The state, the system, the service and the Indigenous community; lessons on inclusive Policy engagement from implementation of AdEquAte project in southern Karnataka

Project Report

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Abstract

Equity is a wider societal issue and has a bearing on health and health care. The research on health inequalities have shown increasing interest in community participation. There is growing amount of research work which shows that social inequalities are impacting health status and access to health services. Transacting social inequalities is not technical issue for better planning or using a new tool but also about inclusive processes on how to involve community/social movements, implementers, policy makers and researchers and bring them on a shared platform. But more importantly the platform also needs to give more agency to the affected communities not just allowing the researchers and evidence to set priority in decision making. The current public health research is largely based out of medical colleges and academia and research organizations the nature of involvement is often symbolic and limited to consultations and participations. Through critically examining the social inequalities of Indigenous communities in the adequate project we sought to reimagine the policy engagement through involving the community-based organization to lead and drive the process. We attempted to create and sustain a platform which is inclusive and sensitive to the voice of marginalised Indigenous communities and involve them in the process taking action on their health situation and decision making. We try to advance the understanding of equity-based approaches and share lessons for improving policy engagement strategies and make them inclusive with respect to Indigenous communities.

Messages

- Mitigating the socio-political exclusion of Indigenous communities through policy engagement partnership with Indigenous community social movements/community-based organizations.
- Creating a shared platform for open dialogues among various stakeholders to create and develop knowledge products for driving policy engagement agendas.
- Inducting the marginalized voices and experiences as a knowledge for policy engagement processes.

Back-ground: **T**owards **H**ealth **E**quity and **T**ransformative **A**ction on tribal health (THETA)[1] project completed the health inequalities survey among the communities residing in and around forests in Chamarajanagar. The results highlighted difference in the health status between Indigenous and other community using quantifiable health indicators. As a result of engagement with multiple stake holders during the workshop the THETA team were asked to design new programme for funding with grants-in-aid

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[1] Prashanth Nuggehalli Srinivas, Vineet Raman, Yogish Channa Basappa, Nityasri S N. January 2020. Health inequalities of tribal communities in India in three regions in northeast, central and south India: Mid-term Progress & THETA Project Workshop Report. Institute of Public Health, Bengaluru.

under provision of Article 275(1)[2] of Indian Constitution. An approach towards using equity orientation in the policy design, the need to work with marginalised minorities among the Scheduled Tribe (ST)[3] population was projected. This process of policy engagement[4] project was named Advancing Equity in Decision Making (AdEquAte) and was situated within the THETA project. As a process of making the policy comprehensive the gaps in research knowledge were identified. This process of policy engagement started off with town hall type discussions during the silver jubilee celebrations of the Solega Abhivruddhi Sangha a Community Based Organization (CBO).

Introduction: The vision of advancing equity in decision making (Adequate) was to use the knowledge emerging from research on tribal health and health equity for the use in decision-making. It also sought for increasing the quantity, quality and relevance of interactions between researchers and policymakers with an overall aim at use of research outputs to facilitate evidence based decision-making and policy design. This project was embedded within the project **T**owards **H**ealth **E**quity and **T**ransformative **A**ction on tribal health[5] (THETA). At the Initial stage of the project consultation for knowledge needs with policy maker was done and this continued to developing knowledge products to respond to gaps identified from research and analysis of the THETA project there by adding to the pool of knowledge. The processes aimed at producing the inputs into policy development. This research knowledge was used for policy engagement[4] with decision makers to embark the policy action towards mitigating the health inequalities of the marginalised indigenous communities. Through this paper we seek to understand the project process with use of knowledge from various actors through inclusiveness and deepening the democratic exercise to incorporate people's views into the policy. This policy engagement exercise involved researcher's, policy makers, policy implementers, Indigenous social movement's representatives, other actors working on Indigenous people health, Indigenous community leaders, people representatives and marginalised Indigenous people to explore ways in which indigenous community health issues could be addressed. This project used academic 'expertise', 'experience' of social movements and indigenous people and research 'evidence'[2] to create a network based collaborative evidence gathering for policy engagement focused on marginalised Indigenous communities' health leading to the policy action towards improving the health of Indigenous community. Overall, the knowledge produced using expertise; experience and evidence[2]

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[2] Ministry of Tribal Affairs, Government of India Available from
https://tribal.nic.in/downloads/Article275/Article275Guidelines.pdf accessed on15th March 2023.
[3] ST is a statutory definition, which defines certain populations or designates certain populations as tribal for the purpose of constitutional affirmative action.
[4] Oxford University, Policy Engagement, available from https://www.ox.ac.uk/research/using-research-engage/policy-engagement/guidance-policy-engagement-internationally/guidance-note-1-what-we-mean-policy-engagement accessed on15th March 2023
[5] Srinivas PN, Seshadri T, Velho N et al. Towards Health Equity and Transformative Action on tribal health (THETA) study to describe, explain and act on tribal health inequities in India: A health systems research study protocol [version 1; peer review: 2 approved]. Wellcome Open Res 2019, 4:202 (https://doi.org/10.12688/wellcomeopenres. 15549.1)

was used by actors at various levels to prioritise indigenous people's health on the road to equity[6].

