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Understanding the Context, Communities and Challenges in the Bodo Territorial Region

A Qualitative Needs Assessment Report

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STUDY TEAM

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The photographs included in this report are of various participant engagement activities conducted during the needs assessment exercises.

Suggested Citation:
KHPT (2023). Understanding the Context, Communities and Challenges in the Bodo Territorial Region: A Qualitative Needs Assessment Report

Acknowledgement

We would like to thank the BTC officials and the BTC representatives, Mr. Jovial Mushahary, and Mr. Victor Narzary, BTC fellows, Mr. Sumit Kumar Das, Ms. Subhrali Kachari, Mr. Har Gobinda Boro, Mr. Dipak Ghimire, Mr. Khanjan Uzir, and Mr. Raj Deka for their active involvement and continued support, which helped us to successfully complete the needs assessment process on the ground.

We would like to thank our KHPT's Breaking the Barriers (BTB) team of Assam for earnestly supporting, and leading the needs assessment exercise. Above all our heartfelt gratitude to the community representatives, frontline workers, and other stakeholders from the state for their active participation in the workshop.

We would also like to thank the leadership at KHPT, Mr. Mohan H. L, Dr. Satyanarayana Ramanaik, Dr. Karthikeyan Kumaraswamy, Dr. Rehana Begum and Dr. Joseph Francis Munjattu for supporting the process.

PREFACE

The Bodoland, officially the Bodoland Territorial Region, which is an autonomous region in Assam, Northeast India has been committed to serving the people of its region. Over the years, while the communities in the BTR have braved the repercussions of years of conflict and have emerged resilient keeping intact its rich cultural and traditional systems, they are also actively seeking opportunities to enhance their quality of life. Therefore, there is a need for concerted efforts to strengthen the health and development efforts in the region. In recent years, development has gained new momentum under the able leadership of the BTR overcoming various challenges and bottlenecks whether it is health service delivery or infrastructure development.

Ensuring equitable health and development of the communities in our region is a prime responsibility of BTR and this vision propels us to keep finding solutions and developing programs that will have a meaningful impact on the region. One of the key focus areas is addressing the barriers to the health and well-being of communities. BTR has been making efforts to improve the quality and the approach of its health initiatives to make it responsive to people's real needs. We also realize that any program's success and sustainability lie in people's acceptance and ownership of it as well as its ability to address the needs of people in a manner that is context and culture-specific. In other words, programs need to be evolved through scientific and evidence-based methods where strategies are thought through systematically and collaboratively with the tribal communities in our region.

Guided by the objective and a strong political will of the BTR to develop a comprehensive community-based health intervention, BTR partnered with KHPT to undertake an in-depth needs assessment exercise. KHPT is a non-profit organization that has been working for the past two decades in the area of public health with a focus on vulnerable populations across India with strong evidence-based, community centred and government-integrated approaches. The findings from the needs assessment have been used to inform key strategic directions for Public health interventions in our region.

This needs assessment report details the methodology and the key findings from the assessment which helps us gain deeper insights into the individual, family level and community level aspirations, concerns, barriers and needs particularly among specific groups like men, women, adolescent boys and girls. The assessment also synthesises the views and experiences of significant members of various structures and committees in the BTR that have engaged with the issues of the region over long periods of time. This triangulation of community responses with decision-maker perspectives has yielded valuable cognizance of what communities need and what would work well in terms of strategy.

We are hopeful that this report marks a unique start in BTR's journey to formulate a comprehensive health model that is holistic and impactful through meaningful collaborations with organisations like KHPT. We hope that this will pave the way for communities to be empowered to access their right to health and also build BTR's accountability to the well-being of the people in the Bodoland territory.

Honourable Chief
BTC

Honourable Secretary
BTC

Mohan H.L
CEO, KHPT

01.

BACKGROUND

KHPT has been implementing a project called 'Breaking the Barriers' funded by USAID that aims to address Tuberculosis among vulnerable population groups. The project is being implemented for the last 16 months in the state of Assam with a primary focus on urban vulnerable populations from Kamrup (Metro) area, tribal populations from the Baksa region, and tea garden workers from the Dibrugarh district.

The annual participatory program review (APPR) of the Assam interventions, conducted by the internal KHPT team offered rich and meaningful insights into the vulnerable communities in the state of Assam.

The team gained an understanding of the barriers faced by the communities; barriers that negatively affect their overall health and wellbeing outcomes. It gave the team an insight into the socio-cultural structures and systems intertwined with the way the communities live, collectivize, associate, and make decisions. The teams' reflections on the visit in the backdrop of the organisation's priorities, focus, and core intention of engaging and impacting the most vulnerable populations in Assam triggered thought processes around developing, implementing, and scaling a comprehensive community-based health and empowerment model focusing on key vulnerable populations of Assam. Subsequent discussions with the Bodoland Territorial Council (BTC) on the needs and the challenges faced by communities in the Bodoland region led to the conceptualization of a detailed needs assessment exercise.

A participatory qualitative needs assessment study was conducted in Bodoland in collaboration between the Bodoland Territorial Council (BTC) and KHPT. This study aimed at gaining a foundational understanding of the context and key challenges faced by the local tribal community in Bodoland. The exercise involved processes of focus group discussions, participatory workshops, one-to-one interaction, and public engagement with various stakeholders.

BTC and KHPT have envisioned the creation of models of comprehensive health and well-being among vulnerable communities in Bodoland, Assam, and design local solutions that are informed of communities' needs and priorities. The findings from the needs assessment will inform the strategy and operational model of implementation, which will be co-evolved by the BTC and KHPT teams.

02.

METHODOLOGY

The study methodology included:

- A detailed secondary research which included literature review and secondary data analysis to identify key themes for investigation
- A participatory qualitative study with different stakeholders at the community and state level to gain insights the broader socio-cultural context of the local tribal communities in Bodoland.

Objectives of the qualitative needs assessment study

- Understand the socio-cultural ecosystem of the local tribal community
- Map the major challenges faced by men, women, and adolescent girls and boys around health and well-being, education, and livelihood
- Gain an insight into the existing support system across different levels such as individual, community, and at the system level
- Understand the role of community structures and the frontline workforce
- Engage with different stakeholders to decipher the needs and challenges of the local tribal community

Research Methods

The research methods used for this study aimed at generating deeper insights from a wide range of stakeholders in the ecosystem. The methods included, **participatory workshops, focus group discussions, key informant interviews, and a public engagement programme.** These methods were used with different sets of respondents over a period of five (5) days to understand the local tribal community, to reflect, and deliberate on the issues related to health, infrastructure, livelihood, education, and gender. The following table outlines the participants chosen for the study and the research methods used for each.

Participant Cohort	Method	Participant Numbers
Members of Tribal Community	**Participatory Workshops**	
Men		16
Women		19
Adolescent girls and boys		16
Frontline workers & local bodies	**Focus Group Discussions**	
Frontline workers (ASHAs, Jeevika Sakhis, CHOs, AWWs)		8
Representatives of Village Council Development Committee (VCDC) and Village Defense Party (VDP)		9
Public Engagement Stakeholders	**Public Engagement Program**	
Officials from various departments		21
Representatives from NGOs		
Academicians		
Activists/ community representatives		

Table 1: Research methods and participants

03.

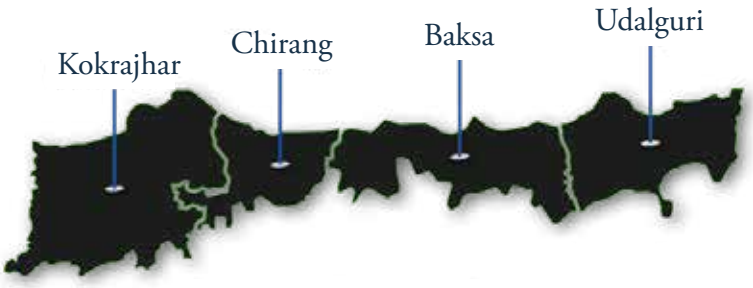
ASSAM CONTEXT

About Bodoland Territorial Region

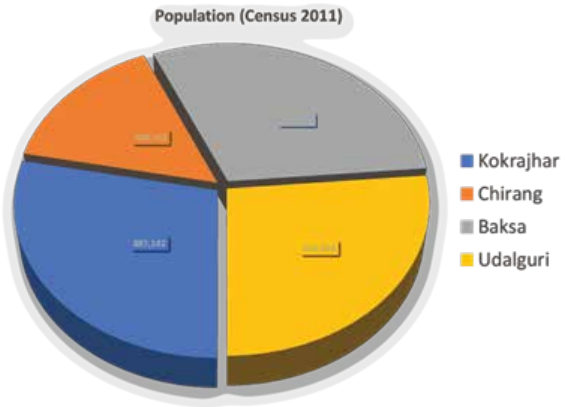
Bodoland, officially the Bodoland Territorial Region, is an autonomous region in Assam, Northeast India. It is made up of four districts on the north bank of the Brahmaputra river below the foothills of Bhutan and Arunachal Pradesh. It is administered by an elected body known as the Bodoland Territorial Council which came into existence under the terms of a peace agreement signed in February 2003 and its autonomy was further extended by an agreement signed in January 2020. The region covers an area of over nine thousand square kilometers and is predominantly inhabited by the Bodo people and other indigenous communities of Assam[1]

Facts about Bodoland

- **Established:** 9 February, 2003
- **Govt. Type:** Autonomus Administrative Region
- **Body:** Bodoland Territorial Council
- **Total Area:** 8,970 Km2
- **Official Languages:** Bodo, English, Assamese
- **Number of districts:** Four, which includes Kojrajhar, Chirang, Baksa and, Udalguri



Bodoland Territorial Region



The total population of BTR is 31,55,359* as per 2011 census.

The Standard of Living Index Rank NE states (Census 2011):
Assam: 8th
Baksa: 24th
Udalguri: 20th
Kokrajhar: 14th
Chirang: 13th

*Bodoland Territorial Council | Department of Tribal Affairs (Plain) | Government Of Assam, India

[1] https://bodoland.gov.in/district.php.

