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ROLE OF NGOs IN COMBATING UNDERNUTRITION AMONGST SAHARIYA TRIBE : A CASE STUDY OF RAJASTHAN

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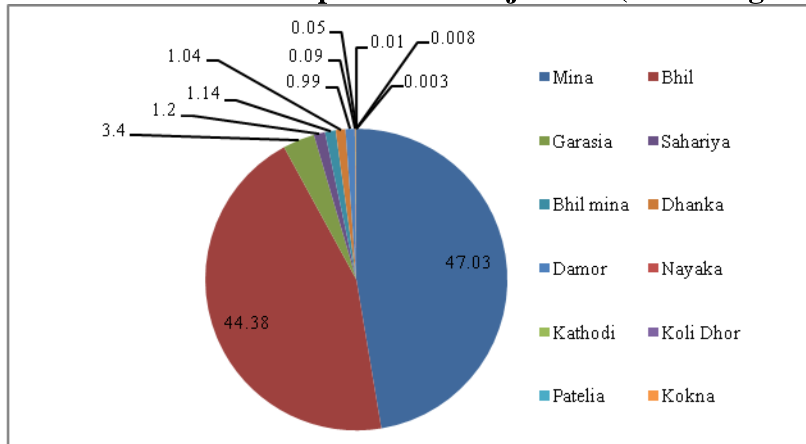
Abstract
*Rajasthan shares 0.76 per cent of India's and 13.5 per cent of State's total tribal population. Out of the twelve notified Schedule Tribes,Sahariya is the only Particularly Vulnerable Tribal Groups (*PVTGs*) in Rajasthan. Baran is highly dominated Sahariya tribe region of Rajasthan comprising of 23 per cent of tribal population and is the worst affected district in terms of hunger death.The present paper is an attempt to locate the contribution of NGOs in the improvement of nutritional and health status of Sahariya women and children in Baran district. The poor health and nutritional indicators in different studies shows that Sahariya women and children are draining their health. Even though NGOs have been intervening since last three decades, however the situation has not improved much. It was noticed that people are becoming more dependent instead of becoming self-reliant. Hence, strategic and region-specific need-based intervention at the local level is required.*

Keywords: Particularly Vulnerable Tribal Groups (*PVTGs*), Rajasthan, Nutritional health.

Introduction

Rajasthan shares 0.76 per cent of India's and 13.5per cent of State's total tribal population. The highest concentration of tribes are located in South and South-Eastern parts of Rajasthan, Banswara (76.4 per cent), Dungarpur (70.8 per cent), Pratapgarh (63.4 per cent), Udaipur (49.7 per cent), Sirohi (28.2 per cent), Dausa (26.5per cent), Baran (22.6 per cent), Karauli (22.3per cent), Sawai Madhopur (21.4 per cent), and Bundi (20.6per cent), respectively*(Manupriya&Ahmed, 2019).*There are twelve notified Schedule Tribes in Rajasthan consisting of 51.33 per centof males and 48.66 per cent of females. The highest population is of Mina Tribe (47.03per cent) and lowest is of Kokna Tribe (1.04 per cent) as highlighted in Fig.1.Here, majority of the Schedules Tribes inhabits in rural areas(16.9 per cent) as compared to urban (3.2per cent) *(Government of India, 2013).*

Fig.1: Schedule Tribe Composition in Rajasthan (Percentage Share)