Rationale

The need for collaborative knowledge needs assessment. As per the UN Human Rights Office Indigenous/ marginalised community have been "traditionally discriminated and they bear a disproportionate share of health problems'. They enjoy fewer health services, receive less health information and are less likely to have adequate housing and safe drinking water, and their children have a higher mortality rate and suffer more severe malnutrition than the general population"[7]. This makes a case for social justice in health, for 'putting in place institutional mechanisms for accessing health care and health services as pathways for realising fairness and fair opportunities' as the societies are not the same'.[8]

Poor tribal health status in India reflects across various reports (citation needed). A complex interplay between socio-political, economic and cultural conditions contributes[9] to the poor health situation. Through the project (AdEquAte) efforts were to create a more fine scale understanding of inequality patterns in multiple areas with tribal communities. Even though there are enough studies on biomedical research on genetic disorders which have contributed to a better knowledge of the genetic determinants of tribal health; however, the environmental and social determinants are less well studied[10]

For the health service providers Indigenous community are distally located in forest fringes or inside the forest who are in small numbers and hard to reach communities for the programme implementation. With the less budget available to the department, they are poorly positioned to start a new programme concerned with Indigenous communities. Indigenous communities are recognized for affirmative action by the Constitution of India and categorised as Scheduled Tribe (ST). This affirmative action is put into practice by the directorate of social welfare, so this department was considered as better stake holder for implementing the programmes meant for social welfare of Indigenous communities. As the strategy to engage with communities and other actors towards health as a social justice various actors were roped in to create the knowledge products which could lead to evidence-based policy engagement and help realise the 'policy action'[11].

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[6] Abimbola S The uses of knowledge in global health*BMJ GlobalHealth* 2021;**6:**e005802.

[7]OHCHR- Right to Health. Available from https://www.ohchr.org/documents/publications/factsheet31.pdf accessed on 22nd Feb 2022.

[8] Eddie Health justice springer

[9] Anderson I, Robson B, Connolly M, et al.: Indigenous and tribal peoples' health (The Lancet-Lowitja Institute Global Collaboration): a population study. Lancet. 2016; 388(10040): 131–57

[10] Ravindran TKS, Gaitonde R: Health inequities in India: A synthesis of recent evidence. 2017

[11] Realising the plan of action followed or pursued

Methods

The case under study

The case study was performed on the policy engagement strategies taken up under the AdEquAte project. This project sought to create a shared platform where the researchers, policy makers, community-based organization/ Indigenous community social movements and implementers were meaningfully involved in sharing their knowledge on health and health care aspects. This aimed to create knowledge products which were used to inform the policy engagement and creation of policy design towards the health of Indigenous community members.

The knowledge in the form of evidence, experience and expertise were developed into to knowledge products adding to the pool of knowledge. Various methods were used to engage community members, policy makers, implementers/service providers and health care seeking Indigenous community members. At the starting point the results of health inequalities survey conducted under THETA project were shared with department of tribal welfare and other actors which lead to conceptualization of innovative projects to address and strengthen the health and health care aspects of indigenous communities.

This partnership, between researchers and Indigenous social movement looked for active participation and interaction with civil society, programme implementers, health care seeking adivasis, and indigenous communities for identification and use of knowledge for policy engagement. The intent was to explore common interests for creation of evidence-based policy. This process was carried out during various stages for research and policy engagement processes. Our approach is to summarise the various methods used for understanding the knowledge needs and development of knowledge products which were used in policy engagement and policy design.

Table1. Methods used for policy engagement process.

Sl no	Method	Appraising the knowledge needs through various methods
1	Town hall style discussions between people's representatives, government official, Indigenous Community leaders with Indigenous community as part of silver jubilee celebrations of Indigenous community social movement.	Dialogue and discussions on • Indigenous communities culture • Forest Rights act • Education of Solega community children • Status of Solega community health and access to health care. • Agriculture and traditional occupation • Perspective on Solega community Development
2	Discussions and dialogues on health agenda during the Forest Rights Acts (FRA) meeting at Sub	Discussions on health agenda during the FRA meeting resulted in demand for