04.

SECONDARY LITERATURE AND DATA REVIEW

A secondary data and literature review was undertaken on individual/familial-social/structural barriers, cultural practices, and workshops with communities and stakeholders to inform the qualitative research. This section details out the key findings from the secondary literature review.

Literature Review

A detailed literature review highlighted the following information about the region, its demography, and socio-cultural contexts:

- Literacy rate in Bodoland (66.25%) is less than the state average (72.20%).
- Sex of the household in Bodoland is primarily male-dominated.
- Sex Ratio at Birth at Bodoland districts (964) is higher than the state average (962)
- ST Population is higher in Bodoland (33.50%) compared to state average (12.40%).
- 85.8% of tribal households in Bodoland identify themselves as Hindu.

Household Characteristics

- Tribal Households in Bodoland have 97.7% improved water access which is higher compared to state average.
- Only 37.6% tribal households in Bodoland have access to clean fuel for cooking.

Access to Public Service

- Tribal Households in Bodoland dominantly rely on public health care facilities. The utilization of private healthcare facilities is low.

The following challenges to the health and well-being of the communities in the Bodoland region is reflected in literature

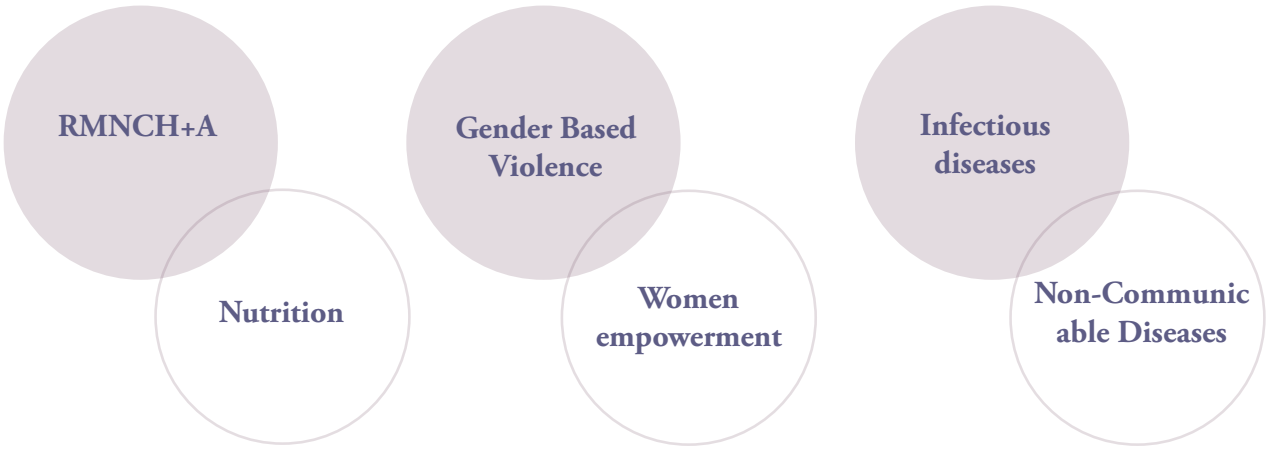
- Level of education is lower and particularly female education is lagging behind.
- Lack of awareness around health and available healthcare facilities and schemes among communities.
- Poverty is a serious issue, with limited economic opportunities for the men and women of the region.
- Gender discrimination is evident where women remain largely unable to exercise/enjoy their basic rights to education, healthcare, economic activities and political participation.

- In terms of economic activity, there is excessive dependence on agriculture, disguised unemployment and poor agricultural productivity and there is a stark absence of significant manufacturing activities.
- Limited connectivity and poor infrastructure aggravate some of the issues of the region owning to difficult terrains and scattered tribal community settlements. This clearly affects the accessibility of people to health facilities and support services.
- In terms of service provisions and health infrastructure, high out-of-pocket expenditure for health services places a heightened financial burden on people, a shortage of human resources, physical infrastructure, and insufficient equipment, and stresses the health systems hampering their ability to address the health needs of the community.

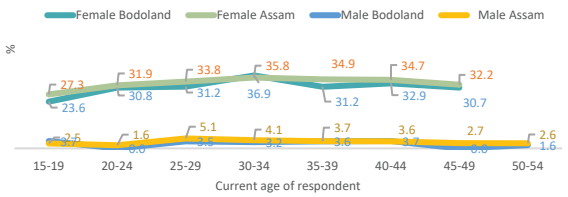
Overall, the literature review consolidates barriers both at the demand and supply sides with lack of awareness, poverty and lack of opportunity for development affecting the population's participation in shaping demand for health, and infrastructural challenges leading to poor availability and quality of health services.

Secondary Data Analysis

The study team reviewed the secondary data closely on topics below



CHILD MARRIAGE

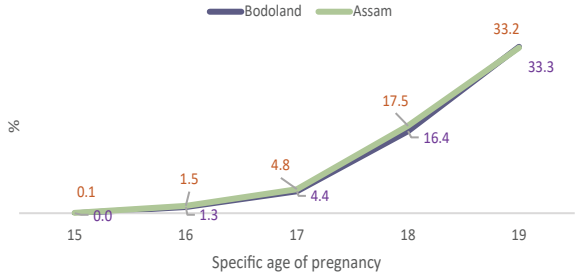


Source: International Institute for Population Sciences (IIPS) and ICF. 2021. National Family Health Survey (NFHS-5), 2019-21: India. Mumbai: IIPS

- Almost one-third of women aged 15-49 in Assam got married before attaining the age of 18 years which remained the same as in previous rounds of NFHS, the situation is more or less similar in Bodoland as well.
- Child marriage is more prevalent in SC and OBC/Others in Bodoland compared to the state average.
- SC in Kokrajhar, ST in Udalgiri, and OBC/Others in Baksa are the most vulnerable communities in terms of child marriage.
- Overall, the prevalence of child marriage is higher amongst females than males by 30 percentage points on average.

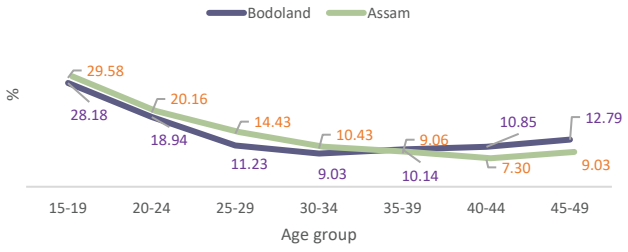
- Among young women aged 15-19 in Assam, almost 12 percent have already begun childbearing, that is, they have already had a live birth or are pregnant with their first child. Bodoland is slightly below than state average.
- Children born to teenage mothers are more likely to die during infancy than those born to mothers aged 20-29.
- The caste-wise segregation data shows that women in SC and ST communities are more vulnerable to teenage pregnancy compared to the state aggregate.
- The specific age-wise segregation shows that the proportion of women who have started childbearing rises sharply from 4-5 percent at age 17 years to 16-17 percent among women aged 18 years and 33 percent among women aged 19 years.

TEENAGE PREGNANCY



Source: International Institute for Population Sciences (IIPS) and ICF. 2021. National Family Health Survey (NFHS-5), 2019-21: India. Mumbai: IIPS

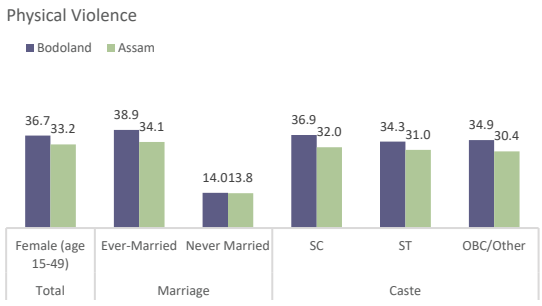
NUTRITION STATUS AMONG WOMEN



Source: International Institute for Population Sciences (IIPS) and ICF. 2021. National Family Health Survey (NFHS-5), 2019-21: India. Mumbai: IIPS

- Overall, the prevalence of underweight amongst women is lower in Bodoland by 3 percentage points.
- Caste-wise segregation finds that prevalence of underweight amongst ST women in Bodoland is equivalent to the state aggregate and more among OBCs/others.
- Marriage status wise segregation finds never married women in Bodoland shows higher prevalence of under-weight.
- Undernutrition is particularly common in the younger age groups (especially age 15-19).

EXPERIENCE OF VIOLENCE



Source: International Institute for Population Sciences (IIPS) and ICF. 2021. National Family Health Survey (NFHS-5), 2019-21: India. Mumbai: IIPS

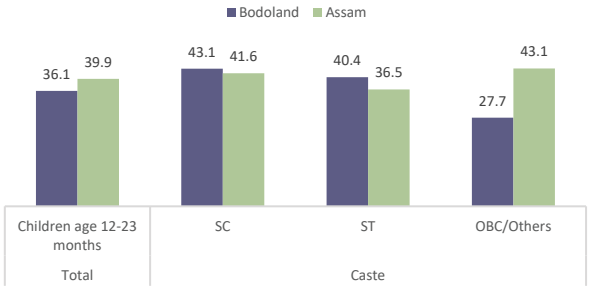
- Data shows in Assam, 33% of women age 18-49 have ever experienced physical violence, proportion is high in Bodoland (36%).
- The reporting of physical violence is more among ever-married women.
- One-third of women in almost all caste groups reported to have experienced physical violence

CHILD HEALTH

Malnutrition- Underweight

Source: International Institute for Population Sciences (IIPS) and ICF. 2021. National Family Health Survey (NFHS-5), 2019-21: India. Mumbai: IIPS

