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Denying access of Particularly Vulnerable Tribal Groups to contraceptive services: a case study among the Baiga community in Chhattisgarh, India

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Abstract: *Baigas are a Particularly Vulnerable Tribal Group (PVTG), categorised as the most vulnerable amongst indigenous communities in India. As a strategy to stall their decreasing population, due mainly to high mortality, in 1979 the government restricted their access to permanent contraceptive methods, and this is enforced as a "ban". Using a case study design with mixed methods, this study aims to understand the experiences and perceptions of Baigas in Chhattisgarh in accessing contraceptive services. Data was collected through: a household survey (*n = *289) in 13 habitations; individual interviews and group discussions with Baiga men and women and health service providers; and anthropometry. The Baiga suffer poor nutritional status and poverty, out of proportion with district and state averages. Of the women interviewed, 61.3% have had four or more pregnancies and 61.3% have experienced the loss of child at least once during pregnancy or later. Baiga women's forehead tattoo, a marker of their identity, is used to deny them contraceptive services. Baiga women either have to travel to the neighbouring state to avail themselves of services, or lie about their identity. They are usually unable to access even the temporary methods. This coercive policy has led to their further impoverishment. Baigas have been demanding the right to contraceptive services. Denying contraceptive services is a violation of reproductive and human rights and the right to self-determination and bodily autonomy.* DOI: 10.1080/09688080.2018.1542912

Keywords: reproductive rights, contraceptive services, indigenous groups, India, coercive population policy, bodily autonomy, maternal health

Introduction

Particularly Vulnerable Tribal Groups (PVTGs) are recognised as the most vulnerable amongst the *Adivasis*.*[1] Earlier called "Primitive Tribal Groups", they were first classified by the Government of India in 1975–1976 using the following criteria: (i) pre-agricultural level of technology; (ii) very low level of literacy; and (iii) declining or stagnant population. Seventy five such communities were classified as PVTGs across what are now 17 States

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*The term "Adivasis" translates into "indigenous people". The Constitution of India and the India government use the term "Scheduled Tribes (ST)" and do not recognise "Adivasis" as "indigenous". Many argue that the term ST is not coterminous with "Adivasis", as many groups who consider themselves as Adivasis are not classified as STs.[1] For the purpose of this article, the term "Adivasis" and "indigenous communities" will be used interchangeably. The term "Scheduled Tribe" will be used only when referring to government data and reports.

and 1 Union Territory.[2] In 2006, the term "primitive" was changed due to its derogatory nature, though in practice governments and others still perceive them as "primitive" and "backward", with devastating consequences for these groups.[2] They face high levels of impoverishment, mainly due to the loss of their traditional livelihoods, which included shifting cultivation, forest produce gathering, bamboo weaving and other forest-based livelihoods, and have been subject to devaluation of their culture and customary practices.[3] Their extreme vulnerability manifests itself in high mortality and malnutrition rates.[2]

Chhattisgarh state recognises five PVTGs, namely, the Baigas, Pahari Korwas, Birhors, Kawars and Abujhmarias. As a strategy to curtail their decreasing population, the Government of India in 1979 restricted their access to permanent contraceptive methods (sterilisation). This order is still being enforced in many states, including in Chhattisgarh.[4]

The 1979 order restricting sterilisation among PVTGs

The order being implemented in Chhattisgarh was passed by the Public Health and Family Welfare Department of Madhya Pradesh (MP) in 1979.† The subject of the order reads "Orders regarding non promotion of sterilization of certain sub communities in tribal areas under the family planning programme".[5] Giving the context of the ongoing "targets" for sterilisation, other contraception methods and maternal and child health services, it states that sterilisation should not be "promoted" among the PVTGs, which include "Baiga Adivasis of Baigachak", whose population has been dwindling or increasing negligibly.[5] The objective of the order is that "the specific sub communities are not harmed by the coercion or incentives of the family planning programme",[5] alluding to the family planning programme during the Emergency in the mid-1970s.[6] The order states that temporary contraceptive methods could be promoted as per the needs of the community and also makes provisions for any PVTG member to undergo sterilisation provided he/she has an affidavit signed by a block level official stating that the person is insisting on sterilisation and that he/she has been counselled on the results of the operation.[5] Despite this provision, the order has been enforced as a "ban" on sterilisation services for the PVTGs in Chhattisgarh, with the PVTGs usually unable to access even temporary contraceptive methods.[4]

The other rationale underlying the order was that the population of PVTGs was dwindling and their numbers had to be increased. However, the government failed to acknowledge and act on the real reasons for the dwindling population that included starvation, chronic malnutrition, and lack of access to adequate health services, which in turn resulted in high mortality rates among these communities.[2,3] Moreover, as the Xaxa Committee (set up to look at the status of tribal people in India, chaired by Professor V Xaxa)[2] states;

"Such a policy denies members of PVTGs the autonomy to make free and informed reproductive choices, and particularly denies any agency and bodily autonomy to women of these communities, who have to bear the burden of the denial of access to sterilisation facilities."