		district Level – The Zilla Budakattu Girijana Abhivruddhi Sangha has been involved in community access to forest. It was a part of ongoing struggle for indigenous community rights on access to land and forest.	• Appointment of more ASHA's for a population of 400 people in tribal areas which are distant and hard to reach. • Advocacy for Placement of MBBS doctors in Tribal PHC's. • Work towards improving access to health services for better population coverage through insurance schemes. • Ensuring that mobile medical units are functioning well with improved service coverage. • Development issues like improved connectivity, better basic amenities like piped water supply and electricity
3	Interviews with various actors for Indigenous health (Stakeholders Interviews): Stake holders were asked to share their experience on working with Indigenous communities and requirements for improving the health services for them.	Following needs were identified for improving Indigenous communities health • Issuing the Adivasi health card which would help them gain access to private medical facilities for the treatment free of cost. • Setting up de-addiction centers and care for mental health issues. • Providing basic facilities like Roads, electricity, water, and other amenities in distant or hard to reach tribal areas. • Ensuring Adequate HR in tribal PHC's • Setting Up Help line numbers at district and Taluka hospitals • Use of Walkie talkie for communication in the distant and hard to reach tribal settlements. • Encouraging their traditional medicine practices. • Need to understand the history of marginalised groups. • Discussions on Rights and services concerned on health with CEO, DC and Other civil society organizations. • Construction of Dharmashalas for Adivasi.	

4	In-depth Interviews with Health care seeking Indigenous community members.	Following themes emerged from in-depth interviews
	• About their family and their economic situation. • How did the disease start? • What did they do for the disease treatment? • Which Hospital they approached? • What happened after they reached the hospital? • Who helped them reach? • How did the staff in the hospital treat them when they approached hospital? • What difficulties did they face when they stayed in the hospital? • How did they overcome it? • Where they discriminated for being from Indigenous communities? • Was money expected from them for the treatment?	• Living in poverty and discrimination of being tribal's • Deep rootedness in social and cultural aspects of understanding health and its influence in health care seeking. • Out of pocket expenditures and indirect costs of treatment even in government facilities • Issues with communication with health care providers • Lack of resources for stay and food provision required for food provision required for care givers at hospital which interferes with continuation with hospitalization and complete treatment. • Inability to navigate the hospital systems for diagnostics medicine and other aspects • Less education and disadvantage of not having good quality education • Powerlessness and lack of good jobs with fair pay.
5	Health Inequalities survey Through a multi-stage stratified sampling technique non-tribal and tribal villages were mapped using geographic information systems (GIS) with vector layers A total of 1514 households were surveyed. 371 Biological samples (e.g. blood) were collected in addition to survey data in the BRT Tiger Reserve site.	Key parameters used to study the difference between ST and Non ST populations • Anaemia Prevalence in Children • Percentage of Stunting • Percentage of Wasting • Percentage of Underweight • Percentage of Children with all basic vaccinations • Percentage of Full Antenatal Care • Percentage of Diabetes among adults • Percentage of Receiving antenatal care from skilled provider

Shared platform for policy engagement

The shared policy engagement platform created through the AdEquAte project aimed to bring in various perspective of the stakeholders/ actors to share their knowledge and

experience. The platform or space provided opportunities to community to share their knowledge which helped them claim agency on their own. A similar approach was designed with other diverse stake holder like implementors, policy makers, decision makers at various levels giving them to bring their experience, evidence and expertise. Overall, the project provided virtual space where in different actors came together to contribute their knowledge to the policy engagement agenda adding to the pool of knowledge.

Involving Indigenous Community/People: This process started as the open discussions with Adivasi people using the forum provided through silver jubilee function of Solega Abhivruddhi Sangha. This process was further extended in the forest rights act meeting where in people discussed about health issues. Later in-depth interviews with 16 health care seeking Indigenous community members to understand the issues of access to treatment was taken up. At the end of the project an interaction with community leaders was taken up on how to use the research findings to shape the policy design to benefit the people were taken up.

Involving policy makers: The research evidence from THETA was used to develop an On-demand status of Indigenous communities in Karnataka. This was used to design innovative policy approaches to work on health issues. The proposed projects led to securing grants from Ministry of Tribal Affairs.

Involving Implementors: This process was achieved through stake holders interview where-in they brought their knowledge and experience of working with Indigenous communities. They pointed at making the systems to respond to the needs of Indigenous community members and strengthen the services and development of new schemes aimed to improve the health status.

Involving Researchers/ Academia: The 2 Indigenous community members were guided and mentored to take up research and develop knowledge products and use them to steer the policy engagement agendas. Researchers also gathered the evidence on the status of health through partnering with Indigenous social movements. They also guided them to take up rights-based approaches on health which was not a focus of Adivasi health.

