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From the Tea Gardens to the Clinic: *Adibaxi* Health in Assam and Caste and Indigeneity in Indian Modernity, India

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Abstract

The tea plantations of Assam, remnants of the British *Raj* in postcolonial India, comprise an important epistemic site for interrogating transformations in the ancient caste system within Indian modernity. Two theoretical interventions become possible through a social inquiry that begins in the plantations of North-East India. First, refuting the alleged "castelessness" of Hindu majoritarian societies like Assam in North-East India, the article discusses how articulations of Indigeneity in India are inflected by the caste-system. Second, it demonstrates the embeddedness of caste-based human differentiation within a central node of postcolonial development—the clinic. Analyzing caste as a trenchant ordering principle in India, in this article, I argue that practices and experiences of caste-based human differentiation have transformed in postcolonial India. The article describes how caste inhabits India's postcolonial medical institutions in a new scientized garb, bolstering overt casteizing practices with a euphemistic discourse of bio-behavioral deviance. I demonstrate how the Indigenous Adivasis, specifically the tea plantation laborers of Assam colloquially termed as the *Adibaxis*, became the object of caste-based socio-biological differentiation both within the plantation and in public health institutions. One of the main conditions of life in the tea plantations of Assam is inadequate medical care. Taking health and healthcare infrastructures as sites of anthropological and critical caste inquiry, I describe how caste-based dispossession is reinscribed onto the bodies of *Adibaxi* tea plantation workers through persistent medical exclusions.

Keywords

Caste and indigeneity, Tea plantations in Assam, Medical exclusions, North East India

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Introduction

It was a hot day in the typical sweltering summer of Assam in 2022. The heat had been intensified by the invisible humidity that hung about in the air, brought on by the seasonal monsoons in this north-eastern region of India. I had just stepped out of the managerial office suite of a tea plantation in Assam that I will call Maikan. Only moments ago, I acquired permission to conduct ethnographic research on the lived experiences of sickle cell disease—an inherited blood disorder—among the plantation workers of Maikan. Stepping out into the veranda of the single-storied colonial structure that made up the plantation management's offices, I was met with a group of Maikan's plantation workers who were summoned to the managerial offices. The people stood forming a neat line in the veranda with curious looks on their work-weary faces, likely wondering why they had been asked to gather in the plantation offices in the middle of what was a busy workday.

Unbeknownst to me, one of the plantation managers, the welfare manager, summoned the workers to introduce me and to inform the workers that I would be a familiar face in Maikan. This eclectic representative of the workforce of the plantation were the descendants of a special group of Indigenous Adivasis brought in the nineteenth century from central and eastern India by the British colonial administration to work as indentured laborers (Sharma 2011). So unique is their history of colonial displacement that today they are referred to as *saah jonogusthi* or the "tea tribes" of Assam.[1] Furthermore, these Adivasi communities are colloquially termed as *Adibaxi* (pronounced as aa-dee-baa-xhi). This Assamese inflection of the Indo-Aryan term 'Adivasi' makes for a linguistic classification that distinguishes the *saah jonogusthi* from other native Indigenous communities of Assam or the tribal communities. Within such linguistic distinction, *Adibaxi* connotates displaced Indigeneity marked by coerced migration whereas the term "tribal" connotates emplaced Indigeneity representing ancestral relationships to land. In the postcolonial tea plantations of Assam today, owing to these social histories, *Adibaxi* communities are largely locked into poorly compensated plantation labor living in abject socioeconomic conditions.

That day, the welfare manager, a privileged caste Hindu Assamese man in his early twenties, spoke in a definitive voice addressing the gathered workers: "This *Baideo* (meaning 'older sister' in Assamese, a term of respect for women) will be coming to our plantation to work amongst you. She is interested in learning about your wellbeing. Try to cooperate with her." Such a directive introduction was essential to legitimate my presence on the plantation. After exchanging these initial greetings and

[1]Assamese is the connecting language in Assam and is also the language in which this research was conducted.

cursory introductions, the workers left to resume their workday. Once they were out of earshot, the welfare manager said to me in a gentle yet cautious voice:

> I will connect you with an ASHA[2] *kormi* (government-affiliated female community health workers). Please go to the *Labor Lines* only accompanied by an ASHA *kormi*. Please keep in mind, and I strongly advice you, do not under any circumstances, go the *Labor Lines* alone.

Labor Lines are the iconic dwelling spaces of *Adibaxi* workers located at the edges of the plantation, at some distance from well-built and well-serviced managerial bungalows. These are mostly mud huts arranged serially on either side of a sometimes paved, often unpaved, alley. These *lines* of mud huts frequently lack the basic amenities of life, like running water and a built toilet. The welfare manager's warning to me to never go to the *Lines* alone perplexed me. It became a defining moment in my ethnographic research capturing the asymmetries of regnant caste and class relations within Assam's plantations. I wondered, what was the portent of hostility that was so palpable to the welfare manager and yet that which remained elusive to me throughout my engagements with the workers, both during and after that summer day? Quite predictably, caste and class relations in the plantations constituted the essence of the omen that motivated the welfare manager to warn me: "do not…go to the *Labor Lines* alone." This article, in analyzing caste as an ordering principle that inflects articulations of Indigeneity in India, traces caste and class power in Assam's tea plantations from labor relations to the clinic.