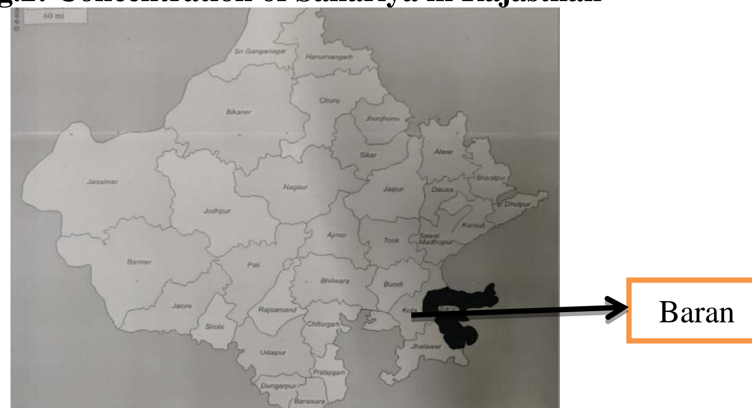
Source: *Census data, 2011*

Out of these twelve notified Schedule Tribes,Sahariya is the only Particularly Vulnerable Tribal Groups (*PVTGs*) in Rajasthan.PVTGs are characterised by pre-agriculture level of technology, stagnant or declining population, extremely low literacy and subsistence level of economy*(Government of India,2013).*The Saharia also known as 'Sehria', 'Seharia' and 'Sahariya' (Vyas, 2016) in various texts has received the said name probably by Muslim rulers of Shahabad, presently a block in Baran, who found them residing in the forest (jungle) because 'Sahr' means 'jungle' *(Glimpses of Tribal Rajasthan, 2006).*

In Rajasthan, the Sahariyas are mostly concentrated in south-eastern parts including Baran, Sawai Madhopur, Kota, and Durgapur districts. They are constituting 1.20 per cent (1, 11,377) of total tribal population in the State comprising of 50.8per cent of males and 49.1per cent of females(*Census 2011).*But their highest concentration is in Baran district. Further in Baran, two blocks namely Kishanganj (60,316) & Shahbad (54,813) have their highest concentration (*Census 2011).*

Baran is highly dominated Sahariya tribe region of Rajasthan (Fig.2) comprising of 23 percent of tribal population (*Census 2011).* The study is based on Sahariya tribe as it's the only Particularly Vulnerable Tribal Group of Rajasthan. Here, the emphasis is on Sahariya women and Sahariya children as they are more susceptible to vulnerability. Besides, the nutritional health conditions of mother and child are directly interlinked.

Fig.2: Concentration of Sahariya in Rajasthan



Source: *Field Review*

The Sahariyas living in Baran came to national attention in 2002 because of several hunger deaths in the community followed by deaths in 2004 and 2009. Deaths of three Sahariya children below the age of five in October 2011 were also reported due to malnutrition (Bhatia, 2012).It also attracts the attention from all sources e.g. media, NGOs, UNICEF and Government (*Acute Malnutrition: Situational Analysis in the States of Rajasthan and Madhya Pradesh, 2010).*

At the end of 2009, Action Centre La Faim i.e. Action against hunger(ACF),an international NGO conducted a desktop review to understand global under-nutrition context in India. For this, Rajasthan was also selected for analysis between April to June' 2010. Here Baran, Udaipur, Rajsamand, Tonk and Bikaner districts were selected due to tribal domination and ill-famed for hunger deaths. It was found that children from Schedule Tribes had highest prevalence of Severe Acute Malnutrition (SAM) (8.4percent) compared to children from Schedule Castes (7.4percent) and Other Backward Classes (5.2percent), respectively. The analysis confirmed that within tribal communities, women and young children are the most vulnerable section for under-nutrition (Acute Malnutrition: Situational Analysis in

the States of Rajasthan and Madhya Pradesh, 2010). Hence, pressing need is being urged to diagnose the under-nutrition status of Sahariya women and children. The present study is therefore an attempt to locate the contribution of NGOs in the improvement of nutritional and health status of Sahariya women and children in Baran district.

Objectives

- To study the nutritional health of women & children of Sahariya tribes in Baran district of Rajasthan.
- To analyse the role of NGOs in up liftment of nutritional health of Sahariya women and children.
- To suggest measures for improving the functioning of NGOs working in the field of nutritional health.

Methodology

The present study is based on review of secondary data. It is an attempt to analyse the poor nutritional status of women & children of Sahariya tribes in their highly dominated areas of Rajasthan. Also, an attempt has been made to analyse the role of NGOs in scaling up the poor nutritional status of this tribe. Through this analysis, a clear picture of their interventions can come up along with their success and failure challenges. It will also providean insight in developing the scope of possible interventions. The different sources of secondary data collection are reports of Government and NGOs,books,articles, magazines, newspapers, Journals, Census data 2011,etc.