The National Population Policy, 2000 of India commits to "voluntary and informed choice and consent of citizens while availing of reproductive health care services"[7] and states that special efforts should be made to provide these services to tribal communities (*Adivasis*) as per their needs.

In Chhattisgarh, various civil society and PVTGs organisations have been engaged in attempts to revoke this coercive policy.[4] The Public Health Resource Network has led this initiative through research, media advocacy, engaging organisations of PVTGs, and building a social consensus.

The research presented in this paper was undertaken in 2016–2017 with the objective of studying the experiences and perceptions of the Baiga community in accessing contraceptive services in Chhattisgarh, in the context of the 1979 order. It was undertaken within a larger study exploring perceptions, experiences and inequities, in relation to health, nutrition and access to public health and allied services, amongst the PVTGs.[8] Issues emerging from restricted access to contraceptive service are explored, within broader consideration of the vulnerabilities faced by the Baiga indigenous community, and Baiga women in particular.

Materials and methods

This study uses case studies and mixed methods.

The district (Kabeerdhaam) with the highest proportion of Baigas (population of 41,601 as per

†Chhattisgarh state was formed on 1st November 2000. It was carved out of Madhya Pradesh.

the 2011 Census) in Chhattisgarh was selected, and within it Pandariya block (a block is a division within a district), one of the two blocks with the highest Baiga population in the district, as there was an existing engagement with an organisation in the Baiga community. This facilitated rapport building for data collection as the Baigas may be reluctant to interact with "outsiders".

To select the study villages, a list of all villages or habitations with the number of Baiga households was sought from the government. Study habitations were chosen through systematic random sampling from this list. In habitations of up to 35 Baiga households, every household was included in the sample. In villages with more than 35 Baiga households, random sampling was used to select 35 for the survey.

In total, 289 Baiga households (with 1442 family members) in 13 habitations were surveyed. In these households, 248 women respondents aged 15–49 years were separately interviewed regarding reproductive and maternal health issues. For the in-depth qualitative study, three villages (Bala, Salhi and Ghutra) were chosen within the sample villages on the basis of their geographical location (varying difficulty in access): Salhi was in the plains, Ghutra was spread over undulating topography and Bala was remote.

The data that this paper presents were collected as part of the larger study. Themes related to the overall study were discussed during the same survey and interviews and it is not possible to differentiate the data collection and methods for the data presented in this paper. The household survey was quantitative and included anthropometry and details on access to government health services, including for reproductive health services. Check lists were prepared for the individual interviews and group discussions (GD) to elicit experiences and perceptions of Baiga women and men on the restriction of access to contraceptive services, with specific probes. Individual case studies related to access to contraceptive services were identified during data collection and further in-depth interviews were undertaken with the women identified. For the qualitative study, individual interviews with 19 Baigas and non Baigas and 10 health service providers were undertaken; and 18 GDs were held with the Baiga community, including community health workers (6 with men, 10 with women and 2 mixed).

The household survey was undertaken by surveyors who were recruited for the study and supervised by DJ and CY. The in-depth interviews were conducted by SN, DJ and CY in Hindi, with CY translating in the local dialect for the respondent if needed. The community members were interviewed in their villages, at their houses or at the homes of their neighbours. Health providers were interviewed at health facilities or in their houses as per their availability. Most of the interviews were recorded and transcribed. A few could not be recorded for reasons related to consent and logistics (for instance, electricity not available for charging). However, detailed notes were kept of the interviews.

Quantitative analysis was done in SPSS, including gender disaggregated analysis. For qualitative data, thematic analysis was undertaken. Data was analysed through description, classification and connection. Data was categorised into themes and attempts were made to find relationships between themes and the context. The themes for analysis covered access to health services, sociocultural, political and economic determinants of health, experiences, perceptions, attitudes and practices. Data triangulation was undertaken. Information from the quantitative study was triangulated with the qualitative study and secondary data. For instance, data from the household survey showed women going outside the state for sterilisations and this was corroborated in qualitative interviews and secondary data, e.g. media reports. Rigour was maintained by presenting the findings to the Advisory Group, peer-researchers and people working in the area.

Ethical clearance was given by the Institutional Ethics Committee of the Public Health Resource Society. Participant information sheets and informed consent forms were prepared in the local language. The information sheets were distributed, with verbal consent, including for photographs. Pamphlets in Hindi on provisions under critical social welfare programmes and slips for height and weight were given to the respondents. Names of all persons and villages have been changed in order to maintain confidentiality. It was also decided that on encountering any of the participants in distress, efforts would be made to extend necessary support for them to access appropriate services. Help was extended during the study, for example, in two of the study villages where there were cases where subsidised grain, given by government to poor families, was withheld as a penalty for not building toilets. Complaints were made to the government food department, resulting in families receiving their entitlement.

