The Nomadic Communities In Five Urban Settlements of Pune City

A Baseline Study – To understand the Current Scenario of Health, Education, Livelihood, Rights and Entitlements of NT and DNT People

2019 - 20

Joint Initiative By

ECONET and SWADHAR – IDWC

Study In-charge – *Swapnil Newale, Rohini Hulgane*

Guidance - *Gauri Bhopatkar, Anjali Bapat*

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This study has been a collaborative process where ECONET and SWADHAR's Project Akshardeep representatives came together to contribute various dimensions and perspectives during the study design. The survey formats used as a base for this study were referred from the documents prepared by YASHADA for village micro-planning survey.

The process of reaching out to scattered population in every corner of study area was possible due to efforts taken by Kavita Sawant, Sushama Orape, Shobha Surate, Rekha Kashid, Shruti Talekar, Bhaghyashri Solkar, Suvarna Adavade, Sangita Adsul, Kanhopatra Sakhare, Laxmi Galfade, Megha Kamble, Sunita Pawar, Mayuri Kate, Shobha Shinde and Vaishali Kank. Some of them had to make repeated home visits to obtain the necessary data. Their persistence and dedication has contributed to bringing this data together.

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Swapnil and Rohini

Contents

ACRONYMS

NT – Nomadic Tribes
DNT – De-notified Tribes
SDGs - Sustainable Development Goals
MDGs – Millennium Development Goals
ANC –Antenatal Check-up
ASHA – Accredited Social Health Activist
ANM - Auxiliary Nursing Midwifery
PHC – Primary Health Centre
UNICEF – United Nations International Children's Emergency Fund
YASHADA –Yashwantrao Chavan Academy of Development Administration
WCD – Women and Child Development
ICDS – Integrated Child Development Scheme
WHO – World Health Organization
NFHS – National Family Health Survey
JSY - Janani Suraksha Yojana
SGR – Sustainable Growth Rate
SRS – Sample Registration System
MMR - Maternal Mortality Ratio
LBW - Low Birth Weight
NBW-Normal Birth Weight
NHM - National Health Mission
BCG vaccine - Bacille Calmette Guerin
DPT vaccine – Diphtheria, Pertussis, and Tetanus
CHC – Community Health Centres
U – PHC –Urban – Primary Health Centres
PMC – Pune Municipal Corporation
PCMC – Pimpari Chinchwad Municipal Corporation
PMPML - Pune Mahanagar Parivahan Mahamandal Ltd.
SMC – School Management Committee
RTE – Right to Education Act 2009
UDISE - Unified District Information System for Education
GER - Gross Enrolment Ratio

STUDY OBJECTIVES

- Identifying, locating and understanding the current status of NT DNT communities in urban settlements (Pune city)

- Conduct the Baseline survey to understand the Health, Education, Livelihood, Rights and Entitlement scenario of identified communities

- Finding out the hurdles and gaps at different levels, to seek the schemes, facilities, rights and entitlements

- Mapping the Scope and Possibilities to engage with communities, local government offices / officials and different stakeholders in PMC & PCMC

INTRODUCTION

Social exclusion and inequalities are the living realities for Nomadic Tribes, De-Notified Nomadic Tribes communities, especially those from the Scheduled Areas. Women and children from these communities are subjected to multiple forms of discrimination within and outside of their community. People from these communities have been discriminated, denied of their human rights and fundamental rights enshrined in the Constitution of India and are compelled to live on fringes of the society aspiring for social-political empowerment and economic development.

Largely, the NT DNT population lives in rural and remote areas. Due to insufficient work opportunities and inefficient government strategies of income generation people of these communities suffer to survival more than any other communities. In search of job, income generation these communities are migrating towards cities where they can find earning at least for basic survival. Migration patterns in these communities are varying, some of them follows regular seasonal migration, few communities prefer business opportunity migration while many of them migrated and settled in the *wasties* since decade. The particular areas are inhabited by people belonging to particular communities, it seems that whoever may have migrated earlier must have settled here and called more people from their village or community to join them.

In rural area we can findthese communities easily but here in urban area they cannot easily identified. There are 53 NT and DNT communities in Maharashtra.[1] Out of these Gosavi, NathJogi, Joshi, NathPanthi, Davari, Bhati, Wanjari, Rajput, Wadar,Vasudeo, Bhati,etc communities found settled in Joshiwada, K. K. Market, Kedareshwar, Gangadham and Sadgurunagar settlements. Most of the people have migrated from different districts of Maharashtra state like Solapur, Osmanabad, Kolhapur, Nanded, Parbhani, Akola, Malegaon and from outskirts ofPune. Entire Gangadham*wasti* is result of migrated families from Madhya Pradesh state.

The geographical locations where targeted communities live are private properties and corporation properties which can be development anytime. They are highly vulnerable with changing the decision of land owner or government's development policies.

[1] http://www.ymnonline.com/data/stureg/caste.html

ABOUT ORGANIZATIONS

ECONET:

ECONET was registered in 1993 under the Bombay Public Trust Act (1950). ECONET is a Development Support Organization working towards Human and Institutional Development (HID) and believes in identifying, nurturing and strengthening local leadership among communities. We are working primarily with Adivasi and Nomadic Tribes in Maharashtra. Out of 53 NT and DNT communities in Maharashtra, ECONET has worked with more than 42 of these, through its various programmes and intervention strategies for past 2 decades. Over a period of time, the organization has not only raised issues of NT, DNT and ST communities, but for the NT/DNT, ECONET initiated with other like-minded organizations a platform (Maharashtra Bhatke Vimukta Manch (MBVM) – network of NT/DNT organizations) for CBOs and grassroots-based groups to mobilize, organize and strategize on a Common Minimum Agenda for Nomads in Maharashtra.

SWADHAR – IDWC:

SWADHAR established in 1995 with aim to help women in distress irrespective of their caste, religion or community. It also works for the education, health and the over-all development of under privileged children, with special emphasis on a girl child from lower income group. SWADHAR means self-reliance and as the name suggests, it works to make every woman and child self-reliant, self-supporting and conscious of their rights so that they can live a decent, dignified life in whatever stratum of society they belong to. To realize its goals, SWADHAR runs various activities through its different projects like women empowerment, child care protection and overall development child, community development and reaches out to around 25,000 women and children through them. SWADHAR dreamed a model for education and development of underprivileged children in nomadic communities between 3 to 18 years in organizational set up and with the participation of parents and society and promote holistic development (Physical, Cognitive, Social, Emotional) of a child between 0 to 3 age group in nomadic community and to encourage the child of 3 to 6 age group to undergo pre-school education as a step towards mainstream education.Organization also works with Adolescent girls in the nomadic communities by providing vocational courses and conducting interactive sessions on various relevant topics to make them confident and self-reliant.

BACKDROP

ECONET has not worked before in urban area, based on the working experience in rural areas this pilot initiative has taken up. This would be first stepping stone for the organization to work for the rights of NT DNT communities within urban settlements and dream for their dignified life.

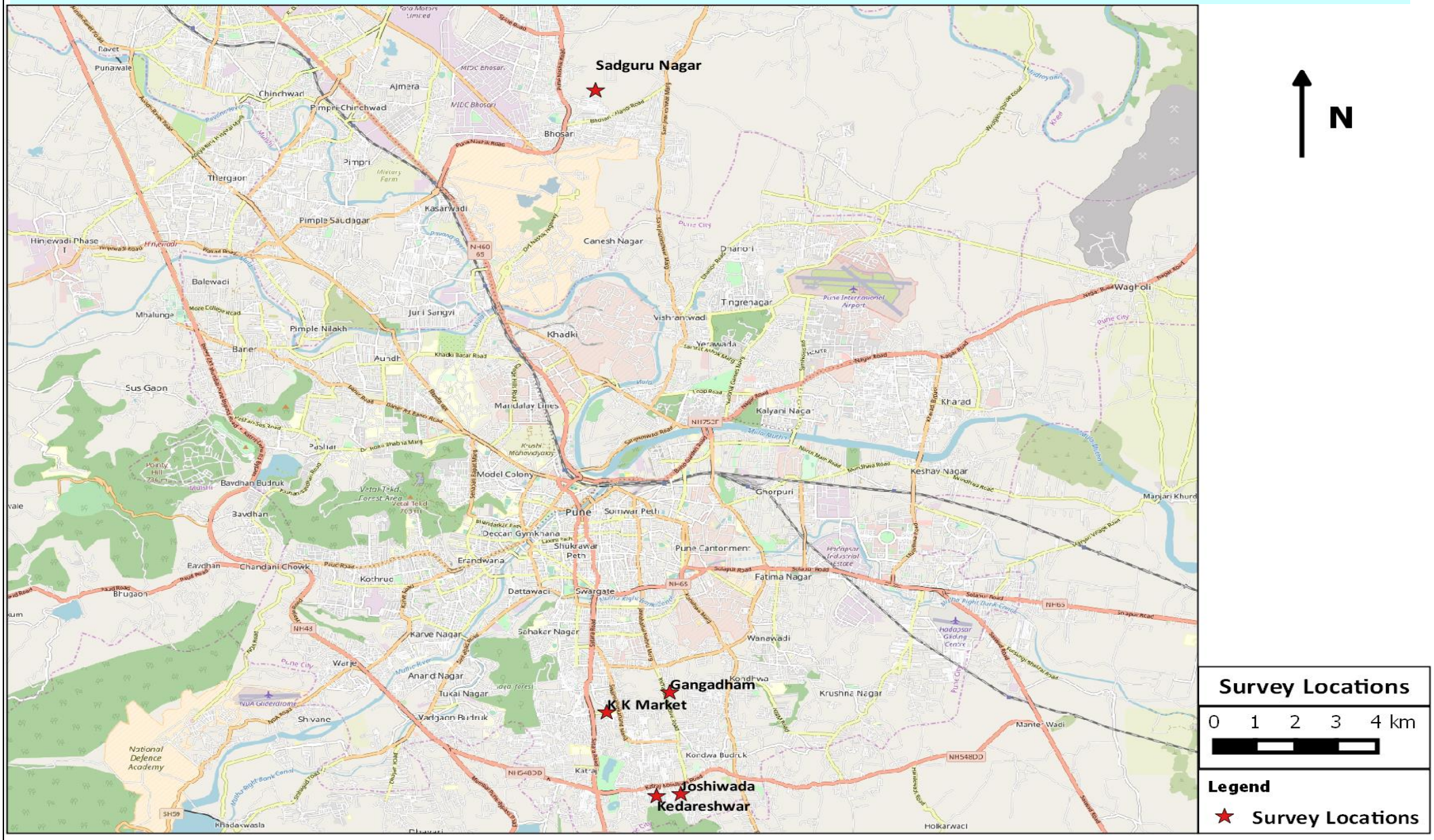
Working with the most underprivileged section of societies, both the organizations has developed their own understanding about these communities over the period and are aware about the issues are being faced by them. SWADHAR since last decade engaged with these communities to ensure school enrollment and quality of education through students – parent's participation. Mainstreaming them is one of the objectives of SWADHAR, however they came up with certain issues like unavailability of identity proofs, certificates and basic documents which are important to mainstream them. ECONET and SWADHAR came together with common interest but with individual expertise. With these communities in mind in the month of May 2019 ECONET in collaboration with SWADHAR (IDWC) conducted a baseline survey in 5 urban settlements of Pune city (where SWADHAR already intervening since last 8 years) to understand the current socio-economic status especially more focus on health, education, and entitlements. The expertise developed over a period and common interest of both the organization turned in this innovative study. Looking forward with the concrete findings based on which strategies can be developed to bring about positive change in the social and entitlement context of NT and DNT communities. This initiative intends to play the role of a catalyst in ensuring NT DNT communities no longer remain on the fringes of development and empowerment.

ECONET in 2006-2007 had conducted a Baseline Survey to study the status of Health, Education, Socio Economic Profile and Livelihood in 11 Districts of Maharashtra state. This study research was published with key findings and raised the issues till advocacy. As clearly mentioned earlier ECONET had never done before a work or study in urban area hence, with continuation on the 2006-07 study we thought to replicate the same in Pune city on pilot basis.

STUDY AREA

SWADHAR - IDWC under its AKSHARDEEP project is already running support classes in K.K. Market, Kedareshwar, Gangadham, Joshiwada and Sadgurunagar. These *Wasties* are settlements of Nomadic communities; hence for the pilot detailed study we selected these five *wasties*. Out of these four *wasties* are located in Pune Municipal Corporation area while one rest in Pimpri-Chinchwad Municipal Corporation area.

GEOGRAPHIC LOCATIONS



SAMPLE SIZE

1. No. of Household surveyed

Name of Community/*Wasti*	Household surveyed
K K Market	7
Kedareshwar	65
Gangadham	63
Joshiwada	34
Sadguru Nagar	43
Grand Total	**212**

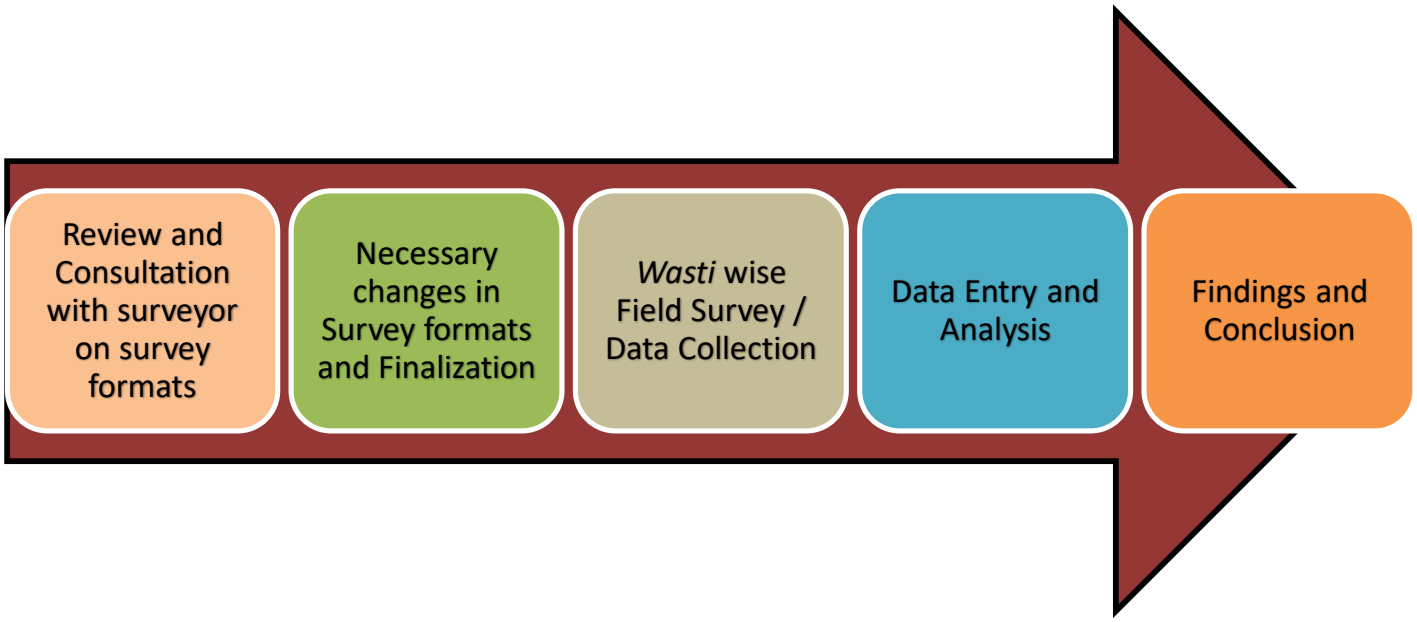
2. Age wise Population

Name of Community/*Wasti*	0 to 3 years		3 to 6 years		6 to 14 years		14 to 18 years		18 to 60 years		Above 60 years		Total		
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	Total
K K Market	2	3	4	2	13	7	6	3	18	23	2	2	45	40	85
Kedareshwar	13	11	11	16	35	42	6	16	84	75	5	8	154	168	322
Gangadham	15	10	17	14	48	45	19	10	70	75	0	1	169	155	324
Joshiwada	3	7	12	12	31	44	12	8	76	81	4	6	138	158	296
Sadguru Nagar	5	3	10	6	27	17	13	9	57	59	2	5	114	99	213
Grand Total	**38**	**34**	**54**	**50**	**154**	**155**	**56**	**46**	**305**	**313**	**13**	**22**	**620**	**620**	**1240**

METHODOLOGY

In 1999 – 2004 UNICEF was testing out the micro-planning processes under its different programs, they validated these formats by testing out in almost 6000 villages of 12 districts. In 2005 Yashwantrao Chavan Academy of Development Administration (YASHADA) and UNICEF have developed a guideline and formats to collect the versatile data and process then named as "Micro-planning". Over the period many changes happened in the process and finally in 2011 – 2013 Rural Development and Panchayat Raj Department Government of Maharashtra have declared to adopt this process in entire state.

As both organizations are looking for the different findings to understand the current status of education, health, their rights and entitlements we found this Micro-planning data collection format useful as it comprises all the information gathering potential. Changes have been made as per the need and approach.



- SWADHAR's AKSHARDEEP Project field teachers have been running support classes in these communities so they have developed a good rapport hence we thought them as a good surveyor for this study.
- Data has been collected by discussing each and every question deeply with family members and then only it has recorded.
- Data is a combination of interview; observations and information already exist with surveyor.
- Gathered data have been analysed communally by both organizations team.
- National and International authorities and institutes guidelines, Government policies, ACTs, GR's, handbooks guideline tools, etc. have been reviewed and referred.

RESEARCH ANALYSIS

I. HEALTH SCENARIO

Definition of Health:

"Health means – "A state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."

"Health is a fundamental human right and that attainment of the highest possible level of health is an important worldwide social goal."[2]

In Nomadic communities many of them are using Nomadism as way of life and therefore they move from one place to another place for survival. They often stay in very unhealthy surroundings in out skirts of villages, roadsides in open places and in the city.

Our one of the Sustainable Development Goals (SDGs) focuses to **"ENSURE HEALTHY LIVES AND PROMOTE WELL-BEING FOR ALL AT ALL AGES"** We all know how important it is to be in good health. Our health affects everything from how much we enjoy life to what work we can perform. That's why there's a Goal to make sure everyone has health coverage and access to safe and effective medicines and vaccines. In the 25 years before the SDGs, we made big strides—preventable child deaths dropped by more than half, and maternal mortality went down by almost as much. And yet some other numbers remain tragically high, like the fact that 6 million children die every year before their fifth birthday.[3]

Now days we claim our Pune city is one of the Smartest cities in India by all the means, but really it is worth saying unless we achieve the minimum basic Human Rights like access to health, education, common and safe amenities, shelter, etc.

Government systems (Health and WCD departments) are working to reach the unreached. However, many more people are still remaining underprivileged from the health facilities and referral services. The Health Scenario is mainly focussing on the current design of the health delivery system in terms of its reach in context of Nomadic communities in reaching out to the Government Health delivery system. The study helps to understand the root causes, gaps and loopholes which are becoming the obstacles in availing the existing government's schemes and facilities.

[2]WHO health definition Health and Human Right

[3] UNDPs Sustainable Development Goals, booklet _ Page no 6

1. REGISTRATION OF PREGNANT WOMEN

Women and Child Development Department, Government of Maharashtra made it mandatory for conceived / pregnant women to register their names within 12 weeks of their pregnancy. Registered women will be eligible to avail all facilities provided by government under its different schemes. Obviously, those who don't register will be deprived from these benefits. In our current survey we found eye opening number of such deprived women who even are not aware of registration.

As we can see in chart no. 1.1 only 49% of the total respondents have registered their names within 12 weeks of their pregnancy. That means 51% of respondents are deprived of government health services such as; prenatal vaccination, nutrition and referral services of medical care and treatment.

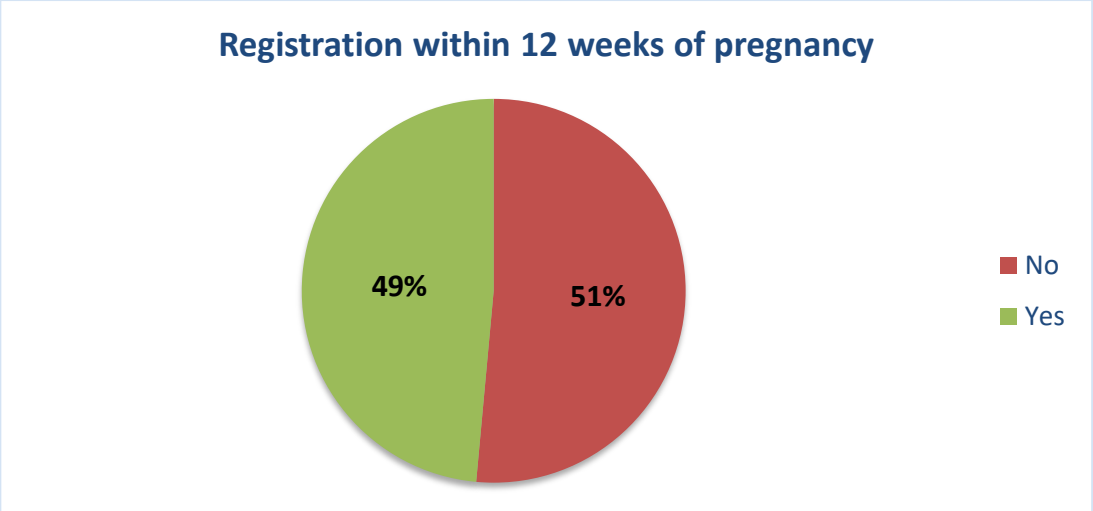


Chart no. 1. 1

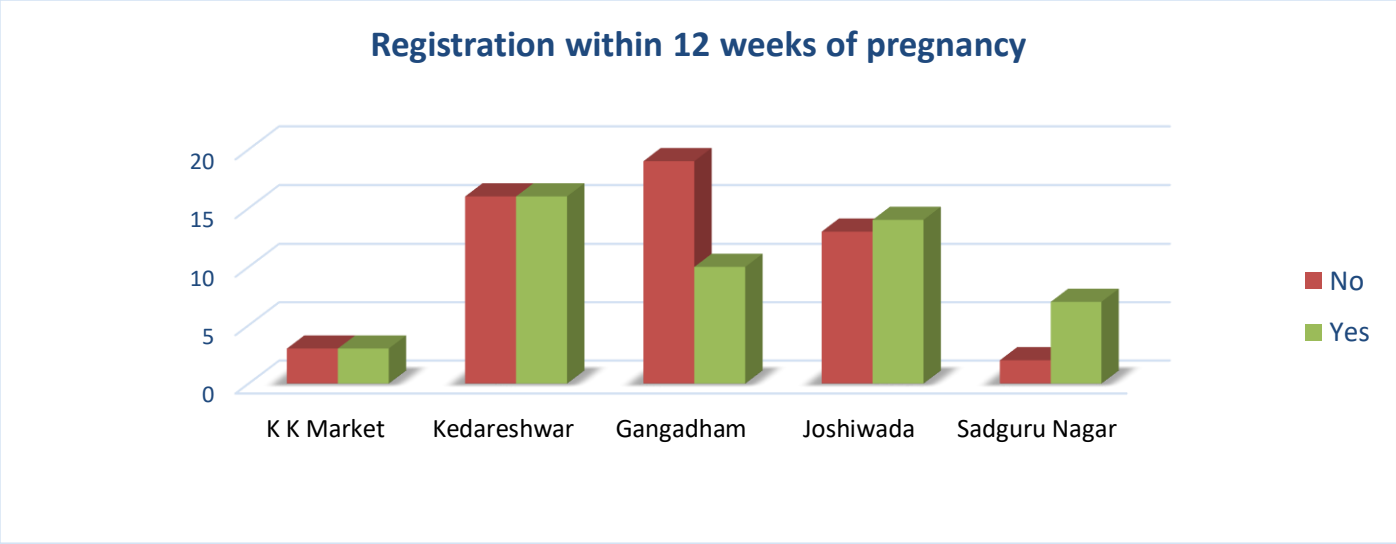


Chart no. 1. 2

2. NUTRITION

Nutrition is very important not only for conceived mother but also for the healthy infant growth. It is supplementary food to the pregnant women to boost her immunity and maintain the nutrition / diet balance. Although this is not a full meal or couldn't give full nutrition but could at least help to sustain her diet balance. Health and Nutrition needs of a child cannot be addressed in isolation from those of his or her mother and therefore the programme also extends to adolescent girls, pregnant women and nursing mothers. ICDS programme seeks to provide all basic essential services to children and mothers in an integrated manner right in their villages or wards. Gradually, the scheme has been expanded to urban slums and to rural and tribal blocks[4]. WCD / ICDS has developed a nutrition / diet chart and also trained the ANC, ASHA's about the same to look after their diet. Certainly, imbalanced diet results in negative health impacts. To avail this government facility conceived women has to register her name with ANM, ASHA's within 12 weeks of pregnancy.