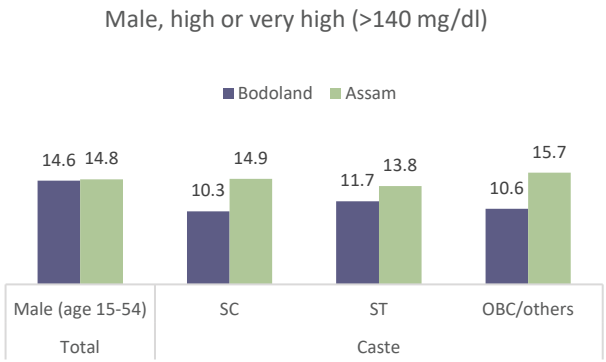
Full Immunisation

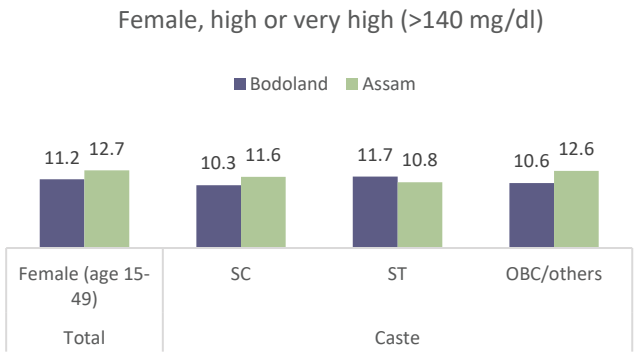


Source: International Institute for Population Sciences (IIPS) and ICF. 2021. National Family Health Survey (NFHS-5), 2019-21: India. Mumbai: IIPS

- Children in the age group of 12-23 months were reported to be fully vaccinated based on information from either vaccination card or mother's recall
- Prevalence of diarrhea is five percent in Bodoland and is higher in the "Baksa and Udaigiri" districts at six percent each.
- Reported diarrhea is higher among male children of all districts of Bodoland except Kokrajhar. It is reported to be low among scheduled tribe across all three districts of Bodoland
- Three percent of children under five years had symptoms of Acute Respiratory Infections (ARI). However, only about half of the children sought treatment for diarrohea or ARI.

NON-COMMUNICABLE DISEASES





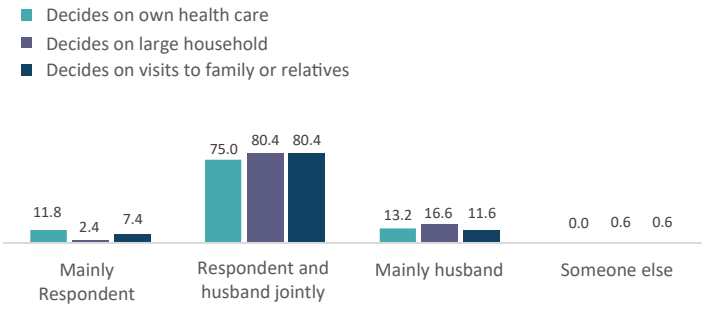
Source: International Institute for Population Sciences (IIPS) and ICF. 2021. National Family Health Survey (NFHS-5), 2019-21: India. Mumbai: IIPS

- In Bodoland, 11 percent of women aged 15-49 have high or very high blood glucose levels.
- Among the tribal women it is slightly high.
- Male in the age group of 15-54, have higher prevalence of diabetes compared to female.

WOMEN EMPOWERMENT

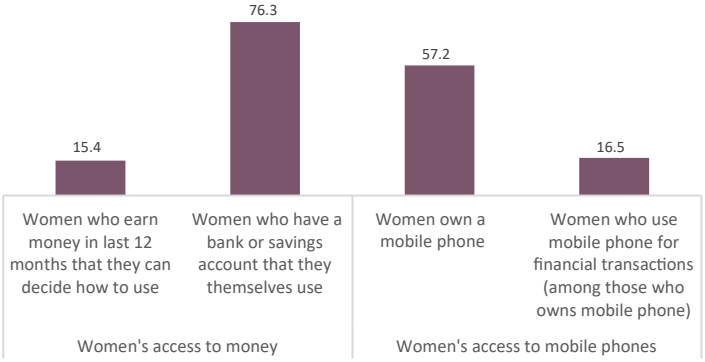
Decision Making

Distribution of currently married women and men aged 15-49 'by who usually make decisions about specific issues, Bodoland



Source: International Institute for Population Sciences (IIPS) and ICF. 2021. National Family Health Survey (NFHS-5), 2019-21: India. Mumbai: IIPS

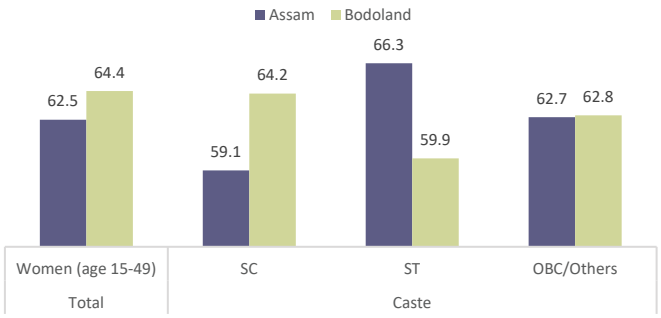
Accessibility



Source: International Institute for Population Sciences (IIPS) and ICF. 2021. National Family Health Survey (NFHS-5), 2019-21: India. Mumbai: IIPS

Knowledge of Financial Services

Women who know of a microcredit programme



Source: International Institute for Population Sciences (IIPS) and ICF. 2021. National Family Health Survey (NFHS-5), 2019-21: India. Mumbai: IIPS

- Decisions regarding health, household, visits to family or relatives are mostly made jointly by the husband and wife
- The percentage of women who are able to take these decisions on their own are significantly low, especially when it comes to decisions on larger household expenses(2.6%).
- When it comes to mobility, the percentage of women allowed to go to places such as market, health facility, outside the village are lower in total in Bodoland (31.23%) compared to percentage for Assam (34.35%).
- The mobility is higher for ST women in Bodoland compared to that of Assam.
- The percentage of women who had earned money in the past 12 months and has the freedom to decide how to use it is significantly low at 15.4%.
- 76.3% of women have bank account for themselves.
- 57.2% of women have access to mobile phones and 16.5% women use mobile phones for financial transactions.
- The awareness about microfinance programs ar low among ST women in Bodloand compared to the percentage for Assam (only 59.9%) compared to 66.3% for Assam.

Ethnographic Observation

The various processes of ethnographic observation such as transect walks in and around the villages, trip to the local market, and house visits were conducted to gain contextual understanding. This helped us to ground the learning from the interactions with the community.

Some of the key ethnographic observations are

- The Bodo community has its own religion and language. They have their own belief systems that are rooted in nature and forests. They have valuable traditional knowledge about plants and forests.
- The settlements/villages are somewhat scattered and far from the main road. The roads are gravelly. Villages are situated as clusters. The locals have well-defined landmarks that act as boundaries and demarcate one village from the other. While the main road is asphalted, the smaller roads inside the villages are not.
- Public transport is limited. There are battery-operated autos (electric rickshaws/autos) that ply through the villages and are the major mode of transport. The minimum fare from one point to other is Rs. 10.
- Cycle is a universal mode of transport for men, women, young boys, and girls. For men and older boys in their 20s, motorbikes are a preferred mode of transport.
- The main roads are not well-lit. There are not many street lights, and the power supply is erratic in the villages.
- Most of the houses have spaces around them, where people have small kitchen gardens. Some rear ducks, chickens, and goats. People are also seen to grow betel leaves, areca nuts, and coconut trees around their houses. Most houses have slanting tin roofs.
- Most houses have a sacred plant in the courtyard of the house that is worshipped by the family. This is kept in the northeastern corner of the house. This is the 'Sejou' plant. In the preparation of 'Bathou Gudi', meaning the sacred space or the altar of God, this plant is surrounded by a round fence of five bamboo sticks.The Bodo community believes that sacred spirits reside under the plant and every evening an oil lamp is lit in front of it as a ritual.
- Quaint little temples are found in the middle of the villages. Often there is a ground attached to the worship space. Children are seen playing in the area. The temple also acts as a space where the community congregates for any meetings/celebrations.

Snippets of everyday life

- Men and women are seen sitting by the side of the road at the end of the day just before nightfall. Sitting by the road and chatting seems to be a common mode of entertainment for them.
- Mobile phone usage is common both among men and women.
- Pharmaceutical shops are seen predominantly on the main roads.
- Each village has a small daily market, that has grocery, and general shops.
- Health and wellness centres were present in two of the villages visited, the Community Health Officer (CHO) does not live close to the centre, and is present at the Health and Welness Centre (HWC) till 3 pm.
- Durga pooja, kali pooja, and laxmi pooja are major events of the year. There are fairs organized locally during these festive times. Men, and women of all ages and groups, dress up and are seen attending the fair in the late evening.
- There are long stretches of paddy fields.
- In two of the villages that we visited, we saw common water tanks where women gather to collect water and carry it back to their homes.
- Schools are located on the main roads and are accessible to children from different villages. Children aged 10 years and above are seen cycling to their schools and younger children are seen being brought to school on a cycle by their parents, generally mothers.

MAJOR HEALTH CONCERNS AT A GLANCE

- Teenage pregnancy is quite common among the Bodo community. Other concerns among the children include anaemia, spacing, and malnutrition.
- In terms of Non-Communicable Diseases (NCDs), diabetes is more common among males aged 15-54 years. With Mother and Newborn Child Health (MNCH) the issues are teenage pregnancy, among children.
- The population most affected by the health issues are men over 35.
- The adolescent age group is also affected due to alcoholism, and substance abuse.
- Mental health is an issue for the local geographies most affected by conflict.
- In terms of gender, the fluidity in the normative expectations provides scope for women to engage in income generation activities, flexibility for mobility, and partake in the decisions of education of children. However, there is a predominance of male decision-making in terms of family income and ownership of resources.
- Equity in terms of opportunities is seen as leaning towards financial affluence, whether it is for private school education, seeking health in the private sector, or scope for future educational opportunities which could offer options for a better life.
- Minimal land holding is attributed to the limited opportunities for aspirations and better life.

Note: These are the health issues identified from the secondary data and the policy makers who participated in the public engagement also were in consensus with the same. During the participatory workshop the participants from the community also pointed out concerns of certain other health issues.

05.

