

“Health Discourse in Chittagong Hill Tracts in Bangladesh”

Md Ahasnul Ameen Tuhin

Thesis submitted for the Degree of
Master of Philosophy in Indigenous Studies
May 2015



“Health Discourse in Chittagong Hill Tracts in Bangladesh”

Md Ahasnul Ameen Tuhin
Master of Philosophy in Indigenous Studies
Faculty of Humanities, Social Sciences and Education
UiT The Arctic University of Noway
Norway
May 2015

Supervised by
Associate professor Olsen, Torjer Andreas

This Thesis is dedicated to:

*My father who had passed away during the fieldwork and my mother who is the
inspiration to go through in life.*

Table of Contents:

List of Figures :

List Of Acronym And Meaning of Local Terms :

Acknowledgement :

Abstract :

Chapter One:

1. Introduction:	15
1.1 Proposition:.....	15
1.2 Definition of Indigenous Peoples:.....	20
1.3 The concept of Development:.....	21
1.4 The concept of Traditional Medicine:.....	22
1.5 Research Questions:.....	22
1.6 Methodology and Data collections:	22
1.7 Relevance of the Study:.....	28
1.8 Challenges and Ethical Reflections:.....	29

Chapter two:

2 Research locate, demography and cultural context of the study

2.1 Introduction:.....	33
2.2 Geographical background of Chittagong Hill Tracts:.....	33
2.3 Demography of the area:.....	36

2.4	History of the region:.....	39
2.5	Indigenous Peoples in Chittagong Hill Tracts:	42

Chapter Three:

3 NGO Perspective on health in CHT

3.1	History of NGO in Bangladesh:.....	45
3.2	NGOs in Chittagong Hill Tracts:.....	45
3.3	Location and Fact of the conducting NGOs:.....	48
3.4	BRAC:	52
3.5	Sunflower Bangladesh:	53
3.6	Shangu Hill:.....	56
3.7	Different Health intervention program in CHT:.....	61

Chapter Four:

4 Government and local perspective on Health in CHT

4.1	Introduction.....	67
4.2	Administrative and Political Structure in Chittagong Hill Tracts.....	67
4.3	Government Administration system in CHT:.....	69
4.4	Local Government Structure in CHT:	69
4.5	Traditional Administrative Structure:	71
4.6	Post Peace Accord Political Situation:.....	74
4.7	Health Policy in Bangladesh:	77
4.8	Health structure in Bangladesh:	79

4.9 Health policy and structure in Chittagong Hill Tracts:80
4.10 Different Health intervention program in CHT:.....84
4.11 Local people’s attitudes towards health intervention program:.....89
4.12 Government attitudes and perspective about Indigenous health:.....92
4.13 Government attitudes towards traditional medicine:.....99

Chapter Five:

Summery and Conclusion.....101
References.....107
Appendix –I.....114
Appendix –II.....117

List of Figures:

1.1 Maps of Bangladesh.....	37
1.2 Maps of the study area (Chittagong Hill Tracts)	38

List Of Acronym And Meaning of Local Term:

Acronym

ASA	Name of NGO in Bangladesh
ADB	Asian Development Bank
Aus AID	Australian AID
BRAC	Bangladesh Rural Advancement Committee
BBS	Bangladesh Bureau of Statistics
CHT	Chittagong Hill Tracts
CHTDF	Chittagong Hill Tracts Development Facilities
CHTRC	Chittagong Hill Tracts Regional Councils
CHW	Community health worker
CIDA	Canadian International Development Agency
EU	European Union
HNPSP	Health Nutrition and Population Sector Program
HPNSDP Program	Health, Population and Nutrition Sector Development
HDC	Hill District Councils
MoCHTA	The Ministry of Chittagong Hill Tracts Affairs
NGO	Non government organization
OXFAM	Name of International AID Agency
PCJSS	The Parbatya Chattagram Jana Samhati Samiti

DANIDA	Danish International Development Agency
SIDA	Swedish International AID Agency
UHC	Upazila (Sub district)Health Complex
Unicef	The United Nations Children’s Fund
UNDP	United Nations Development Program
UPDF	United Peoples Democratic Front
UNFPA	United Nations Population Fund
Upazila	Sub-district
USAID	United States Agency for International Development
WHO	World Health Organization
WB	World Bank

Description of Local Terms:

Adivasis	Local term of Indigenous People
The Bawm	Name of indigenous group in CHT , Bangladesh
Bhante	Religious leader
Boiddo	Local healers
The Chak	Name of indigenous group in CHT , Bangladesh
The Chakma	Name of indigenous group in CHT , Bangladesh
Chakma Raja	Chakma King
Headman	Head of mouza who is responsible to collect revenue
Jumma People or 'Phahari'	Indigenous People living in the hill
Jumma	Swidden cultivation practiced by hill peoples
Jhum	Slash and burn
The Kheyang	Name of indigenous group in CHT, Bangladesh
Karbari village	Head of Village at a mauza who is the local admin in a
The Khumi	Name of indigenous group in CHT, Bangladesh
The Lusai	Name of indigenous group in CHT, Bangladesh
Madarasas	Religious educational institute
The Marma	Name of indigenous group in CHT , Bangladesh
The Mru	Name of indigenous group in CHT , Bangladesh

The Panku	Name of indigenous group in CHT , Bangladesh
Phahari	Local terms of hill people
Pourasova	The local government institution for municipalities
Para Centre	Village Center
Para	Indigenous village
Sadar	District town
Shanti Bahini	Peace Brigade
The Tripura	Name of indigenous group in CHT , Bangladesh
Union Parishad	Considered as the lowest unit of general administrative structure
Upazial	Administrative sub district

Acknowledge

It is my great pleasure to write these final words for appreciation who made this travel enjoyable and remarkable.

First of all, I would like to acknowledge and thankful to all of my research participants for your spontaneous contribution. I am proud of you for making the interview session vibrant and alive. I am thankful to hear your stories and experiences about health discourse. It is always inspiring to hear your stories and experiences which indeed a huge contribution of this research. I would also like to thankful to the indigenous communities, stakeholders and NGO staffs in Chittagong Hill Tracts for their unconditional cooperation and support. It is truly inspiring to talk with them which are also thought provoking. I really appreciate it and have my immense gratitude with them. The research was impossible without their cooperation and spontaneous support. Thank you so much for your open, sincere and generous talk during the interview session.

To my project supervisor Torjer Olsen, thank you so much for your guidance, dedication, encouragement. I am also thankful for your continuous support and challenging me at every stage of this research . I am honored to have pursued this research work under your supervision. I am also greatfull to you for every single moment I have learned from you. Thank you so much for your patience and believe with me.

I am also very much thankful to Norwegian State Educational Loan Fund (Lånnekassen) for financing this program and my gratitude also goes to Center for Sami Studies for financing my fieldwork. I am thankful to all staffs from Center for Sami Studies .It has been great inspiration and opportunity to learn from this Center. To the department of Indigenious Studies and staffs , thank you so much for helping me to learn and develop indepth knowldge in individual courses throughout the program . It was indeed inspiring to all of your individual work and which motivated me to pursue this research . Thank you so much for the thought provoking discussion in the class which generated skills and knowldes in this reseach work .

To my classmates, thank you so much for your great company throughout the program. I have my heartfelt thanks for sharing your thought , knowledge, ideas and firendship. I have

learned a lot from you. Thank you so much for your sharing which inspired me every single moment. I will never forget you for sure.

Last but not least, my heartfelt gratitude goes to my family members specially my mother who is the inspiration to carry out this program and this research. Mom, thank you so much for your encouragement and continuous support.

Abstract

The present study is about health discourse in Chittagong Hill Tracts; this research shows how different health intervention programs are conducted in Chittagong Hill Tracts in Bangladesh after the peace accord in 1997. This research also revealed how health becomes a development issue in Bangladesh especially in Chittagong Hill Tracts. Here, health discourse means how different agents, both government and non-government organizations, try to establish the authenticity and accuracy of modern medicine where traditional medicine has been ignored and overlooked. Concurrently, it shows how agencies represent indigenous people through different health intervention programs. Furthermore this study revealed how through different health intervention program traditional medicine has been marginalized and replaced by the modern biomedicine. Simultaneously, present research revealed the limitations of different health intervention programs run by government and non-government organizations. The research has also addressed and characterized different perceptions and perspectives from many people who are connected to health intervention programs and traditional health practices in Chittagong Hill Tracts. Therefore, the study is combining and representing the phenomena of modern health practice and traditional health practice in Chittagong Hill Tracts in Bangladesh. The present study was carried out in three hill districts in Chittagong Hill Tracts, namely Khagrachari, Rangamati and Bandarban.

Chapter One

1. Introduction:

1.1 Proposition:

In different parts of the world minorities and indigenous populations are frequently subject to ethnic assimilation, discrimination and subjugation. At the same time they are also experiencing health related aggression from the dominant culture (Harris R, Tobias M et al: 2006). Current research accounts show that indigenous people and other ethnic minorities in different parts of the world encounter discrimination and disparities in health related issues (Bhopal R: 1998:316:1970-73, Nazroo JY: 2003:93:277, Reducing Inequalities of health published by Ministry of health, New Zealand: 2002: 3, Ring Ian, Brown Ngiane: 2003:327(7412): 404-405).

Indigenous peoples have long been facing different kinds of imperialism and colonialism from colonial British rule in Bangladesh historically. Additionally, they face multiple levels of challenges and suffering since the colonial invasion of this area. Therefore, due to the aggression from the dominant or mainstream society they now live in a conflicted situation due to colonial and postcolonial invasion in this region. The social structure, traditional culture, and ways of life in these indigenous communities have largely been affected especially in their traditional health and medicine (Stephens Carolyn and et al: 2006: 367:2019).

Much research has implied that in many part of the world indigenous peoples are continuously facing repression and invasion of their traditional culture and land which affects their ways of living; indigenous peoples in Bangladesh are no exception of this colonial phenomena (Gracey Michael and King Malcolm: 2009: 374: 65, King Malcolm et al: 2009: 374:76,77). In this context, Smith argues that indigenous research is inextricably linked to European colonialism and imperialism. She also posed “the word “research” itself is probably one of the dirtiest words in the indigenous world vocabulary,” (Smith Linda Tuhiwai: 1999:1). Even after the independence of Bangladesh, the postcolonial social structure and format has been implemented and formulated through state mechanism. In such a scenario

different international research organizations, local NGOs and international NGOs, and diverse donor agencies, follow the same post-colonial structure in their different health intervention programs. This makes the situation more critical and more decisive for the indigenous peoples in Bangladesh (Stephens Carolyn and et al: 2006: 367:2019). These different agencies try to establish the authenticity and accuracy of modern medicine and try to penetrate the dominant ideology and social patterns of medical care among indigenous peoples in Chittagong Hill Tracts through different health projects. Through these projects NGOs and INGOs focus on how traditional health patterns are useless within the present context in Chittagong Hill Tracts. They try to concentrate on how this traditional health practice and medicine are meaningless to the concentrated community.

Arun Agrawal pointed out that discourse in 1950s and 1960s represents indigenous and traditional knowledge as insufficient, ineffective, and useless to the modern technological society. Traditional knowledge has been considered marginalized and naive in nature, which indicates the authenticity and efficiency of modern medical knowledge (Agrawal Arun: 1995:26:413,414). Therefore, it is seen that through their (both government and non-government actors) health intervention programs both INGOs and NGOs try to focus on its efficiency. Moreover, these NGOs also try to establish how modern medical systems and its medicine are productive and useful for indigenous peoples in this region. It has also been shown that NGO organizations consider themselves as a “messiah” who would like to solve all kinds of health related problems among indigenous people. As a result indigenous medicine has been marginalized and replaced by the modern medicine.

In this research I investigate how biomedicine or modern medicine is trying to establish, replace, and penetrate indigenous communities in different parts of Bangladesh. The study scrutinized ways which indigenous people have been represented through different actors in both government and non-government organizations. It also analyzes the role of government and non-governmental organizations and those are working with different projects based on indigenous health issues. Together this study examined how health is becoming a development issue in Chittagong Hill Tracts after the peace treaty where how this monolithic development causes “otherness” through different health intervention programs.

Different forms of repression and discrimination have been introduced after the independence of Bangladesh. Through the new state indigenous peoples face more challenges, oppression due to lack of sufficient government policies towards indigenous peoples especially in the health sector (Bangladesh Health Policy: 2011). Furthermore, the majority of Bengali people's colonial attitudes make the situation worse. This dominates people's attitude and dominant modern or biomedicine health systems makes indigenous peoples more dependent on the mainstream or so called modern health system and its gadgets (Indigenous peoples in Bangladesh).¹.

It is also noted that in the Bangladeshi national constitution, indigenous peoples have not had any constitutional recognition. This means indigenous peoples in Bangladesh do not have any constitutional rights or support for their voices to rise. The state does not recognize indigenous peoples and their existence neither in the constitution nor on official paper. In terms of language, indigenous peoples do not have any acceptance for their language and other human rights in the national constitution (Bangladesh constitution 2011: Part 1: article 3, part: 1 article 6(2) see more details in the link)¹.

In the 15th Constitutional Amendment, which was implemented in 2011, the Bangladesh government did not offer any safeguard to the indigenous people in Bangladesh. The government did not offer any constitutional protection to the Chittagong Hill Tracts Regional Councils (CHTRC) Act 1998 and three HDC (Hill District Councils) Acts 1998 according to the peace accord. In contrast, indigenous people in Bangladesh demanded reviews of the 15th constitution in order to recognize them as "indigenous peoples". They urged the government to protect their fundamental human rights, land and legal rights, as well as social, cultural and economic rights in the national constitution². Even all kinds of education are run by state language (Bengali). Hence, many indigenous children are unable to continue their education in their own language. In another way it can be said that the government is trying to acclaim its knowledge, superiority, authority and authenticity towards indigenous people and try to

¹"The constitutions of peoples republic of Bangladesh" accessed in December 25, 2014, http://bdlaws.minlaw.gov.bd/print_sections_all.php?id=367

² Sanghati, Bangladesh Indigenous Forum , Dhaka , 2011

make them the “Other” in front of the Bengali population (Bangladesh constitution 2011, part: 1 article 6(2), see more details in the link)³. NGO activities also represent western knowledge and superiority, which is reflected through their projects and proposals and their multiple purposes (Smith Linda Tuhiwai: 1999:10). Finally, most of the NGOs projects are not creating any positive change among diverse indigenous communities in terms of health issues in CHT.

On the other hand, the dominant (Bengali) majority are continuously repressing, subjugating and subordinating the indigenous people at different levels. This discrimination and repression has also come from the government side (Indigenous peoples in Bangladesh)⁴. In terms of health practice, non-indigenous and other actors including government actors portray that they require modern medical facilities and practices, stating indigenous people suffer from several types of health problems, which cannot be healed by traditional medicine (Chittagong Hill Tracts: Unicef: 2011:2). In another way it can be said that both government and non-government actors try to establish the authenticity and accuracy of modern medicine and try to show the inexpediency and inefficiency of traditional medicine. Additionally, these agencies and both government and non-government organizations are trying to emphasize traditional health practice points to the backwardness of indigenous people. The same agencies also try to emphasize indigenous peoples need to use and practice modern medicine, which indicates the authenticity of modern medicine.

Many researchers, scholars, academics, project workers, and other agencies are doing research on etic perspective and different kinds of policies. This etic approach sometimes does not do much good for the indigenous peoples. Rather, these kinds of research bring harm to indigenous people all over the world (Smith Linda Tuhiwai: 1990: 10). Sometimes their voices have been distorted and not represented in the report writing. In many works it has been seen that different projects have been run with their own interests in mind; therefore there is no development among these peoples. In that respect, Smith argues that it is very important to understand indigenous peoples in terms of their cultural, economic, political,

³ “The constitutions of peoples republic of Bangladesh” accessed in December 25, 2014, http://bdlaws.minlaw.gov.bd/print_sections_all.php?id=367

⁴ “Indigenous peoples in Bangladesh”, International working group for indigenous affairs, accessed in July 6, 2014, <http://www.iwgia.org/regions/asia/Bangladesh>

ethical and historical context (Smith Linda Tuhiwai: 1999:25). In CHT, there are different NGOs are working and trying to involve indigenous women in their projects by the demands of the donor agencies, but the fact is that most in the upper ranking official positions are non-indigenous peoples, a point which is highly criticized by indigenous people. Many indigenous peoples have doubts about the work of NGOs as most of the cases the program implementation has been done without proper participation of these communities. Moreover, through these programs a number of non-indigenous people have been recruited under development needs which have been existing and formulated in the developing countries.

The question come does development means to enhance discrimination, moved from their won place, development does not mean decrease of the indigenous land. Development does not mean that a section of indigenous people are getting jobs and higher education rather than the whole community improving. Development does not mean that the whole community lives at risk, whereas a portion of facilitated indigenous people visit foreign countries and claim to be modern. Development does not mean that traditional health practices and medicine becomes extinct whereas mainstream health systems become the only savior of indigenous peoples. Development does not mean to root out of traditional healers and their rituals and to classify them as ‘illiterate’, ‘superstitious’ and ‘backwards’ by health practice and practitioners who believe that traditional medicine does not work in the contemporary era. (indigenous or tribal which identity)⁵.

The fact is that policy makers have to decide what kinds of development they need for indigenous people and for whom they are developing and for whose well-being. It will be meaningless if there is not full participation of indigenous people in different stages of the development programs. In the bureaucratic process, national and local NGOs are getting more and more funding and increase their projects and branches. Even 15th Amendment of the Constitution (1972), which was ratified in 2011, failed to recognize indigenous peoples as

⁵“Indigenous or tribal which identity” accessed in December 12, 2014, a Bengali online newspaper <http://www.bd-pratidin.com/editorial/2014/12/06/48041>.

distinct ethnic communities in Bangladesh (The constitution of Peoples Republic of Bangladesh)⁶.

1.2 Definition of Indigenous peoples:

There is no universal definition of indigenous people that can be implemented all over the world. The formal definition of indigenous people is not applicable in all countries and cultural perspectives due to limitations of the definition. In terms of the indigenous definition, different scholars have defined indigenous people in different perspectives. The United Nations has not taken any fixed definition for indigenous people due to its diversification and debate of the concept of indigenous people, while a working definition of indigenous people by Jose R. Martinez Cobo was accepted in different period.

According to the Martinez Cobo definition “Indigenous communities, peoples and nations are those which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from sectors of the societies now prevailing on those territories, or parts of them. They form at present non-dominant sectors of society and are determined to preserve, develop and transmit to future generations their ancestral territories, and their ethnic identity, as the basis of their continued existence as peoples, in accordance with their own cultural patterns, social institutions and legal system”(working definition on indigenous people by Jose R. Martinez Cobo)⁷. In Bangladesh’s perspective some significant characteristics are common in the Asian Development Bank working group definition of indigenous peoples. Moreover, the concept is more subjective in terms of the cultural context. According to the Asian Development Bank, two characters have been identified in order to understand indigenous people as “(1) decent from population groups present in a given area, most often before modern states or territories were created and before modern borders were defined and; (2) maintenance of cultural and

⁶ “The constitutions of peoples republic of Bangladesh” accessed in December 25, 2014, http://bdlaws.minlaw.gov.bd/print_sections_all.php?id=367

⁷“Definition of Indigenous peoples”, Working definition on indigenous people by Jose R. Martinez Cobo, accessed in November 21, 2013, <http://indigenouseoples.nl/indigenous-peoples/definition-indigenous>.

social identities, and social, economic, cultural and political institutions separate from mainstream or dominant societies and cultures,” (Asian Development Bank: 1998).

1.3 The concept of Development:

The notion of ‘Development’ is still a buzzword in the Third World context; Bangladesh is no exception even after the sharp criticisms of the post-development thinkers. Knowledge is political, shapes perceptions, agendas and policies. Cognitive knowledge of the West which reflects a neo-colonial division of labor in the production of knowledge according to which theory is generated in the North and data (raw materials) are produced the South. In the discourses of history produced by western hegemony, knowledge and power are interwoven. Over the time the concept of development has provided different meanings. Escobar argues that colonial and postcolonial domination of South and North shapes ‘development’ in 20th century. (Escobar Arturo: 1995:6).

According to James Ferguson, the notion of development in the mid-twentieth century referred to economic expansion which indicates the consumption, production, and increasing standard of life which changed its meanings after the World War II into development agencies and to develop the ‘other’. Therefore, the birth of development projects means the birth of ‘backwardness’ to ‘modernity’ which generate funding and institutional organizations and through this process they transfer the western hegemony to the third world countries. Bangladesh is no exception to this process (Escobar Arturo: 1995:6).

In that context hawse have seen this western imported knowledge and power is to a great extent practiced and applied through different projects by various government agencies, diverse development organizations, and NGOs among indigenous communities in Bangladesh. As a consequence, the fieldwork revealed that in a very few cases indigenous people participate in the project design and implementation. The study also showed that many different indigenous groups have little participation in their own policy making. Therefore, inadequate project designs are not bringing any good for indigenous groups. Only a portion of dominant indigenous groups have taken advantage due to their affiliation with both government and non-government organizations. Besides this scenario, we also see that dominant modern health systems and gadgets are imported in Chittagong Hill Tracts. On the

other hand, peoples of this area have little knowledge and are suspicious of these modern gadgets as they rely more on traditional medicine. This traditional medicine is more connected to their cultural bonding.

1.4 The concept of traditional medicine:

WHO (World Health Organization) defines traditional medicine as “the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness,” (World Health Organization definitions of traditional medicine)⁸. Traditional medicine is varied from culture to culture. Traditional medicine is part of cultural practice, which contains the values, beliefs, and worldview of the local people.

1.5 Research questions:

In this microscopic and in-depth study the following questions are scrutinized through the study period.

- What is the role of government and non-governmental organizations working with different projects based on indigenous health issues?
- How have indigenous people have been ‘represented’ through different organizations and how they have been represented through different intervention projects?
- How does health become a development issue in Bangladesh especially in indigenous communities?

1.6 Methodology and Data collection:

The study is a qualitative study aiming to understand health discourse, and representation of indigenous people by government and non-government actors. This study explores the role of government and non-government organizations working with indigenous health issues and

⁸“Traditional Medicine: Definition”, World Health Organization, accessed in August 21, 2014, <http://www.who.int/medicines/areas/traditional/definitions/en>

how indigenous people have been represented through these actors. In this research I employed a number of qualitative tools and techniques. In qualitative research there are a number of common interviews types: namely in-depth, nonstructural/unstructured, semi-structure, structure, key informant interviews (Fetterman. David M: 2010:40).

In this study in-depth interview were conducted among the core participants who are directly involved in indigenous health program and with key informant interviews, who are persons in a position of expert knowledge. I used open ended questions aiming to not only grasp the actual answer from the participant but also trying to understand how and which context they respond (Chilisa Bagele: 2012; 205). In open-ended questions I tried to understand participants' self-perception of indigenous health programs. In that case I used different types of questions including perceptions, knowledge, indigenous values, understanding, opinion and demographics (Chilisa Bagele: 2012; 205,206). The research questions were not the same for all the participants. Some questions were relevant for some participants while others were relevant for other participants.