If we look at the chart, we can see the percentage of women depriving from getting the nutrition. We had seen the status of registration in previous chart which is linked with availing the nutrition. ANM, ASHAs working in these areas somehow / might have managed to provide the nutrition to the non-registered women (8 women) therefore the no of service availing women is more than the no of registered women.We can see in chart no. 1.3 that 68 % of women are deprived from getting nutrition, and the no is alarming. 31 % women are receiving the nutrition under different schemes.

Why the women in the same community are at different levels in context of receiving the nutrition? The causes need to find out. This is really alarming number which need to be focused and take on priority to reduce this up to 0 % to make it praiseworthy.

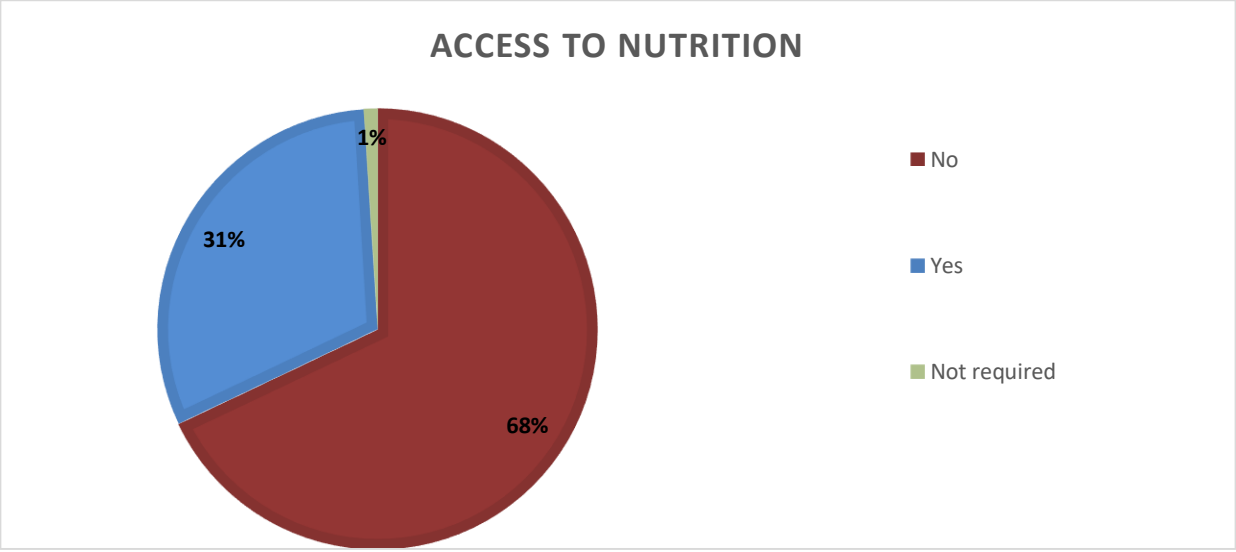


Chart no 1.3

[4] https://womenchild.maharashtra.gov.in/content/homecontent/schemes.php

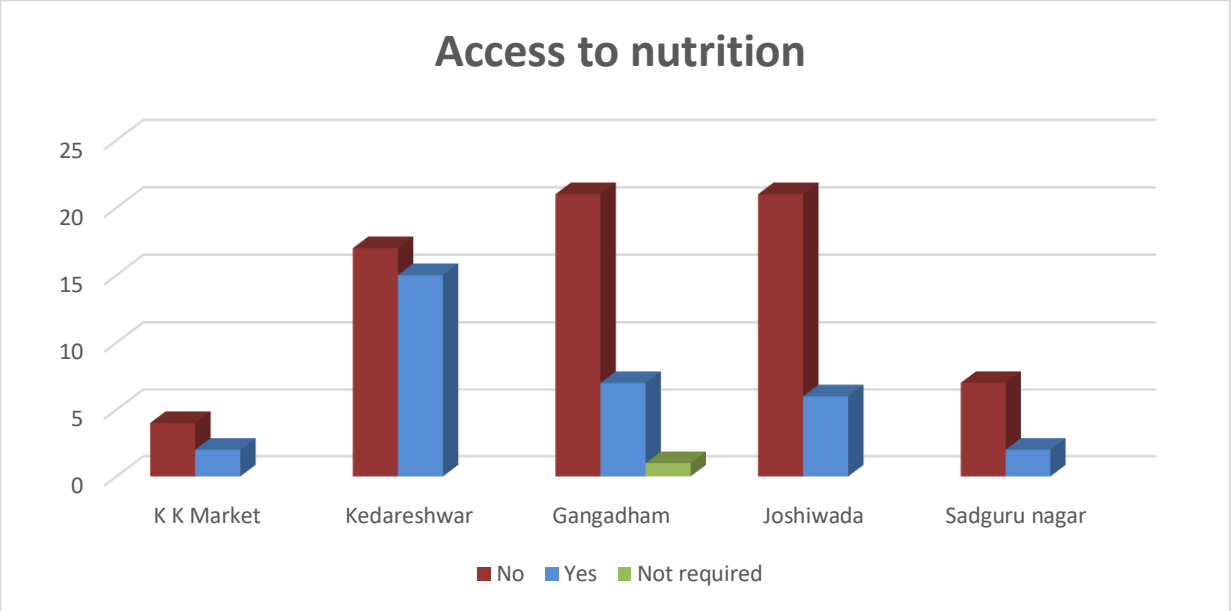


Chart no 1.4

3. THREE ANTINETAL CHECK-UPS DURING PREGNANCY

WCD/ ICDS have recommended 3 antenatal check-ups during pregnancy. 1st ANC check-up is within first 3 months of missing the period. 2nd ANC check-up is on 7th month of pregnancy and 3rd is in 9th month of pregnancy to protect the mother and foetus from further complications as well as to ensure healthy growth of mother and foetus. During each ANC visit it is mandatory to do the check-up of HB for early detection of anaemia, blood pressure, urine for albumin and sugar, weight to ensure that mother and foetus is gaining the weight and abdomen to assess the growth of foetus. Regular ANC check-up definitely tackle the issues early, avoids further complications and reduce the infant mortality and maternal mortality rate.

Though ANC is very important for both mother and infant, we can see in chart no 1.6 that 18% means total 19 number of women have not done their regular ANC check-up and obviously they will be deprived of routine health check-up, vaccination, iron and folic acid supplement, guidance on prenatal care etc. They have more risk of infant and maternal mortality as proper medical care has not taken during the pregnancy. Children are our future and for healthy nation we have to reduce this 18% to 0%. It is appreciative that total 82% means 84 numbers of women have done their ANC check-up.

K. K. Market, Kedareshwar and Joshiwada needs to be focused. It would be helpful to organize awareness campaign in these areas with the help of ICDS / WCD. WCD, ICDS departments are working hard to find out such cases and ensuring zero percentage of deprivation however, ASHAs, ANMs visits and registers can be monitored to tackle the no of deprivation and reasons behind it.

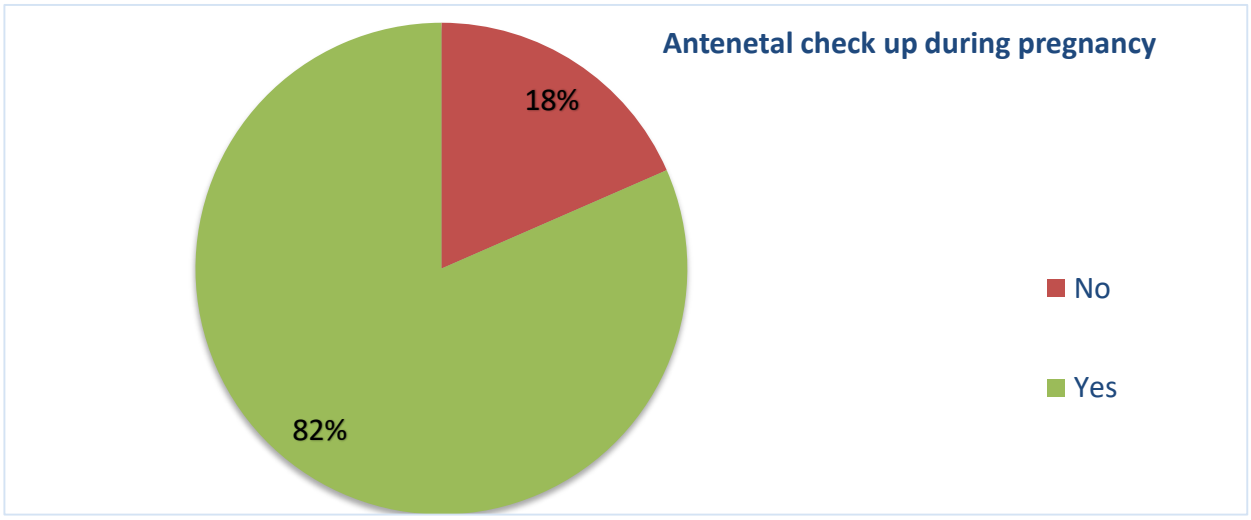


Chart no. 1. 5

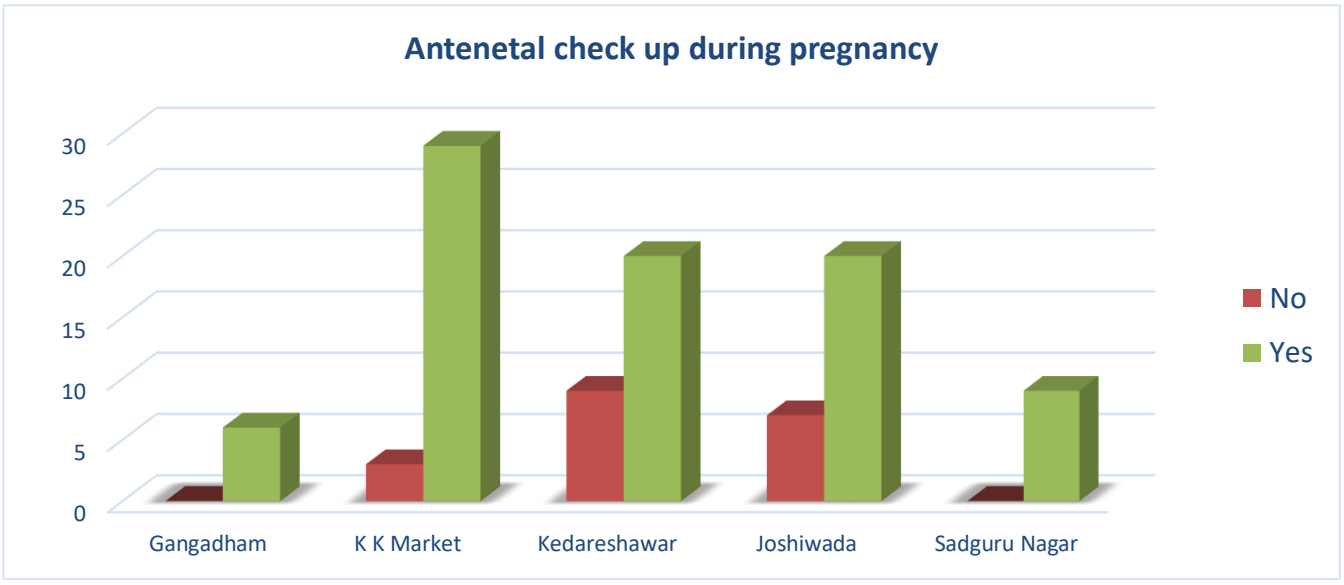


Chart no. 1. 6

4. CONSUMPTION OF 100 IRON TABLETS DURING PREGNANCY

According to WHO, India comes at the bottom of the table with 51% women suffering from anaemia. Anaemia is a serious condition that can have a long term impact for mother and child. A staggering 78,143 pregnant women in Maharashtra are suffering from anaemia.5

World Health Organization's (WHO), World Health Statistics data shows that 40.1% of pregnant women worldwide were anaemic in 2016. The condition is prominent in Southeast Asian countries where about half of all global maternal deaths are due to anaemia and India contributes to about 80% of the maternal death due to anaemia in South Asia. There is marginally decrease in prevalence of anaemia in pregnant women in India from 58% in NFHS-3 (National Family Health Survey-2005-06) to 50 % in NFHS-4 survey (2015-16).6National Nutrition Mission has been setup under the oversight of the Ministry of Women and Child Development with the aim to reduce anaemia among young children, adolescent girls and women of reproductive age (15–49 years) by one third of NFHS-4 levels by 2022.

Daily oral iron and folic acid supplementation with 30 mg to 60 mg of elemental iron and 400 µg (0.4 mg) folic acid is recommended for pregnant women to prevent maternal anaemia, puerperal sepsis, low birth weight, and preterm birth.7WCD has advised to conceived / pregnant women to consume 1 iron tablet daily for 3 months. Pregnant Women must consume 100 iron tablets during pregnancy for the prevention of anaemia. Maternal anaemia is associated with poor intra-uterine growth and conceiving of low-birth-weight babies.8

As we can see in chart no 1.7 total 17% of women have not consumed the 100 iron tablets that means they are more at risk of maternal anaemia as it is common during pregnancy due to increased demand of iron for the growing foetus and placenta; and increased red blood cell mass (with expanded maternal blood volume in the third trimester), which is further aggravated with other factors such as childbearing at an early age, repeated pregnancies, short intervals between pregnancies and poor access to antenatal care and supplementation. Indian Council of Medical Research considers haemoglobin (HB) level below 10.9 g/dl as cut off point for anaemia during pregnancy.

[5] https://m.dailyhunt.in/news/india/english/my+medical+mantra+english-epaper-medmanen/over+78+000+pregnant+women+suffering+from+anaemia+in+maharashtra-newsid-88852698

[6] https://www.nhp.gov.in/disease/gynaecology-and-obstetrics/anaemia-during-pregnancy-maternal-anemia

[7] https://www.who.int/elena/titlesguidance_summaries/daily_iron_pregnancy/en/

[8] http://www.nrhmtn.gov.in/guideline/RGPMA.pdf

We have found that, majority of women who have not done their routine ANC check-up (19) have not consumed the iron tablets (16). It is just because; they were deprived of proper guidance and medicinal support as they missed their routine check-up.

Primarily conceived/ pregnant women from Kedareshwar, Joshiwada and K. K. Market as shown in chart no. 1.8 needs to be taken on priority and promoted for timely antenatal check-up and consumption of iron supplement as well as strengthening of public health measures to improve pregnancy outcomes in support to achieve a sustainable development goal to ensure healthy lives and promote well- being for all at all ages.

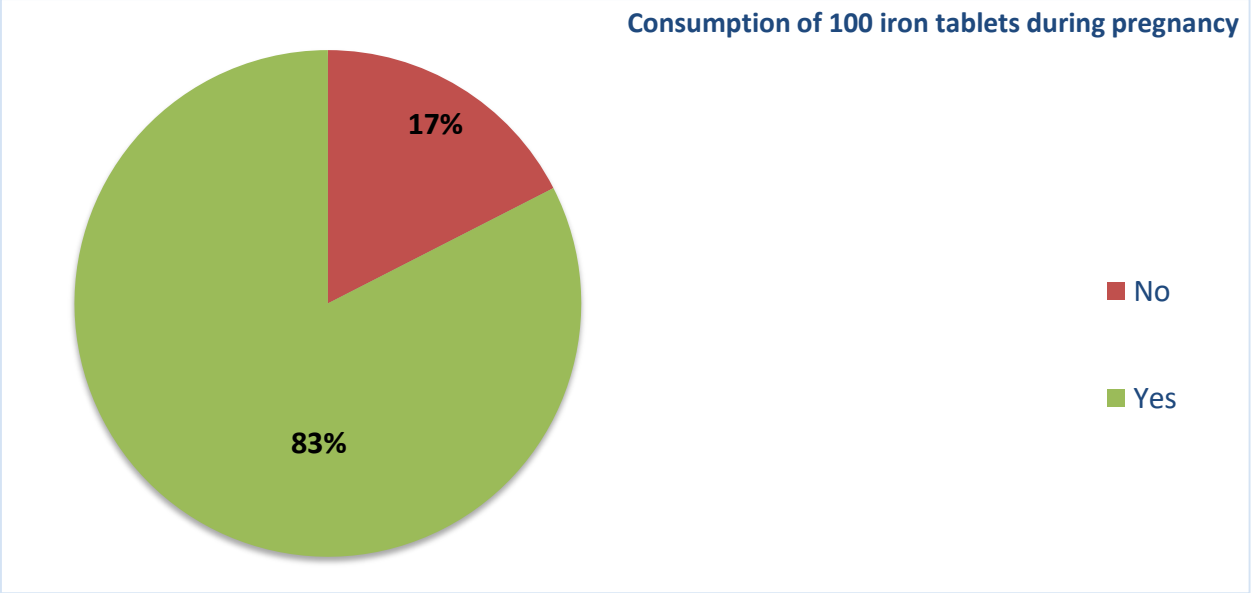


Chart no. 1. 3

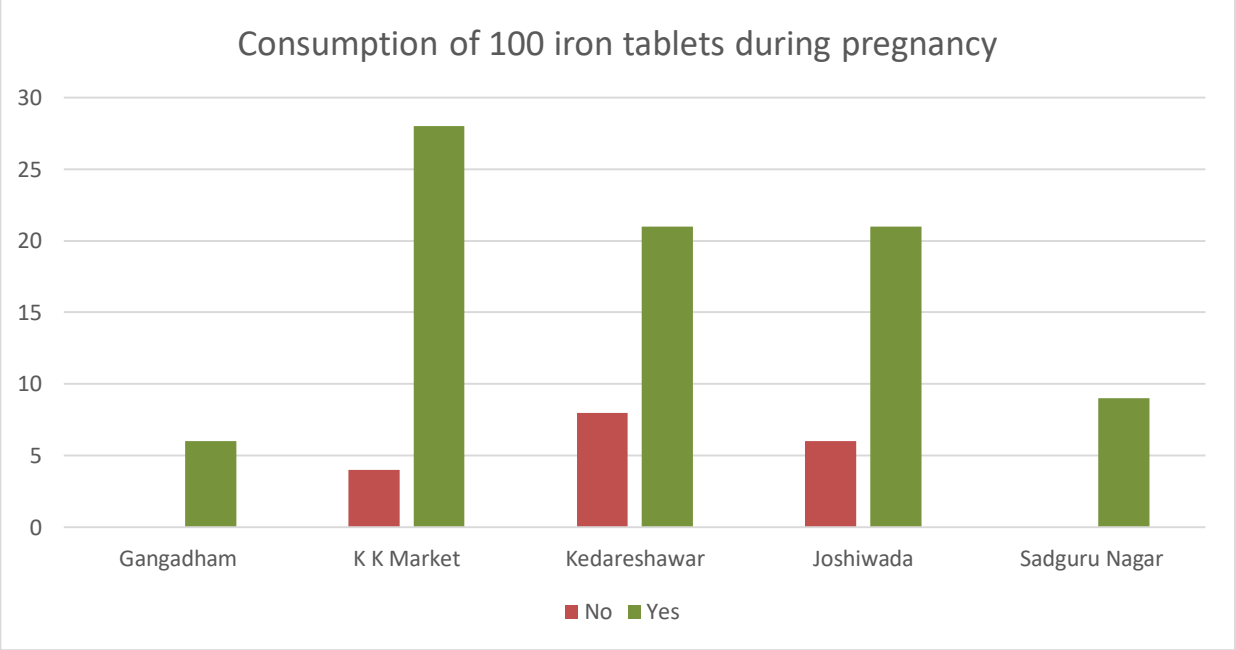


Chart no. 1. 4

5. 2 TT/ BOOSTER VACCINATION

Vaccination helps to protect you and your baby against serious diseases. At a time, you know that you are pregnant; you share everything with your baby. That means, when you get vaccines you aren't just protecting yourself, you are giving your baby some early protection too. WHO recommends TT vaccination to all pregnant women, depending on previous tetanus vaccination exposure, to prevent neonatal mortality from tetanus. WCD has advised and provides 2 TT/ Booster vaccination to pregnant women in 2nd trimester of pregnancy and one month later of first TT dose. If the TT vaccination has been done during previous pregnancy within three years only one TT dose is recommended. TT dose has to be taken before one month of delivery. Tetanus can cause severe morbidity in the mother and neonate. Tetanus is a life-threatening bacterial disease that is caused by the toxin of bacterium called *Clostridium tetani* which is often found in soil. Neonatal tetanus usually occurs in new-borns through infection of the unhealed umbilical stump, especially when the stump is cut with non-sterile instrument. Tetanus is prevented only through vaccination. The WHO reported that neonatal tetanus kills over 200,000 new-borns each year. Almost all these deaths occur in developing countries while it is very rare in developing nations.[9]

Still we can see in the chart no. 1.9 that, 16 % of pregnant women have not done their TT vaccination from K. K. Market, Kedareshwar and Joshiwada. They might be unaware about the neonatal tetanus infection and taking it very casually. So, 16% of new-borns are at risk of neonatal tetanus.

Awareness and promotion needs to be done in these communities to decrease the percentage and promote them for the TT/ Booster vaccination with the help and involvement of local government health care system.