Within Assam's post-colonial plantations, the management predominantly comprises "upper caste" men or Brown *Sirs*, 'Sir' being the formal term used by *Adibaxi* workers to address the managers. In stark contrast, the labor force of the tea plantations constitutes almost exclusively of the Indigenous *Adibaxis* working in the plantations for notoriously low wages. These casteized labor relations spill over to the clinical domain, reflecting on one hand in caste-based clinical expressions of *Adibaxi* backwardness as the cause of their poor health. On the other hand, tensions arising from these casteized labor relations are expressed through deep-seated resentment among the workers regarding the crumbling tea plantation hospitals and the difficulties of accessing care in the public health system. (I detail these tensions in a subsequent section.)

Being from Assam, long before embarking on ethnographic research in the tea plantations, I was aware of the tenuous relationship between the plantation management and the *Adibaxi* workers. It was also public knowledge that these tensions spilled over

[2]ASHA stands for Accredited Social Health Activist. These are female community health workers associated with the national and state-level public health systems.

into the clinical domain, with newspaper articles reporting on confrontations between plantation medical establishments—involving physicians, nurses, and community health workers—and the *Adibaxi* tea plantation workers. These confrontations made it to the news only when they turned violent, particularly in the event of the death of a community member either during or after medical care. The welfare manager's warning to me not only brought these everyday realities to stark relief. But it also situated my anthropological investigation of caste-based human differentiation in the clinic within the structural dynamics of caste and class power within the plantations.

While my broader ethnographic research focused on the lived experiences of sickle cell disease among the *Adibaxi* workers of the tea plantations, in this article, I focus on overall *Adivaxi* health to demonstrate how caste-based dispossession is reinscribed on Indigenous bodies through persistent medical exclusions. Moreover, medical care and healthcare infrastructures within postcolonial plantation assemblages aptly represent how caste-based human differentiation shape Indigenous belonging (Rycroft & Dasgupta 2011) in Indian modernity. Considered "primitive" through the logic of caste hierarchy (Dasgupta & Basu 2012), the Indigenous peoples of India are already relegated to an evolutionary alterity. As an Indigenous region in a Hindu majoritarian nation, North-East India inheres this alterity, colonially described as a "Mongolian fringe" inhabited by *junglee* or wild people with peculiar cultures, customs, religions, foods, and sociality (Baruah 2020; Kikon 2021). Contrary to settler colonial histories of Indigenous dispossession in the Western world, such *Brahmanical* characterizations of Indigenous "primitive" alterity in India justifies either persistent dispossession among these communities, or continuing threats of dispossessing. Diminished health and failing healthcare infrastructures are central components of this structure of identarian disempowerment.

Drawing upon long-term ethnographic research conducted between 2021 and 2024, the article discusses how difficulties in access to healthcare among the *Adibaxis* of the tea plantations of Assam—embodying a troubled Indigenous identity—demonstrates a transformation in the practices and experiences of caste-based human differentiation in postcolonial India. Furthermore, even within the existing medical infrastructure, *Brahmanical* notions of Indigenous alterity seep into clinical spaces, consolidating a constructed *Adibaxi* alterity through an essentialist language of biological difference, scientizing in turn an ancient hierarchical order of organizing human bodies in Indian societies.

Within the everyday lives of the *Adibaxis*, through my ordinary interactions with the plantation worker community, what was palpable to me was not an inherent hostility embodied by the "primitive" *Adibaxi* bodies inhabiting the *Labor Lines*. Rather, the violence immediately evident to me was the structural violence (Farmer 2004) embedded in the socioeconomic and medical institutions of the plantations that

continually disempowered these historically displaced Indigenous communities. Such structural violence takes the form of low wages on one hand and dilapidated plantation hospitals and medical discrimination against the *Adibaxis* in public health institutions, on the other. Thus, the possibility of hostile confrontation shaped by caste and class positionalities, expressed notably by the plantation managerial staff and health workers, formed a complex backdrop for my ethnography of *Adibaxi* health in the plantations. At times, this backdrop materialized as lithe PVC banners prominently displayed outside scantily equipped plantation hospitals, explicitly stating that violence against medical personnels was a punishable offense. At other times, as the welfare manager expressed, it was spoken in hush tones as lived accounts of "primitive" hostility, within and without clinical spaces.

The remainder of the article discusses these complexities within two broader contexts: first, *Adibaxi* and Indigenous becoming in the allegedly "casteless" Hindu majoritarian society of Assam; and second, the embedding of caste-based human differentiation in the medical clinic as experienced by the *Adibaxis* in the public health system. The next section hence begins with a discussion of the first context, exploring how caste-based notions of human difference shape Indigenous belonging in Assam in particular, and North-East India more broadly. The section that follows discusses the manifestations of these structural dynamics as health inequality, with a focus on the tea plantations. The final section analyzes *Adibaxi* experiences of identity-based human difference within clinical spaces. The conclusion reflects on the transformations of caste-based human differentiation in modern India through "euphemistic" discourses of perceived human difference (Bridges 2011), repackaged as the bio-behavioral deviance of the *Adibaxis.*

Caste, Indigeneity, and being *Adibaxi* in Assam

In the introductory section, I mentioned how Indigeneity in India cannot be adequately explained through the framework of settler colonialism employed elsewhere, one based on a clear conceptual distinction between Indigenous original inhabitants and colonial settlers. Elaborating on it in this section, I align with social theorists who have raised similar arguments with respect to Indigenous identities and histories in Southeast Asia (Chua & Idrus 2022). Contrasting with theorizations of Indigeneity in the Western world, in South Asia and Southeast Asia therefore, continuous and repeated migrations make clear conceptual distinctions between the original inhabitant and the settler not only difficult, but futile for comprehending the lived realities of Indigenous positionalities. Adivasi scholar, Virginius Xaxa instead called for a need to acknowledge how the "non-recognition" of the rights of the tribal or Adivasi communities over their "land, forest, water, minerals, and other resources in their own territory…has led to increasing articulation of the idea of indigenous people by

the tribal people" (Xaxa 1999). In other words, continued disempowerment rather than histories of migration and settlement shapes Indigenous identities and contours Indigenous belongings in India.