Nutritional health status of women & children of Sahariya Tribes

In a study conducted at four villages of Kishanganj and Shahbad block of Baran district reflects that the prevalence of underweight and stunting among pre-school Sahariya children and chronic energy deficiency among adults of Sahariya tribe was significantly higher compared to their rural counterparts. The Bitot spot is higher among pre-school children (8.3 percent) indicating Vitamin-A deficiency among the tribal population *(Rao, Kumar, Venkaiah and Brahmam, 2006).*At household level except the intake of cereals and millets, intake of all other foods like pulses and legumes, green leafy vegetables, roots & tubers, milk & milk products, fats & oils, sugar & jaggery was lower than the Recommended Dietary Intake (RDI) among Sahariya community of Rajasthan. Among the pre-school Sahariya children of age 1-5 year; 67.8percent were stunted, 13.4percent were wasted and 72percent were underweight, respectively (Diet and Nutrition Atlas of Tribes in India, 2016).A survey carried out by National Institute of Nutrition (NIN)during October and November, 2004 in Kishanganj and Shahabad block of Baran district, with 120 lactating Sahariya women between the age group of 18 to 45 yearsrevealed that 38.33percentof lactating women were underweight, whereas, 21.66 percent (0-6 months), 18.33percent (6-12 month), 25percent (0-6 months) and 35 percent (6-12 months) represent lack of luster and thinness*(Bairwa, Lakhawat, Bairwa, & Verma, 2017).*

Malpractices like delaying breast-feeding till third day of delivery(85 percent) because of the traditional practice was also reported in studies *(Rao, Kumar, Venkaiah and Brahmam 2006).*Poor transport facility connecting Sahariya hamlets, incomplete distribution of Antyodaya, ration cards to PVTGs households, non- functional anganwadis& poor access to schools implying children's exclusion from the mid- day meal scheme (Khera, 2008).The study of Business Standard (2015) highlight the ignorance of nutritional health and lack of support as most of their husbands are alcoholics and couldn't care. Almost every woman of this tribe is anaemic. Sahariya women don't reach hospital till their condition becomes serious.Itwas also found that until a couple of years ago, Sahariya worked as Halis

(a regional term for bonded labour) .As per NGOs; some are still working as Hali. Educational deprivation was well connected with poor economic condition in Sahariya community *(Kumar, 2016)*. Low socio-economic status &high percentage of illiteracy of the mothers were the main reason of failing of RDI among school going Sahariya children in Baran district. Among the Sahariya lactating women 7.50 per cent were smoking bidi and 47.50 percent were taking other chewing materials like zarda and gutka*(Bairwa, Lakhawat, Bairwa, & Verma, 2017).*

The poor health and nutritional indicators in different studies shows that Sahariya women and children are draining their health due to the above-mentioned reasons. Therefore, to scale up their poor nutritional indicators various NGOs have intervened in the past as well as various NGOs are working in present to reduce the number of cases of malnutrition in this region.

NGOs intervention and its effectiveness in Baran

NGOs have been intervening since more than last three decades in the past in Baran district.It was observed that gradually many reputed NGOs like Lok-Jumbish, Centre for Community Economics and Development Consultants Society (CECOEDECON) and Global Alliance for Improved Nutrition (GAIN) have also have also addressed the issue in the past. Presently new NGOs have taken up their roles. The below mentioned TableNo.1 depicts the key interventionof selected NGOs which have intervened specifically on nutritional healthin the past as well as intervening in the present in Baran district.