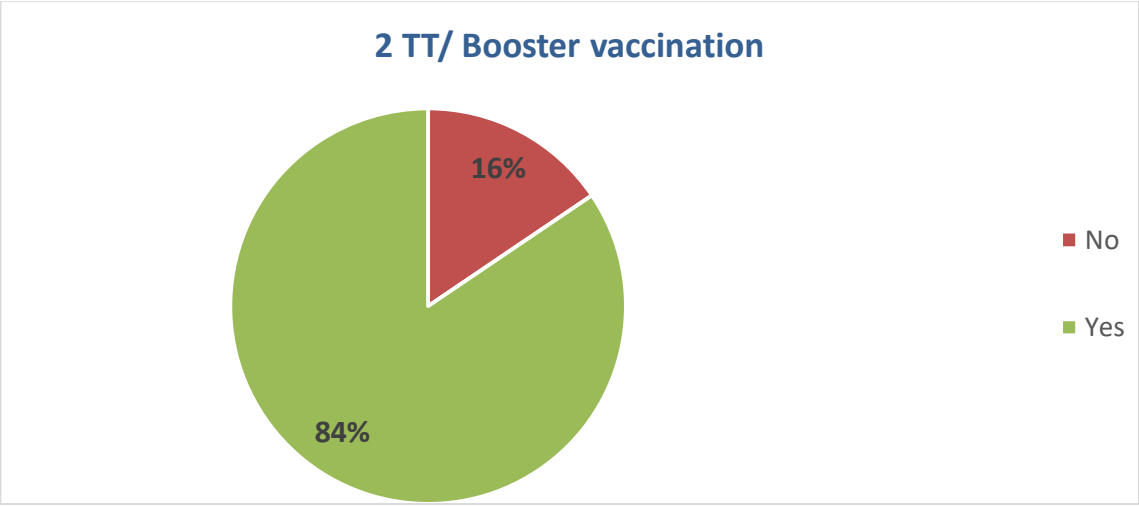


Chart no. 1. 5

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4964703/

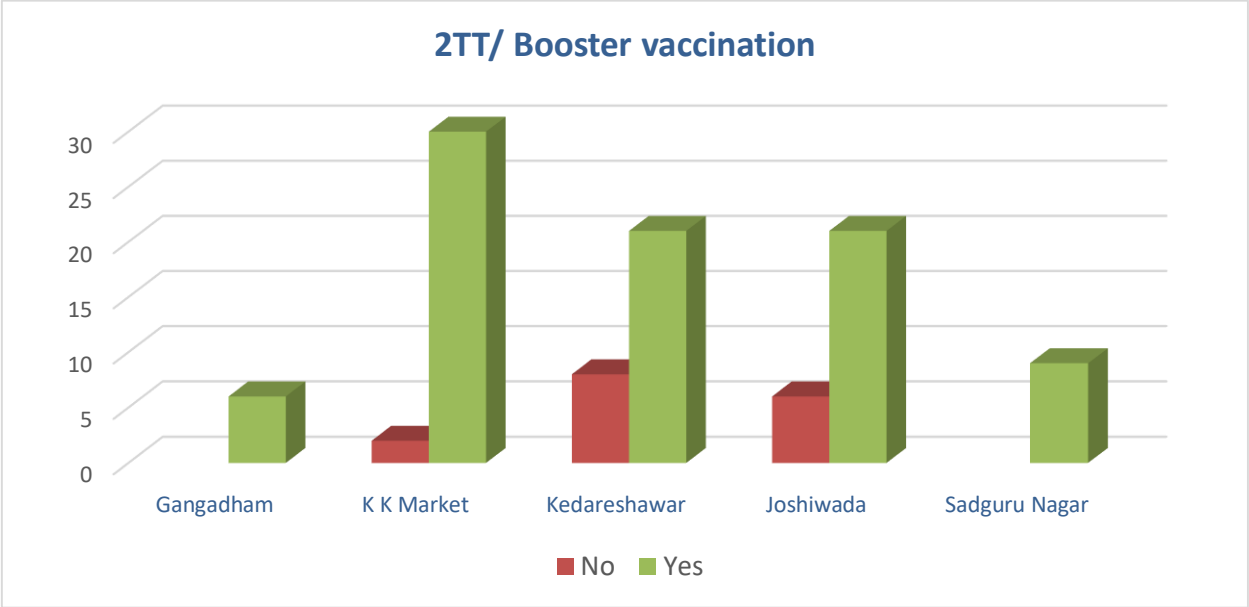

2TT/ Booster vaccination
30
25
20
15
10
5
0
Gangadham
K K Market
Kedareshawar
Joshiwada
Sadguru Nagar
No
Yes

Chart no. 1. 6

6. PLACE OF DELIVERY

The most critical period for the mother and her baby is delivery time. Every woman must have safe, hygienic, skilled attendant and timely access to specialized care in case of emergency to prevent mother and child mortality. India has come long way in improving maternal and new-born health. The Maternal Mortality Ratio (MMR) of India has reduced from 301 maternal deaths per 100,000 live births in 2001-03 as per registrar general of India, sample registration system (SGR, SRS) to 130 maternal deaths per 100,000 live births in 2014- 16. As a result, India has achieved the Millennium Development Goal (MDG) in reduction of maternal and new-born mortality. This momentous achievement has been possible because of various interventions implemented under the umbrella of the National Health Mission.[10] Government of India has initiated a scheme of Janani Suraksha Yojana(JSY)with the purpose of safe motherhood intervention under the National health mission. It is being implemented with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among poor pregnant women. JSY is centrally sponsored scheme, which integrates each assistance with delivery and post-delivery care. The Yojana has identified Accredited Social Health Activist (ASHA) as an effective link between the government and pregnant women.[11] Nearly 32000 pregnant women each year still lose their lives during pregnancy, childbirth and the postnatal care. In addition, 5,90,000 new-borns die each year in the first month of life. The neonatal mortality rate in India is 24 per 1000 live births. Whereas the early neonatal mortality rate is 18 per 1000 live births which is a serious cause of concern.

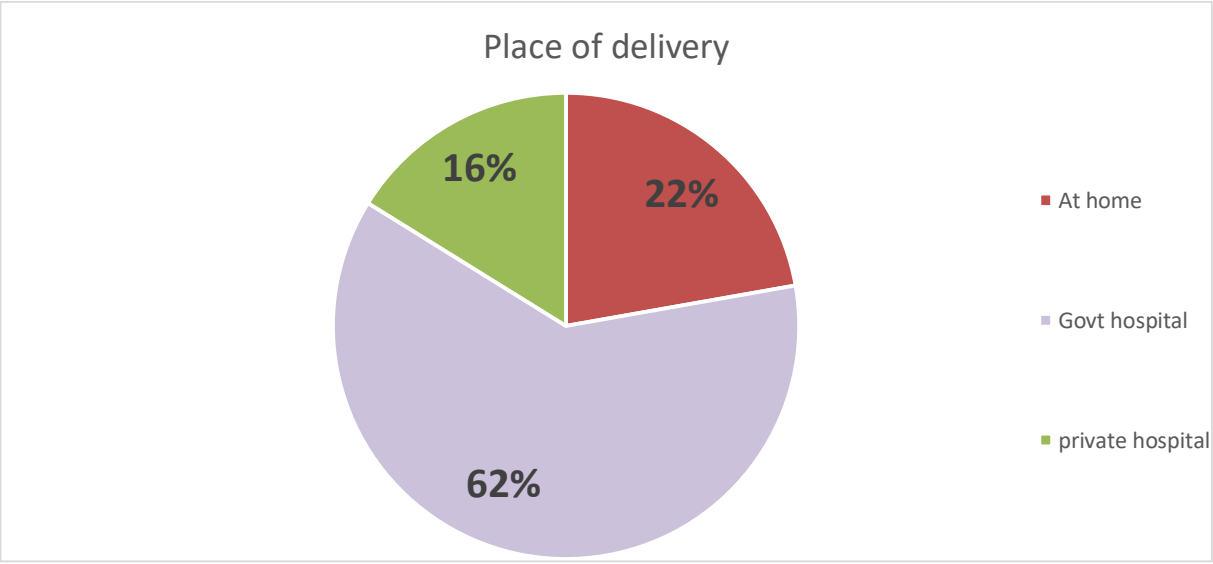


Chart no. 1. 7

[10] https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/MH/Guidelines/Guidelines_on_Midwifery_Services_in_India.pdf, page 23

[11] https://nhm.gov.in/index1.php?lang=1andlevel=3andsublinkid=841andlid=309

As we can see in chart no. 1.11 that, delivery of 22% women had been done at home and the number is very high in Joshiwada. They are more likely to be at risk of maternal and new-born mortality due to no skilled birth attendant with proper prevention, care and precautions. Special attention needs to be given with priority at Joshiwada for the promotion of safe delivery. Total 62% of respondents have gone to government hospitals for delivery and we can say that, the percentage is quite good still 16 % of respondents have preferred private hospitals.

Intervention needs to be done for effective implementation and promotion of National Heath Mission with the help and support of local health system and people. It will give easy access of government health services as well as improve the maternal health of women.

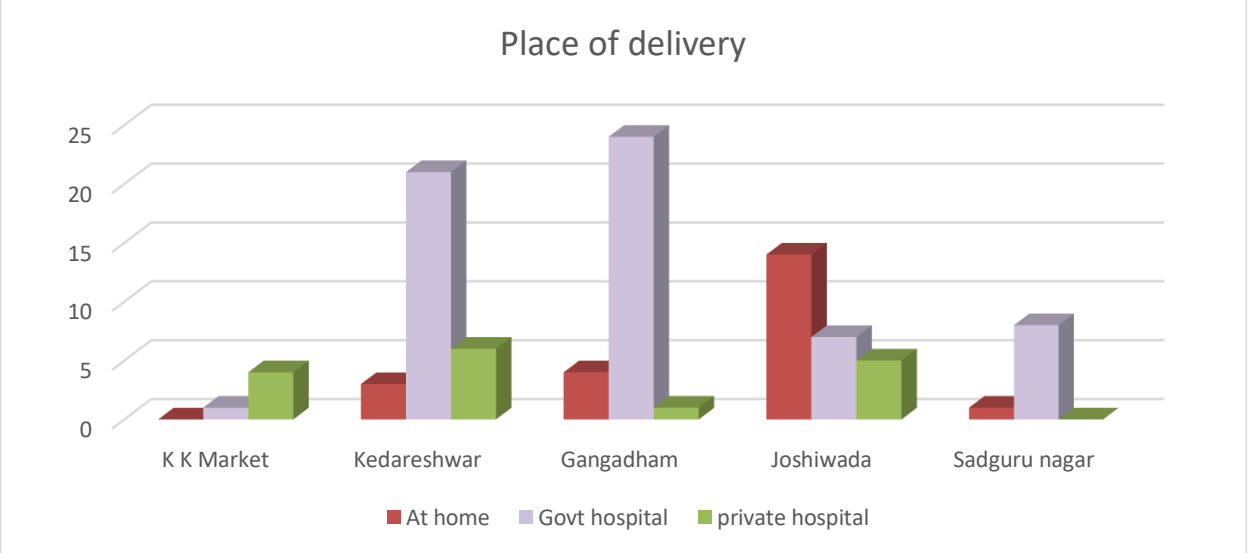


Chart no. 1. 8

One critical strategy for reducing maternal morbidity and mortality is ensuring that every baby is delivered with the assistance of skilled birth attendant which generally includes a medical doctor, nurse or midwife. Experts agree that the risk of stillbirth or death due to intrapartum- related complication can be reduced by about 20% with the presence of skilled birth attendant. Skilled health personnel should be capable of handling normal deliveries safely, able to recognize warning signs for complications and refer mother to emergency care. Non-skilled attendant including traditional birth attendants, can neither predict nor appropriately manage serious complications such as haemorrhage or sepsis, which are the leading killers of mother during and after childbirth. Despite substantial progress over the last two decades, inadequate or nonexistence care during pregnancy and delivery was largely responsible for the annual deaths of an estimated 303,000 mothers and 2.5 million new-borns in the first month of their life in 2007.[12]Though, it is risky to attain deliveries at home due to unavailability of emergency care services. As we can see in

[12]https://data.unicef.org/topic/maternal-health/delivery-care/

chart No. 1.11 that, 22% i.e. total 22 number of deliveries out of 99 has done at home and all were done with skilled person as per respondent's point of view as per survey record. Percentage seems to be high to attain home deliveries in Joshiwada. So here we can say that, these women could be more at risk of maternal and new-born mortality. Percentage is really high and need special attention. On priority we need to find out that whether the person involved in delivery are actually have proper skill and knowledge? Maintain proper hygiene or not? Can deal with the risky situation with provision of proper referral or not? Then think on what kind of strategy we can develop with the involvement of home delivery attendant, government health institutions, hospitals etc.

It is because in some tribal communities like Paradhi their society norms don't allow them to go to hospital for deliveries in fact, the women have to do her own delivery without anyone's help. Now other females somehow manage to help that women and take care of her and her baby. In this case we can at least take one step forward and provide safety measures and skilled attendant at home.

7. BABY WEIGHT AT THE TIME OF BIRTH

Nutrition, Vaccination, Iron and Folic Acid supplement is very important to maintain a good health and development of conceived mother and infant during pregnancy. Poor nutrition of mothers, underage motherhood and inadequate prenatal care are the major causes for underweight and premature babies. Poor and insufficient intake of nutrition during pregnancy not only directly affects women's health but may also leads to low birth weight of baby. Low Birth Weight is defined by the world health organization (WHO) as weight as birth less than 2500 gms. (5.5Ib). It is estimated that 15% to 20% of all births worldwide are LBW, representing more than 20 million births a year.[13] LBW contributes to 60% to 80% of all neonatal deaths. The global prevalence of LBW is 15.5% which amounts to about 20 million LBW infants born each year, 96.5% of them in developing countries.[14] Low birth weight babies are more at risk to have a various communicable and non-communicable infections.

Chart no. 1.14 shows that, 56% (55 women) delivered an underweight (below 2500 gms) babies and ratio seems to be high in Gangadham and Kedareshwar. Out of 55, 39 numbers of conceived women were deprived from nutritional supplement under ICDS during their pregnancy.

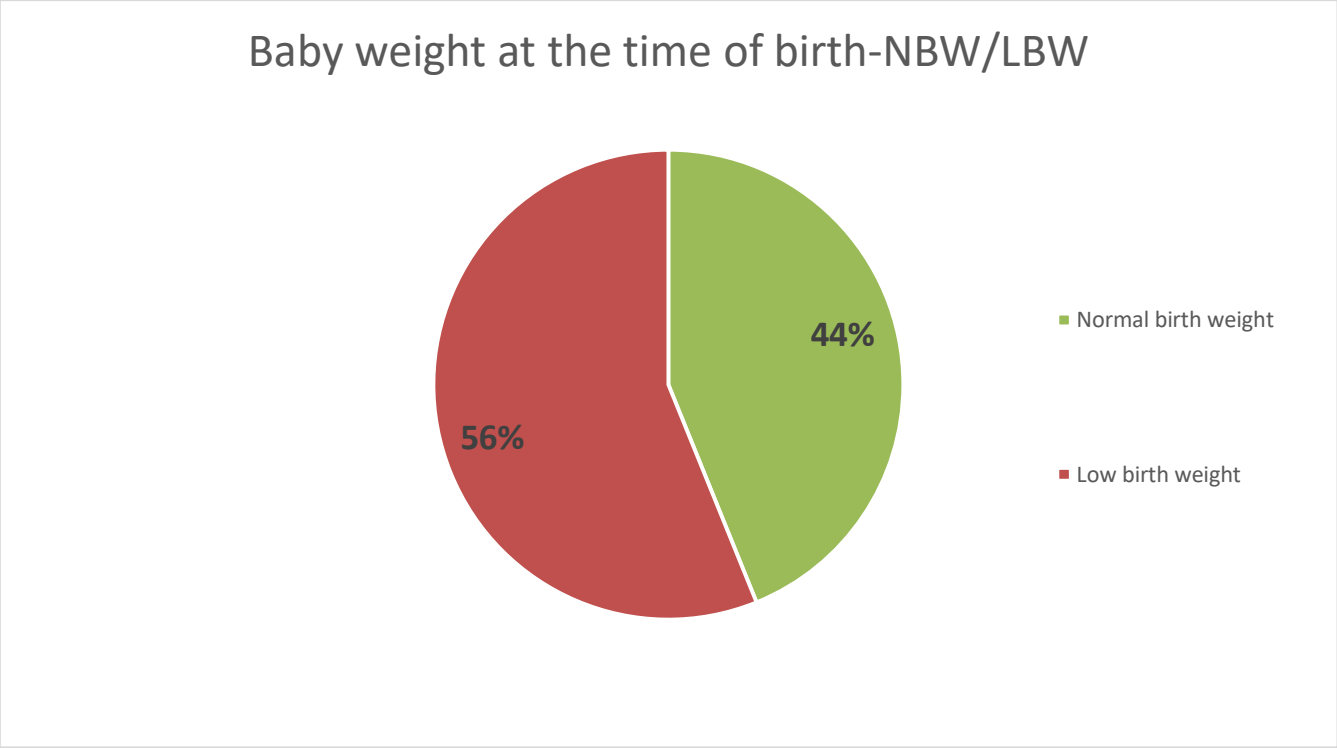


Chart no. 1. 9

[13] https://www.who.int/nutrition/topics/globaltargets_lowbirthweight_policybrief.pdf, page 7
[14] https://www.who.int/maternal_child_adolescent/newborns/prematurity/en/

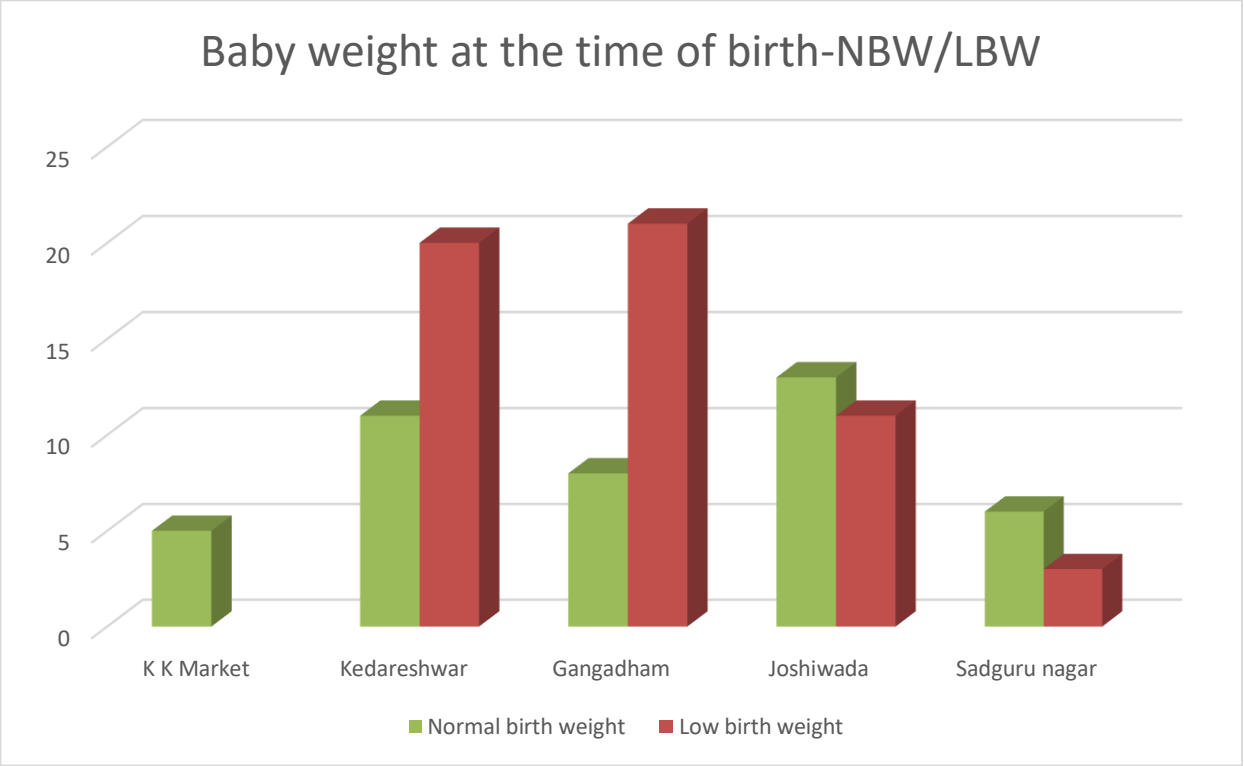


Chart no. 1. 10

There also may be other reasons behind LBW which needs to be finding out by discussing with community. Conceived women must be promoted to have a nutritional supplement along with health services. Percentage is really shocking and needs an immediate intervention to reduce the LBW from 56% to 0% with the help and support of ICDS/ PMC. Awareness needs to be created among the conceived women regarding importance of prenatal care to avoid LBW.

8. BREASTFEEDING WITHIN AN HOUR OF BIRTH

Mother's first milk is rich in nutrients and antibodies. First hour breastfeeding helps to build the immunity and decrease the risk of malnutrition. It also helps mother to improve the lactation and less loss of blood. Breastfeeding within an hour of birth could prevent 20% of new-born deaths. Infants who are not breastfed are 15 times more likely to die from pneumonia and11 times more likely to die from diarrhoea than children who are exclusively breastfed. In India, only 44.6% of mothers initiate breastfeeding within one hour of birth despite the fact that about 78.7% of mothers deliver in institutions [15] breastfeeding continues to make an important nutritional contribution well beyond the first year of life as a significant energy source and providing key nutrients to the growing infant.

We can see in chart no. 1.16 that, 10% (7 mothers) have not initiated a breastfeeding within an hour of baby birth. Out of 7 infants 6 are underweight. That means 10% of children are more likely to become undernourished. 90% of babies are breastfed within one hour of birth and it's really remarkable and appreciable. It is because of efforts taken by government under the umbrella of National Health Mission (NHM), promotion of breastfeeding through ICDS and celebrating breastfeeding week. Gangadham shows praiseworthy result.

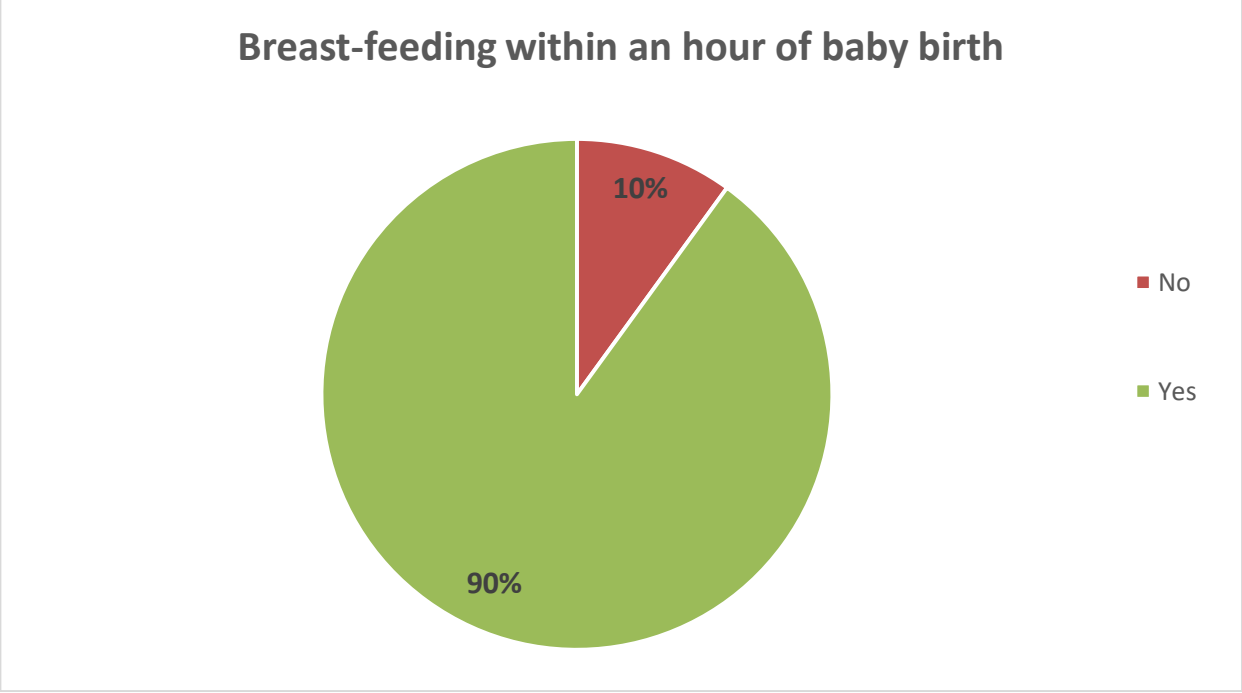


Chart no. 1. 11

[15] https://nhm.gov.in/MAA/Operational_Guidelines.pdf, page 15

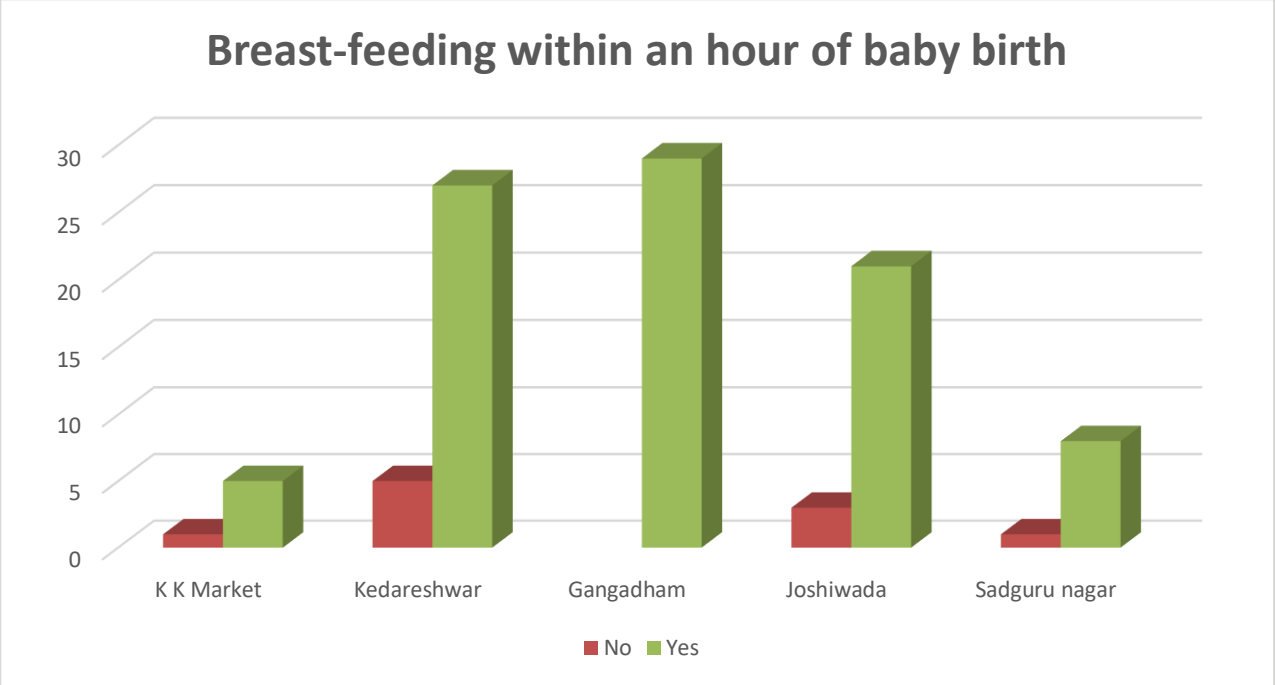

Breast-feeding within an hour of baby birth
30
25
20
15
10
5
0
K K Market
Kedareshwar
Gangadham
Joshiwada
Sadguru nagar
No
Yes

Chart no. 1. 12

9. BCG, DPT (1,2,3), POLIO (1,2,3) and GOVAR IMUNIZATION

Immunization is the process whereby a person is made immune or resistant to an infectious disease, typically by the administration of a vaccine. Vaccines stimulate the body's own immune system to protect the person against subsequent infection or disease. Immunization is a proven tool for controlling and eliminating life threatening diseases.[16] Immunization is very important for the protection of children from life threatening conditions, which are preventable. Under NHM government of India is providing vaccination to prevent seven vaccine preventable diseases i.e. Diphtheria, Tetanus, Polio, Measles, severe form of Childhood Tuberculosis and Hepatitis B, Haemophilias influenza type b (Hib) and Diarrhoea.[17] Though immunization is important to protect from life threatening diseases

We can see in chart no. 1.18 shows that, 8% i.e. 14 respondents have not vaccinated their children and ratio is high in Sadguru Nagar and Gangadham whereas 14% i.e. total 24 out of 176 of respondent said that they have given only one of the above vaccines to their children. Out of 24 children 11 are above 2 years of age, so they already missed their timely dose of vaccination as per immunization schedule. That means total 22% children are more at a risk to have a life-threatening infection. It may cause child mortality, disability, morbidity and related malnutrition.