In this section, I argue further that this "non-recognition" of the rights of the Indigenous peoples is based on *Brahmanical* notions of Adivasi alterity that is at once social and biological, conferring a less than civilized and hence, less than human status to the Adivasi peoples. This is even as the Adivasi is increasingly sought to be assimilated into the caste order as a Hinduized tribal. Nowhere is this constructed alterity more apparent than in the tea plantations of Assam.

Let us return for a moment to the welfare manager's warning in Maikan: "do not…go to the *Labor Lines* alone." This caution is a pithy representation of how identity-based systemic exclusions—structured through an amalgamation of caste and class privilege (Teltumbde 2016)—construct Indigenous alterity in India. The *Labor Lines* that I was warned about are those spatial assemblages of the plantation ecology that are attached with an almost folklorist symbolism pertaining to the social reproductive sphere of the workforce of the tea plantation industry. This identarian symbolism denotes a discrete Indigenous identity that simultaneously embodies colonial displacement and postcolonial exploitation, framing the *Adibaxi* as an ahistorical descendant of indentured tribals. Drawing upon this folklore tinged with the tensions of casteized labor relations, the welfare manager's warning constructs the *Labor Lines* as an intimate sphere where only a "primitive" sociality may be reproduced. Extrapolating this "primitive" sociality to the constitution of bodies and behavior, cautionary expressions ultimately reframe the *Adibaxi* as prone to hostility, characterizing the *Adibaxis* as unreasonable and intractable. Such characterizations shift the causality of violence onto the working-class body while erasing the everyday structural violence that structures the intimate sphere of the *Labor Lines* within the plantation economy.

Going beyond casteized labor relations, such cautionary tales as narrated by Maikan's welfare manager confirm how even managerial objectives relating to the welfare of the workforce, a subset of the managerial responsibilities that is concerned with sustaining the health of the tea plantation workers, is laced with caste-based assumptions of *Adibaxi* alterity. These assumptions and their discursive expressions serve to overlook the material circumstances of medical infrastructures available for pursuing *Adibaxi* health in Assam's tea plantations. The erasures of structural violence become apparent when one considers the severely resource-constrained conditions of the plantation hospitals, as detailed in a subsequent section. Moreover, in the context of Assam, *Adibaxi* loss of health and well-being trouble broader assertions about a post-caste Assamese society (Sengupta & Bharadwaj 2021). Rather, the *Adibaxi*

body exemplifies how interpersonal relationalities and regional political identities are shaped by the dynamics of unequal caste power, particularly in a Hindu majoritarian state like Assam.

In Assam and more generally in North-East India, due to constitutionally recognized ancestral claims of territorial belonging among the native Indigenous communities, caste is often undermined as an ordering principle in Hindu majoritarian regional states like Assam and Manipur. However, decadal attempts at assimilating the tribal communities—each with their own language, culture, customs, and often animist religions—into the Hindu order (Baviskar 2005) belie the pervasion of caste within these societies. In the case of Assam, my own lived experience as a Dalit woman from Assam, my ethnographic research as well as ethnographic research by other Assamese scholars have demonstrated that not just caste but "untouchability", including "untouchability" practiced against Indigenous communities (Barman 2022), are deeply embedded in the socio-religious fabric of Assamese society. In the light of such misrecognitions of the influence of caste in Hindu majoritarian states in the Indigenous frontier of North-East India, specifically the masking of the practices of caste-based human differentiation and "untouchability" in relation to the Indigenous peoples, it becomes not only important to interrogate how caste-power continues to operate in the Assamese society. But it is imperative to interrogate how caste permeates and prevails in clinical spaces through medical discourses and practice.

The remainder of the article situates this interrogation in the continuum between caste-based labor relations in Assam's tea plantations and medical discrimination in the surrounding public health institutions. Tracing this continuum illuminates, first and foremost, how conditions of labor and life in the plantations manifest as poor health outcomes among the *Adibaxis.* Relations of production in the tea plantations of Assam lock *Adibaxi* communities into circumstances of survival wherein the social reproduction of workers is sustained for the capitalist motives of the tea industry. However, when theoretical focus is shifted to the worker bodies, caste-based inequalities begin manifesting as various bodily afflictions among the *Adibaxi* communities. For instance, malnutrition is rampant in the tea plantations and worker bodies are chronically afflicted by anemia, aches and other preventable ailments (Dutta et al. 2016; Konwar et al. 2019). Further, the health indices of *Adibaxi* communities, particularly for girls, women, and children, are among the lowest in Assam. These indices are also largely true for other Indigenous communities of Assam.

Second, the body of the *Adibaxi* tea plantation worker is not only an empirical analytical category. But it is also a conceptual category through which to understand how caste-based practices of human differentiation have transformed within Indian modernity. Consolidating casteizing practices, such transformations highlight how

caste has adopted euphemistic discourses of Indigenous social and biological alterity. As the ethnography below demonstrates, *Adibaxis* are indeed treated differently within medical institutions. It is noteworthy that one of the pertinent insights that emerged from my broader ethnographic research on Adivasi sickle cell experiences is that these communities face caste-based discrimination within medical institutions in the public health system. Such discrimination is routinely masked through euphemistic medical discourses that construct the Adivasis or tribals as "backward" and hence, unable to care for themselves in a manner that can augment their health.