This platform synthesised the knowledge and documentation of knowledge/ knowledge products into evidence for informing policy design and evidence-based policy making. The academia/ researchers used the opportunity to secure recurring grants meant for indigenous communities, there by expanding the work on research in similar setting where people from other ethnic communities or Indigenous people live and reside.

Results
Conceptualisation of disadvantage and marginalization.

Conceptualization of disadvantage and marginalization of the communities through lived experience of health care seeking Indigenous communities. A series of 16 in-depth

Interviews were conducted which looked at the social context of seeking care and experience of seeking health care in health facilities, their economic situation and finical distress associated with care.

Situation of Health care Seeking Adivasi Families

Hospital

No Adivasi healthcare providers in hospitals and limited insides of providers on the historical and social aspect on healthcare seeking

Indirect expenses on medicine and transport and lakh resources for food and stay for care takers

Social and economical disadvantage

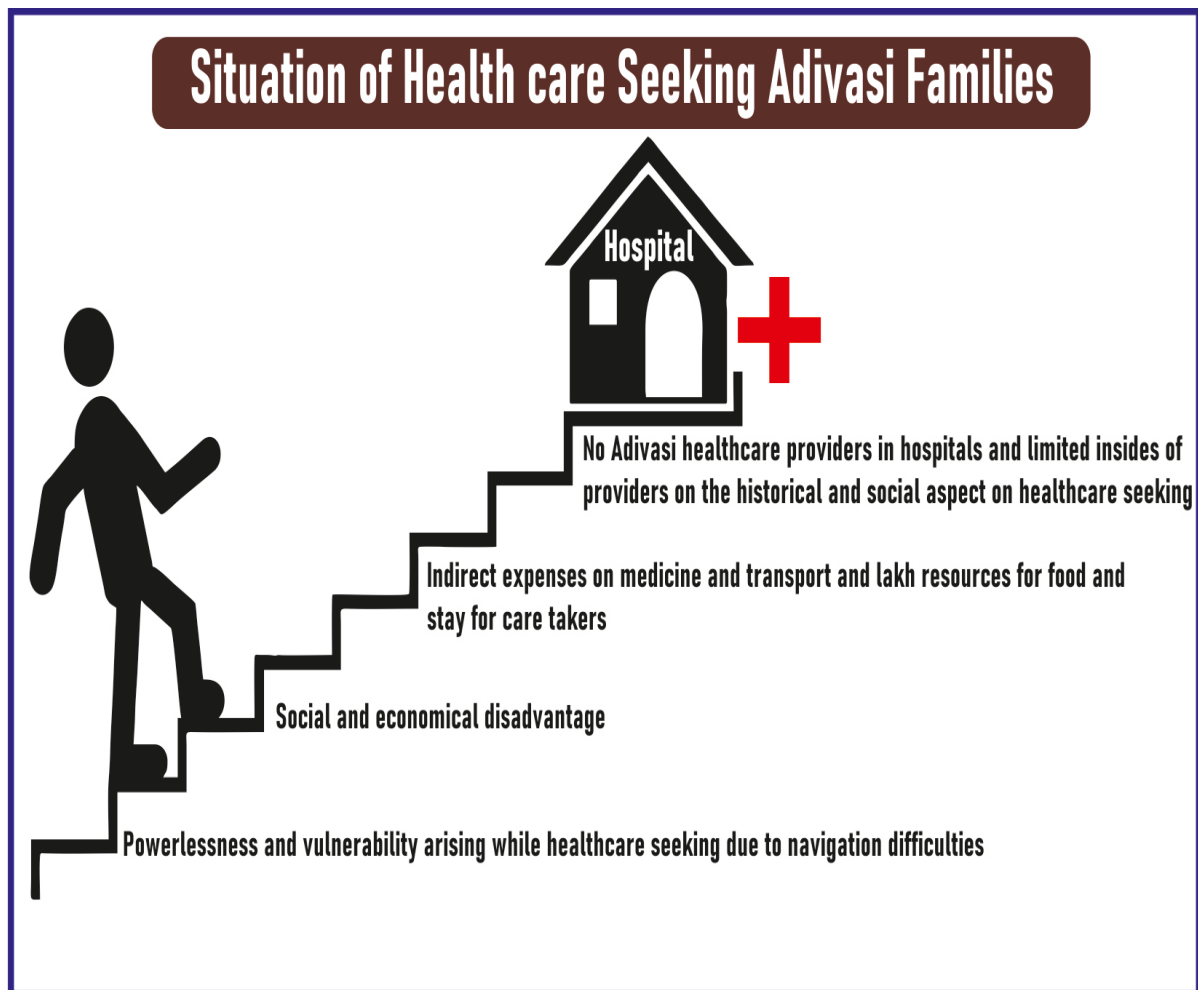Powerlessness and vulnerability arising while healthcare seeking due to navigation difficulties

Figure 1– Themes emerging from In-depth Interviews of health care seeking Indigenous communities.