The interviews were taken with full informed consent and available time and space from the research participants. In some interview sessions the interviews were postponed as the participants were involved in their official and daily activities. The interviews were conducted based on the participant's full consent when they had available time. The whole interview was conversational with both informal and formal discussion. Before starting the interview I introduced myself and informed the participants of the project objective. I tried to ensure that the research participants get the full impression of the interview and the project. The main objective was to introduce the details of the project to the participant and use informal conversation in order to engage them in the project before starting the main interview. The introduction of the project made the participants comfortable and relaxed about the research topics. I also asked the research participants about a possible meeting place in order to ensure that they felt secure and comfortable during the interview. In that case I took interviews in both public places like tea stall, café, restaurant, and NGOs and government offices.

When in a private place I conducted interviews on different time schedules; for example more than five interviews I conducted on holiday in participants' homes and some interviews took

after office hours. It is my impression that there are both advantages and disadvantages of taking interviews both in public and private places, for example in public places research participants don't need to think about selecting the place therefore they feel comfortable and feel free to select any place. For example, some of my participants preferred to talk in tea stalls and restaurants because they think it's more comfortable to go and talk there. On the other hand, in public places it is sometimes problematic to talk about private issues. Therefore, sometimes participants feel hesitant to talk about private or sensitive issues.

In contrast, in private places, research participants feel more comfortable to talk about many sensitive or private issues. In this study I took interviews both in public and private places based on participant's choices. I was more relaxed to take interviews in these spaces. My main intention was to make sure participants feel secure, relaxed, and comfortable interviewing in either public or private places. It's my impression that any barriers regarding this issue can be manageable. During the interview sessions I also tried to observe participants' non-verbal communication such as body language, facial expressions, and mood, which I feel is important in following participants' statements and understandings of indigenous health issue.

There are a number of reasons to select in-depth interviews as a data collection tool. The in-depth interview was proposed towards different personalities both from government and non-government actors who are relevant in indigenous health issues. This method was taken on in order to understand NGOs' health discourse regarding indigenous people and how their program "otherness" has been created. This method is particularly important in capturing individual interpretation and expression of the concept of indigenous health. Through this research tool I tried to grasp and comprehend the picture of indigenous issues among policy makers and their perspective, perceptions and knowledge about this matter. Policy-makers, both government and non-government personalities, design and implement programs in the field. This was the main data collection method in this study. Through this method I tried to get empirical information concerning knowledge, perceptions about local and NGO perceptions about health intervention programs as well as getting knowledge how each perception works in each other in Chittagong Hill Tracts.

I conducted key informant interviews among people who specialize knowledge about indigenous health and indigenous health related programs. I took key informant interviews from a NGO worker (indigenous background) who also worked with different international organization including UNDP (United Nations Development Program). I have been connected with him since I was student at my home university. During my field trip I explained him the details of the project and the research objectives, then he gave consent to share his knowledge, perception, and ideas about different actors in both government and non-government related to indigenous health programs. I also used this method among a health professional from NGO clinic that is also working with indigenous health issue. I met this person through personal networking as I worked as a researcher in different health research organizations.

With regard to key informant interviews Fetterman states, “key informant interviews are excellent sources of information and important sounding boarding for ethnographers,” (Fetterman David M: 1989: 58). “A good key informant are people who can talk easily, who understand the researchers needs and who are glad to contribute,”(Fetterman David M: 1989: 59). “A key informant is more than someone who possesses a lot of information about a culture and is willing to talk,” (Fetterman David M: 1989: 166). I employed this technique during my fieldwork but not necessarily relied on this, as too much dependence on key informants would distract from the objective to understand the subjective experience of indigenous health issue.

In the beginning I started this technique in order to understand the specialized knowledge regarding indigenous health programs, attitudes and perception of indigenous issues by government and non-government organizations. But after the development of the project I shift to other sources importantly for in-depth interviews from the core participants among those which are involved in the indigenous health related program. I used observation methods in my projects as I think it is very important to comprehend the context when I interviewed. This method was used from the very beginning of the informal discussion and introduction of the project. I use this technique among the participants with individual

contexts. For instance I spent time with the participants' daily official and fieldwork activities. Participants from the fieldwork also allowed me to spend time with them in their daily activities about NGO work. Through this technique I also tried to observe their way of talking, their official environment, how many people are working on these NGOs, and the ratio of male and female employees? Which communities are representing these NGOs? Where have they located their office and why?

This method helped me to increase the familiarity of the subjective experience of indigenous health and indigenous health programs. Through these methods I tried to understand the health discourse and politics that are going on in these sectors. I also tried to understand the meaning of health NGOs attitudes towards indigenous people. Moreover they also observed my attitude, topics of interest, my behavior, my ethnicity, and my identity both in national and international education background that I could not hide during my fieldwork. They also asked me the question of why I selected this issue when there were lots of issues which has to be focused also. Through this method I obtained different kinds of experience that I recorded in my field notes.

I also use field notes as a source of data collection. Besides this I also used an audio recorder in my fieldwork but it was only used with the fully informed consent of the research participants. Fetterman argues, "Tape recorders effectively capture natural conversation," (Fetterman David M: 81: 1989). I agree with Fetterman's arguments regarding audio recording, as it would be quite tough to write down all the data during the interview session. After recording the interview, I transcribed the data in a written format. This method helped me to realize the natural conversation and continuation of the participant's perceptions and knowledge regarding indigenous health programs.

I was fully aware of the fact that writing during the interview session makes the participant confused, insecure, and hesitant to talk naturally, in addition to interrupting eye contact between the researcher and the participant. However, during audio recording some participants felt afraid and insecure that their statements might be documented or published. In that case I conducted interviews without audio recording, taking written notes and

confirming with the participants that no data will be disclosed or published without their permission and all data will be analyzed with full anonymity. Audio recording was only done when the participants gave voluntary informed consent.

I followed snowball sampling using my personal network from my former colleagues working in a health research organization and my familiarity of the NGO sectors in Bangladesh. These, as well as some of the university professors from Bangladesh who are working with indigenous issues, helped me to connect with different indigenous organizations and indigenous leaders and activists. There are some advantages to this kind of networking. For example some professors working with indigenous issues directly referred me to the local indigenous political and social organization. Therefore, I easily entered the field while my former colleague helped me to connect with ministry of health and ministry of Chittagong Hill Tracts.

This process kept participants relaxed, comfortable, and trustworthy, which eventually gave me access to be in touch with people both from government and non-organizations along with local people as well. Moreover, it is my impression that introducing the potential participants by acquaintance is always good and acceptable rather than being introduced by a stranger. This potentially creates trust, security, comfort and makes others relaxed to discuss the research topics. However, there are some disadvantages with personal networking; there is the possibility to miss different perspectives and different sources of data.

In the Chittagong Hill Tracts perspective, I observed that due to ethnic violence between the Bengali community and indigenous people there were potential threats to conducting field work, in that sense following personal networking was more secure and trustworthy towards gathering research participants. On the other hand I was fully aware that I must avoid the possible bias and tried to select diversified sampling for data collection. With regard to networking process, I started my interviews with government officials both in Chittagong Hill Tracts ministry and the health ministry. Here I conducted an interview with a secretary present as they are connected to government health program for indigenous people. Then I started my discussions with INGOs and local NGOs personnel. I talked with the national and

local heads of these NGOs as well as with field level workers. Then I talked to other profession of peoples related to indigenous health program.

I conducted 18 interviews among peoples of different profession. Among these interviews both men and women participated. Both genders were selected in order to understand their statements regarding how indigenous people have been represented through different actors. After that I talked with local people in order to comprehend their understanding about the meaning of health. How they think about NGO health service, do they see any change in their daily life?

During my fieldwork I also used a checklist, which guided the questions I used with my interviewees. Furthermore, I analyzed various kinds of government and non-government papers, reports, newspapers, including online news portals, and articles as well as other sources that enabled me to critically analyze the perceptions, ways of representation that government and other international, national and local organizations practice regarding health perspective of indigenous peoples.

1.7 Relevance of the study:

After the independence of Bangladesh in 1971, there have been large numbers of NGOs, international development organizations; national and local organization and government actors which run numerous indigenous programs and programs related to health among indigenous people. A number of studies have been done on different health related programs in Chittagong Hill Tracts. Most of the studies were done with quantitative research and focus on importance of different health related program. In most of these projects their main intention is to discover underdevelopment and backwardness among different indigenous health practices. Through their projects they are prescribing modern medical formulas to indigenous people without considering local medicine, which is rooted in donor agencies demand. This is based on western academic and scientific knowledge (Escobar Arturo: 1995: 3).

It has been seen that in most of the health related projects there is not enough participation of indigenous people, which represents the limitation of project designing and policymaking. Importantly very few studies represent the subjective experience of indigenous health

programs and lack of holistic approach in their health related project. In this regard it can be said qualitative research is important to understand the role of government and non-government actors towards indigenous health programs in Chittagong Hill Tracts.

Most of the indigenous health programs have not properly addressed other voices (indigenous people) and other stories (indigenous people) in their health programs, which indicates the limitation of the knowledge gap. In that case, this study will critically address the activities of development organizations and discuss ways indigenous people have been represented and treated through different organizations. Furthermore, this study will shed light on why health becomes a development issue in Bangladesh in terms of indigenous people. This study will show us the reasons for funding health issues among indigenous peoples.

1.8 Challenges and Ethical reflection:

In social sciences research there are a number of roles a researcher can take which depend on various indicators, namely researchers' social identity, social class structure, education, ethnic backgrounds, religion, dress code, professional backgrounds, gender, language, cast, beliefs, dogma etc. As a scholar of Indigenous Studies my role in this study will be as an indigenous researcher. There are a number of issues I encountered throughout the fieldwork.

First and foremost, my position in this study represents myself as a Bangladeshi citizen with a dominant Bengali identity. Moreover, my western university training influenced my relationships when encountering others. Furthermore, I grew up in the capital city of Bangladesh and the language I speak was different from my respondents. At the same time, during the fieldwork I was representing Tromsø University, which is situated in the North, I had to follow the ethical rules and guidelines from this university, which also represent my different identity from the peoples where I interviewed. Going back to Bangladesh for fieldwork with only a short time period and back again for writing my thesis also encounters the tradition of western scientific knowledge (Escobar Arturo: 1995: 3).

When I talked with the local NGOs some people thought I was a government officer coming there to investigate and audit corruption. Some people were confused about my research and

in the beginning denied the request to interview. Therefore, I had to clarify very clearly from the very beginning that I was here for my Master's thesis, which would harm any person, institution, or organization. I also clarified to them (research participants) that all data are confidential and cannot be disclosed without their permission and no data disclosed will be associated with any institute other than the University of Tromsø. On the other hand, some other people also thought I would help them with funding and other facilities. Some NGOs helped me a lot as they thought I would extend and link the Tromsø University to their organization therefore; they would submit their proposal. I had to clarify that I am only a student coming here for fieldwork.

In that case my position was both insider and outsider, which depended on the context. My role was insider as I had previous knowledge of research and I had been working with different NGOs and I know the NGOs personnel .On the other hand, my role was more of an outsider when I interviewed indigenous organizations as my position here was more of a stranger. My social status, social environment, western education, ethnic and religious identity, and dress code, food habits were to some extent different from the research population.

In this context, the concept of 'emic' and 'etic' approaches was first developed by Kenneth L. Pike which is relevant in my study. According to Kenneth L. Pike, "An emic model is one which explains the ideology or behavior of members of a culture according to indigenous definitions. An etic model is one, which is based on criteria from outside a particular culture. Etic models are held to be universal; emic models are culture-specific," (Barnard Alan and Spencer Jonathan: 2005: 275). In that sense I also consider myself as non-native researcher who has western academic training and positioning. This recalls the tradition of the western scholar who went to an exotic place and discovers "otherness" and then returns back home to starting writing text, (Clifford James, Marcus George E: 1986: 2).

I also went to study a population which was in many ways different from myself. However, I prioritized their perspectives and tried to learn from them. Fieldwork is always more about negotiation and representation of identity politics. The text also represents the imperial and colonial western objective knowledge and superiority and acclaiming their scientific

authenticity, (Clifford James, Marcus George E: 1986: 2). But it does not necessarily say that all knowledge is true, based on fact and free from politics. In that sense Smith argues “Whose research is it? Who owns it? Whose interest does it serve? Who will benefit from it? Who is designed its questions and framed its scope? Who will carry it? Who will write it up? How will its result be disseminated?” (Smith Linda Tuhiwai: 1999:10).

This statement very much pertains to this project and I was aware the fact that results of the text is always arguable. In that respect I cannot say the text I produced would be ‘full truth’ and ‘objective’ or ‘scientific’; rather this study will be more of a critical approach to analyze the text and fact that will represent not less real or less truthful to understand indigenous health program from the participants perspective. I will try to understand the health discourse that has been penetrated through different agencies. In that regard my position is to be more critical and reflexive. In that sense I tried to represent a writing culture. By the term writing culture I mean a close connection with the study people and the researcher and I will try to write text in their perspective and experience in a humble way (Clifford James, Marcus George E: 1986: 2,7). As in many research studies it has seen that there is a lack of connection with the study community and sometimes many cultural components are missing in the written text as they are focusing scientific writing.

This study will emphasize the critical approaches of health discourse, indigenous health programs. In this study I also recognize power relations between researcher and research participants. A researcher has the power to select the research location, study population, research participants as well as formulate the research question, study design, objectives, data analysis, theory and assumption of which are part of the research process. On the other hand research participants have the power to decide to participate in the interview session or refuse it any time. Research participants have the power to stop the interview or postpone it.

Many of my interviewees were surprised that though I am Bengali but at the same time I represented Norway in the eye of Bengali identity. In contrast, in my fieldwork experience I saw that it is very challenging for a non-native researcher to obtain a clear picture of indigenous people due to colonial mindsets and cognitive worldview of the outside

researcher. Many western scholars and researchers try to explore 'exotic', 'primitive' 'barbarism' and abnormalities among indigenous peoples in different parts of the world, which instigates wider discrimination, polarization and division between mainstream people with indigenous people (Haebich, Anna: 2005:7).

As a result it has been seen that many researchers run different levels of projects, especially health projects under the name of development and try to develop their traditional culture in order to change indigenous peoples into being more civilized and modernized. These kinds of mindsets and thinking processes eventually do not bring any good for indigenous peoples in most cases. In that case the notion both etic and emic approach are very much relevant during my fieldwork as I felt them every time when I talked to different indigenous peoples. I knew all of my discussion and talks will not only represent my different Bengali identity, simultaneously it would represent my present university and the country itself.

Chapter two: Research location, demography and cultural context of the study

2.1 Introduction:

This chapter focuses on the location of the Chittagong Hill Tracts, locale of the study, the history of Chittagong Hill Tracts and its background, and the population of the study. It is relevant to discuss the region, which will eventually help us to understand the regions and its location, demographical situation and other factors.

2.2 Geographical background of Chittagong Hill Tracts:

The location of Chittagong Hill Tracts is situated in the South East of part of Bangladesh. This region is totally unique from the rest of the country because of its geographical location, importance, cultural diversity, linguistic diversity and biodiversity. Even this area is completely unique in terms of political and administrative structure within the country due to its semi-autonomous structure along with its limited juridical system (The case of Chittagong Hill Tracts by Raja Devashsis Roy)⁹. Chittagong Hill Tracts is also different in terms of physical characteristics and population. This area has different climate, soil conditions, food and dress codes, which are completely unique from the rest of the country. There are eleven indigenous communities comprising 98% of the population; each indigenous community has its own distinctive culture, language, rituals, dogma and religion. Moreover, this area is also unique for its natural beauty, therefore, a large number of tourists visit this area every year (CHT history and Struggle: Brief History and Struggle of the people of Chittagong Hill

⁹ HR/GENEVA/TSIP/SEM/2003/BP.8: The International Character of Treaties with Indigenous Peoples and Implementation Challenges for Intra-State Peace and Autonomy Agreements between Indigenous Peoples and States: The Case of the Chittagong Hill Tracts, Bangladesh by Raja Devasish Roy .

Tracts, Chittagong Hill Tracts Development Facility, *Banglapedia: The National Encyclopedia of Bangladesh: 2003*)^{10 11}.

Chittagong Hill Tracts is consisted of 13,295 sq km, which is approximately one tenth of the total lands of Bangladesh, surrounded by Myanmar on the south, Mizoram on the east, Chittagong on the west and Tripura on the south (Indian state). Chittagong Hill Tracts were divided into three administrative units (districts) in 1983 namely, the Rangamati Hill district, Bandarban Hill district and Khagrachari Hill district. These districts are also divided into three circles including Chakma Circle (Rangamati district), Bomang Circle (Bandarban district) and Mogh Circle (Khagrachari district).

Importantly, each circle chief, who is also an indigenous chief, heads each circle. They are responsible for collecting tax and solving different kinds of disputes associated with Headman (head of mauza) and Karbari (Head of village at a mouza). Rangamati district is comprised of ten upazials namely, Barakal Upazila, BaghaichariUpazila, Kawkhali Upazila, Belaichari Upazila, Juraichari Upazial, Langadu Upazila, Nanierchar Upazila, Rajasthali Upazila, and Rangamati sadar Upazila. Rangamati district is bordered by the Tripura (state of India) to the North, Bandarban to the south, Mizoram province of India and Arakan and Chin province of Myanmar to the east and Khagrachari and Chittagong districts to the west. The major river of Rangamati districts are Thega, Kassalong, Shublang, Chingri, Rainkahaiaiang ,Kaptai and Kar (Banglapedia: The National Encyclopedia of Bangladesh: 2003). On the other hand, Bandarban district is the hometown of Bohmong Chief (Bohmong circle) who is belongs to the Marma indigenous community. This place is also the administrative headquarters of the Banderban district. The total area of this district consist of 4,479 sq km, surround by Rangamati district on the north, Arakan and Chin provinces of Myanmar and Naf river to the south.

Moreover, Arakan and Rangamati districts of the east and Chittagong and Conx'x Bazar districts on the west. The major rivers of the district are Shankha (shangu), Matamuhuri and

¹⁰ “ Chittagong Hill Tracts Development Facility” CHTDF, United Nations Development Program, accessed in October 12, 2014, <http://www.chtdf.org/index.php/about-us/ctddf-overview>

¹¹ “CHT history and Struggle: Brief History and Struggle of the people of Chittagong Hill Tracts ” The Parbatya Chattagram Jana Samhati Samiti (PCJSS), the official website of Parbtaya Chattagram Jana Samhati , accessed in October 18, 2014 , <http://www.pcjss-cht.org/cht-history-struggle/>

Bakkahali. The three highest peaks (Tahjindong, MowdokMual, Keokradong) also exist in the district (Banglapedia: The National Encyclopedia of Bangladesh: 2003)¹². According to Banglapedia (2003) Khagrachari district is comprised of eight Upazialas, these are dighinala, khagrachhari sadar, lakshmichhari, mahalchhari, manikchhari, matiranga, panchhari and ramgar. This district is bordered by Tripura (Indian state of Tripura) on the north. Rangamati and Chittagong districts are on the south and Rangamati district is on the east, Chittagong district and Tripura (Indian state of Tripura) on the west (see the map: 2). The major rivers of this district are Chingri, Maini, Feni, and Halda (Banglapedia: The National Encyclopedia of Bangladesh: 2003).

Importantly, these rivers contribute hugely to the villagers' daily common lives. Indigenous peoples in the three hill district area believe that these rivers have life which will eventually generate their subsistence and modes of economy as indigenous peoples to a great extent rely on agriculture and therefore also on the rivers and canals. One of the informants in this study who is a village Karbari (traditional leader) informed me "Many rituals are conducted based on river. Especially, many local community peoples have believed the river has huge power to control their life." He also further noted that "if anything bad happened in the village, it is believed that an animal's sacrifice in the river can alleviate and mitigate the problem. Hence, local people worship in the river for both good and bad consequences in their life". This quote of the village leader accentuates the importance of the river in their daily livelihood patterns.

Main Rivers are Shankha (Sangu), Matamuhuri and bakkhali. The four major mountain ranges of the district are the Meranja, Wailatong, Tambang and Politai. Bagakain or Baga lakes are notable. According to the McDonnell report, around 28% of the total area of these districts are under reserved forest which is commonly unavailable for agriculture and only 4% of the land is under paddy cultivation most of which are in the northern valleys (Banglapedia: The National Encyclopedia of Bangladesh: 2003)¹³. The nature of Chittagong Hill Tracts is mostly covered by hills and rivers in a different way than other parts of the country, therefore indigenous peoples mostly practice different kinds of agricultural subsistence and utilize the traditional medicine and plants that also exist within mountain and rivers valley.

¹² Banglapedia: National Encyclopedia of Bangladesh: 2003, accessed in February 13, 2013, <http://www.ebanglapedia.com/en/article.php?id=1270&title=Chittagong-Hill-Tracts#.VUv5aFkTzAE>

¹³ *ibid*,

2.3 Demography of the area:

The demography situation in Chittagong Hill Tracts has changed markedly from 1790 to the end of the 19th century. The percentage of population was increasing in the beginning of 20th century. According to the census of 1991, the estimated population of Chittagong Hill Tracts was 974,447 of which 501,114 were indigenous peoples and the rest of the populations were other communities. According to the census report of 2001, the total population of CHT is 1,342,740, out of which 736,682 peoples were indigenous and 606,058 were Bengali people. The indigenous peoples who are living in CHT are generally called the Jumma people. However, indigenous people in CHT consider that their population could be closer to 800,00, (Bangladesh Population Census 2001)^{14 15}.

The Chittagong Hill Tracts hosts eleven different indigenous communities with hundreds different sects. This includes the Chakam, Marma, Santal, Tripura, Chak, Pankho, Mru, Murung, Lushai, Khayang, Gurkha, Assamese, Bawm, Thnachangya and Khumi. According to the Chittagong Hill Tracts Affairs Ministry, 50% of the population is indigenous and 49% of the population are Bengalis Muslims and Hindus, and 1% is animist. The pattern of human population in CHT shows much of this is territorial based. For example, Chakma are dominant in the Rangamati and Khakrachari districts though other small indigenous communities also living there. On the other hand, Bandarban is dominated by the Marma people; nevertheless this region is highly diversified in terms of different ethnicities (CHT history and Struggle: Brief History and Struggle of the people of Chittagong Hill Tracts: The Parbatya Chattagram Jana Samhati Samiti (PCJSS), Banglapedia: National Encyclopedia of Bangladesh: 2003)^{16 17}.

¹⁴ Agreement between State and Indigenous Peoples: Implementation Status of the Chittagong Hill Tracts Accord, Bangladesh, accessed in November 12, 2014, <http://www.ohchr.org/Documents/Issues/IPeoples/Seminars/Treaties/BP12.pdf>

¹⁵ Bangladesh Population Census 2001: Bangladesh Bureau of Statistics 2001.