Findings and discussion

Household characteristics

The larger study substantially explored the social economic situation of Baigas, however, only part of the data is presented here, to highlight the extent of impoverishment. Of the 289 Baiga families surveyed, 65% reported that non-agricultural labour was their main source of income in the year prior to the survey. Most (92%) families lived in mud huts. Nearly all (98%) families used wood for cooking and only 1% used clean fuel (liquid petroleum gas). Half (49%) of the households had electricity. This included solar lamps, without which the proportion would have been less. When compared with the Kabeerdhaam district average, the Baigas are found to be worse off. Overall district data show that 95.2% of households had electricity and 10.3% used clean fuel for cooking.[9]

Nutritional status of Baiga children, women and men

Anthropometry that was undertaken as part of the household survey revealed the extremely high malnutrition levels among Baiga children and both Baiga women and men. Among Baiga children under five years of age, 55.5% were underweight, 55.5% stunted and 15.6% wasted (Table 1). The proportions of underweight and stunting among the study sample were nearly one and a half times more than the Chhattisgarh state average as per NFHS 4[9] and much higher than the NFHS 4 district average.[10] They were nearly the same as that of Chhattisgarh Scheduled Tribes in NFHS 3 from a decade before.[11]

Among Baigas aged 15–49 years, 56% of men and women had a BMI below 18.5. The proportion of malnourished Baiga men and women was double than that of the NFHS 4 state average (Table 1).[9] The pattern was similar when compared with the NFHS 4 district average.[10] The proportion of thin Baiga women and men is higher than the proportion for Chhattisgarh Scheduled Tribes a decade back.[11]

The data show the high malnutrition levels among children that continue into adulthood. The large difference between the malnutrition levels of Baigas and other Scheduled Tribe populations in the state and district, reflects high

Table 1. Nutritional status of Baiga children under five years and of Baigas aged 15–49 years

Nutritional status	Baiga study (2017)	Chhattisgarh NFHS 4 (2015–2016)	Kabeerdham (NFHS 4 2015–2016)	Chhattisgarh NFHS 3 Tribal (2005–2006)
% of children (under 5 years) underweight (less than −2 SD) ($N = 110$)	55.5%	37.70% ($p < .001$)**	38%	53%
% of children (under 5 years) stunted (less than −2 SD)($N = 110$)	55.5%	37.60% ($p < .001$)**	40%	52%
% of children (under 5 years) wasted (less than −2 SD)($N = 109$)*	15.6%	23.10% ($p = .063$)	18%	26.5%
% of Women (15–49 years) with BMI below 18.5 ($N = 221$)	56%	27% ($p < .001$)**	33%	50%
% of Men (15–49 years) with BMI below 18.5 ($N = 205$)	56%	25% ($p < .001$)**	20%	41.5%

Source: PHRN, 2017[8]
* Missing values.
** Difference between Baigas and Chhattisgarh NFHS 4 is statistically significant.

household poverty, exacerbated by the fact that they are forced to have large families. It also highlights the health status of women who bear the burden of having many children.

Reproductive health and child mortality

The age distribution of the 1442 family members shows that 50% were in the reproductive age group of 15–49 years, with similar proportions for men and women. The average number of pregnancies among women of reproductive age interviewed ($n = 248$), was 4.41 (± 2.61) while the average number of living children was 3.12 (± 1.77). The number of pregnancies among women who were interviewed was high, with 61.3% (152) having had four or more pregnancies. On comparing the number of pregnancies with the number of currently living children for each woman, it was found that 61.3% (152) of women had experienced child or pregnancy loss at least once. The data also shows that 7.7% (19) of the women had experienced a miscarriage and 3.2% (8) a still birth (Table 2).

This data shows that the number of pregnancies is very high. Studies globally have shown that high fertility poses a high risk of maternal mortality[12] and newborn and child survival is positively associated with accelerated fertility transition, i.e. with the shift from high to low fertility.[13].

The issue of high mortality among Baigas was also discussed by the Baigas themselves, the respondents explaining:

"Marat rehete hain. Nahawan pe nahawan hote rehete [We keep on dying. Mourning ceremony after mourning ceremony keeps taking place]." (Baiga man, Salhi mixed GD)

"Khatam ho jaat hai [keep on dying]." (Baiga woman, Salhi mixed GD)

"Mana kar dis sarkaar. Yahan inka jan sankhya kam hai [government has banned (sterilisation), saying that here the Baiga population is low]." (Baiga man, Salhi mixed GD)

Nearly 80 years ago, Elwin[14] wrote about the extent of child loss that Baiga families face due to high mortality among infants and children. As is evident from the data, this situation still exists. It raises a big question regarding the government's actions in trying to increase the Baiga population by making them have more children, rather than improving living conditions and reducing mortality.