Most of the forest associated Indigenous communities in Chamarajanagar district live in poverty and are powerless to secure well paid jobs. Since these are the communities relocated from the forest they have less education among the senior generation. Due to their meagre income lack of savings and social support and deep rooted cultural beliefs they usually seek socially accepted norms of seeking care through talking to priest and other solutions offered to them by people residing in their locality. For them to seek care at proper time requires transportation to distantly located primary care centers where the treatment for exacerbated condition may not be possible requiring more money for seeking care even they approach the secondary and tertiary care. This leads them to discontinue treatment once they have exhausted their financial resources. They also have communication issues with health care providers where they fail to

understand the advice by hospital staff. Added to this is the non availability of space to stay for patient attainders and support the course of full hospitalization. These themes identified guided the policy engagement process with concerned officials at various levels to raise demand for minimum requirements for completing the course of hospitalization. This voice on access health care was supplemented with research findings from the THETA[8] survey with specific service delivery related to quantifiable health care and outreach services, and health inequalities between tribal and nearby non tribal communities were shared with district and state level stakeholders, for agendas for increasing the prioritization of these problems amongst policymakers. The on demand technical assistance for innovative projects was provided to directorate of tribal welfare.

Appraising the knowledge needs through Policy Engagement

Various tools were used to capture the knowledge[12] needs on Indigenous community health for affirmative policy action. The various actors who provided knowledge on people's health in various forms have been classified into four types based on the type of knowledge they brought in as a process towards the Indigenous peoples health issues. This knowledge has been classified into three types, expertise, experience, and evidence. By expertise we mean expert skill or knowledge in a particular field or "technical expertise"[13]. The term experience refers to "practical contact with and observation of facts or events"[14]. Lastly the term evidence means the available body of facts or information indicating whether a belief or proposition is true or valid[15]. Overall the knowledge shared by the various actors was used in ongoing policy engagement towards generating evidence based demands for change in Indigenous community health care access.

Table 2 Locating the evidence expertise and experience of various actors involved in shaping the policy engagement strategy in AdEquAte project.

Actors for Policy Engagement	Evidence	Expertise	Experience
The State (Directorate of Tribal Welfare)	openness to receive evidence from people who have	Providing a mandate to leverage expertise.	Experience of working on developmental

[12] facts, information, and skills acquired through experience or education; the theoretical or practical understanding of a subject. (oxford Dictionary)

[13] Oxford dictionary -
https://www.google.com/search?q=expertise+meaning&oq=expertise+meaning+&aqs=chrome..69i57j0i512l9.18933j1j7&sourceid=chrome&ie=UTF-8

[14] Oxford dictionary
https://www.google.com/search?q=Exprience+meaning&oq=Exprience+meaning+&aqs=chrome..69i57j0i10l9.8960j1j7&sourceid=chrome&ie=UTF-8

[15] Oxford dictionary
https://www.google.com/search?q=evidance+meaning&oq=evidance+&aqs=chrome.0.69i59j69i57j0i10i131i433l5j0i131i433j0i10j0i10i131i433.4181j0j7&sourceid=chrome&ie=UTF-8

	expertise on issues of Adivasi health.		aspects of Adivasi people.
The knowledge systems (Researchers and academicians)	Inclusive and participatory approaches to programme design	Deriving transformative knowledge from research projects.	Embeddedness in in community providing a base on trustful relationships.
The service (Various Actors involved in adivasi health issues viz NGO's, Charitable Hospitals, Primary health centres medical officers, Taluk Tribal Welfare officer)	Practice based Knowledge on what works to improve the health of adivasi people.	Engaging with communities and working with health and developmental issues.	Programme Implementation and gaps in implementation of programme
Affected Community/ Adivasi- (Adivasi communities, Adivasi community leaders and CBO's.)	Shared understand among communities on social economic cultural and political aspects of Adivasi community and their health	Reaching out with community voice to the concerned authorities	Their own lived experience concerned with health and health care

Policy Engagement strategy to develop knowledge products to inform policy or programme related to Indigenous Health

Through THETA[1] the researchers were working in close association with directorate of tribal welfare. The results of health inequalities survey were ready by mid 2019 this provided an opportunity to engage with directorate of tribal welfare and other concerned department to discuss the research findings. A dissemination workshop on the knowledge of research findings were organised involving various government departments and Zilla budkattu Girijana Abhivruddhi Sangha (Sanga). This helped the researchers prioritise the health agenda in the processes of the Directorate of Tribal welfare. An on demand situational analysis of the tribal health status in Karnataka was done. This evidence on health inequalities helped to identify several points for improvement of Tribal health. The researchers were invited to suggest on innovative programmes towards improving the tribal health which could be funded by Government of India. Article 275(1)[16] of Indian constitution, provides grant in aid from consolidated funds of India is used to sanction development schemes which can be undertaken by the state with the approval of the Government of India for the purpose of promoting the

