Community Development Centre: A Covenant with the Baiga (tribe)

Abstract

This case engages with the journey of Community Development Centre (CDC), a small non-profit organisation operating in the Mahakaushal region of Madhya Pradesh for over two decades. The case demonstrates how CDC has created a resilient and responsive organisational culture in a remote and resource-starved environment to address multiple developmental challenges of the region and in particular, of the most marginalised Baiga tribe within it. It underscores the importance of a firm conviction in the cause as a precondition of talent which works in such a context. It draws attention to the persistence and skill required to develop lasting relations of trust with the community and the challenges involved in balancing constructive contestation as well as support for the local and state administration. This case represents many similar small organisations that carry out credible and often pivotal work in their own contexts. Through the example of CDC, this case aims to build an appreciation of how nurturing such organisations is critical to give due share to those who remain invisible to the mainstream developmental discourse.

Keywords: Indigenous Tribes; Forest Communities; Tribal Development; Small Organisations; Regional Contexts

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Citation: Menon, S., Rana, S., Merchant, K., Pandey, A. (2022) Community Development Centre: A Covenant with the Baiga (tribe). Case study. Talent Management in the Indian Social Sector. ISDM Case Centre. Noida.

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This case study was created as part of the research study, "Talent Management in the Indian Social Sector". The research study is a joint initiative of CSIP, Ashoka University, and ISDM to co-create a shared knowledge infrastructure on talent management for the Indian social sector. The study and the preparation of this case is funded by ATE Chandra Foundation, Bill and Melinda Gates Foundation, Citibank, and Rohini Nilekani Philanthropies.

Origins

In the late 1990's, a young student named Ameen Charles—attending courses at Xavier Institute of Development Action and Studies (XIDAS) in Jabalpur district, Madhya Pradesh—went travelling through a group of districts in Madhya Pradesh, building up profiles for each one along with his team from XIDAS. This group of districts together make up the Mahakaushal region: one of the six informal regions into which Madhya Pradesh is divided, based on geographical boundaries, historic culture and traditions. The Mahakaushal region is located towards the south-eastern corner of the state and is usually considered as comprising the districts: Jabalpur, Balaghat, Mandla, Dindori, Seoni, Narsingpur, Katni and Chhindwara. It is characterised in particular by the presence of dense forests, large reserves of important natural resources, and a high population of tribal communities.

The assignment was an eye-opening experience for Ameen, himself a native of Balaghat district in Mahakaushal. He recalls:

> As part of that association with the XIDAS team, I got an opportunity to travel a lot through these districts: Balaghat, Seoni, Mandla, and others. I was able to travel deep into the interiors of these districts and experience them. If you look at the data and the statistics, on Balaghat for example, the data reflects a very good sex ratio (1048, compared to 984 for Madhya Pradesh in Census 2011) which definitely is the case here. However, just a good sex ratio doesn't mean that the status of women is very good, or that everything is going well for them. If we talk about education, or about their participation in livelihood, or their decision-making ability, these things are not very prevalent here. Of course, we don't have high level of violence against women, but in terms of the rights that should be afforded to them, that is not there. So that is one factor. The other main issues we saw were health and education. The condition of both of these were extremely poor. I mean, even today (2022) in the areas where we are working, within a 50-village area, there is not even a single doctor. Not even one government doctor is there nearby.
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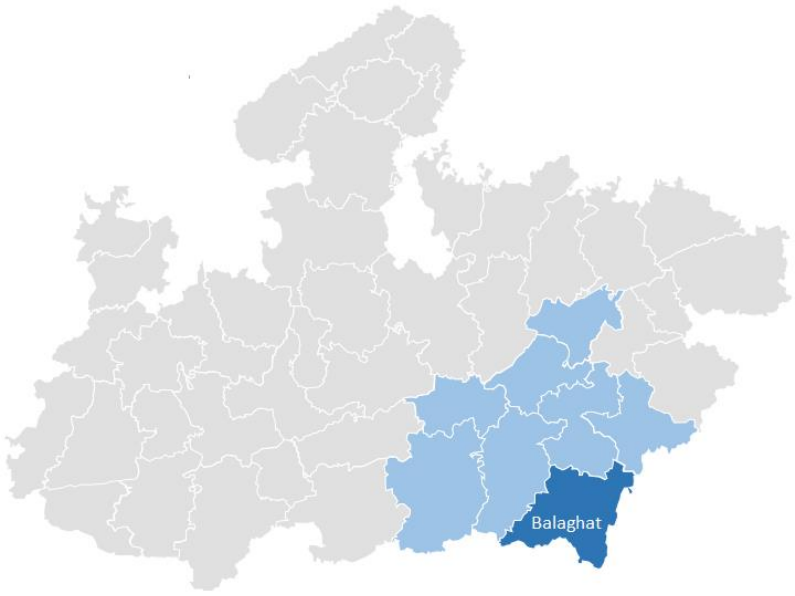
> For a population of about 50,000 to 60,000 there is one PHC (Primary Health Centre), but without a doctor. That is the situation today, but back then (late 1990s), there was not even a single PHC. Sure, the government has constructed the buildings—PHCs have been built, schools have been built, a lot of nice buildings are there—but in terms of their services or their service delivery, that is not there. Also, these communities don't have leaders of their own. The concept of leadership is not there: as in, a leader who can take a stand for them, speak on their behalf and represent their interests. And at that time, there were very few NGOs in the area. Just one or two organisations were working there.

What he saw, experienced and participated in during his travels through the Mahakaushal region (Fig. 1) left a deep impression on Ameen. It was not the impressioned view of an outsider moved by the plight of a region. Rather, it was the strong sentiment of someone who called the region home, and whose formative upbringing and education had been in the villages and public schools of the region. Ameen felt a duty to take up the many possibilities he saw, whereby as a youngster stepping into society, he could put this education and learning to use to help this region. In Ameen's own words:

> [It came slowly], the knowledge which I gained, and I started thinking that I could use that knowledge to do something for the people, and there was a belief within me that I can bring about change. There was that energy that we have when we are young, that we can change everything. The place I'm from, the

village where I come from, I felt there were a lot of things which could be done. I had been able to study, for example, but so many people did not have the same opportunity. The more I spent time in the villages [of Balaghat], the more I felt that I should work in this very community, in this very area. At the same time, I also knew that if I took up a government job, I wouldn't be able to do a lot of the things I wanted to do in the area. With the government, there are a lot of limitations. What is the most I would be able to do? I would disappear into a department, and in that department, I would be able to do a little bit of work. But what happens is, if you go into the department of health or department of education, you will have to do that work for a lifetime. Or, for example, in politics, I was able to see that politicians have the potential of doing some good things, but they don't do it. And on top of that, the system has its own "way" of working, its own particular processes.

Fig. 1 Balaghat and the Mahakaushal region, Madhya Pradesh



Source: ISDM internal, 2022. Note: * The districts comprising the Mahakaushal region are indicated in pale blue

Following the completion of his post-graduation in Social Science and Economics, Ameen joined a non-profit organisation (Jabalpur Diocesan Social Service Society) in Mandla district where he worked for nearly four years, gaining a deeper understanding of the context of the Mahakaushal region. In 2000, he moved to Balaghat, his home district, nurturing a desire to establish an organisation of his own through which he could work with the people of the community he had grown up in. He reflects that:

> If I did my work freely, through an organisation of my own, I would be able to work on an entire region. For example, I have worked in health, in education, in livelihood, and I have been able to learn things like what the issues are that women face. So, to be able to achieve something different or unique, it was important to me to be able to work freely right from the start. Then, even if I worked in just one village, but that work improved the lives of the people there, or changed something for the better, that would be much more satisfying for me.

It was thus that, in 2000, Ameen and two of his friends set up the Community Development Centre (CDC) in Balaghat district, formally registered in 2003 with the motto, "Rights with Dignity."

Balaghat, Madhya Pradesh

Balaghat is situated in the south-eastern corner of the state of Madhya Pradesh, on the border with Chhattisgarh. The district is one of the least populated in Madhya Pradesh, and is densely forested, with the highest forest cover by area of any district in the state (53.44%). It also has the largest proportion of forest cover classified as either "very dense" or "moderately dense" (Talegaonkar et. al, 2020).

The district is also rich in natural resources in the form of forest produce and deposits of important ores and minerals. It has the highest reserve of manganese in the country (Economy, 2022) and the copper mines in the town of Malanjkhand are the biggest open copper mines in Asia, accounting for 70% of India's copper reserves (Malanjkhand Copper Project, 2021).

The forests of Balaghat, contiguous with its neighbouring district Mandla, are also home to the 940 km^2 Kanha National Park, a tiger reserve and the largest national park in Madhya Pradesh. Kanha was established as a national park in 1955 and designated a tiger reserve in 1973 (Kanha National Park, 2022). While a critical habitat for tigers, the forested area covered by the national park is also the ancestral home of the Baiga and Gond tribes, the latter numerically far larger. Together they comprise 22.5% of the district's total population today (its neighbouring districts Mandla, Seoni and Dindori have even higher proportions, as seen in Fig. 2 of Exhibit 1). Until the 1970s, these tribes largely lived in villages within the national park area, spread between the outskirts and the core area of the park.

The Baiga of Balaghat

Over time, through its work in the region, CDC gravitated towards working with the Baiga tribe. Numerically smaller than the other tribes (according to Census 2011, the Baiga had a total population of 4,14,526 in Madhya Pradesh), they were spread out across the state, forming a minority in many villages in the Mahakaushal region (Mathniyan, 2018).

According to Ameen, the tribe today forms hardly 5% of the overall tribal population of Balaghat, and geographically, this population continues to remain extremely scattered. A Baiga hamlet on the outskirts of a non-tribal village can often consist of just five families. To move around is part of their nomadic way of life, which goes along with their custom of not cultivating the same land for too long, as Ameen highlights:

> One reason (why they are so scattered) is due to their practice of shifting cultivation. They stay in one particular area for a while, make a small portion of land as their own (and they cultivate it for a while). Further, let's say that 10 Baiga families are staying in a particular region. If one of them dies there, their custom is that everyone leaves the location; they vacate it. So, if one looks at their landholding in Balaghat, it is quite less, but if you look at the same statistic in Dindori, it is higher. Earlier, they were predominantly in Mandla, in a region called Baigachak, which is an area of 20 villages that is all occupied by Baiga. Now, they are in Dindori, and less so in Balaghat and Mandla.

