 the 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 reflections and refinements.



Regular review meetings of the research team to study the data 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. Language was one of the primary limitations 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 of the Chapter

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, observation, small talks were used to collect data. Most of the interviews were recorded and transcribed and detailed field notes were kept of the small talks and informant interviews. Analysis was an ongoing process along with data collection, using a combination of instruments such as field notes, memos, short life-histories, various forms of pictorial representations including maps 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 areawhere the NGO has been working for eight years and known to the people. Building on the rapport and good will already present, the researchers got an easier access to interviewees on the sensitive topic of conflict. While being identified with NGO 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 and involving so many communities. 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 the data and also the depth to which we could go with some of the Adivasi interviews.

Chapter 4

Findings of the Study

Chapter 4.1: 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].³⁵ 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?

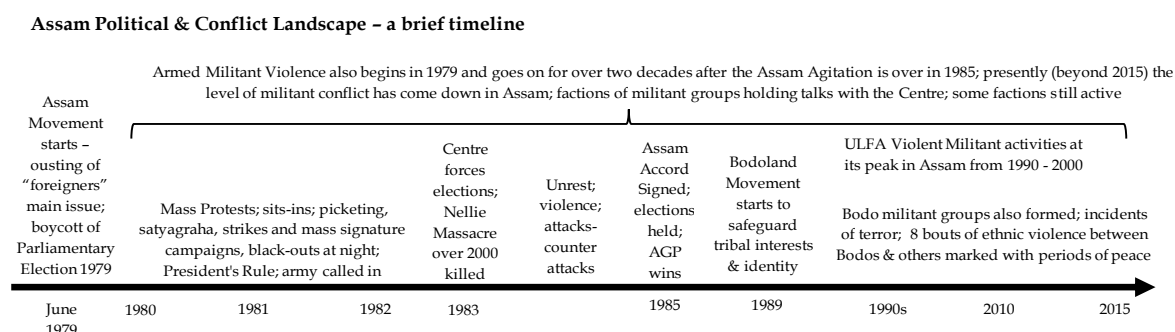
Assam has had a three decades long history of political movement and at times violent struggle. This has impacted governance and the public service delivery. But how much of it has impacted the public health system? What kind of impact has it had? How has political history of unrest, movements and conflict 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 has socio-political changes historically shaped health and the public health system in the area? And conversely, how has lack of health contributed to conflict?

4.1.1 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 4.1.1 Brief Timeline of Assam's Political & Conflict Landscape in the last 30 years



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

Figure 4.1.1 is a brief timeline of the socio-political history of recent events of the past three days in 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 government’s exclusionary attitude and call for protest. This instantly saw 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

The government of Indira Gandhi 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 4 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

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

³⁷<https://www.quora.com/What-was-the-Assam-agitation-or-the-Assam-movement-in-1979-and-how-did-it-change-the-politics-of-Assam>

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 the 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, it was the same time when 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 diploma from pharmacy institute.

While a bit shaken, the public health system in Assam did not collapse during the Assam Agitation. It seemed to have recovered sufficiently for us to see quite decent health services being provided even in far-flung remote areas, such as some of the health centres in the Bodo areas before the start of the Bodoland Movement in 1989. But in the 90's with

³⁸Baruah Sanjib. *India Against Itself: Assam and the Politics of Nationality* [Book]. University of Pennsylvania Press. 1999. 257 pages.

³⁹Licensed Medical Practitioners or LMPs were the allopathic practitioners of Assam state from the British era. LMP diplomas were awarded in undivided Assam by *Assam Medical College*, Dibrugarh though some of these practitioners studied in Medical College in Dhaka. There was a state branch of Licentiate Medical Practitioners in Assam. Some of these practitioners continued to practice till the 1990s.

globalization, liberalization and privatization being the 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.

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

In Chapter 3, we already looked at great depth 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 a large number of interviews and spoke to a range of people both within the health system and also from outside of the system. We spoke to retired doctors who had served in the system earlier and also to new doctors who have joined the system afresh. We also spoke to non-formal practitioners of medicine (pharmacists) regarding the health system and also 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 also Runikhata also have a number of “pharmacists” (unqualified informal practitioners of allopathic medicines). Then, there are also “pharmacists” that people take treatment from in the smaller market places.

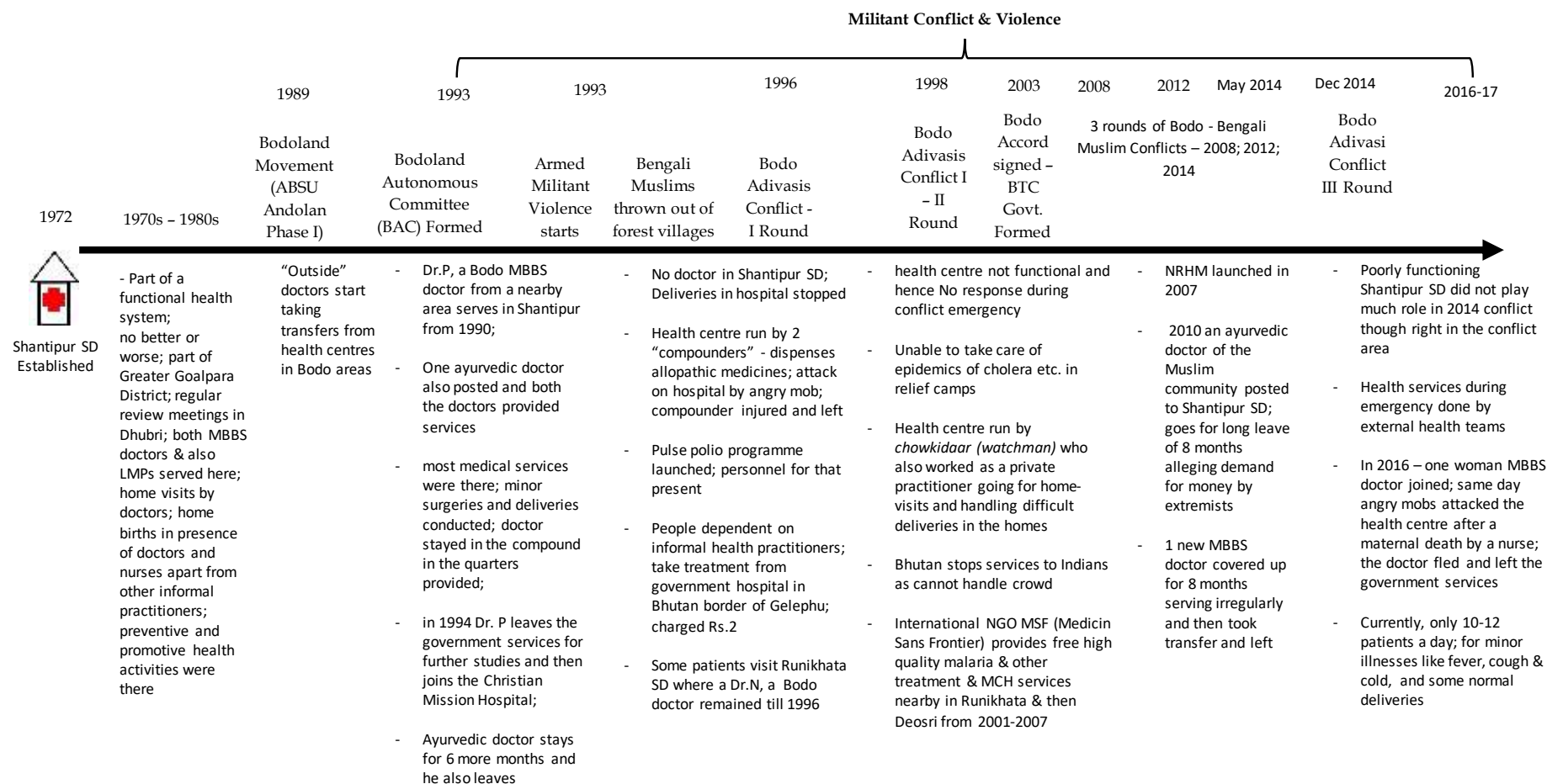
Fig 4.1.2 Map of the Study Area showing State Health Facilities

Referrals from the State Dispensaries are usually to Bongaigaon Town and 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 2 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.

Fig 4.1.2 Shantipur State Dispensary: A Historical Timeline

We studied the Shantipur State Dispensary in depth in order to see if and how external socio-historical events affect the health system. This information gathered from many interviews has been put in a historical timeline below:



From Fig 4.1.2, 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 that could not even provide emergency health services in the repeated conflicts of 1996, 1998, 2012, 2014.