Elsewhere, I write about the biologization of caste through sickle cell genetics, naturalizing caste-based notions of Indigenous Adivasi difference through scientistic discourses of the genetic basis of human difference. Here, my focus is on medical comportments towards the Indigenous *Adibaxi* body in its totality within clinical spaces. In the context of Dalit experiences in medical institutions in southern India, Sobin George has shown how identity determines the quality of healthcare received by Dalit patients in rural Karnataka (George 2019). Likewise, the *Adibaxi* plantation worker body is central to illuminating the euphemisms of caste-based human difference operating in the medical institutions of the supposedly "casteless" (Deshpande 2013) society of Assam, highlighting how caste persists through scientized languages within a central node of Indian modernity, that is, biomedicine. As the following sections demonstrate, these euphemisms manifest as perceptions of the *Adibaxi* as a bio-behaviorally deviant, clinically suspect medical subject. Such euphemisms of caste in clinical spaces hence raises the following pertinent question: What becomes of Nehruvian "scientific temper" (Arnold 2013), the foundational basis of the developmental trajectory of postcolonial India, when confronted by the transformations of caste in India modernity?

In Assam as in the rest of India, socioeconomic capital and institutional power largely rests with the *Brahmans* and the so-called "upper castes." This has meant that most physicians within public health institutions also belong to these privileged castes. When the broader Assamese society is stratified along the lines of caste and Indigeneity in this manner, it follows naturally that such hierarchies are embedded in medical systems. Writing about the embeddedness of racism in the biomedical systems of the United States, anthropologist Khiara Bridges discusses the "deracialized racial discourses" that proliferate and persist in healthcare in the United States (Bridges 2011, pp. 179-182). Similarly, the subsequent sections in this article demonstrate caste in Indian modernity have adopted euphemistic biomedical discourses on caste-based differences in bio-behavioral tendencies, transforming caste into a socio-biological moral normative. Rearticulating the rhetoric of perceived Indigenous alterity is central to this moral normative.

Before unpacking this euphemistic moral narrative that masks caste-based medical discrimination as inherent tribal deviance, it is important to analyze how *Adibaxi* loss of health is constitutive of the plantation economy and ecology. The following section thus begins with a discussion of the health infrastructures that shape *Adibaxi* health experiences within the tea plantations of Assam and the surrounding public health institutions.

Adibaxi Health, Medical Infrastructure and Inequality in the Tea Plantations

Besides the identity of *saah jonogusthi* or "tea tribes," the *Adibaxis* of Assam have another ontological classification, that of the "ex-tea tribes." These "ex-tea tribes" are descendants of indentured plantation workers who have left the realm of plantation labor to find employment opportunities in mainstream society. Some among this community of ex-tea plantation workers live in collective settlements neighboring the tea plantations. For others, socioeconomic mobility allowed their integration with the larger Assamese society. Deep, an *Adibaxi* man in his mid-thirties, was a member of the "ex-tea tribe" community who lived outside such communal settlements, as an ordinary member of Assamese society. Deep's parents and grandparents were plantation workers, and his siblings too continued to work in the same plantation where their paternal ancestors were coercively translocated by the British colonial administration. As is inevitably the case, owing to the acquiring of college degrees and the ensuing relative economic empowerment, members of the "ex-tea tribe" community like Deep are adept at critiquing the systems that continue to keep *Adibaxi* communities in abjection. In conversations with me, many have poignantly articulated the structural violence that permeates life in the plantations. Lack of access to adequate healthcare and the crumbling tea plantation hospitals, aspects that directly impact the life chances of the *Adibaxis*, become objects of pointed critique. Such legacies of imposed privations have instilled a sense of deep indignation, be it among the *Adibaxis* who live and work as plantation laborers or the "ex-tea tribes." Deep's own indignation is important to register in this regard.

During a conversation with me in early 2022, Deep expressed his exasperation with the medical infrastructure in the plantations as follows: "To tell you the truth, *baideo*, when one visits these plantation hospitals, one can see what state they are in. There, sometimes, one cannot even find a piece of suture to close our wounds." ["*Xosa kobole gole, Baideo, ei baganor hospital keikhonoloi gole tar obostha tu gom pua jai. Ketiyaba tate gha seelaboloi xuta edalu bisari napai apuni.*"] A suture for surgically closing any bodily wounds, a *xuta* in Assamese, is a basic medical device, one that is as quintessential as a stethoscope in the clinic. This medical device is a

necessity for dressing physical cuts or wounds routinely sustained by workers during everyday labor and life. Yet, as Deep expressed, even such fundamental medical devices are scarce in the plantation hospitals. Deep's indignation hence communicated a sense of injustice that he felt at the persistent scarcity of even basic medical care in the plantation hospitals. However, his indignation is also diagnostic of the trenchant fissures in *Adibaxi* belonging in Assam.

Constitutionally, the Plantation Labor Act of 1951 mandates that the managerial bodies of all plantations across the country must establish and maintain adequate medical infrastructures within their premises to address issues of worker health. However, in Assam, as testified above by Deep and as is common knowledge, the plantation hospitals run by the managerial bodies are severely deprived of financial and human resources, being perpetually underfunded and chronically understaffed. These plantation hospitals are hence incapable of meeting even the basic health needs of the worker communities. The political economy of the tea industry justifies such inadequacies in legally mandated healthcare infrastructure with the plantations. This political economy has been continually reported in the media as undergoing an economic crisis due to diminishing auction rates and increasing costs of production compounded by climate change.[3] However, notwithstanding the economic vagaries in the prices of Assam tea, there is a more or less constant stream of supply and demand for this global commodity. Even as my ethnographic research was underway, I learnt that certain varieties of premium Assam tea are sold for an exclusive price of Rupees one lakh per kilogram (about 1100 US Dollars per two pounds).[4] In the wake of sustained domestic and international consumption of Assam tea, claims of economic crisis as a justification for underfunded medical infrastructures serving the workers therefore indicate a loss of managerial accountability towards worker health.

