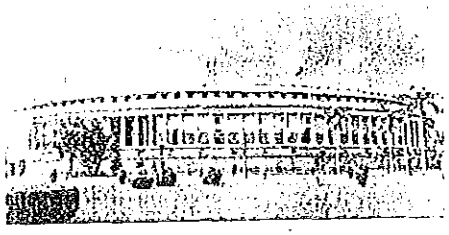

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PARLIAMENT OF INDIA
LOK SABHA

COMMITTEE ON EMPOWERMENT OF WOMEN

(2022-2023)

(SEVENTEENTH LOK SABHA)

SEVENTH REPORT

'HEALTH FACILITIES FOR TRIBAL WOMEN'

LOK SABHA SECRETARIAT
NEW DELHI

August, 2023/Sravana, 1945 (Saka)

SEVENTH REPORT

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'HEALTH FACILITIES FOR TRIBAL WOMEN'

Presented to Lok Sabha on ----------,2023

Presented to Rajya Sabha on ----------, 2023

LOK SABHA SECRETARIAT
NEW DELHI
August, 2023/Sravana, 1945 (Saka)

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(2020-2021)

Dr.Heena Vijaykumar Gavit - Chairperson

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3. Smt. Sangeeta Kumari Singh Deo
4. Vacant*
5. Ms. RamyaHaridas
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29. Smt. Sampatiya Uikey
30. Smt. ChhayaVerma

*Smt. Annapurna Devi has been appointed the Minister of State, Ministry of Education w.e.f 07.07.2021

**Smt Shobha Karandlaje has been appointed the Minister of State, Ministry of Agriculture and Farmers w.e.f. 07.07.2021

*** Nominated w.e.f. 19.04.2021 vice Smt. Jaya Bachchan upon her resignation from membership w.e.f. 18.03.2021

COMPOSITION OF THE COMMITTEE ON EMPOWERMENT OF WOMEN

(2021-2022)

Dr. Heena Vijaykumar Gavit - Chairperson

Members

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4. Ms. Ramya Haridas
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6. Smt. Malothu Kavitha
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30. Dr. Amee Yajnik

COMPOSITION OF THE COMMITTEE ON EMPOWERMENT OF WOMEN (2022-2023)

Dr. Heena Vijaykumar Gavit - Chairperson

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26. Smt. S. Phangnon Konyak
27. Smt. Mahua Maji
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1. Shri Rajesh Ranjan Kumar - Joint Secretary
2. Dr. Sanjeev Sharma - Director[1]
3. Smt. Emma C. Barwa - Additional Director
4. Smt. Raji Manish - Committee Officer[2]

[1] Till 30th June, 2023.
[2] Till 1st November, 2022

INTRODUCTION

I, the Chairperson of the Committee on Empowerment of Women having been authorized by the Committee to submit the Report on their behalf, present this Seventh Report of the Committee on Empowerment of Women (2022-23) on the subject 'Health Facilities for Tribal Women'.

2. The Report is based on the inputs received from the Ministry of Tribal Affairs, Ministry of Health and Family Welfare and Ministry of Women and Child Development at the sittings held on 23rd February, 2021 , 27th July, 2021 and the interaction held by the Committee with Piramal Swasthya, a Centre of Excellence and NGOs viz. Ramakrishna Mission, Bharatiya Lok Kalyan Sansthan and 'Association for Social and Human Awareness' (ASHA) on 5th August, 2021.

3. The Committee wish to express their thanks to the Committee on Empowerment of Women 2020-21 and 2021-22 for selecting and detailed examination of the subject on priority basis.

4. The Committee also wish to express their thanks to the Ministry of Tribal Affairs, Ministry of Health and Family Welfare (Department of Health and Family Welfare), Ministry of Women and Child Development and the other organizations for appearing before the Committee to tender evidence and furnishing the information desired by the Committee in connection with the issues relating to the subject.

5. The Report was considered and adopted by the Committee at the Sitting of the Committee held on 21st July, 2023.

6. For facility of reference and convenience, the Observations and Recommendations of the Committee have been printed in bold letters in Part II of the Report.

NEW DELHI
21 July 2023
30 Ashadha, 1943, (Saka)

DR. HEENA VIJAYKUMAR GAVIT
Chairperson,
Committee on Empowerment of women

REPORT

PART I

NARRATION

I. INTRODUCTORY

The Committee have been informed by the Ministry of Tribal Affairs that according to the Census of India 2011, Scheduled Tribes Population numbers 104 million (10.45 crore) and constitutes 8.6% of the country's total population, inhabiting about 15% of the geographical area, mainly in forest, hilly and border areas. Out of these 104 million, tribal women comprise of 49.7%. There are more than 700 different Scheduled Tribes notified under Article 342 of the Constitution of India. There are 75 groups of tribals in 18 States and UT of Andaman & Nicobar Islands identified as Particularly Vulnerable Tribal Groups (PVGTs) in view of their declining or stagnant population, low level of literacy, pre-agricultural level of technology and economic backwardness.

1.2 Numerically, Madhya Pradesh has the largest ST population, accounting for 14.7% of the total ST population in the country (over 15 million), followed by Maharashtra (over 10 million), Odisha and Rajasthan (over 9 million each). More than two thirds of the ST population is located in the seven States of Madhya Pradesh, Chhattisgarh, Jharkhand, Odisha, Maharashtra, Gujarat and Rajasthan. However, the concentration of tribal is highest in the North Eastern states viz., Mizoram (94.4%), Nagaland (86.5%), Meghalaya (86.1%), Arunachal Pradesh (68.8%) and UT of Ladakh (79.50%).

1.3 The Committee are aware of the fact that the Constitution of India, recognizes the special status of the tribal communities and provides them with special protections, ensured through distinct political-administrative set up through Schedule V and VI of the Constitution. Article 342 of the Constitution defines "Scheduled Tribes" as the "tribes or tribal communities or parts of or groups within tribal communities which the President of India may specify by public notifications".

1.4 Health is a prerequisite to human development and plays a pivotal role in the development of any community or nation. Taking into account this fact as well as keeping in view the socio-economic backwardness faced by the tribal people, various policies and programmes for their healthcare and development have been rolled out since independence. However, while implementing the healthcare programmes for tribal people, their unique healthcare needs arising out of their distinctive social systems and culture as well as their life in a different terrain was somehow not taken into consideration. As a result, the uniform national pattern of rural healthcare was employed in the tribal areas also. Consequently,

notwithstanding the efforts of the Government and the existence of a plethora of health programmes, tribal healthcare could not achieve the desired parameters in comparison to the non-tribal population.

1.5 The Committee have found that during the last decade it has been reckoned that tribal people have poor health and unmet healthcare needs and therefore, their healthcare cannot remain subsumed in rural healthcare. Consequently, explicit and concerted efforts to deliver quality healthcare to tribal people started. However, despite the efforts, it is evident from the data that tribal communities still suffer from malnutrition, higher maternal and under-five mortality, stunted wasted and underweight children, higher incidence of malaria and tuberculosis and a growing burden of modern age diseases like diabetes, cardiovascular diseases and hypertension. The health indicators of tribal population in comparison to the general population as furnished by the Ministry of TribalAffairs is as follows:

S. No	Indicators	% ST	% All
1	Sex Ratio in 2011	990	943
2	Infant Mortality Rate (IMR)	41.6	35.2
3	Under-Five Mortality Rate (U5MR)	50.3	41.9
4	Institutional delivery	82.3	88.6
5	Percentage of children aged 12-23 months who have been fullyvaccinated (all basic vaccinations)BCG, MCV/Measles/MMR/MR and 3 does each of DPT/Penta andpolio vaccine (excluding polio vaccine given at birth)	76.5	76.6
6	Percentage of children under age 5 years who are stunted(Height for age,)	40.9	35.5
7	Percentage of children under age 5 years who are wasted(Weight for Height.)	23.2	19.3
8	Percentage of children under age 5 years who are underweight(Weight for age,)	39.5	32.1
9	Percentage of children age 6-59 months having any anaemia(<11.0 g/dl)	72.4	67.1
10	Percentage of women age 15-49 and below 145 cm, body massindex (BMI), was <18.5	25.5	18.7

(Source: National Family Health Survey – 5 2019-20)

1.6 It is in this context that the Committee decided to examine the issues related to the health care of the tribal people, especially the tribal women who is the epicenter of a tribal familyand directly bear the brunt of all the adverse effects of lack of healthcare in tribal areas.

1.7 Ministry of Tribal Affairs is the nodal Ministry for overall policy, planning and coordination of programmes of development for the Scheduled Tribes. However, with regard to sectoral programmes and schemes of development of these communities, policy, planning, monitoring, evaluation etc. as also their coordination shall be the responsibility of the concerned Central Ministries/ Departments, State Governments and Union Territory Administrations.

Accordingly, Ministry of Health and Family Welfare and AYUSH are the nodal Ministries for Health matters pertaining to the tribal community. Similarly, Ministry of Women and Child Development is overall responsible for welfare of women, which includes nutrition also. Further, "Public Health and hospital" being a State subject, the primary responsibility of providing health care services in the tribal areas is that of respective State/ UT governments.

II HEALTH STATUS OF TRIBAL WOMEN

1.8 Like the general population, tribal people including tribal women, also carry a triple burden of disease which are Communicable, Nutritional and Non-communicable diseases. Ministry of Health and Family Welfare, in their written note, have broadly classified the diseases prevalent in tribal areas on the epidemiological front, as follows:

(i) Malnutrition
(ii) Maternal Health Problems
(iii) Child Health Problem
(iv) Communicable diseases like malaria, TB, leprosy and other skin infections, HIV / STIs /STDs, typhoid, cholera, diarrohea, hepatitis etc.
(v) Non-communicable diseases – findings suggest that hypertension prevalence is already high among the tribal population while other non-communicable diseases are also catching on.
(vi) Mental Health problems and substance use disorders -especially in areas affected by conflict; addictions to tobacco, alcohol and drug s, for instance drug use in North east states. There is also a link between addiction disorders and intimate partner or gender based violence.
(vii) Genetic diseases - Hemoglobinopathies (sickle cell disease) and G-6 PD deficiency are rising.
(viii) Special problems – Silicosis due to working in mines, orthopaedic and surgical problems, gynecological problems, oro-dental problems and eye problems.

(i) Data on the Health of Tribal Women

1.9 The Committee have found that there is insufficient data on tribal healthcare and welfare, especially the data relating to tribal women and girl children. The Committee can understand that no welfare measures can yield fruitful results without accurate data and wished to be apprised specifically about the institutional mechanism in place to generate data on healthcare, economy and other welfare aspects relating to tribal people. In response, the Ministry of Tribal Affairs submitted the following written information:

> "As such no Institutional mechanism is available with MoTA to generate data on tribal healthcare. MoTA is dependent on MoH&FW and State Government for seeking such information whenever required. Tribal related data is generated by the Ministry of Tribal Affairs and other Government Ministries/agencies such as Ministry of Health and Family Welfare, Ministry of Human Resource Development, Registrar General of India, Ministry of Statistics and Programme Implementation (MoSPI), National Crime Records

Bureau etc. through Census, administrative records and surveys. Health Ministry conducts surveys and publishes reports such as National Family Health Surveys, Rural Health Statistics in India etc. which provides data for health including tribals. Department of School Education and Literacy, HRD publishes "Educational Statistics- at a Glance" and UDISE also provides school education data. Department of Higher Education, HRD publishes "All India Survey on Higher Education (AISHE)" every year which provides higher education data. Population related data is obtained by Census conducted by RGI. Also, MoSPI undertakes surveys at regular interval for collecting information/data including tribal. However, MoTA has recently recognized Piramal Swasthya, a Centre of Excellence for Knowledge Management in Health and Nutrition. One of the core mandates of this CoE will be to address the data gaps/ challenges specific to tribal health and nutrition by creating an online repository of all tribal health and nutrition related data, in close coordination with the Ministry of WCD and Ministry of Health and Family Welfare and State Governments. This repository will be ready in the next 3 months."

1.10 Supplementing further on this aspect, Ministry of Health and Family Welfare submitted the following through a written reply:

"There are various institutional mechanisms and survey agencies which generate data ontribal health care on a periodic basis which are as follows:

Source	Database
Ministry of Health & Family Welfare	National Family Health Survey (NFHS),
Other Sources	Census of India
	National Sample Survey
	National Nutrition Monitoring Bureau, Technical Report
	Other Micro-level Sample Surveys and Research Studies.