While exact figures are difficult to find due to the difficulty of locating and registering members of this elusive tribe in any formal count, both Ameen's own experience, and government reports, indicate a declining population. There are a total of 46 recognised Scheduled Tribes living in Madhya Pradesh. The major tribes present in Madhya Pradesh include: Gond, Bhil, Korku, Bhariya, Halba, Kol, Mariya and Sahariya (SHRC,

2020). The Baiga in particular (along with the Bhariya and Sahariya) are considered a "particularly vulnerable tribal group" (PVTG) by the Government of India, in part due to flat or negative population growth. This classification, far from helping the cause of these communities, may have contributed to further marginalisation. A particularly critical report, released by the Ministry of Tribal Affairs themselves, remarks:

> Socio-economic vulnerability and low population levels has led them [PVTGs] to be treated as "endangered" and "on the verge of extinction": terminology which denies them their full humanity. Rather than granting them their autonomy and rights to address historical injustices, this perception has led to disastrous State Government interventions in the name of their "preservation." One such scheme has been the State policy disallowing members of PVTGs from availing of sterilisation schemes in government hospitals. Tribes such as the Paharias, Baigas, Kamars and Pahari Korvas of central India have been denied permanent methods of contraception in an attempt by the State to encourage population growth in the face of their apparently dwindling numbers. This policy originated in an order passed by the Madhya Pradesh government in 1979 to exclude vulnerable tribal communities from the wave of sterilisation drives taking place across north India. However, even decades later, this order continues to be followed. 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. Moreover, it sidesteps the real factors contributing to high mortality rates such as chronic malnutrition, starvation and lack of access to adequate health facilities. (Ministry of Tribal Affairs, 2014)

Amongst the marginalised, the Baiga remain the most vulnerable. It is towards this tribe that CDC gradually pivoted and today its relationship with the tribe and its work with them is a strong motive force, a source satisfaction of committing to a worthy cause and constitutes an integral element of CDC's identity. But who exactly are the Baiga that lent greater strength of meaning to CDC's work?

The Baiga are a semi-nomadic, forest-dwelling tribe of India. Today, they live primarily in the region that covers the Central Indian states of Madhya Pradesh and Chhattisgarh. They are, however, ancient people. Multiple sources suggest a presence in Central India dating back 20,000 years (Kumar, 2021; Singh et. al, 2015). This is several times older than the earliest recorded permanent settlement in the Indian Subcontinent: the Indus Valley (or Harappan) Civilisation, which existed along the banks of the Indus and Saraswati rivers from circa 4,000 BCE (Mark, 2020). The British first came into contact with the Baiga tribe in the Dindori district of Madhya Pradesh, where they were found living in the deep interiors of densely forested jungles, far away from mainstream civilisation (Sarma, 2014).

The sacred beliefs of the Baiga prevent them from ploughing the land, which the tribe considers to be equivalent to ploughing the "breast of one's own mother." Instead, the community has traditionally practised *Bewar*, a form of shifting cultivation that uses fire to clear forest land and which does not use draught animals. Crops are planted in the ash-fertilised soil following the clearing of vegetation by burning. After two or three seasons of planting, the tribe moves on to another region, leaving the original tract to recover. This is again based on the tribe's belief that asking Mother Earth to produce food from the same patch of land over and over again would eventually weaken her.

This practice of *Bewar*, a prudent and practical use of resources, came to be seen by forest authorities as highly destructive to regeneration of the *sal* (Shorea robusta) trees of the forest (Rangarajan et. al, 2006). In 1970, citing tiger and forest conservation efforts, 18 tribal villages were displaced and resettled away from the national park area (CDC, 2014).

Reports indicate that this tribal population, displaced over 50 years ago, has still not been properly resettled (CDC, 2014). It has been reported that the tribes living near the park were forcefully evicted by officials and relocated to barren lands, nearly 30 km from the forest they have always been connected to and reliant upon, with no alternate livelihood options (such as daily wage labour). Their new houses had no electricity and no drinking water, and were often made from makeshift materials (*kutcha*). Further, the Baiga's beliefs regarding ploughing prevented them from transitioning from *Bewar* to settled agriculture techniques. Malnourishment, poverty and alcoholism greatly increased in the tribal population following their displacement (Sarma, 2014).

The displacement in 1970 marked the start of generational cycles of poverty and neglect that the tribe has never fully recovered from, and which have continued into recent times. Evictions have continued into recent times, and the last five remaining villages of Baiga were evicted from the core area of the national park in 2014-15. It is estimated that since 2005, when the National Tiger Authority issued guidelines to make the core area of the park free from human intervention, at least 27 villages have been relocated from the park, with no alternative arrangements made (Jaiswal, 2016).

Difficulty in a modern India

Despite a reported presence in the forests of Central India dating back thousands of years, the Baiga tribe's story over the past century or so has shifted profoundly. They have gone from being a secluded tribe living deep in the forest to living on the outskirts of non-tribal villages, cut off from their forest habitat. The Baiga—based on nearly all commonly used indicators of socio-economic status, health and wellbeing, and the multi-decadal observations and field experiences of practitioners like Ameen—are suffering (Refer to Exhibit 2). Ameen elaborates on the impact that separation from the forest has had upon several generations of Baiga:

> When the forest is taken away from them, it creates a lot of issues, because they can survive really well in the forest. They don't need things like lights and fans. In fact, they are much better and much more healthy. In the past, there was no malnutrition within their families, but now for example, we are working with 300 children, out of which 95% are malnourished and 10% to 15% are in the "SAM" category (Severe Acute Malnutrition).
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> This is largely because of the change that their food pattern has undergone. In the past, during the rainy season, they were able to get fish and crabs from the rivers. They would do a lot of small-scale hunting. They would hunt birds, rabbits and other small animals. Additionally, 15 or 20 years ago, the millets that they traditionally used to eat started to be referred to by other people in a derogatory way, as "Adivasi food." It was a certain form of hate. As a result of that, they slowly stopped cultivating those crops, and now those seeds are no longer there. So, their seed pattern, food pattern, we have completely changed it, and now we are giving them ration (Public Distribution System) foods like rice, while millets are completely out of their meals. The fish they used to be able to find in streams are extinct today due to pesticide runoff from farms. Pesticide use also kills off earthworms and has reduced the fertility of the land. We have altered the entire natural system, so how will they [the Baiga] survive? So, they die early.
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> Finally, people often comment, "Baigas are drunkards. He drinks and so he dies early." Look, he doesn't have anything to do, no jobs, and can't go back to the forest. He gets no form of support from anywhere. So, whatever he gets easily,

> whatever is easily available, like *Mahua* leaves, he makes alcohol out of it and he consumes it and stays under its influence. All these factors are also at play.

This socioeconomic predicament, most visible in the extent of malnourishment, struck a deep chord with Ameen. It is what has been the motive force for CDC's continuing efforts to improve their situation. The tribe's profound vulnerability is compounded by a deep sense of alienation that they experience from mainstream society: from the neighbours who live within the village boundaries that the Baiga's hamlets skirt; from the school environment that some of the Baiga's children experience; and even from schemes ostensibly designed for their welfare. Ameen shares:

> With Baiga you will see that even today, when their children go to the school, often the teachers themselves demotivate the children. They will say, "You are a Baiga, you won't learn anything." However, a lot of their difficulty is because of language. The dialect that they [Baiga children] speak at home is different and in school they are spoken to in Hindi, which they struggle to understand.
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> There have been a lot of incidents with them. Around two or three years back, a solar-powered water pump scheme started, so we [CDC] began the process for the Baiga community. When we started filling up the application forms, we saw that everything—*Aadhar* card number and all the other details—was all online. Look at the joke here, it is like the government is also playing a prank. The entire process was online. Now, if a Baiga, who may not even be educated, requires a solar pump, he will have to fill up the online application form. Where is he supposed to go for an online application? He will have to go to the kiosk, which is 25 to 30 km away from his home. And if he goes there and something [e.g. a required document] is missing, he will have to go home and come back. So, what are we doing? I mean us city people, or the government. We said, "let's make everything digital," and they [Baiga] bear the brunt. It's a joke what is happening with them.
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> So we [at CDC] said, let us assemble their documents in one place and then call them to fill up the application form, and when we inserted the *Aadhar* number of these Baiga people, we were shocked to learn that somebody else had already processed the request and it had been sanctioned as well. Who is held responsible for that? Where do you turn to? And these people have no idea that their *Aadhar* cards are being misused or by whom.

CDC's early initiatives: 2003 – 2009

CDC has been present in Balaghat for over two decades, and over this time, the organisation has come to represent an important partner to the Baiga: one that understands their context, is sensitive to their customs and traditions, and is aware of what the tribe has undergone in its recent history. However, the road to this present relationship was a long one. It took time before CDC started to sharpen their focus on tribal communities, including the Baiga.

For the first seven years following its inception, CDC worked on the regional population as a whole, implementing a major project with one of their early funders, Care India. The project was focused on addressing malnutrition, which had struck an unsettling chord with Ameen when he did his early district profiling study. Under this project, CDC was working in 1,500 *Anganwadi* centres. It was a difficult start for the organisation. They were newly established, and malnutrition was a sensitive issue to be working on in the region. Like in many other states, malnutrition was not an openly and officially acknowledged problem

in Balaghat. Raising issues of malnutrition in these cases are often treated as a challenge to the prevailing State narrative. For CDC, it had serious implications for the survival of the young organisation as well as well-being of its personnel. However, this challenge also served to commit CDC even more to the region.

In the various fora where CDC met with State officials, such as ICDS or other health-related spaces, their attempts to raise the issue of malnutrition were met with denial, as Ameen recounts:

> The state-level officials were not ready to accept that there is malnutrition. If they would have accepted that then there would have been questions on them… We started working on malnutrition despite that. There were huge departments like Women and Child Development, Health Department, this was their work, but we were doing their work, and in return they were filing a case against us… So, these situations do make us angry, but along with it, it does motivate us as well, that OK, if this is the system, we will fight against it… and we continue to get inspiration from the local communities and context within which we work.