From the perspective of the plantation management dealing with this perpetual industry-wide crisis, it is sufficient to provide just enough financial compensation for the labor extracted from *Adibaxi* workers to sustain the social reproduction of a productive workforce. Additional financial investments in plantation health infrastructures are weighed against the cost-benefit calculations of overall profit motives. Predictably, investments in health infrastructures are almost always against managerial interests of profit maximization. Thus, the colonial era plantation hospitals remain in a state of constant dilapidation, teetering on the brink of collapse. Regarding the state of the medical infrastructure in the plantations, community members have often said to

[3]For a media report, see: https://timesofindia.indiatimes.com/city/guwahati/assam-tea-industry-facing-crisis-amid-rising-costs-and-declining-exports-say-atpa/articleshow/116602721.cms <Accessed November 2025>

[4]See: https://economictimes.indiatimes.com/news/india/rare-assam-tea-sold-for-record-price-of-rs-1-lakh-per-kg/manohari-gold-tea/slideshow/88314677.cms?from=mdr <Accessed December 2021>

me: "The plantations hospitals were much better during the time of the British. We have heard our grandparents say this. We were much better off during the time of the British." "*Baganor hospital keikhon British r xomoyote besi bhal asil, koka-aita hote kua xunisu. Britishor dinot ami besi bhale asilu.*" When I first heard this familiar refrain, I was confounded. It was unimaginable to me that the workers felt they were "better off," "*besi bhale asilu*" under colonialism than under postcolonial plantation administrations. This familiar refrain by the *Adibaxi* workers made evident to me how the political economy of the plantation necessitated the diminishing of *Adibaxi* health and life chances to maintain the poorly recompensated reproductive workforce.

Notwithstanding such exploitative reproduction, conditions of medical scarcity justified by the managerial bodies of Assam's tea industry have resulted in the worker community's loss of trust in the larger enterprise of biomedicine. A consequence of this loss of community trust, both in biomedical institutions and its practitioners, is that violent conflicts spontaneously emerge in the plantation hospitals when community health needs are not met, as I discussed above. In the aftermath of such episodic conflict, many plantation hospitals are left without a physician in regular attendance equipped to provide basic healthcare services to the plantation workers. Fearing for their safety in events of unanticipated medical conflict, physicians are known to be reluctant to serve in plantation hospitals further constraining community access to much needed medical care.

These infrastructural conditions thus force the *Adibaxi* communities to seek medical care in the neighboring public health institutions even for minor ailments. However, sequestered in extractive plantation ecologies, the communities find the bureaucracies and pathways of these overburdened public hospitals difficult to navigate. The resulting problems of access mean that many individuals and families in the plantations continue to live with unmet medical needs, even for avoidable medical afflictions. For a critical caste analysis (Ayyathurai 2021; Brueck 2023) of medical spaces as spheres of identity-based exclusion, it is important to interrogate the nature of difficulty of navigation that is routinely faced by the *Adibaxis* in Assam's public health institution.

In the summer of 2022, I accompanied Deep's cousin on a visit to a public hospital neighboring the plantation where his extended family lived. Rather than the visit itself, what I witnessed during the visit became important for me to understand the complexities of navigating the hustle and the labyrinths of public health institutions for the *Adibaxis*. That Deep's cousin, who lives with her family on their ancestral plantation, asked me to accompany her to the public hospital is telling of how members of the *Adibaxi* community anticipate in advance difficulties in navigating public health spaces. To add to the conundrum, the regional and national public health system in India—the primary interface of affordable care for millions of ordinary Indians—grapple with their own shares of funding crisis with an increasing rollback of state

funding for public health infrastructures. The public hospital we visited that day was similarly stricken by resource constraints even as it catered to the everyday medical needs of the Assamese citizens. Most of these citizens have limited or no economic means to afford privatized healthcare.

As I walked into a colonial era building of the outpatient department (OPD) in the hospital, a familiar yet perturbing sight greeted me at the entrance. Along the edge of the outer wall in the OPD's veranda, once again forming a neat line, were a group of about eight *Adibaxi* plantation workers squatting on the floor. They seemed to be patiently waiting, appearing to have been instructed to do so. As I walked past them, they looked at me with faces scrunched up with concern. For an ordinary human being, a visit to hospital spaces can be stress-inducing even on a good day. Being a second-generation learner whose parents utilized educational degrees as a means of exiting caste-based ancestral professions and entered the middle class, I have always had access to adequate medical care. It was therefore hard for me to contemplate how much additional stress can accompany being asked to obediently squat in the veranda of a clinical compound until it was one's turn to receive routine and/or essential medical care. That day, although I did not stop in order to chat with the waiting workers to find out more about their situation, while also being pressed by the immediacy of accompanying Deep's cousin on her consultation visit, I knew the exact circumstances in which this set of workers came to be huddled in this manner in the hospital premises.