Table No.1: Selected NGOs And Their Key Intervention

Name of NGOs intervened in past		Key Intervention Areas
1	Sankalp	Health, Formal, informal and adult education services
2	Shiksha Karmi	
3	Lok-Jumbish	
4	Vanvasi Kalyan Parishad	
5	Swach	
6	Jeevan Lok NirmanSansthan	Food insecurity and severe malnutrition needs through short term and long term sustainable measures
7	Antara	Inclusion of interventions that makes an impact on the maternal and child health challenges.
8	PrayatanSansthan	Family based management of malnutrition
9	Global Alliance for Improved Nutrition (GAIN)	Community based Management of Acute Malnutrition and large scale food fortification
10	Centre for Community Economics and Development Consultants Society (CECOEDECON)	Integrated Community-based Management of Acute Malnutrition (CMAM)
Name of NGOs intervening in Present in Baran		
1	Action Centre La Faim i.e. Action against hunger international NGO (ACF)	Management of acute malnutrition
2	World Vision	Community-based management of acute malnutrition (CMAM) and Supplementary Feeding Programme (SFP)
3	Adani Foundation	Community-based approach to address malnutrition and anaemia

The main aim of the NGOs is to uplift the nutritional health of Sahariya Tribe.Sankalp grew out of the efforts of four college graduates from Kota who first in 1983 engaged in charitable work like free distribution of medicines among the Sahariya community. They formally registered themselves as a society in July, 1984 with its head office in Kota. The working areas were Kishanganj and Shahabad tehsil of Kota district. Initially, when started, it undertook purely educational activities. It undertook a project namely “Need based Development of Sahariyas” of Shahabad block district in Kota.The interventional efforts were related to economic activities and health.In the health intervention, carried out between between 11.08.1985 to 11.08.1987, the aim was to initiate a positive attitude amongst Sahariyas towards issues of health. The strategy adopted was selection of four villages youth from the tribal group, provide them continuous training for three years. Also health centre was run by them for the treatment of common ailments and making first aid available to the local group *(MulyankanAdhyanaPrativedan, 2001).*

Shiksha Karmi, Lok-Jumbish,Vanvasi Kalyan Parishad and Swach among which Swach has started “Maa-badi” centres in 19 villages of Shahbad and 11 villages of Kishanganj *(Vyas, 2016).*

Jeevan Lok NirmanSansthan through the project “Combat Malnutrition Centre” in 60 villages in Shahabad block of Baran district in Rajasthan state worked with special focus on 6000 Sahariya families who have even no funds to pay for fare and medicine expenses to access Malnutrition Treatment Centre (MTC) *(Jeevan Lok NirmanSansthan, n.d.).*

Antara scaled up programs for creating an enabling environment, strengthening village level platforms and self-help groups for demand side measures. It also builds capacity of Government frontline health workers, introduces technology for improved data management and improves quality of care for supply side measures *(Antara Foundation, n.d.).*

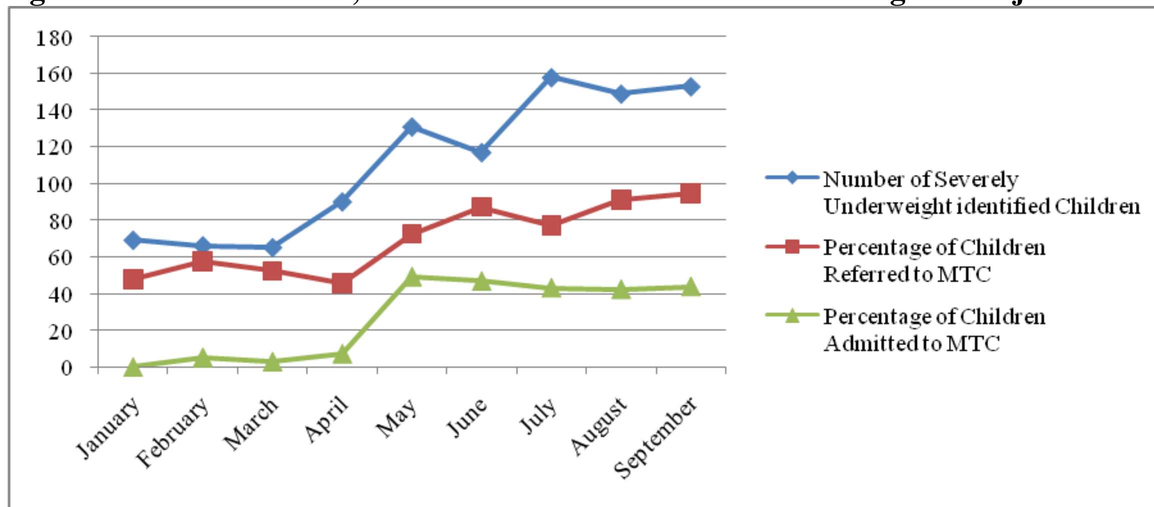
PrayatanSansthan worked in thirty villages of Shahabad block. They worked on issues like child marriage, social beliefs and practices and education*(PrayatanSansthan, n.d.).*