With time, the level of dialogue and the relationship with state and district government officials has improved, and various practices developed over the six-year span of CDC's malnutrition project have since been adapted for use in the state government's Integrated Child Development Scheme (ICDS) project in *Anganwadis* (Ministry of Women and Child Development, 2013). Ameen shares:

> One of the outcomes of this five to six yearlong [CDC] programme was that some of our practices were adopted by the MP [Madhya Pradesh] government, meaning the work that they are replicating in the *anganwadis* is the outcome of that [CDC] programme. For example, we used to organise a "nutrition and health day," and today there is *Mangal Divas*. [In the CDC project] it was malnutrition and growth monitoring and today it is considered as *Vriddhi Nigrani* (growth monitoring), *Godbharai* (traditional Indian baby shower celebrated during pregnancy to welcome the unborn baby to the family), and *Annaprashan* (a rite of passage that marks an infant's first intake of food other than milk).

Despite its later focus on the Baiga, CDC continued to be involved with government bodies in implementing specific regional projects, at the level of a block or group of blocks (primarily in the areas of health and livelihoods). They have found just that right level of distance with government officials: neither too close for comfort nor complete disengagement. This space of balanced intermediation allows them to steadfastly carry the interests of Baiga and the developmental needs of the region while maintaining a constructive working relationship with the administration.

Maturing the intervention

CDC's next major project, a three-year project starting in 2009 (funded by Dorabji Tata Trust), was focused on strengthening the local *Panchayati Raj* system to be able to address community health. It involved raising awareness about local health issues, building capacity for Gram Panchayats to be able to intervene in issues of community health, and building convergence between state/central schemes (such as ICDS) and their community-level implementation through Gram Panchayats.

The experience of working closely on health and nutrition through the *Panchayati Raj* system, both at the level of individuals and the community, was a pivotal period of learning for CDC . The issue of health in the remote villages of Balaghat seemed to be closely tied to the presence of livelihood opportunities. Improvements in livelihood could lead to increasing health-seeking behaviour and expenditure on health as well as education. Ameen reflects on CDC's seven-year phase as a full-fledged developmental organisation:

> We worked for about seven years in Balaghat where we covered the entire district, and four years in Seoni (on health and nutrition), but there was no immediate impact of that work, because behaviour change takes a lot of time. There are a lot of things with regards to health behaviours which are there today which have quite improved, but even today the situation is not that good. What happens when you work with the community on health and nutrition is: let us assume we are working with one particular young girl. Within the next 15 years, she will become a woman and will be part of another target group, and so the next set of messages which needs to be delivered to her will move at a very slow pace. The government has started to pay attention towards malnutrition and its existence, and so some messages, for example about early breastfeeding, have passed on very effectively through government as well as through organisations. But very few people are practising it. The same thing is a little better in urban and semi-urban areas, but in rural or tribal areas, things are still not very good. So, we put in a lot of effort, and we could see some positive changes, but not much.
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> Over this period (2003-2009), at an organisational level there had been a lot of interaction with funders as well, and there were a lot of learning opportunities, which our entire team and our governing board members had taken on board. As a result of all this, we started to feel that things would not improve by just working on health. If we wanted to improve the state of health, we would have to improve livelihood as well, and health could be considered one of the components which determine livelihood. In the same way, we felt that rather than working too much on just health, we should work in some specific geographic region and bring some change across all aspects in that region.

Starting in 2010, a three-year project with DST (Department of Science and Technology, Ministry of Science and Technology, Government of India), marked a new direction for CDC. They would work intensively in a single tribal-majority block of Balaghat (Baihar)—comprising around 70 villages and having nearly continuous forest cover—working on multiple aspects of community development, with a focus on developing livelihood. The block is located very close to the Protected Area of the Kanha National Park where the livelihood challenges of the community are deeply influenced by the close presence of the forest and its wildlife. Crop damage and loss of livestock to wildlife were regular occurrences, for which there was no compensation mechanism in place, along with the ever-present danger of human-wildlife conflicts.

The project, starting with an insight on the importance of livelihood, added another dimension with coordination and technical input from the World Wildlife Fund for Nature (WWF). It aimed to integrate livelihood with environmental conservation: specifically, to reduce the dependence of the regional tribal communities, mainly the Baiga, on Protected Areas of forest for their livelihood. Refer to Exhibit 3 for a detailed overview of this period of work for CDC. Ameen recounts CDC's work on this project, saying:

> We worked with them on the utilisation of their own land, without creating a pressure on the forest, without harvesting from forest, doing these small livelihood-related models and land-based activities, and in the last five to seven years, because of our work, we could see a difference in their livelihood. We were not able to see its impact initially, but the last lockdown and this year's lockdown actually gave us a better picture. The 1,000 plus families with whom we were working were able to sustain the lockdown, a good sign that our work had had an impact.

Forging a bond with the Baiga

This period (2010-2013) of implementing livelihood programs in the Baihar block marked the start of CDC's close involvement with the Baiga. The organisation's granular involvement with the tribe, now a relationship that has lasted over a decade, could not however have begun in earnest without a crucial foundation of trust, for which patience and perseverance were non-negotiables. Ameen reflects,

> In terms of building relationships with the Baiga or with the Baiga community, why can't they trust you? Why do they take time? Because people like us, whether it was in their lives or in the markets, have taken advantage of, fooled and looted them. A lot has been done with them, that's why they can't trust easily. No matter what good you tell them, if they don't want to do something they won't do it at all, because they have been taken advantage of for quite a long time…

Ameen's reflections find an echo from over 80 years ago, in a 1939 book written by anthropologist Verrier Elwin, who lived with the Baiga tribe for six years, travelling with them and learning their history and ways of life. It reads,

> I cannot think of anything more shameful, meaner and disgraceful to an administration that claims to be enlightened, than the way that (its) subordinates openly rob these poor people. I have seen the poorest people robbed of the chicken that they have been saving up for a festival, or a pot of ghee which they treasured since a long time, or the fruits which they got with difficulty. When I introduced plants to them to grow, they usually refused "because the government people will annex the fruit crops." (Reddy, 2016)

As part of the projects with DST and WWF, CDC's field officers started to visit Baiga villages in the Baihar block. These field officers had to overcome, according to Ameen, the transactional nature of the relationships that the Baiga were used to with the "outside world." This relationship was expressed in many ways: for instance, exchanging food rations for work, or showcasing community members in their traditional tribal attire as part of tourist activities in the region in exchange for money. It was this very expectation of some form of exchange that the field officers had to overcome. Their attempt to convey that the organisation was attempting to build a genuine relationship was rightfully met with suspicion.

Realising that CDC staff were not bringing any form of material to exchange, Baiga members would mysteriously disappear when staff visited, seemingly uninterested in any further contact. Ameen reflects on the experience of reaching out to the tribe, with a touch of amusement,

> In the beginning, what happened many times was that when our staff would try to set up meetings or interactions with the Baiga, they (the Baiga) would say that they would come and sit with our staff after some time. Then, when the staff would go to meet them after a while, nobody would come. We'd be told that they've gone to the forest, or they've gone to the market, or they've gone to someone else's house. It continued like this for two years. But our staff continued to go there again, and again, and again, and again. Then, we thought we would try to connect with (Baiga) women, but there were challenges there too. Baiga women consume alcohol as well, and many times they would come (to meetings) and sit under the influence of alcohol.

Ameen continues,

> But when we heard their stories, and saw their condition, like a young girl of barely 20 having three children to look after with no support, we started to feel that we should definitely do some work alongside them. So gradually, when our staff started going again and again to visit them, it happened that first one person became a little motivated, and then gradually they started to connect on their own.

One of the early structures where this interest on the part of the Baiga became evident was a small self-help group (SHG) of women involving 30 families (in Baihar block). Through these projects, CDC sought to develop a sustainable livelihood alternative to enable the tribe to support themselves. The project with DST came to a close in 2012. However, this experience of working substantively with the Baiga had left a lasting impression on Ameen and the team at CDC. It provided a firmer direction to CDC and Ameen decided to locate the right type of funding that would enable them to continue their work with the Baiga.

He next approached Paul Hamlyn Foundation and proposed to deepen CDC's work with the Baiga tribe. The proposed project would engage directly with a small group of Baiga families in a single block (Baihar) over a long period of time, addressing multiple concerns affecting their lives. In particular, the proposal sought to work on improving livelihood security through various agricultural techniques, while improving health and education outcomes for these families.

The proposal caught attention, and a long partnership with Paul Hamlyn Foundation started in 2014, continuing until 2021. This partnership settled CDC. It gave the organisation the freedom to take the time they needed to expand their relationships with the reclusive tribe without the pressure of short-term deliverables. CDC engaged directly with 500 Baiga families over the course of this period: a measure of the time demanded to build relationships. While small change perhaps in an era of "scale," for CDC it is a critical threshold when it comes to doing the work they do with this tribe. Ameen categorically emphasises:

> When we work with this community, we cannot expect any results within a year or two. If we visit a new village, it will take one or two years to understand the community and what exactly we want to do with them. It is not easy. It requires a lot of patience. I mean, these days the kind of projects that we (in the social sector)—either NGOs or government, design for communities like this—we seem to think that if we provide three trainings to the community, there will be awareness among them, their knowledge will increase, and everything will be done, but it doesn't happen like that. If you want to work with them, you have to work gradually, step-by-step and we have been supported in this by funding organisations like Paul Hamlyn Foundation, or Rufford Small Grants Program. They have given us a lot of freedom to work in this way. It wasn't that we had to go to the field and straightaway deliver a specific result. They understood that the entire outcome of this work depends on our relationship with the community.