Sadguru Nagar and Gangadham needs to take on priority for future intervention. CHC/ U-PHC and its subordinate health infrastructure carry out free of cost immunization of infants and expectant mothers as per the national immunization schedule. The Anganwadi workers assist the health functionaries in coverage of the target population for immunization and related mal nutrition. Community mobilization needs to be done and encouraged for timely immunization. Govt hospitals, Anganwadi workers and link worker/ ASHA can help us to reduce the percentage from 22% to 0%.

[16] https://www.who.int/topics/immunization/en/
[17] http://www.nrhmhp.gov.in/content/immunisation

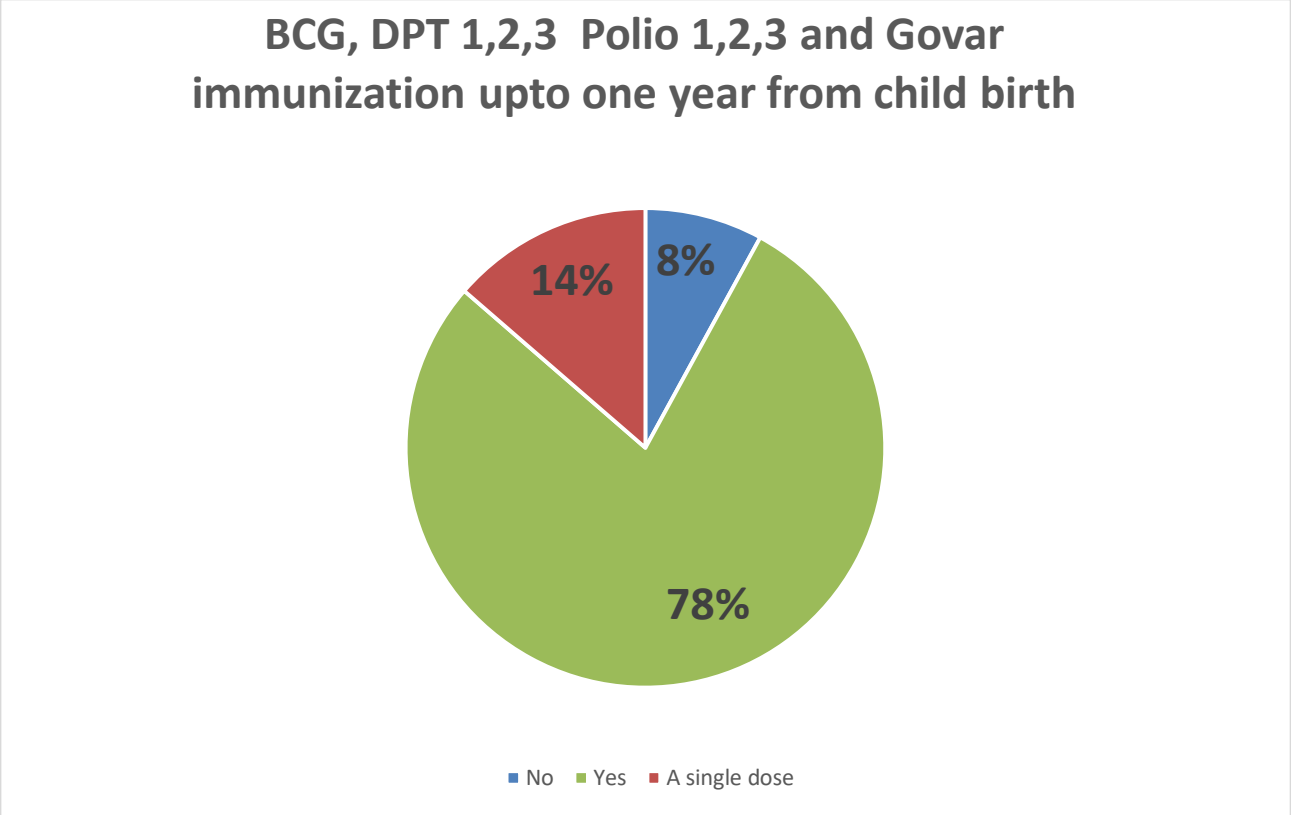


Chart no. 1. 13

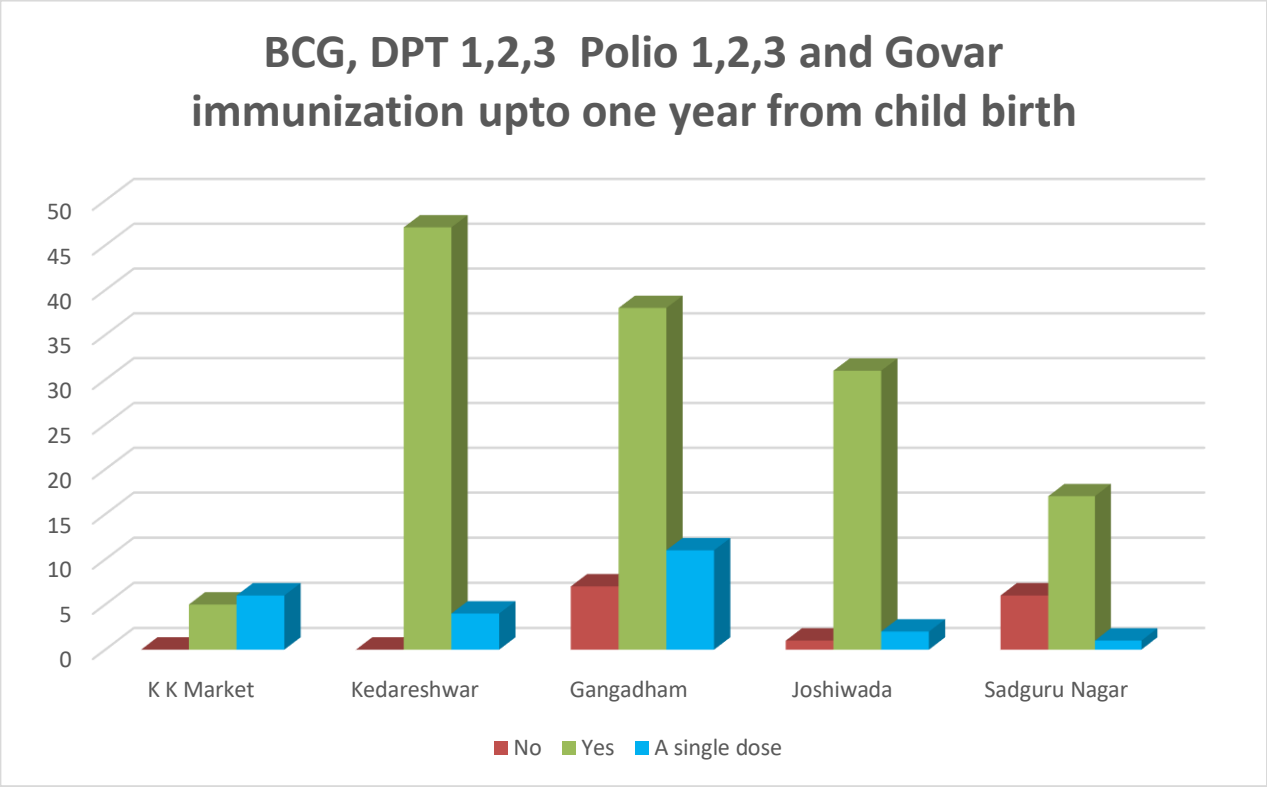


Chart no. 1. 14

II. EDUCATION SCENARIO

1. PRE SCHOOL EDUCATION

The first six years of life are critical since the rate of development in these years is more rapid than at any other stage of development. Research in neuro- science confirms the importance of early years in a child's life particularly since 90% of brain development has already taken place by the time a child is six years of age. Research also indicates that the development of brain is influenced not only by health, nutrition and quality of care but also the quality of psycho social environment that the child is exposed in these years.[18] During this year's children develop the cognitive, physical, social and emotional skills that they need to succeed in life. The early experiences are largely determined by supportive family and community care practices, proper nutrition and health care, learning opportunities, which in turn are dependent on enabling policies and investments for young children and families.

India has 158.7 million children in 0-6 year's age group (Census 2011) and challenges of catering to this important segment of the population for ensuring holistic development of children in the country are well acknowledged.[19] Early child education positively impacts attendance, retention and learning of children in elementary and higher education. ICDS is the largest initiative of govt. of India under Early childhood care and education; ICDS directly reach out to children in vulnerable and remote areas. It provides holistic services such as; supplementary nutrition, immunization, health check-up, referral services, non-formal pre-school education and health education for children below six years and to pregnant and nursing women.

ICDS is playing a very important role in psycho- physical and social development of child below 6 years of age. Though we can see in chart no. 2.1 that, 13% (16 children) are not going to any pre-school out of them 14 children have already crossed their 3 years of age and they will be deprived of getting exposure for their holistic development. Total 9% go to Anganwadi and ratio seems to be is high in Joshiwada. Percentage of children going to PMC Balwadi is very low i.e. 2%. Whereas 63% that is maximum number of children go to SWADHARs Balwadi classes and it's really a positive impact of our continuous intervention.

Efforts needs to be taken to strengthen the system by building capacities of govt functionaries and care givers to create the joyful and free environment in Anganwadi's and make it best. Also increase the percentage of children going to preschool by awareness, sensitization, promotion and mobilization of community people and decrease the percentage of non-going children from 13% to 0%.

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[18] https://wcd.nic.in/sites/default/files/national_ecce_curr_framework_final_03022014%20%282%29.pdf, page 12

[19] https://wcd.nic.in/sites/default/files/National%20Early%20Childhood%20Care%20and%20Education-Resolution.pdf, page 3

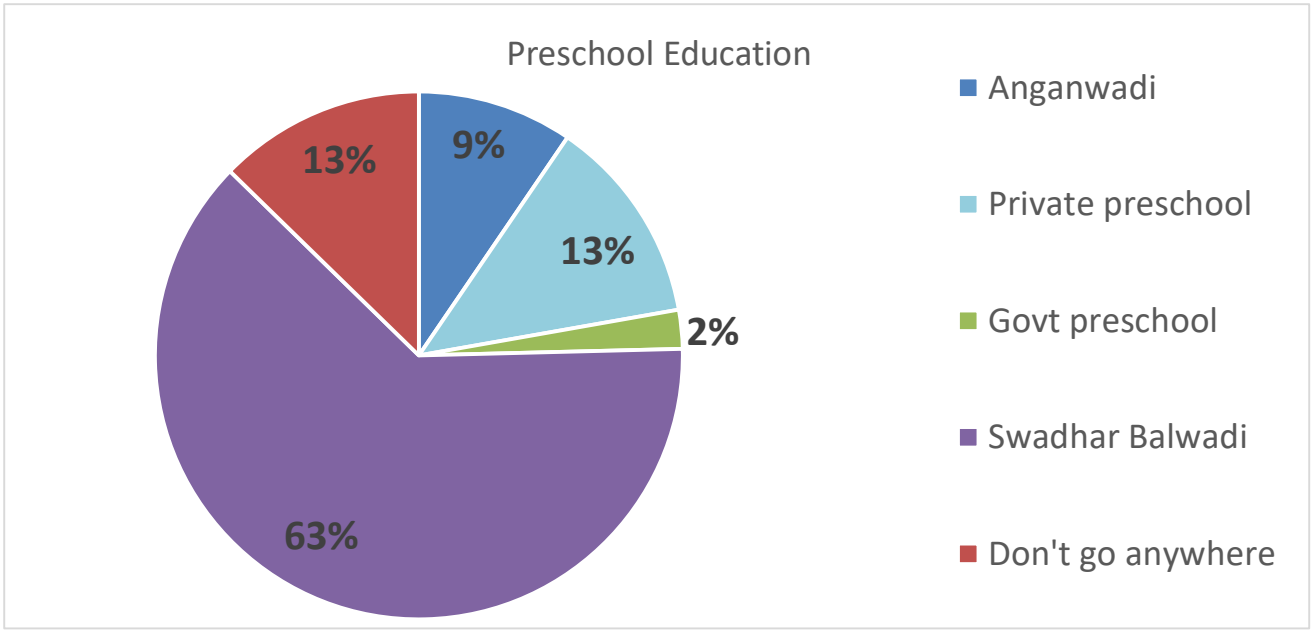

Chart no. 2. 1

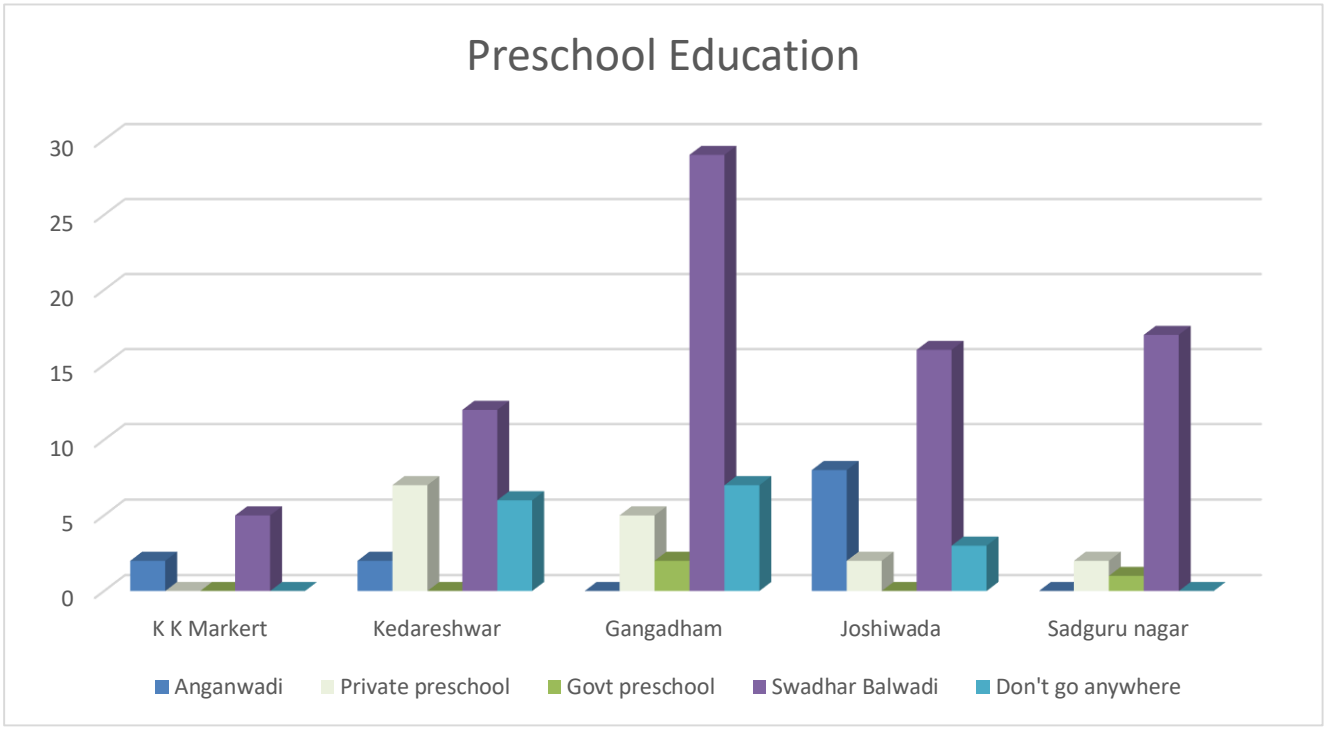

Chart no. 2.2

2. ELEMENTORY AND SECONDARY EDUCATION

a. CURRENT STATUS OF CHILDREN ELEMENTORY EDUCATION (6 – 14 years)

Education is very important factor in one's development. It is regarded as a foundation for the growth of not only the individuals but for the welfare of the entire nation. Education contributes a lot in individuals as well as economic development of the country. Indian govt promotes many programs for primary and secondary education. The constitutional (Eighty-sixth amendment), 2002 inserted Article 21-A in the Constitution of India to provide free and compulsory education of all children in the age of six to fourteen years as a fundamental right in such a manner as the state may, by law, determine. The Right of Children to Free and Compulsory Education Act, 2009, which represents the consequential legislation envisaged under Article 21-A, means that every child has a right to full time elementary education of satisfactory and equitable quality in a formal school which satisfies certain essential norms and standards.[20]

Though Chart no. 2.3 shows that, 16% (49 children) of children are out of school. Out of 49 children 33 are above the age of 7 years and as per RTE they must have been admitted in school at this age. Remaining 16 might be getting admitted as they just 6 years of age. and ratio is high in Gangadham and Joshiwada. Whereas 29% children go to private schools and ratio seems to be high in Kedareshwar and Sadguru Nagar. Intervention needs to be for the school enrolment of 16% children and decrease it to 0%.

We need to find out the reason, why 29% of children prefer private schools though; government / PMC schools do not charge any fees for admission. And according to findings strategy for intervention can be develop with government/ PMC schools to improve the education quality.

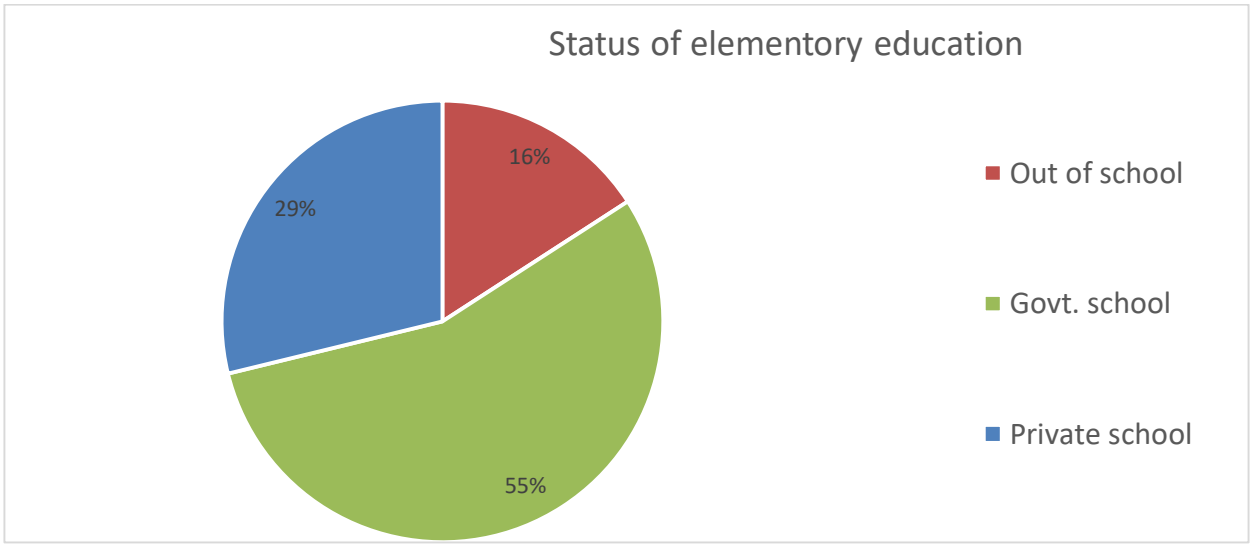

chart no 2.3

[20] https://mhrd.gov.in/

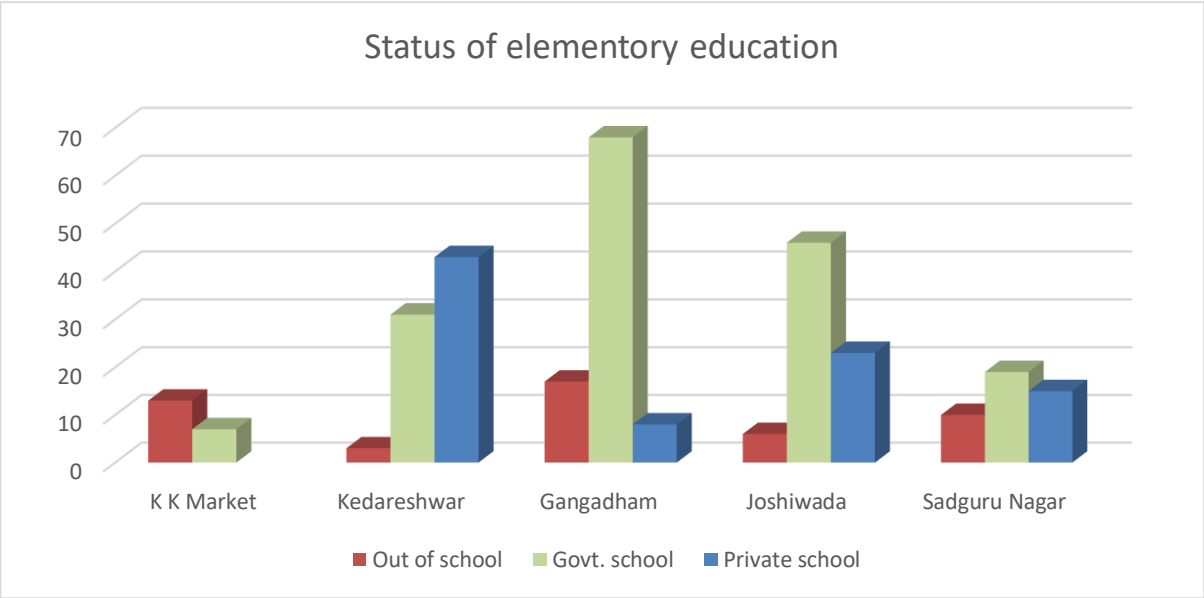

Chart no 2.4

b. SCHOOL TRANSPORTATION (6 – 14 years)

Every day millions of children travel to school through various modes of transport in India. Safe transportation is very important factor for school going children. Many children and specially girls are not able to complete their education due to unavailability of transport facility. Right to Education Act mandates school enrolment but there is no provision for school transportation which might be one of the reasons of school dropout. Chart no. 2.5 shows that, 18% i.e. 55 children do not have any transportation facility for school though they needed it. In future they might become drop out from school due to no transportation facility.