1.11 With regard to exclusive data on the healthcare of tribal women, the Ministry of Tribal Affairs stated that at present there is no centralised repository as well as mechanism for collection or storage of data pertaining to the health of tribal women as mostly the tribal related data is gender neutral.

(ii) Malnutrition and Anaemia among Tribal Women and Children

1.12 The Committee have learnt that as per NFHS-5 (2019-21), 25.5% of tribal women are underweight as compared to 18% percent of non-tribal women in the country and prevalence of anaemia in tribal women is .64.6 percent as compared to 56 % per cent in non-tribal population. The Committee wished to know about the reasons for the same and interventions in place to address malnutrition among tribal women and girls especially those living in hilly, forested areas and also tribal people belonging to Particularly Vulnerable Groups (PVGs). In response, the Ministry of Health and Family Welfare, through a written reply, submitted:

"Malnutrition is a multi-dimensional issue and exists irrespective of income status across the sections of the society. It is affected by generic factors such as poverty, inadequate and improper food consumption due to poor access and availability, improper maternal infant, child feeding, increase in consumption of non-nutritious foods such as HFSS (High Fat Salt Sugar) foods, inequity and gender imbalance, poor sanitary and environmental conditions and restricted access to quality health, education and social care services.

The Government of India has initiated various interventions to address the issues of malnutrition and anemia across the country including tribal population as follows:

- POSHAN (Prime Minister's Overarching Scheme for Holistic Nourishment) Abhiyaan has been launched to address malnutrition challenges in India by engaging all the important stakeholders through convergence. The goal of POSHAN Abhiyaan is to prevent and reduce stunting, underweight and low birth weight by 2% per annum and the reduction of anaemia by 3% per annum. MoWCD is the nodal ministry for implementation of POSHAN Abhiyan with support from other line ministries.

- There are two important schemes under the aegis of Ministry of Women and Child Development (MWCD) to tackle malnutrition in the country namely Aanganwadi Services Scheme and Pradhan Mantri Matru Vandana Yojna (PMMVY) to improve the nutritional and health status of children in the age group of 0-6 yrs.

In addition to aforementioned interventions, Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition (RMNCAH+N) under National Health Mission (NHM) is also implemented to reduce malnutrition across the life cycle. The details of various health and nutrition interventions under National Health Mission (NHM) are as follows:

- The Mothers' Absolute Affection (MAA) program is being implemented to promote age-appropriate Infant and Young Child Feeding (IYCF) practices including early initiation of breastfeeding and exclusive breastfeeding.

- 'Anemia Mukt Bharat (AMB)' programme for supplementation and treatment of anaemia in pre-school (6-59 month) and school going children (5-9 yrs) & adolescents (10-19 yrs), pregnant and lactating women, and women of reproductive age group (15-49) in programme mode through life cycle approach. There are six interventions under Anemia Mukt Bharat which aims to address the anemia both due to nutritional and non-nutritional causes. The six interventions are-

  - ✓ Prophylactic Iron Folic Acid Supplementation.
  - ✓ Periodic deworming.
  - ✓ Intensified year-round Behaviour Change Communication Campaign including delayed cord clamping.

- ✓ Testing and Treatment of anemia using digital methods and point of care treatment.
- ✓ Mandatory provision of Iron Folic Acid fortified foods in public health programmes.
- ✓ Addressing non-nutritional causes of anemia in endemic pockets, with special focus on Malaria, Hemoglobinopathies and Fluorosis.

- Home Based Care for Young Children (HBYC) has been initiated as an extension of Home Based Newborn Care (HBNC) to provide community based care by ASHA workers with focus on improvement in child rearing practices, nutrition counselling and breastfeeding promotion till 15th month of life.
- Sick children with Severe Acute Malnutrition (SAM) are being treated and managed for medical complications at special units called as Nutrition Rehabilitation Centres (NRCs), set up at public health facilities. Special emphasis is being given on establishing at-least one NRC per tribal district.
- Universal Immunization Programme (UIP) is being supported to provide vaccination to children against vaccine preventable diseases.
- Biannual Vitamin A supplementation (VAS) rounds are being conducted for children from 9 months to 5 years age group.
- National De-worming Day is being implemented as a fixed day strategy to administer Albendazole tablets to all the children in the age group of 1- 19 years.
- Prevention of childhood illnesses such as diarrhoea and pneumonia which in turn prevents onset of childhood under-nutrition. Intensified Diarrhoea Control Fortnight (IDCF) and Social Awareness and Action to Neutralise Pneumonia Successfully(SAANS) are the initiatives to increase awareness on prevention and prompt management of these illnesses along with capacity building of healthcare providers.
- Village Health Sanitation and Nutrition Days (VHSNDs) are observed for provision of maternal and child health services and creating awareness on maternal and child care in convergence with Ministry of Women and Child Development.
- Mother and Child Protection Card is the joint initiative of the Ministry of Health & Family welfare and the Ministry of Woman and Child Development to addresses the nutrition concerns in children, pregnant women and lactating mothers.
- Under "Rastriya Bal Swasthya Karyakaram" (RBSK) children of 0 - 18 years of age are screened for selected health conditions classified into 4Ds - Diseases, Deficiencies, Defects and Developmental delays including screening for Severe Acute Malnutrition and provides free referral and treatment facilities for identified children.
- The Government is also promoting use of fortified wheat flour, fortified rice, fortified oil and double fortified salt in public funded supplementary nutrition programmes.
- Prevalence of anemia is multi factorial and is also influenced by the socio-economic status of individual. There is sufficient evidence to suggest that only 50% of anemia is due to nutritional causes such as Iron, folic acid and Vit-B12 etc. There are various other non-nutritional factors leading to high prevalence of anemia among women in tribal areas such as malaria endemicity and prevalence of Haemoglobinopathies namely sickle-cell anemia and thalassemia and fluorosis which is another important nutritional

cause of anemia and is endemic in most of the tribal districts of the country

- Major drivers of nutrition-related anemia include poverty, gender disparity, education status, sanitation and hygiene etc. Multiple pregnancies coupled with low-quality diets and parasitic infections, poor sanitation etc. are contributors to high prevalence in anemia. Moreover, higher prevalence of anemia among lactating women can be attributed to the increased nutritional demand imposed by lactation.

Anganwadi Services (under Umbrella Integrated Child Development Services Scheme) is a centrally sponsored scheme of the Ministry of Women and Child Development which isimplemented by States/UTs across the country. A total of around 13.91 lakh AWCs are operational across the country as on 31.3.2022. The package of following six services is provided under the Anganwadi Services scheme:

i. supplementary nutrition
ii. pre-school non-formal education
iii. nutrition & health education
iv. immunization
v. health check-up and
vi. referral services

Three of the six services viz., immunization, health check-up and referral services are related to health and are provided by NHM & Public Health Infrastructure.

The objectives of the scheme are:

i. to improve the nutritional and health status of children in the age-group 0-6 years;
ii. to lay the foundation for proper psychological, physical and social development of thechild;
iii. to reduce the incidence of mortality, morbidity, malnutrition and school drop-out;
iv. to achieve effective co-ordination of policy and implementation amongst the variousdepartments to promote child development; and
v. to enhance the capability of the mother to look after the normal health and nutritional needsof the child through proper nutrition and health education.

The target groups for these services are children below 6 years of age and pregnant women and lactating mothers. The Scheme is universal and open to all eligible beneficiaries without any discrimination. The population norms for opening of AWCs in Tribal/Riverine/Desert, Hilly and other difficult areas/Projects is 300-800 population for 1 AWC."

1.13. Detailing further on the nutritional status of the tribal people, the Ministry of Tribal Affairssubmitted in their written note as follows:

"In the tribal dominated states, on an average the stunting levels are 5 percentage points, and wasting levels are 4 percentage points higher, for STs as compared to all

social groups (NFHS-5). The estimates by NFHS-5, reveal data on the state of nutrition amongst tribals, where almost two childs out of five children under five years of age is under-weight, and one in every fourth child is wasted. 72.4% tribal children and 64.5% women in the reproductive age groups are anaemic, and almost 41.6 out of every 1,000 children born, die before they complete the first year of their life."

1.14 According to National Family Health Survey-5, a comparison of health and nutritional status of Scheduled Tribes in comparison to 'All' in the country is as follows:

Health & Nutritional status: ST & All NFHS-5		
Nutritional Indictor	**ST**	**All**
Percentage of children under age 5 years who are stunted (Height for age)	40.9	35.5
Percentage of children under age 5 years who are wasted (Weight for Height)	23.2	19.3
Percentage of children under age 5 years who are underweight (Weight for age)	39.5	32.1
Percentage of children age 6-59 months having any anaemia (<11.0 g/dl)	72.4	67.1
Percentage of women age 15-49 and below 145 cm, body mass index (BMI), was <18.5	25.5	18.7

1.15 While expounding on the initiatives taken by the Ministry of Women and Child Development to address malnutrition among the tribal people, a representative of the Ministry submitted as follows during the oral evidence:

"One Department cannot ensure that nutrition is provided to pregnant mothers and children. Basically, it is a bigger subset where health, drinking water supply, sanitation and anganwadi services have to come together because what we are seeing from the data of last few years is that even though you give quality food at the anganwadi centres, if water supply is not upto the norm or there are issues with the water supply, then children tend to get water born diseases. Whatever meal they have taken would not result in proper growth of the children and stunting and wasting levels do not improve to the level desired."

1.16 The Ministry of Women and Child Development also stated during the oral evidence that that there is a need to shift the attention from calorie to micronutrients and that they are going to start a new scheme for fortified rice with micronutrients and vitamins as studies have shown that there is severe reduction in anaemia levels in the women and children who are given meal made from the fortified rice. The Ministry also stated that under the scheme for adolescent girls, the Ministry has included 'out of school girls' belonging to the age group of 11-14 for supplementary nutrition from anganwadi centres. Further, the Committee have learnt that the scheme for Adolescent Girls has been revised from 1.4.2022 and subsumed

under Saksham Anganwadi & Poshan 2.0. Under revised SAG, the targeted beneficiaries has been revised to AGs in the age group of 14-18 years in aspirational districts and NE States.

1.17 The Ministry also stated during the oral evidence as follows:

> "AYUSH has done two or three studies in Tamil Nadu and Karnataka where they have given ayurvedic medicines and it has shown tremendous improvement in anaemia levels in those pilot studies. We propose to extend these pilots to other regions also so that anaemia part can be taken care of. "

1.18 With regard to obtaining data on the results of a nutrition programme, the Ministry of Women and Child Development stated as follows during the Oral evidence:

> "We have started a Poshan Tracker. We have given mobile phones to each and every anganwadi worker in the system. We have this Poshan Tracker app where they fill in the data of all the children who are coming to the Anganwadi Centre. With this data and importing the health data from ASHA workers, we hope that Poshan Tracker over a period of time will be able to give us real time data of improvement in the nutrition level of children. So, Poshan Tracker is a big change. Data is being populated. Except from two or three States, now the data has started coming. We have to put in the system of validation of data, but this particular Poshan Tracker app, which is right up to anganwadi level, has been accepted well by the anganwadi workers. We are also paying them additional honorarium for data entry. We also pay them for the data charges for every month. We thought that it may not be possible for them to enter the data and put in the tracker, but we are very happy to tell you that we have been able to get data from most all the States."

1.19 The Ministry have further informed in their updated replies that now All the States/UTs have started sharing data on Poshan Tracker.

(iii) Sickle Cell Anaemia among tribal and interventions

1.20 Sickle Cell Disease (SCD) is widespread in many tribal groups of India especially among the Dravidian and pre-Dravidian tribes inhabiting malaria endemic regions. About 1 in 86 births among Scheduled Tribe (ST) population have SCD, the prevalence being higher in Central, Western and Southern India. Being a genetic disorder, SCD is inherited by a child from his/her parents. Like most genes, haemoglobin genes are inherited in two sets, one from each parent. An individual in whom both the haemoglobin genes are abnormal suffers from Sickle Cell Disease. An individual in whom only one of the two genes is abnormal is said to be having Sickle Cell Trait. While individuals with Sickle Cell Trait do not have symptoms, they can transmit the gene to their child. If one parent has Sickle Cell Disease and the other is Normal, all of the children will have Sickle Cell Trait. If one parent has Sickle Cell Disease and the other has Sickle Cell Trait, there is a 50% chance of each child having either sickle cell disease or sickle cell trait. When both parents have Sickle Cell Trait, each of their children has a

25% chance of having sickle cell disease.