Today (June 2022), across the blocks of Balaghat, CDC is a real "partner" to the tribe, wherein its own future is closely tied to that of the Baiga. When CDC starts work in new villages these days, individuals from their existing network of Baiga families regularly accompany them, to help vouch for and support their work with new villagers. The communities are far more receptive now to new ideas or projects to be piloted, working together with CDC to implement these projects. Ameen reflects on this fortunate shift:

> So, it takes a lot of time and effort to get along well with people. Also, our team is not a team of outsiders. Everyone is local, from nearby areas within the district, and we have done a lot to build our team's capacity, and nurture the relationship that they have with the Baiga community. As a result, for example,

> say we want to take a (Baiga) woman on a training or a particular type of field exposure. In the past, if you just went and told them that, of course nobody would go with you. But today, the situation is such that, not just for women, even with girls—we are also working with adolescent girls—the tribe have that kind of trust in the organisation. The community understands that if we are required to send them to a training or to an exposure, we will keep them safe. This is a really good thing about our relationship with the tribal community.

However, choosing to locate itself in such a highly region-specific context in a remote location is not without its challenges. In particular, CDC has faced severe challenges in terms of mobilising the resources, financial and professional, necessary to keep the organisation itself functioning.

As such, Ameen is wary of romanticising CDC's work, noting that, "Even though we might be doing good work, we definitely face a lot of problems and disappointments, and these are increasing in recent times." He further points out that tribal development is a particularly difficult niche of work to find funding for. The characteristics of Balaghat: inaccessible, densely forested and tribal-majority add layers of difficulty to the challenge of obtaining resources. Ironically, and in solidarity with a number of other organisations across the spread of India working on concerns of the most marginalised, CDC does not receive local donations, and there are no local donors that can champion the organisation's cause.

Working through resource constraints

Thus, the organisation's internal development story—nurturing a pool of talent able to embody the sensitivity and empathy required to work with the Baiga, and keeping this talent retained and motivated; formalising the organisation's structures and processes to the right level as it grows; and maintaining a level of integration with the mainstream developmental funding ecosystem—is one of a delicate balancing act amidst one overarching constraint: inadequate resources. This story inside the organisational makes itself felt in many ways.

The salaries of the five highest-paid employees of CDC range from Rs. 8,000 to Rs.16,500. During the fiscal year 2020-21, CDC received a total funding of Rs. 1.07 crores. Its level of funding has been growing over the past decade, from a base of about Rs. 23 lakhs in 2010 as it has become more established in the region and more donors and projects have been added to its portfolio (refer to Exhibit 4). However, despite working with reputed donors, CDC receives little to no funds for internal capacity enhancement, organisational development, or to build financial resilience (such as through the establishment of a corpus fund). Specifically, meeting compensation expectations is one of CDC's biggest management challenges. Ameen shares the reality of the situation, with undercurrents of frustration:

> The kind of remuneration we can afford to offer is very low. If we want to hire expert staff from outside, we can't do that, they have different expectations. The maximum that we could afford to give is Rs. 17,0000 to 18,000, but what happens is when students come from prominent social science colleges and institutions, they talk about packages: which is not possible at our end, to talk about any kind of package.

He continues, highlighting the culture of adaptation CDC has tried to institutionalise:

> So, we have a simple strategy: once a person gets associated with us, we try to strengthen their capacity, we increase their knowledge, and we work with them on different issues. The challenge that we face here is to maintain the continuity of this staff, and retain a pool of staff who don't look at this as just a job.
> …

> Apart from that, we strengthen our team's skills through training, and we benefited from that because we could communicate to donors accordingly. Sometimes we need specialists. For example, we might require an expert in the field of agriculture, so we hire specialists for a specific duration, and we do get experts who are able to support us at minimum cost. Apart from that we have other issues [in Balaghat] like gender-related issues, violence against women, child rights-related issues, so to understand these issues, specific trainings are provided [for our staff].

Field-level operations are demanding for Ameen and the team at CDC. Connecting, coordinating, rapport-building and partnering with local communities entails understanding their language, culture, tradition, history and present circumstances. From CDC's experience, when new staff are hired from outside Madhya Pradesh, or even from outside the Mahakaushal region, it takes them six months to a year to fully immerse themselves in the local context. Ameen notes:

> There are a lot of issues: language-related, understanding their culture, their traditions. When you are working with our communities, you have to have an understanding of all these things, and when we bring new staff or outsiders, they will take six months to a year to understand. We have projects which are for three years, two years, and these days we have projects restricted to 12 months and they [donors] would expect impact in those 12 months.

While certain projects and donors, for instance, Paul Hamlyn, do give CDC the freedom to work for long periods of time in communities without specific deliverables, this is not the norm. By and large, when projects are agreed with lengths of one to three years, the expectation from donors is often to achieve measurable impact in a year. Thus, it represents a significant overhead expense for CDC to onboard a new (non-local) staff member onto a project. By the time they start contributing to the project, a year has already elapsed. Their contribution to the project's objectives would be minimal over the first year. As Ameen rightfully raises the question, "How do we do that? So, a good way is to increase the capacity of youth, local youth."

Hence, preference in hiring is given to people who have an existing understanding of the local context.

Tenacious yet sensitive

The deep understanding that local youth often have about existing issues in their communities makes them attractive hires for CDC. They are also available to the organisation at a far lower cost than professional talent from outside the region. Right from its early days, the backbone of CDC's talent philosophy has been a commitment to the recruitment of self-motivated youth—able to function in a challenging context with minimal compensation and are aligned to CDC's vision and approach—and to the development of these youth as leaders.

In particular, these youth need to be able to understand the importance of the community roots that CDC has spent the past 20 years carefully growing, and not be a disruptive influence on their sensitive work with tribal communities. Ameen notes that:

> When we started working on [malnutrition] for the first five to six years, lots of [other issues also] emerged. So, this was the time when we [needed] a big team of staff with limited resources. We were operating on very low salaries. So, we started hiring from the local communities and the local youth. That is, college-

> going girls were trained and we started our project through them. Our entire staff was local staff, as an outsider would not have survived on this salary.
> …
> These local staff must be able to correlate with our value system and our way of working. When you go to a community, it is not like a fixed nine-to-five framework that you operate in. So, in this framework, dedication and willingness [become important]. If I have to work at seven in the evening, I am ready to do that, or if I have to wake up at six and work, I am ready for that. For example, we have this Childline project (Exhibit 5) where staff is required to be ready 24 hours a day. Cases can come at 2:00 a.m. or it could also come at four in the morning. Whenever they are required, the staff has to be ready.
>
> So, extreme professionalism (with defined working hours) will not work, it will create difficulties for us. We expect a person to be ready to work with people and ready to build connections with people. The person should be ready to understand people's problems and should work with us in our effort to do something for the community. We do not expect a person to disrupt the pattern that we have developed in the last 10 to 20 years. The rapport that we have built with the administration team (government) and the community: we expect a person (our personnel) to be part of it.

CDC's leadership looks to develop a degree of sensitivity in their staff, so that they can in turn represent this same sensitivity when interacting with the communities. Members of the tribes, such as the Baiga, relocated away from the forests to the fringes of non-tribal villages in Balaghat, often face discrimination, prejudice, and rudeness. Thus, building sensitivity in their staff is a crucial element of being able to reach out effectively to the people CDC works with.

Field implementation is executed through a structure which enables the coordination of activities and talent across multiple locations.

Shaping a cohesive unit

As of 2021, the organisation had 14 full-time staff and 20 volunteers. 10 years before that, it had 13 full-time staff. While staff strength has oscillated in the interim (reaching as high as 57 between 2013-15 before returning to 14), this has been due to the demands of individual projects. At its core, CDC has remained a small organisation over its entire lifespan thus far. Komal, Programme Coordinator at CDC, elaborates on this:

> If volunteers are to be counted then the number of people engaged with CDC's mission will increase…headcount is according to the project, sometimes it is more, sometimes it is less, so it keeps on changing. Structure does not remain static. If the work is big, there will be a bigger group, if the work project is small, it will be a small group…Above [the volunteers], there are field animators who work at village level. Above them, there are field coordinators, who work in their cluster, sometimes one or two clusters, and they coordinate on that. And then there is the project coordinator who coordinates the entire project, looks after the entire project and then there is the Director above them.

For the role of "field coordinator" (numbering four in 2021), the organisation searches for people with skills who can sense problems from interactions, conversations and observations and develop solutions for these. For "field animators" (six in 2021), the person needs to have sufficient knowledge about the village,

the ability to communicate and coordinate with people, and knowledge of public schemes. CDC also checks to ensure that staff recruited for its projects are not affiliated to any religious or political party and have no record of malpractice.

Volunteers have been a part of CDC's pool of talent from its early days. Their numbers have increased steadily over the years, from five in 2010 to 20 in 2021. Volunteers are often youth from local colleges, recruited on the basis of their interest in and their understanding of CDC's work. Depending on the project to which they are assigned, they are provided relevant in-house training by CDC. For instance, about local government schemes, the effects of malnutrition and its treatment, or guidelines on working with children, amongst others. They can participate in several different activities within CDC's projects, including: disseminating information to communities; staffing the 24-hour helpline on CDC's Childline project; working with children in CDC's village education centres (where each child is given a daily glass of fresh milk and a nutritious *laddu* prepared with various pulses and jaggery); and helping community members vote during elections, among others. While there is no fixed term of engagement required from a volunteer, CDC observes that most of their volunteers tend to stay on for between one and a half to two years.