¹⁶ "CHT history and Struggle: Brief History and Struggle of the people of Chittagong Hill Tracts" The Parbatya Chattagram Jana Samhati Samiti (PCJSS), the official website of Parbatya Chattagram Jana Samhati, accessed in October 18, 2014, <http://www.pcjss-cht.org/cht-history-struggle/>

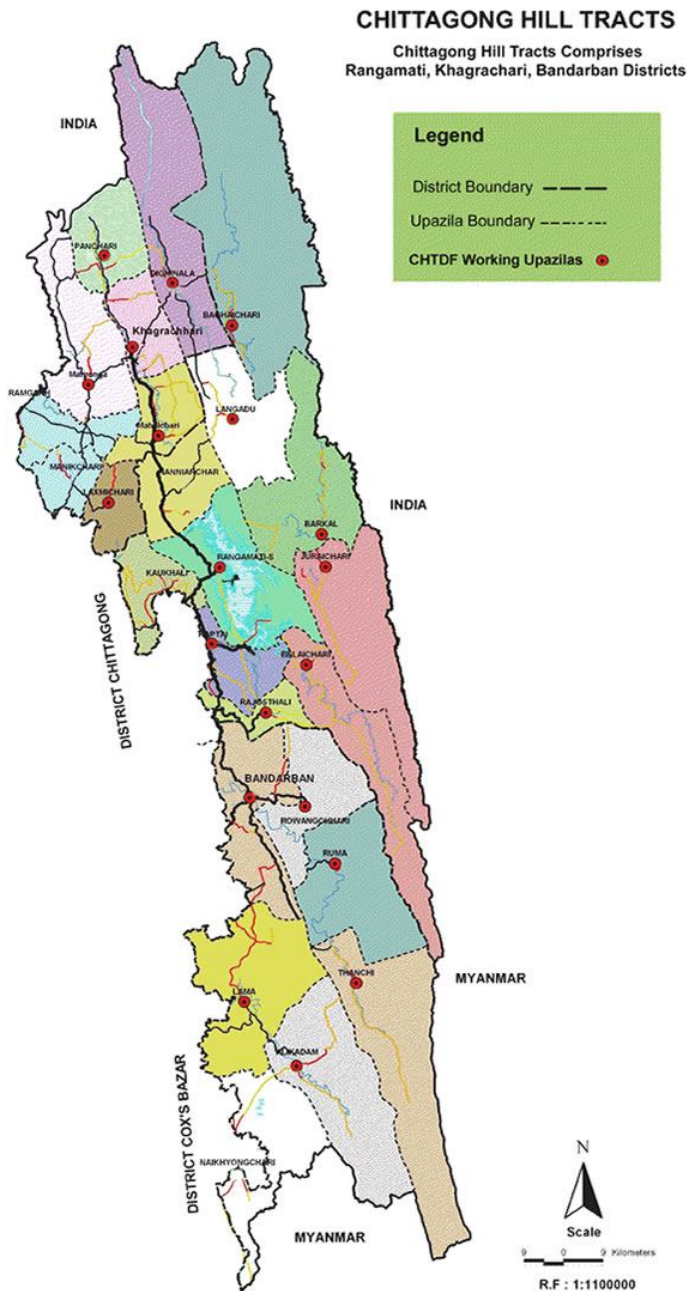
Banglapedia: National Encyclopedia of Bangladesh: 2003, accessed in February 13, 2013, <http://www.ebanglapedia.com/en/article.php?id=1270&title=Chittagong-Hill-Tracts#.VUv5aFkTzAE>

¹⁷ Ibid,

In terms of religious backgrounds, in Rangamati the highest number of indigenous peoples are Buddhist making up 53.83% of the population, followed by Muslim at 39.28%, Hindu at 5.62%, Christian at 1.12% and others 0.15%. In this district there are different indigenous peoples including Chakma, Bawm, Chak, Khumi, Lusai Mo, Panku, Murang, Kheyang, Monipuri and Santal.



Location of Chittagong Hill Tracts in Bangladesh (Map:1)¹⁸.



Location of the Study Area Chittagong Hill Tracts (Map: 2)¹⁹.

¹⁸ “Location of Chittagong Hill Tracts in Bangladesh” Chittagong Hill Tracts Facility, accessed in November 12, 2014, <http://www.chtdf.org/index.php/component/content/article/95-work-location-map>.

¹⁹ “Maps of Chittagong Hill Tracts”, Rangamati Hill District Councils, accessed in May 5th, 2013, <http://www.rhdcbd.org/maps.php>

The average literacy rate in Rangamti is significantly the highest compared to other CHT districts in Bangladesh though this rate is comparatively lower in other parts of plain land in Bangladesh.

In Bandarban most people are Muslim followed by Buddhist, Christian, Hindu and other believers. This region is the place of multiple indigenous communities including Mru, Khumi, Marma, Tripura, Bawm, Tanchangya, Ckakma, Chak, Lushei, and Panko. The literacy rate of this district is 39.5%. In terms of educational background there are number of colleges, high schools, government schools, primary schools, NGOs school, and madarasas (religious educational institutes) running in the region (Banglapedia: The National Encyclopedia of Bangladesh: 2003). It is also noticed that in Khagrachari, by religion practice most are Buddhist followed by Muslim, Hindu and other religions.

In terms of population, the Chakam, the Marma, and the Tripura are the consecutive largest ethnic populations of CHT where the rest of them are small communities. These three communities consist of the half of all the population and the rest of the people are non-native Bengali community members. The average education of this region is generally low compared to other districts of Bangladesh.

2.4 History of the region:

According to Bangalpedia (2003), this region was first placed about 1550. In 1575 the king of Arakanese control the region until 1666 then the Mughals controlled the section since 1666 to 1770. After that it was under the rule of East India Company and British colonial rule annex Chittagong Hill Tracts in 1860 as a part of British India. They treated this region as an extension of Chittagong district. The colonial ruler passed a regulation in 1900, which claimed this region as having special status and restricting settlement for 'non-tribal' peoples and initiate individual administration for Chittagong Hill Tracts.

Indigenous peoples regarded this law as a means of protection for their identity, culture and existence. In 1947 with the establishment of Pakistan, the Chittagong Hill Tracts came under the rule of Pakistani government and the regulation of 1900 was changed several times. In

1962 the construction of hydroelectric dam Kaptai was completed, submerging around 40% cultivable land and displacing 10,000 families, (JennekeArnes and KirtiNishan Chakma: 2010:24, CHT history and Struggle: Brief History and Struggle of the people of Chittagong Hill Tracts)²⁰. In 1964 the ‘special status’ of Chittagong Hill Tracts was completely abolished. After the independence of Bangladesh from Pakistan in 1971, CHT came under the jurisdiction of the Bangladesh government. During the Bangladesh liberation war indigenous peoples connected to the liberation forces and played an important role in CHT but the Chakma Raja (Chakma King), a member of national parliament, supported the Pakistani army as he thought that might lead a better interest of his community.

This made the Bengali community generally suspicious towards indigenous peoples who were treated as traitors by the then government. Importantly, the relationship between Chakma Raja and Pakistani government before the liberation war in 1971 is still a controversial issue wherein Bengali peoples still believe this issue to show an indication of disloyalty of indigenous peoples toward Bangladesh national state. After the independence a delegation of the Chakma community people led by the late Chakma Parliamentary member Manobendra Narayan Larma claimed the autonomy of CHT and requested the retention of the 1900 regulation as ‘special status along with stopping the settlement of non-indigenous peoples in CHT.

Nevertheless, the then Prime Minister Sheikh Mujibur Rahman and founding father of Bangladesh, denied the legitimacy of CHT as an autonomous region while also telling them to forget their identities and merge into a ‘Bengali’ identity. Importantly Sheikh Mujibur Rahman and his Bengali people also faced discrimination and repression during Pakistani rule, however after the independence from Pakistan he failed to understand the same essence of the indigenous peoples’ demand (Jenneke Arnes and Kirti Nishan Chakma : 2010:23). Followed by Mujib’s denial, indigenous peoples formed the ‘Chittagong Hill Tracts Peoples United Party’ in 1972 and later introduced its armed wing, the ‘Shanti Bahini’ (Peace Brigade). This party introduced the term ‘Jumma’ (swidden cultivation practiced by hill peoples) as the

²⁰ “CHT history and Struggle: Brief History and Struggle of the people of Chittagong Hill Tracts ” The Parbatya Chattagram Jana Samhati Samiti (PCJSS), the official website of Parbtaya Chattagram Jana Samhati , accessed in October 18, 2014 , <http://www.pcjss-cht.org/cht-history-struggle/>

collective name of eleven indigenous groups. During the Zia regime, CHT was fully militarized and simultaneously, he set up CHT Development Board for the “backward tribal” people. Until 1976 CHT was under military rule and was a training ground for counterinsurgency.

Importantly, in the name of counterinsurgency against the ‘Shanti Bahini’ (Peace Brigade), the Bangladesh army set up a massive human rights violations, killing, massacres, torture, rape, forced marriage to Bengalis, and cultural and religious aggression against indigenous peoples, (JennekeArnes and Kirti Nishan Chakma: 2010:23). Besides this insurgency, the Bangladesh government pushed around 400,000 landless, financially disadvantaged people to CHT for settlement which occurred between 1976 and 1985 under the transmigration program. This Bengali settlement dramatically changed the composition of the population in CHT from 26% to 41% Bengali by the year from 1974 to 1981. These Bengali settlers occupied a large scale of indigenous lands, which later became the conflict issue among indigenous peoples, Bengali settlers, and the army. Significantly, the Bangladesh government collected economically marginalized Bengali people from different parts of Bangladesh promising to provide enough food, land, and cattle for cultivation. In 1983 the Chittagong Hill Tracts United Party leader, Manobendra Laram was killed by dissident fraction and Manobendras brother Jyotirindra Bodhipriya (Santu) Larma took over the leadership (Jenneke Arnes and Kirti Nishan Chakma : 2010, CHT history and Struggle: Brief History and Struggle of the people of Chittagong Hill Tracts ” The Parbatya Chattagram Jana Samhati Samiti (PCJSS))²¹.

After much bloody violence between indigenous peoples, Bengali settlers, and military forces, in 1997 there was peace accord signed by Sheikh Hasinas Awamil League government and Chittagong Hill Tracts United Party. Opposition parties denied the accord led by BNP along with Bengali settlers. Similarly, a section of indigenous people are also denied the peace accord demanding full autonomy and formed another indigenous political party called United Peoples Democratic Front (UPDF) in 1998 (CHT history and Struggle: Brief History and Struggle of the people of Chittagong Hill Tracts, Jenneke Arnes and Kirti Nishan

²¹ ibid,

Chakma: 2010:24)²². Before the peace treaty in CHT there were not any NGOs working for the development of CHT people which came across due to armed conflict between the Bangladesh army and indigenous communities, especially Chakma ethnic people. It is also revealed that the CHT conflict was basically run by Chakma communities and the peace treaty also assigned by Chakma-run political group named Parbataya chattagram Jana Samhati Samiti (PCJSS). However the fact is that after the peace accords a large number of NGOs including international NGOs, national and local NGOs are working on CHT issues including health issues. On the contrary, the government blamed NGOs for destabilizing the region by working on controversial issues.

2.5 Indigenous Peoples in Chittagong Hill Tracts :

In this study I conducted interviews from the Chakma, the Marma, the Khumi, the Bawm indigenous communities. Here I discussed in detail the diversified indigenous communities in CHT. Indigenous people living in Chittagong Hill Tracts have been called ‘Jumma’ or ‘Phahari’ (those are living in the hill). Among all indigenous peoples in Bangladesh, the Chakma, the Marma, and the Tripura are the three largest ethnic groups; jointly they consist of half of the population in CHT compared other small ethnic communities and Bengali settlers.

In terms of area, Rangamati is the largest district in CHT and Bangladesh; most of the Chakma live in Rangamati. During the Mughal era they were followers of Islam and then they became followers of Buddhism during the regime of Raja (king) Dharam Baksh. The Chakmas are Buddhist and they follow their religion in all spheres of life, including their social, cultural, economic life; from life to death they follow the different rituals of Buddhism. The Chakmas are divided into 150 sub-communities. These ethnic communities are mainly male dominated and have strong fraternity. In terms of education this community has the largest percentage of literacy compared to other indigenous groups. They burn the body after their death .

²² Chakma Kirti Nishan and Arens Jenneke Indigenous Struggle In CHT edited by Mohaiemen Naeem: Between Ashes and Hope Chittagong Hill Tracts in the Blind Spot of Bangladesh Nationalism, Bangladesh, 2010

The Marmas are referred to as Moghs and mostly live in the Bandarban district. Some of the Moghs live in Cox'sbazar and Pataukhali districts. They preferred to be called 'Marmas' as they believe there is no race called 'Moghs' and they consider the name 'Moghs' to be given by Bengalis. According to the statistics Marmas are mostly of Buddhist religion though some of them are converted to Christians. Besides this fact according to Banglapedia, major Marmas also consider them to call "Rakhain". This word is rooted in Burmese language. Their written language is also rooted from Burmese-Arakan group. During the study period I observed that NGOs working with 'Marma' dominated area implemented different kinds of intervention programs. On the other hand, in terms of traditional medicine still many community peoples mostly rely on local healers and traditional practitioners. It's my impression of the field that they believe in their ancestral medical practices, which are cheap, useful and pragmatic. This will eventually connect them culturally, socially, and spiritually.

Tripura's are the third largest indigenous community following Hinduism, but their way of practicing is different from the non-indigenous Hindu believers, which can be marked by their rituals and worships. They have a huge connection of India's part of Tripura state and live far away from the city center, therefore it's my impression that they are very much used to various forms of rituals and healing practices which are followed in traditional ways.

It can be said that due to the geographical location of Chittagong Hill Tracts most of the indigenous community followed their ancestral medicine because of available medicinal plants and belief systems, which are transferred from generation to generation. Besides these three major indigenous communities the rest of the small communities practice Buddhism, Christianity and animism. However, in the last couple of decades small indigenous communities are becoming converted to Christianity because of missionary activities generated from the neighboring countries India and Myanmar. Significantly new generations of small indigenous peoples are continuously converted to Christianity due to different kinds of facilities and advantages from these missionary personnel especially in education and

health services (Buddhist people converted to Christianity by Christian Missionary)²³. While most of the minor (by number of population) indigenous communities are living in Bandarban district and their means of economic source is agriculture specialty is ‘Jhumma’(slash and burn) cultivation and due to Jhum (slash and burn) cultivation these land is called ‘Jumma land’ and the whole community collectively known as “Jumma people” .

Indigenous peoples of this area have their own language, which is different from one community to another community. In this study I saw some communities speak more than two languages due to living closely with neighboring communities. In some cases external or exogamous marriages occur based on dating, but socially this kind of marriage is not supported and promoted. One of the informants who is by profession a village medical practitioner noted that “dating, marriage and marriage outside the community is highly restricted because of community unity, and integrity along with rules and regulations is highly considered. Therefore these kinds of family relationships are not considered valid.”

The field study revealed that decision making for both man and women plays an important role. Men are the dominate decision makers in many cases not only in the Bengali mainstream society, but also in indigenous communities. In terms of ritual, each and every community follows their own rituals that include birth, death, wedding, healing practice, agriculture. The ‘Jumma people’ have different kinds of crops rituals, which are applied before and after the crops plantation.

²³ “Buddhist people converted to Christianity by Christian Missionary” Bengali newspaper covered indigenous news in Chittagong Hill Tracts, accessed October 12, 2014, <http://parbattanews.com/2015/03/আলীকদমে-মুকুংদের-আর্থিক/#. VRkigSj7DtZ>.

Chapter Three:

NGO Perspectives on health in CHT

3.1 Introduction :

This chapter discusses indigenous health discourse in different perspectives and I try to show how each perspective is related to one another in order to understand health discourse. This chapter discusses the history of NGOs in Bangladesh and NGOs in Chittagong Hill Tracts. This history is very significant and relevant to understanding the phenomenon of indigenous health in Chittagong Hill Tracts. I also discuss kinds of intervention programs run by the NGOs in Chittagong Hill Tracts.

In this chapter I also look into the process of modern medicine trying to replace traditional medicine and how and to what extent this process is marginalized and threatening the existence of traditional health practices. I also show how traditional health systems work, sustain, practice and represent indigenous cultural identity. I explain the reason for NGOs activities in CHT especially regarding health issues and how they transfer and translate the knowledge systems. It is also noted that through these processes both government and non-government organizations are working in the name of development, especially health improvement and development among indigenous people.

3.2 History of NGO in Bangladesh:

Historically, the NGO flow of Bangladesh began during the war for independence in 1971. Initially, their main task at that time was to rehabilitate and provide humanitarian relief services for the economically and socially distressed people then surviving famine and flood in 1974 and other natural calamities. At that time several NGOs including BRAC, Grameen Bank, and Proshika started their work with the support of international fund for humanitarian relief, infrastructure, poverty alleviation and other long time development strategies in the light of immense government corruption and lack of government capacity to provide

wellbeing to the mass population (Davis John K 2006 & Wood 1992:4). On the other hand after the 2nd World War, the western colonial master emphasized world development under the doctrine of discovery, exploration, and settlement in the colonized countries. The colonized theory of invention and discovery is very much pertinent to the NGO sectors in third world countries (Haebich, Anna: 2005:15). Under this theory the western colonizer emphasizes the crisis and emergency assistance for development while they try to focus on new interventions and new fields for exploration and commercialization, therefore the flow of funding becomes familiar in the underdeveloped countries. Bangladesh is not beyond this scenario.

In such a context, the global development fund came to favor to NGOs as means of preferred mechanisms of development assistance. As a result, a number of Bangladeshi NGOs have received a huge amount of funding and support for different levels of development including poverty alleviation, good-governance, micro-credit program, health, education, women empowerment, water and sanitation for the target population. In the 1990s this sector grew rapidly due to international focus in this region while at the present time Bangladesh receives two billion USD as foreign aid annually; among this foreign aid 15% directly goes through NGOs (Stiles :2002 as quoted in Rahman Sabeel :2006:454).

Concomitantly, other study noted that “international aid ballooned from roughly \$150 million in USD 1990 to nearly \$450 million USD in 1995, the peak year of the decade to 2000,” (Stiles 2002: 837, Rahman Sabeel :2006:454). Another study pointed out that there are approximately 22,000 NGOs working in different parts of Bangladesh, where 35% of the population directly gets services such as credit, education, health, sanitation and other things (Devin: 2003: 229).

Before the independence under the Pakistani rule, there were some international and national NGOs which also worked in the country, namely CARE, who worked for food aid 1955. The Catholic agency CARITAS Pakistan had a branch in East Pakistan (Bangladesh) working for those affected by natural disasters. These statistics indicate that NGO workers in this region have a long history (Devis John K: 2006:3). Importantly, the characteristics of NGOs have been changed from humanitarian rehabilitation and relief to service delivery and economic

programs like micro credit program while most of the leading NGOs run micro-credit programs at the village level while their main target peoples are poor and distressed women, as in the society women are subordinated, subjugated, and lack a voice. Here the point is that these NGOs gain funding as international aid organizations and operate loan businesses in the name of micro credit program. World Bank noted that 70% of all funds are consumed by the 10 largest NGOs in Bangladesh (Devin J: 2003:230). Substantially, the work of BRAC is very important to understand NGO work in Bangladesh. From the very beginning it worked on emergency assistance support like relief and rehabilitation but the context has changed after post-independence.

BRAC extended its working area to program “integrated community development including agriculture, horticulture, fisheries, adult education health, family planning, micro-credit, vocational and other training programs,”(Chen 1986:3 as quoted in Devis John K 2006:5). At present, BRAC is a giant NGO in Bangladesh and it works in each and every part of the country while many projects are run with the collaboration of the Bangladesh government as the state has not enough capacity to reach the people, therefore absence of government support results in NGO influence in social development. Substantially, most of the NGOs interested credit programs or loan revolving programs from the very beginning of their involvement in NGO while BRAC launched a savings and credit program in 1974, (BRAC: 2004: 9 as quoted in Devis John K: 2006 :4).

Then Grameen Bank started their micro finance program in the name of ‘social capital’ model while 46,955 borrowers in 1983 increased become 6.6 million at present (Associate Press: 2006 as quoted in Davis John K: 2006:7). Moreover, the empowerment agenda by NGOs had become strong in 1990 and early 1980s where BRAC was the taking the leadership role. Research indicates advocacy and community empowerment have been problematic in the history of Bangladesh (Davis John K: 2006:5). Interestingly, the relation of NGOs and government are not so good due to power politics and partisan politics. In 1978, the Foreign Donation Regulation Ordinance was announced to control the huge NGO sectors by monitoring the use of international funds for flooded foreign aid. The most significant step was taken in 1990 when the government introduced NGO Affairs Bureau to the center between the state and NGOs receiving foreign aid (Ahemed: 2001:2).

More importantly, most of the international funds are channeled from UNDP, WHO, UNFPA, Oxfam, DFID, USAID, World Bank etc. Most of the NGOs in Bangladesh work based on foreign aid to alleviate poverty and human development in the light of improvement of education, health condition, empowerment, self-sufficiency, and sustainable development (Rahman Sabeel: 2006). While the fact is that these kinds of work can only run until the flow of aid continues, which will ultimately hinder holistic development in the long run. As health interventions or any kinds of development activities run by development partners or NGOs cannot work if donor agencies stop providing funds, in that sense foreign aid is an obstruction of holistic development of the country. On the other hand, through different NGOs some sections of people are getting more facilities and services than the rest of the population. There are some negative images of NGOs in Bangladesh due to the nature of its projects, as most of the projects are short term. As a result those working in the NGOs have little prestige and honor with a low social status.

Furthermore, this research also showed how a number of NGOs are working and exploring development in name of improvement, modernization, self-development and holistic development, but in this study many informants stated their view that development does not mean social exploitation, development does not mean generating divisions among the community members, development does not mean to divide and rule by dominant authority. The question is raised as to who gives the authority to develop indigenous people and their fortune? Importantly, this study tried to explore why development organizations are working for different health intervention program. The following sections deliberate about the how different NGOs working in various kinds of health intervention programs in CHT. At the same time the following discussion also represents different perceptions about health intervention programs and traditional health practice.

3.3 NGOs in Chittagong Hill Tracts:

Historically, Chittagong Hill Tracts have been exploited in the name of development projects since the British colonial period. During the Pakistani rule, the Pakistani government took on massive development projects without the consent of local indigenous peoples. As a result 10,000 indigenous people or about one fourth of the indigenous population was forced to leave and 40% of the cultivable land was inundated due to construction of the hydroelectric dam. This pattern of development had continued after the independence of Bangladesh

wherein the Bangladesh government introduced Chittagong Hill Tracts Development Board in 1976 to promote CHT development project with the collaboration of Asian Development Bank under the project of road infrastructure, large scale projects to build telecommunication, roads, power station and other infrastructure development rather than human development. While the fact is that though the development organization worked before the treaty, it was small scale and most of the time it was an infrastructural issue but after the treaty, the situation has changed dramatically, a large number of NGOs have been working on different development issues namely education, capacity building, confidence building as well as health issue.

In another sense it can be said that both national and international NGOs actually discover the new field of intervention after the peace treaty in order to fulfill their requirements; that is to say ‘develop’ the indigenous peoples in their (NGOs) won by formula rather than by indigenous approach. At present CHTDF (Chittagong Hill Tracts Development Facilities) is working under CHT Affairs Ministry. After the peace treaty in 1997 a large number of NGOs and donors flocked to the Chittagong Hill Tracts with different projects. Most of the funding of this region have provided by Asian Development Bank, UNDP, UNICEF, Aus AID, OXFAM, WHO, International Development Cooperation Agency (SIDA), Japan, UK Aid, World Bank, DANIDA, Save the Children etc., (Chittagong Hill Tracts White Papers published by Jumma Net)²⁴.