Moving from the experience of this one health centre, let us try and see what the larger picture about the health system is. For ease of understanding, we will look at the public health system in the 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 the 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 community, ignoring other career prospects which were easily available at that time. Before the conflict in the early 1990s, there were 11 MBBS doctors serving in various health centres under the Sidli Block. Non Paramedics were present in the hospitals and trucks used to bring medicine to the most peripheral facilities of Amtaka. Preventive and promotive health activities were there and home visits were done by the doctors. Home births were done in presence of doctors and nurses apart from other informal practitioners.

“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 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 Amtaka once a month with supplies.

However, there were challenges as well. 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”. – Dr. Sujit Daimary⁴⁰, Bodo male doctor; worked in different government PHCs for many years

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

⁴⁰All names in this paper have been changed to protect identities of the respondents.

“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. (Not just health) but most *government services and facilities in the area drastically declined during the andolan.*

The ABSU andolan commenced in the year 1987 when BPAC (Bodo Peoples Action Committee) was formed within the ABSU to spearhead the demands of the organization. The andolan stretched for a long period of five years, till 1993. The period saw massive destruction in state owned resources. 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 places. In Bordangi, the forest office was totally burnt down to ashes. The period saw total boycott and destruction of government infrastructure. The repressive measures used by the government to tackle the movement led by the ABSU gave a halt to functioning market systems, hospitals and health centres.

It was a mass movement, all the Bodos – both men and women - participated in the movement. Many students lost a year or more in schools and colleges. The non-Bodo government officials were attacked during that period. These attacks had very bad consequences whereas non-tribal government officials then used this ‘insecurity feeling’ as an excuse to get transfers out of this area. Shantipur hospital did not have doctors for a period of 7-8 years few years after the andolan”. – *NoboBrahma, 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*

2. The Health System During Conflict

- *Conflict did affect health services & health delivery in the affected areas*
- *The collapse of the health system was so great that it could even respond in emergency*

Once conflict starts, what happens government health systems and services? Most of the health personnel we interviewed have had direct experience of the conflict. Across age, across time and geography, they candidly and honestly shared their experiences and opinions.

“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 pediatrician 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, that was not sufficient because most of the doctors were Assamese at that time.

After the violence started, there was no electricity 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 where during the Bodo-Muslim conflict in 1993, a Bodo 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". – *Dr. Sujit Daimary, Bodo male doctor; worked in different government PHCs for many years*

It is telling that in the years of militancy and conflict, it was not just the non-Bodo health personnel who felt threatened. Doctors from the host community of Bodos, who stayed back because this was their home did not have it any easier. In fact, in many senses the pressure was much greater on them, being Bodos.

"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 residences were nearby, 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, 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 medicines 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".

- *Dr Gopal Basumatary, a retired doctor still serving in two of the most peripheral hospitals of Chirang District strongly feels that violence had direct bearing on the healthcare of the area.*

"in those days (of the disturbance) all of us were picked up at gunpoint and we had to go with them 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 come 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 whole of my life and these guys never forget. At least you guys question me, but those guys even don't question, they just shoot'. They would come for shelter and food and there is not a single household where they have not gone. What do you do? Horrible times those were" - *Dr. Sujit Daimary, male doctor of the Bodo community; worked in different government PHCs for many years.*

That the health system had collapsed to such an extent that they were of no help in responding to emergencies. In the 1996 conflict for instance, no medicines reached the relief camp for 5-6 months. People could not go to the forest to collect herbal plants to prepare the traditional medicines. Due to the fear psychosis, doctors and other health personnel were hesitant to visit the relief camp. Adivasis who lived in the camp at that time report that the

first medical aid to reach the Adivasi relief camp in Deosri relief camp 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 on 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 2001.

The contrast between the health system in Chirang and neighboring Bongaigaon is stark. In 2000, the manpower resources were very poor as almost no allopathic practitioners joining and the senior ones either taking transfers or retiring. The then DPM of Bongaigaon District, Dr. Sachin Brahma strongly feels that conflict had an implication on this and also government policies of appointment also negatively impacted the health system. Appointing a Bengali Muslim worker in a Bodo village does not help much. According to SurajMardi, the village headman of Koraibari Adivasi village, "it was only after the conflict of 2014 that we (Adivasis) became aware of the NRHM and their services. In the previous year the NRHM team visited the area after the news of nine people dying from malaria spread out. ASHAs kept visiting their area after that visit and there were some promotive or preventive activities going on".

Post-Conflict Phase & the Health System

Though the NRHM had already been launched before MSF left the area in 2007, it remained unpopular till 2010. Most of the rural hospitals in the field area are 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. Then, for some time, there were a group of *Rural Health Practitioners*⁴¹ placed in the PHCs. The Assam legislature enacted this act from 2004 and as of now there are more than 1000 such practitioners in different corners of the state. These practitioners were trained in the Medical College, Jorhat with the aim to serve the rural areas. The hurried decision, despite strong opposition of the medical fraternity has created a parallel group of practitioners without recognition from any medical body and with an uncertain future.

Dr Naveen Basumatary was sceptical about the quality of the services offered by these rural practitioners. *"It is not easy to say 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. But it is unconstitutional to create separate practitioners to serve separate regions. 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 areas"*

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

⁴¹Rural Health Practitioners (RHPs) were introduced in Assam in 2004 to fill the gap of trained doctors in rural areas. They are trained for 3 years in the medical colleges and then employed by the NRHM on a contractual basis.

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 when the staff have some 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'. So, we prefer the pharmacy in Shantipur. 9 out of 10 women now take to the 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 had this to say about 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"

"The Nepalis are clever and have money also. They know when a case is getting bad and then take directly to the doctor or hospital. Our Santhali people wait till the last moment until it is too late. They have no money and keep hoping it will get better on its own. They try some home treatments first. If that does not work, then they come to pharmacy and also to the ojha. The government health facilities would have helped our people but Shantipur Hospital is *bekaar* [useless] as no 'good doctors' will come and stay. They are all scared. There are no good medicines, only very basic ones" – *Ganesh Hasda, Adivasi male pharmacist in Deosri who is well respected even as a community leader*

Currently, not just the Adivasis but the Bodos also do prefer government health facilities as is explained by Dr. Sujit Daimary, a Bodo male MBBS doctor who has served as a government doctor in the days of the conflict, "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 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".

Fear & Insecurity of Health Personnel

With more and more young doctors passing out from the medical colleges unwilling to join the government health system, it causes a shortage of doctors in Assam. Add to that a negative threat perception associated with areas which have experienced past conflict, and there is little chance that doctors will want to risk working in such areas. by Dr. Natraj, a senior medical and health officer, presently working in the next district in 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 regarding the “dangerous area” of Bodoland with no security and threat to life is one big factor in deterring health personnel from coming to serve here. In the course of our research we had a very interesting interview with a young Bengali Hindu MBBS doctor who has been working in the Runikhata State Dispensary regarding the fears he had about coming to a BTAD area. JL’s field notes of 14th September 2016 regarding the talk with the doctor and also his colleague, the pharmacist in the Runikhata SD throws light on this phenomenon.

“Sachit Das is a young MBBS doctor - a Bengali Hindu from Bongaigaon who finished his medicine from Dibrugarh - and has been posted to Runikhata PHC the past 3 months or so. When he heard about his being given the 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 the NHM was adamant about his joining Runikhata State Dispensary. 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. Well, he then joined. It has been 3 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. “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! But he felt 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 most will not even join and so live with and spread the fear.

I also spoke to the Bengali pharmacist and he says that as soon as night falls, he starts getting "fever" out of fear. Day time there is no problem as people are well behaved but comes night and then alcoholism starts and with that the levels of aggression increases. He has already got threatened and almost beaten up a couple of times. Even as we were speaking he kept uploading documents on to the computer - his applications and documents needed to get posted out of this area back to Udalguri (where he comes from). Earlier, he was posted in Amtaka State Dispensary and insisted that “it was much, much better”. I was rather surprised as Amtaka was much more interior with only Bodos than Runikhata - which is right on the highway and has many more different communities. His main reason for finding Amtaka “safer” and easier to be in than Runikhata was that the ABSU office is close by and there is an active Hospital Management Committee. They took care of such issues of "daadagiri" but here he felt unsafe as no one from the local people takes an interest in the management of the hospital and they are left to fend on their own.

The senior Bodo staff in the Runikhata PHC we spoke to later confirmed that it would be much better if the ABSU and others would take an interest. One of the accountants posted there (A Bodo) said that it has been a year since he has been there but not once has any local organization visited the hospital to take ‘khabor’ (news).

- JL’s field notes, 14th September 2016

While the threat of extortions and illegal demands for money made by the non-state actors are there, another fear is that general lawlessness encourages people to take law into their own hands. Violence is used to solve conflicts and though violence against health personnel

though not very common, it is not totally absent either. The fear of people resorting to violence is palpable in this interview with a pharmacist (a non-Bodo) working in one of the further health centres in Basugaon area:

“the biggest deterrent for the doctors (to join here) is fear of safety. They are concerned about their security. 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 pharmacists. We had to give them the ‘demand money’ as we have been threatened that they might lift our children or others in our families. 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 in their phone. This scared me a lot and there was no one practically 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”.