Seeking motivation in every action

For CDC, an important element of motivation stems from the sensitivity that the organisation attempts to nurture in its personnel. Their highly region-specific work, often with a group of families, means that personnel are able to draw their motivation and the strength to continue their work from small, yet significant, human experiences. Despite its 20-year presence in Balaghat, the organisation is very careful to not let the achievement of targets or the pursuit of operating at larger scales overwhelm the underlying human connection they have to the vulnerable Baiga tribe. Often, the team at CDC can spend months worrying about the situation of a single child. Securing a safe and healthy result for that child after months of effort can comprise "good performance" at the organisation, as well as represent a significant source of motivation. Ameen opens up this aspect of CDC's work:

> I would like to share one recent story (2022). There was a girl child who was just born in the Baiga community. She was around 15 or 16 days old, and her mother was not able to lactate. Our staff got to know that the mother had nothing to eat at her place, and in place of milk she had only been able to feed the child some rice water so far. This lady, the mother, was barely 19 years old, and her husband was out to get some work. So, we started working with that lady and the child and it took us six months to bring that child back to a normal stage. But now, when we see that child, we feel that maybe we are doing some good work, and doing this work is very essential, because staying dependent on the public system is not sufficient: they don't have that kind of motivation and sensitivity.
>
> We face disappointment as well. There is one Baiga child, for the past eight or nine months, we have been worried about him. He had burnt both his feet and he was facing a lot of issues while walking. We had a lot of communications with CWC (Child Welfare Committee) and the district administration but his family had no *Aadhar* card and his documents were taking so long to prepare. It was a big challenge for us, but when we are able to overcome challenges like these, it motivates us to push ourselves further.
>
> …
>
> Another example, we were doing some seed support in a village, we'd given some families around 5kg of seeds. So, when we go to the villages, and we sit with those people and talk, and those people inform us that, "This year I grew one quintal of potatoes," then I just feel, wow, I should do even more. If our

> work is having an effect on their lives then we should do more. Those potatoes, his children will eat and become healthier. Some of them, he will sell and get some income. Similarly, we had installed a drip irrigation system for 10 to 12 Baiga families, I mean, it was the first ever time they were able to grow wheat and *Chana* and the happiness with which they told us that they've done it for the first time ever was amazing. They've had the land for years but it hasn't worked out. So I feel that if, even partly because of our presence, someone's life is seeing positive changes, and the direct effect of those changes will be on improving some children's lives as well, then despite the challenges, we should keep going.

Over time, the organisation has developed several in-house practices and spaces to recognise and express its appreciation for successes in its teams. Team leaders who perform well, are given small gifts and are appreciated regularly. They are also invited as resource persons to demonstrate their work to others in the organisation.

The nature of work which makes every member highly responsible provides opportunities for the team to interact with high-profile individuals from the government or other bodies. Shiv Kumar, who works on the Childline project as Project Coordinator notes that:

> We get opportunities to sit with the Collector, District Judge, Superintendent of Police (SP), Inspector General of Police (IG), Deputy Inspector General of Police (DIG), head of education department, various MPs (Member of Parliament). With these higher-level authorities, we get a feeling of satisfaction, or a sense of pride…that we get an opportunity to share the stage with these people, sit together on a sofa, have tea together and talk to them. So, we do not give prominence to how much money we receive, nor do we ever place any sort of pressure on the organisation about salary increments.

Over time, the type of people working with CDC, selected primarily for strong alignment with the organisation's cause, and a genuine concern for the tribal community that the organisation engages with, has resulted in a culture whereby interpersonal relationships and connection to CDC's work endure past the exit of personnel. Shadab, an accountant at CDC, notes that even after leaving the organisation, people remain connected, coming into the office or giving feedback where required.

Keeping this close-knit bond alive requires giving it the kind of careful attention and emphasis that the organisation's work itself demands. The team makes extensive use of WhatsApp groups to draw inspiration from each other's work and help each other with problems in real-time, but equally for encouragement and moments of light-hearted camaraderie, as Shadab describes:

> We have WhatsApp groups wherein all the information is updated on a regular basis, like: where are the team? What are they doing? They upload pictures of who they are meeting and the activities they are doing? What activities are they doing? So, all the staff are aware of each other's' work. This helps with motivating the staff that, okay they met so-and-so person and are doing so well, or for example if we talk about our rain shelters which are being constructed, if a person has built a rain shelter: how it was constructed, or how well it was constructed, that gets uploaded. This motivates the team, and they think: if he has done so well, I should do it much better; or motivates us to understand how to improve our own constructions. So, things like this are discussed continuously in our groups.

> On this (WhatsApp) platform, and in Zoom meetings, we also discuss the challenges and issues faced by us on that day as a team. It refreshes us and lightens the mind and heart, so we are able to go back and tackle the challenge again. We also use the groups to "chill": it's not like we are always talking about the challenges or the pressured work that we do. We say nice things too, and [Ameen] is always helpful and provides suggestions for issues we may be facing.

During COVID-19, CDC took steps to ensure that employees spent most of their time with their families without worrying about project deliverables. In addition, the employees were consistently supported and provided with health kits containing oximeters, blood pressure monitoring devices, blood-sugar testing kits, face masks, thermometers etc. COVID presented a moment of reflection. It further pushed the need to ensure the well-being of its own team members. According to Komal, CDC is looking to put together a fund for employees' health-related emergencies and is interacting with donors to earmark funds for this.

A balancing act within

As CDC's work has expanded along with its donor base, the contours of the funding ecosystem at large have also changed in more recent times. The greater output orientation, demand for measurement and reporting and a greater thrust on documentation have posed a dilemma for CDC. The context in which CDC operates still echoes the ghosts of a past while the world around it keeps shifting, at times too rapidly. The notions of scale, increased digitisation and professionalisation are forces that sit in stark contrast with the needs of a simple and highly vulnerable group of people like Baiga.

This creates its own conflicting pressures on the kind of talent that CDC's work demands and the talent that can fulfil the demanding requirements of those at distance from the work. Further, it also creates strains on the ability of CDC to work on the well-being and development of its own personnel with what the organisational finances can support. Funds remain relatively short-duration and tied to project execution. In turn, this also acts as a constraint to sustain the kind of mission-driven but familial organisational culture which forms the backbone of the organisation's work. Ameen highlights this using the example of maternity benefits:

> We had a donor, and whenever we were planning to appoint a female staff member, they would check if she was about to get married. If she is planning to get married, we can hardly say to her, "No, you cannot get pregnant for three years." Almost all donors have maternity-related policies within their own organisations, but when they work with their partner [such as CDC], they are hesitant in giving long maternity leaves. Even if we [internally] wanted to make a maternity leave policy, it will be difficult for us to implement it well, because we are completely dependent on donations and donors. So, what can be said about such a situation? At times it does happen that the donor asks us not to appoint the person, or [says that] if you are giving [maternity] leave, we will not provide their salary. Once the delivery is done, you can get the staff re-joined.

Keeping in line with its overall ethos, CDC prefers not to have a formal human resources management (HRM) vertical (it is merged with and handled by employees who also perform other internal administrative functions). CDC instead prefers to evolve people practices which make sense in its own context.

For example, CDC's work with women in Balaghat is a thread that has remained throughout the organisation's 20 years in the region. It works with adult women, college-going young women, adolescents and girl children as part of many of its programs. The organisation has a core mandate to ensure gender equality and gender justice through all its interventions and programs. As such, the organisation works to

ensure an internal atmosphere which is free from discrimination and harassment, with a particular focus on sexual harassment. A strong culture of gender sensitivity is present at all levels of the organisation, which begins at the earliest interaction of a prospective recruit with the organisation during the recruitment process. A psychometric analysis is conducted as part of interviews to assess a candidate's attitudes and perceptions of gender, as Komal underscores:

> When we interact with candidates during the interview, we gather this information. For example, there are questions like "'what should be the rights of women or men? What kind of inequalities are being faced by them? Should it be there? How many sons and daughters do you have? How much are you educating them?" So, these kinds of questions are asked to them, which gives us an idea about their understanding and attitudes related to gender.

Apart from having a working definition of sexual harassment, the POSH (Prevention of Sexual Harassment) policy describes a systematic process to be followed upon report of any such complaints as well as disciplinary action to be taken, if required (Refer to Exhibit 6).

Similarly, the organisation's work with Childline in Balaghat: working with children to ensure emergency protection, long-term safety, basic rights, education, health, and equal opportunities, has led it to articulate a formal Child Protection Policy (CPP) in 2005, to guide staff interactions with children. A three-member Internal Complaint Committee closely monitors the proper implementation of CPP and POSH: a significant investment for a small, resource-constrained organisation.

On the other hand, there are aspects of talent management where CDC's policies and practices are deliberately left less formalised and articulated. The organisation's definition of what constitutes good performance accounts for the objectives of a particular project to ensure that project outputs and outcomes are met, while not losing sight of the fact that an exclusive output orientation does not set in.

For instance, if rain shelters (small shelters for communities where they can grow vegetables) are being constructed as part of a livelihood project, targets are set for the staff accordingly, in terms of the number of shelters to be built. In this instance, if an individual manages to exceed the target number of shelters, that is considered good performance. However, on other projects which may be operating over long periods of time, the knowledge and ability to consistently address community concerns and build relationships also constitute elements of performance.

Providing staff with a safe environment, affording them the freedom to complete projects without micromanagement, and keeping them motivated to remain with the organisation for long periods of time is part of building a cohesive internal community within CDC. Ameen shares that:

> We are not a large team. So, if we have made a plan for three months, we will discuss its progress only after three months. We will not ask for an update within 15 days and ask if the target has been reached. Even after three months, if someone has not done certain things, there is no punishment for that.

In closing

In the landscape of Indian civil society, an organisation like CDC is characterised by a deep commitment to a specific region and a specific group of people, working dedicatedly for their wellbeing over long periods of time.

The considerable resource constraints within which CDC operates are not only internal. As Ameen pointed out, it is very difficult to get corporations or members of society interested in their cause: mainstream society as it is today can be indifferent. Help, for such an organisation, is difficult to come by. In spite of all this, CDC has worked in the region for 20 years. The primacy of this cause overrides many other concerns which can take centre stage in other nonprofits at a similar stage in their lifecycle, such as size, scale or scope of programs.

The past for CDC is a story of grit and persistence, discovering and learning what building an organisation that survives under trying conditions entails. Its efforts in navigating a challenging context with awareness and sensitivity have brought attention to a little-known community and a group of families whom society preferred to keep at a distance. Like many organisations operating in similar terrains and working amongst the most marginalised, it has programmes, culture, credibility, commitment and talent indigenously tailored to its circumstances. Organisations like CDC challenge the normative.

The future for CDC will not be a departure from its past, indeed it will be a continuation of its past. As Ameen looks back at this entire journey, the question for him will be to create a leadership that will hold this continuity. There are no templatised solutions and answers.

