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Tribal populations and India's response to Covid-19: Has it been inclusive enough? | Deepika Joshi

Introduction

The death of a 15-year old indigenous child from the Amazon region due to the Covid-19 infection has brought attention to the vulnerability of indigenous communities, around the globe, to the ongoing pandemic, with community leaders and researchers expressing concern. In India, the Covid-19 crisis has not yet hit the tribal population, in their traditional habitats/spaces. However, uncertain and unpredictable features of such novel viruses, and newer evidence emerging everyday about various aspects of "behaviour" of this virus, warrants discussions, on measures to contain its spread to the tribal population of India.

There has been some conversations on the same. Others have reported the effect of lockdown on migrant Scheduled Tribe (ST) population. In my research work with Public Health Resource Network (PHRN) and subsequent experience of working with the Baiga Particularly Vulnerable Tribal Group (PVTG) in Chhattisgarh, we found how the 'Particularly Vulnerable' status of the community works to their disadvantage. For instance, the government of Chhattisgarh had issued an inhumane executive order (now quashed) on restriction on permanent contraception for Baiga communities to 'contain' their 'dwindling' population. The 'conservation' of the community members became paramount to rights over their bodies and impacted tribal women's health.

Previous evidence has shown marked inequities in an influenza pandemic. During the current pandemic too, reports show that African-Americans are being disproportionately impacted by infections and death as also the poor and working class populations, even in the higher income countries. The sufferings of migrant workers, as a result of poor and unthoughtful planning for the lockdown, are already learnings for us here in India. These sufferings could have been averted if government's response to the pandemic was informed by values, principles, and frameworks of human rights and ethics of responding to pandemics. Against this backdrop of a Covid-19 pandemic within tribal population in India, I discuss some geographical considerations, health inequities and systemic issues, to illustrate potential for exacerbating the extant inequities and factoring in of the same in pandemic planning and response.

Environmental Injustice, Poor healthcare services, and Pre-existing health conditions

A recent study by State Health Resource Centre (SHRC) found that the population living near the coal powered thermal plants in Korba district (41 % ST population) have greater exposure to particulate matter resulting in higher respiratory illnesses, making them a vulnerable group to Covid-19. Studies by Peoples First Collective India in Tamnar block of Raigarh by (49 % ST population) and by Cropper et al across India found similar impact of fine particulate linked to higher respiratory complaints and cardio-pulmonary deaths respectively. It is noteworthy that four states with high proportion of tribal population (Jharkhand, Odisha, Chhattisgarh and Madhya Pradesh) alone account for 78 % of coal reserves in the country.

Apart from poorer health indicators of tribal communities, the inequity in healthcare delivery and human resources in tribal areas is marked by number gap (inadequate number of people and facilities), functions gap, cultural gap, knowledge and attitude gap, and performance gap. This is despite heavy reliance of ST communities on the public health systems. The inequity in access to care has been astutely noted in Hart's Inverse Care Law where "The availability of good medical care tends to vary inversely with the need for

it in the population served". The vast network of private hospitals being urban centric is not of much help to tribal population.

Further, a study in Chhattisgarh shows how enrolment in state funded health insurance schemes is not accompanied by equitable availability of hospital services i.e. "The geographical areas that were suffering from multiple vulnerabilities had poorer availability of hospital service". The heavily tribal-dominated districts were highest in the vulnerability index developed by authors. This indicates the difficulty of providing health protection to tribals through such insurance models and the need to strengthen public provisioning of health services. Any disruption in routine access to healthcare services arising of the lockdown or resource diversion to Covid-19 will much adversely impact the indigenous communities, as a result of the existing health and economic inequities. Moreover, though considered to be urban lifestyle diseases, heart conditions, hypertension and cancer are found in equal or higher numbers in the tribal population (apart from communicable diseases). The aforementioned gaps thus disproportionately affects the tribal populace and heightens their risk to Covid-19.

Lockdown and Relief: **Impact on livelihoods of tribal populations**

Non-Timber Forest Produce (NTFP) collection forms a substantial part of the livelihood and annual income of tribal households. Positively, a government order dated 6th April 2020 advises states to procure NTFP at Minimum Support Prices (MSP) post Covid outbreak "providing them safety and ensuring livelihoods" through Pradhan Mantri Van Dhan Yojana (PMVDY) and another order on 1st May hiked the MSP for NTFPs. However, NTFP procurement by government is an aspect historically neglected and inadequately ensured except a few NTFPs like tendu(East Indian Ebony) leaves, which are used for wrapping tobacco to make beedis (locally made cigarettes). The PMVDY is too recent to have put MSP procurement or cash infusion mechanisms in place and leaves much for implementation. In the open market too, reports on non-functioning of weekly markets, restriction on vehicle movements (for traders) and poor prices for products are already arriving. The centre and states urgently need to speed up the efforts on procurement and ensuring speedy payments, to ensure the food and livelihood insecurity of tribal households during lockdown.

Much has been written on the inadequate relief and relief structures for the poor and recommendations made for food security schemes, MGNREGA, and cash transfers. The difficult geography, terrain and lack of infrastructure, such as roads, transportation facilities and banks, adds to vulnerabilities of tribal communities in accessing relief. In a pandemic scenario where communication is crucial, lack of mobile connectivity leads to poor and delayed access to solutions. Indigenous households are less likely to be supported by solutions such as mobile-based helplines, in situations of hunger, medicines crisis etc during lockdown or pandemic. A PHRN study (2017) had found that only 33% households in the Baiga community in Chhattisgarh and 14 % households in Sabar community in Jharkhand had mobiles compared to national average of 84%. Smartphone based contact tracing tools like Aarogya Setu may fail to provide the desired assistance in developing a public health response to this pandemic.

Activists have also been expressing fear about the "lack of clarity on the protocols to be followed by environmental monitoring agencies" during lockdown period, for mining and steel projects. Many of these are located in states with tribal population, a scenario ascribed the clichéd epithet of 'resource curse', the policy tweaking risks the health of tribal communities. In that, it is noteworthy that the Govt of India included mining works as essential services via an order (9015/H&FW) issued by the Health and Family Welfare Department on March 24, 2020. This order jointly with the invocation of the Epidemic Disease Act 1987 (EPA 1897), issuance of additional regulations under the EPA 1897 by states like Odisha, and Essential Services Maintenance Act (ESMA), 1981 allows operations of mining industry to continue during lockdown. These legislatives frameworks collectively prohibit workers strikes and protest

in the mining industry. Manju Menon and Kanchi Kohli reported the plight of mining workers which include members of tribal populations via coercive measures by contractors in these spaces, resulting into unsafe and unprotected work spaces and conditions for workers with immense health risks during the covid pandemic.

Closing remarks: Priorities and considerations for inclusive Covid-19 planning

Tribal communities may bear a disproportionate burden of diseases and risk to covid-19. Lack of accessibility to both accurate information and timely healthcare services, myriad demographic and social conditions such as poor safety net and precarious livelihoods impose poor health and add to their vulnerabilities in a pandemic. This scenario is not by chance but arises from avoidable scenarios of historical neglect, exclusion from planning process, environmental injustices and inequitable development, to name some. All the above factors need to be considered in developing plans for pandemics while also involving indigenous communities, as was done in New Zealand with the Maori population. Health equity should be the central tenet during Covid-19 pandemic response to protect the vulnerable groups, particularly the tribal population. More importantly, once the crisis is over, we have much to learn from their worldview in terms of sustainable and ecological way of living, lack of which has been ascribed to the rise in the Covid-19, SARS-CoV-2, Ebola variety of zoonotic diseases.

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