Whereas 38% of children i.e. total 134 numbers of children have transportation facility. Interesting thing is that out of 134 children only 32 children go to private school and they might have transportation facility of their school. Remaining 102 children go to PMC School yet they have to travel by public transport. Remaining 44% of children do not need school transportation facility as school is in the nearby areas. Intervention needs to be done to make avail of transport facility to 18% i.e. 55 children with the support of PMPML or schools. Parents, school authorities and transportation person needs to sensitize on safe school transportation and promoted to take initiative to make it available for their children.

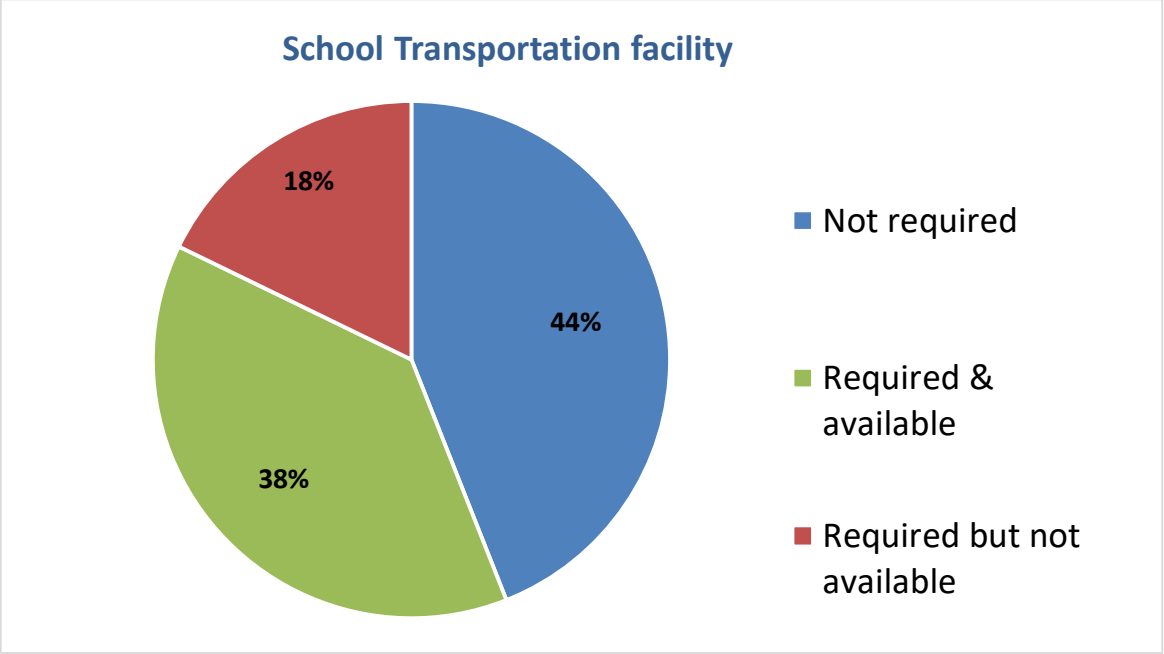

Chart no. 2.5

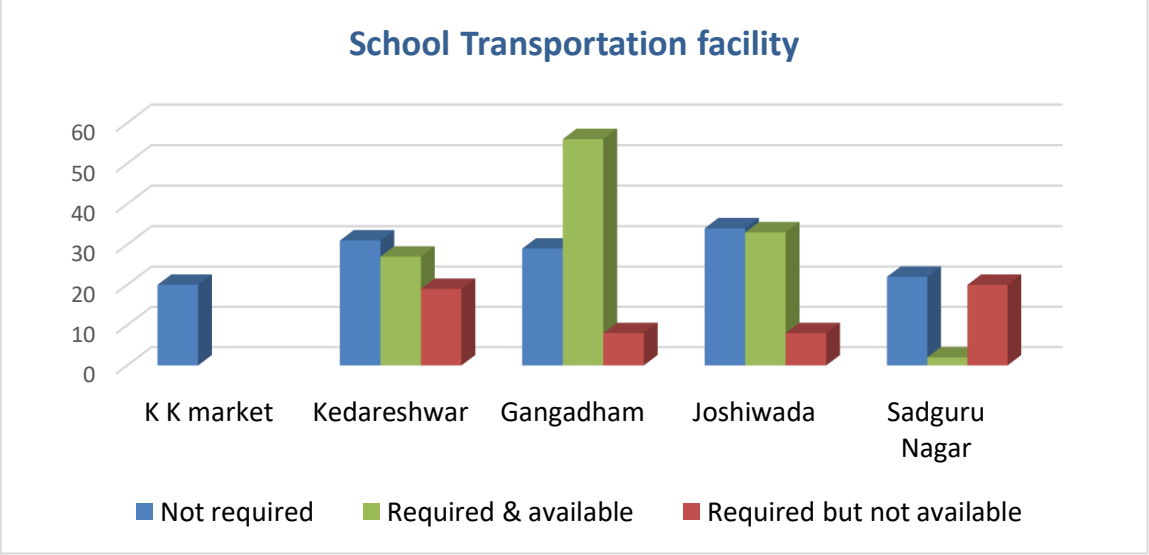

Chart no. 2.6

c. SUPPORT CLASSES conducted by NGO or private classes (6 – 14 years)

Chart no. 2.7 shows that, 71% children i.e. 218 children go to SWADHARs support classes and ratio is high in Sadguru Nagar. In all *wasti*'s respondents prefer SWADHARs classes for their children. If we see in graph no. 2.8 ratio of children going to private class is high in i.e. 4 children of Kedareshwar and still those children are attending SWADHARs support classes instead of any private classes and ratio is high in Gangadham.

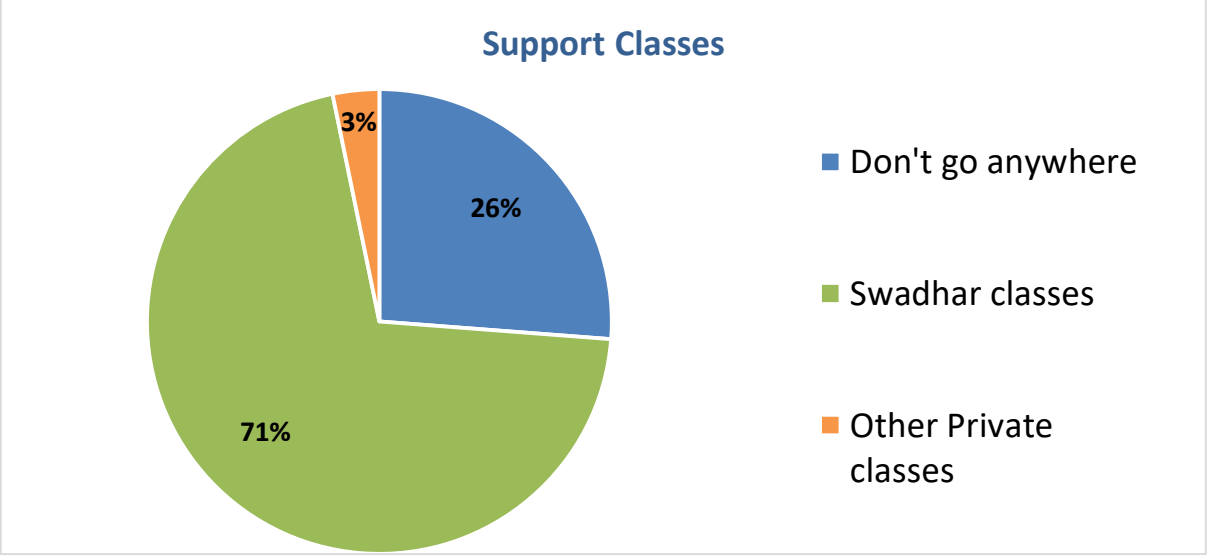

Chart no. 2.7

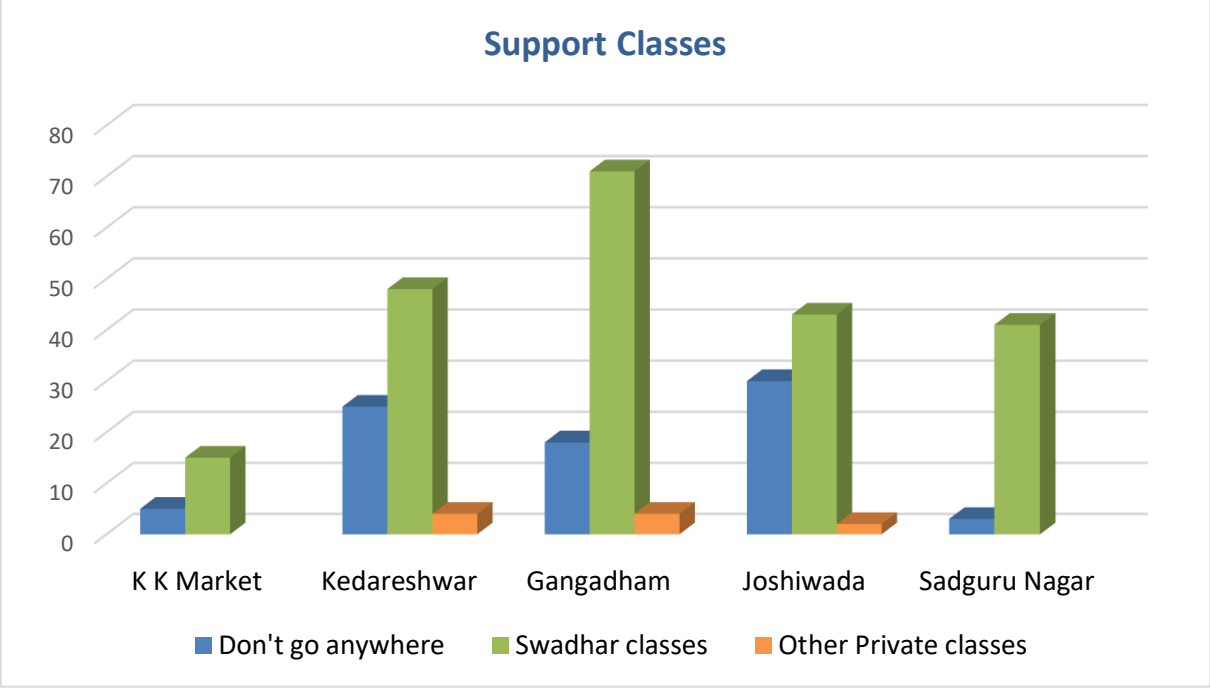

Chart no. 2.8

d. *REGULARITY INTO SCHOOL*

In Europe and Central Asia despite of increasing education enrolment rates, millions of children are out of pre-primary, primary and secondary school. Some children never enter school, which constrains their learning opportunities; while others drop out before completing lower or upper secondary education. [21] Children from marginalised communities, nomadic communities, low socio-economical background, working children, migrant children and children in conflict with law are more likely to be out-of-school or at risk of drop out.

Out-of-school children (pre-primary or compulsory school age) means;

a) Children who have never entered school or any kind or recognised education provision (e.g. Home schooling), while some would have only "delayed" their entrance in Grade 1, for instance others will never enter the education system.
b) Who have drop out from school before completion of compulsory education

Dropping out refers to the process of a pupil abandoning his or her studies before completion of a cycle of education, whether compulsory or not.

Children at risk of dropping out are those children enrolled in any compulsory or post compulsory provision but who are displaying risk factors or signs indicating that they might drop out, such as a high level of absenteeism.[22]

ELEMENTORY EDUCATION (6 – 14 years)

In spite of various schemes brought in to ensure free and compulsory education. The dropout rate; at the upper primary and higher secondary levels in Maharashtra continuous to rise. The dropout rate of upper primary students has gone up from 1.06% (2016-17) to 1.56% (2017-18), whereas that for higher secondary school students increased from 2.4% (2016-17) to 2.9% (2017-18)

Chart no 2.9 shows that 8% i.e. total 23 children leaved school last year or before that and out of 23 children 19 are girls whereas 1 % i.e. 4 children left school this year. It clearly indicates that, in surveyed areas dropout rate before completion of elementary education is 8% and ratio seems to be high in Sadguru Nagar and Gangadham as well as number of girls is high in drop out children. Good thing is that total 81% of children go to school regularly.

Need to find out the reasons of high dropout percentage in girls. Sensitization, mobilization and encouragement of parents as well as children needs to be done to decrease the dropout rate from 8% to 0% with the help of local NGO/ PMC schools. There is need of Strengthening and capacity building of schools, SMC's, etc for effective implementation of RTE.

[21] http://www.oosci-mena.org/uploads/1/wysiwyg/reports/ImprovingEducationParticipation-WEB.PDF, page 9
[22] http://www.oosci-mena.org/uploads/1/wysiwyg/reports/ImprovingEducationParticipation-WEB.PDF, page 12

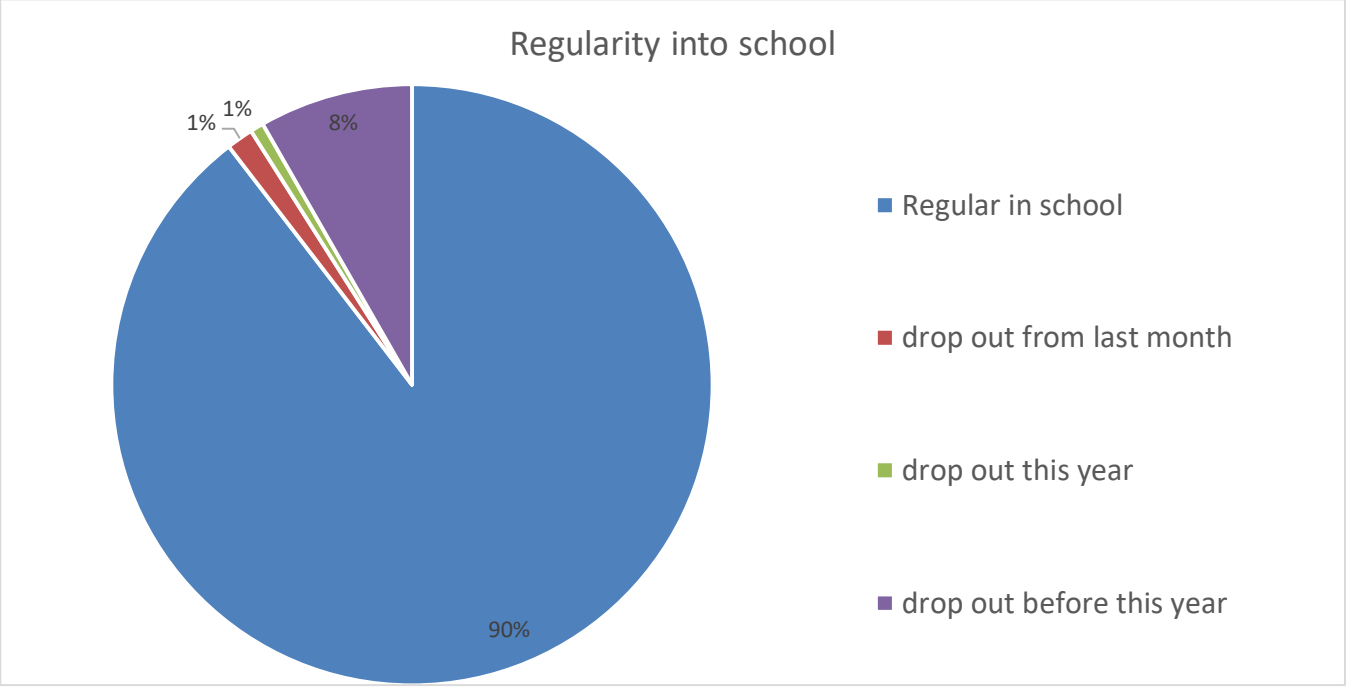

Chart no. 2.9

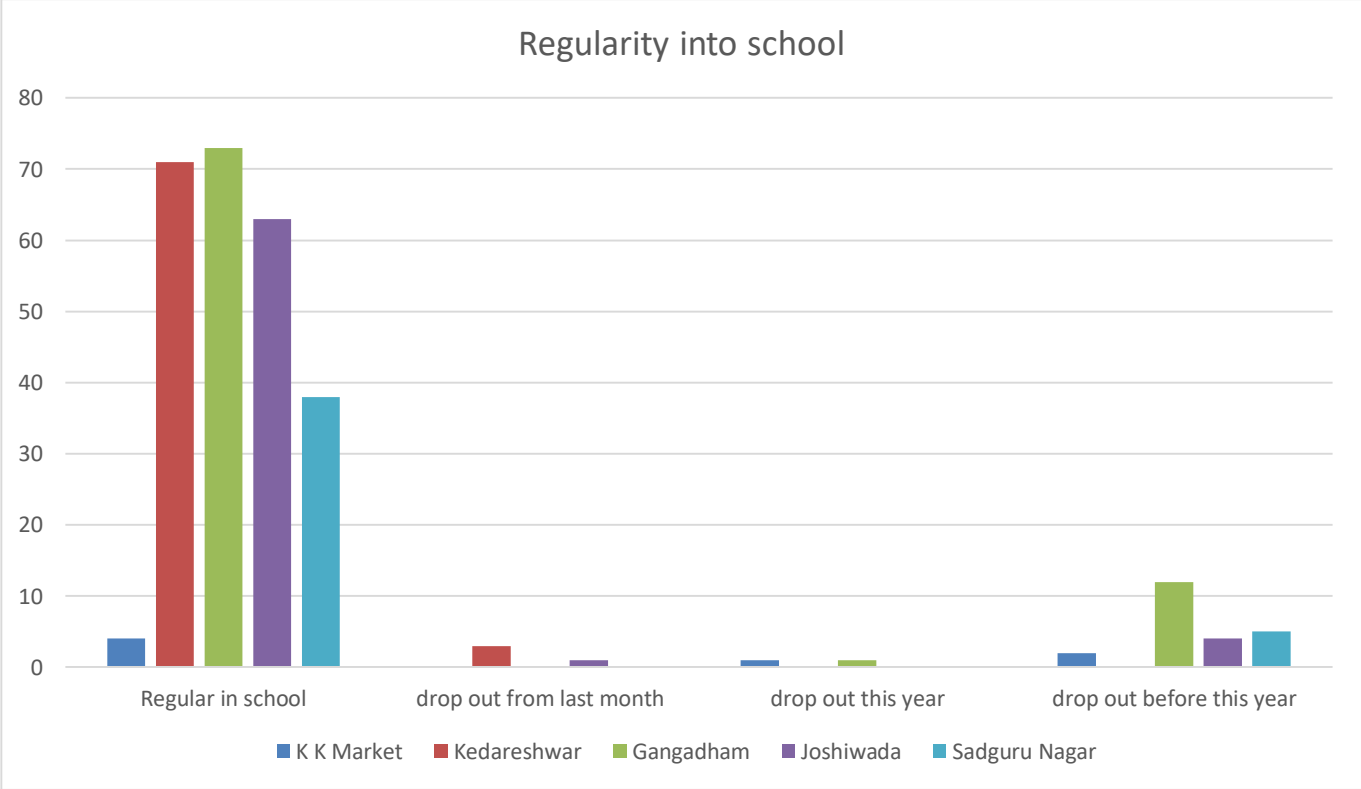

Chart no. 2.10

SECONDARY EDUCATION (15-18 YEARS)

As per Unified District Information System for Education (UDISE) 2015-16, the Gross Enrolment Ratio (GER) of girls at secondary level is 80.97% and the Gross Enrolment Ratio of boys at secondary level is 79.16%. Further annual average dropout rate of girls is 16.88% which is less than dropout rate of boys of 17.21%.[23]

Chart no. 2.11 shows that 62% i.e. 63 children left school last year or before that whereas 6% i.e. 6 children have left school this year. It clearly indicates that today 68% of children drop outs as per definition given by UNICEF and ratio seems to be high in K.K. Market and Gangadham. It's really a matter of concern and needs to bring a special attention of education department to decrease the dropout rate. Only 32% i.e., 33 children go to school regularly and ratio is good in Joshiwada and Sadguru Nagar. Children and their parents should be sensitized about the importance of education and promoted to complete the higher education.

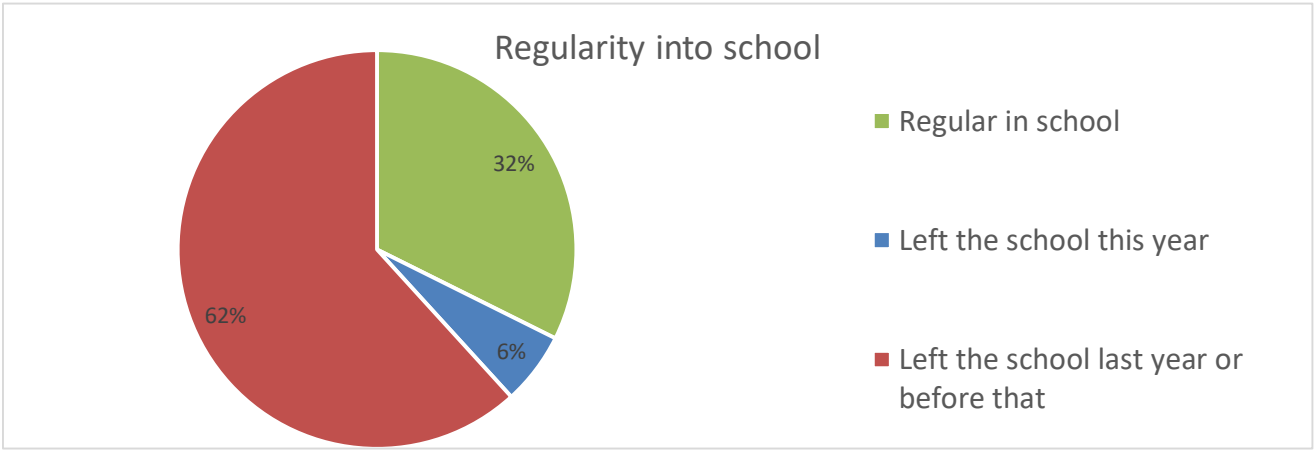

Chart no. 2.11

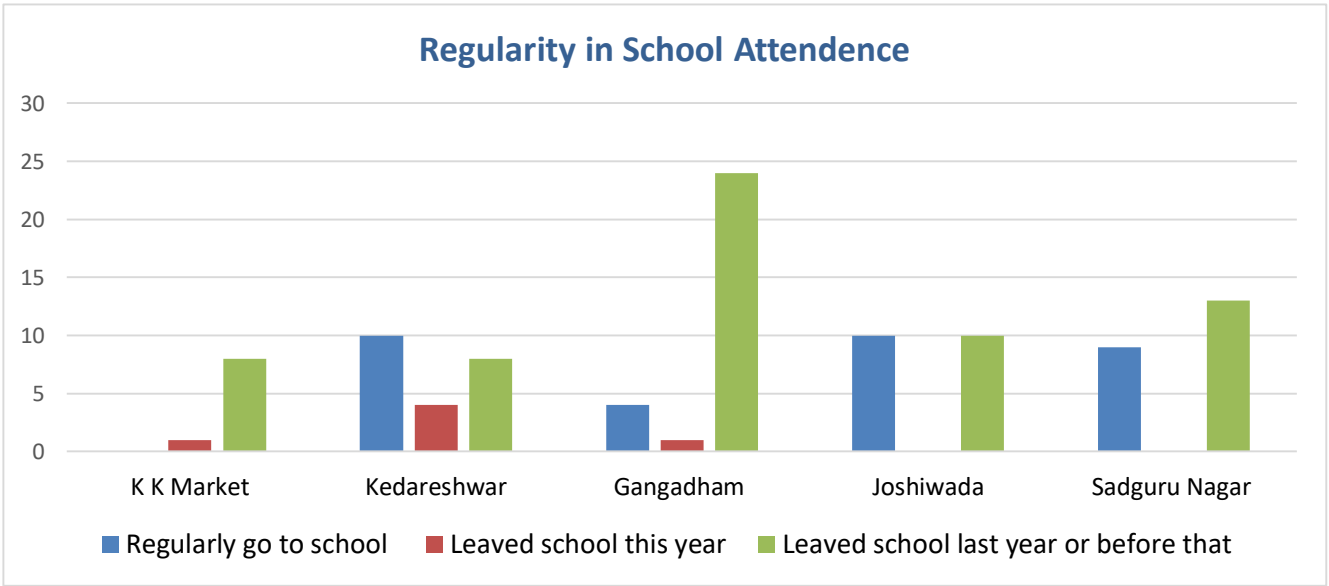

Chart no. 2.12

[23] https://mhrd.gov.in/sites/upload_files/mhrd/files/drop%20out%20rate%20release.pdf

3. WORK STATUS OF CHILD

a. Children from 6 to 14 years age group

Child Labour (Prohibition and Regulation) Act, 1986, amended in 2016 defines "child" as any person below the age of 14 years. Under Section 3 (1) of the Act No child shall be employed or permitted to work in any occupation or process. It is cognizable criminal offence to employ a child for any work. Acts defines adolescent as a child between the age of 14 to 18 years of age. Under Section 3A No adolescent shall be employed or permitted to work in any of the hazardous occupation or processes set forth in the schedule.[24] As per India's 2011 census, there were more than 10.2 million "economically active" children in the age group of 5-14 years- 5.6 million boys and 4.5 million girls. 8 million children were working in rural areas and 2 million in urban areas. Although in rural setting the number of child workers reduced from 11 million to 8 million between the years 2001 and 2011 censuses, over the same period, the number of children working in urban setting rose from 1.3 million to 2 million.[25] Over the past two decades India has put in place a range of laws and programs to address the problem of child labour. Many social organizations in India are engaged in the work to eradicate the child labour and somehow, we made it possible.