Summary of Chapter

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 in the fact 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 health centres and people of every community used the services at the health centres. Though there were severe challenges like shortage of medicines and lack of vehicles, the health system was a functional one reaching out with community programmes right 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 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. 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.

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 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. 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 pro-active approach needs to be adopted if we are to get back on track a health system collapsed by two decades of conflict and fragility.

Chapter 4.2

Health & Well-being of Conflict Affected Communities

In an area of conflict and fragility, people tend to lead vulnerable lives. But what happens to their health, well-being and development 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? Pedersen⁴² 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 how this 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 from the eyes of different ethnic communities of Bodos, Adivasi and Nepali people 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 such as loss of livelihoods, land, housing, culture, safety & security, community mediate to create ill health?

From understanding the experiences deeply, we hope to know what kinds of interventions and supports might be required to help families cope and recover from the upheavals caused by conflicts in their lives and remain healthy.

⁴² Duncan Pedersen, Political violence, ethnic conflict, and contemporary wars: broad implications for health and social well-being; Social Science & Medicine 55 (2002) 175-190

4.2 a. Description of the Study Area

The study areas include Deosri, Koraibari, Mohanpur, North Simlaguri, Bhurpar Balabari and Kuswmdwisa. These villages are under Sidli block of Chirang district.

Fig 4.2.1 Map of Assam showing Chirang District & the Study area

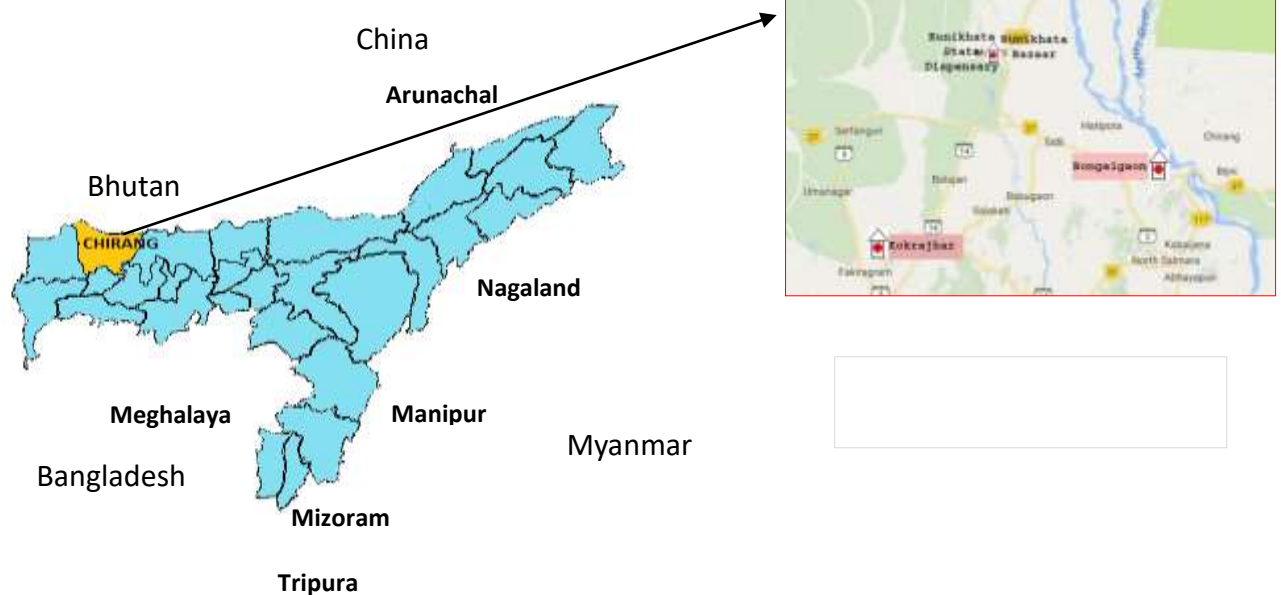


Fig 4.2.2 Map showing Shantipur & the Study area

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 villages come here, The All Bodo Students Union (ABSU) Shantipur Unit office, Police Check Point, State Bank of India Customer Service Point and State Dispensary. The state dispensary is located in Shantipur. People from Dadgari (border of Bhutan) onwards come for treatment here. It is the first available government facility in the area. At the state dispensary there is one Ayush Doctor who resides in the quarter and is available for treating



Shantipur State Dispensary opposite the Shantipur Market & Police sub-station



people.

Shantipur is also of the biggest markets in this area. The market is open daily but the big weekly market is open on Saturday. On the Saturday market people from all the villages including the distant villages come to this market. On market days, the place is vibrant with a lot of people, vehicles, buyers and sellers. The sellers varies from the regular shop keepers to the ones who comes on a weekly basis to bring their fire woods, vegetables, meat, spices, utensils, crafts and medicines. The most interesting part in this market from the study point of view is the medicine sellers. One can see different types of medicine sellers ranging from the one who is announcing the illness with a big sound system and the treatment & medicines available & arranged in a very neat order with banners to the one who is selling herbal medicines quietly in the corner and to the one who is selling allopathy medicines openly on the floor displaying the medicines for sale just like how clothes and utensils are displayed in the market. Over the years we commonly know that medicines are supposed to be stored in a cool dry place but in a market place like Shantipur medicines are spread and displayed in the scorching heat.



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

Deosri village is one of the villages that hosted a huge number of Internally Displaced Persons (IDPs) during the 1996-98 conflict between the Bodos and Adivasis. The people who were living in the Deosiri relief camps were Adivasis who fled from villages such as Amteka, Baghmara, Shantipur, Nakedara, etc. At present the resettled village is known as Deosri Relief Camp. With most of the inmates having moved away and settled in forest land, Deosri Relief Camp looks more like a settled village than a relief camp now. The Adivasis who did not move back to their respective villages in the year 2006 have built non-

permanent mud huts in this village. There are 46 households (2013) with a population of 230 persons. None of these 46 households have access to toilets, bathrooms, wells and handpumps. Their source of water is the Nijula River. There is one Lower Primary School which is located in Mohanpur. The nearest health center is Shantipur State Dispensary which is at a distance of 3.5 Km.

In the year 2005-06 when the people were asked to leave the relief camp for those who moved out of it move to the next closest village i.e. Mohanpur village. 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. In Mohanpur there 10 households which have wells and 13 households with handpumps. The nearest health center for them is the Shantipur State Dispensary which is at a distance of 4 Km.

There are people who went back to Koraibari from where they originally were and some went to find new land in Koraibari because Koraibari is still a forest area. Koraibari is one of the villages which is located at a distance of 12 Km away from Deosiri market. There are 160 households with a total population of 698 persons. Koraibari is located deep inside the forest. There are mud paths that lead to Koraibari village. The distance from Koraibari to Shantipur State Dispensary is 15 Km. The nearest pharmacy is located in Phulbari village which is at a distance of 4-5 Kms approximately.

The people in Koraibari village travel by bike or cycle if they have one or they go by walking if they have to go to Deosri. There are no markets in Deosri. There is only one small tuck shop in the entire village. People either have to go to Deosri for the regular marketing or wait for the weekly market that is in Shantipur on Saturdays. There is no public transport that goes to Koraibari. When one travels from Shantipur either they have to get down at Phulbari or Deosri and go from there by walking to their village. There is only one lower primary school which is run by the NGO and functions from the Army's tent which was left for the people of the village to use it. The Middle school and high school students have to travel to Deosri and Shantipur respectively.



(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

North Simlaguri is 11 km 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.

Kusumdisa No. 2 has 77 households. The first settlement in the area dates back to the year 1984 before the Adivasi- Bodo conflict .Samir Boro and his family along with other five families were some of 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 belong to 55 families from the village. Each family in the village occupies more than 15 Bighas of land. Other remaining families from the village are supposed to be the sons and have moved out from the parent's family after marriage.



Road leading to Kusumdisa Village

Bhurpar Balabari 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 to settle the lands which were actually prone to soil erosion. Those areas were

claimed by the Bodos of Bhurpar who were mostly Christians. They were allowed to settle in Bhurpar Balabari No.2 when they agreed to vacate the place on receiving the compensation from the government. The people after moving out from the relief camps 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.

4.2 b. Effects of Conflict on Health & Well Being⁴³

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. 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.