Table 2. Characteristics of women in reproductive age group

Characteristics	Total no. of respondents (*N*)	Value
Mean age of women, years (±SD)	248	37.49 (±13.69)
Mean age at marriage, years (±SD)	247*	17.48 (±2.95)
Mean age at first pregnancy, years (±SD)	233*	19.24 (±2.63)
Mean number of pregnancies (±SD)	248	4.41 (±2.61)
Mean number of living children (±SD)	248	3.12 (±1.77)
Number of women with four or more than four pregnancies (%)	248	152 (61.3%)
Number of women with lesser number of living children than the number of pregnancies (%)	248	152 (61.3%)
Number of women who ever had miscarriage	248	19 (7.7%)
Number of women who ever had a still birth	248	8 (3.2%)

Source: PHRN, 2017.
*Missing value.

Access of the Baiga community to contraceptive services

The study reveals enormous challenges faced by Baiga families in accessing permanent and temporary contraceptive services. These challenges relate not only to the availability of these services in the health system, but also to healthcare denials, with Baiga identity being at the core.

Of the women of reproductive age who were interviewed, 48.8% had used contraceptive methods (Table 3). Of those who had used

Table 3. Utilisation of contraceptive services

Dimension	*n*	%
Women who have ever used contraceptives (*N* = 248)	121	49.0
Respondent or husband who have undergone sterilisation (*N* = 121)	99	81.8
Women who had ever demanded temporary methods from health workers (*N* = 242)	14	5.8
If yes, then whether they received (*N* = 20)	13	65.0
Where was sterilisation done (*N* = 99)		
Sterilisation camp organised by the government	69	69.7
Government facilities	26	26.3
Private hospital	1	1.0
Others	3	3.0
Total	99	100
Those who had to go outside state for sterilisation (*N* = 99)	67	67.7
If given a choice, those who would like to go for permanent contraception (*N* = 140, 2 missing)	55	39.3

contraceptives, 82% (themselves or their spouse) had undergone sterilisation. The other methods used were negligible, amongst which *jadibooti* [traditional herbal medicine] was the most popular method. Most women had undergone sterilisation in camps (69.7%) organised by government and 26.3% had gone to other government facilities, while one person went to a private facility. More than two thirds (67.7%) had to go out of the state to get the sterilisation done. Of those who had not yet got permanent contraception, 39.3% said that they wanted it. These findings were reflected in the qualitative findings presented below.

Tattoo, the marker of identity as a Baiga, used to deny contraceptive services

The tattoo that Baiga women traditionally have on their forehead and long hair for men are the identifying markers as Baigas. Interviews with Baiga women revealed that the forehead tattoo is used to identify a woman as a Baiga and deny her contraceptive services. One woman told us "*Yahan godna wale nahi karin* [here they don't do of those who have tattoo]" (Baiga woman, Salhi mixed GD). The case of Raniya Baiga is presented here in order to highlight this aspect.

Case 1: Raniya Baiga

Raniya Baiga of Gangpur is a lean, tall lady with the distinctive Baiga tattoo clearly visible on her forehead. She has had five pregnancies and three of her children are alive. After her fifth pregnancy, she decided to undergo sterilisation. She went to the government Community Health Center (CHC) in Pandariya block at the beginning of 2014 and pleaded with the nurse to allow her to undergo sterilisation. She told the nurse: "*Prasav mein bahut taqleef khaatey, kara dena* [I suffer a lot during delivery, please do it]". But the staff at the hospital sent her back. Raniya Baiga tells us the nurse "*Bhaga dis. Kahe nahi hoye Baigaman ke* [told me to get lost and said Baigas cannot get sterilisation done]".

But Raniya Baiga was determined to get the service and kept going back to the CHC every week requesting them to do the sterilisation as she did not want to get pregnant again. They sent her back saying that she was too weak and anaemic. In one of the visits, the doctor gave her some medicines to build her strength. Subsequently she obtained help from the Auxiliary Nurse and Midwife (ANM) of her sub-centre who was aware of her suffering during delivery and was sympathetic. She was then

Raniya Baiga, showing her facial tattoo

able to get sterilisation done. We asked her why she thought she had been refused. She said:

"Kaa pata didi? Baigaman ke parivaar zyada nahi chahe to band kare. Bachcha paida karte hain lekin khet khaar bhi nahi hai to kaise palenge. Patta bhi nahi hai [I don't know why they refuse sterilisation. If Baiga people don't want more children, they should be able to stop. We give birth to children but we don't have any land so how will we bring them up? We don't even have any land deeds]."

Raniya Baiga's sterilisation took place in 2014, just weeks before thirteen women died in Bilapsur district after having undergone sterilisation under unhygienic conditions in a government "camp".[15,16] In the aftermath of the tragedy, the government stopped providing regular contraceptive services all over the state.[15] Government data shows that in the year after the deaths, sterilisation numbers dropped to less than half those from the previous year.[17] One of the women who died was a Baiga and opposition political parties and commentators were quick to point out the supposed "ban" on sterilisation for this group of people. While the services were stopped for many months for everyone all over the state, the events led to a more rigidly enforced "ban" for PVTGs.[16] If Raniya Baiga had been a few weeks late, then she would not have received the services until much later, when the government again reinstated some services.