Due to the socioeconomic fact that *Adibaxis* continue to be largely locked into the life of a plantation worker, the aggregate level of education in these communities is depressingly low. Most *Adibaxi* children attend primary schools run by the plantation management, institutions that are also mandated by the Plantation Labor Act 1951. However, the fate of these foundational educational institutions is not very different from the legally mandated plantation hospitals. The education imparted in these schools is not of the best quality. Furthermore, owing to the economic burden faced by worker families in the plantations, there is a high rate of school dropout among *Adibaxi* children.[5] Those who do acquire college degrees acquire upward social mobility through white collar professions and become members of the "ex-tea tribes" community. However, the percentage of *Adibaxis* who can attain upward social mobility as well as a life outside the plantations is relatively low.

Lack of educational attainments is therefore one of the primary reasons that make hospital bureaucracies and clinical pathways difficult to navigate for *Adibaxi* community members. However, this is not the sole reason. As educated members from among these communities have often narrated to me, *Adibaxi* patients face repeated discrimination in Assam's public hospitals. Such socio-material circumstances

[5]For a media report, see: https://cracr-pd.org/children-of-tribes-in-india-tea-tribes-in-assam/#:~:text=Therefore%2C%20it%20can%20be%20concluded,risk%20of%20substance%20abuse%20etc. <Accessed December 2025>

ultimately necessitated the formulation of a sub-ontological classification among the plantations workers, historically known as the *Sirdars* or the supervisors (Bates & Carter 2017). These supervisors acted as intermediaries between the British and Adivasi communities, playing an important role in the coerced recruitment of the Adivasis from central and eastern India as indentured laborers in the nineteenth century. Today, this supervisor acts as an intermediary between the plantation management and the workers, mediating contracts and workloads. What is relevant for the context presented in this article is that there exists a role similar to that of the supervisor in the clinical domain, an aspect pertaining to worker welfare. These roles that are usually assumed by *Adibaxi* men are known as "Case Attendants."

I first learnt of "Case Attendants" during a conversation with an ASHA worker, the female community health workers who I was asked to take with me to the *Labor Lines*, in a different plantation. The primary duty of the "Case Attendant" is to accompany *Adibaxi* workers to the neighboring district hospitals. The hospital can be an alienating space to such *Adibaxis* who have poor literacy and are wary of being treated differently while going through vulnerable moments of ill-health. Such experiences of alienation arise from challenges in filling medical forms, comprehending which tests have been ordered by the physicians, where to locate the ward in overcrowded public hospitals where the designated tests are carried out, how to arrange money for the tests, when to collect the test reports, and how to interpret physician diagnoses. Compounding these concerns, physicians presume *Adibaxi* "backwardness" and often become frustrated when a community member is unable to understand or adhere to the prescribed treatment regimes. These are also moments when physicians behave more brashly or distantly with an *Adibaxi* patients, more so than they would with other patients. The *Brahmanical* perception of *Adibaxi* unreasonableness and intractability thus follows the workers from the tea gardens to the clinic, much like "untouchability" shadows Dalit communities in postcolonial liberated India.

It is these difficulties of navigating casteized medical spaces that the "Case Attendant" is assigned to mitigate, to make sure that the plantation workforce is sustained at the baseline of health through access to preliminary medical care. The "Case Attendant" therefore becomes a sort of temporary custodian of *Adibaxi* bodies within the medical institution, with sick *Adibaxi* members being dependent on the intermediary's agency. Hence, I encountered a row of patiently waiting *Adibaxi* workers on a hospital verandah in Assam, likely waiting for their "Case Attendants" or an accompanying community health worker to tell them what to do next. However, even this mode of manufactured dependence is not available uniformly to all members of the "tea tribes." No "Case Attendants" were available for assigning to sick *Adibaxi* members in the two plantations where I worked extensively. This special intermediary is most extensively employed in large and well-functioning plantations. However,

what is important for the present discussion is not whether "Case Attendants" should be a mainstay of all plantations across Assam. That a "Case Attendant" is a necessary intermediary for a group of adult workers in acquiring access to medical care is itself evidence of the subtle yet significant manifestations of identity-based discrimination in the public health system. The manner in which an entire Indigenous community may be made to become dependents on another's agency within medical systems owing to these manifestations demonstrates how caste-based notions of human difference inhabit biomedical spaces in contemporary India.

From *Adibaxi* Difference to Inherent Tribal Deviance

This section discusses how a euphemistic moral narrative in biomedicine mask caste-based othering in clinical spaces in Assam, framing and redefining the *Adibaxi* as an always medically suspect subject embodying an inherent tribal deviance. To analyze how such notions of inherent *Adibaxi* deviance became embedded in medical practice and its discursive domains in the supposedly post-caste Assamese society, it is necessary to contextualize where such euphemisms stem from and how they are mobilized as casteized medical folklore. In introducing casteized medical folklore—prevalent in health landscapes of Assam—as an analytical category, I build upon Khiara Bridges concept of "racialized folklore" surrounding Black women's bodies prevalent in the biomedical systems in the United States (Bridges, 2011 pp. 103-143). The concept of casteized medical folklore demonstrates in addition the assimilative capacity of caste as an ordering principle, folding into this order even those Adivasi ontologies that were traditionally outside the caste system. This assimilative capacity of caste as an ordering principle absorbs the Indigenous ontology into the Hindu, albeit maintaining an alter less civilized ontological ascription for the tribals. Casteized medical folklore normalizes this caste-based othering of Indigenous communities through the acceptable euphemisms of socio-biological difference. Such euphemistic articulations of Indigenous socio-biological difference are rooted in notions of inherent tribal deviance. In Assam, *Adibaxi* "backwardness" and hostility are a constitutive element of the casteized medical folklore surrounding the "tea tribes."