Chart no. 2.13 shows that only 2% (8) of children are employed as they get wages for it and ratio is high in Gangadham. Out of those 8 children, 3 children go to school as well, remaining 5 are drop outs. Total 18% i.e. 55 children help their parents in household work. Only 1% i.e. 3 children from K. K. Market help their parents in family occupation and none of them go to school. Good thing for us is that total 79% i.e. 243 number of children are not involved in any kind of labour work but out of them 36 children do not go to any school and shocking thing is that, 34 are girls. So here we can easily make out that total 42 children are out of school and need to enrol in the school.

Intervention needs to be done for school enrolment of children and especially of girls in all areas.

[24] https://pencil.gov.in/THE%20CHILD%20LABOUR%20(PROHIBITION%20AND%20REGULATION)%20AMENDMENT%20ACT,%202016(1).pdf, page 2

[25] http://unicef.in/Whatwedo/21/Child-Labour

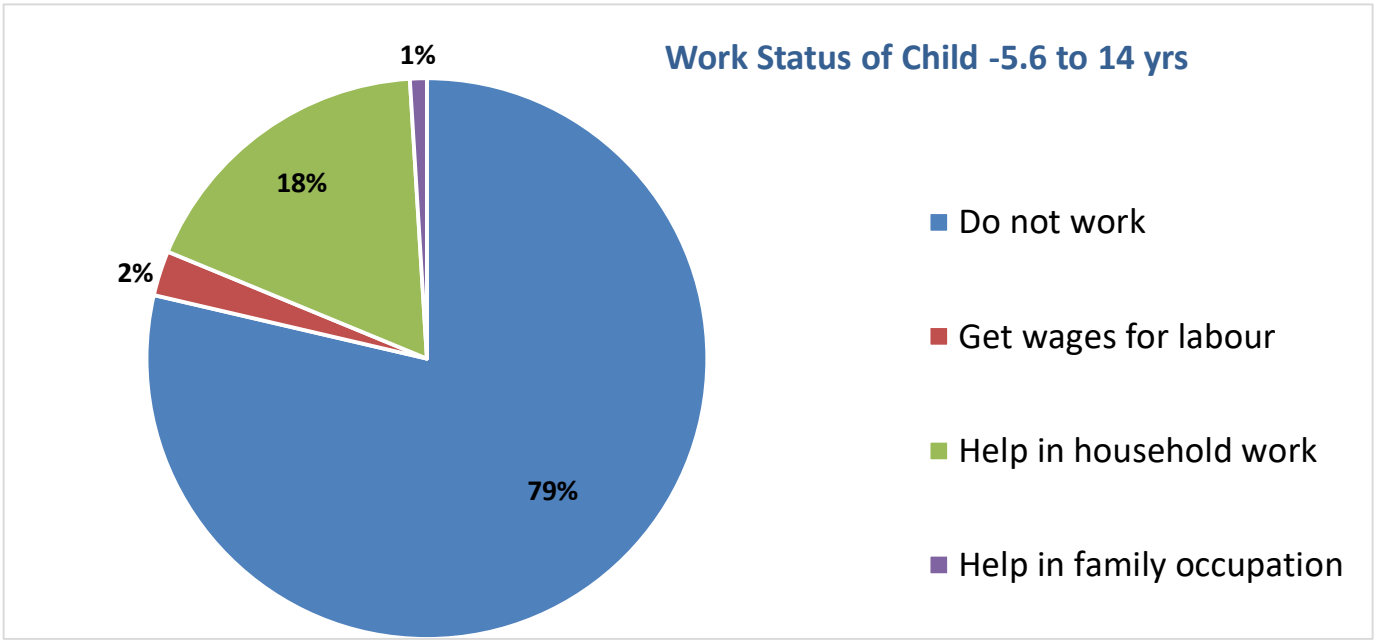

Chart no. 2.13

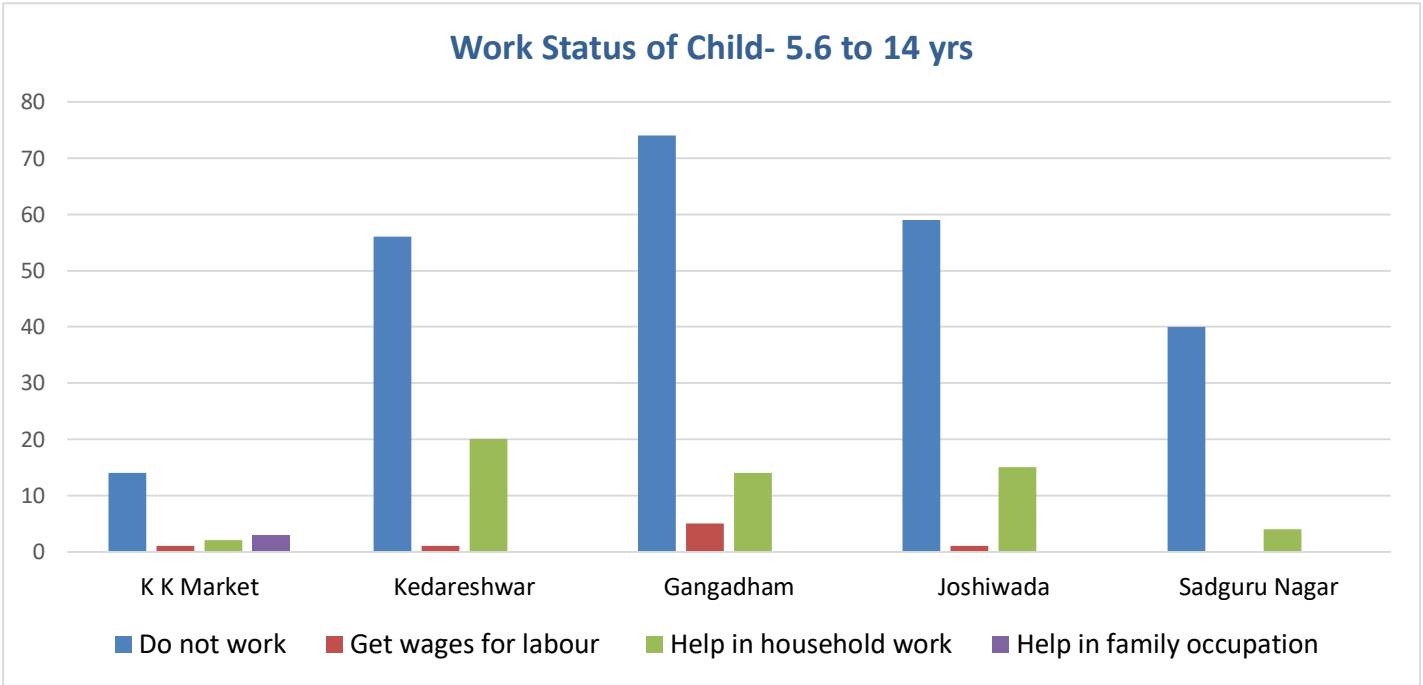

Chart no. 2.14

b. Children from 15 to 18 Years age group

The factors that contributes to child labour- including "hazardous" child labour- include poverty and illiteracy of child's parents, the families social and economic circumstances, a lack of awareness about the harmful effects of the child labour, lack of access to basic and meaningful quality education and skill training, high rates of adult unemployment and under-employment and the cultural values of the family and surroundings. Often children are also bonded to labour due to family indebtedness. Out of school children or those children at risk of dropping out can easily be drawn into work and more vulnerable to exploitation. Girls, especially those from socially from socially disadvantaged groups, tend to be at a higher risk of being forced into work.

Child Labour (Prohibition and Regulation) Act, 1986, defines adolescent as a child between the ages of 14 to 18 years of age. Under Section 3A No adolescent shall be employed or permitted to work in any of the hazardous occupation or processes set forth in the schedule. Juvenile Justice (Care and Protection of Children) Act 2000 and amendment of the JJ Act in 2006, includes the working child in the category of children in need of care and protection, without any limitation of age or type of occupation. Section 23 (Cruelty to Juvenile) and Section 26 (exploitation of juvenile employee) specifically deal with child labour under children in need of care and protection.

Though we can see in chart no. 2.15 that, 27% i.e. 28 children are involved in various kind of labour work and ratio is high in Gangadham. Those children are more likely to be deprived of education, self-development and face discrimination/ harassment. 27% is really an eye opening and need to take on priority for intervention to decrease up to 0%. Also need to find out the reasons of engagement in labour work of 27% children. 26% i.e. 27 children help in family occupation.

Need to find out and develop linkages with various technical training institutions in and around Pune which provide short term courses with very nominal fees or have scholarships for marginalised children. These children can be counselled and promoted for technical training which will build their knowledge and skill. Like this we can at least place them in safe and dignified occupation which will ultimately improve their standard of living.

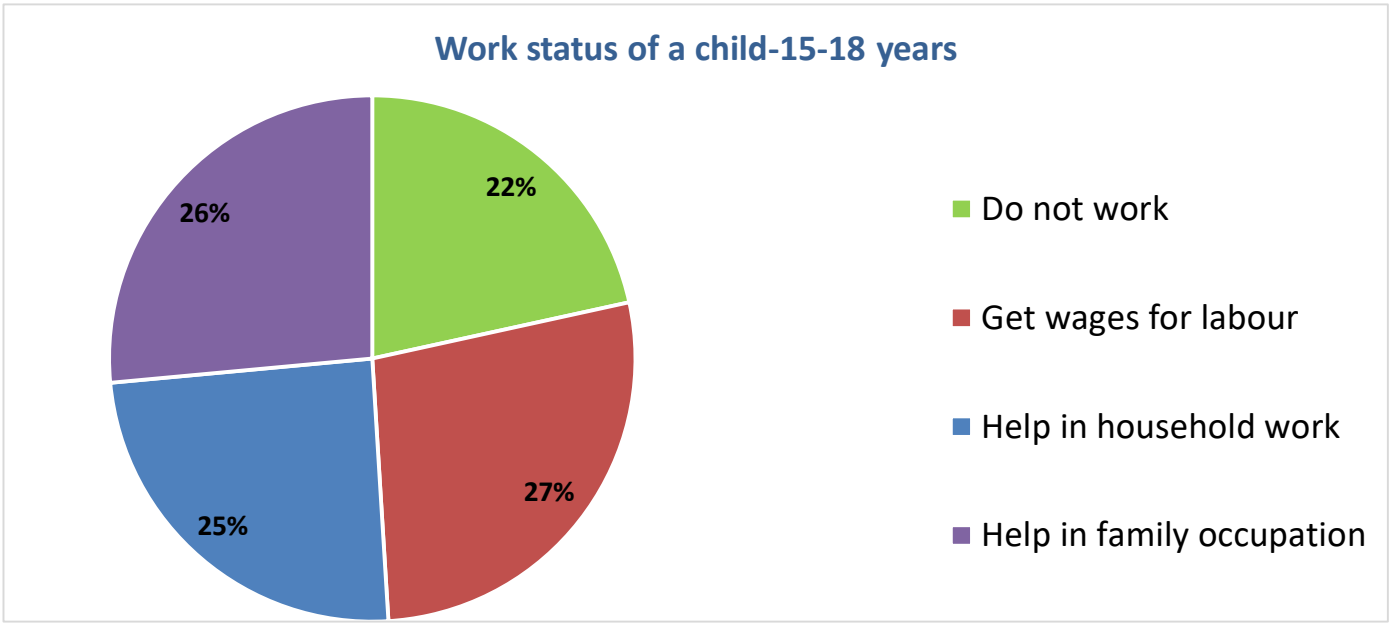

Chart no. 2.15

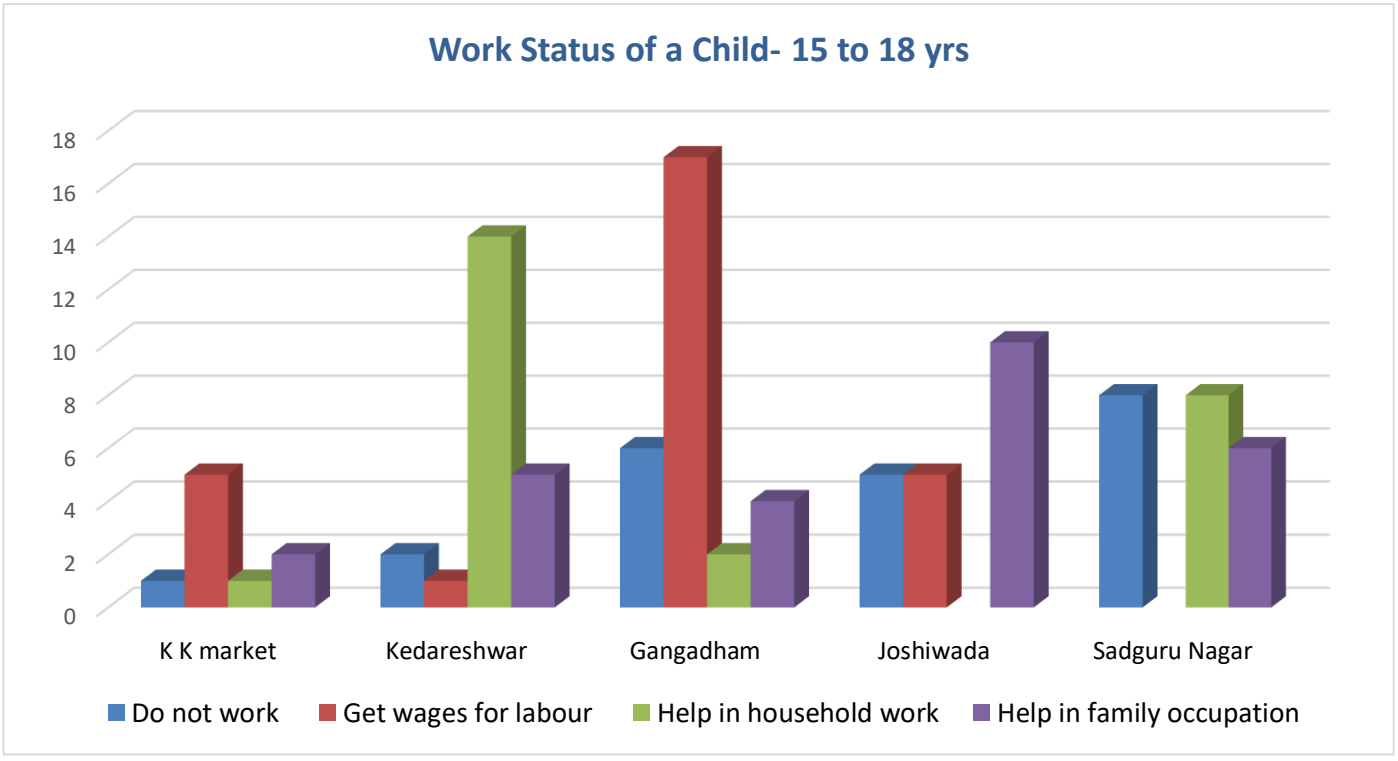

Chart no. 2.16

III. LIVELIHOOD

Livelihood plays most important role for food security in each one's life and nomadic people are not exception for it. Based on their livelihood pattern it can be suitably classified into pastorals and hunter- gatherers, goods and service nomads, entertainers and religious performers etc. But the modern process of development i.e. mechanisation, urbanization, commercialization, large scale infrastructural development, growth in communication and transportation, enhanced social and spatial mobility and shift from agrarian economy to an industrial one which was ushered in at independence and which accelerated in eighties and nineties has made a great impact on lives of the nomadic people. It has affected the traditional occupations of the nomadic people. Most of the nomads have had to either abandon their occupation or reduce the scale of their activities considerably.

As we can see in chart no 3.1 that, 28 % i.e. 145 people from surveyed areas are still practicing their traditional way of livelihood in Pune city. Whereas Chart No. 3.2 shows various traditional occupations in which they are involved such as Godhadi /quilt making, camel riding, astrology, bullock play, begging and *Gondhali*. Majority of women are involved in Godhadi making. Percentage of self-employed respondents is very nominal that is 1% (4 people). They are mainly involved in own business of welding, Auto Rickshaw driving and windows sliding work, whereas only 2 respondents are doing government job. It is noted that 8% of people are doing private jobs such as, driver, supervisor, poster sticking, security guard or watch man and various types of casual labour work. 22% i.e. 117 respondents are doing other kind of work mainly involved in labour work. The fact that 41% i.e. 214 respondents are unemployed is really an eye opening percentage. From this we can make out that, these people are forced to do any kind of wok at a very low wages due to lack of education, skills and knowledge. And additionally the respondents face the stigma as a criminal which discriminates them everywhere even at work place as well as work choice too.

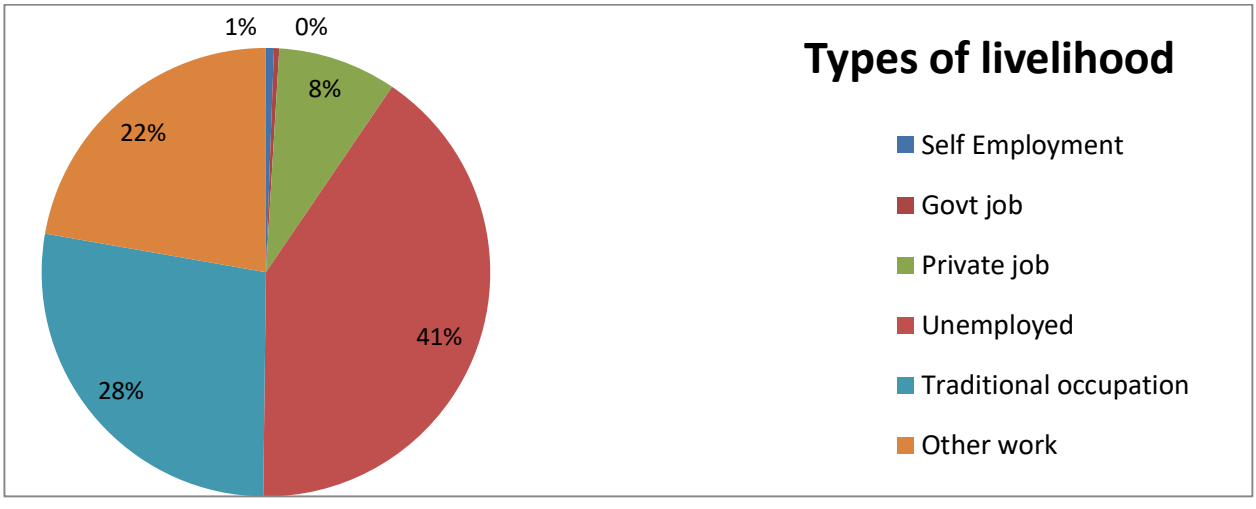

chart no. 3.1

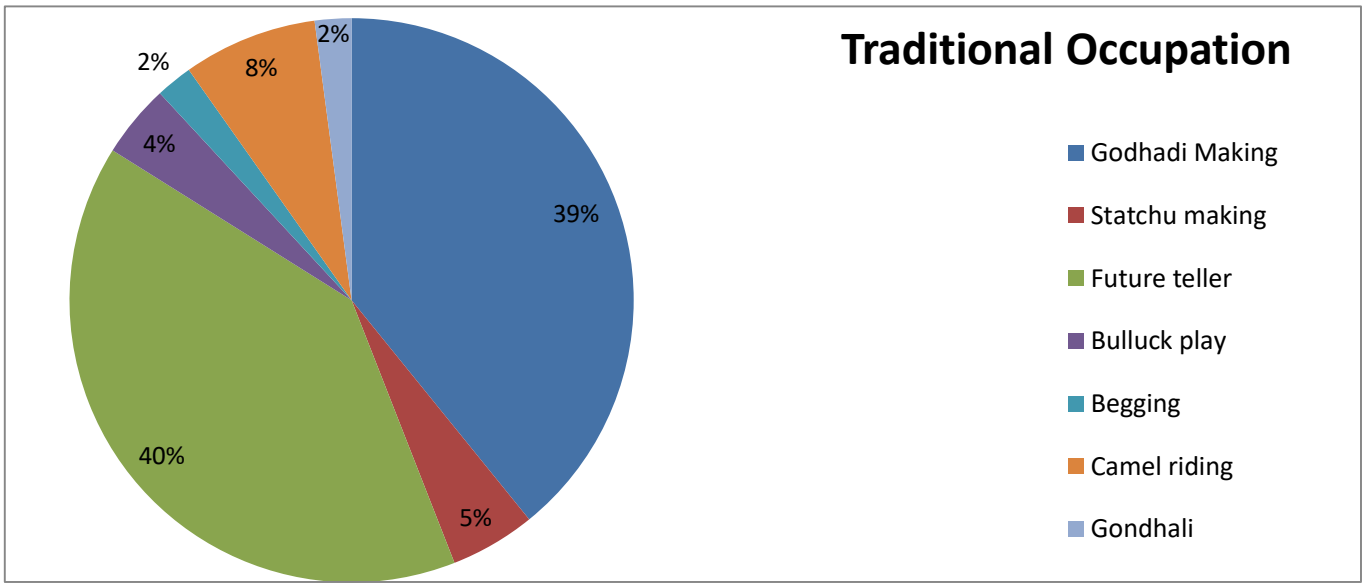

chart no. 3.2

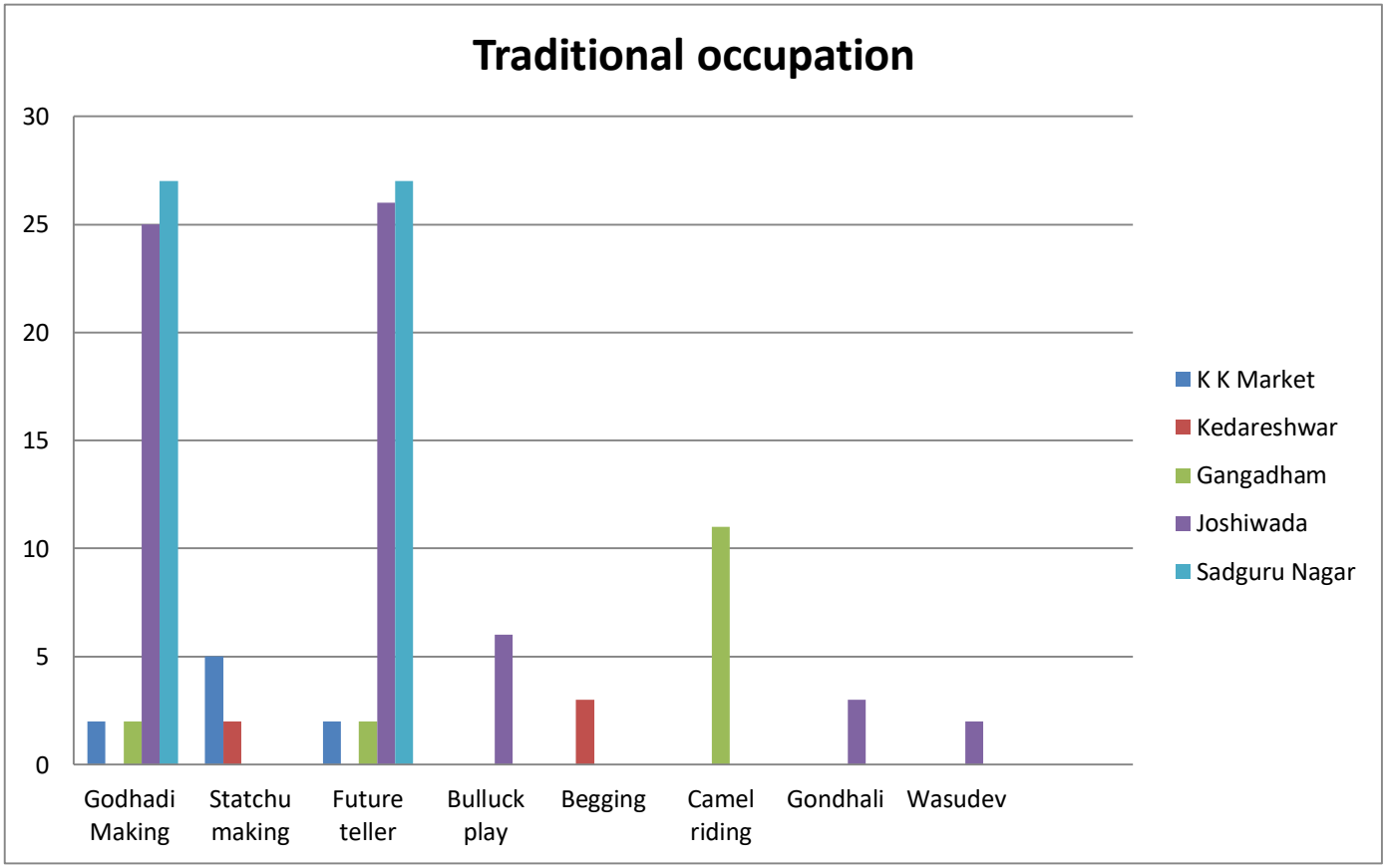

chart no. 3.3

IV. RIGHTS AND ENTITLEMENTS-

1. BIRTH REGISTRATION-

Birth registration is a permanent and official record of a child's existence. *"The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and as far as possible, the right to know and be cared by his or her parents"* In India, an estimated 26 million children are born every year of which about 10 million go unregistered.[26]Birth registration is a first step towards establishing his or her legal identity. Registration is also a vital tool for a nation's development because the process of registration means collection of data on vital statistics (Number of births and deaths). It is an essential element of national planning for children since it provides a demographic base. It is compulsory to register births and deaths to the registrar of Births and deaths under the registration of Births and Deaths Act, 1969 (Act No. 18 of 1969). Head of house is responsible to register it to the Registrar of birth and Deaths of the concerned area within 21 days of occurrence.[27] A birth certificate is issued by Municipal Corporation/ Municipal Council in urban areas whereas in rural areas authority is the Tahsildar at the Taluka level, while the authority is Gramsevak (Grampanchayt Office) at the village level. The children who remain unregister are more likely to be deprived of entitlements as a human being.