FINDINGS OF THE QUALITATIVE RESEARCH

GROUP 1: MEN

A total of 16 men representing the Bodo community participated in a one-day workshop that aimed to understand their lives, their perspectives, and attitudes, and engage them in deliberations/ conversations using participatory tools. The section below highlights some of the key findings on important data aspects such as

1. **Understanding gender roles**
2. **Perspective regarding women**
3. **Men's responsibilities in different domains**
4. **Concerns inside and outside the house**
5. **Barriers and enablers to health and wellbeing**
6. **Aspirations for self and family**

UNDERSTANDING GENDER ROLES

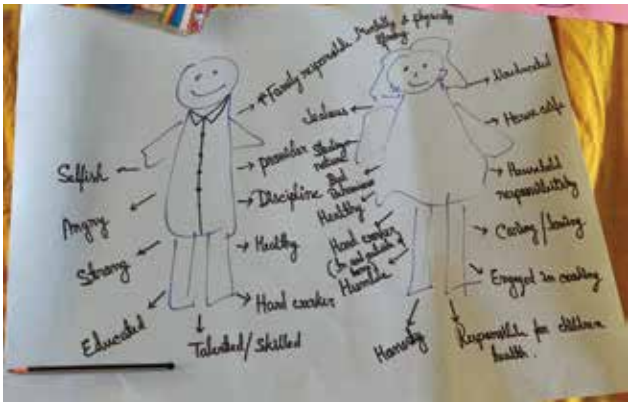
Discussions on gender roles were elicited through an activity, wherein the participants were shown pictures of a culturally appropriate man and a woman and were asked to associate characteristics for each.

- Men are aware of alcoholism leading to conflicts within and outside the family. They are also cognizant of the fact that some of the familial conflicts actually are gender-based violence, owing to alcoholism.
- There is a strong notion of masculinity/manhood ingrained in the gender norms for men. The character of a man is judged by how well he is able to provide for his family. The role of a man as perceived by the group was to contribute to household expenses and be able to protect the family members from either physical harm or disrepute.
- There are a number of gender expectations; a man has to be strong, hardworking, earning, and responsible. These are internalized to the extent that if a man is not being able to meet the expectations of the mentioned roles, it causes frustration and leads to domestic conflicts.
- Men associated themselves with the emotion of anger. When explored further, it was understood that external factors such as the inability to earn a decent livelihood, provide a dignified life to the family, inability to pursue personal ambitions due to limited resources, etc. were some causes of this anger.
- Men perceived themselves as having more involvement in the village or community activities. The concept of women playing a leadership role in society was never brought up by the group.

Participants at the workshop with men

PERSPECTIVES REGARDING WOMEN

- Men associated women with being caretakers and hard workers; their primary role being taking care of the children, and managing the household.
- Men associated women with negative emotions such as jealousy and stealing. According to the group, stealing means manipulating household expenses and setting aside some money for expenses as she chooses.
- Gender expectations are strong, with men saying that women need to be beautiful inside out and should be loving, warm, caring, and humble. The group also said if women carry out their responsibilities in terms of taking care of the household and bringing up children, a family would function smoothly.
- Women's contribution to the family income in terms of work related to, poultry, animal husbandry, farming, kitchen gardening, and traditional crafts, is not seen as formal work by the men.
- Men were not averse to the idea of women taking up salaried jobs; this however does not relieve her from any of the domestic responsibilities. A working woman would not result in changing the gender roles in the family.
- Men welcome women taking the lead when it comes to responsibilities of the household and children (education, healthcare, etc.). The domestic tasks a woman takes up are not seen as a job that requires compensation or consideration, it is seen as a woman performing her duty.
- Men perceived women to be healthier, and more resilient in terms of health issues. They say this basis the amount of physical work a woman does, Also, women are expected to be in good health to take care of the family

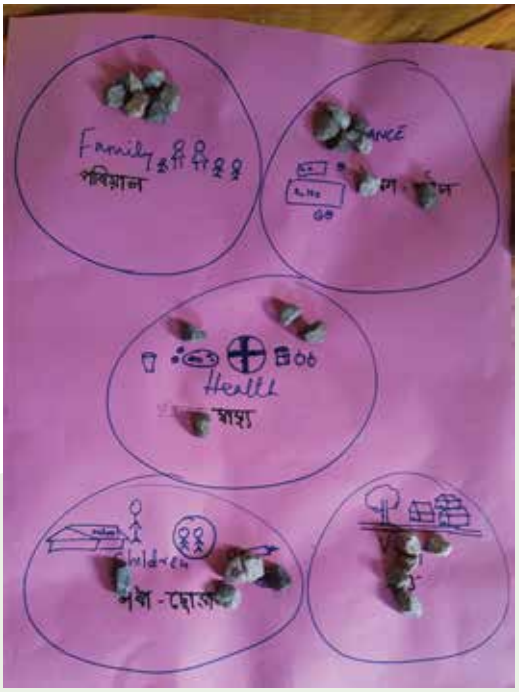


What participants associated with man and woman

MEN'S RESPONSIBILITIES IN DIFFERENT DOMAINS

Finance

- Men prioritized their responsibility primarily as a breadwinner. For most men, money was of prime importance. It can ensure everything from good education to proper health and a good life for the family.
- The structural challenges that exist in the region compel the men to think more about income generation, managing their limited finances, and their aspirations for their children.
- Men do not see their children engaging in traditional livelihoods as they have faced declining productivity vs the amount of labour that agriculture demands. They also have not seen much infrastructural development when it comes to agriculture. Men instead aspire for industries in their region that can employ the next generations.



Responsibility mapping by men

Health

- Men agreed that they have a role to play when it comes to health seeking.
- Reduced health seeking behaviour due to satisfactory levels of functional health which allows them to carry out daily routines.
- A health facility is the desired solution when it comes to any health problem in the family. However, people see lack of connectivity, ill-equipped health facilities at the sub- centre level, and limited awareness as factors that prevent them from practicing appropriate health-seeking actions.
- Good health is seen as directly proportional to the income of the household.
- There is an understanding of nutrition in the community however any steps to increase/balance the nutrition in the family could not be seen.

Village

- Though men think that they should be involved in activities for the common good of their village/community, in reality very few played a proactive role in taking up common concerns.
- Limited information among the men about various social assistance schemes and benefits seems to act as a barrier for men to be involved in community activities.
- Lack of unity in the village to pursue common benefits or initiatives was seen as a factor by the group that is deterring development.

Family

Men see their role as leading the family. They see their primary role in providing for the family, making decisions, and managing finances.

Children

- The future of their children is important for men. They are worried that there are no employment opportunities for their children.
- The men are cognizant that with both parents engaged in income generation activities, the family seldom gets time for interaction which prevents children from sharing their concerns with their parents.
- Men are very enthusiastic about educating their children, both boys and girls. Their involvement in their children's education is limited to finances. The group cited busy schedules and limited education are primary reasons for their inability to be involved in their children's education.

> "Sometimes reaching the Primary Health Centre (PHC) is a challenge for us. Even if we go, the PHC/Community Health Centre (CHC) is not well equipped to handle any serious health concern. The services are inadequate, no doctors, no saline even. It is just a concrete structure."

> "If we work on ourselves first the rest of the concerns around health, community, finance, everything will improve."

CONCERNS INSIDE AND OUTSIDE THE HOUSE

In order to understand the problems faced by the community, the participants were asked to list out problems inside and outside the picture of a house. The following table captures the issues as identified by the respondents in terms of barriers inside and outside their houses.

Activity of mapping concerns inside and outside home

Inside	Outside
Uncertainty about having enough food for the family in the house	Bad roads (*Prioritized)
Furniture	Water problem
Cooking gas	Not all houses have toilet facilities
Financial constraints (*Prioritized)	Livelihood
Erratic supply of electricity	Transportation
Domestic Violence	No community spaces (“No library”)
Familial issues	No security for life
Finding time for themselves is difficult, they are overloaded with housework, husbands do not support them with housework	

Table 2: Concerns identified by men for inside and outside the home

BARRIERS AND ENABLERS TO HEALTH AND WELLBEING

Connecting the previous activity of identifying problems, a brainstorming session was done to map and discuss the barriers and facilitators the community perceives in health, wellbeing, and the pathway to achieving their aspirations. The table below captures the barriers and enablers that evolved following the session.

Participants listing down barriers and enablers

Barriers	Enablers
Lack of money	Presence of schools till class X
Lack of education- though there are schools, these are not beyond class 10, so lack of higher education facilities nearby	Parents are supportive of children to study
Tuition is there, need money to pay for tuition	Presence of FLWs
Use of pesticides in farming	Govt has installed water tanks for colonies,
No facilities in the sub-center	ABSU has already initiated a campaign to put an end to production and sell of local liquor
Water-borne diseases are common-owing to water logging during floods	Give alternate livelihood to those selling liquor then they will stop making it
Alcoholism accelerates financial crisis. It adversely impacts health and concentration of the younger generation	If the income status improves, alcoholism might end
Lack of support system	Women in our community are motivated to come together for a common cause - eg: they came together to stop sale of liquor

Table 3: Barriers and Enablers towards health, wellbeing, and aspirations for men

MALE ASPIRATIONS

Participants were asked what were their aspirations for themselves individually as well as for the community. The major aspirations listed by the participants were:

- Earning a decent livelihood or gainful employment. A number of participants spoke about having alternate local employment opportunities, mainly non-agricultural. In this context, they spoke of infrastructural changes—setting up of companies/industries, weaving industry, and better connectivity.
- For the participants, such development would also ensure that they and their children are exposed to the outside world, which could offer them income opportunities.
- Noticeably their aspirations were related to their children/future generations and the overall community than themselves.