Global Alliance for Improved Nutrition (GAIN)aswiss-based foundation launched at the United Nations in 2002 to tackle the human suffering caused by malnutritionhas worked on Baran-Poshan projectin Kishanganj and Shahbad through POSHAN (Positive and Optimum Care of Children through a Social Household Approach for Nutrition)*(Gain, n.d.).*

Centre for Community Economics and Development Consultants Society (CECOEDECON)since May 2011 has worked on the project namely “Awareness raising and capacity building for Integrated Community-based Management of Acute Malnutrition (CMAM)” with the support of Action Contre La Faim (ACF) for three years in eleven villages of Kishanganj block. Severe Acute Malnutrition(SAM) children were detected from the project area by measuring MUAC (Mid Upper Arm Circumference) and weight and then referred to the closest Malnutrition Treatment Centre (MTC).Follow up during their treatment and also after their discharge were done at the MTC.The community workers regularly visit the homes of SAM children and counsel the mothers and other family members(Working of Malnutrition Treatment Centers, 2013).Awareness camps (one per village) on malnutrition, breastfeeding and complementary Feeding were conducted. A total of 72 children were detected as SAM while 23 as Moderate Acute Malnutrition (MAM) through this project.

A report submitted by Child Development Project Officer (CDPO), Shahabad to their concerned district office stated that in Shahabad block the total number of children registered under 0-5 years were 15735. out of which, 12509 were traced and 256 children were reported as severely underweight. After this, CECOEDECON in 2015 in partnership with ICICI foundation and Department of Women & Child Development, Government of Rajasthan started intervention for one year called “Strengthening Convergent Action for reducing Malnutrition” in the entire block of Shahabad in Baran covering 216 Aanganwadi centres. The project aimed at strengthening the system of Integrated Child Development Services by improving health & nutrition services & increasing awareness on malnutrition related issues among the community. During the different months of the project in 2015 as shown in Fig.3, the number of severely-underweight children identified using MUAC, referred to MTC and admitted in one year trend shows that with the increase in time span, a greater number of children were identified in severely-underweight category.

Fig.3: Children Identified, Refereed and Admitted to MTC during the Project in 2015



Source: *CECOEDECON Quarterly report, 2015.*

The above Fig.3, illustrates that during summer and rainy season highest number of severely-underweight children were identified and admitted to MTC. As mentioned in the report by CECODECON that in January none of the child was admitted to MTC due to the excessive cold weather due to which the parents or the family members were limited to their houses and as a result the children were getting proper care. Later that the up and down in climate pulled the family members to manage with such situation. Now, the children were lacking proper care after that most of the child were identified in severely-underweight category. However, due to the facilitation of services in pilot area of the project, in March, the number of children admitted to MTC decreased as compared with February*(Quarterly report, 2015).*However, the above figure also depicts that there is a wide gap between the number of children identified and between the children referred to MTC.

Action Centre La Faim i.e. Action against hunger international NGO (ACF)was founded in 1979 in France. It is exclusively dedicated to ending hunger and malnutrition. In the year 2011, it started its work in Baran.In this year, to reduce mortality and morbidity related to child under-nutrition up to the age of fifty nine months, it launched a program in thirty six villages of Kishanganj in collaboration with CECOEDECON and Government frontline workers including Aanganwadi Workers (AWW),