Within the state, Baiga women with the forehead tattoo are denied permanent contraceptive services. For those Baiga women without the tattoo, the services are available, but only if they deny their identity as a Baiga. Devkuwar Baiga's case illustrates this.

Case 2: Devkuwar Baiga

Devkuwar Baiga of Salhi does not have a tattoo on her forehead. Her family had migrated from the hills to the plains two generations ago. Women of the family had stopped getting tattoos as, according to her, they did not want to look different from the non-Baigas. When she decided she did not want any more children, she went to Pandariya CHC and wrote her caste as *Gond* [a non-PVTG indigenous community], and not Baiga, and got it done. She tells us, "*Haman Gond likha dis* [I wrote my caste as Gond]".

Families forced to go out of state to receive permanent contraceptive services

For Baiga women who have a tattoo, one of the only options to access sterilisation services is usually to get it done in the neighbouring state Madhya Pradesh (MP). Even though the same order exists in MP, they seem to be lenient when it comes to Baigas from a different state. Women told us that during the "sterilisation season", that extends from after the rainy season and throughout the winter, health workers come to the village from MP and take women for sterilisation in vehicles (Bala, women's GD). Sometimes women get together and hire a jeep to go to the health facility in MP. Devri Baiga is one such person who underwent sterilisation in MP.

Case 3: Devri Baiga

Devri Baiga had seven pregnancies, of which five children are alive. She knew that she could not get a sterilisation done as she has a *godna* (tattoo) on her forehead. Three years ago she went to MP and got a sterilisation done.

Going out of state to access these services does not come without its dangers. Soon after the Bilaspur deaths mentioned above, the media reported the case of 27-year-old Sukhiyarin Baiga who died days after undergoing sterilisation at a Primary Health Centre in MP[15]. Her sutures had opened and became infected. She did not receive post-operative follow-up as she had been operated upon in a different state.

Gaps in availability of spacing methods

The 1979 order allows for spacing methods to be provided to PVTGs. However, larger health system issues in supplies and training and acceptability of methods has meant that the Baigas' access to temporary contraceptive methods too is restricted.

Health staff and community health workers in the area spoke during interviews about their experiences and challenges with respect to provision of temporary contraceptive services. The health staff and workers said that they were free to provide spacing methods to the Baigas. ANMs said that oral pills, condoms, IUCD are "allowed" for Baigas with no restriction (ANM Chanwari Interview; ANM Bhelri Interview). They did not have "targets" for sterilisation in their area because of the Baigas, whereas other ANMs had "targets". One ANM said she was glad that she could never get into trouble for not fulfilling these "targets" (ANM Chanwari Interview).

At Kui Primary Health Centre (PHC), which covers Baiga villages, IUCDs are inserted and the

PHC staff are trained. Post-Partum IUCDs are also provided (ANM & SN Interview Kui PHC). However, another ANM said that people in her area did not use IUCDs, mainly because "*Copper T se sambandhit darr hai logon mey* [people are scared of Copper T]." (ANM Chanwari Interview)

Health workers at the PHC opined that ANMs in the sub-centre are unable to provide IUCD services despite their training because they do not have the essential supplies required. Irregular and inadequate supplies of oral contraceptives, IUCDs and condoms were cited (ANM & SN Interview, Kui PHC) and reiterated by the other ANMs (ANM Chanwari Interview; ANM Bhelri Interview). Inadequate training of outreach health staff also emerged as an issue. For instance, the Chanwari ANM said that she had not been trained to insert the Copper T device.

The denial of permanent contraceptive services combined with the unavailability of temporary contraceptive methods, highlights both the gaps in the public health system, and in the government family planning programme.[18]

Gendered nature of family planning and implications for Baiga women

The experience of the Baigas in accessing contraceptive services needs to be seen in the context of the gendered nature of family planning that puts the onus of contraception on women.[19] Contraceptive methods are targeted mainly at women and, in the absence of any alternatives being effectively promoted for men, women and sterilisation remain at the core of family planning policies. This is the case not only in India but also elsewhere in the Asia Pacific region.[18] The restriction on access to contraceptives affects PVTG women more, as they now have to deal with multiple vulnerabilities. Living in a situation of socio-economic and political marginalisation, they have to bear the burden of numerous pregnancies and childbirth, on one hand, while struggling to access the contraceptive services that the government has chosen to deny them, and the contraceptives that they could have used are not made available. PVTG women are also subject to adverse reproductive outcomes that further affect their health and wellbeing. The case of Sukhni Baiga is presented to illustrate further the multiple challenges and burdens faced.