OVERALL KEY PRIORITIES FOR MEN

Aspirations

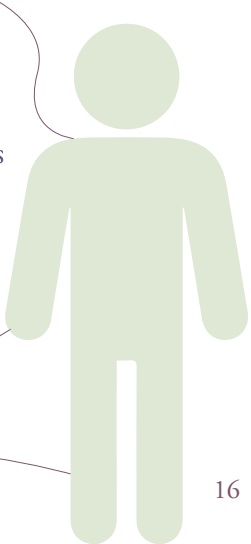
- Better income
- Educational opportunities for children
- Employment opportunities
- Quality of life
- Better infrastructure

Health and Social Security needs

- Strengthening of existing health infrastructure with the presence of trained health service providers
- Gainful employment opportunities that can considerably improve their quality of life

Current Situation

- Lack of income generation opportunities
- Quality and access to education
- Lack of local employment sources
- Lack of access to health and out of pocket expenditure, lack of awareness
- Structural challenges



GROUP 2: WOMEN

Sixteen (16) women participated in a one-day workshop that aimed to understand their lives, their perspectives, and attitudes and engage them in deliberations/ conversations using participatory tools. The section below highlights some of the key findings on important data areas such as

1. **Understanding gender roles**
2. **Perspective regarding men and their roles**
3. **Women's responsibilities in different domains**
4. **Concerns inside and outside the house**
5. **Barriers and enablers to health and wellbeing**
6. **Aspirations for self and family**

Role play activity

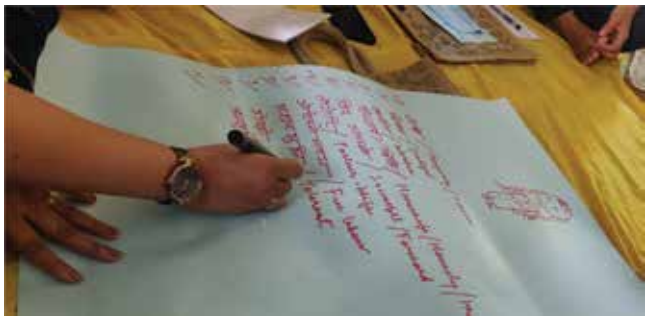
UNDERSTANDING GENDER ROLES

Discussions on gender roles were elicited through role-play. Two of the participants were asked to perform a role play wherein they played a day in the life of a husband and wife. Following the role-play, the participants were asked to share their interpretations of the role-play. This led to discussions of gender roles for men and women.

- Gender-specific roles and behaviour are internalized and accepted — they pointed out the man's dominance and woman's submissiveness.
- Women saw their role primarily in family, health, and well-being.
- Even though most of the participants were involved in livestock, poultry, and agricultural activities, they did not see themselves as contributing to family income, except Anaganwadi and ASHA workers. A primary reason behind this is income from such subsidiary livelihoods is irregular due to lack of training, improved practices, or technical inputs.
- Women shared they can decide on their own, how they spend money when it comes to health needs and children's education. However, majorly spending habits are guided by discussion and directions from men.
- Women need to play a lead role when it comes to family matters/emergencies, as most of the time husbands are out of the house.
- Women are expected to carry out all preventive practices when it comes to health. Nursing someone back to health is the woman's responsibility.
- Majority of the women said they play an active role when it comes to children's education, even tutoring them at a primary level. Women see their responsibility in preparing a child for school and making sure they receive sufficient inputs like books, tuition, a favorable study environment at home, etc.

PERSPECTIVES REGARDING MEN

- Men's involvement in household activities and children is limited.
- The role of men is also limited when it comes to healthcare. Their role is more in transportation to facilities or procuring of drugs or diagnostics; and not so much as a caregiver.
- Most men consume alcohol which is a commonplace behavior in the community.



Mapping gender roles

WOMEN'S RESPONSIBILITIES IN DIFFERENT DOMAINS

Health

Women see a major role for themselves in health. Women take children to the hospital without waiting for their husbands. They feel that they should be alert about the family's health in terms of taking care of sanitation and hygiene and diet

- Women take care of preventive health and use home remedies for minor ailments such as cold and cough.
- Women grow vegetables in kitchen gardens, wherever possible.

Finances

- Husbands give their wives money mainly to save and spend only on necessities that are related to the household and children.
- Alcoholism adversely impacts family income and expenditure. This also leads to conflicts in the family.
- Most participants said important financial decisions are by mutual discussions between the husband and wife. However, women taking financial decisions independently was not practiced.
- Women did not talk about any expenditure for their personal needs or recreation.

Education

Majority of the women see for themselves an active role when it comes to children's education.

CONCERNS INSIDE AND OUTSIDE THE HOUSE

In order to understand the problems, we asked the participants to list out problems inside and outside the picture of a house.

Participants mapping concerns inside and outside home

Inside	Outside
Finance /Food security/kutcha houses	Tobacco usage
Do not prioritize their general health/illness Lack of mental health support	Road/Transport
Toilet	Sub-centers are not well equipped
Cooking gas	Library- a common space that can create an environment of studying among children
Alcohol	Scarcity of drinking water
Drinking water	Temple- can provide space for women to get together, hang out, spend some time together
Erratic supply of electricity	No cremation ground
Water logging- no proper drainage system	No ambulance
Home lacks an environment for study	No access to medical emergencies
Houses are not big enough for livestock	
Unemployment/Disguised employment	
Flooding in the house	
Financial constraints affecting the quality of education	

Table 4: Concerns identified by women inside and outside home

BARRIERS AND ENABLERS TO HEALTH AND WELLBEING

Barriers	Enablers
Wage labor	Public Distribution Systems
Small land holdings	Local employment opportunities such as handloom, livestock, poultry fishery
No regular employment	Homestead land
Inflation (this affects basic needs, such as cooking gas)	Kitchen garden
Disguised unemployment	Youth interested in alternate options of local employment
The cost of production is more than the income for agriculture and handloom	Openness to skill development (eg. bamboo furniture making and handicrafts)
Produce is less	Existing basic infrastructures such as - Anganwadi, primary schools, subcenters etc.
Demand for local grains is less	Village Defense Party (VDP) can be leveraged to address community health concerns.
Limited market for handloom, difficult to compete with machine product prices	
Lack of redressal mechanisms	
Lack of quality training for handicrafts and for marketing them	
No market for bamboo craft, handloom. The transportation of produce is also a challenge.	
Not all villages have sub-center/HWC. PHC/CHCs not well equipped to handle serious health concerns.	
Distance between PHC to village is between 3.5 to 14 kms	
Lack of good infrastructure	
History of conflict in the region	

Table 5: Barriers and Enablers towards health, wellbeing, and aspirations for women

Through this activity participants mapped and a discussion was facilitated to understand the barriers and facilitators the community perceives in health, wellbeing, and the pathway to achieving their aspirations.

FEMALE ASPIRATIONS

- The primary aspiration for women is linked to their children, for them to have higher education and employment opportunities for children.
- Women aspire to be entrepreneurs and seek formal training opportunities to explore and express their potential. They feel the need for skill development programmes and trainings for themselves and their children.
- A number of women aspire to have a pucca house of their own, with a garden and a good approach road.
- Many participants shared that they need a community space such as a library where their children can concentrate and be productive. Similarly, they also feel the need for a community space where they can gather for exchanges among themselves- sing/dance, and use the space to deliberate upon their concerns.
- The participants also aspired to have more opportunities where they can leverage their existing resources. (Example: bamboo industry)

OVERALL KEY PRIORITIES FOR WOMEN

Aspirations

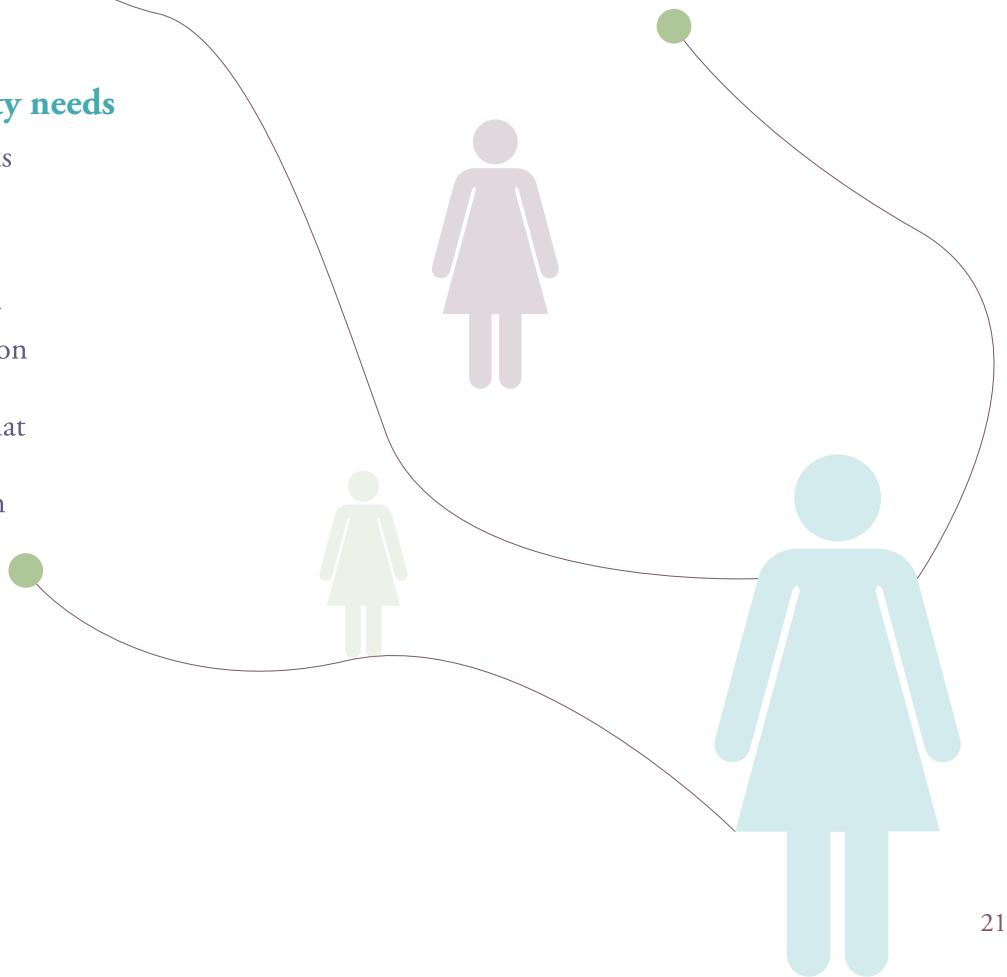
- Income generation opportunities
- Aspirations for children
- Houses unaffected by floods
- Community spaces for women
- Using skills as income generation opportunity
- Better life and well-being