In 2002, UNDP set up a risk assessment task for the feasibility study on conducting aid projects in the Chittagong Hill Tracts. After this assessment UNDP started their first intervention program in 2003 under the initiate on CHT Development Facilities entitled “Promotion of Development and Confidence-Building in the CHT”. This project has been done with the collaboration with international partners including European Union’s (EU), UNDP, Australia (AusAID), Canada (CIDA), Denmark (Danida), Norway, Japan (Jika-Japan International Cooperation Agency), The United States of America (USAID) along with Ministry of Chittagong Hill Tracts Affairs in Bangladesh. UNDP is an umbrella organization

²⁴ Chittagong Hill Tracts White Papers: The Issues of Conflict, Human Rights, Development, and Land of the Indigenous Peoples of the Chittagong Hill Tracts, Bangladesh 2003-2006, Chapter 7, published by Jumma Net, An NGO supporting the indigenous Jumma Peoples of the Chittagong Hill Tracts, Bangladesh.

that controls and manages the funds for Chittagong Hill Tracts. Besides UNICEF, WHO and other international organizations, including the World Bank are also generating funds for CHT development programs (Chittagong Hill Tracts White Papers published by Jumma Net)²⁵.

The aims of the UNDP project are to enable local people to conduct small-scale development projects which strengthen the capacity of local aid organizations and community organizations in CHT, which implement change with the local body of Regional Council. With this project UNDP also collaborated with local authority with Regional Council, Hill District Councils and other local bodies including three traditional circles to promote and continue small scale development activities namely capacity building, women empowerment, policy advocacy and confidence building, health service, education service, and agricultural extension and food security.

In these programs UNDP has emphasized the local participation for the ‘Para’ (village) and Union development for confidence building and capacity building at the local level. The European Union has extended its support further to CHTDF (Chittagong Hill Tracts Development Facilities) for implementation of a new project “Supporting Local Development in the Chittagong Hill Tracts (CHT) since early 2011 (UNDP-CHTDF report: 2011). According to UNDP this program will enhance the capacity of the Chittagong Hill Tracts’ institutions for service delivery and increase their own development. In the health project they focus on health care services including malaria treatment, diarrhea, ARI, and maternal health service based on satellite clinics and female community health workers. In specific cases they provide medicine on the basis of their availability from the center. Additionally they work at investigating malaria parasites and urine albumin, sugar and R/E. On the market day they try to provide volunteer medical service among the local people. In addition, they provide training to community health workers, and medical teams in a particular village once in a week (United Nations Development Program, Bangladesh)²⁶.

²⁵ Ibid,

²⁶“Health”, Chittagong Hill Tracts Development Facility, United Nations Development Program, Bangladesh, accessed in November 10, 2013, <http://chtdf.org/index.php/focus-areas/health>.

They also promote child health care issues. At the community level UNDP provides Birth Attended training to Family Welfare Assistants and Health Assistants. UNFPA provides family planning services to distribute contraceptives and deliver counseling. At present UNDP covers 15 upazilas (sub-districts) with 75 satellite clinics in three hill districts with the improvement and promotion of modern health service. It is further noted that WHO is not working directly in the CHT, but nevertheless has jointly worked with Ministry of Chittagong Hill Tracts Affairs and other institutes providing technical support to improve health management and good governance on health sector. WHO also provides technical support to immunizations and is involved in surveillance of communicable disease in CHT.

Additionally, the World Health Organization is implementing projects on fight against malaria and promotes the health of pregnant women and mothers of newborn children at the cost of \$3 million USD in 2002 in phase II (United Nations Development Program, Bangladesh)²⁷. Moreover, UNAIDS working with HIV/AIDS in CHT with partner organizations do not work actively in this region. On the other hand the Japanese government extended their assistance in CHT in 2005 under the project of “Strengthening the Community Based Health Care Program in Chittagong Hill Tracts” with the national partner NGO BRAC. In addition Danida spent \$32 million USD for technical support to supply drinking water, health and sanitation, agriculture and transport support in the CHT. It is pointed out that Danida has shown keen interest in the Bangladesh government implementing the peace accord. While the Asian Development Bank delivered \$30 million USD for seven years on long term projects, they are working with Regional Council as its partner and its aim is to develop rural infrastructure, micro-finance, capacity building of the local government institutes and NGOS in three Hill districts (Chittagong Hill Tracts White Papers)²⁸.

The main work of UNICEF is to provide mother and child health care initiatives with the CHT Development Board as counterpart since 1980. Apart from this, UNICEF also provides services through ‘Para’ (Village) center at the rural level. The *para centre* provides vitamin A

²⁷ Ibid,

²⁸ Chittagong Hill Tracts White Papers: The Issues of Conflict, Human Rights, Development, and Land of the Indigenous Peoples of the Chittagong Hill Tracts, Bangladesh 2003-2006, Chapter 7, published by Jumma Net, An NGO supporting the indigenous Jumma Peoples of the Chittagong Hill Tracts, Bangladesh.

and important dietary supplements on a very small scale along with promoting vaccination, family planning, and is currently building on sanitation. UNICEF is also working with World Food Program to implement food for education in order to enhance the number of school going children (Sayem: 2009:9).

In most cases foreign aid is channeled through large national NGOs namely Bangladesh Rural Advancement Committee (BRAC), World Vision, Prashika, and ASA, who are prominent working with foreign aid under the health project. Moreover, other NGOs, namely Christian Mission Hospitals, Leprosy Mission, Family Planning Association of Bangladesh, Sajeda Foundation along with a growing number of local NGOS are working with TB and malaria in CHT with support of community health workers at the field level, (Sayem: 2009:10). More importantly, most of the NGOs and donors are concentrated on Rangamati Hill district due to most of the national and local offices and indigenous political party offices being situated there. Significantly, head of regional council's office and head of Chittagong Hill Tracts Development Boards' office and Rangamati Hill District Councils offices all are located there. Therefore, all the NGOs office are located there in order to get facilities and to have lobbying with different projects as it is very important to have a close connection with regional councils and the CHT development board in order to manage different projects and get sub-contract of the projects.

As we know, in some cases big NGOs do not directly conduct research, rather they prefer working with small NGOs to conduct program interventions with a low budget. On the one hand, many small NGOs are mostly dependent on big NGOs because of their capacity and long experience of conduct interventions the in different health related programs in plains lands.

3.4 Location and Fact of the conducting NGOs:

I conducted fieldwork with three different NGOs running intervention programs on different health issues in three hill districts in CHT. During my fieldwork I looked at how NGOs represented health among indigenous peoples as well as how other factors were responsible for creating feelings of "otherness" towards indigenous peoples. Most of the interviews were taken from three hill districts namely Rangamati, Bandarban and Khagrachari districts.

Through these interviews I examined their perspectives about health programs and how they think about health programs towards indigenous peoples. It is important to note that international organizations are not actively working in these remote places, rather they allocated the funding among national and local NGOs in order to implement their programs.

3.5 BRAC:

BRAC is the largest national NGO working with different development issues all across the country. It was established in 1972 after the independence of Bangladesh started work with relief and rehabilitation programs among war victims. Over time BRAC become a giant NGO in Bangladesh and from the very beginning started implementing policy, from relief services to poverty alleviation, to promotion of women empowerment. But over time it has changed its policy to micro finance, education, and health. Presently it works with different health projects in collaboration with the government Republic of Bangladesh.

In Rangamit Kawkhali Upazila (sub-district) they are working with global funds and governments of the Republic of Bangladesh on the issue of malaria, TB diagnosis and treatment, distributing mosquito nets in the field, providing water sanitation, and hygiene. BRAC started the journey in Kawkahali Uppazila in 2005 under the global fund project on malaria, TB, prevention and maternal health along with the micro finance project among indigenous and Bengali people on this upazila (sub district). There are 20 community health workers working in this upazila based on diversified ethnic backgrounds, the majority with Bengali peoples. Among this 20 CHW (community health workers) 12 are women and 8 are men and many are recruited by reference of regional council's members and other political party's references.

Once a week they arrange free medical services in an open market (bazaar) where people from different ethnic background receive services. Although they provide chemical nets, for all peoples, including both indigenous and non-indigenous, there are a number of limitations of their program. They have few health workers and offer low payment to the employees. These NGO health workers do not reach remote places; rather their activities are mainly focused near the marketplace.

During my fieldwork I found that a number of NGOs are working near to the upazila (sub district) in order to get access with NGOs, and government and non-government offices that represent the centralized system. BRAC provides health service only where communication is available or easy to reach. Due to poor payment, staff has lack of motivation towards their work and lack efficiency with skills; they cannot provide their full service simultaneously. On the other hand, every worker has some target capacity from the BRAC office therefore; he/she must fill up their monthly target population in order to maintain their job. In this NGO I talked with a local area manager and other staff who have been recruited as community field workers.

It is important to note that through these programs are NGOs their main objective is to 'develop' CHT's indigenous people (Escobar: 1995:5). Both national and international NGOs understand that indigenous people need development and modern medicine. One informant (from BRAC local area manager) 40 stated, "Indigenous people are living in a 'backward' place and 'backward' condition compare to mainstream Bengali society. In such a context both national and international NGOs are starting work in Chittagong Hill Tracts. Where the fact is that the Bangladesh government still does not recognize them as indigenous peoples rather than state recognized them as 'small ethnic communities' before that these peoples had been addressed as 'Tribal People'. Where they have not given any constitutional rights as a result their rights are not being established and such a lack of constitutional rights and government ignorance to provide the basic service. This situation encouraged NGOs to generate their activities in this region to fill up the government's service gaps".

He also noted that "government has a lack of capacity to conduct health intervention programs due to lack of funds and lack of willingness created by political reasons. On the other side, the government medical system is not updated and systematic and lacks discipline doctors, nurses, and other materials. Due to this reason, different NGOs come to provide service. He also pointed out that, "Our main objective is to help the government reach the millennium development goal. In that regard we are providing health service for the disadvantaged indigenous people. For that reason once in a week our team goes particular village market to give free medical support and treatment. We provide service for child care, maternal health to improve their quality".

In my field observation I saw that in upazila (sub district) level hospitals there were lack of medical equipment, resources, lab technicians, nurses, doctors, building infrastructure and medicine. Even doctors and nurses are absent in their working place in many cases and irregularities are very common in upazila (sub district) level health complex which creates huge health service gaps in CHT. In such a situation local NGOs try to provide medical services among indigenous and non-indigenous people. But still they have limitation in terms of manpower, resources, and both financial and technical support”.

Whereas, another participant who has worked in the same BRAC since the beginning of its foundation in CHT and has knowledge with maternal and child health told me that; he has been working from the very beginning of this NGO and knows the program very well, that’s why BRAC recruited him. He took several trainings in Dhaka on the issue of maternal health and child health along with malaria and diarrhea. His main job responsibility is particularly malaria and TB (tuberculosis) diagnosis and treatment. He noted that “as it is known that CHT is very set on renouncing malaria. Before the intervention program many people died by malaria. Due to dense forest and hill environment many kinds of mosquitoes are available in this region, hence it has seen that many local people are infected with this fatal disease. As a result, international organizations are focusing on malaria intervention”.

This respondent also noted that “BRAC in Rangamati Kawkhali Upazila (sub-district) freely provides chemical mosquitoes nets to indigenous people within their range. On the other hand, TB (tuberculosis) and malaria programs are also a part of millennium development goal, besides BRAC, Kawkhail branch gets the money from Global (GFATM) fund, therefore according to the donor guideline they are implementing TB and malaria programs to help the government. Moreover, government has not enough capacity to successfully implement this program. Here they (BRAC) are helping the government to ensure the success of TB intervention programs in this region. Apart from this, BRAC is also running micro credit program on the same target people. In this way we are trying to create capacity building among indigenous peoples”.

In my field observation as a researcher, I also noticed that BRAC introduced a micro credit program among indigenous people. In this case BRAC targets the local indigenous and non-indigenous people. Culturally indigenous people don't have any hands on experience and don't have any knowledge about the rules and regulation about the micro credit program, which is created by the mainstream population. Similarly, they are not used to saving money as whatever they earn by cash they use it for their family. Therefore, through micro credit program BRAC is new to the indigenous people its usefulness is questionable. During my fieldwork I also noticed that a number of indigenous people registered for the micro credit program but many faced challenges in repaying the credit from this program.

BRAC registered all the people those are taking medical service from their health program, and then they introduced micro credit program among indigenous people. BRAC knows very well that hill and indigenous culture is different from plains land culture and there are few chances to succeed at the micro credit program. Despite this fact they introduced this program to expand their business policy. In other way it can be said that they are offering and promoting health services with the collaboration of government and non-government support, while at the same time they also conducting micro credit program among the local indigenous peoples despite the fact that indigenous people don't have experience with micro credit programs.

3.6 Sunflower Bangladesh:

Sunflower set up their journey after UNDP worked in this region in 2006. Sunflower is a local indigenous based NGO in Khagrachari. It is also conducting intervention programs in Langudu upazila in Rangamati district with the fund of UNICEF under the issue of child and maternal health as well as with the UNDP funding they work on malaria prevention and treatment in the Khagrachari Sadar. They are working under the policy and guidelines of UNDP. At present they have 15 field workers in Khagrachari Sadar who have training on community health and providing health services among the indigenous peoples. The staff is recruited based on gender ratio, class, education and religion. Among the staff there are Chakmas, Chak, Marma, and Bengalis and everybody has monthly target for the target

population. Importantly, each and every field worker is responsible to full fill his or her monthly target. They offer basic health services to the indigenous and Bengali people.

All health services are free and medicine is free based on its availability. Due to their monthly target the workers travel to different villages in the Khagrachari Sadar but generally do not know which are ethnic violated places. Therefore, in practice they are not covering all places based on their policy guidelines. At the same time, due to lack of manpower they cover a small population of this sub district. In many cases the community health worker cannot reach to the remote villages due to security and other obstacles, such as a lack of transportation. In some cases it was seen that indigenous people in the remote places are not familiar with modern biomedicine or its gadgets. They are still using traditional medicine which also provides another obstacle. In my fieldwork, I saw that they couldn't provide emergency services or provide lifesaving medicine; rather, they provide basic treatment, which could not fulfill many patients' requirement. At times they even prescribed medicine which indigenous or non-indigenous people couldn't capable to buy. They claim they are offering all kinds of treatments, which is prescribed by the donor agency, however, in practice they offered only basic treatment, which is not fulfilling indigenous peoples' need.

In total there are 22 staff members where the head of the NGO is of indigenous background. Sunflower is working for malaria prevention by providing and increasing the awareness-building program among indigenous peoples as they are working in the Sadar upzila (sub-district). Therefore, people are already aware about malaria prevention and diarrhea program. They refer critical patients first to UNDP funded satellite clinics and if they are not capable of handling it then they are referred to the district hospital. At this NGO I talked the community health service workers.

During the discussion with the head of Sunflower who was also playing a role as key informant, a local NGO conducting intervention programs in Khagrachari Sadar under the health program funded by UNDP informed me that "the state is addressing indigenous people as 'tribal people' then 'small ethnic communities' which is not agreed upon by indigenous political parties, leaders, and religious leaders, indigenous journalists, intellectuals, scholars, activists and so on. On the other hand, if anybody runs a project and wishes to implement it,

they must write the term 'small ethnic communities'. Otherwise the state will not permit any development projects.” It is my understanding that these kinds of derogatory terms cause discrimination and subjugation from the mainstream Bengali community. As the Bangladesh government documented in 15th Amendment to the National Constitution, all indigenous people consider tribes “upajati ” (sub nation), small ethnic communities, minor races etc. but indigenous people have rejected as these terms for their connotation of “ backwardness” and “primitiveness” Interestingly, indigenous peoples have been termed as being of Bengali ethnicity in the 15th Amendment of the Constitution, which was adopted in June 2011,(Indigenous world 2012:336, Bangladesh Chapter, publish by IWGIA).

In regards to funding the informant further stated, “When any donor circulates any project then we send the proposal according to the donor demands. So in that regard we have not any particular issue, rather we are working in different issues based on availability of the fund. Even in my field observation by talking to the ministry of health and family welfare I saw that they are sharply following the government policy regarding indigenous programs. The Bangladesh government particularly uses the term ‘small ethnic communities’ and if any NGO uses the term “indigenous people” in their project the possibilities of getting funds is low.”

The same informants further noted, “At present Sunflower is working under the CHTDF-UNDP fund especially in health. If you send a proposal on improvement and promotion of better health status among small ethnic communities then it is easy to get attention from donors and policy makers.” Moreover, he also noted that the Bangladesh government has the target to achieve Millennium Development Goal 2015 especially in health related goals to reduce child mortality, improve maternal health, and combat HIV/AIDS, malaria and other diseases, therefore the government and international NGOs offer and facilitate financial support on these issues. But still there are other diseases that need to be solved, for example water related diseases, including anemia, diarrhea, dengue, hepatitis, cholera, polio, typhoid, malnutrition etc. Where the number of cases is too high for the basic resource of medical instruments are not available especially emergency equipment. He further noted in terms of staff that we are in some cases very few compare to the total population.

This research revealed that the number of health workers is limited in contrast to the number of patients, especially non-indigenous people. On the other hand, due to lack of resources it is tough to provide health services in remote areas, therefore it will be hard to follow the prescription of donor agencies to fulfill Millennium Development Goal. The fact is that there are a number of diseases, for instance communicable and non-communicable diseases, which are still under the shadow. On the other hand the practical picture is that the traditional health system in Chittagong Hill Tracts is still strong and used by the indigenous people. Therefore, though NGOs provide health services and medicine participants' experience suggested that they are not so focused on modern medical systems, rather they prefer their own healing practices due to tradition, faith, and cultural continuation. Research participants also noted that, "still due to religion and close cultural bonding indigenous people prefer local medicine and as number of local healers or boiddo (local healer) have more power in terms of social acceptance and prestige." This research also shows that local people, in their primary stage of malaria, preferred boiddo (local healer) medicine for malaria treatment but they communicated with NGOs medical teams or government medical services when the case was serious. The fieldwork also noticed that they followed the guidelines of boiddo (local healers). So if the local healers gave them signals to communicate with medical doctors only then would local people communicate with medical doctors.

During the research period in Rangamati Hill District I contacted a local person who had involvement in the guerrilla activities before the treaty and was now working for Sunflower in Langudu upazila at Rangamati district. During the interview he pointed out several reasons behind the NGO activities in CHT. He stated, "before the peace accord indigenous people did not have chances to do something for their communities. Now they (indigenous people) have opportunities to do something for their people." In that context indigenous people have started work on Adivasis (local term of Indigenous People) to better involvement in the mainstream society. On the other hand Adivasis needs modern health systems by the fact that they have long been deprived, victimized, and discriminated against from the dominant Bengali society.

Hence phahari (another local term for hill people) do not have proper knowledge of modern treatment and medicine. This informant also noted, "Adivasis (local term of indigenous peoples) constantly face contact with different infectious diseases and other fatal diseases

which cannot be healed by local medicine. As well, our traditional systems are becoming useless due to a lack of natural resources and lack of expert traditional healers, who nowadays cannot deal with these fatal diseases. On the other hand, due to over population, lands are becoming occupied and scarcely used for food therefore; the number of medicinal plants has dramatically decreased. In the above situation we are seeking funds from international and national NGOs in order to provide modern health systems in the remote area of Chittagong Hill Tracts.”

This informant further described NGO activities in CHT area as “We feel from the center, local people have not had enough capacity and experience to run such kinds of intervention programs, that’s why we are working here to help them and enhance their capacity building in terms of health issues.” It is my impression as a researcher that after the peace accord a number of international organizations were interested in working in this region and consequently all the big national NGOs and local NGOs therefore sent their proposal to these organizations for gaining fund raising in this region, but the fact is that all the funds are about soft issues like health, education, capacity building, confidence building etc. However, these funds do not cover human rights and land rights issues, which are more debatable and controversial issues in this region.

I saw in my fieldwork experience that land disputes between indigenous and non-indigenous people is still one of the major challenges in hill areas. Many health related programs are also facing problems to get access to both communities due to this fraction. On the other hand, due to the increase of land price and other daily accommodation price, hill people are facing huge problems to maintain their family expenses whereas NGOs are only focusing on health and education issues which will not fulfill their basic needs. In my field work experience I saw that NGOs are working only where funds are available for implementing the program in this region but NGOs don’t know what will happen if the fund is stopped.

Though the government introduced a tribal health component for the better service in these regions it does not work due to lack of doctors, nurses and other resources including technical and non-technical issues which are to some extent very important for medical service. Nevertheless, there are still some good local traditional healers who are continuously

practicing local medicine and local people are still following their prescriptions. In my field work observation I saw some people who believe that traditional healers have some charismatic control over the disease, but I think they know the leaves and medicinal plants that are used to treat a particular disease.

3.7 Shangu Hill:

Shangu Hill is situated in Ruma upazila (subdistrict) in Bandarban district. Shangu Hill started health work in 2006 under the UNDP fund on malaria and diarrhea prevention and improving maternal and reproductive health. It is registered by regional councils and hill district council, which are local administration body in CHT region. While there are 12 field workers who have training regarding community health services they are providing services with local people especially the Bawm community and other small communities living in the hill.

They are running their programs under the UNDP and Global fund. Global fund manages this fund from a national NGO as a sub-contractor and their vision is to improve and disseminate health knowledge to the local people, especially indigenous communities, therefore national NGOs cooperate with them to run different health issues in CHT. However, they offered health services only near the market place and other populated places rather than in the remote hill areas. Therefore, the advantage was only received by those living near the market place while most indigenous people live in remote areas and Bengali people live near to the market place. Therefore, most of the medical facilities were consumed by Bengali people rather than indigenous people. Additionally, the service was very limited due to remoteness and lack of road communication. Besides these NGOs, I also talked with different people those have experience on health intervention programs run by NGOs under the international fund.

During my conversation with a doctor who has been working in Shangu Hill a local NGO funded by UNDP-CHTDF noted the current situation of CHTDF's health project along with the advantages and disadvantages of the program. This doctor was also playing a role as a key informant because of his long work experience among indigenous people in CHT. This NGO is working both the Bandarban district and the Rangamati district together with the same fund. The main objective of this NGO is to maintain and improve malaria, diarrhea and

maternal and child health which is part of Millennium development goal by 2015. It is noted that Bangladesh government have already achieved success to reduce child mortality rate for those under five, reduce the prevalence of underweight children, lowering the infant mortality rate and maternal mortality ratio, and reduce the prevalence of communicable diseases though the reducing rates of these factors are low in Chittagong Hill Tracts region (Bangladesh progress on MDG 2015)²⁹. United Nations fixed an eight-millennium development goal to eradicate extreme poverty and hunger to develop global partnership for development. The eight-millennium development goals for 2015 are: eradicate extreme poverty and hunger, achieve universal primary education, promote gender equality and empower women, reduce child mortality, improve maternal health, combat HIV/AIDs, malaria and other diseases, and provide global partnership for development. All countries in the world, all leading international organizations and stakeholders, agree on these goals and Bangladesh is one of the UNDP partner countries to implement these goals (The Millennium Developments Goal for 2015)³⁰.