1.21 The Ministry also informed the Committee that the percentage of Sickle cell carriers among different tribal groups vary from 1 to 40.The implementation of strategy to tackle SCD by the Government has not so far yielded much desired results. Hence, as a strategic initiative, newborn screening programmes for sickle cell disorders among the tribal and non-tribal populations have been initiated in India during the last three to five years. The government has informed that these screening will be strengthened through continuous guidance to the states. Screening of sickle cell anemia among tribal students is also done. This Ministry of Health and Family Welfare, under its Schemes provides emphasis on health cards for tribal population indicating their health status specially with respect to screening and treatment of Sickle Cell Anemia. This approach is to combine screening and identification of sickle cell patients, along with counseling and treatment. The purpose of health cards is to capture the spread and prevalence of the disease, so that interventions could be provided accordingly.

1.22 Informing further about measures taken to address SCD, Ministry of Tribal Affairs stated in a written reply as follows:

> "In order to create awareness, a sickle cell support corner has been created, (scdcorner.in), which also has a knowledge repository. Blood samples of approximately 1.5 cr. tribals were tested for SCD and 10.5 lacs were found to be carriers and 50,000 had SCD. SCD Support Corner will develop data repository of such tribals and plan to start awareness campaign and to mitigate health issues affecting such patients".

1.23 Further, the Ministry informed that the Sickle Cell Corner aims to create a self-registration system for people with Sickle Cell Disease and Sickle Cell Trait. In addition to registration, this portal provides the resources and information around SCD. The dashboard in this portal helps to understand the scale and distribution of SCD. The registration is voluntary and it is not recommended to refer this data for programme planning and research purposes. Ministry of Tribal affairs along with the Ministry of health has prepared training Modules for sickle cell disease with the eminent experts across the country. A road map for sickle cell diseaseis under process

1.24 The Committee also noted that the Ministry of Social Justice and Empowerment has taken a note of the challenges faced by the SCD patients having limited validity under Rights of Persons with Disability Act and have increased the validity of Disability Certificate from 1 year to 3 year. In this regard, the Ministry of Tribal Affairs submitted as under during the oral evidence:

> "*And for disability certificate, you are right. Hon. Minister had written to Minister of Social Justice and they have done it to three years and for minimum disability, they have said that it is 25 per cent. The file has gone to Ministry of Law and Justice. Very soon, when this comes a notification will be done. But Hon. Minister has again written to Minister of Social Justice because disability is not going to decrease. It is going to*

increase every year. So, any child who is more than five years, it should be a permanent disability and it should not be partial. So, we are already seized of the matter and hon. Minister is personally taking up this issue with Disability Ministry."

1.25 When the Committee desired to know about the number of women and girl children affected with SCD, the Ministry submitted as follows:

"Sickle haemoglobin was first detected by Lehman and Cutbush in 1952 among the tribal from Nilgiris. During the last 54 years, several groups of investigators conducted hospital based or epidemiological surveys in various ethnic groups. Based on these surveys, prevalence of sickle gene is found to be 0-18% in north eastern India, 0-33.5% in western India, 22.5-44.4% in central India and 1-40% in southern India and the gene frequency of Hb-S varies between 0.031- 0.41. Wide variability in the prevalence of Hb-S trait is observed in population groups within small geographical areas. Apart from malaria, factors like endogamy, ethnicity and inbreeding are responsible for this variability.

However, to know the exact number and curative treatment, the research is required in sickle cell disease.

In regard to above Ministry of tribal affairs along with the Department of science and Technology has taken up a research in CRISPR mediated genetic correction of Sickle cell disease. The promise of gene editing approaches for correcting the mutation or elevating fetal hemoglobin (HbF) in such patients leading to a one-time cure of the disease has led a few countries to initiate clinical trials for testing the feasibility of these approaches. Recently, CRISPR based gene editing has been tried out successfully on patients in the USA indicating an initial positive response to this treatment approach.

1.26 With regard to the research undertaken on SCD, the Ministry of Health and Family Welfare informed that the Indian Council of Medical Research (ICMR) under its Tribal Health Research Forum (THRF) activities as well as other programmes under the National Rural Health Mission (NRHM) in different states have initiated programmes to enable advances in genetics to reach these communities.

1.27 The Committee have been informed that for Management of Haemoglobinopathies patients (thalassemia and sickle cell disease) the blood has been made free for all who are visiting the Government district Hospitals

1.28 As a part of awareness generation with regard to SCD, community education and awareness programmes to remove any myths regarding transmission of disease, gender bias, stigma related to sickle cell disease and carrier states and informing the community about appropriate prevention options and their availability through public health facilities is carried out regularly by the Government along with other Ministries.

1.29 Ministry of Health & Family Welfare also gives financial assistance to BPL patients for

treatment of life threatening diseases at different hospitals under the Rashtriya Arogya Nidhi (RAN) and also the Health Minister's discretionary grant. The category of treatment support provided from RAN fund includes Bone Marrow Transplants for Thalassemia, Sickle Cell diseasespatients and corrective surgeries for Hemophilia.

(iv) Early Marriage and Related Health Risks

1.30 Early marriage exposes tribal women to greater health risks and early pregnancy. With regard to the steps taken to address this issue and the specific outcomes in this regard, Ministry ofHealth and Family Welfare submitted in their written replies as follows:

> "Teen age pregnancy is highest among ST in all social groups. 30% of ST women in 20- 24 years are married before the age of 18 years, 64.6% of tribal women in the 15-49 years age group suffer from anaemia and 46% of maternal deaths are contributed to anaemia.
>
> As per the findings of NFHS-5, in 17 out of 26 States (for which data was comparable with NFHS- 4 for this indicator) the proportion of scheduled tribe women age 15-19 years who have already begun childbearing has declined compared to NFHS-4.
>
> MoHFW had employed effective programmes, under the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCHA) strategy to make health gains in maternal and child health areas and immunisation, which are –
>
> - Janani Suraksha Yojana (JSY),
> - Janani Shishu Suraksha Karyakram (JSSK) that gives free entitlements along with ambulance services to pregnant women (under National Ambulance Service), free drugs and diagnostics to reduce OOPE etc. has helped increase institutional deliveries. These schemes helped close the urban rural divide and also favourably impacted tribal women.
> - Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) to improve coverage of ANC and identification and tracking of high-risk pregnancies to bring down MMR and NMR.
>
> Some State level interventions to intervene in early child marriages are:
>
> i. Rajasthan: Sanjha Abhiyan
> ii. Madhya Pradesh: Lado Campaign
> iii. Jharkhand: Mukhyamantri Sukanya Yojana

(v) Family Planning Measures and Related Awareness

1.31 When the Committee desired to know about the family planning methods among the tribal people and their receptiveness to contraceptive methods, the Ministry of Health and Family Welfare submitted as follows in a written reply:

"The knowledge of modern contraceptive in tribal men and women in the age group 15-24is fairly high at 97.0% and 96.8% respectively as per NFHS-5 (2019-21).

Family Planning Program offers an expanded basket of contraceptive choices under National Family Planning Program on voluntary basis irrespective of caste and creed. The Government promotes all family planning choices equally and it is the prerogative of the clients to choose a method as per their reproductive rights and the services are provided free of cost in all public health and accredited private/ NGO facilities as per demand.

Current modern contraceptive basket includes Male and Female sterilization for limiting and Combined Oral Contraceptive Pills, Intra uterine Contraceptive devices (IUCD 380A &375), Injectable Contraceptive medroxy progesterone Acetate, Centchroman (Non-hormonal oral pill) and emergency contraceptive pills. The beneficiaries are also providedwith Nischay Kits (pregnancy testing kits) for early detection of pregnancies. "

1.32 With regard to the percentage of tribal women who have resorted to spacing between children and have adopted family planning measures, the Ministry of Health and Family Welfareinformed the Committee as follows in their written replies:

- 14% of tribal women use spacing methods for family planning (NFHS-5).
- Currently the prevalence of modern contraceptive among tribal women is 55.1% (NFHS-5).
- The demand for contraceptives satisfied through modern methods is 74.8% (NFHS-5) for STwomen who are currently married aged 15-49 years.

As per NFHS-5, in 23 out of 27 States (for which data was comparable with NFHS-4 for this indicator) there is an increase in the use of modern methods of contraception among scheduled tribes."

1.33 With regard to awareness among tribal men about contraceptive methods and the specific steps taken to popularize male contraceptive methods amongst the tribal people, the Ministry of Health and Family Welfare furnished the following information in their written replies:

"Around 24.4% men are using modern contraceptive method in tribal population as compared tothe national level of 25.8% in the age group 15-49 years. The prevalence of male sterilization is 0.8%. To further increase the male participation and promote the use of male contraceptives, the Government of India organizes National Vasectomy fortnight every year for creating awareness about male participation and generating demand for male contraception methods. An entire media campaign promoting role of men and their responsibility was created to burst the myths around male contraception and promote sharing of family planning responsibilities.

(vi) Maternal and Infant Mortality Rate in Tribal Regions

1.34 As per the Sample Registration System (SRS) report by Registrar General of India (RGI), Maternal Mortality Ratio (MMR) of India has reduced from 130 per 100,000 live births inSRS 2014-16 to 122 in SRS 2015-17, 113 per 100,000 live births in SRS 2016-18 and to 103 in 2017-19.

1.35 When the Committee desired to know about the state-wise Maternal Mortality Ratio and Neo Mortality Ratio among tribal women and newborns, the Ministry of Health and Family Welfare submitted the following in their written reply:

> " As per latest available SRS, 2017-2019 report, Neonatal Mortality Rate (NMR) at National level is 22 per 1000 live births. Sample Registration System (SRS) does not provide data on NMR for tribal population. However, as per latest available report of National Family Health Survey-NFHS - 5 (2019-21), NMR for tribal population is 28.8 per 1000 live births. Similarly, data on Maternal Mortality Ratio (MMR) is available for National level only i.e. 103 as per SRS (2017-19) data of RGI."

(vii) Institutional Delivery Among Tribal Women

1.36 With regard to the percentage of institutional delivery among tribal women, the Ministry of Tribal Affairs submitted as follows during the oral Evidence:

> "The most important thing which we have identified compared to the general statistics of our country is the percentage gap in institutional delivery. As per NFHS-5data of 2019-21, the institutional delivery among ST stood at 82.3 per cent whereas for the All category in our countrywas 88.6 per cent. So, there is a gap of about 6.3 per cent and then there are other related things as our higher IMR, higher NMR etc. Everywhere, there are gaps of more than 4 in NMR/IMR and 8.4 per cent in under 5 mortalities among ST as compared to All."

1.37 When the Committee desired to know about the interventions by the government to ensure safe motherhood for tribal women and strengthen institutional delivery among tribals, the Ministryof Health and Family Welfare furnished the following written reply:

> "GoI has undertaken various initiatives to strengthen the Institutional deliveries among pregnant women including tribal women prominent among which are:
>
> - Janani Suraksha Yojana (JSY)
> - Janani Shishu Suraksha Karyakaram (JSSK)
> - Surakshit Matritva Aashwasan (SUMAN)"

1.38 The Committee desired to know about the outreach of Janani Suraksha Yojana among

the tribal women and whether incentivizing tribal women have motivated them for institutional delivery, Ministry of Health and Family Welfare furnished the following information in their written replies:

"Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Health Mission (NRHM). Launched with the objective of reducing maternal and neonatal mortality, the Janani Suraksha Yojana (JSY) promotes institutional delivery among pregnant women especially with weak socio-economic status i.e. women from Scheduled Castes, Scheduled Tribes and BPL households. The scheme, launched on 12 April 2005, is under implementation in all states and Union Territories (UTs), with a special focus on Low Performing States (LPS).

However, in remaining States where the levels of institutional delivery are satisfactory, pregnant women from Scheduled Castes, Scheduled Tribes and BPL households only are entitled for JSY benefit. These states are categorized as High Performing States (HPS) under JSY."