Accredited Social Health Activist (ASHA) ,Auxiliary Nurse Midwife (ANMs) etc.for raising awareness through a capacity building program. The programme focuses on management of acute malnutrition. On a monthly basis, about 74 per cent of all children under the age of five present in the intervention area were screened out of which 47 per cent were referred to the MTC. Besides, more than 1000 MAM children were detected and referred to the nearest AWC. Every month, an average of 380 follow-up visits at home level were performed for SAM and MAM children by the NGO (*Acute Malnutrition: Situational Analysis in the States of Rajasthan and Madhya Pradesh, 2010).*Now, it is working in all villages of Kishanganj block together with the front line health workers through the Community Mobilizers (CM) by covering the children of 0-5 years of age, pregnant & lactating mothers, men in the age group above 15 years and Care givers. The work span is categorized in three broad categories. First is assessment i.e. diagnosis of malnourished children at village level in one of the three ways i.e. (a) weighing and measuring the child (b) measuring the mid upper arm circumference (c) looking for signs of oedema. The second category is treatment which includes providing home based treatment to moderately malnourished children and referring them to Aaganwadi Centres, whereas, referring severely acute malnourished, to the nearest MTC. For the prevention part, activities at village level are conducted in which information and demonstration sessions for awareness generation are done, mothers and the community at large are counseled and educated on the causes and symptoms of malnutrition, maternal and child nutrition, sanitation etc. Home visits are carried out for all the SAM/MAM cases, pregnant and lactating women.Also,sustainability part is focused, in which beneficiaries and caretakers of under-5 children e.g. Anganwadi and ASHA workers are imparted training for identifying the early signs of malnutrition and taking corrective actions (ACF Report,2019).Despite of all these initiatives, the prevalence of Global Acute Malnutrition (GAM) is at 33.7 per cent [29.6- 37.895per cent CI] while the prevalence of Severe Acute Malnutrition (SAM) amounts to 7.6 per cent [5.1 – 10.195 per cent CI] which depicts that GAM and SAM prevalence in Kishanganj block has not decreased*(Acute malnutrition: An everyday emergency Baran).*The limitations faced by the NGOs were that post-monsoon season shows higher number of deaths since the past three years of intervention as MTCs are overcrowded in these seasons and cannot respond to all the needs of SAM treatment. Large-scale migration twice in a year, threatens the nutritional status of children under 5 (reasons like workload on women increasing and therefore less time available for proper care practices, etc.).No continuum of care available for SAM & MAM children when they are back to their villages. There is a preference for traditional ways to treat diseases due to economic reasons and difficulty to avail and then comply with the MTC services. Limited social support for the family left at home, with the mother not available and other children to take care *(Acute malnutrition: An everyday emergency Baran).*

World Vision works in nearly 100 countries worldwide and has been in India since 1958. Today it is working over 6252 urban, rural and tribal communities spread over 191 districts in 26 states(worldvision,n.d.).The focus of all development work is on children. In Baran, World Vision is working since 2005. During 2012-2013 it started working with CECOEDECON,ACF, ICICI Foundation. At present his two projects are functional. Technical programme and community engagement with sponsorship programme. The area of ‘Technical Programme ‘project is twelve gram panchayats of Kishanganj block. Specifically, in the malnutrition area they are focusing on stunting, wasting and underweight. The technical programme mainly provides services through approaches like community-based management of acute malnutrition (CMAM) through community mobilizations by building relationships and fostering active participation of the community, identifying and mobilising the community volunteers for CMAM, measuring Mid-Upper Arm Circumference (MUAC) of all

children under the age of five years. The second approach is supplementary feeding programme (SFP) through providing take-home food rations and routine basic treatment for families of children with moderate malnutrition but no medical complications, providing support for other groups with special nutrient requirements, including pregnant and lactating mothers. The third approach includes outpatient therapeutic programme (OTP) by providing home-based treatment and rehabilitation using ready-to-use-therapeutic foods (RUTF) for children with severe acute malnutrition but no medical complications, monitoring children's progress through regular outpatient clinics and providing food rations to the whole family of each severely malnourished child. The fourth approach is working closely with existing local health institutions or medical NGOs to provide services for stabilisation centre/inpatient care by providing intensive in-patient medical and nutrition care to acutely malnourished children with complications such as anorexia, severe medical issues or severe oedema and linking with OTP to allow early discharge and continued treatment in the community.