However the trends do not indicate any clear picture of reducing child and mother mortality rates among indigenous peoples in Chittagong Hill Tracts. It is well informed that a number of international organizations are working in Chittagong Hill Tracts area for the different DMG (Millennium Development Goal 2015)³¹. Different health related intervention projects are run but the scenario is different when it comes to remote villages and minor ethnic groups in Chittagong Hill Tracts. It was also disclosed in the fieldwork that apart from Chakma, Marma, and Tripura indigenous communities, most of the other small indigenous communities have gotten little access to these NGO facilities.

During the discussion with the doctors in “Shangu Hill” my informant noted, "this NGO focuses on child health, maternal health, malaria, and other communicable disease and other service." In my field work I saw that this NGO was also working in Langudu sub districts under the Rangamati districts providing medical service by boat to the indigenous peoples. This NGO has a medical team led by a MBBS doctor (of Bengali ethnicity), two nurses, and

²⁹“Bangladesh’s progress on the MDGs”, The Millennium Development Goals, UNDP in Bangladesh, accessed in November 12, 2014,<http://www.bd.undp.org/content/bangladesh/en/home/mdgoverview.html>,

³⁰ “The Millennium Developments Goal for 2015” United Nations Development Program, accessed in September 19 2014,<http://www.undp.org/content/undp/en/home/mdgoverview.html>

³¹ Ibid,

two lab technicians. “Shangu Hill” generally works in the market place on a market day. Communication has been the main priority since without communication they cannot reach the desired communities. Most of the cases “Bengali settlers” (those are coming from plain lands with the state support) are getting access of these medical services by the reason of familiarity of the modern medicine whereas very few indigenous peoples are taking medical service because of lack of knowledge of modern medicine. At the same time the study also noticed that indigenous peoples those are living in hill areas, which means those living higher on the hill they are unwilling to come into a crowded place and come in contact with Bengali people. Furthermore, indigenous people have different native languages, which differ from one ethnic group to another. Therefore, they (Bengali doctors) face challenges to understanding indigenous peoples’ illnesses and their health seeking behavior, which is different from the plain land population.

During discussions with the doctor of “Shangu Hill” he pointed that “in terms of cultural distinctness, indigenous peoples are more used to their local medicine as it is widely accepted by local medical systems as well as there is strong personal faith in it. The percentage of their presence in modern medical systems is very low because of strong traditional medicinal practice and local belief systems.” The informant further stated “indigenous community’s religion is another reason to strongly follow healing traditions. The fact is that in Chittagong Hill Tracts the majority people are religious-minded and the major religion is Buddhism; however most of the religious leaders (*Bhante*) prefer indigenous medicine because of its effectiveness, trustiness, and authenticity for prevention and healing of the disease”.

This fieldwork further disclosed that due to conflict situations and a lack of trust between Bengali and the indigenous people many indigenous people do not come to the marketplace where medical services are provided. The language barrier is another drawback, which leads to a large absence in the modern medical system among indigenous communities. Also long queue in the upazila (Sub district) or Medical service center also discourages the indigenous people from getting modern medical service. As most of the upazila (Sub district) medical services and NGO medical team have a limited number of staff and instruments, they cannot help all those who present for services.

During my fieldwork I talked with a community health worker who works in “Shangu Hill” on the issues of malaria, diarrhea, and maternal health under the finance of UNDP and Global fund. When I discussed the importance of the program she reported, “from my point of view I think this program is very important for hill peoples as they face water related disease especially in the summer. As hill peoples have lack of knowledge of water hygiene and cleanness and they don’t know how to clean the drinking water as they are used to taking natural mountain water which is contaminated with different kinds of bacteria. In the above situation we provide health service in order to save them from their unhygienic lifestyle. In this case financial support is definitely needed to promote modern medicine for life saving solutions.”

Fieldwork investigation revealed that most of the indigenous NGOs try to justify the authenticity of modern medicine. Importantly NGOs also admitted the importance of traditional medicine due to its effectiveness and traditional use. They (NGOs) also noted the importance of pluralistic medical systems. Moreover, when we talked about the NGO activities in most of the cases community health workers working in the field emphasized the necessity of modern biomedicine. Furthermore, it can be said that after the peace treaty in CHT international organizations discovered the new field of intervention that is widely seen in different projects in CHT, especially health related projects. In many cases, the study showed that medical teams had been combined with indigenous staff while in many scenarios they were not properly able to reach remote places. In such a scenario this has become a big debate about NGOs success rate.

The lack of coordination with other organizations, including government agencies is another challenge to intervention programs and lack of proper community participation is also considered a challenge to health related programs. Many health intervention programs have duplication in that similar kinds of health issues are being addressed by different NGOs without any proper co-ordination and combination. There are gaps from project planning to implementation, resulting in mismanagement and system loss. Fieldwork experience indicated

that financial irregularities are especially prevalent among different NGOs working in Chittagong Hill Tracts.

Although NGOs' activities have not changed, the local traditional systems of indigenous peoples have strong ties towards their worldview. Traditional health practices face remarkable challenges to its existence due to westernization, modernization, globalization processes and the introduction of modern medicine in the Chittagong Hill Tracts. Also, there are many different levels of politics going on to manage fund including the lobbyist group working to convince the international organizations.

Regarding the issue of indigenous people in CHT, the head of "Shangu Hill" noted that, "as an indigenous background CHT has been discriminated in different ways. People in this area are dealing with different kinds of traditional healers who lack scientific knowledge to deal modern diseases. Importantly, our ancestral healing systems have not gotten any scientific approval. The traditional medicine does not take care of the whole disease. It might cover some of the disease but in a wider context it does not fulfill the needed requirements. On the other hand, this is 21st century, where all around the world people are enjoying modern medical practice whereas hill peoples are using local medicine. It does not look good. It is a kind of discrimination. Modern medicine has some kinds of power. For example, if you are sick and use modern medicine you will be cured very soon on the other hand local traditional medicine requires a long time for curing the illness. Though it is fact the traditional medicine is much more effective to the body and soul then modern medicine. But you know that people are always interested in using medicine which has rapid action for recovery."

During my fieldwork experience I noticed that most of my informants who are connected with health related programs, both NGOs and government staff, have the vision that modern biomedicine and its medical systems can cure and identify the disease precisely and accurately. This monolithic view has rejected and refused the existence and contribution of traditional medicine in Chittagong Hill Tracts. One of my informants, who works as a community health worker in BRAC NGO in Rangamit Kawkhali Upazila, informed me that, "modern medicine is very important for the community peoples as they are using backdated

and superstitious medicine during the time being. This traditional medicine is not curing any critical or severe diseases especially malaria and other communicable diseases. Community people living in the remote areas are facing huge health challenges especially in the rainy season when diarrhea is very prevalent. Many children are died because of cultural superstitious, uneducated traditional healers and those making less effective medicine for the children.” The informant further revealed that indigenous peoples have a long tradition of using local traditional medicine but time has changed a lot, and a number of indigenous people now familiar with modern biomedicine because of its positive effects.

The field investigation revealed that a number of informants who are working in the NGO have strong understanding of modern medicine. It was also observed that most of the head of the NGOs staffs have modern education, which also motivated them to promote health services dominated by modern biomedicine. During my fieldwork I also noticed that from top to bottom, health service providers and people related to health programs have this monolithic view. In these situations it can be seen that in Chittagong Hill Tracts both government and non-government agents are working for modern bio-medicine while international agencies like UNDP are financially assisting others to promote this modern bio-medicine. This dominante ideology has also penetrated among local indigenous people working in different health programs. This field research also found that five indigenous respondents implied the importance of modern biomedicine. In terms of intervention programs in Chittagong Hill Tracts this has been of key importance after the peace agreement between Bangladesh government and the indigenous political party, Parbatya Chattagram Jana Samhati Samiti (PCJSS).

This chapter clearly shows the tendency and background of NGO activities in Chittagong Hill Tracts especially health intervention programs where government, international organization, and other stakeholders emphasize the importance of Millennium Developments Goals for 2015. In another way, pluralistic medical systems have been overlooked by these agencies.

Chapter Four:

Government and local perspective on Health in CHT

4.1 Introduction :

This chapter scrutinizes administrative systems and political structures in Chittagong Hill Tracts. Together it discusses the government attitudes towards NGOs' health programs and traditional medicine. This chapter also tries to focus what kinds of health policies have been taken by NGOs and government both national and CHT context. Besides this, it also examines different interpretations and perceptions of health structures in CHT.

4.2 Administrative and Political Structure in Chittagong Hill Tracts:

Chittagong Hill Tracts is a unique and distinct place from the rest of the country in terms of government systems, geographical location, health structure, culture, tradition, customs and linguistics. The government system in CHT is totally different and distinct from the rest of the country. At present there are three governments' administrative systems executing law in CHT due to its diversified political and cultural structure while in rest of the country has only one administrative system, (The case of Chittagong Hill Tracts, Bangladesh by Raja Devasish Roy).³² This phenomenon is indicates its distinctiveness and sensitivity from the rest of the country in various issues. This structure is also very important in order to understand different health intervention program in CHT.

In Chittagong Hill Tracts any kind of health intervention programs go through this political and administrative structure. It is also noted that all kinds of development activities are also

³² HR/GENEVA/TSIP/SEM/2003/BP.8: The International Character of Treaties with Indigenous Peoples and Implementation Challenges for Intra-State Peace and Autonomy Agreements between Indigenous Peoples and States: The Case of the Chittagong Hill Tracts, Bangladesh by Raja Devasish Roy

running through these political and administrative structure in Chittagong Hill Tracts. Similarly, this administrative structure is a very unique symbol of power exercise towards NGO activities, which eventually shows the relationship of power relation and intervention program between government, non-government and local indigenous people.

The three administrative systems are:

- General Administrative System
- Local Government System or Self-Rule Government /Decentralize Government System
- Traditional Administrative System (Especially in CHT region)

British first annexed the area in 1860 and gave the region a special status while acknowledging its distinctive identity of indigenous peoples. Since then CHT has been practicing and following the government structure under the CHT regulation of 1900. Under this system law and order, control, judiciary powers, policing power allotments of lands, and tax are controlled by the Commissioner in Chittagong and over time some power had been given to the Deputy Commission in the respective districts. Equivalently, powers of administration were given to Forest Department under the Act of 1927.

More importantly, local law and order has been controlled under the traditional administration system of the three circles of Chittagong Hill Tracts. The three traditional circles are controlled by their own respective chief or Raja (King) namely Chakma Raja, Mong Raja and Bomang Raja under the domain of Rangamati, Khagrachari, and Bandarban districts respectively. On the other hand, local government administration or decentralized or self-rule government administration structure had been initially formed in the Hill District Council Act and reformatted and revised in 1997 under the provision of Peace Accord between Bangladesh Government and PCJSS (Chittagong Hill Tracts Development Facility: Governance of CHT)³³.

³³“Chittagong Hill Tracts Development Facility: Governance of CHT” United Nations Development Program , Bangladesh, accessed December 12 ,2014 //chtdf.org/index.php/cht-issues/cht-institutions

4.3 Government Administration system in CHT:

The Chittagong Hill Tracts consists of three administrative districts namely Rangamati, Khagrachari and Bandarban. In the district levels, the office of the Deputy Commissioner represents general administration system of the central government. Local government bodies are formed with Regional Council, the Hill District Councils, the Upazila Parishad, Union Parishad and the Poursava. Poursava is the local government institution for municipalities while Union Parishad is considered as the lowest unit of general administrative structure, (Ministry of Chittagong Hill Tracts Affairs: Governance of CHT)³⁴

4.4 Local Government Structure in CHT:

According to the Peace Accord in 1997 a decentralized or local government has been formed with the extension of Regional Council and three Hill District Councils while in light of the Peace Treaty the Ministry of Chittagong Hill Tracts Affairs (MoCHTA) has been established in 1998 and headed by an indigenous Minister who is responsible for all the development activities in CHT and followed the recommendation of Regional Council and three Hill District Councils.

The Chittagong Hill Tracts *Regional Councils* was formed in 1997 under the Peace Accord between Bangladesh Government and PCJSS which is formally started its journey in 1999 under the Act of Chittagong Hill Tracts Regional Councils 1998 (Act no 12 of 1998). The main mission of the *Regional Council* is to supervise, regulate and coordinate all of the development activities under the Hill District Councils and all other development tasks. According to the Regional Council acts during the supervision and regulation, if any disagreement, clash or conflict occurred in between one hill district council or all hill district councils then the decision of Regional Council shall be final (Chittagong Hill Tracts Regional Council)³⁵. In addition, Regional Councils regulate the local councils including municipalities as well as coordinating and organizing the Chittagong Hill Tracts Development Board under the Chittagong Hill Tracts Development Board Ordinance of 1976. Coordination and organization of the general administration of the three hill districts, includes law and order

³⁴ “Ministry of Chittagong Hill Tracts Affairs: Governance of CHT” Ministry of Chittagong Hill Tracts Affairs , accessed December 13, 2013 <http://www.mochta.gov.bd/index.php/index/othercontent/CHT> ,

³⁵ “Chittagong Hill Tracts Regional Council “ about Chittagong Hill Tracts Regional Councils, accessed November 10, 2014, <http://www.chtrc.org/mainenglish1.php> .

along with development. This also includes regulating indigenous traditions, practice and social justice. On the other hand Regional Councils has authority to issue licenses to set up industries in CHT under the national industrial policy. At the same time Regional Councils has the authority to coordinate and regulate all NGO activities in CHT. Therefore, all NGOs are bound to follow their policy and rules for conducting any NGO intervention program. Additionally the Regional Council has the duty to monitor relief and disaster management systems in three hill district.

Moreover, in accordance with CHT Regional Council Act 1998, all executive power is possessed by the Chairman and this power will be exercised by the Chairman directly or any other person empowered by the Chairman himself. The formation of the CHT Regional Council consists of one chairman (of indigenous background), twelve indigenous members, six non-indigenous members, two indigenous women and one non-indigenous woman member, along with the Chairman of three hill districts councils (Chittagong Hill Tracts Regional Council)³⁶. Regional Council is a very important power structure in CHT which plays an important role for all kinds of NGO activities including all kinds of NGO health intervention programs. Therefore, in order to understand NGO health intervention program it is necessary to look at this power structure.

According to the Regional Council Act, a Chief Executive Officer for the Regional Council is to be recruited from the status of Joint Secretary of the Government. The recruitment of the executive officer shall be given preference from indigenous communities. The Government nominates the Chairman and other members of the Regional Councils. At present, the Chairman of PCJSS holds the principal position of the council.

Hill District Councils have been established under the Hill District Councils Acts of 1989 (revised in 1997 after the Peace Accord) in three hill districts for the socio-economic development of this region. Hill District Councils are responsible for coordinating and monitoring all development works of Government and NGO operations in the three hill

³⁶ *ibid*,

districts. Hill District Councils have the authority to implement different development projects from the government and also to run the different government and semi-government departments transferred to the council. All departmental staff report to the departmental head and the departmental head reports to the Chairman of Hill District Councils. According to the CHT Peace Accord, a total 33 subjects have to be transferred from the Ministries to the respective hill district councils. At present more than half of the subjects are transferred to the hill district councils including health and education. However, some subjects are yet to transfer including police department, forest department and land department. The Hill District Council may implement and formulate the development plans of the subject transferred to them and largely dependent on the central government fund as they have little capacity to generate their own revenue.

Moreover, three Hill District Councils are now the focal point of administration as well as development activities of three hill districts. Apart from this, Hill District Councils are implementing development projects under the transferred subjects through Government channel (Rangamati Hill District Council)³⁷.

4.5 Traditional Administrative Structure:

Apart from both general and local government structures in CHT, we also see traditional administrative structures based on traditional customs and the practice of indigenous peoples in Chittagong Hill Tracts. This traditional administration is a very old political and administrative system in CHT which has been continued for hundreds of years and transferred from one generation to another generation. Under this traditional administrative system, there are three Circles in CHT whereas; each circle has its own circle chief or Raja (King) who has authority to solve different kinds of dispute, social problems especially when Headman or Karbari could not able to solve the dispute among the community. In tandem, circle chiefs are also responsible for maintaining and sustaining the traditional culture, customs, rituals and

³⁷ "Rangamati Hill District Council" planning and development, accessed October 22, 2013, www.rhdcbd.org.

social harmony in their respective circles as well as they are accountable to collect yearly revenue from the respective or particular region, (Banglapedia: 2003)³⁸.

The Circle Chiefs are also members of their corresponding or relevant Hill District Councils as well as involved in other local bodies including Chittagong Hill Tracts Development Board and Regional Councils. It is important to say that Chakma Circle is belong to Chakma Chief located in Rangmati district, Mong Circle belongs to Mong Circle Chief located in Khagrachari district and Bomang Circle belongs to Bomang Chief in Bandarban district. Similarly, these three Circles Chiefs are correspondingly involved in the local administrative district (Banglapedia: 2003)³⁹.

Importantly, each circle is divided into Mouzas where the Headman is the traditional leader of these Mouzas. Chakma circle consists of 177 Mouzas located in Rangamati, Mong circle consists of 83 Mouzas mostly located in the Khagrachari district and the Bomang circle is consists of 109 Mouzas located mostly in the Bandarban district. It is also noted that each Mouza has several Paras (village) where Karbari is the traditional responsible leader of the Paras. Generally, Karbaris, in their respective Paras are accountable to resolve the local disputes and social problems while they are the last unit of traditional administrative systems. Moreover, it is noted that the Deputy Commissioner through the direct reference of Circle Chiefs recruits Headman's and Karbaris are appointed by the Circle Chiefs.

It is noted that socially both Headmans and Karbaris are treated as honored and wise people who can deal with and maintain social law and order by collecting taxes, distributing land among the communities as well as traditionally both these posts have been transferred from one generation to another through blood lines;for instance grandfather, father and finally son

³⁸ Banglapedia: National Encyclopedia of Bangladesh: 2003, accessed in February 13, 2013, <http://www.ebanglapedia.com/en/article.php?id=1270&title=Chittagong-Hill-Tracts#.VUv5aFkTzAE>

³⁹ Banglapedia: National Encyclopedia of Bangladesh: 2003, accessed in February 13, 2013, <http://www.ebanglapedia.com/en/article.php?id=1270&title=Chittagong-Hill-Tracts#.VUv5aFkTzAE>

will be Headman and Karbari in their respective zones, (Chittagong Hill Tracts Development Facility: United Nations Development Program Bangladesh: Governance of CHT)⁴⁰.

Fieldwork observations noticed that most of the NGOs tried to connect both Headman and Karbaris in their respective territories regarding health intervention programs and informed them about NGO activities and objectives. However there are a number of debates and controversies regarding the involvement of Headman and Karbaris. It's also the fact that this local authority has influence with local people, therefore they are the first key persons to involve community people. Moreover, both national and international NGOs try to convince the local authority in order to successfully implement their respective health intervention programs. Without approval from the local authority, both national and international NGOs cannot work in CHT. Therefore, it was noticed that there are number of lobbyist group working to convince the local authority in order to implement their health intervention program. While it was also seen that local authorities sometimes influence development organizations to recruit their loyal supporter in those NGOs. This scenario occurred in order to understand the activities of NGOs in CHT.

The local power structure is very important to understanding health discourse. The field research also noticed that local power authority to some extent involved in these health intervention programs and allowed both national and international NGOs to work in their respective areas. Some Karbaris also informed me that both pluralistic medical system required dealing with critical health problems. In one interview, a local Karbari (traditional village leader) informed me that he allowed the modern medical intervention program in his territory because he believes that a pluralistic medical system is very relevant for his community as both medical systems have their own strength and weakness. He also noted that modern medicine is vital to recovering from some critical diseases which traditional medical systems cannot handle. As he noted sometimes local traditional health practitioners do not recognize some critical diseases and illnesses, for example cancer or tuberculosis. Sometimes local health practitioners are not able to identify the causes of the disease and in that case they are referred to contact the medical doctor as soon as possible. For instance he

⁴⁰“Chittagong Hill Tracts Development Facility” United Nations Development Program Bangladesh: Governance of CHT. Accessed December 14 , 2014 ,<http://chtdf.org/index.php/cht-issues/cht-institutions> .

informed me that in severe malaria, patients cannot survive without modern medical systems, which indicate his view point about modern medical practice he also emphasized that traditional medicine is also part of the culture which cannot be ignored in anyway.

He continued, “The local medical system is part and parcel of the society. Community people have faith and trust with local health systems, as this traditional health practice has been run from one generation to another generation. We have local belief systems and rituals. Local traditional practitioners understand the person’s illnesses more intensively based on their experience and aptitudes. Additionally, they can understand the problem, understand the mind and body, the disease phenomenon, the local culture and attitudes which make them efficient at handling the disease pattern. Moreover, traditional practitioners have the capacity to understand nature and its plants. This is another reason why many local people first prefer to visit local traditional practitioners.”

One respondent from Rangamati hill district stated that his family is utilizing both kinds of medical systems depending on his situation. This means his mother generally used traditional health practices because she felt more comfortable to communicate with local health practitioners. Whereas his older brother and sister both preferred modern biomedicine and traditional medicine though he further stated that government medical system is not sufficient for treatment and they have long queue; in that circumstance they contact with private doctors. Fieldwork revealed that the government health system is not sufficient to deal with local demands. In most of the cases, nurses were working in the place of doctors and medical recourses were not enough to handle diagnoses. It was also seen that many patients bought necessary medical equipment from a private medical center by the reference of doctors and nurses as some corrupted hospital staff transfer the necessary medical equipment to private sellers.

4.6 Post Peace Accord Political Situation:

After the peace accord was signed between Awami League government and the PCJSS (ParbattayaChattagram JanaSangahati, the Chittagong Hill Tracts United Peoples Party) in 1997 2nd December, a group emerged within the PCJSS movement who considered the accord

unacceptable, as this accord did not accept the “full autonomy” of Chittagong Hill Tracts. Importantly it is noted that peoples of CHT named ‘Jumma people’ therefore before the peace accord Jumma people formed three organization namely the Hill Students Council, the Hill Peoples Council, and Hill Women’s Federation while they campaigned for the PCJSS (ParbattayaChattagram Jana Sangahati, the Chittagong Hill Tracts United Peoples Party) demands and protested for repression and discrimination against the Bangladesh Government but during the year of the peace accord the three organizations divided into two fraction groups based for and against the treaty.

As a result in 1998 the new peace accord denial group formed the new political party, UPDF (United Peoples of Democratic Front) for the ‘full autonomy’ rather than implementation of peace accord (Jenneke Arnes and Kirti Nishan Chakma: 2010 :25). The dispute and conflict between these two parties eventually escalated with killing and abductions in Chittagong Hill Tracts. While in my fieldwork I observed that this political fraction between two local parties makes the situation worse for the common indigenous people in CHT. It is also pointed out that due to political and ideological conflict between two groups, different areas are now dominated by two political groups and as a result abduction and ransom are prevalent in CHT. Even holistic socio-cultural development cannot be achieved due to this political and ideological difference.