1.39 Eligibility and Cash Assistance for Institutional Delivery under JSY are as follows:

Category	Rural area (Rs.)	Urban area (Rs.)	Eligibility
Financial Assistance for Institutional Delivery			
Low Performing States (LPS)	1400	1000	Available to all women regardless of age and number of children for delivery in government /private accredited health facilities.
High Performing States (HPS)	700	600	Available only **to BPL/SC/ST** women regardless of age and number of children for delivery in government /private accredited health facilities.
Financial Assistance for Home Delivery			
Low Performing States (LPS)	500	500	Available only to BPL women who prefer to deliver at home regardless of age and number of children.
High Performing States (HPS)	500	500	

1.40 The Ministry also stated that separate data on tribal beneficiaries of JSY is not maintainedas it is clubbed with Below Poverty Line (BPL) and Schedules Castes (SCs) also.

1.41 Government of India launched Janani Shishu Suraksha Karyakaram (JSSK)on 1st June,2011. The initiative entitles all pregnant women delivering in public health institutions to have absolutely free and no expense delivery, including caesarean section. The entitlements include free drugs, consumables, free diet during stay, free diagnostics and free blood transfusion, if required. This initiative also provides free transport from home to institution, between facilities in case of a referral and drop back home. The scheme was expanded to cover complications during ante-natal and post-natal period and also sick infants up to 1 year of age.

1.42 The Government launched 'Surakshit Matritva Aashwasan'(SUMAN) with an aim to provide assured, dignified, respectful and Quality healthcare at no cost and zero tolerance for denial of services for every woman and newborn visiting the public health facility in order to end all preventable maternal and newborn deaths and morbidities and provide a positive birthing experience. The expected outcome of this new initiative is "Zero Preventable Maternal and Newborn Deaths and high quality of maternity care delivered with dignity and respect".

1.43 In order to increase awareness and community mobilization as well as to track high risk pregnancies, Village Health Sanitation and Nutrition Day (VHSND) and Outreach camps are alsoorganised.

1.44 Since retention of health workers in the tribal area is a challenge, the Ministry of health and Family Welfare has developed a differential strategy for such hard-to-reach areas through more incentives, residential facilities to health care staff and job opportunities for their siblings/spouse as per their educational status.

1.45 When the Committee wished to know the reasons behind tribal women abstaining from the services of health centres during pregnancy and delivery, the Ministry of Health and Family Welfare furnished the following written reply:

> "Tribal families are less keen to abandon the traditional and convenient home delivery.Moreover, on the supply side, there are many barriers:
>
> 1. Retention of health workers in the tribal areas,
> 2. Lack of Accessibility to health facility due to long distance from habitation and lack of proper transportation,
> 3. Loss of time and wages due to hospital admission.
> 4. Alien-ness of the hospital environment during an event that is linked with many traditional beliefs, inconsonance between tribal views and procedures of child birth and the modern methods (e.g., many tribal communities traditionally use the squatting position for giving birth),
> 5. Lack of support of family and traditional birth attendants
> 6. Old beliefs and practices
> 7. Lower level of education
>
> These are some of the reasons behind tribal women abstaining from the services of healthcentres during pregnancy and delivery."

1.46 Explaining further, the Ministry of Health and Family Welfare stated in their written replies:

> "The fact is that for many tribal women, particularly those living in remote and difficult terrains, home deliveries are more. Therefore, in addition to institutional delivery, SBA training is imparted to ANMs. SBAs and ASHAs in tribal areas are being oriented about safe delivery practices. The focus is on early detection of complications, provision of immediate care and transport facilities to the nearest equipped health centre, should the need arise. Tribal women are given the choice to decide where they want to give birth, andboth the places be made safe.
>
> For tribal people living in very remote areas, arrangements for living near the PHC around the time of delivery (transit accommodation) are established and

supported under NHM, some examples are: -

8. The Maher Ghar scheme of Maharashtra which proposes to provide for stay facilities near 57 PHCs in 9 tribal districts. Pregnant women from tribal communities can stay in these Maher ghars with their youngest child and one relative, 4-5 days before their expected delivery date.

9. Tamil Nadu and Andhra Pradesh have also introduced birth waiting rooms in tribal areas."

(viii) Post-natal Care for Tribal Women

1.47 With regard to the mechanism in place to ensure post natal care for tribal women and newborns, the Ministry of Health and Family Welfare submitted the following written reply:

"Structured mechanism for providing postnatal care to lactating mother and newborns are in place under RCH programme.

As per GOI guidelines, for any pregnant women undergoing Institutional birth in public health facilities, a minimum of 48 hours' post-delivery stay is mandatory in order to combat the post-natal complications that may occur in mother and baby.

In case of home delivery or delivery at Sub Health Centre, there is a provision of minimum of4 post-natal visits done by the concerned ANM/ASHA on 1st day (within 24 hours), 3rd day, 7th day and 6 weeks after delivery with additional provision of visits for the newborn on 14th, 21st and 28th day.

Home Based New Born Care (HBNC), through ASHAs, is being implemented across the country since 2011. Under HBNC, six scheduled home visits are being carried out after birth by ASHA in case of institutional deliveries (on days 3rd, 7th, 14th, 21st, 28th& 42nddays) and seven scheduled home visits (within 24 hours, on days 3rd, 7th, 14th, 21st, 28th& 42nddays) in case of home deliveries.

To further strengthen this initiative, Home Based Care of Young Children (HBYC) Program was launched in April, 2018 to provide additional five home visits by ASHAs (3rd, 6th, 9th, 12th and 15thmonths) with the support of Anganwadi Workers to ensure exclusive and continued breast feeding, adequate complementary feeding, age appropriate immunization and early childhood development.

Thus, for both the institutional deliveries as well as home deliveries, there is a well-established mechanism of providing post-natal check up to the mother and newborn within the first two days of delivery and thereafter."

1.48 As per National Family Health Syrvey-5 (2019-21), the postnatal checkup for lactating mothers and newborns are 61.7% and 79.0 % respectively. Therefore, the Committee desired to know the reasons for the difference in the post-natal checkup data of tribal mother and child. In response, the Ministry of Health and Family Welfare submitted the following written reply:

> ". in NFHS; different question sets are being used to capture the data.
>
> In NFHS, the questionnaire on post-natal care of mothers [*mothers who received postnatal care from doctor/nurse/LHV/ ANM/midwifery/other health personnel within 2 days of delivery (%)*] is non-specific and only asks about care and not about health check-up. It also does not include any question on place where the check-up took place.
>
> Whereas the questionnaire on First Postnatal check-up of New born [*Children who received a health check after birth from doctor/nurse/LHV/ANM/midwife/other health personnel within 2 days of birth (%)]* is about physical check-up both at home and at facility level. It specifically asks for name/type of facility where the health check-up took place. At facility level, there is no separate case sheet of normal newborn after delivery and so record of check-up may be missed."

(ix) Communicable Diseases in Tribal Women and Interventions

1.49 The Committee understand that tribal people suffer from communicable diseases like malaria, tuberculosis, Leprosy, other skin infections, HIV/STIs/STDs, typhoid, cholera, diarrhoea, hepatitis, etc. as well as non communicable diseases like hypertension, diabetes mellitus etc. Prevalence of hypertension is already high among the tribal population, while other non-communicable diseases are also catching on. The Ministry of Health and Family Welfare apprised the Committee during the briefing that National TB Elimination programme (NTEP), National Vector Borne Disease Control Programme (NVBDCP), National Leprosy Elimination Programme (NLEP), Integrated Disease Surveillance Programme (IDSP) and National Viral Hepatitis Control Programme (NVHCP) are the major programmes designed under National Health Mission to address Communicable Diseases.

1.50 With regard to the spread of leprosy among tribal people, the Ministry of Health and FamilyWelfare furnished the following through written reply:

> "Under the National Leprosy Eradication Programme (NLEP), as per the reports submitted by States/UTs for the year 2019-20, a total of 21,469 cases (18.76%) have been reported from Schedule Tribes (ST) population, including both tribal men and tribal women. Further, as per the report, female/women patients constitute 39.21% of the total leprosy cases detected during the year 2019-20. If the same percentage is applied to the tribal cases of leprosy detected during the year, approximately 8418 tribal women would be there among tribal leprosy cases in the year 2019-20.

For the year 2020-21, total 13,117 cases (20.12%) have been reported from Schedule Tribes (ST) population, including both tribal men and tribal women. Further, as per the report, female/women patients constitute 36.44% of the total leprosy cases detected during the year 2020-21. If the same percentage is applied to the tribal cases of leprosy detected during the year, approximately 5266 tribal women could be estimated to be there among tribal leprosy cases in the year 2020-21.

Special efforts are being made for ensuring the screening of 100% population in tribal areas with special needs, eg. Hard to Reach Area (HTRA) / geographically far flung areas where the Female/Male Front Line workers do not reside on a permanent basis. The states are making efforts to train some local female and male community volunteers including persons affected by leprosy residing in such areas for Active Leprosy Case Detection on Regular basis (ACD&RS). Further, special efforts are being made in tribal areas for community awareness through intensified IEC activities."

1.51 When the Committee desired to know about the percentage of malaria cases among tribal women and the initiatives taken by the Government to curb them, the Ministry of health and Family Welfare furnished the following written reply :

"In 2020 (prov), a total of 1,81,831 malaria cases and 63 malaria deaths were reported across the country. Of these, 1,10,236 (60.6%) cases and 43 deaths (68.2%) were reported from 177 tribal predominant districts of India.

..... out of 1,10,236 cases, 35,769 (32%) malaria cases were reported among females living in 177 tribal predominant districts.

Steps taken by the Government to curb Malaria in the last five years are as follows:

- In accordance with the WHO's Global Technical Strategy for Malaria Elimination; Govt. of India launched the National Framework for Malaria Elimination (NFME), 2016- 2030 in February 2016 by Hon'ble Union Health & Family Welfare Minister.
- National Strategic Plan for Malaria Elimination (2017-2022) was launched in July 2017.
- Constitution of National Task Force for oversight of all malaria elimination activities in the country under the Chairmanship of Health Secretary along with representation from Ministry of Tribal Affairs.
- Till 2021 (June), 26 states have constituted State and District Task forces for Malaria Elimination.
- Early diagnosis and complete treatment: use of Rapid Diagnostic Test Kits and anti-malarials, ASHA incentives for diagnosis & ensuring complete treatment at community level.
- Case-based surveillance and rapid response.
- Integrated vector management (IVM):
  - Indoor residual spray (IRS) - 2 rounds of IRS for vector control in areas with Annual Parasite Incidence >2.

- Long-lasting insecticidal nets (LLINs): a total of 97.7 million LLINs have been distributed to the community residing in high malaria endemic areas (sub centres with Annual Parasite Incidence >1).
- Larval source management (LSM)
- Epidemic preparedness and early response.
- Behaviour Change Communication and community mobilization
- Tribal Malaria Action Plan: TMAP has been prepared for implementing appropriate strategies in the identified tribal-dominated districts [having tribal population of 25% or more and slide positivity rate (SPR) of 1% or more (in the year 2012)] Antenatal clinics in these areas are also engaged for creating awareness and behavioural change communication (BCC) amongst tribal women.
- Inter-sectoral collaboration in Tribal areas such as training of teachers for screening of school children for malaria and sensitization on prevention & control of malaria; inclusion of malaria in the curriculum of training programs undertaken by tribal research and training institute, Department of Welfare;
- Awards to Districts/ States for achieving 'Zero indigenous case status' and maintaining it for three consecutive years on attaining sub-national malaria elimination, have been instituted for Year 1 and Year 3.
- WHO has initiated the High Burden to High Impact (HBHI) initiative in 11 high malaria burden countries (10 African+ India) implementation of "High Burden to High Impact (HBHI)" initiative has been started in four states i.e. West Bengal, Jharkhand, Chhattisgarh and Madhya Pradesh in July, 2019.