In our surveyed area 92% i.e. 162 children were registered after birth (Chart no. 4.1) out of them only 80% have received their birth certificate. Whereas 14% (22 children) still do not received their birth certificate That means they are more likely to be deprived of their right to timely vaccination, supplementary nutrition (ICDS) as their right to identity, education, health facilities etc. The ratio seems to be high in K. K. Market and Gangadham as per chart no. 4.3

Immediate intervention needs to be done to get birth certificate of 14% children with the help of PMC to ensure their right as a citizen of India as well as right to entitlements. Awareness creation and promotion on importance of birth registration certificate among the community people can help to decrease the number from 14% to 0%.

[26] https://unicef.in/Story/365/Why-is-birth-registration-important

[27] http://www.censusindia.gov.in/2011-Documents/CRS_Report/CRS%20FINAL%20REPORT%202016_21062018.pdf, page- 11

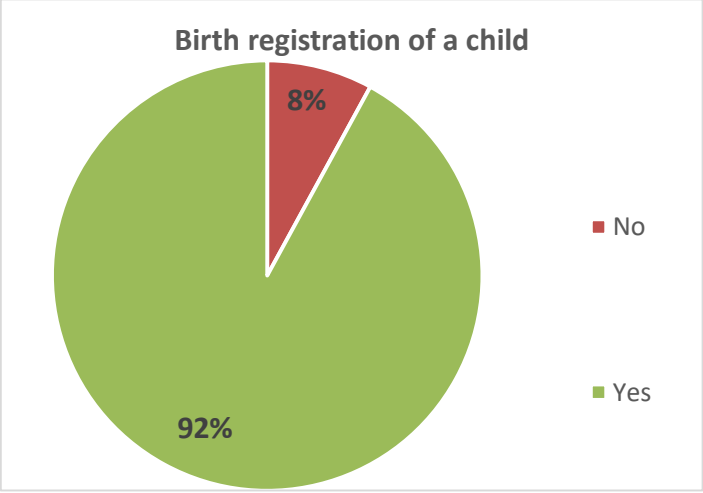

Chart no. 4.1

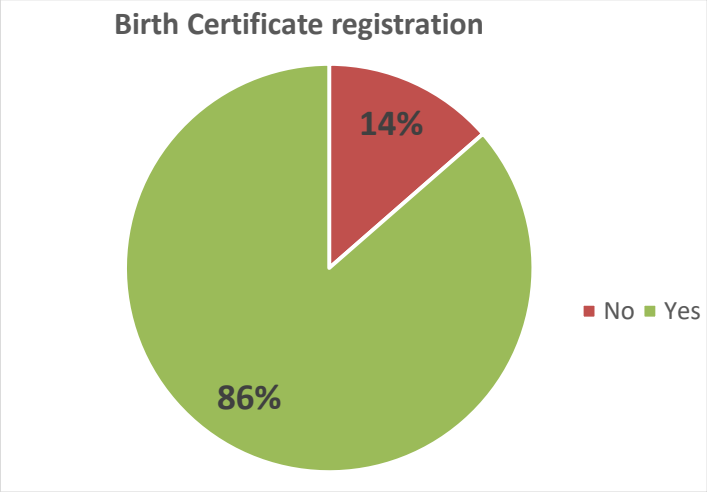

Chart no. 4.2

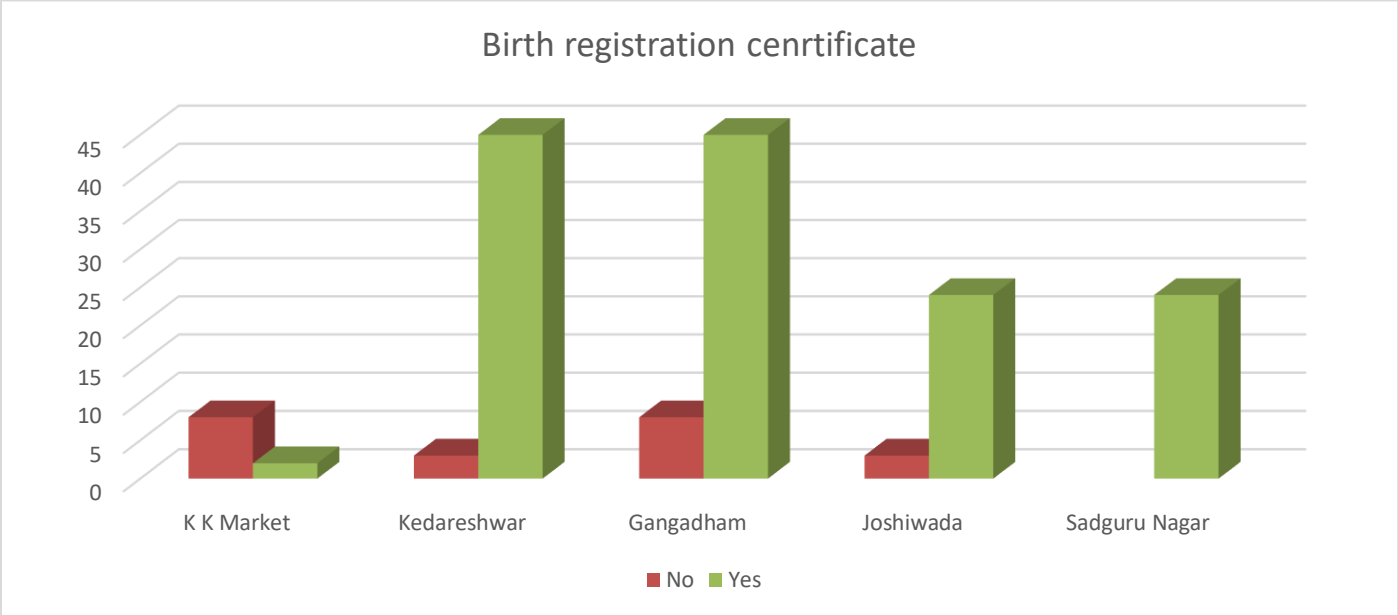

Chart no. 4.3

2. RATION CARD

Ration card is very important legal document in India. It is important to seek benefit under the food security scheme and entitlements. It helps individual to avail various government schemes.

Though it is important we can see in below chart no 4.4 that, 17% i.e. 37 families do not have ration card. That means they are more likely to be deprived of various government schemes including monthly ration. Though the 82% families are having ration cards, but most of their card belongs to their native place(village). Due to which they are unable to get benefits of ration facility provided by government.

Percentage of not having ration card seems to be high in Gangadham around 44% i.e. 28 families out of 63. This requires urgent attention and action. 94% i.e. 61 out of 65 families have their ration cards in Kedareshwar.

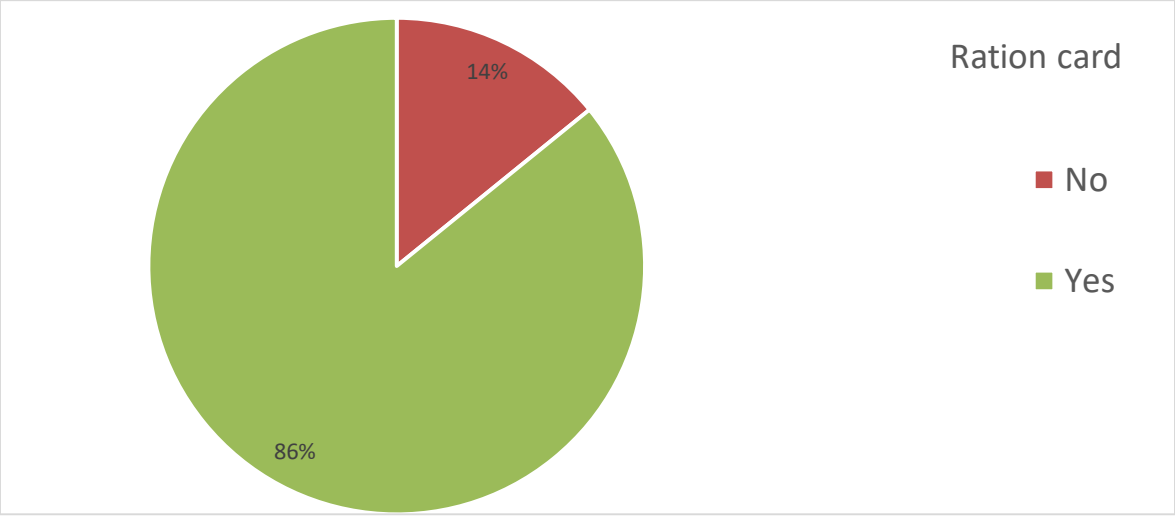

Chart no. 4.4

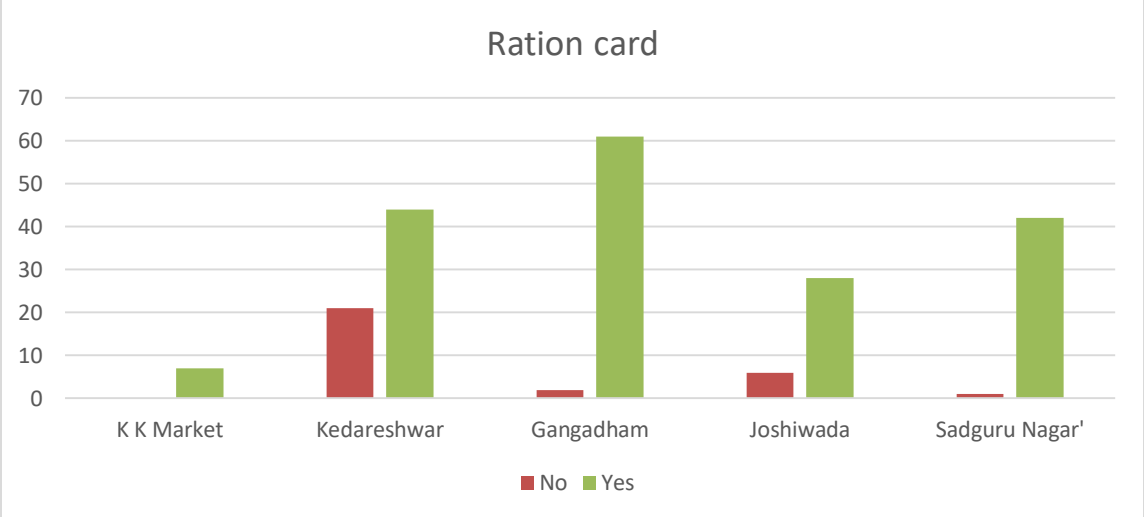

Chart no. 4.5

3. IDENTITY DOCUMENTS

Identity documents are very important to prove the citizenship as well as get benefit of various government schemes and programmes. Below table shows availability of various documents.

Area Name	Total no. Of respondent	Caste Certificate	Bank Account	Voter ID	Pan Card	Driving licence	Residence Certificate	Aadhar Card
K K Market	85	14	14	26	0	0	0	66
Kedareshwar	322	98	102	128	104	52	30	240
Gangadham	324	104	78	104	33	18	18	234
Joshiwada	296	47	54	127	69	17	7	221
Sadguru Nagar	213	52	50	111	55	30	14	167
Grand Total	**1240**	**315**	**298**	**496**	**261**	**117**	**69**	**928**

4. OWNERSHIP OF LAND and HOUSE

In surveyed area most of the people were migrated from Madhya Pradesh, Rajasthan, Karnataka and small villages of Solapur, Nanded, Buldhana and Pune district for the purpose of livelihood. Majority of the people are living in these particular areas from almost more than 10 years and settled down here.

LAND OWNERSHIP-

As shown in below chart no 4.6, 81% i.e. 171 families do not have land and percentage is really high. It ultimately affects their pattern of livelihood as they are landless as well as their traditional occupations are not viable in today's context. Only 19 % i.e. 41 them have their own land at their native place but not more than 1 acre. Very few of them have more than 1 acre and ratio is high in K.K. Market and Kedareshwar.

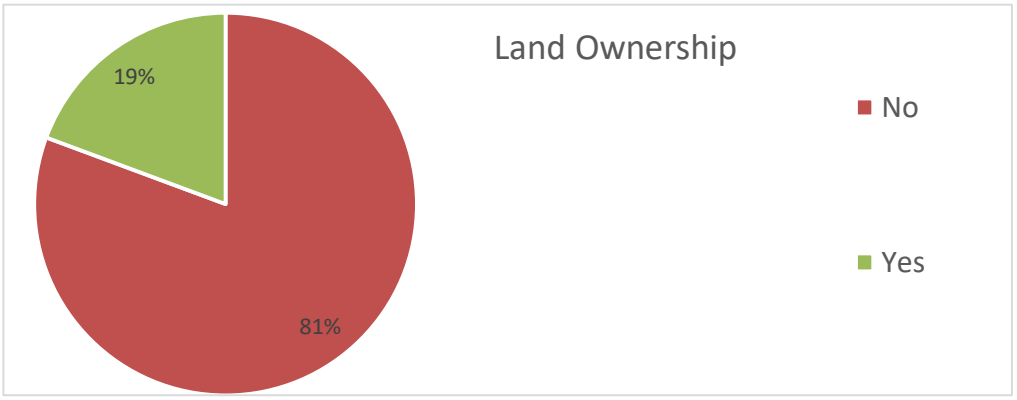

Chart no. 4.6

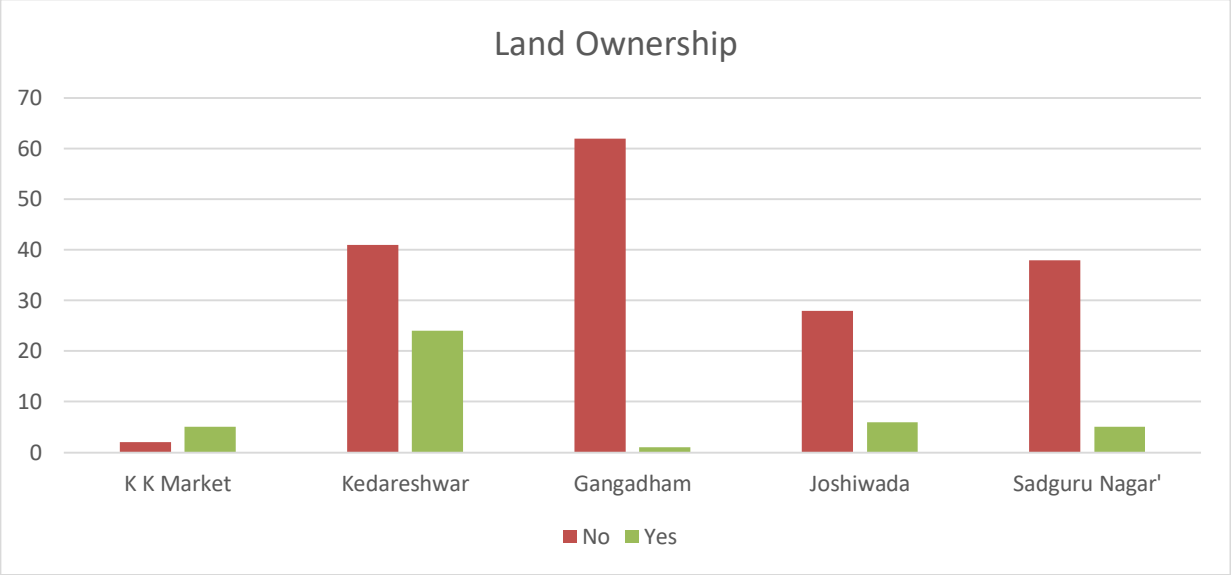

Chart no. 4.7

HOUSE OWNERSHIP-

As shown in chart no 4.8 26 % i.e. 55 families are houseless that means they lives on open spaces in their tent and ratio is high in Joshiwada and Kedareshwar. It clearly indicates that, these families are living in unsafe and unhealthy conditions and they are more at risk and deprived of their basic rights. 56 % i.e. 119 families are living on rent whereas only 18% i.e. 38 families have their own house and ratio is high in Kedareshwar. Here the meaning of own house is they don't need pay a single rupee as a rent. The land is encroached by them; but don't have concrete information about land ownership i.e. whether it belongs to government or private.

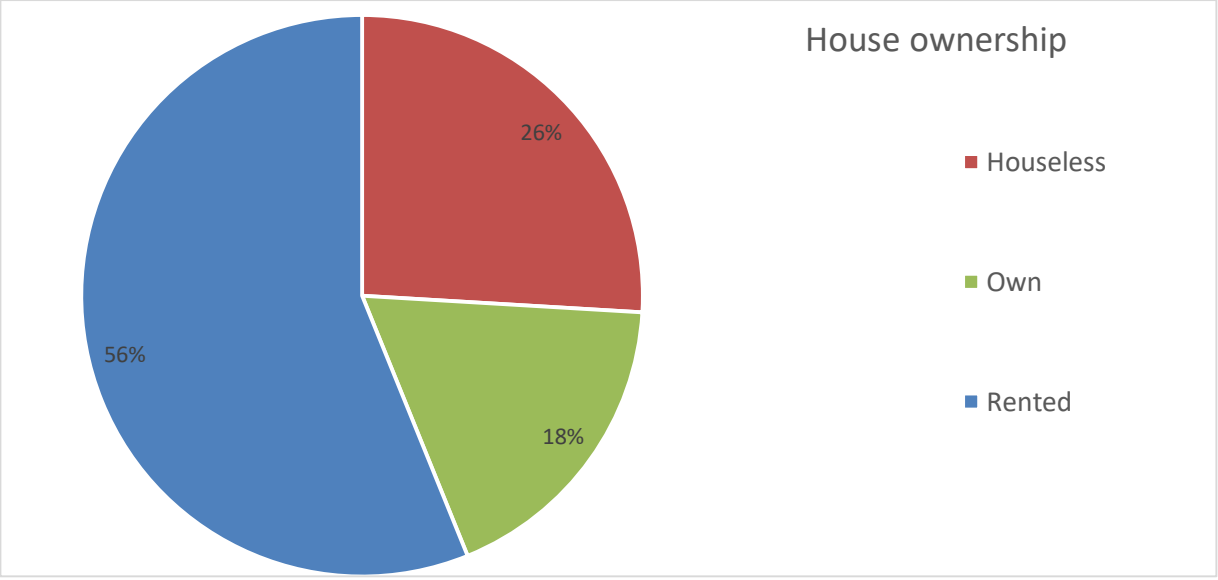

Chart no. 4.8

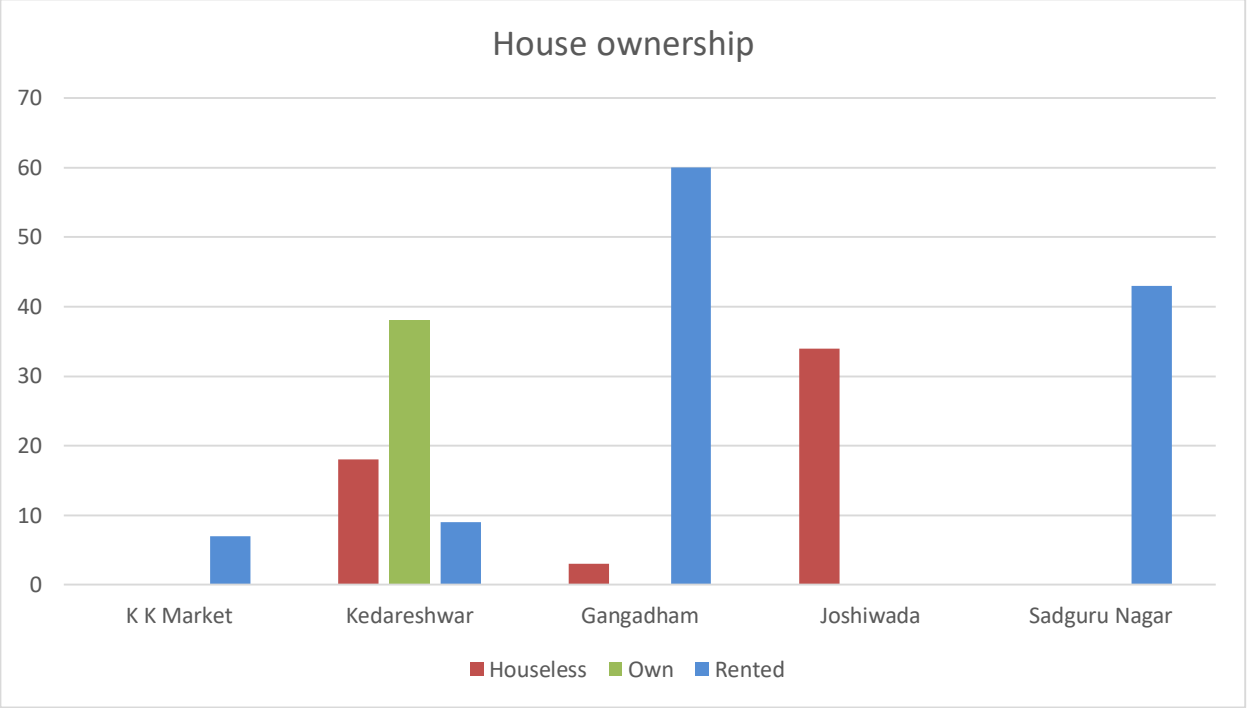

Chart no. 4.9

5. BASIC AMENITIES

Electricity, toilet and drinking water are very basics needs of every human being. Every human being has a right to live a secure and dignified life but still a section of society is deprived of their basic rights and are mostly belongs to poor or marginalised communities.