But Ameen has increasingly begun to delegate greater responsibility to the rest of the team, a decision that was pushed to the foreground when he was diagnosed with COVID-19. He reflects:

> See, I was infected with COVID in the month of April (2021) and until now, that is September 2021, I [still] have some or the other [health] complications, and because of that I have not been to the field for the past six months. But our work, that is, the relief work, is being done by our field staff. Right from report writing to accounts, finance, everything is being done by them. My role as a leader, I have confined it, and I have delegated roles and responsibilities to the coordinators or the staff below the coordinators

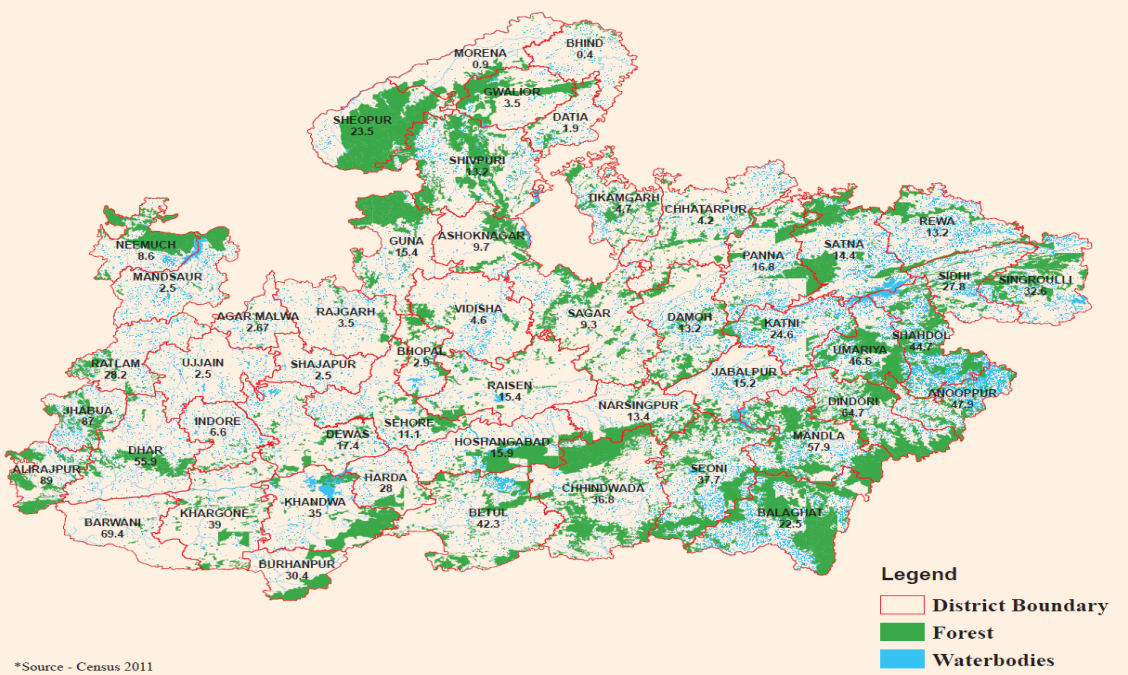
Though many responsibilities have been delegated to the staff, many critical responsibilities that are indispensable to the function and survival of CDC, like building relationships with external stakeholders and resource mobilisation, are still dependent on Ameen.

Like with everything that CDC has evolved, the meaning and form of leadership in the context of Balaghat and the Baiga will also be something it will arrive at on its own: whether it will constitute one or two individuals, adopt a collective approach to leadership or discover something altogether different. Whatever emerges, one thing will be clear: the bond it has with the Baiga will come to deeply influence its governance, leadership and management. It is this very bond, a source of satisfaction, a symbol of CDC's persistence and store of their future work that makes even a supposedly small concern like this an institution in its own right: for CDC continues to intimately mean something significant to the community they have dedicated themselves to.

Exhibits

Exhibit 1: Distribution of natural landscape and sample landholdings in Madhya Pradesh

Fig. 2: Map of Madhya Pradesh showing forest cover and district-wise Scheduled Tribe distribution



Source: SHRC, 2020

Table 1: Landholdings in districts of Mahakaushal region, Madhya Pradesh

		Per head Landholding (Ha.)	
District	**% ST population**	**ST**	**Non-ST**
Balaghat	22.5	1.57	0.64
Mandla	64.7	2.33	0.79
Dindori	57.9	2.53	0.97
Katni	24.6	1.47	0.82
Seoni	37.7	2.04	1.15
Jabalpur	15.2	2.32	0.8

Chhindwara	36.8	2.77	0.94
Narsingpur	13.4	1.95	1.16

Source: SHRC, 2020

Exhibit 2: Scheduled Tribe indicators for Balaghat, Madhya Pradesh

Table 2 provides a list of social status and health-related indicators for the Scheduled Tribes (ST) of Balaghat, compared to non-tribals (Non-ST). Some of the statistics below can be compared to the study findings specific to the Baiga tribe of Balgahat stated after Table 2.

Table 2: Social status and health-related indicators for the Scheduled Tribes (ST) of Balaghat, compared to non-tribals (Non-ST)

Indicator		**Balaghat**	
		ST	**Non ST**
No of Households		197	715
Household			
1	Household have an Aadhaar Card (%)	72.89	79.27
2	Households have BPL card (%)	81.7	57.38
3	Households access to internet (%)	1.15	5.75
4	Households owning a mobile/telephone (%)	63.41	79.99
5	Households have Pucca House (%)	7.98	25.89
6	Children under age 5 years whose birth was registered (%)	77.44	86.27
7	Households generally seeking treatment from public health facility (%)	52.34	36.6
Marriage and Teenage pregnancy			
8	Women (20-24 yrs) married before age 18 years (%)	11.66	7.64
9	Women (15-19 yrs) who were already mothers/pregnant at the time of the survey (%)	4.8	1.36
10	Woman (15-24 yrs) using hygienic methods during menstruation (%)	16.19	53
Maternal Health			
11	Mothers who had full antenatal care (%)	10.32	17.63

12	Institutional births (%)	69.7	87.76
13	Home delivery conducted by skilled health personnel (%)	3.63	3.93
14	Children (12-23 m) fully immunised (BCG, measles, and 3 doses of Polio and DPT) (%)	65.61	64.38
Children Health			
15	Children under age five years suffered from diarrhoea (last 2 weeks) (%)	3.3	6.3
16	Advice or Treatment sought for children suffering from diarrhoea (%)	*	65.24
17	Children under five with fever or symptoms of ARI (Acute Respiratory Infection) (last 2 weeks) (%)	na	100
18	Advice or Treatment sought for children symptomes of ARI (Acute Respiratory Infection) (%)	na	82.88
19	Households reported any infant death (male) (%)	na	11.59
20	Households reported any infant death (Female) (%)	na	12.14
Family Planning			
21	Currently using Any family planning method (%)	55.21	58.95
22	Currently using Female sterilisation (%)	47.95	52.41
23	Currently using Male sterilisation (%)	4.62	1.5
24	Total unmet need (%)	10.81	9.78
25	Total unmet need for spacing (%)	5.79	5.17
Nutritional Status of Children and Adults			
26	Children under 5 years who are stunted (height-for-age) (%)	39.59	29.76
27	Children under 5 years who are wasted (weight-for-height) (%)	34.61	31.69
28	Women whose Body Mass Index (BMI) is below normal (BMI < 18.5 kg/m2) (%)	41.75	42.51
29	Men whose Body Mass Index (BMI) is below normal (BMI < 18.5 kg/m2) (%)	26.33	42.93
Anaemia among Children and Adults			
30	Children age 6 – 59 months who are anaemic (<11.0g/dl) (%)	80.08	67.49
31	Non-pregnant women age 15-49 years who are anaemic (<12.0 g/dl) (%)	82.63	65.22
32	Pregnant women age 15-49 years who are anaemic (<11.0 g/dl) (%)	(88.41)	53.89

33	Women age 15-49 years who are anaemic (<12.0 g/dl) (%)	82.87	64.83
34	Population suffering from Tuberculosis (per 100,000 population)	115	88
Blood Sugar Level among Adults			
35	Women age 15-49 years with high (>140 mg/dl) blood sugar level (%)	3.32	4.98
36	Men age 15-49 years with high (>140 mg/dl) blood sugar level (%)	0	8.47
Hypertension among Adults (age 15-49 years)			
37	Women with above normal BP (Systolic 140-159 mm of Hg and/or Diastolic 90-99 mm of Hg) (%)	6.83	5.36
38	Men with above normal BP (Systolic 140-159 mm of Hg and/or Diastolic 90-99 mm of Hg) (%)	41.97	37.11

Source: SHRC, 2020

The poor state of development indices, food intake, health status, and malnutrition among the Baiga tribe is also widely reported in literature. Regarding the dietary patterns of the Baiga, a study by Tata Institute of Social Sciences, School of Health System Studies reports that:

> The diet of the majority of the households (based on their recall during the last 24 hours) consisted of rice, *kodo*, *kutki*, *dal* (legumes, which they either produce themselves or buy from the PDS (Public Distribution System) with little or no vegetables (depending on affordability). Respondents reported that meat consumption was dependent on availability of money. Some of them admitted that they catch fish, crabs and prawns from the stream or the river. There was no consumption of dairy products like milk, curd, etc. in any household. The inclusion of fruits in daily diet was not reported by any household. They consume forest produce like fruits of *mahua* or *tendu* (both are fruit-bearing trees), but *mahua* fruits are usually brewed to make a local alcoholic beverage (*mand*), consumed by both Baiga men and women…It is obvious that the Baiga diet is not a balanced one; it is dictated by affordability. It comprises mostly carbohydrates with little proteins and still less vitamins. Such a diet during pregnancy may result in various kinds of deficiencies in women and can affect the healthy growth of the child. (SHRC, 2020)

The consequences of poor nutritional status are further aggravated by and linked to poor maternal and child care, unsatisfactory health services, open field defecation and improper or nonavailability of drainage systems. A study on the nutritional status of pre-school children from the Baiga of Balaghat found 65.9% children to be underweight and 35.4% to be severely underweight; around 49.6% and 42.3% children were in the category of “stunted” and “wasted,” respectively. The figures for severe stunting and severe wasting were 28.8% and 10.7%.