Achievements (effectiveness) of these steps to curb malaria disease are as follows:

- India has made substantial progress in reducing malaria burden. The country has achieved a reduction of 84.5% in malaria morbidity and 83.6% in malaria mortality between 2015 and 2020.
- Among 177 tribal districts, there has been 86.6% reduction in malaria morbidity and 83.4% reduction in malaria mortality between 2015 and 2020.
- Malaria has been made notifiable disease in 31 states/UTs.
- During the last 6 years, 9.77 crore LLINs have been distributed in the high malaria endemic areas of various States/UTs.
- In 2020, 116 districts in the Country have reported 'zero malaria case' out of which 22 are tribal districts.
- Total 34 states/ UTs and around 676 districts have achieved API less than 1.
- As per recently launched, World Malaria Report (WMR) 2020, India is the only high endemic country which has reported a decline of 17.6% in malaria cases and 19.9% in malaria deaths in 2019 as compared to 2018. "

1.52 In response to the Committee's query about the percentage of women and girls affected by TB and the steps taken by the Government to create awareness about TB among the tribal people, the Ministry of Health and Family Welfare furnished the following written reply:

"Tuberculosis has been a priority public health issue identified to be addressed by the Government of India. The National Tuberculosis Elimination Programme (NTEP) is implemented under the aegis of the National Health Mission (NHM) and provides free diagnosis, free treatment and delivers public health functions to reduce the incidence of Tuberculosis (TB) in the country. Government of India has committed to achieve targets for TB under the Sustainable Development Goal by 2025, five years ahead of the global timelines.

Studies have revealed that the remoteness, under nutrition and the living environments primarily contribute to high vulnerability of and poor access to healthcare by the tribal communities. All this poses a challenge in the management of TB in these populations.

The goals of tuberculosis treatment are:

- To decrease case fatality and morbidity by ensuring relapse free cure
- To minimize and prevent development of drug resistance
- To render patient non-infectious, break the chain of transmission and to decrease the pool of infection.

Under NTEP, the benefits of the programme are available to all sections of the society on a uniform and equitable basis, irrespective of caste, gender, religion etc. However, in tribal, hilly and difficult areas, special provisions have been made to expand diagnostics and treatment centres, programme management units, to improve access to TB patients and coverage of TB services under NTEP.

- Tuberculosis Unit (TB Units) - 1 for every 1 lakh population in tribal, hilly and difficult area as against 1 for every 2 lakhs general population. Every TB unit is supported with a supervisory staff for management of diagnosis and treatment services in the area. NTEP has mapped > 800 Tribal TUs in Nikshay

- Designated Microscopy Centres (DMCs) for diagnosis of TB - The norms for establishing microscopy centres has been revised from 1 per 1,00,000 general population to 1 per 50,000 population in tribal, hilly, and difficult areas.

- Compensation for transportation of patient and attendant in tribal areas – Rs. 750 is provisioned to TB patients notified from designated tribal areas to support travel to access TB diagnosis and treatment centres.

- NTEP has introduced Active TB Case (ACF) finding in key / vulnerable populations which includes Tribal areas. Systematic active TB screening is being undertaken in these vulnerable populations for early identification of TB symptomatic and early diagnosis of TB under the campaign known as Aashwasan
. The 100 districts 100 days campaign (later scale to 174 districts) A consultative workshop was held on 24 August 2022, learning of Aashwasan was released along

with SoPS future such campaigns

TB Notification: -

Year	Total TB patients notified			TB patients notified amongsttribal population		
	Male	Female	Total*	Male	Female	Total*
2018	1336595	762630	2100903	131105 (9.8 %)	64708 (8.5 %)	195939 (9.3 %)
2019	1507976	891145	2401379	143526 (9.5 %)	72247 (8.1 %)	215962 (8.9 %)
2020	1117274	694784	1813028	109733 (9.8 %)	56591 (8.1 %)	166392 (9.2 %)
2021	1303843	842128	2146898	118851 (9.1%)	61853 (7.3%)	180766 (8.4%)
2022 (Jan-Jun)	751706	486053	1238273	70134 (9.3%)	36667 (7.5%)	106834 (8.6%)

- **Total figures also include Transgender TB patients.*

- **Percentage of female tribal TB patient initiated on treatment: -**

Year	No. of female tribal TBpatient notified	No. of female tribal TB patient initiated on treatment	No of female Tribal TBpatients with successfultreatment outcome
2018	64708	63749 (98.52 %)	57303 (88.9 %)
2019	72247	70890 (98.12 %)	62786 (88.6 %)
2020	56591	55389 (97.9 %)	44511 (80.4 %)
2021	54830	53761 (98%)	37151 (90.3%)
2022 (Jan-Jun)	79373	77663 (97.8%)	69222 (89.1%)

Recognizing promising prospects in joint collaboration, Ministry of Tribal Affairs and Ministry of Health & Family Welfare are complementing each other in achieving objectives of development tribal communities. A joint action plan has been issued to all the States and UTs and a Tribal TB Initiative has been launched in March'2021. All the States/ UTs are being encouraged to customize the plan as per local context and intelligence."

(x) Mental Health Issues among tribal women

1.53 With regard to the mental health issues faced by the tribal women, the Ministry of Health and Family Welfare submitted written reply:

> "The government has been implementing the National Mental Health Programme(DMHP) being supported from implementation in 692 districts of the country, basic mental health service are being provided to all needy, including tribal women, at all districts supported under the program. Although there is no separate scheme to provide mental health services for tribal women, however, there is flexibility given to the states to do so and seek support from the centre under National Health Mission.
>
> Further, under the Ayushman Bharat, Health and Wellness Centres (AB-HWCs) are being set up at Sub Health Centres (SHCs) and Primary Health Centres (PHCs). The AB-HWCs are envisaged to provide preventive, promotive, rehabilitative and curative care for an expanded range of services encompassing mental healthcare at primary healthcare level."

1.54 The Committee found that National Mental Health Programme (NMHP) is being implemented across the country since 1982. There are various components of programme for institutional support and District Mental Health Programme. The Ministry of Health and Family Welfare elaborated on this further as follows:

> "Services provided under District Mental Health Program at district level includes provision of psychosocial support to the community, use of e-platform for provision of tele-psychiatric services, home delivery of psychotropic medicines to patients, provision of counseling services to patients in quarantine/ isolation center and capacity building of frontline workers. District Mental Health Program is being implemented in 692 districts. Tribal women are beneficiaries in the tribal areas where the National Mental Health Program is operational.
>
> National Psychosocial Support Helpline is operational at National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru to provide psychosocial services during the COVID-19 pandemic. A Digital Academy with three institutions including NIMHANS is operational for capacity building of health care workers for continuity of mental health services during COVID-19 pandemic.
>
> A Training of Trainers program was done for psychosocial support to nurses and other healthcare worker. Strengthening mental health services at primary care level is done by developing guidelines on Mental, Neurological, and substance use disorders at Health and Wellness Centres (HWCs) under the ambit of Ayushman Bharat. "

(xi) Substance Abuse among tribal women

1.55 With regard to the rising cases of substance abuse among tribal women, the Ministry of Health and Family Welfare submitted the following written information:

"As per the National Mental Health Survey (2015-16), the prevalence of substance use disorders (SUDs), including alcohol use disorder, moderate to severe use of tobacco and use of other drugs (illicit and prescription drugs) was 22.4% in the population above 18 years. But Substance use disorders prevalence (dependence+ abuse) was 0.6% in the 18+ population. It was highest (29.4%) in the 50-59 age group. No separate data is maintained at the central level for prevalence of mental health issues and substance use disorders among tribal women.

Mental Health Problems and Substance Use Disorders – especially in areas affected by conflict, addictions to tobacco, alcohol and drugs, for instance drug use is widely prevalent in North Eastern states. There is also a link between addiction disorders and intimate partner or gender- based violence."

(xii) Health Care Infrastructure in Tribal Areas

1.56 With regard to the shortage of healthcare centres in tribal areas as compared to the applicable norms and the measures taken to address the shortfall, the Ministry of Health and Family Welfare furnished the following written information:

"As per RHS 2020-21, the overall deficit of 25.4% sub-centres, 29.2% PHCs, and 27.9% CHCs has been observed in tribal areas.

To address the shortfall on this account following steps are taken:

- Relaxation in the population norms for establishing health facilities in tribal areas. For e.g., for general population CHCs can be established for 1,20,000 population whereas the same for tribal population is 80,000.

- Similarly, PHCs for tribal population can be for 20,000 instead of 30,000 in plains and Sub Health Center can be established for a population of 3000 instead of 5000 in plains.

- In addition to the above for tribal, hilly, and sparsely located population, Health facilities can be established based on time to care approach.

- All tribal and LWE affected districts which are below the state's average of composite health index have also been included as high priority districts. Such districts/areas would receive higher per capita resource allocations as appropriate.

- On account of these special provisions for Tribal areas, the increase in Health Facilities has been more in Tribal areas as compared to other areas.

Type of Facility	All India			Tribal Areas		
	RHS2005	RHS2020	% Increase	RHS 2005	RHS 2020	% Increase
SHCs	146026	1,55,404	6%	16,748	29,745	78%
PHCs	23236	24,918	7%	2,809	4,203	50%
CHCs	3346	5,183	55%	643	1035	61%
Total	172608	1,85,505	7%	20,200	34,983	73%

1.57 As regards the norms relating to establishment of health centres in the tribal areas, Ministryof Tribal Affairs submitted the following through written information:

"Ministry developed a concept of "Comprehensive Primary Health Care in Tribal Blocks" which do not have PHC/CHC facilities and can be mapped with "Comprehensive Tribal Primary Health Care Model" on PPP basis. The concept of MoTA based on the model which is being successfully implemented by Pravara Institute of Medical Sciences (PIMS), deemed to be university, Loni, is also Centre of Excellence of Ministry of Tribal Affairs (Pravara Model) presently on its own.

The comprehensive health action plan will be implemented by the revising guidelines of NGOschemes of MoTA which is under process.

Comprehensive Tribal Primary Health Care Model

Level 1 -Tertiary Health Care Facility – Medical College HospitalLevel 2 - Tribal Primary Health Centre (TPHC)

- Mobile Medical & MCH Clinic
- Motorbike Ambulance (within the jurisdiction of (TPHC)
- Medical Ambulance (4-wheeler for PHC to Higher level Hospital)Level 3 –

Community/Village Health Services

- One Gram Arogya Bank - 1 Arogya Mitra & 1 Traditional Healer
- One Female Health Volunteer/ASHA for every 50 families

Level 1 - Tertiary Health Care Facility

The Tertiary Hospital will provide necessary support to Primary Health Centre by telemedicine centres. Tertiary Hospital will organise monthly specialised Health Check like Ophthalmology, Skin, cardiology through doctors doing MD and Interns on

rotational basis so that they also have feel of tribal specific health issues. The THC will identify and train the manpower required for Level 2 and level 3 services including Tribal Healer. Depending upon the Infrastructure available with tertiary hospital, at least 2 Tribal Primary Health centre can be attached to 1 THC. Each PHC should cover at least 10 villages or 20000 population. The THC will also maintain data base of each tribal linked with Aadhar and Aayushman Bharat card and the data will be shared centrally with MoTA through a dedicated portal.

Level 2 – Tribal Primary Health Centre (THC)

- TPHC is a first contact point for providing the preventive and curative health care servicesin the tribal areas. A TPHC covers a population of around 20,000 and offers services including Antenatal care, post-natal care, general health care, and other vertical health programs (malaria), selected emergency services, nutrition centre for treatment of MAM & SAM children, geriatric health care, youth health clinic, health education, health awareness, counselling and diagnostic services. THC extends its services in the villages through Mobile Medical & MCH clinic and motorbike ambulance-cum-health clinics regularly on a fixed advanced tour program.

a. Mobile Medical & MCH Clinic:Mobile clinic extends the selected diagnostic services and also conducts the health education and awareness sessions in the villages. The mobile clinicreports to the MO, TPHC. Mobile Clinic has facility of examination table, ECG and BasicLaboratory,
b. Motorbike Ambulance-cum-Health Clinic:Motorbike ambulance manned by one Male and One female nurse conducts health clinics in the remote villages where routine Mobile Medical & MCH clinic cannot reach.
c. Medical Ambulance-The TPHC also extends the emergency ambulance services to the tribal villages. The services are extended for transportation of emergency patients to the tertiary health facility.