As described in the previous sections, the dilapidated medical infrastructure within the plantations invokes an indignation among *Adibaxi* communities that is rooted in the injustice of their economic exploitation and ensuing bodily privation. On occasions that are replete with medical strife, this indignation bursts out as episodic violence in response to the regnant medical injustice that conditions *Adibaxi* struggles for health and survival. At the same time, *Adibaxis* are also known to be treated differently within clinical spaces. As a result, there is a deep mistrust of the biomedical enterprise, its institutions and its personnel among the plantation workers.

For instance, during the global coronavirus pandemic, ASHA workers in the tea plantations had great difficulty in convincing the communities to voluntarily receive their COVID-19 vaccinations. During my ethnographic fieldwork, from conversations with these community health workers assigned to the plantations, I learned that the ASHA workers themselves faced defensive questions from certain community members while trying to carry out their COVID duties. Some community members asked: "How much did the government pay you to make us take this poison?" This is even as the *Labor Lines* and the plantations saw a severe outbreak of this fatal and contagious viral disease.[6] These questions reflect how the communities in the plantations viewed biomedical institutions and its health workers as an extension of the state, entities that have repeatedly failed them. Thus, these essential health workers at the frontlines of the coronavirus pandemic in India often bore the brunt of community mistrust during an exceptional time of global health crisis (Das & Das 2021). This was also a time when inequalities in healthcare systems, reflections of broader social and economic fissures, were rarified through the global circulation of a viral particle.

Notwithstanding the exceptionality of COVID-19 experiences, there is little that is extraordinary about the medical mistrust that multiplied along with the coronavirus in the social reproductive sphere of the plantation. The above accounts of the coronavirus pandemic that the ASHA workers shared with me formed a continuum with, rather than an exceptional phase in, the medical experiences of everyday *Adibaxi* life. The arrival of a globally circulated viral particle to the tea plantation, its tea factories, and its crammed *Labor Lines* simply capitalized on regnant inequalities to ironically manifest as both increased infection and increased medical mistrust.

To contextualize this continuum, consider an ethnographic scene from my fieldwork in the second tea plantation where I carried out my ethnographic research, a plantation that I call Bokulia. One afternoon in mid-2022, I was in a smooth mud-smeared front yard of a mud and thatched roof hut in one of the several *Labor Lines* in Bokulia. While many houses in the *Lines* are now built with brick, cement and steel, known as *pucca* or permanent houses, there are several houses that are still built with mud, straw, bamboo and other natural materials owing to their cheap costs. That day, I was accompanied by an ASHA worker, Padma who was my assigned companion in Bokulia. Padma and I would arrange in advance how and when I would go to the *Labor Lines* and which specific *Line* we would be visiting together. As was sometimes the case, Padma, a native Indigenous woman in her early forties from a neighboring village, would sprinkle in her own medical duties towards the end of my field visit. That summer afternoon in Bokulia, we were in the smooth mud-smeared courtyard after the field visit because Padma wanted to check off one on her long list of daily

[6]At the time, coronavirus outbreak in the tea plantations became a major health news in Assam, further adding to the myriad crises of the tea industry.

community health duties. Although the hut before us seemed empty to me, Padma called out to someone from the yard. At length, a painfully thin woman ambled out reluctantly. I watched on as Padma looked at the woman with a considerable degree of concern and said in informal Assamese, "Hey, I have come to see how you are doing." "*Tur khobor lobo ahisu akou.*"

The women began talking and I stood as a silent companion. But I soon became absorbed in my own observations. At first, I was struck by the woman's almost emaciated figure, uncommon even for the plantation worker community maligned with malnutrition. It was not immediately evident to me that Padma came to check in on the woman for a specific medical issue. After a while, I noticed that the woman's forearms were covered in dark scars from what seemed to be an aggravated skin infection. Feeling a sense of urgency for the woman's well-being, I could not help myself from asking whether she had been to the doctor to treat her skin condition. The woman seemed absolutely disinterested in speaking with me. I left it at that and Padma, gradually and with kindness, broached the topic of her going to the nearest public hospital to get a doctor to examine the skin condition. The woman did not seem convinced. After talking with her for a little while longer, Padma, too, was forced to leave it at that and we left the neat mud-smeared courtyard.

Later, as we were walking out of the *Labor Lines* to leave for our respective homes, I asked Padma what skin condition the woman was suffering from. Padma answered in an exasperated tone: "I don't know what is wrong with her skin. I have told her several times to go to the doctor. But the people get angry with me if I push them too much." Padma's frustration at the woman's obstinance is not simply a subjective reaction to the ailing woman's refusal to visit a doctor. But it is a form of frustration that is shaped by an important epistemic and discursive element of healthcare delivery. In the biomedical domain, such behavior is interpreted through the objective concept of "health seeking behavior." This psycho-clinical index evaluating subjective decisions to seek modern biomedicine for disease and sickness, as opposed to opting for traditional medicine, becomes a sort of scientized measure of the tendencies toward integration with mainstream society, or lack thereof (Kar 2016; Sarmah & Dutta 2019). "Health seeking behavior" is of significant public health interest amongst the *Adibaxi* communities of the tea plantations and the native tribal communities of Assam. Embedded in this scientistic approach to measure community acceptability of modern biomedicine is the assumption that the *Adibaxis* and tribal communities of Assam are somehow far from health infrastructures because they are distant from civility. Overlooking intermittent and underfunded plantation and public health infrastructures, such public health categories reiterate that Indigenous loss of health exists because of their "backwardness" arising from their "primitive" ways. Such scientized concepts as "health seeking behavior" are evidence of prejudiced

medical comportments towards tribal bodies, that in turn mobilize public health categories as euphemisms for caste-based notions of Indigenous difference.