4.2.1 Fleeing, Forced Displacement & Health in Relief Camps

In this study we focussed on understanding how displaced households experience conflict and how they cope with it. Our interviews spanned across 5-6 villages of displaced populations of Adivasis and the Bodos. We tried to look at the differences between those who have experienced displacement afresh in 2014 and those who were displaced twenty years ago.

a. Fleeing - the first big disruption

- *Irrespective of the community, fleeing from conflict is the first in a series of life disrupting events which becomes catastrophic for Bodos and Adivasis for many of whom, this is not the first time.*
- *Secondly, loss of relationship and trust between conflicting communities is one of the earliest losses in an ethnic conflict.*

“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 the 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 some other 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 cord of the new born baby had not 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

⁴³ All names in this report have been changed to protect the identities of the respondents.

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”.

– TaraDaimary, Bodo woman, fled the 1996 and 1998 violence, lived in a number of Relief Camps before settling down in Bhurpar Balabari

“During the 2014 conflict 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 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 Koraihari village



A view of Koraihari Adivasi Village in 2014 conflict – Adivasi men stand as granaries smoulder even on the fourth day after it got burnt.

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. So, we quickly managed to sell off most of their buffaloes at throwaway prices, we sold a buffalo costing 8-10 thousand for as little as 3000 rupees. But with that money, they managed to buy food the first few months and were better off than others”

- RamanHasda, 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 up 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 the 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 Koraihari; village headman's wife; we found her to be in an inebriated at 3 p.m. in the afternoon

Sanjiv & Nidhi's Story – Bodo couple living in Bhurpar Balabari now; was displaced from Deosri in 1996; they went back but was again displaced in 1998 and did not go back.

Sanjiv: "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 bighas⁴⁴ of land from a Santali and another seven bighas from someone else for paddy cultivation. The Santali 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* (Santal 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 run away as their (Santhal) 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 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.

⁴⁴ In Assam, roughly 3 bighas of land is equal to 1 acre

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 and 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".

Nidhi - Sanjiv'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 3 dokhnas (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 was 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. It 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 a herb called **jaku muli** which stopsthe 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.



An Adivasi woman of the 2014 conflict with her child - born a day before she fled her village to the Deosri Relief Camp.

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 but live 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.

Munni Tudu - Adivasi woman; 40 years old; displaced in 1996 conflict and did not go back; now living in 3 No. Deosri Village

"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 and bring them back. One of the Bodo women give the old lady a half bottle. She tucked it into her blouse and asked her to quickly flee. We had hardly reached back our house when the attacks reached us. I didn't know what to do. My brains were not working. Here both the old man and woman drunk and a brother-in-law who was "half-brain" (mental disorder).... My husband had left only that same morning to go out and work and so, he was not around. What to do? What not to do? Who to take? Who to leave behind? I told the half-brain, 'leave the mother and take the father' and so he carried the old man on his back. I took the child and we started fleeing and came to the camp.

We left the old lady behind as she was totally drunk and could not even stand by then. My child kept crying for the old lady as she was very close to her. I was also worried and wanted to go back for her but there was no way. But she survived. She went to a nearby Bodo household for water and they gave her. We had so many cattle - two sheds of cattle and they asked her "are these your cows"? She would deny and say "No, no. These are not ours. You take them". She had to say that or else they might even cut her up. Like that, we also had a very fat pigs and hens and goats. We lost it all. Anyway, she was in the jungle for two-three weeks. There were others too who could not run immediately. A relative of ours

gave birth that day of the conflict.... It was so difficult to run when she was in labour. They fled from the house and gave birth in a side , there was a little bit of jungle to hide and she gave birth there. It was really dangerous. Anyway, many of them hid in the jungle and slowly, slowly made their way to a school where many of our people had gathered. The Bodos wanted to burn the school down but they begged for their lives saying that “we are Oraon Adivasis and not Santhals, don’t kill us”. They were spared and slowed came and joined us in the Deosri camp”.

b. Coping with Life & Health 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 militants were there 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 long 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 tough 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 have to cope with frequent and multiple child deaths.

A glimpse of Relief Camp life following 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



Clamoring 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

Sona Mushahary was already married for many years before the 1996 conflict broke out and they fled to Tukrajhar relief camp. While there, her husband was sick for three days and then died. She struggled to collect firewood from the forest and sell it for food for her family. It was hard labour and because of that, she contracted Tuberculosis (TB). Though she was given free medicines from the government hospital, she took it regularly for only two months after which she stopped because she could not swallow the medicines and would vomit every time she took it. Just after they moved to this present village, her married son also died. "He was sick for few days and since there was no money in the house we could not even take him to a good hospital and he died". His wife is now married to someone else but she kept back their son with her. –*Sona Mushahary, Bodo woman originally from Deosri now living in Bhurpar Balabari near Runikhata after fleeing the 1996 & 1998 conflicts.*

"Our house in Deosri was in the present day Nepali basti (Village). In the 1996 conflict we fled to Tukrajhar Relief camp but we returned after some time. Most of our utensils were damaged. We managed to cook food in some of the pots but used to eat in banana leaves as we had no plates. In 1998, once again we fled when conflict broke out. This time we never went back. We came to live in Runikhata Relief Camp. There, my mother-in-law died. She had some big ball like object inside her stomach but we were dependent on daily wage labour and so, how could we save money to take her to the hospital? We then came to this village and my nine-month old son fell sick and died. Again, we did not have any money to take the baby to the hospital". –*Kiran Narzary, Bodo woman originally from Deosri now living in Bhurpar Balabari near Runikhata after fleeing the 1996 & 1998 conflict*

c. Post Relief Camp : Complex Interaction of losses & Ill-Health

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

Conflict, especially 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.

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 4.2.3 : Post-Conflict Vulnerability Map of Bodo Household following 2014 Conflict



Figure 4.2.2 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. Poverty & Losses gets embodied after a conflict

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.

iii. Increase in Risk Factors of Ill-Health after conflict

Post a conflict episode, 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. We will look at a couple of life-histories of women to see how they have coped with conflict, starting with that of Rashmi Narzary of North Simlaguri Village.

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 3 daughters and 1 son. The Bodo-Adivasi conflict of 2014 saw her life turning 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 the *"santhals cut my husband"* when the search team confirmed his death when they discovered his clothes and

shoes were 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 just 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 as she 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 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 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 never 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, she 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”.

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 was 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’s during the conflict. Above all living in the relief camp with all the sorrows and grievances they did not give any reasons for celebration. “All we could do was to grieve over our losses and watch the nearby villages enjoying Bwisagu festivities.”