Level 3 – Community / Village Health Services

a. Arogya Bank and Arogya Mitra (Female) & Traditional Tribal Healer (Male)

Arogya Bank is main health facility in the village equipped with adequate furniture, First Aid Box, Primary Drugs & supplies, digital BP apparatus, Glucometer, Digital thermometer, Digital Stethoscope, weighing machine, height measuring tape, preliminary dental, physiotherapy equipments, Ayurveda & Traditional Tribalsystems of medicine facilities, health library& IEC material etc. Arogya Mitra is preferably a Nursing Aid (400 hours training) or a retired teacher, retired health professional, social worker or a volunteer. Arogya Mitra directly reports to the Tribal Primary Health Centre. Arogya bank covers population of 2000 and act as a focal center for Mobile clinic, Motorbike ambulance and Tribal Health Centre. A minimum of Five Arogya Banks will have to be established under each TPHC.

b. Female Health Volunteer (FHV) –FHV/ASHA is a grass root level honorary health worker in the tribal village trained in the primary health care in a modular training conducted by a tertiary health care facility. She covers approximately 50 families in the village. FHV acts a viable link between the village community and cluster level Gram Arogya Bank and Mobile Medical Clinic, Motorbike Ambulance-cum-health clinic and Tribal Primary health centre. FHV/ASHA reports to the Tribal Health Centre though theArogya Bank."

1.58 Elucidating on the role of Arogya Mitra, the Ministry of Health and Family Welfare furnished the following written information:

"Arogya Mitra also known as Pradhan Mantri Arogya Mitra (PMAM) is a system established under the scheme 'Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (AB-PM-JAY)'. This scheme endeavours to offer secondary and tertiary health coverage of Rs. 5,00,000 (per family) to more than 10 crore beneficiary families, accounting for more than 40 percent of India's population at empanelled hospitals.

Pradhan Mantri Arogya Mitra (PMAM) assists beneficiaries at Empanelled Health Care Provider (EHCP) to streamline the health service delivery and provide a seamless experience to the beneficiary. Arogya Mitra is placed at each EHCP, is a certified frontline health serviceprofessional who shall be present at each of the EHCP and shall serve as a first contact point for beneficiaries. They are available in all empanelled Hospitals including those in tribal areas.

The Arogya Mitra is responsible for the following broad areas:

- Guiding the Beneficiary about the overall benefits under AB PM-JAY and providing information about receiving prompt treatment at EHCP
- Operating the Beneficiary Identification System to identify and verify the beneficiariesentitled under AB PM-JAY
- Operating the Transaction Management System such as submitting requests for Pre-Authorization, Updating Surgery/Treatment Details and Filing for Claims
- Ensure the privacy and confidentiality of personal and sensitive beneficiary information is maintained while operating IT systems under AB PM-JAY.

Each Arogya Mitra is be trained in all aspects of their roles and responsibilities. Training will use both face-to-face as well as online modes. Post training, eligible PMAMs would take up tests and would receive a certificate on successful completion of the test.

The State Health Agency/Agency (if hired)/Hospitals is responsible to conduct refresher training of the Arogya Mitra ensuring they are aware of any changes in their role. "

1.59 The Ministry of Health and Family Welfare in regard to the health facilities in tribal areas, stated during the oral evidence:

"Since reaching the last mile has been our priority and since the facility presence in the tribal areas was discussed, I would like to report that since the time NHM came into being, there has been a 73 per cent increase health facilities in tribal areas compared to a 10 per cent increase All-India. So, we have tried our best to ensure that when all the sanctions, as Sir, was saying are given in PIP, a complete priority is given to tribal areas. If we see for sub-centres, why this increase is 9 per cent in All-India tribal areas, this increase is 78 per cent. In PHCs, it is 8 per cent in All-India, it is 50 per cent in tribal areas. In CHCs, it is 61 per cent in both. On total, it is 73 per cent increase in tribal areas against 10 per cent increase in All-India level. Even if we look at the shortfall in public health facilities, which we constantly compile based on the rural health statistics, overall, shortfall in the country is 20 per cent whereas in tribal areas, it is 12 per cent. Having said this, Madam, even for this 12 per cent, we are working continuously to ensure that this gap should be closed and in our next phase of NHM, which we have proposed before the Finance Ministry, we have very clearly stated that the saturation of public health facilities in tribal areas will be one of the biggest priorities under the national health mission, next phase, because all the CSS schemes are now up for extension so as NHM. Now, in our proposal, we have very clearly elucidated that the saturation of public health facility in tribal areas will be our biggest priority."

1.60 The Ministry of Health and family Welfare further submitted during the oral evidence asunder:

"Another newer initiative, Madam, which was launched in 2018 by the Hon'ble Prime Minister is the Ayushman Bharat Health and Wellness Centres. We have now a target of setting up of 1,50,000 such health and wellness centres in the sub-centres and the primary health centres. I am happy to report that currently 80,638 such health and wellness centres are operational. The difference in these heaith and wellness centres compared to the previous sub-centres and PHCs is that they are close to the community. They are going to be given not only curative but also preventative and health promotional activities by way of conducting regular yoga or other exercise sessions, by way of timely screening of people and by way of non-communicable diseases like diabetes. These health and wellness centres will not only provide the mother and child health services but they are now providing an expanded range of services, about 12 packages of services, which cover services not only for mother and child but also for non-communicable disease, palliative rehabilitative care, oral, eye, E&T, mental health and the first level of emergencies and trauma care. These centres will also provide free drugs and diagnostics in these health and wellness centres.

The number of tests that would be available diagnostic test and the drugs that would be available, both have been expanded in these centres so that drugs and diagnostics which form a big part of the out-of-pocket expenditure by people, these are available to the peopleclose to their homes."

1.61 In regard to insurance schemes, Ministry of Health and Family Welfare submitted during the Oral Evidence that under Ayushman Bharat Pradhan Mantri Jan Arogya Yojana whichis an entitle-base scheme in which the identified beneficiaries from the Socio-Economic-Caste Census database are automatically covered. Among the six deprivations of the SECC database, there is also the ST population. They constitute about 15.3 percent of the total beneficiaries under the PMJAY which is about 7.69 crore beneficiaries are automatically covered under the pradhan mantri Jan Arogya Yojana.

1.62 With regard to the initiatives taken for aspirational districts, the Ministry of Health and Family Welfare informed during the Oral Evidence that out of the 112 aspirational districts, thereare 60 districts which are tribal districts and in these districts a special three-year action plan whichcovers the reproductive maternal child and adolescent health have been prepared.

(xiii) Ambulances/Motor Bike Ambulance/ Emergency Transportation in Tribal Areas

1.63 When the Committee desired to know about the States that provide free emergency transportation to take pregnant tribal women to health centres and the reasons for general lack of emergency transportation system in tribal areas, the Ministry of Health & Family welfare stated in their written replies as follows:

"Currently under NHM, all States are being supported for provision of free ambulance services through two models, namely, Dial 108(ALS/BLS) and Dial 102 (Patient transport) services. Dial 108 is predominantly an emergency response system, primarily designed toattend to patients of critical care, trauma and accident victims etc. Dial 102 services essentially consist of basic patient transport aimed to cater to the needs of pregnant women and children though other categories are also taking benefit and are not excluded.

The support under NHM for Emergency Referral Services under Dial 108 type Ambulances includes support for both Basic Life Support (BLS) and the Advanced Life Support (ALS) Ambulances. While one advance life support (ALS) ambulance (with ventilator) is supported for an average population of 5 Lakh, one BLS (without ventilator) Ambulance is supported for over one lakh population. If the need arises, there is a provision of allocating one ambulance per 50,000 populations in the plains/densely populated areas. In addition, Janani Shishu Suraksha Karyakram (JSSK) affords free entitlements along with ambulance services to pregnant women (under National Ambulance Service), free drugs and diagnostics to reduce OOPE etc. in all states to help increase institutional deliveries.

Under JSSK and SUMAN every pregnant women including tribal women are entitled for free referral and transport. Under National Health Mission (NHM), Govt. of India (GOI) provides technical and financial support for emergency medical services in States/UTs through a functional National Ambulance Service (NAS) network linked with centralized toll free number 102/108.

For ensuring better access to ambulances particularly in NE region, GOI has constituted an expert group to examine and recommend the type of vehicle and ambulance in North Eastwhich has predominantly the tribal population."

1.64 On the availability of Motor Bike Ambulances in tribal areas, Ministry of Health and Family Welfare submitted the following through written reply:

"As per information available at https://www.unicef.org/india/stories/motor-bike-ambulance-providing-accessibility-health-services-indias-remote-regions, with UNICEF support, now modified four-stroke motorcycles, which works as a 'Motor-Bike Ambulance', is proving to be a boon for the people of the region, bridging the last mile to health care. The motorcycle ambulances ferry patients and pregnant women and infants, from remote areas to the nearest primary and Community Health Centers (CHCs) and haveemerged as a lifesaver for the people of the region.

These ambulances are fitted with a side-carriage for the comfort of the patient and are equipped with medicines and a functional first-aid kit to meet emergency needs. The ambulances are operated by skilled drivers adept in providing first-aid. The concept has already seen much success in African countries.

The project was designed and initiated in June 2014 with UNICEF's support, in association with SAATHI Samaj Sewa Sanstha, an NGO and the state government's Health Department. Since its inception, 14 more motorcycle ambulances have been deployed in Chhattisgarh with government funding, which have transported over 7,900 women and infants to hospitals and CHCs. The initiative has significantly contributed towards bringingthe MMR in the state down to 141 from 173 per 100,000 live births in 2014-2016, and alsohelped raising the number of institutional deliveries."

(xiv) Mobile Medical Units

1.65 On the adequacy of mobile medical units in tribal areas and their good maintenance, the Ministry of Health and Family Welfare submitted the following written information :

"GoI has developed guideline on MMU in year 2015 under which there are 3 models. The responsibility for maintenance and repair lies with respective states. The primary responsibility to provide Mobile Medical Unit (MMU) services too lies with the respective State Governments/UTs.

Under the National Health Mission (NHM), technical and financial support is provided to States/UTs to strengthen their healthcare systems including support for Mobile Medical Unit service, based on the proposals made by the States/UTs as per their requirement in their Programme Implementation Plans (PIPs) within their overall resource envelope.

As per the GOI guideline on MMU, the currently approved norm is one MMU per district with a normative population of 10 lakhs, with a cap of five MMUs per district. This has been further relaxed for hilly and tribal areas, where the populations are widely dispersed, geographical terrain is difficult and public health services are deficient.

Funds for the maintenance of the vehicle/MMU are in build in the Opex cost and being provided to the states based on the proposals made by the States/UTs as per their requirement in their Programme Implementation Plans (PIPs) within their overall resource envelope."

1.66 Explaining the disadvantages observed in health delivery by Mobile Medical Units, Ministry of Health and Family Welfare submitted the following written information :

"As per MIS (Dec 2020), total 1691 MMUs are presently running under NHM in the country. MMUs are temporary mode of providing health services. It is not an assured mode for providing health care services, so, states need to have simultaneous plans for assured services through health care facilities. There are states where MMUs are underutilized, including services, diagnostics, and some other states where follow up is not being undertaken properly.

Operational challenges of MMU are as under: -

- While running in hilly & remote areas, there are chances of breakdown and damage to the vehicle due to the difficult terrain.
- Frequent maintenance of vehicle is a challenge in hilly and tribal areas.
- MMUs has limitations in providing all the Comprehensive Primary Health Care (CPHC) health care services to the community including wellness activities, telemedicine, comprehensive primary health care etc.
- Also, the Morbidities and MMU schedule have no correlation.
- AB-HWCs, once established at every Sub Health Centre, will provide health care services close to the community including in remote and tribal areas."