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[16] Government of India Ministry of Tribal Affairs. Guidelines for allocation of funds and implementation of Programmes/Activities under Proviso to Article 275(1) of the Constitution of India during 2020-21 and onwards. Available from https://tribal.nic.in/downloads/Article275/Article275Guidelines.pdf. Accessed on 29th July 2022

welfare of the Scheduled Tribes. Working in association with the department of tribal welfare a draft plan on health and education was developed and shared with Project Appraisal Committee (PAC) Government of India (GOI)- Ministry of Tribal Affairs (MOTA) for financial approval towards the project. The discussions of PAC and Government of Karnataka on the proposal led to approval of grants in aid for the financial year. Revolving grants were secured by the tribal welfare department, for mapping ethno medicinal practices, establishment of tribal health cells in community medicine departments of concerned government medical colleges. Providing basic Infrastructure to PHC's, improving health care access to Adivasi population (construction of Dharmashalas) along with strengthening public engagement with science, environment and health behaviour among forest dwelling tribal communities. These funds are allocated on a revolving basis every year. (Citation needed) These were the larger wins of framing the policy which needed to be realised. The Representatives from the Indigenous people's movement were appointed to pursue policy engagement with various actors to pool in the knowledge from other actors, identify new knowledge which could be added to the pool of existing knowledge on Indigenous people health.

In order to support the policy action for the approved project various actors were roped in for their knowledge on Indigenous health issues. The processes were documented adding to existing research knowledge there by filling gaps with knowledge products emerging from engagement. They actively engaged with various actors to understand and document the knowledge needs, the table below explains the various forms of knowledge and tools used to create knowledge products.

Table 3 Knowledge needs and knowledge products

Actors	Knowledge Needs provided	Tools Used	Type of knowledge	Use of knowledge
Researchers and Academicians	Evidence on quantified health inequalities of Indigenous population on access to health services compared to non Indigenous people.	Survey on access to health services and collection of biological samples to establish health inequalities.	Evidence on health inequalities for increasing access to health services	Knowledge used for giving inputs for an innovative policy design
Directorate of Tribal Welfare	Use of statutory compliance for affirmative action on Scheduled Tribes through grants-in-aid under provision to Article 275(1) to bridge the gap between ST and Other population	Designing a policy for financing programmes on tribal health.	Experience of working on developmental aspects of Indigenous people.	Securing the recurring grant for the project on tribal health.

peoples representative	Status of health and development of Indigenous Communities	Town Hall type discussion with Peoples representative.	Experience sharing with demand for affirmative action through the government	Bringing the status of Indigenous communities to central government.
Non Governmental Organizations and charitable hospitals.	Experience of working with adivasi community on their health and developmental issues.	Stake holder's interview.	Experience of lack of human resource in tribal areas. Need for Non communicable diseases and primary care for ailments. Free medicines to be made available to the community	Strengthening the work of Tribal Primary health centers by providing basic infrastructure facilities to PHC. More number of medical mobile for primary care
PHC medical Officer	Need to work on preventive aspects of the disease and early treatment of disease	Stake holder's interview.	Experience of treating tribal people	Call for communities to get treated at early stage of the disease
Zilla budakattu Girijana Abhivruddhi sangha and social movement leader.	Experience and difficulties of adivasi people seeking care.	In-depth Patient interview on experience and difficulties, who sought or seeking health care from rights and equity based perspective	Experience	Policy Inputs towards construction of dharmashala. One Indigenous social worker at public Taluka hospitals and district hospital Nodal officer at medical college and District Hospital
Hamlet level leaders and Indigenous community	Knowledge on social economic cultural and political aspects of Indigenous community	Stakeholder's interview.	Lived experience of Indigenous communities concerned with health care	Reaching out with community voice to the concerned authorities

It also included inputs from other actors concerned with Indigenous community health issues. The knowledge needs assessment extended to engaging communities in policy processes linked to social justice struggles. The community engagement strategies were

based on already created platform on the issues on access to land and forest rights of the Indigenous communities through Forest Rights Act (FRA)[17].

Framing the knowledge generated from policy engagement towards Policy or programme structure

The health systems in Karnataka are engaged with provision of health care across Karnataka for the entire population. And the Indigenous communities are hard to reach people and poor coverage of services in rural/difficult areas are often limited which are reflecting in regular surveys like NFHS. So the directorate of social welfare is brought in to frame new projects where the regular health systems fail to perform accurately in terms of service provision and outreach.