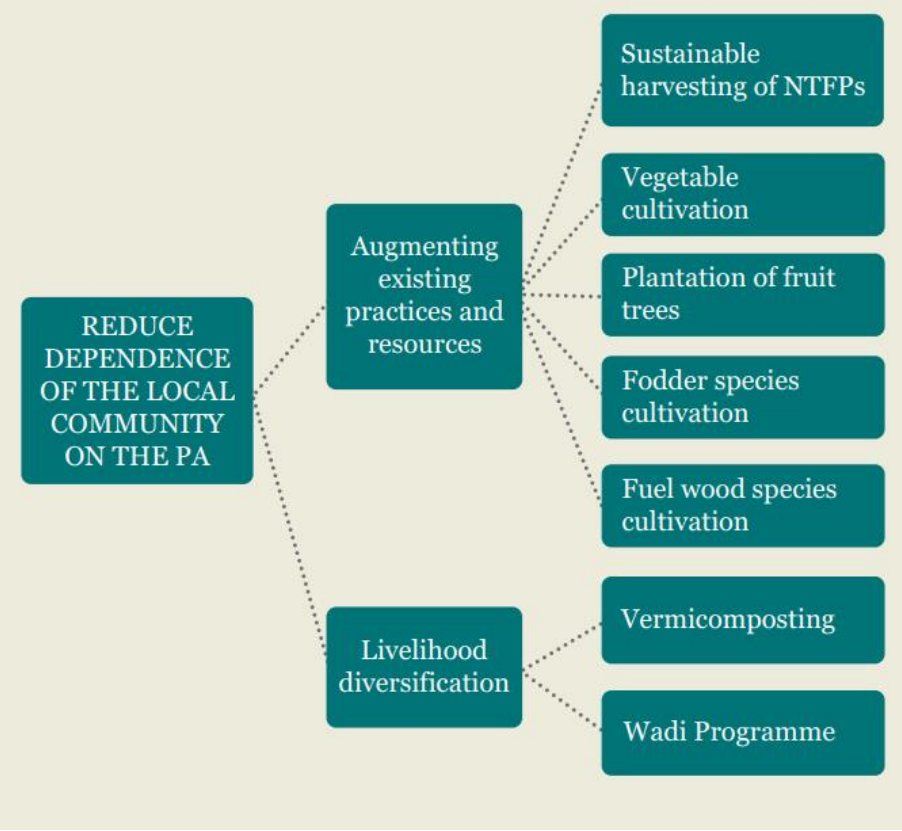
The study also highlighted the dietary pattern of the Baiga, mentioning that only the mean intake of cereals was above RDA (Recommended Dietary Allowance). Consumption of all other nutrients was found to be considerably lower than the RDA for the general Indian population.

For adults of the tribe, the study found that "About 55.8% of adult males and 62.9% females had varying degrees of chronic energy deficiency (BMI < 18.5)." This was significantly higher than the figures for the adult rural population of Madhya Pradesh as a whole were 28.6% males and 38.8% females. The study concluded that inadequate dietary intake had led to widely prevalent malnutrition amongst the Baiga (Chakma et. al, 2014).

Exhibit 3 2009-2011: integrating livelihoods with environmental conservation

This was a project undertaken by CDC in partnership with WWF and DST (Department of Science and Technology, Ministry of Science and Technology), aiming to integrate sustainable livelihoods with conservation efforts in Protected Areas such as those comprising national parks and wildlife reserves. Fig. 3 below shows CDC's model for reducing the dependence of local communities on the Protected Areas around Kanha National Park in Baihar block of Balaghat district.

Fig. 3: CDC's sustainable livelihood model



Source: Uppal et. al, 2012 Note: PA refers to Protected Area, and NTFP to non-timber forest products

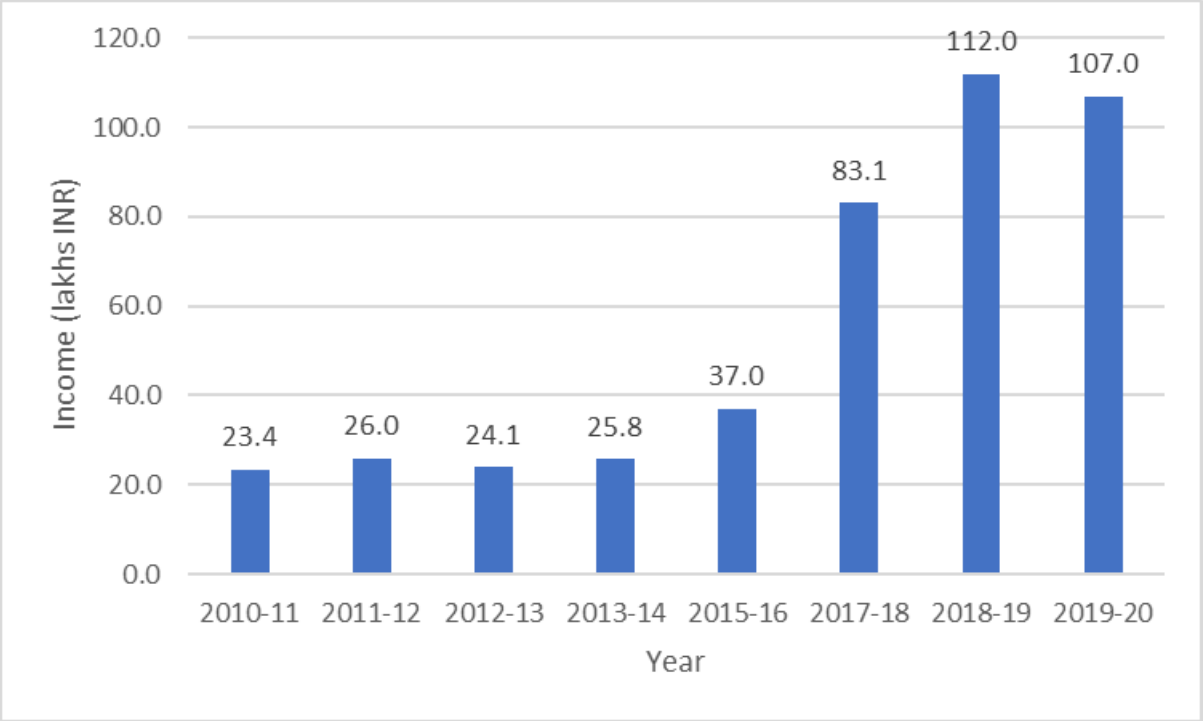
The final report on the project summarises the outcomes of CDCs efforts:

> Vegetable cultivation by the community members and subsequent sale of the vegetables in the local weekly market is the most successful activity in the project. 30 households from Balgaon and 20 households from Lapti participated in the activity. The causal factors of the success are demand in the local market and comparatively immediate returns on investment. Until 2008, before the project started, vegetable cultivation was hardly taken up by the local

community members as an income generation activity. In the DST funded project, the activity was conducted through women SHGs. Seeds were provided as per the requirement and interest of the participants. Training programmes on seed treatment, cultivation, processing and marketing were conducted. The trainings have been conducted by the agriculture and horticulture department field staff. Coordinated efforts of the CDC staff and the community members have made vegetable cultivation an important income generation activity. In one year this activity generated on an average 20 man-days of work thus contributing to employment generation. Average household income from vegetable sale is more than Rs 4,500 per year. This is almost double the annual income of a family. (Uppal et. al, 2012)

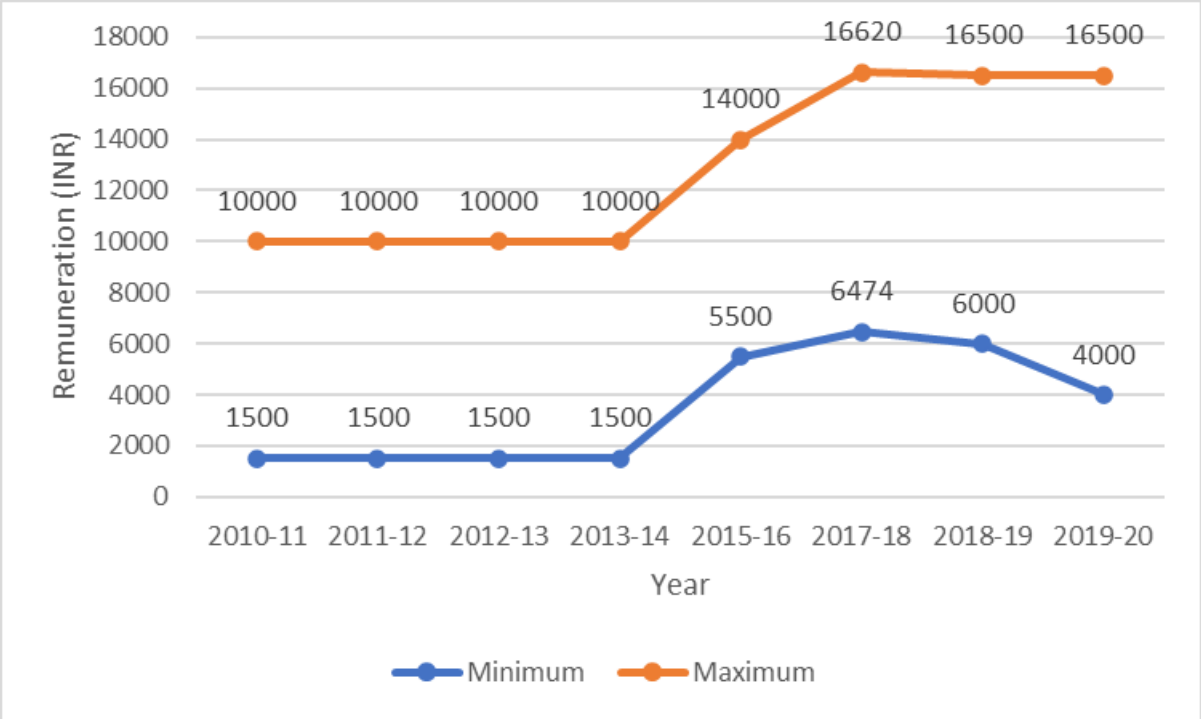
Exhibit 4: CDC financial data and program outreach