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

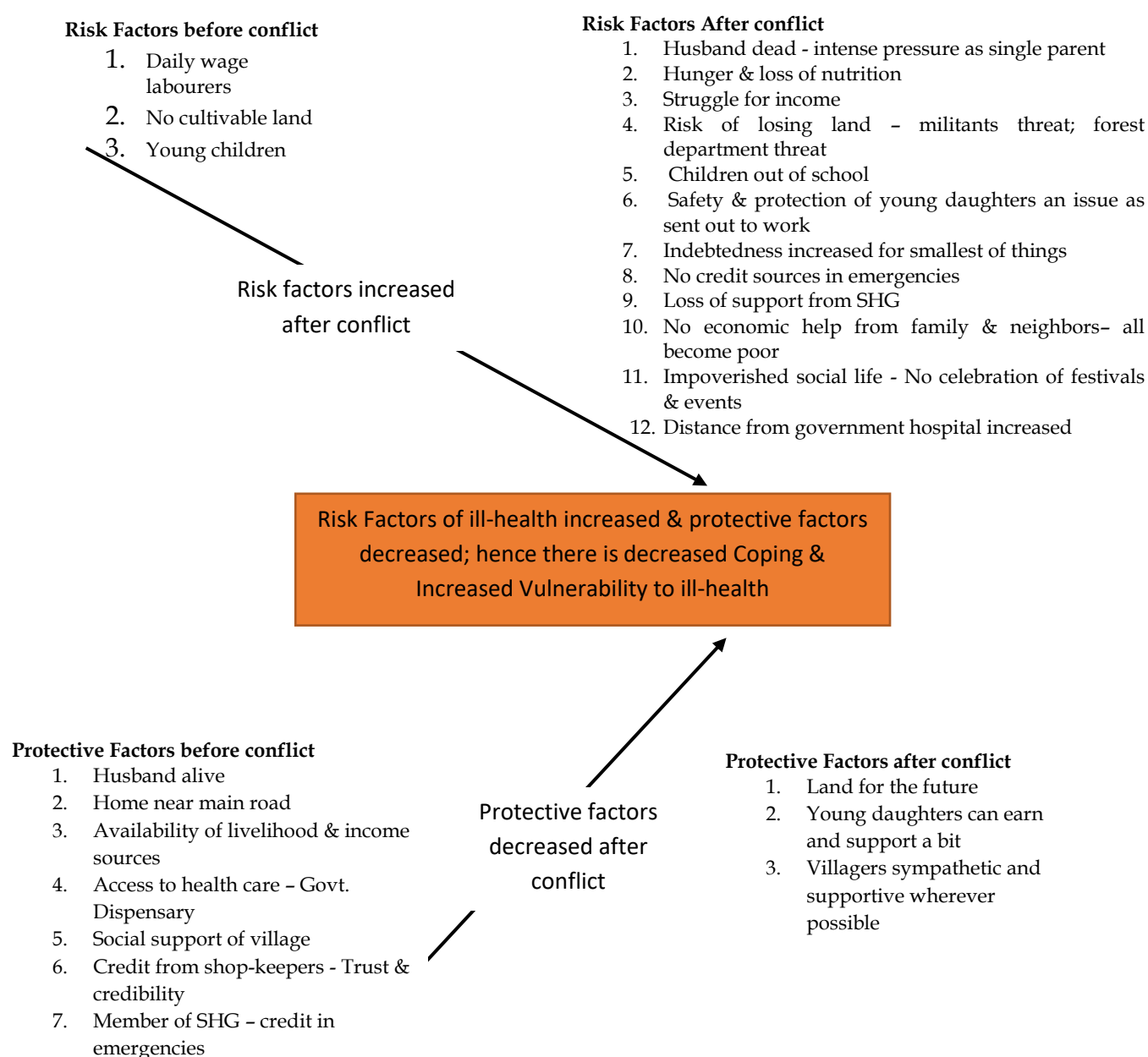


“Even after the people resettled in North Simlaguri we were not in a position to afford to celebrate Bwisagu of 2016. The wounds of 2014 conflict are not yet healed; the people were still struggling to

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.

Figure 4.2.4: Mapping of Post Conflict Risk & Protective Factors of Ill-Health



In Figure 3 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 risk – increasing their chances of being abused or trafficked.

Conflict & Health of Vulnerable Groups

Daily survival becomes a big challenge after a conflict, especially if the household has been forcibly displaced. While this places huge stress on all the members of the household, do certain groups such as women, children or those with special needs such as pregnant women, physically or mentally challenged or the elderly experience the loss differently? How do they cope and remain healthy? What do they do to cope?

i. Conflict & Women's Bodies & Well-Being

"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)".

Where do women dry their menstrual cloth in a reliefcamp?

The very crowded relief camp situation was a special challenge for menstruating women who used to tie the freshly washed and dripping wet menstrual cloth to their bodies to dry because "where was the place to dry it?" –***Adivasi Women; 3 No.Deosri Village; lived in the Deosri Relief Camp for over ten years from 1996-2005***

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

The accumulated stress and tension seems to "wear" their bodies out. Women respondents in our study link their bodies being weak and unhealthy to many things – prominent among them being mental stress resulting from stress after the conflict – food insecurity, fights in the house, wife-beating, alcoholism. If we look at some of the stressors in women's lives and what they have to cope with after a conflict, one can understand the effect it must be having on their bodies.

"What tensions do men face? As long they



The poor condition of a "house" in Korabari village after people went back from the relief camp after the 2014 conflict.

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 Women; 3 No. Deosri Village; lived in the Deosri Relief Camp for over ten years from 1996-2005

Rise in Alcoholism Post Conflict

Women talk about the rise of alcoholism and wife-beating after the conflict. In our field work, 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.



Men asleep after drinking at a village meeting to discuss the functioning of the village school in Koraibari village.



“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 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 now we 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. Here we have the two leaders looked up by the Adivasi community talking about the problem.

“Alcohol consumption changed hugely after our displacement. Earlier, only during ‘parabs’ we drank. In the conflict, people lost everything they had. They became “heart-broken” 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” to buy alcohol or 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 drove 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.



A “house” in Northern part of Koraibari village in the middle of the forest; 9 children of this village died of malaria after the displacement following 2014 ethnic violence.

ii.Effect of Conflict on Health & Well-Being of Young Girls

In our study we find that young 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 Koraihari; lived in relief camps in 1996-2005 and again in 2014

5 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. 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 Gelengphu. 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.



A young girl in Koraihari lends a helping hand in looking after her sibling. Most young girls help out in the family and in the event of a conflict and further impoverishment, they get set out to work in order to keep supporting and helping the family.

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.

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

"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 8 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.

iii. Conflict Retards Children's Development

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. In this section, from the eyes of a young 12 year boy, we see what conflict does to children forcibly displaced.

"Will our children be like what we are today?"

Life-History of Evan Soren, a 33 year old Adivasi man 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 young 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 Rs. 10,000 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".

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 like 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 most probably not have 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)*

4.2.2 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) document⁴⁵ 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"*.

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 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 open 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".⁴⁶

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.

"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 he 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

⁴⁵ UNHCR Social and economic impact of large refugee populations on host developing countries; Social 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>

⁴⁶ Same as 1 above

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 their village and their 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.

- **N1-Rohit Chetri (RohitChetri, 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”.

- **N7 AmitGurung (AG, Nepali Buddhist Male, 28 years; lives in Deosri, works as community mobiliser in an NGO)**

“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”.

- **N7 Amit Gurung (AG, Nepali Buddhist Male, 28 years; lives in Deosri, works as community mobiliser in an NGO)**

“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”. **N6-Mansi Chetri (MC, Nepali Hindu widow; 50 years; small shopkeeper in local market).**

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. Sixteen or seventeen Nepali people died within one week. In the relief camp (of the Adivasis), many more died. 7 or 8 people 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” **N8- Suraj Pradhan (SP, Nepali Hindu Male; 39 years; lives in Desori; 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”.

N1-Rohit Chetri (Rohit Chetri, Nepali Male, 45 years, Hindu, lives in Deosri)

PL 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”.*

“During the conflict, the main sicknesses were vomiting and diarrhoea. Infection spread from the relief camp to the Nepali Basti as well. The Shantipur Dispensary was blocked off because of the fighting, but there was a pharmacist in the relief camp who could provide medicines”.

N5-Babita Pradhan (BP, Nepali Hindu woman, 63 years, 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”.

- **N7 Amit Gurung (AG, 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”. - N7 Amit Gurung (AG, 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”. N7 Amit Gurung (AG, 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.⁴⁷

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”. N8- Suraj Pradhan (SP, Nepali Hindu Male; 39 years; lives in Desori; leader of community)

SP 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”.

- N2 Kamal Pradhan (KP, Nepali Male, 63, headman of the village during the conflict period)

⁴⁷ UNHCR Social and economic impact of large refugee populations on host developing countries Social 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>

“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”.

- N5-BabitaPradhan (BP, 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 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!”.*

- N8- Suraj Pradhan (SP, 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)

4.2.3 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



Soil erosion in Deosri is eating up large chunks of land and threatens the very existence of people there.

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".

– BadalChettri, Nepali pharmacist practicing in Deosri market

JL's field notes of 3rd July 2017

An Ecological Time Bomb

"When we reached the house of the headman of Koraiabari 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.

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 Koraiabari 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 tensed as 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

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 Koraiabari. 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 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 Raan hat 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 patch 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 (yam)! 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 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 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 persons 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 the 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).



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



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

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 *guntis* (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”.

4.2.3 Summary of Chapter

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.

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 in 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 that 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 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 have 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, 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.

Chapter 4.3 Health Seeking among Conflict Affected Communities

Introduction

This chapter talks about the health seeking behaviour among conflict affected communities. It looks into the different health seeking behaviour based on the different health facilities- government and non – government which are present in the area. The role of Informal health practitioners and how each ethnic community access health care in a conflict area.

4.3.1 Matrix of Health Facilities Availability

Sl. No.	Village	Community	Nearest Health Center	Distance to Nearest Health Center	Do Health Personnel stay at Health Center ?	ASHA Worker available or not	Number of Pharmacies in the village
1	Bhurpar Balabari	Bodo	Runikhata	1 Km	Some health personnel stay but not doctor	Available	11-12 (approx)
2	Kusung Dwisa No. 2	Bodo	Shantipur	10 Km	Doctor Stays; 2 nurses are there but do not stay	Available	0
3	North Simlaguri	Bodo	Shantipur	14 Km	Doctor Stays; 2 nurses are there but do not stay	Not Available	0
4	Deosiri RC	Adivasi	Shantipur	3.5 Km	Doctor Stays; 2 nurses are there but do not stay	Available	1
5	Mohanpur	Adivasi	Shantipur	4 Km	Doctor Stays; 2 nurses are there but do not stay	Available	
6	Koraibari	Adivasi	Shantipur	12 Km	Doctor Stays; 2 nurses are there but do not stay	Available	1 (<i>Located in nearest village i.e. Phulbari</i>)
7	Nepali Basti	Nepali	Shantipur	4 Km	Doctor Stays; 2 nurses are there but do not stay	Available	2

4.3 b. Informal health practitioners in conflict areas

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 as 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.

i. Role of Traditional healers

Traditional Healers also known locally as the Ojha Guru or Kobiraj are practitioners who have been curing people either by offering pujas & sacrifices or herbal medicines. Giving jungle roots, herbs and jadibuti 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. Niranjana 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 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. ChandraMurmu, a traditional healer from Deosiri said *"For doctors they do blood test to find a person sickness but for me I used to meditate and diagnose the sickness of a person...also for the medicines I am able to see in the meditation what is required for the illness."*

Lohit, a 25 year old faith healer has patients who come to him for serious cases and illnesses. His patients include both serious illness and those having problems with the Gods. *"The serious patients that come to me are the ones that are bed ridden whose doctors and ojhas medicines has not work on them. When a person contracts multiple illnesses 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. With time after being introduced to medicines people do not entirely depend only on medicines alone but visit a traditional healer because they are not satisfied with the medical treatment alone especially if it is a prolonged illness.