As per framework from Abimbola on use of knowledge on global health[18], the Knowledge generated has primary and subsidiary users, the research evidence brought out by academia and research institutes are subsidiary to knowledge from practice arena (knowledge generated from implementation). The knowledge of distant decision making (by policy makers) is subsidiary to implementation (implementers who gain knowledge or learn by implementing the policy). This distinction suggests four uses (or units) of knowledge (table -4) Two uses/units are primary: emancipators or Communities and CBO's who are the people using knowledge to transform the structural determinants of their own health. Plumbers or department of social welfare these are implementers using knowledge for change. Another two uses/units are subsidiary: engineers or researchers and academia are policy designers using knowledge from primary units and civil society who seek new knowledge for implementation.

Table: 3 Units of Knowledge uses

Position	Activist /constructive	Corrective/ Accepting.
Proximate	Indigenous communities Sangha leaders, Community leaders and peoples representatives.	Government department
Distant	Researchers and Academicians.	NGO's community organizations.

Adapted from Seye Abimbola[17]

For the quest for equity in health, knowledge on experience of health care seeking was produced primarily by health/health care seeking Indigenous people who shared their experience to 'generate small wins—that is, continuous day-to-day 'organic' micro-innovations'. On the other hand the directorate of tribal welfare (government department- subsidiary) use the knowledge for 'often large wins, or 'surgical' or major innovations, designed or enacted'[4] as a policy. Researchers brought in their academic knowledge to design an overarching framework for the directorate of tribal welfare to

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[17] Ministry of Tribal Affairs Forest Rights Act (FRA) https://tribal.nic.in/FRA.aspx
[18] Abimbola SThe uses of knowledge in global healthBMJ Global Health 2021;6:e005802

work in unison with other government departs to implement the policy. While the NGO's and other stakeholders brought in their knowledge to fill in the smaller and finer aspects of working with communities which would cater to the improvements in overall health care for Indigenous communities. Here the Directorate of Tribal Welfare was subsidiary i.e, it was brought in to help Indigenous community when the existing health systems have failed to deliver or cater to health needs of Individual.

Application of Knowledge for policy design and action[17]

Communities and CBO's The knowledge on Indigenous people's experiences seeking health care relay on their own experiences, and they indicate them when they need the help of the government department. The Indigenous communities are those who use their knowledge to transform the structural determinants of their own health. They use their knowledge to construct new reality for them and seek alterations of social structures and rules that put a disadvantage to them.

The social welfare Department The Government department provides help when requested and offer help when their access to evidence for affirmative action is weak. They are implementers using knowledge for change. The Government department produce knowledge from implementing their programmes and services. They learn by doing.

Researchers The researchers offer help and evidence towards the goal of improving the health status of Indigenous communities. They are policy designers using knowledge from people. They bring in academic evidence and create an overarching framework within which government department would function. They share knowledge through publication and teaching they package and some time generate new knowledge.

Other Actors: The NGO's civil society, community organization and other actors work on engaging with government system to modify, continue or discontinue the policy engagement process. They are the ones who offer help when the government structures are weak bringing in their knowledge. Their experience in providing health and development activities bring in knowledge of implementing the programmes.

The Indigenous communities are activist or constructive people who generate knowledge from their experiences demanding the need for change structures which improves their access to health services. Social welfare departments are people who use the knowledge to correct the health status and are proximate actors who cater to needs of community. Researchers are constructive actors who generate fame work in the form of creating a policy which could be used to benefit the community they are distant actors to facilitate change. The NGO or community organizations are the people who have knowledge on filling the gaps when the existing systems fail in to deliver. These units of Knowledge

change positions of being proximate, distal, constructive or corrective at various levels starting from community level to global level.

Results of incorporation of Knowledge into policy engagement through advancing equity.

Incorporating Indigenous communities and their voices

The project incorporated Indigenous communities and their representatives to interact with Directorate of Tribal Welfare (government Department) to hear from communities on their views about the situation and discuss solutions to it. This process was carried out in the form of town hall style discussion with peoples representatives, direct discussions with directorate of tribal welfare on ground level realities related to Indigenous communities. The discussions have been taking place on regular basis at State and District level. These served as the formal platforms to discuss issues related to Indigenous communities leading to acknowledgment/ hearing and learning from the primary knowledge of Indigenous communities. Through this opportunity Indigenous communities were able to make 'small wins[17] concerned with communities day to day needs on health and development.

Facilitating the Indigenous community's social movements for knowledge generation

The researchers worked in close associations with Indigenous community representatives guiding and working with them to develop rights based approaches to health. These efforts were reflected in the form of knowledge products developed by policy engagement with various actors leading towards policy action efforts. This work was to encourage the ability to learn for their own work and 'develop their own learning structures, as they iteratively produce and use knowledge'[3]. Overall efforts were to introduce the movement representatives to understand and develop rights based approach into their work which could feed into their engagement with various actors and government systems.