Fig. 4: CDC annual income 2011-2020



Source: Annual reports, 2011-2020

Fig. 5: Maximum and minimum remuneration of staff at CDC, 2011-2020



Source: Annual reports, 2011-2020

Table 3: CDC project outreach in 2020

Supported by	No. of Families	No. of Panchayats (Nagar Palika)
Action Aid Association (LIC)	200	20
The Hunger Project	1387	30
Wipro Foundation	200	10
Jagori Rural Charitable Trust	100	10
Paul Hamlyn Foundation	236	30
Consortium for Street Children	200	02

Source: Annual Report, 2020

Exhibit 5: CDC Childline Project

A total of nine staff members and one volunteer work in rotating shifts to implement the project. Shiv Kumar, head of CDC's Childline project describes how the 24-hour 1098 helpline number is staffed and managed:

> We have a fixed shift system for the entire team of 9 people, there are 3 female staff and the rest are male. For the women, the timings are divided between 9 am to 5 pm for one, and 10 am to 6 pm for another. For the male staff, the timing is divided between 10 am to 6 pm for one, and from 12 pm to 8 pm for another. The volunteer who is part of the team, stays 24 hours at the centre. He is given a room in the office and his duty hours are from 8 pm till 9 am in the morning.
>
> When we have our first morning meeting, we talk about the activities we did the previous day and our target for the day. Most of the time, if we have an eight-hour shift then four hours are for fieldwork and four are for documentation work at the office. It's not mandatory that we do outreach for four hours only, field work in itself is time-consuming, because going to field locations, having conversations, conducting awareness programs, can go over time, so we could be doing outreach for five to six hours and documentation work for two hours. Like this, everyone has their plan, all the team members submit their plans for the month: what activities they will work on in the next 30 days, and who will they work with? For instance, if it is something with the government, which officials will they work with?
>
> During outreach, the kind of issues that emerge are: village people may not be aware of the 1098 (helpline) service. We provide them the required information. Through that, we receive cases. *Anganwadi* workers, ASHA (Accredited Social Health Activist) workers, staff of (Department of) Women and Child Development, act as "volunteers" for us, in that they direct cases to us for us to have a look. When we do awareness programs in the village, we involve ASHA workers or any other health workers: if schools are there, school teachers are invited, as well as the *Sarpanch* (village heads), and then we promote and create awareness about Childline—the concept of "good touch" and "bad touch," sexual harassment, sexual abuse—all this information is given to the children in their school. After that, within one month we conduct an open house program, which is required to be done in the month. Our guideline instructs us to do it at least once within a month. The open house is like an open platform. It serves as an opportunity for us to invite all the villagers together wherein we conduct awareness activities in the open house about all the activities we do and about their safety.
>
> We also provide counselling. All the cases that we have, every 15 days, we do counselling for them. Let us assume we have a victim of abuse. They might be completely disturbed mentally and not getting any support from their community either. We would conduct counselling for them every 15 days, to try and motivate them, or to ensure they receive any government aid they are entitled to. So for example, we would initiate a process with the help of the police station for rape victims. There is a government compensation of Rs. 2 lakh for rape victims which is in place. We process that on the victim's behalf. And for Childline, we have monthly meetings with our Director (Ameen) and review meetings every three months with the manager of Childline Foundation who is based in Mumbai. We make a report for them on all the cases we have handled

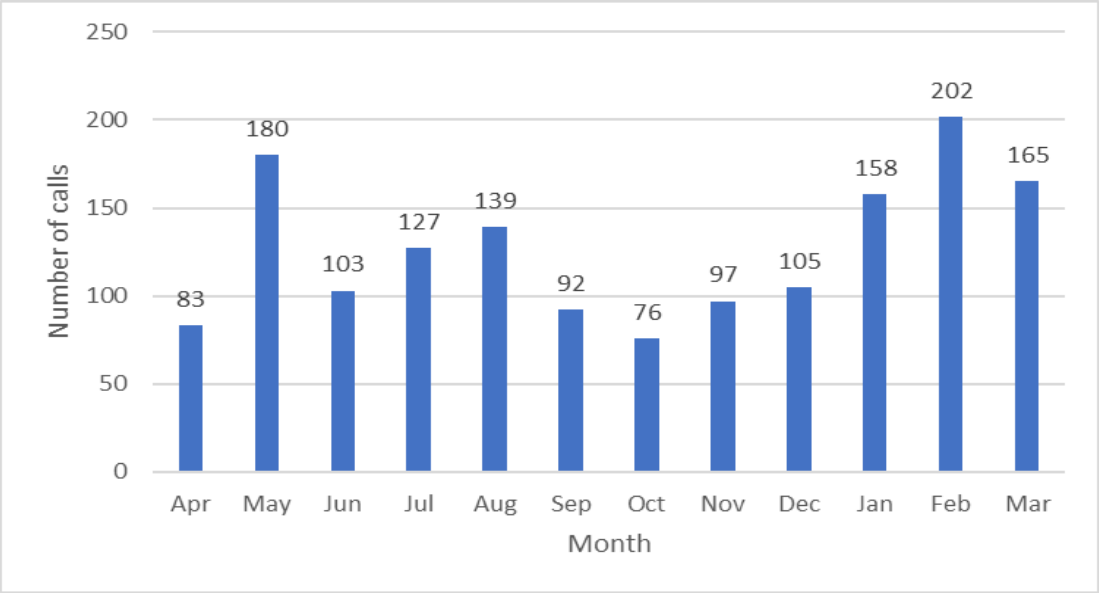
during those three months, along with the analysis of the categories and classifications of those cases.

Table 4: Number of cases and case types handled by CDC's Childline project team in 2019-20

Case classification	**Number of cases**
Protection from abuse	153
Missing	119
Parents asking for help	86
Sponsorship	34
Child lost and found	33
Shelter	29
Medical help	20
Restoration	8
Emotional Support and Guidance	6
Total	488

Source: Annual report, 2020

Fig. 6: Calls received on CDC's 24-hour helpline



Source: Annual report, 2020

Exhibit 6: CDC HR policy overview

The HR Policy for the Community Development Centre has been developed by the founder members with the consultation of key functionaries and experienced individuals from the social development sector.

Table 5: CDC HR Policy overview

RECRUITMENT PROCEDURE	• Requisition for recruitment submitted to HR Unit; requisition contains the job description/job profile of the proposed staff.
	• On receipt of the above requisition, the HR unit will start the actual recruitment process.
	• A public notice will be served through newspaper, CDC website, devnet jobs.
	• From among the applications received, a list of candidates to be prepared to be called for an interview as per the published criteria.
	• The HR unit constitutes an interview board to conduct the interview.
	• The interview process may include all or any of following methods:
	  ○ Written test
	  ○ Computer test
	  ○ Group discussion
	  ○ Viva-voce interview
	• After completing the interview process, one interview report containing the recommendation of the board signed by each board member to be forwarded to the HR unit for further course of action.
	• Based on the recommendation report, the HR unit will issue the offer letter for appointment.

	● Upon acceptance of the said offer letter, the HR unit will proceed to issue the appointment letter in the form of Assignment letter or Agreement for employment.
INDUCTION TRAINING	● The selected candidate will join the service and undergo an orientation programme after joining the service. Induction is a strategic means to welcome a new entrant at CDC to make him/her feel acknowledged as an honoured member of staff. The policy underscores the need for induction highlighting that the induction training enables a new employee to situate into a new milieu to establish a relation with the goal, objectives, mission, vision, practices, policies and strategies of CDC. ● Induction Training is designed for five days during which the participants interact with the administrative personnel; undertake field visits to the various units & divisions. Any further required clarification needed can be taken up later during the service period of the individuals. ● CDC undertakes four induction training sessions in one financial year with the newly recruited contractual staff. The ideal timing is in the month of January, April, July, October, preferably in the first week. ● The objective of induction is to enable the participants to: ○ State the mission & vision of CDC. ○ Describe organisational structure, system & style of functioning. ○ Explain CDC model of community health program using LFA. ○ Explain implementation strategy. ○ Describe a peer education program. ○ Describe child rights & protection. ○ List out the administrative rules & regulations. ○ Explain CDC's role.
PERFORMANCE REVIEW	For all categories of staff, yearly review of performance is made. Based on this review report, salary increments and/or shifting to next level or fresh contracts in the same/higher grade is made.
SALARY INCREMENT	This is generally as per terms of contract of each employee and normally increment is considered after the completion of each year/contract. In the case of a contract employee, a fresh contract is made with/without increment. In the case of a regular employee, increment/no increment is considered after the end of each completed year of service. Increments are considered based on the recommendations of the concerned departmental heads, evaluation of performance, contribution to the organisation and other factors like regularity, timely reporting and leaving place of duty absenteeism etc. These are to be generally followed as per findings of the Performance Evaluation Report. Annual increment is also depending on the funding agency and approved budget.
PROMOTION POLICY	● For employees at the levels of Project Worker, Project Assistant and Sr. Project Assistant, the criterion for promotion is competence and experience. ● For promotions at the levels of Project Associate and Sr. Project Associate the criterion is knowledge, competence, and experience. ● For consideration of promotion to the post of Project Officer and above, educational qualification is an additional requirement in general.

	However, special considerations of promotion from the post of Senior Project Associate to the post of Project Officer may be made on a case-to-case basis at the discretion of the Executive Director.
EMPLOYEE WELL-BEING	**LEAVE** There is provision of (a) Casual Leave; (b) Sick Leave; (c) Earned Leave; (d) Compensatory Leave for all employees **OFFICE LOAN** To meet emergency requirements, staff members are allowed to take an office loan. The loan is permissible to an extent of one month's basic + D.A. and adjustable over a maximum equated monthly 10 instalments. **MEDICLAIM INSURANCE** Requisite premium pertaining to Mediclaim policy of regular and contractual employees and their kith & kin up to a ceiling of total policy amount of Rs 50,000/- is reimbursed. **EDUCATION GRANT** Each regular employee gets the benefit up to a maximum of two children in the form of textbooks required by them.
PAY REVIEW	**Pay Review Committee for regular employees** Every five year a Pay Review Committee is formed with representation from all categories of regular employees for making recommendations to the Governing Body.

Source: CDC internal, 2021

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