"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. He could not treat all the suffering persons because he could not make a collection of the herbal plants and roots. He could not go to the forest because of the conflict.

After the 1996 conflict people mostly suffered from malaria. People used to go to the doctor for treatment. Some people who were not recovered came to him for treatment. He treated everyone who came to him with his herbal medicines. I treated some patients in the 2014 relief camp in Deosiri. 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 and the minimum I have received is ₹50."

- *Mr. Badal Tudu is a 70 years old man. He is a follower of Bajrong religion (form of Hinduism). He reached Koraihari 3 years before the conflict of 1996 in search of land. When the conflict broke out he lived in Deosiri RC. He started this practice back in his previous village when he was 20 years old. Both his parents were traditional healers. He learned this from his parents.*

"The persons or families who have spent money on ojhas, doctors, medicines and still not recovering comes to me. If the family gods and goddesses are displeased with the family the sufferings and illnesses cannot be cured with the doctor's medicines or the ojhas herbal medicines. My main task is directing the family to do the required rituals and offerings. If the family gods are displeased the rituals will be perform which will send away the illness. If a person is found to be possessed by the evil spirits the person is advised to offer a black hen to the gods. After performing the rituals they are advised to visit the doctors again.

The sudden loose motions, stomach ache and not able to eat are said to be caused by the gods who are not worshipped by them. There are numerous gods outside whom they do not worship. A person having stomach ache a particular kind of evil spirit called 'kubir' has to be chased. In case of leg pain the evil spirits known as 'chokro' has to be chased. A person having pain on the hips the evil spirit name 'sikari' has to be chased. In case a person is suffering from ailments in the chest they have to offer a black hen to a spirit known as 'runsundri'. A person who suddenly runs around like a mad person can be controlled by offering a black hen. All these occur suddenly so they do not have to visit doctors the people can recover through offering pujas and giving offerings.

There are people who have been coming to them directly whenever they fall ill because in their previous experience when they have been ill they have never recovered through a doctor or ojha intervention and have recovered through a deosigiri faith healing. They have an expectation that if they come to a deosigiri they will recover. The adult sufferings are mainly because the gods are displeased but in the cases of children they believe that they have the cure for their illness."

- *Mansi, female, bodo, deosigiri from Gasagaon village*

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 rupees 11 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.
- Mobile No.



“People come to me with Dry TB, ‘Hamos’ which is also called malaria, swollen body , Jaundice, broken legs & hands for treatment. I give jungle roots for curing the illnesses. He treats women with ‘Pordhol’ meaning a women not getting child by giving them jungle root medicines and some Jaributi medicines from the market.

Some people come because they believe they are being affected by black magic such as family problems occurring every now and then, illness not getting recovered even after taking medicines from the doctor. For these types of belief I offer puja with coconuts, banana, beetle nut and flowers. one woman from Mohanpur was suffering from malaria. She was taken to Kokrajhar hospital for treatment. She spent Rs.30, 000 in buying medicines but still she was not recovering. So she came to me for treatment saying that after taking many medicines still she is not recovering. She thought maybe someone has done Black magic on her. I did the puja and saw that she was affected in the chest by black magic. I told the woman to offer coconut, banana, beetle nut and flowers for puja. After doing the puja I brought jari buti and jungle root medicines from the jungle. I grinded them and gave it to the woman. After taking the medicines she recovered.”

- *Chandra Murmu, male, an adivasi traditional healer living in Mohanpur. He learnt the art of traditional healing from his father and other gurus.*

ii. “Pharmacists” in Village markets

The ‘Pharmacists’ whom the people refer themselves for illnesses are the untrained, self learned and non-license pharmacy. These pharmacies are run by locals to cater to the local needs of the people. The pharmacist has never had any training as pharmacists but they can give medicines for any illness; they administer saline, injections and test for malaria. Due to the poorly functioning government health centre and also non-availability of medicines, there is a high dependence of people on the pharmacists. Some of the pharmacies served as health care providers during the conflict period and continues to function till the present. Most of these pharmacists have won the trust and confidence of the people. People have faith in them.



A “pharmacy” found in small and big market places where people go to for all kinds of allopathic medicines and all kinds of treatments.

“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 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]”

- Ganesh Hasda, a male Adivasi pharmacist in Deosri. He is 36 years and he learnt 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.

It is interesting that in interviews with the traditional healers, they tell us that people visit them if they are not cured by modern medicines. But on the other hand, pharmacists tell us that there are cases where people prefer to initially go to traditional healers and if they do not get cured then they visit the pharmacy for medicines.

Traditional and Modern Understanding of Malaria

Over the years there has been a change in the understanding of people in understanding illnesses especially of malaria. There were different names given to malaria before the 1996 conflict. Treatments for malaria also change over time after the conflict.

“Before 1994-95 people have not heard of the word ‘malaria’ but the symptoms of *BhalukJhor* were mainly shivering, high temperature and bitter taste in the mouth. For cure of this disease, people approached *ojhas*/traditional healers. As the name signifies, *bhaluk* means bear and *jhor* means fever, so the medicines comprised of bear fur. There would be large numbers of spectators to see the bear performing a dance whenever and more than the dance, people were interested in getting the fur of the bear which could help them recover in case of *bhalukjhor*. A very few number of people visited the pharmacy or hospitals. They were more attached to traditional healing methods.

When *bhalukjhor* was finally diagnosed as malaria around the year 1994 I was incompetent to use the microscope for testing malaria. It was only when the malaria test kit came up in 2007 I started using the kit to detect malaria. Prior to this the symptoms were the only indicators for malaria treatment. The symptoms of *bhalukjhor* were very identical to what people now call as malaria. There was huge rise in the number of malaria cases by the year 1996, conflict period. Government health service centres and the few pharmacy of the area were just inadequate to address this rising issue. I suspect that malaria spread abnormally because people gathered in huge numbers in the relief camp. When MSF came to tackle malaria it could control its increase to a considerable extent. But there was huge malaria cases even after five years of their intervention. When I started using the malaria test kit in the year 2007 I recorded 100% malaria positive cases. Even though MSF could reach distant village doing awareness programmes there were still many villages which were left behind.”

- Bikas Boro, a bodo pharmacist from Bordangi who is popularly known as “Bikas Doctor”. He runs a clinic from his house. He trained himself while working under some local pharmacist for 7 years before he opened his shop in 1999.

A day spent with pharmacists in a village market - JM's field notes of 8th & 9th November, 2016

Rajib and Sankar are two pharmacists who share a pharmacy business together. 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. Jaundice is also another frequent illness of the area.

I was waiting for Sankar in his pharmacy, his wife comes to inform that her husband would not be coming today. I thought of moving away but decided to spend a little more time observing Rajib, Sankar's pharmacist partner treating patients. It was really interesting and I spent an entire evening over there watching him ply his business. 5 patients that day- three men and two women came for painkiller tablets. Then, one adivasi man from Korabari came to buy medicines for his wife who is suffering from severe pain because she had delivered a baby in the house that morning. Rajib gave him two tablets worth Rs.10 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 18 patients that day.



Rajib and Sankar with their medicines in their pharmacy in a village market. They get an average of 10-12 patients a day.

Like the Bodos, the Adivasis also have a similar traditional experience and explanation for malaria. It was only after the conflict that they came across modern medication and treatment for malaria.

“During those days the 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 Deosiri 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 reliefcamp. 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

Pharmacies nowadays are more preferable by the people because they are known people and people can get immediate treatments and medicines through credit.

"We need to pay both in our local pharmacies and the government hospital. But in the local pharmacies, we can get the credit. Moreover, they are well behaved and nice to us. Most importantly, they are available for us round the clock, unlike in hospitals when the staff have some fixed duty hours."- *Amba Tudu; Adivasi woman from Mohanpur Village*

After a decade of conflict, people are losing faith with the government health system. The unavailability of medicines makes people go to the pharmacy directly. In the words of Lucy and Mary, women from Mohanpur, "*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 just go to the pharmacy straightaway anyway, why go to the hospital?*".

iii. 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 Medico 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 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 recovery quickly 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"*.