Fieldwork investigation demonstrated that local indigenous communities are to some extent depriving themselves from different government and non-government opportunities due to local fractions. One of interviewee who is working as community health worker in “Shangu Hill” in Langadu sub-district in Rangamati district stated that “due to political and ideological disagreements among different indigenous political groups, local people to some extent cannot get the facilities of NGOs health and other services, as some local political group has objection towards NGOs activities which hinder the basic human rights towards indigenous people.” Furthermore the informant accounted that “because of political fractions and rivalry between PCJSS (Parbattaya Chattagram Jana Sangahati, the Chittagong Hill Tracts United Peoples Party) and UPDF (United Peoples of Democratic Front) many local indigenous people are underprivileged in terms of economic conditions. Especially in some upazilas (sub-districts) in Rangamati it is very risky to conduct NGO intervention programs due to a lack of

security and the prevalence of political and ideological conflict among local indigenous communities. In this place sometimes people are afraid to go outside after evening because of lack of security which government force cannot cover. In my field work experience I noticed the existence of political and ideological conflict among different political groups which emerge after the peace treaty between Bangladesh government and PCJSS (Parbattaya Chattagram Jana Sangahati , the Chittagong Hill Tracts United Peoples Party) in 1997.

During fieldwork, it was also noticed that Rangamati Town is mostly dominated by PCJSS (Parbattaya Chattagram Jana Sangahati , the Chittagong Hill Tracts United Peoples Party) and its student and youth wing while some Upazilas (sub-districts) from the same district are dominated by UPDF (United Peoples of Democratic Front) and its student and youth wing. Moreover, Khagrachari town is dominated by UPDF (United Peoples of Democratic Front) but other Upazilas in Khagrachari are dominated by PCJSS. It is also noted this peace accord is also denied by the main opposition nationalist party and the ‘Bengali Settlers’ in Chittagong Hill Tracts. While the Peace Accord completely dissatisfied the Jumma young activists making a huge conflict among the indigenous groups and escalated the blood bath of this region (Jenneke Arnes and Kirti Nishan Chakma: 2010:24).

Due to armed conflicts in CHT there were not any NGOs working for the development of CHT people before peace accord. But the picture had been changed after the peace accord where a large number of NGOs including international NGOs, national, and local NGOs have been working on CHT issues, including health issues. On the contrary, the government blamed NGOs for destabilizing the region by working on controversial issues. The government also accused different NGOs of converting local people to Christianity (Parbattanews.com: Converting indigenous people to another religion)⁴¹.

⁴¹ “Converting indigenous people to another religion”, Parbattanews.com, a indigenous online news, accessed in December 12, 2014, <http://parbattanews.com/%E0%A6%86%E0%A6%B2%E0%A7%80%E0%A6%95%E0%A6%A6%E0%A6%AE%E0%A7%87-%E0%A6%AE%E0%A7%81%E0%A6%B0%E0%A7%81%E0%A6%82%E0%A6%A6%E0%A7%87%E0%A6%B0-%E0%A6%86%E0%A6%B0%E0%A7%8D%E0%A6%A5%E0%A6%BF%E0%A6%95/#.VQhK1xDF-vJ> .

4.7 Health Policy in Bangladesh:

In order to understand indigenous health policy, one needs to understand how government health policy shapes the national health policy and indigenous health policy. The Health, Nutrition and Population Sector (HNPS) strategy is treated as the national health policy in Bangladesh. It was introduced in 1998 in light of the progress and escalation of health, population, nutrition and addressing the challenges. This health policy has been run under the direct supervision of the Ministry of Health and Family Welfare (MOHFW), Government of Bangladesh. While at present the 3rd phase is being implemented since 2011 to 2016 under the name of Health Population and Nutrition Sector Development Program for the improvement of health, population, nutritional status in Bangladesh (Bangladesh Health Policy: 2011)⁴².

The priority of the program is to focus on improving the service and utilization of HPN (Health, Population and Nutrition) in order to reduce morbidity and mortality which will improve the maternal and child health, decrease the population growth, and progress the nutritional status specially for women and children. In the recent years there is a major change in the health service facilities now the government focusing more a package of essentials health service based on priority needs of clients, delivering the service from more fixed point rather than door to door service by the community health worker. The main target of this program is to reduce the expected cost and increase the efficiency to meet the peoples' demand while government is also considering the improvement of private sector in order to cover the health gap in remote place.

On the other hand the main objectives of the HNP program is to improve public health situation in Bangladesh as well as to confirm emergency health for everybody and to confirm quality and cheap health for all population, to prevent all infectious disease among all population, to reduce the health service between rich and poor people, and simultaneously to reduce health service gaps between city and village people and to improve the safety measures for maternal health service, to popularize family planning strategy, and make poor

⁴² "Bangladesh Health Policy 2011", Ministry of Health and Family Welfare, Bengali PDF version, accessed in October 12, 2014, http://www.mohfw.gov.bd/index.php?option=com_content&view=article&id=74&Itemid=92&lang=en

people more comfortable , reduce gender inequality, ensure private medical services and reduce the cost of private medical service to the poor people, to reduce the gap of man power and reduce the gap of medical instrument, modernize the health education and its gadget, improve the immunization process, to develop and improve coordination among different agencies including government health services along with non-government and private health service, and to ensure the low price of essential medicine for all citizens, (Bangladesh Health Policy :2011)⁴³.

Critically, it can be said that government has had some success improving the health service among general people by reducing the maternal and infant mortality rate and by reducing the under five year mortality rate. In some other health indicators the government has improved declining population growth and total fertility rate, EPI coverage has increased, life expectancy at birth rate has increase, reduce the rate of TB (Tuberculosis) in different place in Bangladesh has been successful, and to some extend a great achievement in eliminating polio and leprosy in major districts, HIV/AIDS is at a very low rate, and they have succeeded in increasing the network of health care service, while malnutrition and micro-nutrition are reduced, (Health Policy Bangladesh: 2011)⁴⁴.

Though the government develops the health service and delivery system however, the ministry of health and family welfare affair faces a number of challenges to implement the HNPDP (health, population and nutrition development program) program. There are different reasons behind this gap. First of all, there are huge gaps between health service and health staff in Bangladesh, there is a low rate of service deliveries by skilled birth attendants, due to climate change a number of new diseases arrive which the doctors faces difficulty, rise of non-communicable disease including cardio-vascular disease, diabetes, cancer, still government has not reduced the gap of health service provider, based on gender criteria.

⁴³ ibid

⁴⁴“Bangladesh Health Policy 2011”, Ministry of Health and Family Welfare, Bengali PDF version, accessed in October 12, 2014 , http://www.mohfw.gov.bd/index.php?option=com_content&view=article&id=74&Itemid=92&lang=en

Importantly there is still a huge gap of the doctor to patient ratio, which is significant in terms good health indicators and the ratio of doctor nurse is still low according to the international standard. Low budgets for health and the low quality of health service provider are also mentionable. According to WHO every country should be allocated \$34 for each person whereas in Bangladesh only \$5 is allocated; such a ratio can indicate the health situation in Bangladesh, (Health Policy, Bangladesh: 2011)⁴⁵.

Moreover, lack of health management, lack of proper planning, lack of health knowledge among economically deprived and distressed people is a very common characteristic. While inadequacies of human resources, lower utilization of public health service facilities by the poor as well as lack of quality assurance system, accountability in health service and weak legal framework are also drawbacks of the government health policy. On the other hand many studies show due to malnutrition during the pregnancy, many mothers deliver underweight babies in different part of the country. Importantly, this health policy does not cover indigenous health issues, as indigenous people and their health seeking behavior is different from the rest of the country. The national health policy cannot convey any laws or clauses for indigenous people where indigenous people represent 1% among the whole population. This indicates how the government is ignorant and less attention is paid towards indigenous people in Bangladesh. This also shows how government represents indigenous people in their national health policy.

4.8 Health structure in Bangladesh:

It is important to note that Ministry of Health and Family Welfare (MoH&FW) is completely responsible for health planning, policy and decision-making at the national level. For that reason there are four directories, which follow the direction of MoH&FW (Ministry of Health and Family Welfare).

These are:

- Directories of Health Services
- Directories of Family Planning

⁴⁵ *ibid*,

- Directories of Drug Administration
- Directories of Nursing Services

Moreover, each division of Bangladesh has a divisional director from both health and family welfare department whereas; at district level a civil surgeon is responsible for reporting to the director of health services and is also responsible to have general and hospital service. There are four hundreds upazila (sub-district) health complexes out of 476 upazila (sub-district)⁴⁶.

4.9 Health policy and structure in Chittagong Hill Tracts:

The health situation in Chittagong Hill Tracts is completely different from the rest of the country in terms of geographical location, ethno-lingual and cultural difference therefore it is quite tough to implement national health program (HNPDP). Studies shows that in the plain land where a health worker cover 4,000 people in village whereas the range is quite impossible in CHT due to the scattered nature of living patterns of indigenous peoples. Often it is difficult to reach remote place for the community health worker for providing service. Therefore the national health policy (HNPDP) cannot cover the health problem in Chittagong Hill Tracts a comprehensive study is needed to understand the health program in Chittagong Hill Tracts, (Ministry Of Health And Family Welfare; Social Assessment and Tribal Health Nutrition and Population Plan for the HNP Sector Programme (2005 to 2010)⁴⁷.

In this regard Ministry of Health and Family Welfare introduced tribal health policy, which is named Tribal Health, Nutrition, and Population Plan (THNPP) in 2004 for effective implementation of HNP (Health, Nutrition and Population) program in tribal areas. Government states that this tribal health policy is made by the consideration of social, cultural, economic and linguistic sensitivity and this health component can cover the 25% of the total tribal population. This new health policy for the indigenous peoples called 'tribal sensitive' and participatory implementation of HNP (Health, Nutrition and Population)

⁴⁶ "Health Nutrition and Population Sector Program (HNPSP), Tribal HNP Plan (THNPP) Executive Summary", Ministry Of Health And Family Welfare, accessed in October 14 , 2013,

http://www.mohfw.gov.bd/index.php?option=com_content&view=article&id=78&Itemid=59&lang=en

⁴⁷ *ibid*,

services in CHT area (Ministry Of Health And Family Welfare; Social Assessment and Tribal Health Nutrition and Population Plan for the HNP Sector Program, from 2005 to 2010)⁴⁸.

At the same time the government considers this health component would be empowering to the ‘tribal’ people by participating in the stakeholders committee at district, upazila (sub-district) and union levels, that would give them choice to establish village level health center (training for the fieldworkers, give efficiency of the tribal doctors and connected with District, Upazila (subdistrict) and Union while this health component can be effective by monitoring and evaluating the processes of all activities in Chittagong Hill Tracts ⁴⁹ .

It is also noted, government policy maker and staff have very little ethnographic and statistical information about tribal people in CHT, which is main obstacle to implementing tribal health policy in CHT. It is also pointed out that in accordance with government policy indigenous peoples are named and tagged as ‘tribal people’ (sub-nation) or “upajati”, while small ethnic communities which has a huge controversy and debate among the indigenous peoples in CHT. Indigenous people in Chittagong Hill Tracts disregarded and rejected these derogatory and disrespectful terms which have connotation with association with backwardness and primitiveness⁵⁰. These are other obstacle to the ministry of health and family welfare affair to realize and understand the present situation of indigenous or ‘Adivasis’ people.

It can be said that lack of information to measure indigenous populations as well as a lack of ethnographic studies, and failure to understand indigenous health assessments are main reasons of the failure to implement CHT tribal health programs. Besides these drawbacks, post-accord conflict and lack of local capacity are also mentionable. Importantly, according the CHT Peace Accord, the subject of ‘health’ is transformable from the Ministry of Health and Family Welfare Affair to the Hill District Regional Council; this system is completely different from the rest of the 61 districts of Bangladesh while other plain land districts health

⁴⁸ *ibid*,

⁴⁹ *ibid*

⁵⁰ “Country Technical Notes on Indigenous Peoples’ Issues: PEOPLE’S REPUBLIC OF BANGLADESH” , submitted by Raja Devasish Roy, page :01,update 2012.

service is under the direct control of Health Ministry. Moreover, it is a fact that due to lack of human resources and technical capacity of Regional Council, this lacking of supervision causes huge health gap in CHT (Ministry Of Health And Family Welfare; Social Assessment and Tribal Health Nutrition and Population Plan for the HNP Sector Program (2005 to 2010)⁵¹.

On the other hand, according to the peace accord in 1997, the Ministry of Chittagong Hill Tracts Affairs is completely responsible to look at all activities including health and give approval of the staff and materials for the Regional Council and Hill District Councils. While information about health is available in the health ministry is very old and represents very few facts of CHT therefore it is tough to measure the progress of health indicators in this region. Furthermore, in the field I noticed that health service delivered by the government is not satisfactory or adequate to meet the demand of indigenous peoples in Bangladesh.

Fieldwork experience revealed that most of the health service positions are vacant in health sectors. Most of the hospitals in upazial (sub-district) are run by a health assistant, nurses, or other lower ranking hospital staff rather than doctors. A notable lack of suitable nurses in all levels in the health care system is major hindrance to the health system in Bangladesh especially in Chittagong Hill Tracts region. As mentioned previously in most of the cases doctors are not interested in working in CHT due to remoteness and isolation from the rest of the country. Less attractive salaries or low salaries also motivate health service provider to be unwilling to work in Chittagong Hill Tracts. In many cases health service providers' positions remained unfilled by the government health ministry. Furthermore unofficial and informal medical service charges are widely practiced. A study conducted by Ministry of Health and Family Welfare (MOHFW) demonstrated that unofficial and informal service charges by the health professional are ten times larger than government charges and this practice are very common in all levels of health system in Bangladesh⁵².

⁵¹ "Health Nutrition and Population Sector Program (HNPSP), Tribal HNP Plan (THNPP) Executive Summary", Ministry Of Health And Family Welfare, accessed in October 14, 2013, http://www.mohfw.gov.bd/index.php?option=com_content&view=article&id=78&Itemid=59&lang=en

⁵² "Unofficial fees in Bangladesh: price, equity and institutional issues, Health Policy 1999; 14: 152-163 by Killingsworth JR, Hossain N, Hendrick-Wong et al.

Besides this lack of communication, lack of facilities in terms of private medical practice, lack of medical instruments and medicine and lack of motivation to work in CHT are the main reason of health service gap in this region. In terms of health facility and medical equipment both government and private sectors have little logistic support to deal with critical situations of indigenous peoples especially for women.

It is also noticed that in most the cases health service providers are available only where the geographical location in other way infrastructure is good and road communication is very good and possible to reach. But in fieldwork it was seen that both government and NGOs do not cover the areas, which were remote and hard to reach in terms of communication. Both agencies justify their argument for the sake of security, which I found irrelevant to the notion of holistic development. Holistic development can only come in hand when all walks of indigenous people can reach different kinds of health facilities with respecting their traditional health practice as well. However, some community health workers claimed to be providing health services in the remote areas but the definition of remote area is still vague and unclear to NGOs. Sometimes they do not cover the real distance of indigenous village.

Furthermore, the health seeking behavior in CHT is completely different from the rest of the country even if, the health seeking behavior varies from one ethnic community to another ethnic community, which makes this different health structure in CHT. Similarly, some portion of indigenous peoples in CHT are not so much familiar of modern health system due to its complexity, expensive health services, and unavailability in the remote places. One informant who works for Sunflower noted that “indigenous people have their own belief and ritual systems where they prefer to contact local traditional health practitioners who live nearby. In remote areas indigenous communities don’t have modern health services because of lack of road infrastructure and lack of security due to ethnic conflict and lack of trust towards modern medical systems and Bengali people. On the other hand, local indigenous people are sometimes discouraged to contact modern doctors or hospital by their local leaders, as there are some prejudices about modern medical practice. In most of the cases when community people have any instant illness and disease they contact their nearby healers or

health practitioners where patient knows the healer from their childhood which motivates and increases the level of trust and cultural ties among traditional medical practitioners. Traditional practitioners use the fresh plants and leaves as a medicine which are also good for the patients as most of medicine is rooted from natural plants. On the contrary, this is also the fact that in serious cases community people refer to hospitals but sometimes it was too late to cure the disease of mishandling by the traditional medical practitioners. These factors are also responsible for not having interest to connect modern health system.”

Therefore, based on fieldwork experience it can be said that local health service is prevalent among indigenous peoples and traditional medical systems in Chittagong Hill Tracts is sustainable and cost effective and easily available which contributes to the recognition and acceptance of traditional medicine in CHT. According to the government ‘tribal health policy’, it is mentioned that the pluralistic medical service is especially used to preserve and promote traditional medical systems for the indigenous peoples of this area, however, it has not seen such kinds of strong activities in the field level health service.

4.10 Different Health intervention program in CHT:

It is important to note that after the peace treaty different organizations are working on different health issues based on contemporary global health issue. Different organizations are working under the umbrella of UNDP and Ministry of Health and Family Welfare Affairs transferred to Ministry of CHT Affairs. It is also fact that in most cases funds are released based on donor agencies’ prescriptions and these multiple programs will disappear when these kinds of support from the development agencies will be stopped. In this section I describe different health programs run in CHT with different flagship of NGOs as well as I deliberate the government and NGOs objective of MDG (Millennium Development Goal) 2015 on health programs.

As was mentioned earlier the subject of health has been transferred to the local government and is responsible to Hill District Councils through the channel of Civil Surgeons offices of the deputy directors of family planning who supervise 300 doctors and nurses and about 800 hundred community health workers. They are also responsible for providing health services to

all Upazila (sub-districts) in CHT as well as responsible for over 235 health facilities at district, upazila, union and community levels, (Health Bulletin: 2009, Management Information System, Director General Health Service). Besides this, government set up of the medical facilities, a number of NGOs also built medical service network in CHT especially UNDP which set up fifteen satellite clinics and step by step develops 75 mobile clinics across 15 upazila (sub-district) out of 25 upazila in Chittagong Hill Tracts.

According to the UNDP clinics staff cover 1,000 patients in a month with one-day mobile medical team. At the same time, in case of Satellite Clinics through Hill District Councils they recruited and trained 1,000 women as Community Health Workers. Besides, they provide health services like malaria testing and treatment of malaria, diarrheas, ARI, maternal services which are given through their concern Satellite Clinics. Similarly UNICEF and WFP (World Food Program) are jointly implementing community based health initiatives in CHT. UNICEF working with the collaboration of government under the project of Integrated Community Development Project to development of Para (village) Centers in a selected communities and to train up Para workers. The main objective of the program is to develop health education, early childhood development along with water, sanitation, and health promotion. Additionally, the World Food Program is working with UNICEF under the project of Food for Education Program.

However this program is covered with very few upazila (sub-district) with concentrated to the city center of the upazila therefore this program does not cover the whole CHT or all indigenous communities which are considered the main drawback of NGO intervention programs on health. Furthermore it has been seen that a portion of indigenous peoples those are already living in city center of the upazila are getting all sorts of modern facilities and advantages compared to those living in the remote place in the hill area.

Besides this UNFPA works with family planning services and distributes contraceptives and provides counseling for long term methods of contraception. USAIDS is a supporting national HIV/AIDS program in the Rangamati district in CHT. Though UNDP demonstrates that there Satellite Clinics are made by the consultation of decision makers at union, upazila (sub-

district), and district level (Chittagong Hill Tracts Development Facility United Nations Development Programme, Bangladesh)⁵³. However there is a debate for selecting the upzaila, as all the upazila and union level paras (village) are not covered by the UNDP satellite clinics and other facilities. Upazila and union level paras (village) are selected based on political and local influence. Fieldwork investigation noted that UNDP and other NGOs working localities, which are dominated by Parbatta Chattagram Jana Shanghati Samiti (PCJSS), the peace accord signed indigenous political wing, which was later renamed their political name as Jana Shanghati Samiti (JSS). On the contrary, there are few NGOs or no NGOs who are working locales, which are dominated by UPDF (United Peoples Democratic Front) the former member of (PCJSS) who oppose the peace accord (Chittagong Hill Tracts Political Parties)⁵⁴. Therefore, people from all paras (villages) do not get access of UNDP activities, which lead to debate regarding UNDP activities.

Here it is noted that Chittagong Hill Tracts are divided by three indigenous political groups. Notably, the political group who involved the peace accord in 1997 has the most advantage of any group in terms of access UNDP para development program and other facilities. Even most of the administrative posts and other posts have been allocated from this particular indigenous political group namely PCJSS (ParbattayaChattagram Jana Sangahati, the Chittagong Hill Tracts United Peoples Party). While the peace accord opposed indigenous political group has not gotten any access due to their different political stand, the other political group, which emerged in 2007 as a reformist group named Jano Samhati Samiti (Reformist) also challenged and denied the leadership of PCJSS and Mr. Larma (Leader of PCJSS)⁵⁵.

Additionally, due to political fractions, feuds, and informal toll collections by the indigenous political parties huge hurdles to implement any kind of health intervention programs are created. It is also mentioned that in this study six informants talked about illegal and informal tolls collected by indigenous political parties in their different intervention programs

⁵³ “Chittagong Hill Tracts Development Facility United Nations Development Programme”, Bangladesh, accessed in December 19,2014, www.chtdf.org

⁵⁴ “Chittagong Hill Tracts Political Parties” [GlobalSecurity.org](http://www.globalsecurity.org/military/world/bangladesh/political-parties-cht.htm), accessed in <http://www.globalsecurity.org/military/world/bangladesh/political-parties-cht.htm>

⁵⁵ *ibid*,

including health intervention programs. This situation is very much apparent in UPDF (United Peoples Democratic Fronts, an indigenous political party) who control the area as well as other remote areas in Chittagong Hill Tracts. It can be said that some indigenous parishes (villages) get access to UNDP facilities and some do not. In my fieldwork I found there is a difference between the promised task and practical work at the field level.

Especially UNDP, as corruption along with malpractice of funds are relevant in partner NGOs. During my research period in CHT, one respondent from BRAC noted about misusing the funds by the partner NGOs especially in health intervention programs. This informant noted that “different ways local authorities of BRAC misuse the funds for the health intervention program. For instance, some staff of these NGOs misuse and misinform and sometimes exaggerate the local travel and food cost, and overstate the price of official machines such as a photocopy machine, printing machine, and other office materials.

In terms of buying medicine and first aid instrument staff members overstate the price of the product, and sometimes they made unnecessary bills for different health purposes which might be not needed at all. My informant stated, “in my experience I saw that sometimes they overstate the house rent, or the salary of different levels of staff. In tandem, in many cases NGOs exaggerated and manipulated the data and budget. In the case of implementation of the program the project manager tries to show the overstated expenditure but in reality they would not use such amounts.. Sometimes project managers use the donor money in their own private life which eventually creates challenges for the particular project.”

While as a student researcher I also noticed that sometimes staff members deliver overstated information which was not in fact what they talked about. For example when I asked about the local price of first aid medicine (one packet of paracetamol) they told me it was bought for \$3 dollars when in fact this medicine can be bought for \$1.5 dollar from different companies. When I asked as a researcher about this issue with one staff member from BRAC, he gave me a different explanation, which might not be real fact.

Simultaneously, fieldwork interviews noted that in most of the cases both government and NGOs are working under the implementation of Millennium Development Goal by 2015 in CHT. It has seen that donor agencies try to focus on Millennium Development Goal 2015. Importantly, Bangladesh government committed to achieve Millennium Development Goal 2015 and committed to implement most of the MDG targets including reduce child mortality and improve maternal health along with combat against HIV/AIDS, Malaria, TB (tuberculosis) and other diseases. Hence the Bangladesh government focuses more on modern medicine and indirectly ignores the importance of pluralistic medical system. (Millennium Development Goals 2015: Bangladesh's Progress on the MDGs)⁵⁶.