Current Situation

- Dealing with natural calamities
- Quality of education
- Infrastructural issues
- Male decision-making predominant in finance management
- Workload- household as well as agricultural work and livestock care

Health and Social Security needs

- Health and social security needs identified by women is mainly related to their children's and family's health needs
- Women did not prioritize their own health and relied majorly on home remedies
- They sought to be trained so that they can carry out some home-based income-generation opportunities



Adolescents actively engage in the mural wall activity

Sixteen (16) adolescent boys and girls participated in a one-day workshop that aimed to understand their lives, perspectives, and attitudes and engage them in deliberations/ conversations using participatory tools. Most of the boys and girls were in the age group of 14 to 16 and were school-going. There were two boys who were drop outs.
The section below highlights some of the key findings on important data areas such as

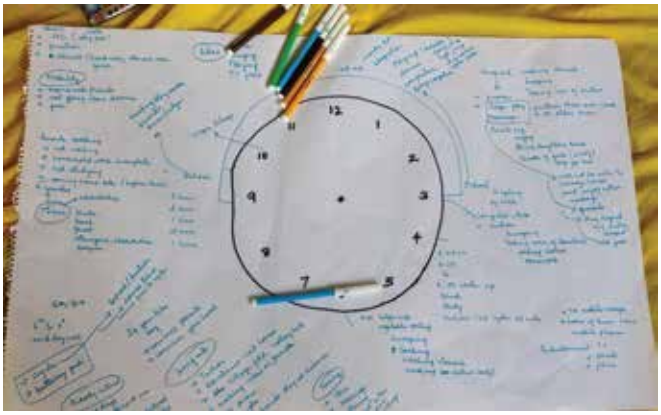
1. **Understanding gender roles**
2. **Perspective regarding women and their roles**
3. **How do they spend their time**
4. **Concerns inside and outside the house**
5. **Their dreams and aspirations**
6. **What are the enablers and barriers in realizing their dreams/aspirations**

MURAL WALL ACTIVITY TO IDENTIFY PERSONAL ASPIRATIONS

The mural wall activity was an exercise done to bring out personal aspirations and dreams through art. This activity was used to let the participants reflect on their dreams and to help break the ice. As part of the activity the participants were encouraged to draw whatever came to their mind when they thought about their dreams and aspirations on chart papers that were posted on the walls. Post the activity the participants were encouraged to share what did the drawing mean to them. Everyone was asked to volunteer, and speak about their dreams and aspirations. The responses were most spontaneous, with the adolescents saying:

The mural wall created by participants

"A DAY IN MY LIFE": MAPPING DAILY ROUTINE FOR BOYS AND GIRLS



Day in a life mapping

- Women need to play a lead role when it comes to family matters/emergencies, as most of the time husbands are out of the house.
- Women are expected to carry out all preventive practices when it comes to health. Nursing someone back to health is the woman's responsibility.
- Majority of the women said they play an active role when it comes to children's education, even tutoring them at a primary level. Women see their responsibility in preparing a child for school and making sure they receive sufficient inputs like books, tuition, a favorable study environment at home, etc.

UNDERSTANDING GENDER ROLES

- Mobility for girls is not very restricted/ can we say controlled mobility. However, girls are usually allowed to go only a particular distance and are expected to come back before it gets dark.
- Boys viewed women as someone who 'stays inside the house'.
- Even at their tender ages, boys have been observed to drop out of school and engage in livelihood activities to provide for the family.
- Boys do not have such restrictions on their mobility.
- Cycle is a primary mode of transport for girls.
- Young boys want bikes. It seems to be associated with a sense of masculinity. This can also be further linked with accessing opportunities
- Mobiles are widely used by boys. In a family, it is the brother who has the mobile phone and the sister has to share it with him in most cases.
- Girls wanting to be singers/dancers are not sure if their families will support their dreams; also, they are skeptical if these would be respected occupations in their community.
- Both the boys and girls shared it is normal to express interest in the opposite sex but if the boy and girl take decisions regarding the relationship with the consent of their parents, it can resolve many issues.

FINDINGS AROUND KEY DOMAINS

Family

- Both boys and girls spoke about elopements as common in their localities. Most times the shame or embarrassment associated with a girl eloping leads families to accept it.
- Both boys and girls prefer to speak with their mother, elder siblings, or friends when it comes to sharing any issue they might be facing in their lives.
- The adolescent group recognizes alcoholism as an issue and perceives it as something that leads to fights within the family.

Community

- According to girls, boys/men from their own area generally do not tease or pass comments, but from other areas they do. Girls also shared that crowded places such as local fairs (mela) are where the teasing usually takes place.
- There is a sense of community and belonging among the adolescents that seem to define their demeanor/behaviour to one another.

Health/Mental health

- Girls are aware that eloping at a young age for girls is not good as she is mentally and physiologically not prepared to handle marital life.
- They feel the need for a counsellor who can guide them in their career decisions.
- Both girls and boys have aspirations but lack a guide who can help them configure the paths or inform them of opportunities.
- Some of the participants shared a feeling of self-doubt or lack of confidence.

Education

- Financial constraints of the family are an issue for getting a quality education. They feel parents may not be able to support them financially.
- Lack of availability of good infrastructure and poor student-teacher ratio in schools are major concerns for adolescents. Both boys and girls seek higher education options, and training facilities that can make them ready for a job.

CONCERNS INSIDE AND OUTSIDE THE HOUSE

In order to understand the problems men, identify within and outside the house, we asked the participants to list out problems inside and outside the picture of a house.

The following table outlines the major concerns participants listed down during the activity.

Activity of mapping

Inside	Outside
Lack of proper environment in the house to study	Lack of places for students to train further
Absence of basic infrastructure in the house	There is no one to guide them in realizing their dreams
Financial constraints- they feel parents may not be able to financially support their dreams	For girls, mobility, and lack of social acceptance of certain aspirations such as becoming a singer/ dancer etc.
Lack of electricity, cooking gas, and water supply in the house. For girls it means spending a lot of time in cutting, collecting firewood.	Lack of job opportunities
Alcoholism leads to conflicts in the family and even domestic violence. It affects their studies "Money spent on alcohol can be spent on needs of our house, it is a wastage of money, instead books can be bought."	Roads: Bad roads affect the mobility of the children. There are limited alternate local modes of transport
	Lack of landholding. Absence or lack of land also affects them, as it is seen as a need for the family to build a house. A lot of children help in sowing during their vacation

Table 6: Concerns identified by adolescents inside and outside home

BARRIERS AND ENABLERS TOWARDS REALISING THEIR DREAMS AND ASPIRATIONS

The participants circled as a group and were shown paper models of an adolescent boy and girl and a destination created using paper that represented their dreams and aspirations. We placed barriers models made out of paper between the models of the boy and girl and the destination. This was to help the visualize and be engaged in the discussions better. The participants were then asked think of barriers and enablers in their lives and community in the road towards achieving their aspirations. The participants took turns and shared the barriers and enablers they felt. The team mapped these onto the paper model using sticky notes.

This activity paved discussion on the barriers and facilitators on the pathway to reaching their dreams and aspirations. The following table outlines the barriers and enablers that came up in the discussion.

Barriers	Enablers
Girls do not have any decision-making power	Community and family support are there to study, for both boys and girls
Financial constraints	Mid-day meal for children in schools
Marriage is prioritized by the family for the girls, not really encouraged for higher studies or work	Cycles being provided to students by the government in schools
Lack of higher education/training options	
Family disruptions due to alcohol induced violence affects them mentally	

Table 7: Barriers and Enablers towards realizing dreams and aspirations for adolescents

ASPIRATIONS

- Both boys and girls aspire to be financially independent.
- Some of the girls aspire to be dancers, singers, IAS officers, and engineers.
- Aspirations among boys seem to be dominated by ideas of masculinity/patriotism. Some of the aspirations they shared are working in the armed forces, becoming a footballer, etc. Participants spoke of role models who were in their immediate contexts such as a teacher in the school or an uncle who is in the army.

> "Once I become an IAS officer I will improve the condition of the schools, complete all the pending work of infrastructure in school- computer availability, unavailability of teachers."

Aspirations

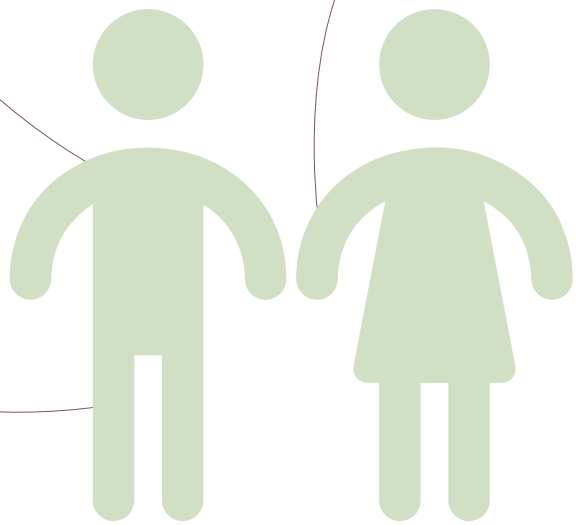
- Aspirations for quality education
- Working towards professional life of choice
- Continuing education
- Cordial family life
- Better life and well-being

Current Situation

- Lack of quality education
- Lack of employment opportunities
- Addictions and drug abuse
- Required support from family lacking for education
- Work burden and managing school requirements
- Familial disturbances
- Eloping
- Controlled mobility and time restrictions for girls and gendered responsibilities

Health and Social Security needs

- In terms of physical health, the boys do not mention much. The adolescent girls talk about menstrual cramps and headaches.
- Both boys and girls do speak about feeling the need to talk to someone, the need for a counsellor/guide/mentor.
- They also speak about mental health being affected by fights within the family, which mainly stems from alcoholism.