4.3. c. Treatment pathways by families in conflict areas

i. Accessing health care and treatment by different groups

Households severely affected by conflict, displacement & its subsequent and multiple losses resort to different means of accessing health care and treatment. Money, more specifically, its unavailability determines the kind of treatment choices available to people.

"Families from Koraibari prefer home delivery to institutional delivery. 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 to send any outgoing or incoming calls. Technically they go for home delivery instead of rushing to the Asha's house to inform her which is some 3km from the village. Nights in the village are scary with wild elephants moving around.

During the summer it is impossible for an ambulance or any other jeep to enter the village because of the severe bad road condition. The distance between the village and the main road is neither less it should not be more than 5 km. Once it happened that an ambulance called at night reached the village only in the morning. Ambulance started to come to Koraibari only after the year 2015. Prior to this period the village did not have any road. Prior to this families used a bullock cart to take mothers for delivery to the hospital. In case they were referred to other hospitals the nearest option was Tukrajhar."

- *Suraj Mardi, male, Adivasi, village leader, Koraibari*

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. This is amply seen in the case of

Mohan and Rupsi, a Bodo couple displaced in the 2014 violence and who moved to North Simlaguri after staying six months in the relief Camp.

The Deaths of Mohan & Rupsi's Children in North Simlaguri

They moved out of the relief camp and they were a few months in their new place. It was the harvest season i.e. November/ December of 2015. Rupsi used to take the boys who were now 3 ½ and 2 ½ years along with her to the harvest fields where she worked for someone. Though Mohan asked her not to go out for work because of the young children, she wanted to earn a little extra and help lessen his burden. Even in the previous village i.e. Komola Mandir, they had worked together in the harvest field and got paddy as payment. Here while she worked, the boys used to play around their mother. "Often they had to sleep in the open under the hot sun when they were tired or sleepy, else they would go and play in the nearby stream for long hours with the other children. Leaving the children at home was even more risky and dangerous and so I had to take them".

Soon, the children fell sick. Mohan said "Earlier my children recovered from illness with the medicines I got from the state dispensary in Shantipur. Even while living in the relief camp, my son recovered quickly from the illness with medicines from the pharmacist". This time too, the couple got medicines from the pharmacists and waited for the boys to recover but the younger one did not improve. Since he was not improving from 'tablets' they bought from the pharmacy, the couple took him to an 'ojha', a traditional healer in Simlabagan village, 2 km away. The ojha, an old lady had a good reputation for her practice and she diagnosed the child with jaundice. She boiled some leaves with which she bathed the child. "On our way back home, my son started talking and by the time we got home, he was already recovering and improving. Though he refused to drink his mother's milk he ate a little rice when we forced him. Thinking he was better I went to cut yam stems to feed the pigs" says Mohan. While he was away, a man from his village came running and informed that his son had just died. Rupsi said "it was a Thursday on the day he died and I remember he was also born on a Thursday 2 ½ years ago".

The elder son had recovered from his illness when the younger boy was seriously ill. But hardly had they buried the brother that the older one started to fall ill again and this time it was even more serious. Mohan borrowed two thousand rupees (which in six month he would repay with an interest of ₹1000) to take the older boy to the hospital. Paying ₹900 as fare, he took the boy to the Tukarjhar Baptist Mission hospital some 20 kms away. But the doctor was out and so the person in charge there asked him to take the son to boy to the government hospital in Bengtol, 5 kms away. Finding the boy in a serious condition, the doctor there asked him to rush the child to the Catholic Mission hospital in Bongaigaon town, another 25 kms away. Mohan recalled "When the doctors there in Bongaigaon heard that child had been in this condition for the past 4 days, they did not even bother checking him up.

By then, he realised that he only had only 1100 rupees in his pocket and he could not afford to take his son to another hospital. He knew that he would not be able to borrow any more money as getting the earlier 2000 rupees had been a struggle "we are new settlers to the area and money lenders do not trust we can pay their money back and so do not give us. But we begged that we were ready to sell the tin roof of our house, our two pigs, we could borrow money even at a higher rate of interest by mortgaging our land". Not knowing what to do and seeing his son's condition, "His skin had become so pale. His eyes were nearly closed

and lips were drying up and he was breathing with great difficulty whispering so softly that I had to lower down my ears near to his lips to hear what he was saying.”

The final option left for them was to visit the ojha (traditional healer) on their way back home in a place called Bhurtinali, half-way home to their village. The ojha treated his son for 2 days but the boy kept asking to be taken back home and since they suspected the child to be suffering from typhoid, they took the child to another ojha in Runikatha who they heard specialized in this. The ojha applied a paste of herbal medicines on the child and while they were returning home from there, the elder boy breathed his last in his father's arms. “We buried him next to his brother with the hope they can reunite.

- Mohan & Rupsi, a bodo couple, Internally Displaced Persons of the 2014 conflict and currently living in North Simlaguri

In this case, we can see the desperate attempts of poor resource starved parents to save their children. Poverty and lack of coping resources after a conflict delays treatment and makes a common episodes of illness into health catastrophes leading to death. The same can be seen in the next story of Binod and Lakhi Tudu, an Adivasi couple living in Koraibari.

Binod & Lakhi Tudu, Adivasi couple living in Koraibari Village

Binod and Lakhi Tudu are an Adivasi couple living in Koraibari village. Binod married Lakhi when she was just 15 years old. 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, they 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 then when they returned from the camp.

Figure 4.3.1: Post-Conflict Poverty & Illness Pathway of 16-year-old Sarna



Figure 4.2.3 shows how poverty after a conflict negatively affects health-seeking behavior of an affected household leading to ill-health and death. In Lakhí'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 2. 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 village in the forest from the relief camp in May 2016, nine young children and two women (one of them is Sarna in Figure 2) 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.

Ethnic or Economic basis in Health Seeking Behaviour?

There is a difference seen in the way Adivasis seek modern medical treatment vis-à-vis the Bodos and also the Nepalis. From our study, it is clear that the difference is economic and

not ethnic or cultural. The Adivasis delay in seeking modern allopathic treatment is because they cannot afford to buy medicines and hence they wait for the last moment. "The people 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 2 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 recovered with just one injection the person stops the course. On many occasions people cannot complete because they do not have the money for the injections".

- *Rajib Mushahary, popular Bodo male Pharmacist practicing in a village market; has both Adivasi and Bodo clients*

"Our community people do not depend much on doctors/ hospitals! Though there has been a drastic decline in practicing different home remedies, villagers are still largely dependent on Kobiraj who heals illnesses through prayers and offerings (puja-path). Kobiraj also prepares herbal medicines for few illnesses. There are many Kobirajs in our village. I personally also offer prayers and offerings to heal illnesses. During emergencies problems like sudden severe abdomen pain, the families directly call in a kobiraj. For decades kobiraj have successfully addressed this particular emergency. A kobiraj is capable of diagnosing almost all types of diseases in case they fail to diagnose and the illness persists the patient is referred to other kobiraj or hospitals/ pharmacies.

I fractured my wrist two months ago. I first consulted Ganesh a pharmacist in lower Deosiri. I paid ₹55 for each injection. My total expenditure in the pharmacy was ₹ 700 as he also gave me some of his tablets. As the number of injections increased my hand got worsened with pain. When I realised that the injections were not doing any good to my hand I started performing the prayers & offerings (puja-path) and prepared herbal medicine to apply on my hand. In our village, no one with broken limbs was 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. Another incidence in the village, an old man was taken to Shantipur SD in a bullock-cart. Doctor from the SD referred to town hospitals. The family did not have any cash or resources which could give those cash. Even Santosh (Santal pharmacist in Shantipur) pharmacy was closed that particular day. The family returned after purchasing few tablets from the pharmacy which did little help to recover. On return all the villagers gathered to the family of the old man and offered puja after which he recovered. The old man today is healthy and fine."

- *Suraj Mardi, male, adivasi village leader, Koraibari*

There is a small difference also seen among the Hindu Adivasis and Christian Adivasi families in accessing health care. The Adivasis who are Christians prefer to go to the doctor and pharmacist while the Hindu adivasis access both modern medicines and traditional healers.

"When I was a young girl, there were neither roads, nor bicycles, nor doctors. The nearest market was Bengtol. The only medicine was the "jadi-booti" for small fevers. I, touchwood, has never had a fever. Now, at my present age, I have body ache once in a while. All my children were born at home, and my mother assisted in childbirth. I was unaware of

vaccinations, so my children did not get any. One of my children fell ill soon after birth. There was one doctor in Kokrajhar. I walked there with my child to get her treated. Our community did not have any kavrāj or ojha, these were present only in Hindu communities. When I was young, we would consume roots of certain trees to cure ourselves. Typhoid, jaundice, malaria, are all new forms of diseases I am hearing of. I only ever fell ill once during my stay in the relief camp, when I took some herbal medicines for cure. When my children fell ill, however, they were given medicines by MSF.”