It is such scientized discourses of *Adibaxi* and tribal alterity that constitute the euphemistic moral narratives that permeate public health institutions in Assam. The moral burden of seeking healthcare and hence maintaining good health is shifted onto the communities, exonerating the structural conditions that lead to a loss of community trust in the biomedical enterprise. Furthermore, such euphemistic moral narratives percolate to the bottom of the public health pyramid made up by community health workers like Padma. In this manner, casteized medical perceptions of the "backward" Adivasis become normalized through the subtle language of poor "health seeking behavior." Due to the alleged objectivity of such such scientized language masking *Brahmanical* constructions of Indigenous "primitiveness," the casteized medical folklore of hostile unreasonable *Adibaxis* become a subconscious justification for holding the *Adibaxis* solely accountable for their loss of health, even by *Adibaxi* and tribal community health workers.

However, what gets erased in this shifting of accountability is that medical mistrust has become deep seated among the *Adibaxis* because the state, plantation hospitals, public health institutions, and the biomedical enterprise have collectively failed to address their loss of health and bodily privations. Being denied basic and dignified medical care, emaciated bodies and depleted life chances are an everyday reality for these worker communities. Consider for example that in Bokulia, I made several attempts to meet with the resident doctor at the plantation hospital. But each time, Padma and the scanty hospital staff comprising a pharmacist, an auxiliary nurse and two other ASHA workers told me that the doctor was not in the hospital at the time. Upon inquiring seriously, the health workers told me that Bokulia had not had a hospital physician for about five years. The only physician who had been coming to the hospital was a visiting physician who had originally been assigned to a neighboring Primary Health Centre run by the state's public health department. Even when the visiting physician was in attendance, it was only for a couple of hours and infrequently throughout the week.

Here, it is worthwhile to critically analyze how the absence of an attending physician shapes conditions of medical access in the tea plantations. Physicians are reluctant to serve in tea plantation hospitals because their own decisions to serve, or not, are influenced by the figure of the hostile *Adibaxi* worker who has by now acquired a portentous folklorist status. Such portentous medical folklore erases how the structural violence of the plantation economy as well as medical discrimination in public health spaces foreshadows any capacity for eruptive hostility displayed by some members of the plantation worker community.

An anthropological investigation of the euphemisms embedded in casteized medical folklore is hence important for understanding why certain communities are reluctant to engage with modern biomedicine. Rather than inherent tribal deviance, it is such medicalized narratives of caste-based notions of Adivasi difference that determine health outcomes for the *Adibaxi* communities in the tea plantations of Assam. When episodic violence becomes the center of analysis, what gets erased and normalized are the systemic exclusions that are a product of the ancient practices of differentially ordering human societies according to their location of birth within the purity-pollution scale. These ancient practices are entrenched within not only the socioeconomic and political institutions of India, but also the medical. When the biomedical "gaze," theorized by the French philosopher Michel Foucault, is refracted through the lens of the entrenched caste system, caste as an ordering principle finds a biological basis for consolidating its power in postcolonial modernity. During the anti-colonial era of the Independence struggle, when Dr. B. R. Ambedkar called for the "annihilation of caste" in modern India, he drew attention not only to the peopled practices of caste, but also to such structural components of the caste system (Ambedkar 2014). These structural realities, despite claims of a post-caste society in Assam, leave nobody and no body "casteless." Critical attention to casteized medical folklore is hence pivotal for analyzing not only the assimilative capacity of the caste system. But it also important for highlighting how caste repackages itself through an appropriation of biomedical discourses in the contemporary era of scientific, technical and medical progress.

Conclusion

Contemporary scholars of South Asia have illuminated novel arenas in which caste exerts its differentiating power, be it in the affective dimension through expressions of disgust or, sensory perceptions of odor lingering about "Untouchable" bodies (Kapoor 2021; Lee 2021). This article contributes to this emerging body of scholarship by theorizing clinical spaces as a significant arena within which caste-based othering happens. More importantly, it demonstrates how caste as an ordering principle has transformed in Indian modernity, adopting biomedical logics to justify caste-based practices of human differentiation. Furthermore, situating anthropological inquiry in Assam highlights how Indigenous communities—whether the *Adibaxi* tea plantation worker or the native tribal—are conferred with a differential socio-biological status through casteized medical practices. Such practices sustain a *Brahmanical* medical discourse of inherent tribal deviance, one that has far-reaching implications for communities thus differentiated.

However, transformations in the caste-system in Indian modernity does more than solely differentiate the "primitive" tribal—who is also subject to persistent practices

of "untouchability"—within medical institutions. Through such transformations, caste as an ordering principle also reinvents itself via the normativity of euphemistic moral narratives. Such moral narrative falls back on the principles of purity and pollution, with the "untouchable" and the "primitive" being ascribed with a lesser degree of purity and hence lesser human worth. Within these euphemistic moral narratives of health, one is healthier if one is more moral. Analyzing this transformed moralizing health discourse through the historicity of caste, the moral logic of this discourse appears to be that one is healthy if one behaves morally, and one is more moral if one aspires to socio-biological purity. This transformed moral discourse on health therefore belies the subtle embedding of caste logic in biomedical narratives. To comprehend the impact that these euphemistic narratives of socio-biological difference have on the life chances of historically oppressed communities in contemporary India, such subtleties must be foregrounded in critical caste scholarship.

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