"I want to travel, I want to visit many places and see them, it is my dream"

"I want to work and have a secure future, I really want to buy a car and ride"

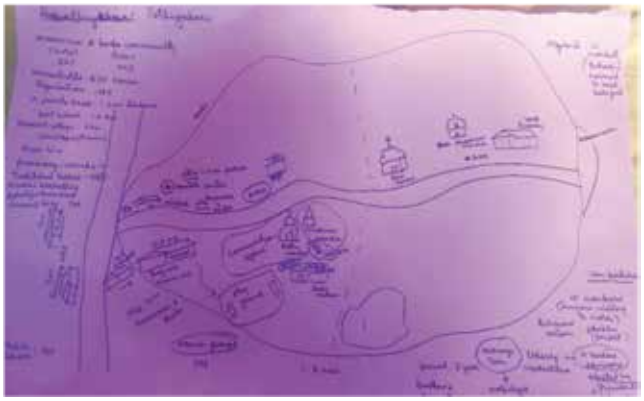
"One day in future I want to become a forest officer and save and protect the forests because I love nature very much"

"I want to join BSF or army and I want to serve my country"

"I want to become a teacher, I really like my teacher, she teaches so well, and someday I also want to become like her and help children by teaching nicely"

FOCUS GROUP DISCUSSIONS WITH VCDC (Village Council Development Committee)

The Focus Group Discussion (FGD) method was used to gain insight into the roles and responsibilities of VCDC and also to understand to what extent is the committee linked with its local communities. We also undertook a mapping activity of the VCDC members to comprehend how the members of the committee understood accessibility, availability and challenges around existing infrastructure.



Mapping the village, infrastructure, accessibility and challenges

FINDINGS AROUND KEY DOMAINS

Health

- Sub centers are sporadically placed and the Community Health Officers (CHOs) are present between 10 am to 2 pm; they generally commute from distant villages and are not present 24*7. There are pharmacies in the market lanes, where doctors visit for a duration of time. People tend to get medicine from the pharmacy and also get free medicine available at the AWW.
- There are not many traditional healers present, even if there are they do not come out, because in the past there have been incidents of violence against them (witch hunting).

Village Defense Party (VDP)

- Village Defense Party locally referred to as VDP is a local policing group, they are linked to the local police station. They seem to be involved only when the community asks for it. For instance, in case of elopement, if the parents file an FIR, the VDP gets involved, otherwise not.
- Members of VDP are also selected by the people in the village. Every month a meeting is held at the local police station to discuss issues. They are given a monthly honorarium by the government. There are 25 members, including women members.
- Members of the VDP are given badges as mark of identification.

Education

Most villages have access to schools and schools are within 1.5 to 4.0 km. Most children go to a government school, however, there are also private schools. There are two colleges, in Mushalpur and Thumna, at varying distances from the different villages.

Women's collectives

- Women have separate groups and these are mainly SHG groups.
- These SHGs groups do not function beyond their thrift and credit role

Discussion with VCDC members

Traditional Leadership

- The religious leader is called Prabhu - who worships at the temple. Tuesday is considered to be an important day. The religious leader plays an important role in the community. Temple is a community space—most village events tend to take place here.
- There is a collective of 15 community members, this collective accepts any person from the community willing to work for the community. There is a president and secretary for this collective and also four elderly advisors called 'upodestha' working with the president and secretary. They are selected by the village in the same sabha where the president and secretary are chosen. The primary criteria include willingness to work, and a good understanding of the village issues. The process is of proposal and approval (prashtav - samarthan) by show of hands. Women do not participate in these selection meetings.

A temple inside the village

Village council and development committee (VCDC)

- VCDC is the same as the Gram Panchayat (GP) at the state level, in Bodo Territorial Region (BTR) the Village council and development committee is the GP. One VCDC has three to four revenue villages. VCDC has a president 'afatgiri', a secretary 'nehatari' and members. President and secretary are selected every two years. There is a peon 'halmazi' who is responsible for mobilizing people, he is paid as per his work or sometimes for a year, as per the work assigned. It differs from one village to another.
- The VCDC's primary role seems to be the facilitation of social assistance schemes such as Pradhan Mantri Jan Arogya Yojna (PMJY), Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA), Antyodaya, National Rural Livelihoods Mission (NRLM) etc. It does not carry out any financial transactions. Any financial transactions are handled directly by the block office. The activities undertaken include but are not limited to canal repair and small roads, planting trees, embankment, listing beneficiaries for housing, old age pension, etc. There is very limited decision-making power.
- The VCDC does not play any role in terms of activities related to health.
- State to BTR- fund flow is reported to be less and further to VCDC is said to be even less. VCDC is controlled by the Block Development Officer (BDO), it is not linked to any political party.
- Election duties are not given to VCDC, but members are called for party meetings
- From the discussions it was evident that there is a lack of convergence between departments and the activities initiated are under the line budget of the concerned different departments.
- Community participation only in so far as the limited benefits and schemes are concerned. There seems to be a misconception among the people that VCDC is a political entity.

ACTIVITY FOR LISTING CHALLENGES IN THE COMMUNITY

The activity of listing challenges in the community led to discussions regarding infrastructure, health, education, employment, and social issues.

Lack of employment opportunities

- For women with education and skills there aren't enough opportunities.
- Livestock can be an opportunity for women but training has been inadequate, also they have never received any seed money from the government or SHGs to start a business.
- Scarcity of land and water is also creating problems of unemployment, leading to limited, even lack of income.

Health

- Lack of quality care and human resources. For the smallest of health issues, people are referred to higher centers (Nalbari or Guwahati Medical College (GMC). For instance, for plastering a broken hand one had to travel to the GMC or the district centre at Nalbari.
- Most common health concerns shared were, stomach pain, kidney stone, sugar, and hypertension. These are most common among the age group of 50-plus men and women.
- Lack of health seeking for non-communicable diseases, especially blood pressure.
- Child marriage/elopement is common. People do recognize the adverse impact on health- such as malnutrition among mother and child.
- Lack of attention on health seeking due to greater emphasis on functional health. They compare themselves with non-tribals and say we are healthier.

Changes you want to see in future

- A community hall in the village.
- Skill training center and intensive skill development trainings.
- 25-30 bed hospital so that we do not have to go to Nalbari or GMC, also testing facilities- TB testing
- More and better roads.
- Increased irrigation facilities.
- More financing for construction of toilets.
- Better employment opportunities.

Education

- Education is a primary challenge, owing to the inadequacy of schools, the quality of education, and the student-teacher ratio.
- Financial constraints- boys and girls drop out of school; boys either take up labour work, and girls are married off.

Social issues

- The mobile/internet has impacted elopement- some even leave a woman/man post-marriage with a kid and live with someone else. This adversely impacts the family and child. If the person is abandoned after marriage again, acceptance is a challenge.
- SHGs are present, but they do not get finance from the banks, as the government has not sanctioned finance for SHG loans to the banks.
- Alcoholism is rampant and is affecting family and social life.

The discussion on facilitators provided the following points

- Handlooms have revived after the formation of BTR.
- Post the launch of Jal Jivan mission- drinking water has become available.
- There are toilets in schools.
- Construction of dams, roads etc.

Health and wellness centre

AT A GLANCE

- Need for convergence and coordination between departments.
- People's involvement in the VCDC is limited to availing benefits and schemes, more participation required.
- The VCDC as a body does not have much power but is a respected body. To an extent, it can only influence decision-making in the community.
- VCDC members are well aware of the local issues. They may be trained and used as a resource to spread important information on any health issue.
- Since the VCDC members are included in party meetings, VCDC is a politically influenced body.
- VCDC does not have any financial powers.
- Role of VCDC in health is not seen as an agenda.
- The work of frontline workers and activities of VCDC are seen separately. These two entities can work together to respond to any health needs of the community.
- VCDC can be to address structural issues amidst all the barriers.

FOCUS GROUP DISCUSSIONS WITH FRONTLINE WORKERS

(participants: Auxiliary Nurse and Midwife (ANM)- Mushalpur, Village president, Anganwadi Worker (AWW), Accredited Social Health Activist(ASHA), Jeevika sakhi- -State Rural Livelihoods Mission (SRLM), CHO)

Focus group discussion

PROBLEMS IDENTIFIED IN THE COMMUNITY BY FRONTLINE WORKFORCE

Youth

- Problems faced by young adults have increased especially in the age group of 16-17 years for girls and 20-22 for boys.
- Teenage pregnancies, anemia, birth complications, abortions, low birth weight, and lack of family planning are some of the health-related issues for the age group.
- Substance abuse is a major issue among youth accentuated because of uninvolved and unvigilant parents (alcohol, ganja, gutka, tobacco). A lot of this is attributed to peer influence. Involvement in alcohol and drug selling is also a cause of concern.
- Apart from effects on health, the other effects are, adversely impacting the relationship within the family, and there are instances of cheating, stealing, and lying.

Women

- The local production and sale of alcohol by women is common. The pressure to stop is met with resistance as there are no alternate local livelihoods options that can support similar income.
- Menstrual hygiene and reproductive health issues are a cause of concern for the health providers.
- There is prevalence of domestic violence.
- There is lack of appropriate interventions among local tribes to address such issues, and the locals resist any initiative or involvement of the frontline workforce to respond to them. Their actions are seen as interference by the community.
- Eloping is prevalent in the community and is accepted at many levels. Healthcare providers identify it as an issue that it affects children's education, leads to early pregnancy, and other health issues.
- Parents do not monitor children's behaviour.

> "A woman came crying to the jeevika sakhi asking for 50 rupees. when she asked what the problems was, she narrated 'my children are both addicts and they have gradually sold everything in the house and there is nothing left in the house, not even utensils, and I have no money to eat also..."

Health

- High percentage of NCD cases in 35+ age group. Hypertension is more common than diabetes.
- People do not accept family planning practices, as they fear it will have side effects.
- Lack of health awareness, beliefs, myths, and misconceptions around services has repercussions on the work of the frontline workers.
- Reliance on functional health acts as a barrier to preventive health.
- People do not seem to trust the public health system due to the poor quality of care.
- Income scarcity accentuates the out-of-pocket expenses towards health.
- More than treatment expenses the expenses towards travel, food, and accommodation adds to the burden.