Creating sustainable platform to effectively monitor the progress of Policy action

As a part of effective mechanisms to monitor the progress of policy action the movement representatives have been in consistent touch with government departments to ensure that policy is being implemented in a phased manner. The creation of Tribal Health Cells to ensure that knowledge needs are being met through community involvement and the study of Indigenous population health goes ahead through developing a manual which would act as guide to take up research on Indigenous health issues from Indigenous community world view looking at social and structural determinants of health of the communities rather than a narrow biomedical point of view. And the research from tribal health cell focuses on socio political and economical, aspect of things rather than just a biomedical perspective which focuses on illness and its determinants.

Discussions

Leveraging knowledge products for equity orientation

The knowledge[11] brought in by various actors are not the same and they do not have the same power (citation needed). The ideal role of a research organization is that it helps appreciation of how differences in social position and power shape identities and access of different actors and does not treat them as equal and their knowledge are not equal and one has to treat the knowledge's differently(Citation). The lived experience that cluster level grass roots leaders bring has to be transformed and given more power, as the programme or policy is to be rolled out to the concerned community. Academia here takes different idea but they are not activists and they bring this different knowledge into negotiations and also the diverse histories. There is also no history of engagement between health department and adivasi social movements. Working with Indigenous communities for a long time has brought in regular engagement between researchers and Indigenous community movement. The role played by the researcher is to amplify the community voice by leveraging the research findings to enhance the need for action required on the community voice. The knowledge of various people has been pooled and was used to leverage it in platform. The Idea is to include the voices from marginalised communities from various processes into discussions and use the knowledge to achieve equity. Eventually the CBO's and Social Movements should be able to do this on their own. But in this case because of historical process the CBO's and Indigenous movements, on long term the policies and projects on these needs to figure out an exit strategy. The activist should be capacity build to lead and set their agenda on their own.

How could inclusive policy engagement mitigate knowledge injustices

The Indigenous social movements have been taking up rights based approaches for enhancing or betterment of the living conditions of Indigenous communities. They have been involved with this kind of struggle for longer time in the form of writing letters and staging protests for fulfilling their requirements for better living conditions. Their network has been active in identifying people who are ill and need hospitalization for their health conditions. Hearing the voice of people with lived experiences help mitigate knowledge injustices generating the knowledge from Lived experience. And this is central to addressing the health care demands from Indigenous population. They rarely get to interact with concerned social welfare department or health department. When platform is created for such an exchange of information or knowledge it will lead to positive acknowledgement and affirmative action's making or allowing the systems to be more responsive to the needs of Indigenous communities.

Use of knowledge in global health a Frame work.

This framework helps in understanding how the knowledge developed by various actors interplay during the policy engagement. It helps to draw lessons from the use of

knowledge in various forms of policy engagement. The knowledge developed by actors brought together into the platform helps to realise the need for collaborative action with customised designing of the programme which help realise action on health aspects promoting equity centric practices. Since the social welfare department is concerned with affirmative action on ST they can leverage the knowledge into more customised community centric programmes which help mitigate the social inequalities helping communities address the proximal and distant causes of health and health care efficiently. Overall this frame work helps in construction of new paradigm by pooling the knowledge from various stake holders. It also brings in the Intersectoral action required to address the equity aspects as a central theme.

Role of lived experience in policy engagement

As described earlier in the section lived experience brings in the social construction of realities in which the communities live and experience health. It also brings in the need to look at equity orientations beyond health care required for healthy living conditions calling for action on social determinants of health like better education, well paying jobs, better preventive programmes at community level. It also helps explain the equity aspects comprehensively directing the state/ policy makers to design and implement customised need-based programmes to reduce social vulnerabilities among the marginalised Indigenous community. Conceptualising the equity aspects from broader societal angle helps in developing better planning to address and improve the living conditions in which communities struggle to achieve. Overall lived experience helps in understanding the health situation of the marginalised communities and overall marginalisation which calls for comprehensive affirmative action from the concerned department.

Conclusion

The aim of this policy engagement process is to include the knowledge from Indigenous communities on their health and design projects and prioritise the research catering to the day-to-day needs demanded and represented by the communities leading to overall improvement in the health which caters to their wellbeing. Advancing equity into the overall situation of marginalised Indigenous communities needs a deeper understanding of their life situation and dimensions rather than just a biomedical approach of understanding and solutions to that. The aim is to prioritise the knowledge from Indigenous population over what the government departments, researchers/policy makers and other stake holders think as priority.