(xv) Adequacy of Healthcare Professionals And Medicines in Tribal Areas

1.67 With regard to the number of trained doctors and nurses in the health facilities in the tribal areas and vacancy of medical professional posts during the last five years, Ministry of Tribal Affairs submitted the following written reply:

".....In India, across 10 states with sizable tribal population, the percentage surplus/deficit of healthcare providers in tribal areas is found to be -3.2% ANMs at HSCsand 18.3% at PHC, -8.6% Allopathic doctors at PHC, and -81.7% specialists at CHC

which depict the huge deficiency of specialist doctors and thus quality healthcare, lacking Human Resources for Health (HRH) in the existing primary healthcare system. This is the state of healthcare delivery system in tribal areas despite having more than 50% and 66% of tribal population being dependent on public health system. In terms of health care personnel, it is observed that there are shortfall of doctors, specialists, nurse and paramedics, Lab technicians in tribal inhabited areas in comparison to all areas in India. Rural Health Statistics (RHS 2020-21) data issued by Ministry of Health and Family Welfare, reveal that shortfall of Specialist at PHC is 81.7% in tribal areas whereas 79.9% % in all areas in the year 2020-21. Further if we see the trend of growth and changes of human resources in existing health care system, the most significant issue is that the instance of percentage of human resources shortfall is decreasing in the recent years e.g. shortfall of Health Worker (F) / ANM at Sub Centres is 13.4% in 2012 to 3.2% in 2020-21, shortfall of Health Worker (M) at Sub Centres 60.2% in 2012 to 54.0% in 2020-21, shortfall of Doctors at PHCs is 18.3% in 2012 to 8.6 in 2020-21 shortfall of Surgeons at CHCs is 83.4% in 2012 to 82.1% in 2020-21, shortfall of Rediographers at community health centres is 68.4% in 2012 to 59.3% in 2020-21, in the tribal areas. Further, the decreasing trends in shortfall of laboratory technicians at PHC and CHCs is noticed in the recent years to 34.9%in the year 2021 from 43.9% in the year 2012 in the tribal areas. In case of shortfall of staff nurses at PHCs and CHCs the percentage of declining number of personnel is most astonishing and it has come down from 38.3% in the year 2012 to 20.4% which is almost reduced to almost half in a decade."

1.68 In this regard, Ministry of Health and Family Welfare also furnished the following written information:

"Attracting and retaining doctors and specialists to rural areas has long been a challenge for the public health system. Given the inaccessibility of tribal areas and the propensity to regard them as demotivating postings due to lack of adequate socio-economic and cultural infrastructure, this problem is further compounded in tribal areas.

Human Resource	Tribal Areas		All India	
	% shortfall in 2013	% shortfall in 2021	% shortfall in 2013	% shortfall in 2021
Specialists at CHCs	84 %	81.7%	72 %	79.9%
Laboratory Technicians at PHCs and CHCs	48 %	33.8% PHC 1.1% CHC	45 %	27.1%

According to RHS 2020-21 there is a shortage of 69 GDMO, 3186 Specialists, 1340 LTs and 607 Staff nurse in the tribal states in India."

1.69 When the Committee desired to know whether the Ministry of Health and Family Welfare has received complaints about non-availability of doctors or nurses or para-medical staff in the last five years and the monitoring mechanism in place to ensure that the deputed doctors/nurses/other medical staff are available in the tribal health centres, the Ministry furnished the following information:

"Under NHM, the States/UTs are supported financially and technically to strengthen their health care systems including for HR in tribal areas as per the demands posed by States/UTsin their Programme Implementation Plans.

However, the administrative issues including the monitoring of availability and attendance of health personnel at various health centres lies under the purview of State/UT Governments.

Hence, as and when complaints regarding non-availability of doctors or nurses or para-medical staff are received, same are forwarded to respective State Governments for necessary action at their end.

All support and flexibility is provided under NHM for states to incentivise Human resources for Health to work in remote and difficult areas including the tribal areas

Under NHM, Government of India provides support to States/UTs for hard area allowanceto healthcare professionals for serving in rural and remote areas and for their residential quarters so that they find it attractive to serve in public health facilities in such areas.

The States are also encouraged to adopt flexible norms for engaging specialists at public health facilities. These include various mechanisms for 'contacting in' and 'contracting out' of specialist services, empanelling private medical facilities to provide requisite Specialists and other methods of engaging specialists outside the government system for service delivery at public facilities and the mechanism to include requests for these in the state Program Implementation Plans (PIP) under the National Health Mission.

NHM provides for following types of incentives and honorarium to staff for ensuring service delivery in rural and remote areas in the country

- Honorarium to Gynecologists/EmoC trained, Pediatricians & Anesthetist/LSAS trained doctors for conducting C Sections.
- Incentives for staff for serving in rural and remote areas: Hard area allowances and special packages are provided to attract health HR, especially medical officers and specialists, to remote and difficult areas.
- Other incentives for service delivery: Incentives like special incentives for doctors, incentive for ANM for ensuring timely ANC checkup and recording, incentives forconducting ARSH activities etc

In addition, non-Monetary incentives such as preferential admission in post graduate courses for staff serving in difficult areas and improving accommodation arrangement in rural areas have also been introduced under NHM.

Government of India has requested the States to formulate HR policies so that availability of health HR is improved and rational deployment of available HR is a practice. It is also to be noted that Formulation of policy on rational deployment of existing HR is an agreed conditionality for support for Human Resources under NHM."

1.70 On motivating health professionals to work in tribal areas, the Ministry of Tribal Affairs further informed:

"Several States have taken up initiatives to incentivize working in tribal areas which has helped in increasing the institutional staff availability to some extent. E.g. Chhattisgarh government gave more autonomy to district collectors along with access to flexi-funds such as National Health Mission (NHM) and district mineral funds (DMF) making it possible for them to offer specialists salaries that are two-and-a-half to three times of what they'd get elsewhere."

1.71 The Committee were informed that the shortage of necessary drugs in tribal health centres and monitoring of the stock and availability of the same through written information:

"The primary responsibility of providing drugs to all including in tribal areas is that of respective State Governments. However, to ensure availability of essential drugs and diagnostics and reduce the Out of Pocket Expenditure (OOPE) of the patients visiting the public health facilities, Government has rolled out the Free Drugs Service Initiative (FDSI) and Free Diagnostics Service Initiative under National Health Mission (NHM).

Under this, financial support is provided to States / UTs for provision of medical equipment and free essential medicines in public health facilities based on the requirements posted by them in their Programme Implementation Plans (PIPs) within their overall resource envelope. This support includes for strengthening/setting up robust systems of procurement, quality assurance mechanism, warehousing, prescription audit, grievance redressal, dissemination of Standard Treatment Guidelines, and IT backed supply chain management systems like Drugs and Vaccines Distribution Management Systems (DVDMS).

DVDMS is a web-based Supply Chain Management System that deals in purchase, supply, distribution and inventory management of various drugs, sutures, surgical and consumable items. It has an in-built provision of monitoring and checking the availability of medicine at all facilities at district and state level. DVDMS links various Regional/ District Drug Warehouses (DWH), District Hospitals (DH), their sub stores like Community Health Centres (CHC) and Primary Health Centres (PHC). Moreover, it has the functionality for distribution of drugs to patients, thus enabling tracking of consumption till last mile."

1.72 On the status of availability of medical counsellors in the hospitals and health centres, the Ministry of Health and Family Welfare submitted the following written reply:

> "Counsellors in hospitals and health facilities including in tribal areas are available under various programme heads such as for RMNCHA, adolescent health, child health, mental health, TB, National AIDS Control Programme etc., the status of which is maintained by the state governments and is within their domain."

(xvi) Asha and Anganwadi Workers

1.73 On a query regarding the of ASHA workers in securing health for the tribal people, especially the women and children, the Ministry of Health and Family Welfare submitted the following in a written reply:

> "ASHA has been put in place all over the country, as the first port of call for supporting community in accessing primary health care services. Right from the beginning of NRHM in 2005, all tribal states and tribal areas across the country were taken up for deployment of ASHAs.
>
> In tribal areas, the ASHA has been deployed at the level of habitation, covering, on an average, a population of 300 to 500 (the general norm for ASHAs is to cover approximately 1000 population), to enable closer access of healthcare for the community. There is a deeper reach of public health services through ASHAs, particularly in the tribal communities. The role of ASHA in the RMNCHA program has been significant and is now being sought to expand to NCDs as well."

1.74 The Committee have found that the expert committee on tribal health recommends that there should be one ASHA per 50 households or 250 populations in tribal areas. The ASHA are chosen from the community they serve. She may be less educated but are trained for expanded functions. The ASHAs are guided/supported by the Health and Wellness Centre. As on April 2021, a total of 9.8 lakh (95%) ASHAs are functional in all the States and UTs except Goa and Chandigarh against a target of 10.34 lakh as per population norms. Around 1.7 lakh ASHAs are functional in tribal/hilly areas of 31 States and UTs. ****(deleted)

1.75 The Committee learnt that Anganwadi Services (under Umbrella Integrated Child Development Services Scheme) is a centrally sponsored scheme of the Ministry of Women and Child Development which is implemented by States/UTs across the country. The objectives of the scheme are:

1. to improve the nutritional and health status of children in the age-group 0-6 years;
2. to lay the foundation for proper psychological, physical and social development of the child;
3. to reduce the incidence of mortality, morbidity, malnutrition and school dropout;
4. to achieve effective co-ordination of policy and implementation amongst the various departments to promote child development; and

5. to enhance the capability of the mother to look after the normal health and nutritionalneeds of the child through proper nutrition and health education.

1.76 On the services rendered by an Anganwadi worker, , the Ministry of Women and Child Development furnished the following written information:

"Roles and Responsibility of AWWs are:

i. To elicit community support and participation in running the programme.

ii. To weight each child every month, record the weight graphically on the growth card, use referral card for referring cases of mothers/children to the sub-centres/PHC etc., and maintain child cards for children below 6 years and produce these cards before visiting medical and para-medical personnel.

iii. To carry out a quick survey of all the families, especially mothers and children in those families in their respective area of work once in a year.

iv. To organise non-formal pre-school activities in the anganwadi of children in the age group3-6 years of age and to help in designing and making of toys and play equipment of indigenous origin for use in anganwadi.

v. To organise supplementary nutrition feeding for children (0-6 years) and expectant and nursing mothers by planning the menu based on locally available food and local recipes.

vi. To provide health and nutrition education and counselling on breastfeeding/infant & youngfeeding practices to mothers/anganwadi Workers being close to the local community, can motivate married women to adopt family planning/birth control measures.

vii. To help and coordinate the pregnant and lactating mothers visiting the centre to get the birth of their child registered and share the information with the village level functionary who has notified as Registrar of Births.

viii. To make home visits for educating parents to enable mothers to plan an effective role in the child's growth and development with special emphasis on new born child.

ix. To maintain files and records as prescribed.

x. To assist the PHC staff in the implementation of heath component of the programme viz. Immunisation, health check-up, ante natal and post natal check etc.

xi. To assist ANM in the administration of IFA and Vitamin A by keeping stock of the two medicines in the Centre without maintain stock register as it would add to her administrative work which would effect her main functions under the Scheme.

xii. To share information collected under ICDS Scheme with the ANM. However, ANM will not solely rely upon the information obtained from the records of AWW.

xiii. To bring to the notice of the Supervisors/CDPO any development in the village which requires their attention and intervention, particularly in regard to the work of the coordinating arrangements with different departments.

xiv. To maintain liaison with other institutions (Mahila Mandals) and involve lady school teachers and girls of the primary/middle schools in the village which have relevance to herfunctions.

xv. To guide Accredited Social Health Activities (ASHA) engaged under National Rural Heath Mission in the delivery of health care services and maintenance of records under the ICDSScheme.

xvi. To assist in implementation of Krishori Shakti Yojana (KSY) and motivate and educate the adolescent girls and their parents and community in general by organizing social awareness programmes/campaigns etc.

xvii. AWW would also assist in implementation of Nutrition Programme for Adolescent Girls (NPAG) as per the guidelines of the Scheme and maintain such record as prescribed underthe NPAG.

xviii. Anganwadi Worker can function as depot holder for RCH Kit/contraceptives and disposable delivery kits. However, actual distribution of delivery kits or administration of drugs, other than OTC (Over the Counter) drugs would actually be carried out by the ANMor ASHA as decided by the Ministry of Health & Family Welfare.

xix. To identify the disability among children during her home visits and refer the case immediately to the nearest PHC or District Disability Rehabilitation Centre.

xx. To support in organizing Pulse Polio Immunization (PPI) drives.

xxi. To inform the ANM in case of emergency cases like diahorrea, cholera etc."

1.77 With regard to the honorarium/incentive offered to them for various services, it has beeninformed as under:

"The Central Government on 01.10.2018 has enhanced honorarium of AWWs from ₹ 3,000/- to ₹ 4,500/- per month; AWWs at mini-AWCs from ₹ 2,250/- to ₹ 3,500/- per month; AWHs from ₹ 1,500/- to ₹ 2,250/- per month; and introduced performance linked incentive of Rs.250/- per month to AWHs and Rs.500 to AWWs. In addition, States/UTs are also paying additional monetary incentives/honorarium to these functionaries from their own resources"

Award: In order to motivate AWWs/AWHs, there is provision of an award scheme @ Rs.50,000/- for 100 selected AWWs and Rs.40,000/- for 50 selected AWHs.