Adani Foundation, established in 1996 is a part of Adani Group with Its head office in Gujarat and having seven Branch offices. Presently, it is working in 18 states,2,250 villages and towns across the nation.Adani Wilmar Limited (AWL), has associated with Adani Foundation, the CSR arm of Adani Group in the quest against malnutrition and anaemia.In Rajasthan, the branch office is in Atru block of Baran district(adanifoundation.org).

Here, a Project namely SuPoshanwas started in Kawai site of Atru block during 2016-17. During the year 2018-19 through the project,43 Aanganwadi centres of 28 villages were covered. The project aims toaddress malnutrition, anaemia, maternal health and improved menstrual hygiene towards improving the nutritional and health status of children (0 to 60 month), adolescent girls (10 to 19 Year) and pregnant, lactating & reproductive age group women (19.1 to 45 Year) in the working villages. In the project, 25 "SuPoshanSanginis" and community volunteers were selected from local villages and were involved and empowered to provide basic healthcare services covering 3334 children, 3347adolescent girls and 6661pregnant, lactating & reproductive age group women(Suposhan report, 2019).The major achievements of Suposhan Programs 2018-19 are highlighted as follows:

Table No.2: Major Achievements of Suposhan Programs 2018-19

Sl.No.	Particular	Achievements
1	Severe Acute Malnutrition (SAM) to Moderate Acute Malnutrition (MAM)	6
2	Moderate Acute Malnutrition (MAM) to Healthy	64
3	Adolescent girls Severe to Moderate	3
4	Adolescent girls Moderate to Mild	171
5	Adolescent girls Mild to No Anemia	156
6	Women's with Reproductive age group severe to Moderate	02
7	Women's with Reproductive age group Moderate to Mild	103
8	Women's with Reproductive age group Mild to No Anemia	52

Source: *Suposhan report, 2019*

During the field investigations, the active NGOs personnel of Adani Foundation and World Vision working in Baran district mentioned the challenges while working in the region for the Sahariya community that*"The Government has made the Sahariyas dependent due to which the community have developed an attitude that we are getting everything for free so why need to work."* They further stated that*"They are getting aid from NGOs side also. The Government has a number of schemes and programmes for them but most of them lacks sustainability. Two aspects of Sahariyas needs to be immediately looked upon i.e. health and education. Even a special Additional District Magistrate (ADM) has been appointed next to district magistrate only for Sahariya."*

Besides the NGOspersonnel, the District Collector of Baranhave also reported that, "There is no dearth of food for Sahariyas because they get enough of it from the Government. They report high fertility and infant mortality. They are not even aware of what is good or bad for children. Here, toddlers are fled with the twin addiction of snacks and pan masala. There is reluctance to take children to the MTC for treatment, even for feeding the child basket is given after discharge. Despite getting paid for wage loss, the parents leave the centre against medical advice. Despite screening, treatment and monitoring, the children fall back into the SAM category once they are discharged from the centres and therefore despite interventions for the past three years, the situation remains dingy with SAM at 7.6 per cent and severe childhood *malnutrition* (*SCM*) at 14.9 per cent among children aged 6-59 months.The challenge is in creating awareness of eating the right kind of food and leading a hygienic life("The Hindu", 2015)."

Conclusion

The aforesaid interventions projects that the past interventions have made them fully dependent either on the Government or the NGOs for the fulfillment of short term gain. Also, somewhere or the other the main problem rotate around attitude, lack of communication, perception and understanding, underlying loopholes in the existing Government implementation or strategy. Besides the intervention which has been done and presently going on by the NGOs and the Government, a lot more is needed to be done for the Sahariya community of Baran.

A strategic region-specific and need based intervention, keeping in mind the different determinants of undernutrition, at the local level, is the need of the hour for the Sahariya community of Baran. Large scale participation of Sahariya community is must for the successful outcomes of the intervention. Therefore, this paper provides a scope for a better intervention for sustainable outcomes. The intervention should be participatory in nature, making the Sahariya community of Baran self-reliant and self-aware. The intervention should cover all aspects of their untouched areas especially focusing the nutritional needs of the vulnerable group i.e. Sahariya women and Sahariya children as every aspects of the development is entirely dependent on the nutritional well-being.

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