Case 4: Sukhni Baiga

Sukhni Baiga is around 45 years old and lives in Bala village. Like most Baiga women she has a prominent, though fading tattoo on her forehead that signifies her identity as a woman belonging to the Baiga community. Her oldest child is 28 years old. Her first attempt at sterilisation was after her sixth pregnancy. Two children had died by then (Table 4).

In the beginning she went to Kui Primary Health Centre (PHC), but she was sent back. Over the next two years she went there twice, whenever she heard of a "camp" being organised. She pleaded with them to do the operation. She asked them: "*ka karke posbo?* [how will I fend for so many kids?]". But they sent her away both times. She told us: "*matha la dekh nurse nikaal dis* [the nurse kicked me out when she saw my forehead tattoo]". After being turned away from the PHC three times in three years, Sukhni Baiga went to the Community Health Centre (CHC) in Pandariya, thinking that she would be able to get the services at a higher level facility. However, there too, they refused to operate on her and sent her back

Table 4. Pregnancy outcomes of Sukhni Baiga and the timeline of her attempts to access sterilisation services

Number of pregnancy	Sex of child	Current age and status of child
1	Male	28 years
2	Female	Died
3	Female	Died
4	Male	26 years
5	Female	25 years
6	Male	18 years
First attempt to get sterilisation		
7	Male	Died
8	Male	16 years
9	Male	Died
10	Female	13 years
11	–	Miscarriage
12	–	Miscarriage
Hysterectomy		

home. This happened twice. During this period, she became pregnant six more times. Of these pregnancies, two children died and the last two pregnancies ended in miscarriages. After two miscarriages she fell ill for many months. When the situation worsened, she went to Kabeerdhaam District Hospital where she was advised to have a hysterectomy. Before they could operate, she had to get a written "permission" from the Sub Divisional Magistrate, after which she was able to get the hysterectomy done.

Poverty, culture, identity and role of government

Though the sterilisation "ban" has clear implications for the number of children in a Baiga family, the government does not seem to have addressed the issue of child survival. It is important to place government policies and action within the larger socio-economic and political context impacting indigenous communities. The Baigas in the study have themselves talked about their high mortality rates and declining population; however, they also spoke of their distress with respect to the strain on their land and economic resources due to large families. In Bala village, women got very agitated when asked about what they thought of the restriction in Chhattisgarh. One Baiga woman said,

"Sarkaar boli Baiga ka jan sankhya badhaane ke liye…..Ab barha de jan sankhya, ab karta khawai? [Government says that this "ban" is for Baigas to increase their population. Now that we have increased our population, how do we feed everyone?]." (GD Women, Bala)

In Salhi, respondents said that they wanted fewer children as they do not have land, and earn mostly by wage labour, so they found it difficult to sustain big families (Salhi Baiga mixed GD). Similarly, the men in Bala were concerned about how, with large families, they would distribute land to their children.

The larger study linked to this paper found that lack of ownership of quality land, forest legislation restricting access to forests, loss of traditional forest-based livelihoods and displacement without adequate compensation or rehabilitation have kept the Baigas in a cycle of poverty.[2,8] The International Conference on Population and Development (ICPD) Programme of Action recognises that the higher morbidity and mortality among indigenous people and their declining population is due to loss of their land and resources, ecological destruction and displacement, among other factors.[19] As argued by the Xaxa Committee,[2] in passing and enforcing the 1979 order, the government avoided recognising and acting on the actual determinants of the declining population of PVTGs manifested in their high malnutrition and mortality rates. Furthermore, data and experiences narrated in the study also point to the fact that enforcement of this order may in fact have pushed these families further into poverty.

The situation of extreme poverty and high malnutrition, along with large families, is made worse by the lack of an adequate health service delivery system in these areas.[8] Denial of permanent contraceptive services is linked to their identities as Baigas; women who do not have a forehead tattoo are able to access the services but only if they deny their identity as a Baiga. Being forced to give up one's cultural identity under the threat of denial of services has implications for health and well-being, as culture is a significant determinant of indigenous health.[20,21] As the larger study[8] showed, not only in health, but in most aspects of the lives of the Baigas, the state and its institutions, including schools and the health system, play a big role in forcing people to give up their traditions and cultural identity: denying them services, humiliating and branding them as "primitive" and "wild" if they did not. For instance, Baiga men, who traditionally wear their hair long, narrated how boys are humiliated by being forced to cut off their hair once they enter school. Within the health system too, such instances may be seen. Baiga women traditionally deliver in a squatting position, which is now considered as an acceptable position for normal delivery by the World Health Organization,[22] but neither government nor the private health sector allow for this in their facilities.[8]

Efforts made by the Baiga community to revoke the order

Discussions on the issue of restriction of sterilisation with Baiga men revealed that many had tried to get the restriction revoked. They demanded that they should be free to undergo the operation.

"Marhi te la operation karna zaroori [it is better to get the operation rather than die/get into such big trouble]."