- *Lucy Hasda, female, adivasi, Mohanpur*

Though the Christians Adivasis say that they go only to access modern medicines but one of the traditional healer mentioned that there are a few who go to the traditional healer secretly. “For treatment mostly the adivasis come to me. Christians also come to me when they are not recovering with the medicines or prayers but they come secretly. Some ojhas do not treat the Christians. I practice ahimsa. I do not have any discrimination among the people.”

- *Chandra Murmu, male, an adivasi traditional healer living in Mohanpur. He learnt the art of traditional healing from his father and other gurus.*

4.3 f. Summary of the chapter

Traditional healers and pharmacists in the days to come will continue to be the 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 they also look upto to the traditional healers for a mental satisfaction. People feel satisfied with the service that these informal health practitioners render. for 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 come displacement and various losses which affects daily lives of people. Treatment seeking behaviour of the people is also determined by one of the economic factors for the people. If there is enough money then people do not have to worry about reaching out for treatment.

Chapter 4.4 Role of State in Responding to and Promoting Health & Well Being of Communities in Conflict

a. Governance in a Fragile Conflict Affected Area

Is conflict the result of poor governance or is poor governance the result of conflict? In Fragile Conflict Affected Areas (FCAS), this is a very difficult question to answer and even seemingly pointless for those affected by 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 regard, 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 and thirdly, most of the communities are “illegal occupiers” of forest land and hence, their rights as citizens seem to be suspect.

“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 Simlagri) has a ration card. No one else has”

- *Field notes of junior researcher JM of 21-9-2016 about North Simlaguri; a Bodo Village displaced from Kombla Mondir in the 2014 conflict*

The Deosri VCDC “office” functions out of the verandah of the old run down “forest office”. This same building depending on the need 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 VCDC⁴⁸ (Village Council development Committee) 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 Act) work, issue certificates to people etc 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

⁴⁸The 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.

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

From Field notes of BL dated 2nd December 2016

“JL and I were interviewing Ganesh Hasda (the pharmacist in Deosri) when from the corner of my eye, I saw three little boys of around 5-6 years playing in the VCDC veranda. They first swept the floor, then carried tables and chairs from inside a room and arranged it neatly outside in the verandah where the VCDC members sit and conduct their duties. After “playing” for some time, they came and stood near us waiting expectantly. Ganesh gave them five rupees to buy sweets and they left. Only then did I realise that these little children were in-charge of cleaning the VCDC office and the way they were doing it so neatly, tells me they do it every day”!

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. One of our respondents who is a 33 year old Adivasi male displaced from Koraibari and now works as a mobiliser in an NGO puts it succinctly , “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 they recognize us as citizens only then?”.

b. Status of Rehab Policies in Conflict Areas

⁴⁹The 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.⁵⁰In 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 State also has no clear policy on relief and rehabilitation of IDPs beyond providing relief rations in the emergency, that too largely it was inadequate.

“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]⁵¹

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,

⁴⁹ Johanna Lokhande, Centre For Social Justice, Ahmedabad; posted in “Counterview” on May 23, 2013; <https://counterview1.files.wordpress.com/2013/05/assam.jpg>

⁵⁰ A.K Srivastav, 2015 http://shodhganga.inflibnet.ac.in/bitstream/10603/105403/10/10_chapter%2004.pdf

⁵¹ 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

“By the end of 2004 the government announced compensation of Rs.10,000 following which the families had to leave the relief camp. Hearing the amount (the) 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 to keep people healthy and prevent ill-health. There are many services 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) which guarantees 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 4.4.1: Matrix of Government Facilities Availability in Villages of Study

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

Deosri VCDC has 1236 households under it, with 6800 population. Fig 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.

a. Access to Government Health centres

Except for Bhurpar Balabari which is close to the Runikhata State Dispensary, all the other 6 villages access Shantipur State Dispensary. The distance from their nearest government health centre is an average of 6.5 kms with some being right next to the hospital whereas both Koraibari and North Simalguri (the most affected in the recent 2014 conflict and hence by far the most vulnerable) are as far as 12 kms away. We have already seen that even where access is there, the quality of services in the Government State Dispensaries is highly inadequate and not of much use to people who need it.

b. PDS & MGNREGA

The Public Distribution System and now subsidised food grains under the Food Security Act does not function the way it is supposed to function.

MGNREGA or the *Mahatma Gandhi National Rural Employment Guarantee Act* which guarantees 100 days of work to every family is as good as non-functional. BH who is a VCDC member talks about NREGA work in Deosri VCDC,

“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 labour was not paid even after two or three months (if they were paid at all). Now systems are much better and the labour money gets 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. (After working) they keep enquiring if their money is deposited. Then, bank is so far away 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 3-4 job cards extra and take that payment which we use for our expenses. We can then even pay the VCDC members something for their work and at least reimburse their expenses. What to do? How do we function otherwise?”.

c. ICDS Programme

Food insecurity and hence loss in nutrition leading to illnesses and also deaths is one of the major negative fall-outs of conflict. We have already seen a number of cases where children and vulnerable populations like women and adolescent girls

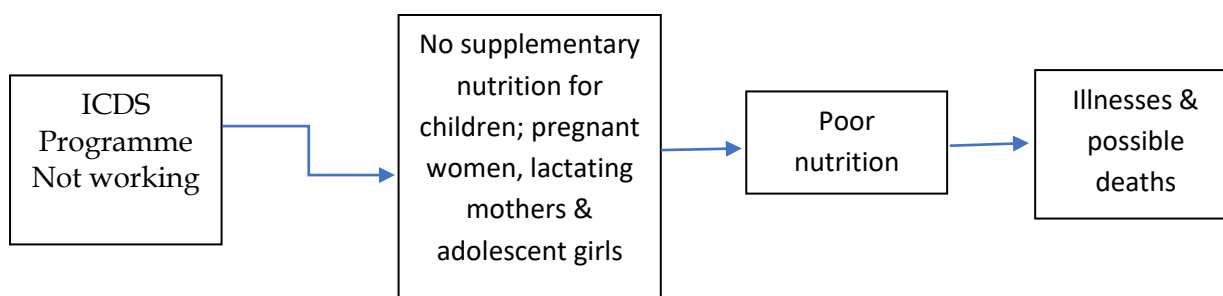
In all the 7 villages of study, irrespective of communities, the government's flagship ICDS (Integrated Child Development Scheme) which provides for early childhood health, supplementary nutrition and education (also popularly known as Anganwadi centres) do not function in the area. Under this scheme, 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 an *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 4.4.2 : Effect of Non-Functional ICDS in Study Area



Government Schools

In the earlier chapter in 4.2, we saw how availability of schools play a vital role in determining if students, especially the girl students drop out of school after a conflict and become vulnerable to abuse and exploitation. From the matrix we can see that 3 of the 4 villages we studied did not have even primary schools in the village. When primary education itself is not present, one can imagine how much more difficult the access to secondary and high schools would be for the children from these conflict affected villages.

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 regular mid-day meals. A free and wholesome mid-day meal on a regular basis assumes disproportionate importance for children from conflict affected households since the family's food security has been highly compromised following conflict.

“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*

From the many cases in Chapter 4.3 that we have seen of children's illnesses and deaths following conflict, inadequate nutrition plays a big part in making children vulnerable. One wonders if it is just a coincidence that conflict affected villages like North Simalguri Bodo and Koraibari Adivasi villages where there are ICDS centres or mid-day meals for children is also where 13 children died of illnesses after the conflict of December 2014.

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.



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*

“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 the stream. When the stream water dried up in the dry season of Winter, we would reach till



A high quality Mark II handpump given by a humanitarian NGO for conflict affected families in Northern Koraibari in 2015; now it lies disused after it got spoilt and the villagers do not know how to repair it.

Sanitation

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

one main reason is that they are relatively well-off and can afford it. The headman of Koraibari says he does not remember the PHED department people ever visiting their village.

Summary of the Chapter

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 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 is 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.

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 taking making sure food and nutritional security, health services, schooling and children's health is protected following a conflict.

Chapter 5 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 in the fact 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 health centres and people of every community used the services at the health centres. Though there were severe challenges like shortage of medicines and lack of vehicles, the health system was a functional one reaching out with community programmes right 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 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. 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.

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 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. 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 pro-active 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 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 in 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 that 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 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 have 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, 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.

Traditional healers and pharmacists in the days to come will continue to be the 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 they 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 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 of people.

With conflict come displacement and various losses which affect the daily lives of people. Treatment seeking behaviour of the people is also determined by one of the economic factors for the people. 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 is very inadequate and arbitrary.

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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 taking making sure 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 availability 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 available food for work and cash for work programmes 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.

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