However, the success rate of achievement is considerably different in different districts in Bangladesh. In case of CHT the success rate of improving quality of health is very low due to different impediments and compared to plain land district in Bangladesh. It can be noted that government and NGOs are mostly motivated to success MDG objective in order to gain more funds in health sector. Therefore, it can be said that due to lack a of consultation and coordination with lack of cultural appropriate health policy with the local indigenous peoples create considerable obstacles to achieving Millennium Development Goals in this region. The government has harmonized with the local administration namely CHT regional councils, CHT hill district councils and CHT Development Board in order to coordinate with concern health department.

But it has seen in fieldwork that the shortage of efficient and knowledgeable health workers, lack of management, costly health systems, failure to properly recruit and retain health professionals, low salaries for the community health workers along with poor working environments, lack of proper supervision and shortage of important equipment, and lower coverage with poor infrastructure and misuse of funds made the health services ineffective. In addition some incidences of abduction among health workers who are recruited from the outside of CHT create lack of interest to implement the program. In tandem local political

⁵⁶ "Millennium Development Goal 2015 Bangladesh", accessed in 15 the October, 2014, <http://www.bd.undp.org/content/bangladesh/en/home/mdgoverview/>, <http://www.bd.undp.org/content/bangladesh/en/home/countryinfo/>

conflict along with local communal conflict between Bengali settlers and indigenous communities create huge challenges to implement and improve the health program.

4.11 Local people's attitudes towards health intervention program:

Discussion with the local peoples indicated that they have different opinions of health intervention programs. As I mentioned the Chittagong Hill Tracts is run by a different administrative system, namely the central government, local government and the traditional administrative system therefore it causes huge challenges and confusion to coordinate and supervise the health program.

After the peace treaty a large number of NGOs are working under different health program in three hill districts. However these health interventions covered only a small area with limited capacity along with duplication, which can only cover small number of peoples. Here duplication means, most of the NGOs are working with similar kinds of issues, which eventually do not do any good for the concerned populations. It was also seen that in some cases funds and other NGOs services were considered based the political affiliation, as it was seen that three districts of Chittagong Hill Tracts are ethnically and politically divided which rooted in peace accord among Bangladesh government and Parbatya Chattagram Jana Sanghati Samiti (United Peoples Party of the Chittagong Hill Tracts) in 1997. Chakma indigenous community dominates this indigenous political wing, which is the biggest ethnic community in Chittagong Hill Tracts.

In many ways this community is advanced in terms of economics, politics, culture, education, and accessing power both in political and administrative structure. Therefore a large number of intervention projects are running among mostly the Chakma dominant indigenous groups compared to small indigenous communities. During my fieldwork I talked with people of different professions regarding NGO health intervention programs, especially UNDP work. One research participant from "Shangu Hill" situated in Ruma upazila in Bandarban district belonging to the Chakma community informed me that "NGOs intervention programs have not changed the health situation in Chittagong Hill Tracts; rather they created more complexity and complication among indigenous peoples". He also stated,

“due to NGO intervention in this area they (Chakma community) are slowly losing their traditional medicine.”

I talked another respondent who is a school teacher in Rangamati district and belongs to Marma community who had been asked to share his perspective regarding health intervention program in Rangamati. The respondent stated, “NGOs working in this region do not change the fate of indigenous peoples, rather they only serve the purpose of facilitating people in CHT who are already involved different intervention programs.” The same respondent also indicated, “There is a negative image of NGO activities among local people in Rangamati. As NGO activities do not cover different communities and only few community peoples (mostly of the dominant indigenous community) are getting advantages and facilities from these intervention programs.” Therefore, the respondent claimed that a real holistic approach should be considered.

I found through the NGO activities to some extent specific local people are getting services under the coverage area. On the other hand, a number of other minor local groups are getting only partial facilities or have not received any facilities due to remoteness and lack of capacity and local power politics. For instance, it was already mentioned that it's not so simple to introduce health intervention programs in a particular upazila. A number of factors including political influence, ethnic conflict, economic opportunities, and social formations of both indigenous and non-indigenous community, must be concerned.

One respondent from Ruma upazila in the Bandarban district who is by profession a karbari from Marma community (traditional leader in a Para/village) reported that, “Private medical service is very limited in this upazila, the problem is that UNDP set up upazila satellite clinics despite the fact of their low capacity and services. These satellite clinic services are limited only for market days. On the contrary, many Paras (villages) are a far distance from the market place. Due to bad road conditions, many sick people are unable to contact satellite clinics. Though the service is free many medicines have to be bought from the Bandarban main market which is not possible for local indigenous peoples in Ruma upazila due to expensive transportation costs.”

During the fieldwork I found that many of my indigenous informants mentioned that due to lack of infrastructure, especially in rainy season, along with low service capacities among health providers, high price of medicine, shortage of life saving medicine, language problems, being uncomfortable with Bengali community, and a lack of ability to properly express their health problem are the major causes to reluctant medical service. One informant asserted that, “When anyone from my community faces any disease they seek local health practitioners or traditional healer because local people believe that the traditional practitioner can understand their illness and disease more closely rather than modern doctors or hospitals nurses as they are stranger to indigenous peoples. Medical doctors have not had any social and cultural ties and relationship with local people. Simultaneously, traditional practitioners have medicinal knowledge based on practical experience on nature.”

Even in my fieldwork I noticed this in remote upazila for instance Ruma. In this upazila indigenous peoples are mostly dependant on traditional medicine because modern medical facilities are not available and are expensive as well. On the contrary, in many cases it was noticed nurses were providing medical service rather than doctors, as doctors did not attend on their duty station on time. Sometimes doctors took different kinds of leaves of absence both documented and undocumented, which directly affected and raise the questions regarding the quality of government health service in Chittagong Hill Tracts. Though NGOs organization provide services it was a very limited range.

When NGO health service was talked about, a senior NGO community health worker who works at Sunflower in the Khagrachari district stated that “there are some gaps for service providing as NGOs always work with specific projects with specific budgets therefore though they (NGOs) are willing to work with remote places due to lack of available funds, they (community health workers) are not able to provide service to all people.” She also cited that “NGOs only work on those issues which are under the consideration of international organizations.” She informed me that they have limited capacity to negotiate with donors, since most of the NGOs are surviving with international funding. It means if there are no funds or financial support from the international or national organization, then local NGOs cannot work and they cannot manage to keep the staff. The informant continued, “NGOs are willing to run projects focused on the local demand and requirement. But sometimes they (NGOs) could not do that due to strict terms and project policy of donor organizations. As

NGOs cannot work in isolation rather NGOs have to work under different directions and requirement of the donors and big organizations for instance UNDP.”

Furthermore she reported the other scenario of misusing of foreign funds. In that regard she indicated, “Sometimes NGOs manipulated and exaggerated the information about the real picture based on donor prescription; for instance if the program implementing NGOs know that exaggerated information will create more possibilities to get funds then the health program implementing NGOs influence the fact of the health situation. Moreover, sometimes NGOs select the place of satellite clinics by the influence of the local political leaders because if NGOs denied the word of the local political leader then they will faces multiple levels of problems in implementing the program, therefore it is a win-win situation among NGOs and international organization.”

While during fieldwork in Khagrachari district it was noticed that sometimes different NGOs tried to manipulate the real information in order to get funds and other facilities. Therefore what the NGOs say and do is different in some sense. For instance, in this study one NGO official claimed that they conducted health intervention programs in all villages in an upazial in the Bandarban district. Notwithstanding, fieldwork interviews with indigenous peoples notified me that this was not the real truth. Sometimes NGOs even change the project area with a low capacity of employees. For instance, during my fieldwork one participants from Sunflower in Khagrachari district said that their project manager changed the project area to another place because his parental home was there. I cross-checked the information with other staff members of this NGOs, and even I talked to the project manager about this issue, but he told me the project location had been changed because this particular area needed more assistance and advocacy from UNDP funded program though he denied any partiality and biasness. This research participant also admitted that sometimes big NGOs forward and transfer their projects to the small NGOs in order to get financial advantages or commission.

4.12 Government attitudes and perspective about Indigenous health:

The government of Bangladesh introduces the ‘tribal health, nutrition and population plan (THNP) which is regarded as the tribal health component for CHT introduced in 2004 though

the Peace Accord which was signed in 1997. According to the Ministry of Health And Family Welfare Affairs this tribal health policy has been taken under the special reflection of specific cultural, linguistically sensitivity, economic and social factors of CHT area. The health ministry also considers the social and cultural distinctness and economic activities in Chittagong Hill Tracts, which are completely different from the rest of country. It is also mentioned government is committed to fulfill the MDG (Millennium Development Goal) target by 2015 (Health Nutrition and Population Sector Program, Ministry of Health and Family Welfare)⁵⁷. Therefore Ministry of Health And Family Welfare Affairs has delivered instruction to all NGOs working in CHT to follow the MDG issues. Whereas UNDP and other partner organizations also recommend this goal and support the government in implementing this target in CHT. As a consequence, all government actors and non-government organizations are working with very specific issues like maternal and child health along with malarial, TB and HIV/AIDS.

It is also mentioned that this indigenous health policy which government treated as ‘tribal health component’ as Bangladesh Government did not recognize the term ‘indigenous’ therefore all government documents addressing indigenous peoples as ‘tribal people’⁵⁸. Even international donor organization accepted the term in accordance with supporting and promoting government health strategy in CHT. In order to implement the all development program in CHT, international organizations needed the government approval which can only

⁵⁷ Health Nutrition and Population Sector Program (HNPSP) , Ministry of Health and Family Welfare , Peoples Republic of Bangladesh , accessed in 24 November , 2014 , http://www.mohfw.gov.bd/index.php?option=com_content&view=article&id=78&Itemid=59&lang=en

⁵⁸ Bangladeshi UN representative, Ishrat Jahan Ahmed forwarded the statement that “her delegation supported the rights of any group that was disadvantaged. Bangladesh adhered to all major international human rights instruments and supported the rights of indigenous peoples. However, the Declaration, in its present form, contained some ambiguities, particularly that “indigenous people” had not been identified or explicitly defined in any way. Further, the text did not enjoy consensus among Member States. Under such circumstances, Bangladesh had abstained in the vote”, GENERAL ASSEMBLY ADOPTS DECLARATION ON RIGHTS OF INDIGENOUS PEOPLES; ‘MAJOR STEP FORWARD’ TOWARDS HUMAN RIGHTS FOR ALL, SAYS PRESIDENT, United Nations , accessed in 29 , August ,2014, <http://www.un.org/press/en/2007/ga10612.doc.htm> .

possible when they accept the government indigenous policy in CHT. Despite the debate on the notion of “indigenous peoples” all parties, both international and domestic NGOs, avoid the term (indigenous peoples) in order to communicate with the local indigenous peoples for their development. I talked with different government officials both at the ministries of health and family welfare as well as ministry of CHT affairs in order to understand the health policy and its meaning toward policy makers in CHT.

During the fieldwork I talked with the ministry of health and family welfare affairs secretary to understand government strategy on health in CHT. The secretary of health ministry informed me, “The government is very sensitive and takes special care to Chittagong Hill Tracts due to its cultural diversity, biodiversity and unique livelihood pattern, distinctive health seeking behavior which has been different from the other part of the country. In such a context the government introduced tribal health components for CHT.”

The informant further accounted that, “The government is very careful about cultural and linguistic sensitivity of indigenous peoples in CHT which would obviously comprehend the existing health gap, as well as helping how to implement different health program is appropriate to their individual cultural context. In that case our development partners are supporting our tribal health components in order to reduce health discrimination with the rest of the country.” The secretary of health ministry further reported that, “After the Peace Treaty in CHT, significant opportunities have been offered to develop the socio-cultural along with primary health care of this region where people in this region are facing multiple levels of disease due to malnutrition, poverty, malpractice and lack of health awareness specially child and maternal health which has to be improved.

In that context, the government forwarded instruction to the secretary of health and family welfare affairs ministry for monitoring and evaluation of the activities provided for them. This included empowering the tribal people to plan their health policy, training health workers at union, upazila and district level, recruiting tribal background doctors and medical service which is supposed to be delivered according to the local demand. The ministry was also instructed to annex local governments including, the regional council, hill district council and district health department to implement the tribal health policy.”

Nevertheless, during fieldwork as a student researcher I could not find the compatibility of tribal health policy as the concern authority did not set up the program, whereas according to the peace treaty the subject of health has been transferred to the local government and local health department but the fact is that from the center (central administration which located in capital city of Dhaka) they had not forwarded any instruction to implement transferred subjects to the field level. Therefore, whatever the health ministry addressed is only in the surface level rather than of a practical nature. On the contrary, it had been also been talked about with the secretary ministry of CHT affairs; this ministry is responsible for monitoring and looking after the government affirmative action of all development projects in CHT.

During the discussion with the health policy the secretary (who is also of indigenous background) it was reported that, “The government is very serious in its willingness to implement of all clauses of CHT accord which is taking more time to come to action because of complex political situations both national and CHT.” He further continued, “Average population density in CHT is comparatively low compared to plain land where this region is mostly covered by forests and hill areas. Therefore, development activities have been taken with special consideration of socio-cultural, economic, political, religious and other factors. Moreover, this region was in unrest about 25 years and there had not been any development activities, but the situation has been changed after the treaty. At present a large number of interventions are taking into account the participation of indigenous peoples at a much wider level compared to any other time.”

He further noted, “Large number of foreign development partners are extending their support to the development of Chittagong Hill Tracts. However, there are some local factions and conflicts and we are working on that issue in order to solve it with introducing dialogue among all political groups. Even if we try to communicate with concern parties to resolve this fraction that sometimes causes an embargo to implementing the development work.” The informant further stated that, “Prime Minister Shekh Hasina recruited special advisor for Chittagong Hill Tracts Affairs to look after and monitor the whole development activities, our ministry is to responsible to monitor and implement the activities referred to by regional

councils and hill district councils. Moreover, the health and family welfare ministry introduced health policies for the tribal peoples in CHT. Government also introduced CHT Development Board for all kinds of development activities in CHT whereas every year government allocated a good amount of budget for CHT Development Board and ministry of CHT affairs. Tribal health policy has been modified and formulated by the consultation of the concern people in CHT.”

This informant noted different development and government strategies and activities in CHT. Yet during fieldwork it had been found that a shortage of management and a shortage of coordination among different local institutions, fund mismanagement and misinterpretation, surplus or less distribution of the fund, are the major challenges to achieve the government development program in Chittagong Hill Tracts. In the above interview the land grabbing by the Bengali settlers, deforestation, introducing rubber plantation, ecotourism, agro forestry in the name of holistic development was also brought up, but the secretary of Chittagong Hill Tracts affairs ministry avoided these topics, noting that this is not his concern. In another interview talking with a local government implementation officer in Rangamati district, I was told, “There are some gaps to what government says and what they do.”

This research participant who works in Rangamati hill district council office and stated with anonymity, “Sometimes we know the misuse of funds but we could not do anything due to local political influence. Even if some funds were allocated for health they are used in other sectors due to the instruction from the higher authority. Sometimes we reformat and redistribute the budget allocated by the central government. Approximately 50% Bengali settlers live in three hill district areas especially close to the administrative office. Practically, these people are economically marginalized and disadvantaged, as previous governments started transferring the distress and economically marginalized peoples from plain land to CHT in different time period. This idea was generated by the policy makers of that time based on population density in different districts. As we all know Chittagong Hill Tracts has less density compared to other districts in Bangladesh. More importantly, these economically marginalized people brought with them the promising to allocate 3 acres (one acre equal to 4047 square miles) of indigenous land, a pair of cattle for cultivation and 80 kg rice per month for each family. This motivated the plain lands people to settle for life in CHT.”

During my field work in this study I found that the land dispute is the biggest challenge for the development of CHT. The government working only on surface level, they have not resolved the land dispute, which is the main reason for communal and local political conflict in CHT. It's certainly found that the land dispute is the main reason of holistic development in CHT. In some places in CHT health intervention projects cannot be implemented due to land disputes between Bengali and local indigenous peoples, which trigger the security concern to the respective NGOs. Eventually, both indigenous and Bengali settlers are victimized by the ethnic clash. The situation indicated that since land has been occupied by the Bengali settlers which directly responsible to destabilize the region. Land grabbing by the Bengali settlers causes huge challenges to implement the peace accord as well. On the contrary, Bengali settlers who live in three hill districts do not get direct coverage of health intervention.

Most of the international development organizations are practically working with indigenous people and most of the projects have been developed for the indigenous people in this region. Therefore, Bengali settlers have practically received no NGO service. This negligence towards the Bengali settlers creates huge disappointment and dissatisfaction that sometimes motivates them to create ethnic conflict towards the local indigenous peoples in CHT. On the other hand, after the peace treaty government had not taken any programs for Bengali settlers, this is very sensitive and therefore long dissatisfaction towards government and non-government agency influences them to engage conflict with indigenous people. In terms of health, it has been found that there is no sign for tribal health policy in three hill districts. Further there is a huge gap of government health service at district and upazila (sub district) level. Shortage of sufficient doctors and nurses along with shortage of medical instrument are to some extent common scenarios.

In government district level hospital, medicine is supposed to be free for the indigenous peoples, however in the fieldwork observation it had been found that most of the cases concerning physician prescribed medicine were bought from the private pharmacy or private own medicine dispensary. These medicines are expensive and sometimes impossible to buy for indigenous peoples. Importantly, many cases of medicine prescribed by the doctors or

nurses were available in private medicine shops rather than government run dispensaries. It is noticed that from the government hospital medicine has been free for the poor and disadvantaged people under the government rules but during the fieldwork it was noticed that the reality was far from actual fact.

According to the health secretary, medicine should be supplied from the district level government hospital. But fieldwork experience in Rangamati district hospital shows that in most of the cases where doctors prescribed medicine, it had to be bought from the private pharmacy. Practically, these medicines are to some extent expensive and as a consequence indigenous peoples are not interested in contacting the government health services. Additionally, if any local patient buys the medicine from the private pharmacy for the first time, they will not go to buy for the second time due to expensive treatment cost. Opposite scenarios from the field work indicated that hospital medicines were illegally sold to the nearest private pharmacy where a portion of hospital staff are involved with this illegal trade; as a result hospital patients do not get access to free medicine provided by the health department and this setting has been also applicable for other hill districts hospital. These situations eventually cause huge challenges to achieve government and nongovernment targets to implement different health intervention program in Chittagong Hill Tracts.

This picture is also common at upazila level hospitals as well. The government set up 10 beds upazila hospital in all three hill districts but the interesting thing is that most of the cases it was noticed that doctors assigned to the respective upazilas did not have the available time. As a result local peoples did not get medical services from the government doctors. Furthermore most of the health services posts are vacant as doctors are not interested in working in remote places like the hilly area where they could not access private practice, which demotivates the health service provider towards working in remote areas of Chittagong Hill Tracts. Many doctors in CHT are interested to work in the urban or city area because of extra financial support, they consider working in the remote place as having nothing to do. It's the general impression that medical service is to be noble work but in developing countries' context especially in Bangladesh it's more about professional matter. Therefore, it's noticed that the upazila hospital in Ruma in Bandarban is almost without doctors, with nurses were offering medical services substituting in the doctor's place. Furthermore medical

instruments like the operation theatre and other medical instruments are so old and useless that they are impossible to use now. Such a huge drawback of the government medical services in CHT causes enormous challenges to improve and provide health services in CHT.

4.13 Government attitudes towards traditional medicine:

The Ministry of Health and Family Welfare Affairs introduced Tribal Health, Nutrition and Population Plan since 2004 with the consideration of cultural, geographical, environmental, and economical sensitivity. Importantly, it is also taking into account according to the ministry, tribal people have been facing different kinds of new disease which they have not had any capacity to cure; therefore they need a special health policy which can promote them to deal with challenges. The proposed health policy addresses different rules and policy to implement at the upazila (sub district) and union level.

However, during the fieldwork I could not find any guidelines and instructions regarding traditional medicine, (it is noted that government use the term 'tribal', therefore I refer the term 'tribal')⁵⁹. My field work experience shows the local importance and use of traditional medicine, yet both government and NGOs medical services are not so cultural sensitive and useful due to different problems and shortages along with mismanagement. On the other hand historically, religiously and culturally, indigenous people in CHT are closed to traditional medicine due to its unavailability, their cultural beliefs and cost effectiveness, and especially the distance village from the city center.

⁵⁹ Bangladeshi UN representative, Ishrat Jahan Ahmed forwarded the statement that “her delegation supported the rights of any group that was disadvantaged. Bangladesh adhered to all major international human rights instruments and supported the rights of indigenous peoples. However, the Declaration, in its present form, contained some ambiguities, particularly that “indigenous people” had not been identified or explicitly defined in any way. Further, the text did not enjoy consensus among Member States. Under such circumstances, Bangladesh had abstained in the vote”, GENERAL ASSEMBLY ADOPTS DECLARATION ON RIGHTS OF INDIGENOUS PEOPLES; ‘MAJOR STEP FORWARD’ TOWARDS HUMAN RIGHTS FOR ALL, SAYS PRESIDENT, United Nations , accessed in 29 , August ,2014, <http://www.un.org/press/en/2007/ga10612.doc.htm> .

Moreover, it is important to say that, most of the CHT indigenous peoples are living a great distance away from villages and their ways of life are to a great extent unique compared to plain land peoples. Generally, the pattern of disease is different from the plain land people as well due to geographical location. Whereas, the ministry knows about this there is lack of combined health policies, to fulfill the local demand. During my fieldwork several traditional practitioners mentioned the importance of government support and promotion for their local medicinal practice.

I found that there is a huge gap of acceptance between doctors and traditional healers or practitioners. For example, many medical doctors reject the importance of traditional practice as they think this kind of health system is not necessary and applicable in the modern society whereas in the recent era modern medical system use advanced medical technology which is absent in the traditional or local medical system. Critically, this kind of discriminatory approach to the traditional medicine cannot be good for the CHT health context. Local government the in three hill district councils have not taken any persuasive approach towards local medicine though they know very well the importance and acceptance of traditional medicine especially in curing both communicable and non-communicable diseases.

It is also noted that the lack of information and ethnographic data with lack of comprehensive knowledge about CHT's local health systems are the main challenges to implementing government and NGO health policy. Therefore, proper needs-based culturally combined policies should be taken into consideration.

Chapter Five :

Summery and Conclusion

In this chapter I discuss the summery and conclusion of the present research which has been conducted in Chittagong Hill Tracts in Bangladesh, situated in south-eastern part of the country. The present research has been carried out with health discourse of different government and INGOs, NGOs health intervention programs. Here health discourses mean the kinds of health intervention programs both government and INGOs, NGOs implementing on CHT indigenous peoples and the reason behind that. At the same time, throughout this study I examined how different agencies represented the indigenous peoples in their health intervention program. These different health intervention programs and the traditional medicine has been replaced and marginalized by the western or modern medicine.

This study has also represented and characterized interpretations from different walks of people who are directly connected to various health intervention programs and traditional health practices in Chittagong Hill Tracts in Bangladesh. Simultaneously, this study represented government and non-government perspectives and perceptions regarding both modern and traditional medicine and how these different perspectives connected to each other. Therefore, this study is connecting and representing the voices of both from modern health practice and traditional health practice.