"Apna mann ke hona chaahi [we should be able to do what we want]." (GD Men, Bala)

In Salhi they recalled that Baiga men and women of the area had gone together in a tractor to Kui in 2003–2004 to meet the Collector and the then Chief Minister (CM), who had come there for a visit (Salhi Baiga mixed GD). They told the officials that they wanted to get contraception services as they did not want such large families. However, the officials and CM told them that it was not possible for them to remove the order.

"Lekin mana kar dis. Bole jan sankhya kam ho raha hai. Karahi to Doctor phas jayega. Jamanat nahi hoga [They refused. Said that our population is decreasing. If we get it done then the operating doctor will get into trouble. The doctor will not get bail]." (Salhi Baiga mixed GD)

Though the Baigas and other PVTGs in Chhattisgarh have been demanding for many years the right to unrestricted access to contraceptive services and the freedom to choose their family size, the government has not acted on their demands.[4] Often their voice gets lost within the larger *Adivasi* identity. In 2017, ten Baiga families, along with Jan Swasthya Sahyog, a rural health NGO and Jan Swasthya Abhiyan ('People's Health Movement', comprising a network of organisations) have filed a Public Interest Litigation (PIL) in Chhattisgarh High Court challenging the 1979 order on the grounds that it violates the constitutional rights to life, dignity and of equality before law.[23,24] The petition has also noted that in 2012, Baigas from about 60 villages of Bodla Block, Kabeerdham District, submitted an application to government asking them to repeal the order.[23]

The petition provides details about eight Baiga families who are seeking relief from the Court. All these families had approached the hospital run by Jan Swasthya Sahyog to undergo sterilisation. These families had 3–10 children, the women were weak, and the families were poor and did not want to have any more children.[23] The wife of one of the petitioners had undergone abortion at three months of pregnancy through self-medication and was facing complications at the time of filing of the petition. Applications were submitted by the families to the government officials at the block, district and state levels to be "allowed" to undergo this operation either at a government hospital or at Jan Swasthya Sahyog. At all levels, government officials refused to provide "permission" to them for sterilisation. This refusal seems to have been a direct outcome of the Bilaspur sterilisation deaths. A few months after the PIL was submitted, the government of Chhattisgarh issued a new order on sterilisation of PVTGs.[25]. Although they claimed that the order had responded adequately to the concerns of the petitioners, in actuality, it still has the provision of asking for permission.[26] The case is still in progress in the court.

Women, human rights and the state

The above narrative needs to be placed within the wider context of social norms, gender politics, and economic and political processes from the local to global level.[27] It also needs to be seen in the context of how indigenous communities, *Adivasis*, have been treated by colonialists and the state.[28] The order seems to stem from the Indian Government's policy of "paternalism" towards *Adivasis*, a legacy of colonial rule.[28] Paternalistic policies deny the right to self-determination and have been identified as a political determinant of indigenous health, with negative impact on the health of indigenous women.[29]

Coercive family planning policies and state control over women's bodies are not new to India.[6,30,31] In 1975, soon after a National Emergency was declared, there was a push for family planning by the central and state governments, resulting in coercive measures, including forced sterilisations.[6] The 1979 order is grounded in these coercive family planning policies that continue to inform the state's family planning programme, even today.[30] Women and gender relations have always been at the centre of these policies, constituting the "politics of reproduction".[27] The order emerged from this period, with the aim of "protecting" the PVTGs from the excesses of the Emergency and to stall their dwindling population. However, as we find above, it is mainly the Baiga women and their children who have borne the brunt of negative consequences of this policy.

Health and, more specifically, sexual and reproductive health and rights, relate to economic and social conditions and they need to be seen within the human rights framework that is linked both to gender justice and to economic justice.[32] In this case, we find that even though there have been protests against this policy by the people who have been affected by it, the policy has not changed over four decades. While this could be due to political marginalisation of the PVTGs, it could also suggest that there is a tacit agreement among government and the political class that the rights of a PVTG woman are subordinate to

the survival of the community. It is critical that this issue is seen within the human rights framework.[32]

The 1979 order is a violation of existing international conventions on the rights of indigenous peoples,[33] women's rights,[34] sexual and reproductive rights[19] and the right to health.[35] The ICPD Programme of Action relating to the right of the indigenous population states that "Governments and other important institutions in society should … address their specific needs, including needs for primary health care and reproductive health services. All human rights violations and discrimination, especially all forms of coercion, must be eliminated".[19]

In India there have been recent orders by the Supreme Court reiterating that a woman has a sacrosanct right to her bodily integrity[36] and upholding the right to privacy as a fundamental right which has consequences for women's right to bodily autonomy,[37] which are positive developments and could show the way forward.