1. **Electricity-**
   We can see in the Chart no 4.10, 14% i.e. 30 families don't have electricity. That means they have to live in a dark, their children have to study in candle or kerosene / oil lamp which ultimately affects their eyesight as well as may lose their interest to study or do homework. It will give bad impact on their educational status and ultimately on future. This ratio is high in Kedareshwar and Joshiwada.

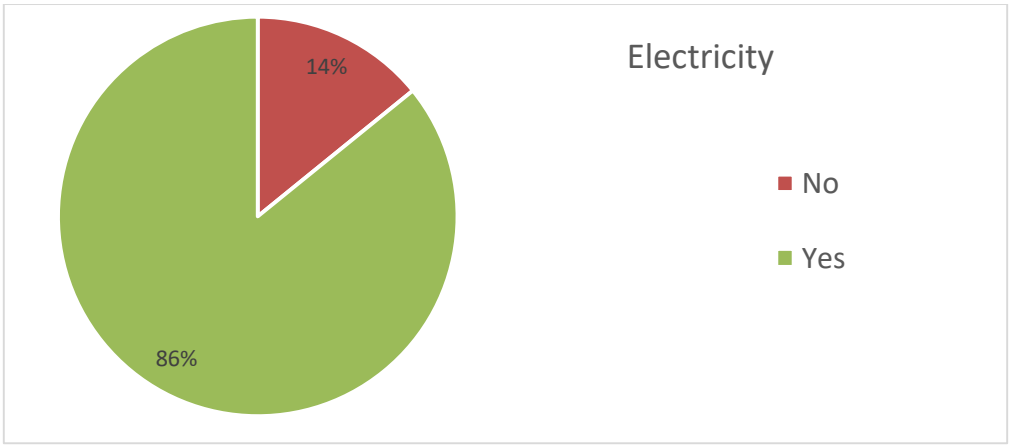

Chart no. 4.10

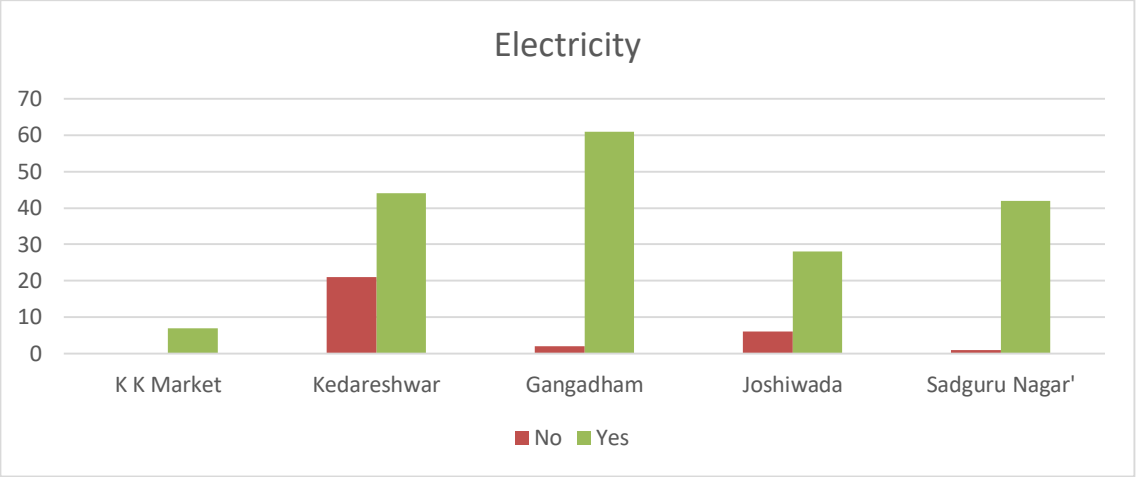

Chart no. 4.11

2. Toilet-

Chart no 4.12 shows that only 18 % i.e. 38 families have their own toilet. It is really an Eye opening percentage that 82% i.e. 174 families from all surveyed areas including do not have their own toilet. Families who do not have their own toilet 2% of them use common toilet. Except Kedareshwar, there are toilets in other 4 Wastis. Whereas remaining 79% of families defecate in the open space though they are living in a Pune city. It will definitely bring negative impact on their health especially on health of women. Because they might have to go before sunrise and after sunset for their nature's calls as Pune city is crowded. So, during the day though they might feel to go but they have to wait for dark. Girls and women are more at risk of sexual assault. As they are going on open spaces they are more likely to have a various kind of contagious disease as it is not hygienic at all. It is really a shocking percentage and immediate intervention required to be taken for construction of toilets with the help of Pune Municipal Corporation.

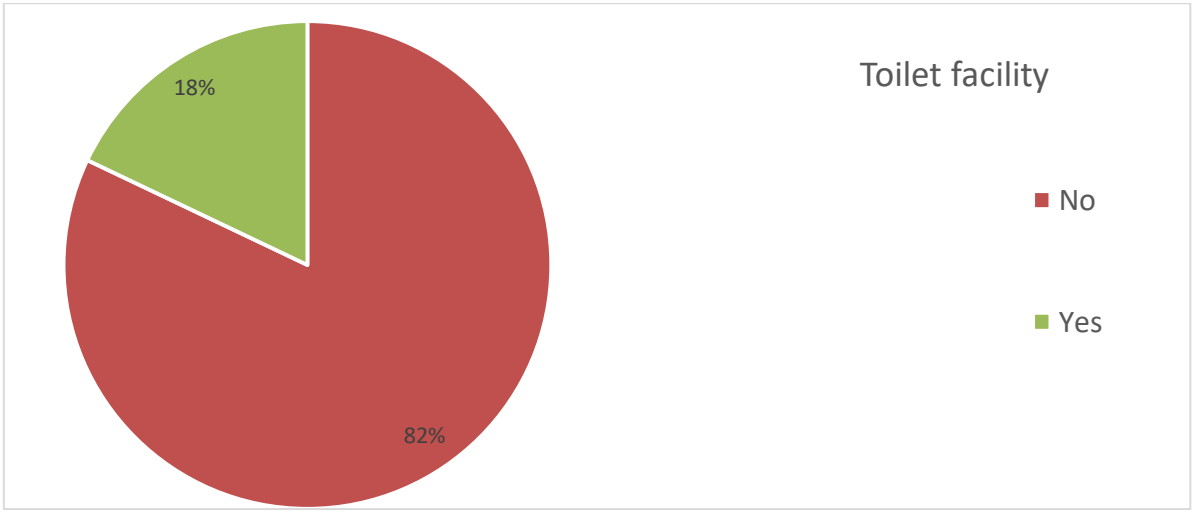

Chart no. 4.12

Chart no. 4.13

3. **Drinking Water-**

Chart no 4.14 shows that drinking water is available for all families in all seasons through various sources. Such as hand pump, common water tap and private water tap etc. Only 3% i.e. 7 families from Kedareshwar have private tap water connection of their own whereas 1% i.e. 2 families get water from hand pump. Remaining families fetch drinking water from public tap in all the surveyed areas.

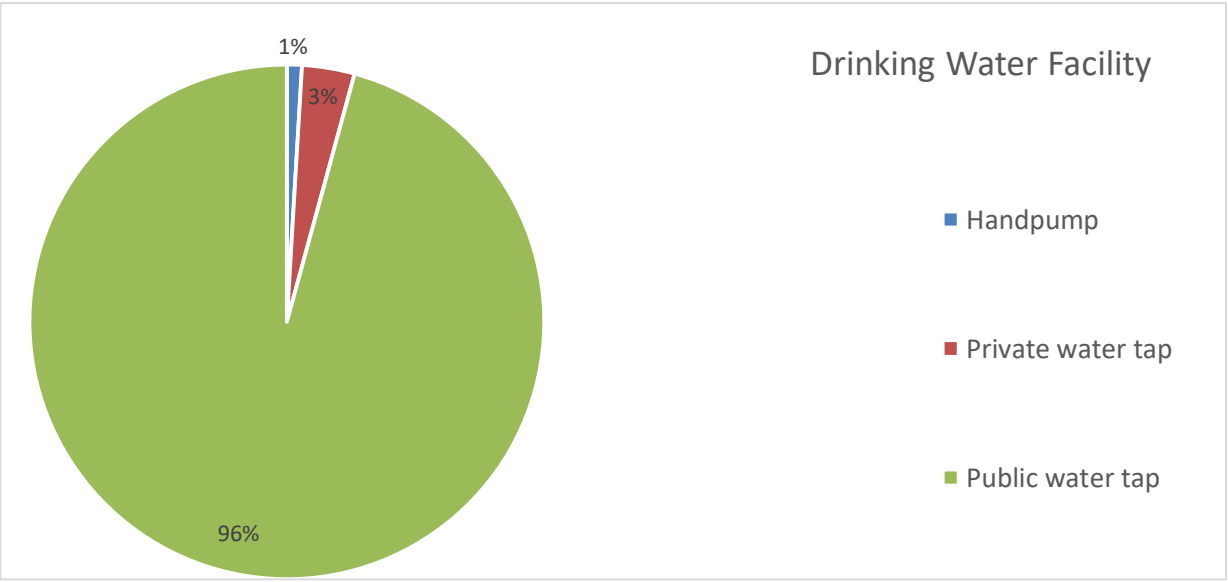

Chart no. 4.14

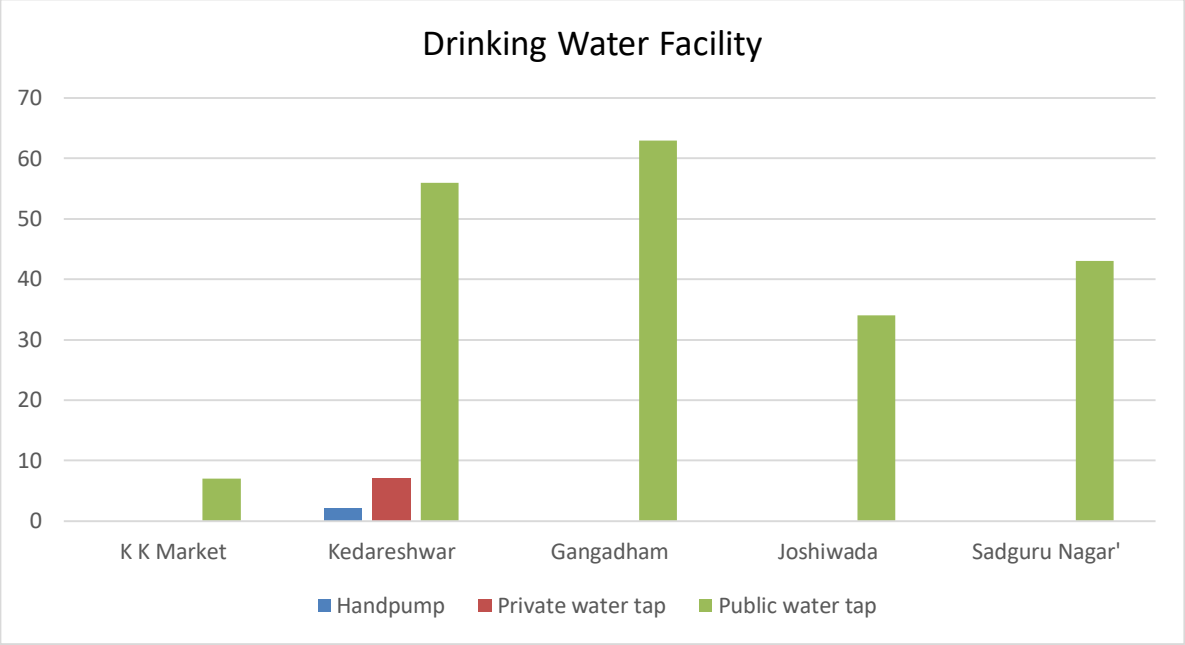

Chart no. 4.15

4. Fuel used for cooking-

As we can see in chart no. 4.16, 49% i.e.104 the families use only firewood for cooking. All families from K K Market and Joshiwada are using firewood for cooking as all families from this area use firewood. Majority of families from Sadguru Nagar also use firewood. 26% i.e. 56 families use only LPG for cooking whereas 24% i.e. 51 families use LPG and firewood both and this ratio is high in Gangadham. 49% i.e. 104 families use firewood as a fuel, it is really interesting to find answers for where from in the Pune city they get firewood? How much do they spend on it weekly or monthly? Or if they are collecting firewood, how much time they spend on it? Families from Kedareshwar and Gangadham use LPG and ratio is high in Kedareshwar.

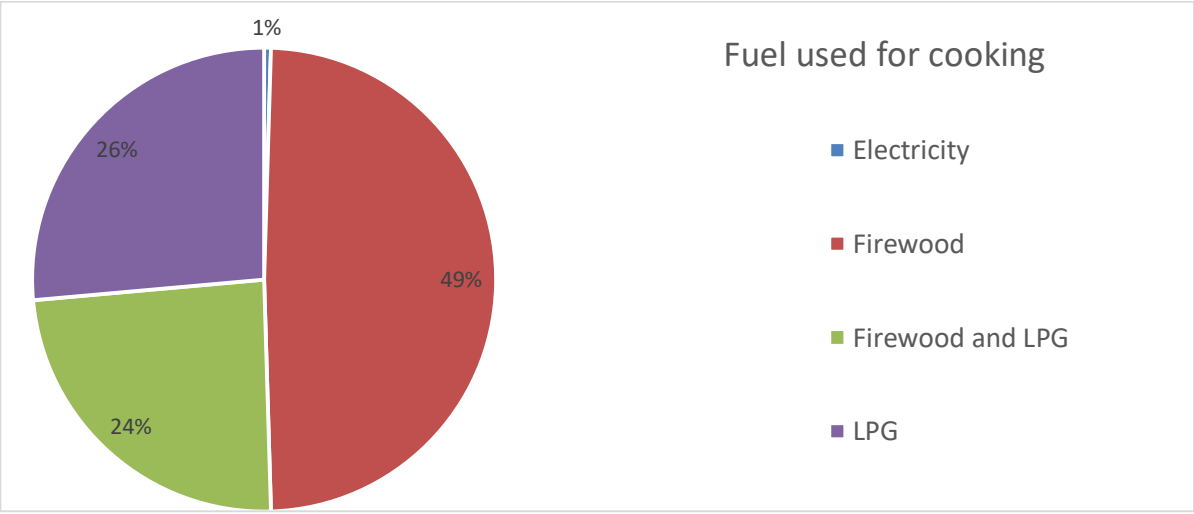

Chart no. 4.16

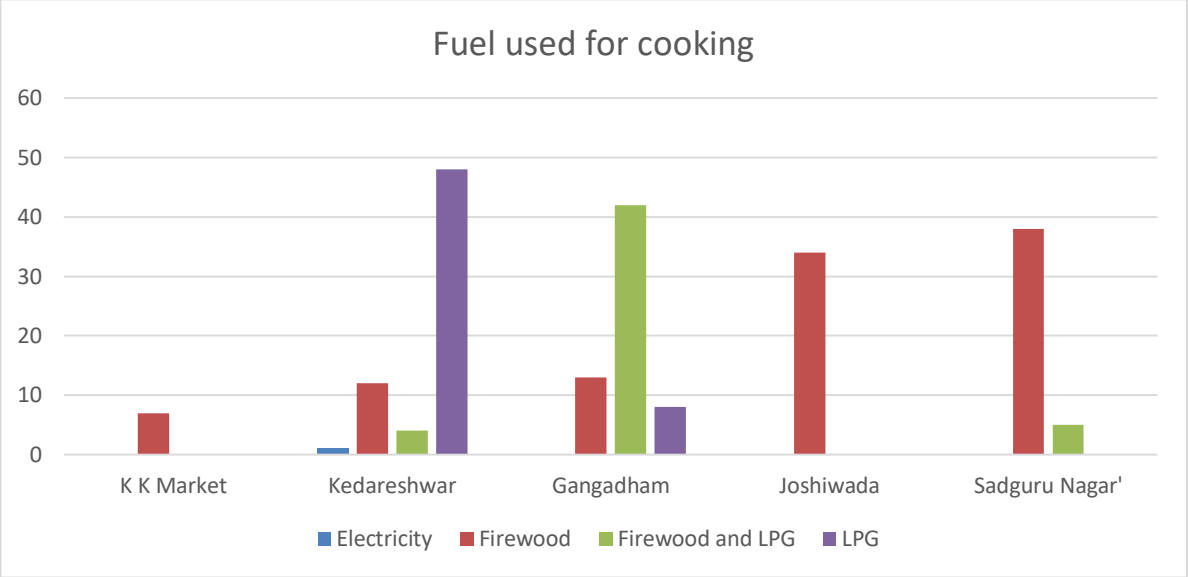

Chart no. 4.17

6. SOCIAL NORMS and CUSTOMES-

Nomadic communities used to have their own Jat Panchayats to deal with various matters arise in their community. Each community also have their own social norms and customs and they have to follow it strictly otherwise Jat Panchayat interferes and give punishment for it such as; to boycott that person or family. In majority of cases female have to suffer more as decisions were male centric and female have to prove her innocence. Age of the girl at the time of marriage is one of the most important factor in their social norms.

As we can see in chart no. 4.18 24% i.e. 21 girls got said that girls in their family got married at the age between 2-9 years of their age and percentage seems to be high in Sadguru Nagar and Kedareshwar. Also 11% i.e. 10 girls got married at the age between 10-14 years, whereas 32% i.e. 29 girls got married at the age between 15-17 years and again ratio is high in Kedareshwar, Sadguru Nagar and Joshiwada. From this percentage we can make out that; total 67 % i.e. 60 girls got married before completing their age of 18 years. It is really an eye opening situation.

Intervention needs to be done to reduce the percentage of child marriages to avoid further complications related to physical and mental health, education, economical independence etc. Kedareshwar, Sadguru Nagar and Joshiwada needs to take on priority for intervention. Community meetings, awareness programs and linkage with local authorities and police system can help to reduce the percentage of child marriages and create opportunity for girls to make their future bright.

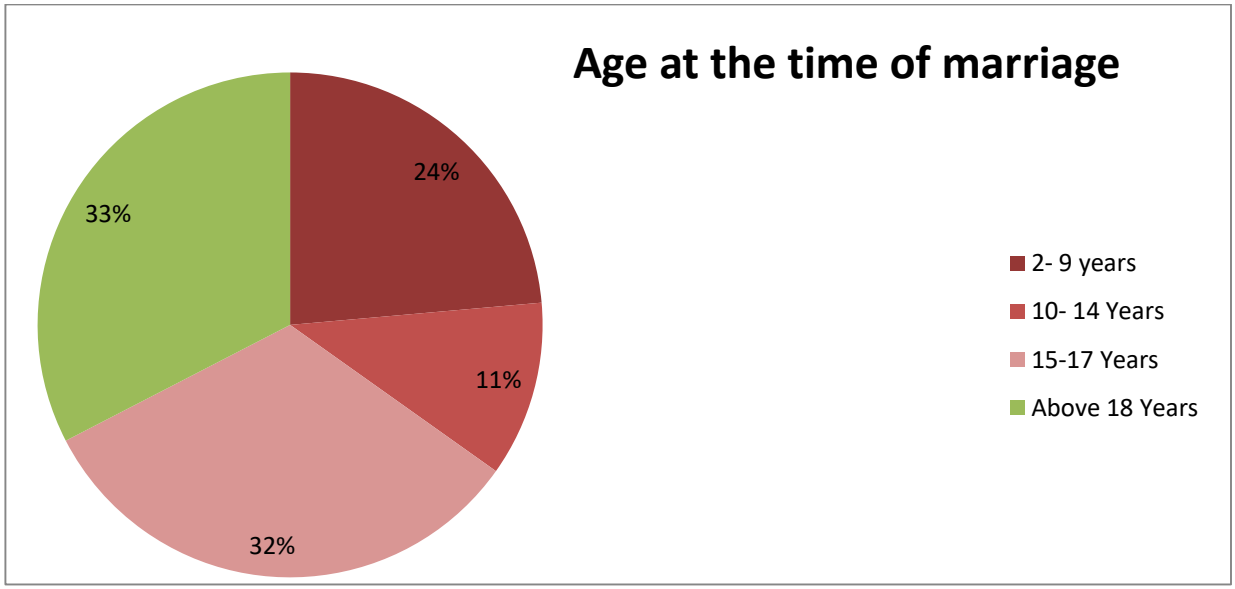

Chart no. 4.18

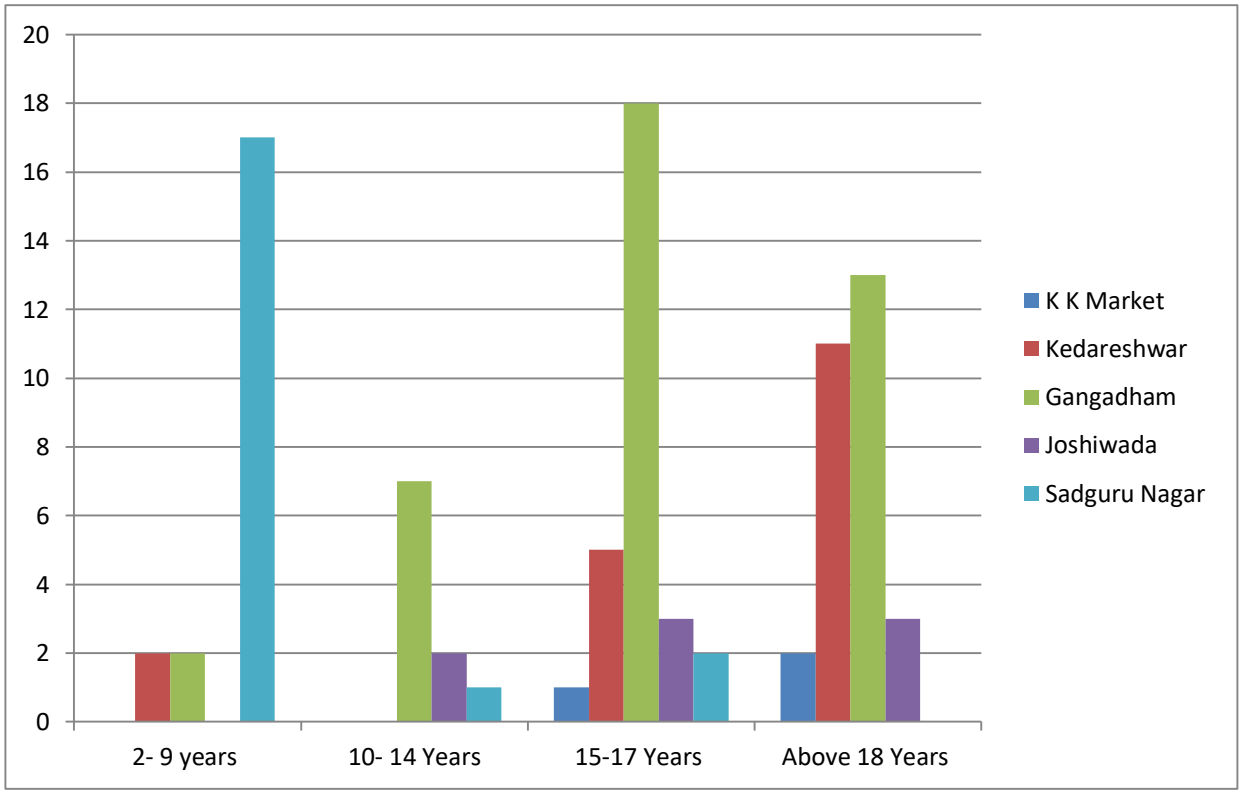

Chart no. 4.19

ROAD MAP & STRATEGY FOR FUTURE WORK

❖ Future Actions to be taken up

- Engagement with different government offices to undertake the future actions
- Consultation with WCD, UCD to share the findings from current study
- Prepare strategies and road map for future work
- Replication of the study in other locations to check out the same status of NT DNTs
- Brainstorming and consultation at organizational level to minimize the gaps, errors found during current study
- Strategizing on the financial support to conduct the study which will cover rest of the NT DNTs settlements in Pune city

SWADHAR IDWC
Pune

ECONET

ECONET -
Gulmohar Retreat RH -2 S.No.
14-6 Fatimanagar Wanowari,
Pune – 411 040 Maharashtra, India

Supported By: MISERIOR, Germany