This study further examines the application and justification of modern medicine in CHT, and on the contrary how the traditional medical practice has been marginalized. The traditional medical system faces challenges under the different NGOs and government intervention programs in Chittagong Hill Tracts.

The research was conducted with a three-month intensive fieldwork program from June to August in 2012 under the tree hill districts in Chittagong Hill Tracts in Bangladesh. Qualitative research tools and techniques were used to understand health discourse along

with 18 in-depth interviews which were taken during the field work among informants of different profession in CHT in order to understand the purpose of health intervention programs as well as to understand local medical practices. This study simultaneously examined different interpretations regarding modern medical practice and local medical practice. How are these medical practice (modern and traditional) connected to indigenous perceptions of health, which is connected to understanding health discourse in Chittagong Hill Tracts (CHT)?

In this study I talked with different government, non-government staff, and community health workers those working in different NGOs, as well as local people those are directly relevant to the study objectives. Professionals interviewed included the secretary of the Ministry of Chittagong Hill Tracts Affairs, secretary of Family and Health Welfare Affairs Ministry, officials of Chittagong Hill District Regional Councils, different NGOs staffs including community health worker. Additionally, I also talked with local peoples including Karbari (traditional leader), *Boiddo* (traditional healer or practitioners) and local peoples.

These interviews main objective was to know how different actors represented indigenous peoples in health policy, which are taken by the concern ministry, INGOs, NGOs. At the same time I investigated how local medical practice is facing challenges due to the dominance and invasion of western medicine in Chittagong Hill Tracts. In this context three research questions have been constructed. These are: a) What is the role of government and non-government organizations that are directly working with indigenous issues especially health?, b) How are indigenous people 'represented' through different actors (government and non-government)?, c) Why has health become a development issue in Bangladesh, and more precisely in Chittagong Hill Tracts in terms of indigenous people?

The findings of this study implied that both government and INGOs, NGOs concentrated on modern or western medicine in CHT while demonstrating its authenticity, efficiency, and usefulness among indigenous peoples in CHT as they have been facing a number of vital diseases which are also the focus of international communities as both government and NGOs are committed to achieving Millennium Development Goal by 2015. Moreover, both

government and NGOs are concentrated on international donor prescriptions rather than local need based demands. While these health programs do not represent the whole community but rather a small section of people who are gaining advantages by these intervention programs. This study also revealed that the development organizations are particularly focusing diseases, which are connected to Millennium Development Goals rather than other prioritized diseases, for example non-communicable diseases including hypertension, diabetes, and heart disease which have been ignored. Simultaneously, other communicable diseases namely, flu, rabies, measles, sexually transmitted diseases etc. are also ignored in different health intervention programs which indicates the weakness of holistic development specifically health intervention programs.

Moreover, the intervention programs do not cover the whole CHT area rather only where available communication has been developed. Furthermore most of the intervention program have been conducted on Chakma (single largest indigenous community) dominated area as the peace accord has been conducted by this community of people; therefore it has been seen that political influence is connected with health intervention programs. Where fieldwork interviews indicate that a number of INGOS, NGOs and government actors are working similar health related issues, this study shows that there is a duplication of health intervention programs without proper coordination and co-management.

Fieldwork investigations further revealed that especially diarrhea and malaria health intervention programs have been conducted by the most of the NGOs with the same intervention area. This implies the duplication of health intervention programs. It has been seen that other communicable and non-communicable diseases have been ignored by these different agencies. Furthermore, it had been noticed that the government promotes a monolithic medical system in Chittagong Hill Tracts in other way the government and NGOs are encouraging and disseminating knowledge about modern medicine with the support of development organizations while traditional medicine has been systematically ignored and overlooked.

On the other hand it has been noted and crosschecked through the informants that misuse and mismanagement of medical funds and services in different government funded hospitals and satellites clinics by the medical staffs. Hence, in many cases local people cannot receive free medicine or drugs from the government run hospitals where the same medicine which is prescribed by the doctors which are available from the private medicine shops. Importantly, a section of government medical staff members are involved this illegal selling of medicine. Whereas, importantly both government and non-government actors have limited sources of medical staff which cannot fully cover the CHT demand along with lack of proper management. These situations, which mean the shortage of medicals materials, staff members, and medicine along with mismanagement, and mishandling the existing sources, are the major challenges of achieving government and NGOs targets to implement different health intervention programs.

Simultaneously, in government medical systems, in many cases doctors or nurses are absent in their respective places, therefore both indigenous and non-indigenous people cannot receive proper medical service. Language barriers also cause challenges to understand indigenous health seeking behavior in CHT. Most of the health providers are from different ethnic backgrounds, which make a huge challenge to cover health intervention programs. While NGO medical teams have not covered the whole indigenous population as the fact is, these NGO medical services are only provided in the market once a week. Therefore, if any indigenous people have illnesses they have to wait for the market day, which is another major drawback for the NGOs' health intervention programs.

Moreover these NGOs medical service cover only where road conditions are available and easy to reach but it this service does not cover where the infrastructure communication is hard to reach. Such a situation clearly shows the weakness of policies in both government and non-government agencies. Fieldwork experience also indicated that such kinds of health policies are based on donor prescription and do not convey any favor towards indigenous peoples in CHT. Moreover, the government does not recognize indigenous people in Bangladesh, rather they define indigenous people as “tribal” or “small ethnic minority people” (Bangladesh constitution 15th amendment: 2011) which shows the government's position and attitudes towards indigenous people in Bangladesh and especially in CHT. It is also noted that

government and non-government attitudes towards indigenous people is considered with the theme of sustainable development and they are working under this theme though in practice it cannot be achieved without avoiding local traditional medical practice as local indigenous people are using their medical practice from generation to generation. In that case pluralistic medical practice is imperative and crucial.

Therefore, we see that all kinds of health intervention programs have a lack of consultation with indigenous people, which directly affects the outcome of these intervention programs. Some sections of indigenous people get facilities and advantages by involving such kinds of programs. As there are some requirements from the donor agencies to recruit indigenous participation therefore a number of educated indigenous people are involved with such kinds of intervention program but the majority of indigenous populations have not gotten any positive favors from such health intervention programs. On the contrary, it has been seen that indigenous medicine has been marginalized and replaced by modern medicine whereas throughout the health intervention program these agencies try to establish the uselessness and meaningless of traditional practices among indigenous people.

Nevertheless, in the local context it was seen that most of the indigenous communities are using and practicing traditional medicine, whereas traditional medical practice has been more recognized than the modern medical service. Moreover, it can be noted that there are not any necessary steps from the government side to promote pluralistic medical systems as both biomedicine and traditional medicine has its strength and weakness but appropriateness using of both medical systems can be sustainable for indigenous people.

Fieldwork experience also indicated that the government has lack of knowledge about local medical systems which have inadequate knowledge about indigenous cultural values and customs. Therefore, it is understood that a number of health intervention programs have been continued without proper consultation towards indigenous people in Chittagong Hill Tracts. As a corollary, the proper outcome cannot be achieved and such kinds of activities both from government and non-government organizations cannot bring affirmative change in terms of health for the indigenous people in CHT. The field interview also indicated that perceptions

on health among government and non-government agencies are different from the local indigenous communities.

This perception indicated that there is a lack of holistic understanding about indigenous medical systems. As the whole, research findings revealed that after the peace treaty, all agents including government and non-government agents were working to implement health intervention programs without exploring different disease and illness in this region. It is very important to understand how the most dominant discourse on modern biomedicine has been introduced in Chittagong Hill Tracts in the name of development and modernization in order to achieve the Millennium Development Goal of 2015 while there is no way to ignore the existing traditional medical system.

References

Asian Development Bank. “The Banks Policy on Indigenous Issues”, 1998.

Ahmad, M. M. “The State, Laws and Non-Governmental Organizations (NGOs) in Bangladesh”. *International Journal of Not-for –Profit Law*, 3(2001)3.

Ahmed Syed Masud et al. “The health workforce crisis in Bangladesh: shortage, inappropriate skill-mix and inequitable distribution” *Human resource for health, Biomed Central*, 9(2011)2.

Agrawal Arun. “Dismantling the Divide between Indigenous and Scientific Knowledge”. *Development and Change*, 26(1995), 413-439.

Annual Report Chittagong Hill Tracts Development Facility UNDP-CHTDF report: 2011,
Link

http://www.chtdf.org/chtdf_files/chtdf_documents/Publications/AnnualReports/CHTDF_AnnualReport2011.pdf

Banglapedia: The National Encyclopedia of Bangladesh: 2003 accessed October 2014,
<http://www.ebanglapedia.com/en/article.php?id=1270&title=Chittagong-Hill-Tracts#.VVI3Uan86-C>

Barnard Alan and Spencer Jonathan. *Encyclopedia of Social and Cultural Anthropology*. Routledge, London and New York, 2002.

Bhopal R. “Racism, “Socioeconomic deprivation, and health in New Zealand”. *Lancet* ,367(2006),19858-9.

“Bangladesh’s progress on the MDGs”, The Millennium Development Goals, UNDP in Bangladesh, accessed in November 12, 2014,
<http://www.bd.undp.org/content/bangladesh/en/home/mdgoverview.html>,

BRAC.”BRAC Annual Report”. Dhaka, 2004.

“Buddhist people converted to Christianity by Christian Missionary” Bengali newspaper covered indigenous news in Chittagong Hill Tracts, accessed October 12, 2014, <http://parbattanews.com/2015/03/আলীকদমে-মুরুংদের-আর্থিক/#.VRkigSj7DtZ>.

Chakma Kirti Nishan and Arens Jenneke. “Indigenous Struggle In CHT” edited by Mohaiemen Naeem: *Between Ashes and Hope Chittagong Hill Tracts in the Blind Spot of Bangladesh Nationalism*, Bangladesh, 2010.

Chilisa Bagele . “*Indigenous Research Methodologies*” .Sage publications, 2012.

“Chittagong Hill Tracts Political Parties” GlobalSecurity.org, accessed <http://www.globalsecurity.org/military/world/bangladesh/political-parties-cht.htm>

“Chittagong Hill Tracts Development Facility United Nations Development Programme”, Bangladesh, accessed in December 19, 2014, [www. chtdf.org](http://www.chtdf.org) .

Chittagong Hill Tracts Regional Council “about Chittagong Hill Tracts Regional Councils, accessed November 10, 2014, <http://www.chtrc.org/mainenglish1.php> .

Converting indigenous people to another religion, Parbattanews.com, a indigenous online news, accessed December 12, 2014, <http://parbattanews.com/%E0%A6%86%E0%A6%B2%E0%A7%80%E0%A6%95%E0%A6%A6%E0%A6%AE%E0%A7%87-%E0%A6%AE%E0%A7%81%E0%A6%B0%E0%A7%81%E0%A6%82%E0%A6%A6%E0%A7%87%E0%A6%B0-%E0%A6%86%E0%A6%B0%E0%A7%8D%E0%A6%A5%E0%A6%BF%E0%A6%95/#.VQhK1xDF-vJ>

Clifford James, Marcus George E. *Writing Culture The Poetics and Politics of Ethnography*. University of California Press, Barkley, 1986.

Dhamai Binota Moy. Bangladesh Indigenous Peoples Forum. “Strengthening Partnership between States and indigenous peoples: treaties, agreements and other constructive

arrangements” quoted in HR/GENEVA/TSIP/SEM/2003/BP.8: The International Character of Treaties with Indigenous Peoples and Implementation Challenges for Intra-State Peace and Autonomy Agreements between Indigenous Peoples and States: The Case of the Chittagong Hill Tracts, Bangladesh by Raja Devasish Roy .

Davis John K. “NGOs and Development in Bangladesh: Whose sustainability counts?” *Institute for Sustainability and Technology Policy* ,Murdoch University, Western Australia, 2006.

Devine ,J .”The Paradox of Sustainability: Reflections on NGO in Bangladesh”. *Annals of the American Academy of Political and Social Sciences*, 590(2003)227-42.

Escobar Arturo. *Encountering Development: The Making and Unmaking of Third World*. Princeton University Press, 1995.

Fetterman David M. *Ethnography Step by Step* Sage Publications, 1st edition, 1989.

Fetterman. David M. *Ethnography Step by Step*. Sage Publications, 3rd edition 2010.

Gracey Michael and King Malcolm. “Indigenous health part 1: determinants and disease patterns”. *Lancet*, 374(2009)65-75.

GENERAL ASSEMBLY ADOPTS DECLARATION ON RIGHTS OF INDIGENOUS PEOPLES; ‘MAJOR STEP FORWARD’ TOWARDS HUMAN RIGHTS FOR ALL, SAYS PRESIDENT, United Nations , accessed 29 , August ,2014. <http://www.un.org/press/en/2007/ga10612.doc.htm>.

Harris R, Tobias M et al. “Effects of self-reported racial discrimination and deprivation on Maori health and inequalities in New Zealand: cross-sectional study”. *Lancet*, 367(2006), 2005-2009.

Haebich, Anna “The Battlefields of Aboriginal History”, in Martyn Lyons and Penny Russell, *Australia’s history: Themes & Debates*, UNSW press 2005, (2005)1-21(20).

“Indigenous or tribal which identity” accessed in December 12, 2014, a Bengali online newspaper <http://www.bd-pratidin.com/editorial/2014/12/06/48041>,

“Indigenous peoples in Bangladesh”, International working group for indigenous affairs, accessed July 6, 2014, <http://www.iwgia.org/regions/asia/Bangladesh>

Jumma Net, An NGO supporting the indigenous Jumma Peoples of the Chittagong.

“Chittagong Hill Tracts White Papers: The Issues of Conflict, Human Rights, Development, and Land of the Indigenous Peoples of the Chittagong Hill Tracts, Bangladesh 2003-2006” chapter 7.

Killingsworth JR, Hossain N, Hendrick-Wong et al. “Unofficial fees in Bangladesh: price, equity and institutional issues”, *Health Policy* 14(2)(1999)152-163.

Mikkelsen Cæcilie. “Indigenous world 2012” Bangladesh Chapter, *IWGIA*, Copenhagen 2012.

Ministry of Health and Family Welfare, Peoples Republic of Bangladesh.”Health Nutrition and Population Sector Program (HNPSP)”, accessed 24 November, 2014, http://www.mohfw.gov.bd/index.php?option=com_content&view=article&id=78&Itemid=59&lang=en

Ministry of Health and Family Welfare.”Tribal/Ethnic Health Population and Nutrition Plan for the Health, Population and Nutrition Sector Development Program “(HPNSDP) 2011 to 2016”, (HNP Situation of Tribal/Ethnic Communities) 2011.

“Millennium Development Goal 2015 Bangladesh”, accessed 15 the October, 2014, <http://www.bd.undp.org/content/bangladesh/en/home/mdgoverview/>,

<http://www.bd.undp.org/content/bangladesh/en/home/countryinfo/>

Ministry of Health and Family Welfare.”Tribal/Ethnic Health Population and Nutrition Plan for the Health, Population and Nutrition Sector Development Program “(HPNSDP)” 2011 to 2016.

Ministry of Health and Family Welfare. “Bangladesh National Health Policy 2011”. Link : http://www.mohfw.gov.bd/index.php?option=com_content&view=article&id=74&Itemid=92&lang=en

Ministry Of Health And Family Welfare. “Health Nutrition and Population Sector Program (HNPS), Tribal HNP Plan (THNPP) Executive Summery”, accessed October 14, 2013, http://www.mohfw.gov.bd/index.php?option=com_content&view=article&id=78&Itemid=59&lang=en

Ministry of Health and Family Welfare Bangladesh. “Health Policy 2011”. Bengali PDF version, accessed October 12, 2014 , http://www.mohfw.gov.bd/index.php?option=com_content&view=article&id=74&Itemid=92&lang=en

“Ministry of Chittagong Hill Tracts Affairs: Governance of CHT” accessed December 13, 2013 <http://www.mochta.gov.bd/index.php/index/othercontent/CHT> ,

Nazroo James Y. “The Structuring of Ethnic Inequalities in Health: Economic Position, Racial Discrimination, and Racism”. *American Journal of Public Health*, 93.2(2003), 227-84.

Rangamati Hill District Council planning and development accessed October 22, 2013, www.rhdcbd.org.

Reducing Inequalities of health published by Ministry of health, New Zealand: 2002. The document is available in Ministry of Health website <http://www.moh.govt.nz>

Ring Ian, Brown Ngiare. "The health status of indigenous peoples and others" *The gap is narrowing in the United States, Canada, and New Zealand, but a lot more is needed. BMJ*, 327(2003),404-5.

Roy Raja Devasish. "Country Technical Notes on Indigenous Peoples' PEOPLE'S REPUBLIC OF BANGLADESH", 2012.

Sanghati, Bangladesh Indigenous Forum, Dhaka, 2011

Sayem Dr. ASM. "BEST PRACTICES & ALTERNATIVE INTEGRATED COMMUNITY BASED MODEL IN DELIVERING PRIMARY HEALTH CARE SERVICE FOR CHITTAGONG HILL TRACTS OF BANGLADESH : Appropriate primary health care strategy for Chittagong Hill Tracts of Bangladesh ,2009.

Smith Linda Tuhiwai. *Decolonizing Methodologies Research and Indigenous Peoples*. Zed Books Limited, London and New York, 1999.

Stephens Carolyn and et al. "Disappearing, displaced, and undervalued: a call to action for Indigenous health worldwide". *Lancet*, 367(2006)2019-28.

Stiles, K.W. *Civil Society by Design: Donors, NGO, and the Inermestic Development Circle in Bangladesh*. Westport, CT: Praeger, 2002.

"The constitutions of people's republic of Bangladesh" accessed December 25, 2014, http://bdlaws.minlaw.gov.bd/print_sections_all.php?id=367

Unicef ."Chittagong Hill Tracts". 2011

United Nations Development Program Bangladesh: Governance of CHT. "Chittagong Hill Tracts Development Facility" Accessed December 14, 2014, <http://chtdf.org/index.php/cht-issues/cht-institutions>

United Nations Development Program “The Millennium Developments Goal for 2015”, accessed September 19 2014,<http://www.undp.org/content/undp/en/home/mdgoverview.html>.

United Nations Development Program.”The Millennium Development Goals for 2015”, accessed November 2014. <http://www.undp.org/content/undp/en/home/mdgoverview.html>

United Nations Development Programme, Bangladesh. “Health”, Chittagong Hill Tracts Development Facility, accessed November 10, 2013, <http://chtdf.org/index.php/focus-areas/health>

Vaughan J. Patrick et al. “Health Care Systems in Transitions III, Bangladesh Part 1 , An Overview of the Health Care Systems in Bangladesh” *Journal of Public Health Medicine* 22(2000)5-9 ,

http://www.researchgate.net/profile/Kent_Buse/publication/12541633_Health_care_systems_in_transition_III_Bangladesh_Part_I_An_overview_of_the_health_care_system_in_Bangladesh/links/00b495188d398e34b8000000.pdf

Wood, G. “Introduction” in B. Kramsjö and G.D. Wood (eds) *Breaking the Chains : Collective Action for Social Justice Among the Rural Poor of Bangladesh* , Dhaka University Press ,1992 1-35.

Research Questions:

- How do you define indigenous/ “tribal” peoples in Bangladesh?
- Do you think the same definition is agreed by the local indigenous peoples and why?
- Since the independence how many projects/programs are run among indigenous peoples?
- What kinds of issues are addressed by these projects?
- Why do you think these projects are important for those peoples?
- Why do you think they need development and what is the reason behind that?
- What are the advantage of these projects?
- What kinds of drawback do you see in these projects?
- What kinds of challenges do you face during the implement the program?
- Who makes problem for implementing the program and what is the reason behind this?
- What are the outcomes of these intervention programs?
- What do you think about what kinds of programs indigenous peoples actually need and why do you think that?

- Are these programs representing the whole community or a section of community; which people are covered by these programs?
- What kinds of community (big or small and why?) are being prioritized for intervention programs?
- How many people work in your office and how many are indigenous peoples? If they are indigenous which community/ ethnic group do they represent and what is their background?
- Why do indigenous women get more priority in the job rather than men?
- Why have these NGOs established their offices in a particular place?
- What are the NGOs goals for these projects and how have their policies been guided by the donor demand or target?
- What is the government policy over the time among indigenous peoples?
- Frankly speaking, who are the beneficiaries of these programs and why?
- Who are the losers of these projects?

- Why do they need modern education or mainstream education and how do indigenous peoples really feel about mainstream education and why?
- Indigenous peoples have their own health systems, nonetheless why do you think they need biomedicine?
- Why do indigenous peoples think that their medicine is still working?
- Who are the donor agencies and what is their prospect or aspect towards indigenous peoples?
- What kinds of program/projects donors usually provide funds and why?
- Why is 'aid' is needed for indigenous peoples?
- Who are planning and designing these projects or programs? Are they indigenous or non-indigenous peoples?
- Who (indigenous or non-indigenous) write the reports and why?
- Who are the researchers on these projects and what are their backgrounds?
- Are there any kinds of corruption in the long process of the project implementation? If any, then why these are going on and what's the reason for that?

Thank You

Check list:

- Government and non-government policies
- Location of the INGOs and local NGOs
- Health
- Donor agencies
- Aid
- Bureaucracy
- Indigenous and non-indigenous leaders
- Religion
- Different indigenous community
- Constitution
- Education
- Otherness
- Representation

- Development
- Profession
- Politics regarding indigenous programs
- Power relations
- Colonial structure
- Documents or papers
- Worldviews of both indigenous and non-indigenous peoples
- Intervention programs
- Discrimination or repression
- Imperialism

List of People:

- Secretary of CTH Affairs
- Assistant secretary of CHT Affairs
-
- First and Third class employee of the government
- Field level govt. officer and lower class employee both indigenous and non-indigenous
- Government Consultant of the project
- NGOs consultant of the project implementation
- Different NGOs officials and lower ranking employees, both indigenous and non-indigenous
- Field level NGO officials and lower ranking employees, both indigenous and non-indigenous
- Indigenous leaders
- Indigenous peoples
- Political leaders related to indigenous issues
- University professors both indigenous and non-indigenous
- Different profession of indigenous peoples etc.

Consent Form

This is to inform you that I am Md Ahesanul Ameen Tuhin, former student of Dhaka University at the Department of Anthropology. At present I am continuing my Master's of Philosophy degree in Indigenous Studies at the University of Tromsø, Norway.

I would like to invite you to conduct an interview for my Master's research on "Health Discourse in Chittagong Hill Tracts in Bangladesh." The main focus of this study will be to understand the role of NGO and non-NGO agencies towards indigenous peoples. In that regard, I would like to discuss with you what kinds of policies are being put forth for indigenous peoples by different donor agencies along with other NGO and non-NGO agencies. What are the advantages and disadvantages of these projects? I would also talk to you about the perceptions of the knowledge of indigenous peoples about these programs. In terms of health, what do you think about health programs and what are the existing policies of health regarding indigenous peoples? The whole interview session will take between 40 and 50 minutes.

Your participation in this study will be completely voluntary. You have the full right to decide whether or not participate in the interview and you may decide to continue it or stop it at any moment during the interview session. All information and data are strictly confidential and will never be disclosed without your consent. Your identity will anonymous.

Shall we start the interview

Date:

Signature of the participants