However, while the struggles of Baigas and other PVTGs to reclaim their reproductive rights continue, new challenges have emerged in the reproductive rights arena in the form of neoliberal economic policies, increasing privatisation of healthcare, overall under-resourcing of the public health system, and continuing inequity in access to sexual and reproductive rights and services.[38,39]

Conclusion

The study shows the extent of denial and harassment faced by the Baigas, due to the 1979 order, in trying to access permanent contraceptive services, and its implications for the health and well-being of women, their children and families. The state identifies Baiga women from their forehead tattoo and denies them the services. They are forced to travel out of state at great risk and cost to themselves, without any scope for post-operative follow-up. The population of PVTGs in Chhattisgarh is now increasing, but the implications of the "ban" for the health of women and children are quite startling. Nearly two thirds of Baiga women of reproductive age experienced four or more pregnancies and a similar proportion had experienced a miscarriage or the loss of a child at least once. Even though the study could not directly assess the effect of the sterilisation restriction on mortality, the data on the gap between the number of pregnancies and living children illustrate some connection. Both forced sterilisation and denying access to sterilisation are different reflections of the same coercive "population policies" that have denied individuals, especially women, the right to their autonomy and bodily integrity. It is pertinent to note that while this study was among the Baiga PVTG, the situation among other PVTGs in the country may not be very different, and in some cases, it may be worse.

PVTGs have faced the brunt of the government's "development" policies that have led to their further marginalisation. They have also been neglected in the provision of public health and other public services. The order from 40 years ago, that was once thought to "protect" the PVTGs, has led to violations of the human rights and reproductive rights of PVTGs, especially of PVTG women. By restricting their access to permanent contraceptive methods, the state seems to absolve itself of responsibilities to create conditions for survival of these groups, putting the onus for survival onto PVTG families, and mainly onto PVTG women, while violating their right to self-determination and bodily autonomy.

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Résumé

Les Baiga sont un Groupe tribal particulièrement vulnérable, classés comme les plus fragiles parmi les communautés autochtones en Inde. À titre de stratégie pour stabiliser la baisse de leur population, due principalement à leur forte mortalité, en 1979, le Gouvernement a restreint leur accès aux méthodes contraceptives permanentes et cette mesure est appliquée comme une « interdiction ». Utilisant une conception d'étude de cas avec des méthodes mixtes, cette analyse vise à comprendre les expériences et les conceptions des Baiga à Chhattisgarh dans l'accès aux services contraceptifs. Les données ont été recueillies par une enquête auprès des ménages ($n = 289$) dans 13 habitations; des entretiens individuels et des discussions de groupe avec des hommes et des femmes baiga ainsi que des prestataires de services de santé; et l'anthropométrie. Les Baiga souffrent d'un mauvais statut nutritionnel et de la pauvreté, à un niveau hors de proportion avec les moyennes du district et de l'État. Parmi les femmes interrogées, 61,3% avaient eu quatre grossesses ou plus et 61,3% avaient perdu un enfant au moins une fois pendant une grossesse ou ultérieurement. Le tatouage frontal des femmes baiga, une marque de leur identité, est utilisé pour leur refuser les services contraceptifs. Elles doivent se rendre dans l'État voisin pour obtenir des services ou mentir sur leur identité. Elles sont habituellement dans l'incapacité d'avoir accès même aux méthodes temporaires. Cette politique coercitive a encore

Resumen

Baiga es un Grupo Tribal Particularmente Vulnerable (PVTG, por sus siglas en inglés), categorizado como el más vulnerable de las comunidades indígenas en India. Como estrategia para detener la diminución de su población, debido principalmente a una alta tasa de mortalidad, en 1979 el gobierno restringió su acceso a métodos anticonceptivos permanentes, impuesto como "prohibición". Utilizando el diseño de estudio de casos con métodos combinados, este estudio procura entender las experiencias y percepciones de baigas en Chhattisgarh para acceder a los servicios de anticoncepción. Se recolectaron datos por medio de: una encuesta domiciliaria ($n = 289$) en 13 asentamientos; entrevistas individuales y discusiones en grupo con hombres y mujeres baiga y prestadores de servicios de salud; y antropometría. La población baiga sufre desnutrición y pobreza, fuera de proporción con los promedios distritales y estatales. De las mujeres entrevistadas, 61.3% han tenido cuatro o más embarazos y 61.3% han sufrido la pérdida de un hijo como mínimo una vez durante el embarazo o posteriormente. Las mujeres baiga llevan un tatuaje en la frente como marca de su identidad, el cual es utilizado para negarles servicios de anticoncepción. Las mujeres baiga tienen que viajar al estado vecino para obtener servicios, o mentir acerca de su identidad. Por lo general, no pueden obtener ni siquiera métodos provisionales. Esta política coercitiva ha causado su continuo empobrecimiento.

appauvri les Baiga qui réclament le droit à des services contraceptifs. Leur refuser ces services est une violation des droits de l'homme, des droits reproductifs et du droit à l'autodétermination et à l'autonomie corporelle.

Las baigas han estado exigiendo su derecho a servicios de anticoncepción. La negación de esos servicios es una violación de los derechos reproductivos y humanos, y del derecho a la autodeterminación y la autonomía corporal".