Structural

- Access to health facilities is a challenge and is accentuated by bad roads and lack of transpor tation and connectivity issues, ambulance services.
- Lack of proper infrastructure like roads, water connection, better irrigation facilities affects everyday life.

Other

- Water scarcity.
- Poor quality of government schools compels parents to send children to private schools and this increases education expenses.

The discussions with frontline workers also brought out the facilitators/support systems and challenges in their service delivery.

Challenges	Support/Facilitators
Structural challenges (bad roads, lack of transportation facility)	Community support (people participate in meetings)
Lack of convergence between departments	People are open to awareness creation
Lack of health awareness among people	SLRM trainings are successfully conducted
Overburden of work due to insufficient human resources	Situational support at the time of emergencies
Geographical distribution of ASHAs and ANMs	
Existing schemes are affected by consistent supply	
Lack of support and supportive supervision at the system level	
Lack of administrative support (AWW) 70% of anganawadi have no infrastructure	

Table 8: Challenges and support for frontline workforce

Support/facilities required

- Consistent and seamless supply of medication.
- Technical support and trainings for ANMs.
- More human resources for health care Community Health Officer (CHO), Auxiliary Nurse and Midwife (ANM).
- Supervisory support (CHO, ANM).
- Addressing concerns regarding payment issues for Accredited Social Health Activist (ASHA) workers.
- Training for upgrading skills of ASHAs.
- Population-wise distribution of ASHA and ANMs.
- Infrastructure for anganawadi and upgrading all the facilities including Anganwadi Workers (AWW).
- Addressing issues around beneficiary selection misappropriation.

AT A GLANCE

- Health issues go unidentified. Due to primary focus only on functional health many underlying health problems are often ignored or go unnoticed till the symptoms are severe enough to disrupt normal functioning.
- Maternal, Newborn and Child Health (MNCH) issues are of prime concern because of anaemia, teenage pregnancies, eloping (abortions, miscarriages) and challenges are around immunization and birth spacing.
- Social issues like dropping out of school, drug and alcohol abuse is creating multiple level of challenges (family level, community level, physical and mental well being).
- Infrastructural challenges: anganawadi buildings needed, human resource gap, supply side issues for medicines and diagnostics, access a challenge due to scattered villages.
- Problems around Menstrual Hygiene Management (MHM) and lack of health awareness among women and men in general.

A public engagement program was conducted in Khokrajar; which is the administrative center for BTR. The participants were representatives from NGOs, the health department, the social welfare department, etc.

The objective was to understand if there are any rural and urban differences in the problems and challenges faced by the local tribal population. The discussions pointed to the fact the rural-urban divide is not very significant. However, the districts vary in terms of exposure to and experience of Bodoland conflict. The areas affected by conflict to a greater extent are Khokrajhar and Chirang.

It was shared that the conflict has over the years created not only structural challenges but also developmental and emotional challenges for the residents of the districts.

Some of the key recommendations from the participants included: the operationalization of central flagship programs, convergence platforms for effective and efficient implementation of services, evidence-based learning, and involvement of policymakers in the ideation processes.

Participants at the public engagement programme

LISTING ACTIVITY

The first activity conducted with the participant was the listing activity in small groups. Through this we attempted to see the range of problems that can emerge from different perspectives. As a follow-up of this activity, a group activity was carried out to identify key priority areas for intervention. The responses from the listing activity and the discussion that followed were:

- Early marriage and the need for reduction in teenage pregnancy.
- Increased community participation is needed in all government schemes.
- Accessible 24*7 hours health dispensaries.
- Poor health-seeking behaviour and need to bring behaviour change to improve the health-seeking behaviour. **("How to change the community behaviour is of key importance").**
- There is a need for community initiative and ownership of all health initiatives.
- The mindset/attitude of people needs to change, which can improve the health-seeking behaviour of the community.
- The mental health of women and children needs to be prioritized.
- Mental health of children born and raised in conflict zones, in refugee camps carry the fear element, it impacts their mental health.
- Poverty.
- There has been huge investment in infrastructure, but there are no doctors available.
- We need to bear in mind that Bodoland is in transition and not everyone might be ready to accept the change.

Group Discussion

Listing Activity

AT A GLANCE

Mental Health	Health	Non-forest (non revenue) villages
• Women and children-suffering most study shows 60,000 women have mental health issues triggered by the repeated conflicts. • Need for mental health professionals. • Key question is how to provide mental health support at district and community level.	• Reproductive, Maternal, Newborn Child plus Adolescent Health (RMNCH+A) with special emphasis on nutrition • Substance abuse • Need for more compounders/barefoot health nurses, who can serve as local health professionals. • Make existing health systems more accessible to the community.	• Targeted focus on non-revenue forest villages (1500 villages). • Women and adolescent are furthermore vulnerable • Multiple underlying challenges owing to the nature of the settlements • Everyone seeks a 'safe, smart and green Bodoland'.

CHALLENGES IDENTIFIED IN THE LISTING ACTIVITY

Community

Challenges

- There is a lot of high-risk pregnancy
- Dependence on ojhas and local healers
- Lack of awareness and ownership for health in the community

System Level

Challenges

- The citizens of the non-revenue village do not have any valid id or bank account which prevents them from availing govt benefits.
- Lack of evidence-based research and need for strengthening of monitoring systems
- There is health-seeking behaviour but poverty and accessibility of health services limits people from going to the doctors and they end up going to quacks.
- No platform for mutual sharing and feedback
- The land where people are living is identified by govt. as forest land, so people may even be asked to vacate. Even if there is no actual forest, they may not be allowed to live here.
- Government does not recognize the need of the people in the non-revenue villages. These areas are identified as forest areas. Schools in these areas are run by locals, not recognized by the government. No mid-day meal, no nutrition among children, adults.
- Lack of training for the frontline workers, IEC for awareness, No interdepartmental review and feedback mechanisms, no platform for mutual sharing and feedback

COURSE OF ACTION THAT EVOLVED FROM THE GROUP ACTIVITY

Community Level

Course of Action

- Strengthening of monitoring systems are needed
- ASHA/AWW or FLWs can be capacitated to respond to the counselling needs
- Need for convergence of all departments – Convergence or common platform can ensure policy changes, so need for constant advocacy with the govt.
- Trained and equipped FLWs and facilities needed
- Explore options of technology driven convergence
- Some kind of convergence between social welfare and MGNREGA- construction of AWCs
- Implement the RTE Act
- Persistent advocacy with the BTR to ensure all the flagship programs reach the unserved
- Barefoot doctors
- Mapping unserved community/population
- Last mile service provision
- Future course of action for non-revenue villages
- Include the forest department to provide NOC for construction of health center and AWC

System Level

Course of Action

- Demand generation is equally important. Supply and demand need to go hand in hand
- Use You Tube/short films, social media for message dissemination

06.

OVERALL FINDINGS

The following section offers, in brief, some of the core issues identified by the respondents, communities, and possible ways forward for future intervention.

MAJOR HEALTH ISSUES

- Undernutrition of women, children and young adults
- NCD – Hypertension, diabetes (higher among males aged 15-54)
- Teenage pregnancies
- Mental health issues
- Dependence on traditional medicines
- Water-borne diseases are common-owing to water logging during floods

MAJOR VULNERABILITIES ACROSS GROUPS

Men

Disguised unemployment and absence of significant opportunities for income generation, alcoholism, and substance abuse.

Women

Facing domestic violence, malnourishment and anemia, limited participation in the community level activities, limited decision-making power within the family, financial spending habits are guided by directions from men, high workload in terms of having to take care of work both inside and outside home.

Adolescents

Alcoholism and substance abuse, fights within the family affect their mental health, teenage pregnancies, early marriage, lack of facilities at educational institutions, absence of counseling support, limited involvement and support from parents for education and career.

Frontline Workers

Systemic issues of supply, inadequate human resources, need for enhanced skills and trainings, behaviour change communication skill set to effectively deal with lack of health awareness and myths and misconceptions in the communities.

COMMON VULNERABILITIES AS A COMMUNITY

Lack of necessary infrastructure (accessibility of health facilities, lack of human resources in health facilities and educational institutions, transportation facilities and roads) frequent natural disasters, residual effects of ethnic conflicts, substance abuse and alcoholism, poverty and limited opportunities for quality education, employment and income generation.

PRIORITY AREAS FOR INTERVENTION

Categories	Health & Wellbeing	Non-health
Men	Non-communicable Diseases, Hypertension, diabetes	Addressing all structural and community barriers – Transportation facilities Employment &income generation activities
Women	Anemia and Nutrition, MNCH, addressing gender-based violence,	
Adolescent	Menstrual Hygiene Management, Sexual & Reproductive Health, Mental Health, Life skill education, Nutrition	Quality of education Accessibility of public health care
Frontline workers	System level support to provide seamless services (supply, buildings for anganawadi, training and skill development for effective behaviour change communication)	

DIRECTIONS FOR STRATEGY

- Creation of community spaces (for women & adolescents) to share, learn, engage and innovate to address specific challenges.
- Create skill development programs and opportunities for income generation (for both men and women).
- Life skill education, career counselling for adolescents.
- Address gender-based violence, fostering better gender relations.
- Create a model for mental health support.
- Leverage the existing community structures, such as SHGs, VCDC, VDP to create a supportive environment for the community.
- Enable the communities to speak up about the challenges they are facing, and work towards addressing these
- Develop and implement a model on nutrition interventions with community and VCDC at the core.
- Capacitate existing VCDC/VDP members/traditional advisory council (afatgiri) members and use them as resource for addressing health, and other concerns
- The existing models of Spoorthi for adolescents, GPAAA for collaboration and convergence, and the health communities model can be implemented.

Note: The findings are not to be generalized for the entire BTC population, these are potential directions for strategy in a pilot mode.

Disclaimer: This report is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of KHPT and do not necessarily reflect the views of USAID or the United States Government.

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