Uniform: Government has made a provision for a set of two Uniform (saree / suit per AWW/AWH per annum)."

1.78 On being asked about the monitoring mechanism followed in the Anganwadi Scheme, WCD stated as below:

"The Anganwadi Services Scheme has an in-built monitoring system since its inception to track the physical progress of the scheme in respect of various input process, output and impact indicators through regular reports, monthly, half yearly, quarterly etc. maintained in standardized Management Information System (MIS). A web-based Rapid Reporting system has also been introduced for the Anganwadi Services under Umbrella ICDS for capturing on-line data. A robust ICT enabled platform named Poshan Tracker has been designed to capture real-time data on implementation and monitoring of Anganwadi Services across the country. The Poshan Tracker management application provides a 360-degree view of the activities of the Anganwadi Centre, service deliveries of Anganwadi Workers and complete beneficiary management."

1.79 During the oral evidence of the Ministries, the Committee had unanimously expressed their deep appreciation about the unmatchable services rendered by the ASHA workers even during the COVID 19 pandemic.

1.80 In response, the Ministry of Women and Child Development further stated during the Oral Evidence as follows:

"In fact, if you see in rural areas, there are 13 lakh anganwadi workers, around 11.5 lakh anganwadi helpers and you have 9.6 lakh ASHA workers. So, altogether, we have 33.7 lakh workers who are the foot soldiers on ground and whatever issues we are facing, these are the people who are going to each and every house. In the worst of Covid-19, Anganwadi workers have been giving take home ration to all the families.

..... we tried our level best to get them declared as frontline workers but that was not agreed to by the Finance Department. By doing so, at least in that case, the workers who had passed away would have got a substantial amount as insurance. That was one issue. "

1.81 With regard to the coordination between ASHA workers and Anganwadi workers, the Ministry of Women and Child Development submitted as follows:

"Three of the six services viz., immunization, health check-up and referral services are related to health and are provided by NRHM & Public Health Infrastructure. National Rural Health Mission (NRHM), the Reproductive and Child Health Programme Phase-II, comprehensively integrate like Infant and Young Child Feeding, Immunization against six vaccine preventable diseases, vitamin A supplementation and iron and folic

supplementation, setting up of Nutritional Rehabilitation Centres to address severe and acute malnutrition etc. These programmes under NRHM are implemented in convergence with the Anganwadi Services. This convergence gets effectuated through the grass-roots functionaries i.e. AWW under Anganwadi Services Scheme and ANM and ASHA Workers under Ministry of Health & Family Welfare as under:

1. Observance of monthly VHND at AWCs – immunization, ANC, PNC etc
2. Referral of sick/malnourished children by AWWs to health facilities and ANM
3. Biannual rounds of Vitamin A supplementation (as done in several States)
4. Use of joint Mother Child Protection [MCP] card by ANM and AWWs
5. Participation at meetings of Village Health Sanitation and Nutrition Committee [VHSNC]
6. Monthly meetings by ANM and AWW at SC level.
7. Joint trainings conducted by NHM."

(xvii) Traditional Medicines and Healers in Tribal Community

1.82 On the role of healers and the importance of traditional medicines in the lives of tribal people, the Ministry of Health and Family Welfare submitted the following written information:

> "Even today, many tribal communities rely on herbal and indigenous systems of medicine. In 2015, a study funded by Government of Meghalaya found that 87% of the respondents believed their traditional system of herbal medicine to be efficacious and 46.% reported using it in the 3 months prior to the survey. In comparison, only 31% had heard of any of the AYUSH (Ayurveda, Yoga, Unani, Siddha and Homeopathy) systems and only 10.5% had ever used it in their lifetime."

1.83 With regard to the efforts taken to integrate traditional healers in tribal communities into formal healthcare system, the Ministry of Tribal Affairs furnished the following written reply:

> "It is now being widely accepted that several basic needs of primary health care in tribal areas are being managed by the traditional community healthcare providers (Tribal healers). They are the repositories of centuries of wisdom and knowledge of health practices. The traditional community healthcare providers (Tribal healers) are the repository of diverse community and region-specific ecosystems, knowledge, skill and experience. Ministry is contemplating to recognize the knowledge and skills of traditional community healthcare providers (Tribal healers) to get them empowered for providing quality health services to the community in tribal dominated areas. In order to protect traditional tribal knowledge of treating diseases with locally available medicinal plants, which is fast vanishing, Patanjali Research Institute has been given pilot project for research on Tribal Healers and Medicinal Plants in Uttrakhand."

(xviii) Research and Data on Tribal population and Traditional Knowledge

1.84 With regard to research and preservation of information on the traditional medicinal knowledge of the tribals, the Ministry of Health and Family Welfare submitted the following written reply:

> "As per the information furnished by MoTA, Tribals have a vast traditional knowledge of treating diseases with locally available medicinal plants. To protect this knowledge, Patanjali Research Institute has been given pilot project for research on Tribal Healers and Medicinal Plants in Uttarakhand.
>
> Similar projects have been given to AIIMS-Jodhpur, Parvara Institute of Medical Science and Mata Amritamai Institute for Rajasthan, Maharashtra and Kerala respectively.
>
> TRI Uttarakhand has been made nodal centre for coordination of research works being conducted for tribal medicine so as to create a centralized knowledge hub on the subject. An integrated centre for AYUSH has been set up in Uttarkhand with WHO support."

(xix) Social Determinants of Tribal Health

1.85 On the action taken to address the social determinant issues faced by the tribal people, the Ministry of Tribal Affairs submitted the following written reply:

> "Ministry in collaboration with Ministry of Rural Development has done mapping of sectoral gaps down to the level of Gram Panchayat & Village. The data has been maintained at the online portal. These data may be utilized for chalking out strategies for mitigating sectoral gaps at village level in the field of Education, Health, Immunization, Drinking Water, Sanitation, Road Connectivity, Mobile / Internet Connectivity, Housing, Electrification, LPG Connection, financial inclusion, insurance coverage, Skill development and Entrepreneurship development etc. The efforts made through TSP / STC strategy have brought out improvements in terms of literacy, health, livelihood etc."

1.86 The details of gap analysis done by Ministry of Tribal Affairs based on data available in Census 2011 and Mission Antyodaya maintained by MoRD, out of 1,17,000 tribal villages with ST population of 25 percent or more in 177 Tribal dominated Districts, are given in Annexure.

1.87 In order to assess the poverty status of the tribal people, the Committee desired to know about the starvation deaths that have happened among tribal people in various States and in response, the Ministry of Tribal Affairs submitted the following written reply:

> "As such no Institutional mechanism is available with MoTA to generate data on starvation deaths that have occurred among tribals. MoTA is dependent on MoH&FW and State Government for seeking such information whenever required. Tribal related

data is generated by the Ministry of Tribal Affairs and other Government Ministries/agencies such as Ministry of Health and Family Welfare, Ministry of Human Resource Development, Registrar General of India, Ministry of Statistics and Programme Implementation (MoSPI), National Crime Records Bureau etc".

(xx) Constitution of National Tribal Health Council

1.88 The Committee found that the Expert Committee on tribal health had given a recommendation for constitution of National Tribal Health Council, an apex body along with Tribal Health Directorate and a Tribal Health Research Cell. In this regard, Ministry of Tribal Affairs stated as follows during the oral evidence:

"Your second question was this. What Abhay Bang Committee had said about the National Tribal Health Council? I would like to tell you that after that, the Ministry had prepared a Tribal Health Action Plan. That Action Plan was shared with the NITI Aayog and the Ministry of Health and Family Welfare. It was also shared with all the States. So, a joint committee was formed. The Secretary (Tribal Affairs) and the Secretary (Health) had taken a meeting with the Principal Secretaries (Tribal Welfare) as well as the Principal Secretaries (Health) of all the States. Nine States have also given their details about how they want to saturate these gaps. On 24th of March, the Ministry of Health and Family Welfare and the Ministry of Tribal Affairs have signed an MoU on elimination of tuberculosis also. So, an MoU on T.B. eradication programme has also been signed. Ministry of Tribal Affairs further informed that a Tribal health cell was established at ministry of tribal Affairs to look after the issues related to Tribal Health in convergence with other associated Ministries."

(xxi) Role of NGOs in the Healthcare of the Tribal Population

1.89 With regard to the NGOs working for the welfare of the tribal people under the Ministry of Tribal Affairs and monitoring of their activities, Ministry of Tribal Affairs, submitted as follows:

"Ministry of Tribal Affairs implements Scheme of 'Aid to Voluntary Organizations working for the welfare of Scheduled Tribes' to enhance the reach of welfare schemes of Government and fill the gaps in service deficient tribal areas, in the sectors such as education, health and promotion of education among tribal girls in the identified low literacy districts of the country.

The NGOs / VOs funded under the scheme are monitored as per the following schematic procedures:

- Annual inspection by District Authorities
- Scrutiny and recommendation by multi-disciplinary State Level Committee
- Mandatory submission of annual audited accounts and utilization certificate by

NGOs/VOs

- Inspection by Officers of Ministry of Tribal Affairs time to time
- Filing of expenditure by aided NGOs / VOs on PFMS Expenditure Advance Transfer (EAT) module
- Third party monitoring by an independent agency appointed by the Ministry"

1.90 Ministry of Health & Family Welfare have many schemes to involve NGOs in various national programmes to tackle the problems of tuberculosis, blindness, cancer, HIV/AIDS and leprosy etc. The Department of Family Welfare runs a unique scheme of Mother NGO (MNGO) to manage and fund the smaller NGOs known as field NGOs.

1.91 The Committee also held interaction with Piramal Swasthya, an organisation closely working with the Ministry of Tribal Affairs as the Centre of Excellence for Knowledge Management in Health and Nutrition as well as the NGOs Ramakrishna Mission, Bharatiya Lok Kalyan Sansthan and ASHA (Association for Social and Health Awareness) in connection with the examination of the subject.

1.92 During the interaction, Piramal Swasthya stated their views on various tribal issues like lack of data, inadequacy of human resources, inter-ministry convergence for tribal welfare, setting up of National Council of Tribal health, addressing tribal issues at the local level as follows:

> "So, the first problem that we need to address is the data. We need to ensure that we get specific data at the block level or district level to make interventions and take action on it. My colleagues here spoke about malnutrition and anaemia that are very, very active problems in the community but until and unless we know which block, which district has this problem and what is the degree of malnutrition, it is very difficult to address that particular issue. ....."
>
> "..You asked me about what are the other things outside of what both of my colleagues have talked about. One of the biggest challenges is the human resources in healthcare. We spoke about ANM not being there. Similarly, if you look at the data that we have compiled, almost 70 per cent specialists are not available in the tribal districts specifically. In fact, in non-tribal districts, there are challenges but in the tribal districts, it is exaggerated even further."
>
> ". The third big problem that I see is that of convergence between different Ministries. The WCD Ministry, Ministry of Health, Ministry of Tribal Affairs and Ministry of Rural Development actually have to work together and form a convergence"
>
> ".....What we recommend very strongly is that if we can set up a National Council on Tribal Health specifically, it could then lay the foundation for setting up of a Tribal Health Mission. You would have heard of National Health Mission. National Rural Health Mission and National Urban Health Mission came up first and then they were merged to form the National Health Mission. I think we have all seen that there has been a very large impact of National Health Mission overall. In that context, if a Tribal Health

Mission is formed which focuses specifically on tribal Districts – there are about 170 tribal Districts – and if we channelise interventions, budgets and human resources to these areas, I think it will make a great impact in the long run."

"Lastly, there is a need to engage with community at a much larger level. What is happening now is that for the sake of saying we are going to hear tribal voices we form a committee at the grassroots level, etc. There is a need to understand what the specific challenges of tribal populations themselves are and then try and address them at the local level."

1.93 Bharatiya Lok Kalyan Sansthan stated as follows during the interaction:

"I am not going into the work we are already doing because you all know about it and we work throughout the country. Last year, about 20,00,000 people were served by us in the tribal areas of which nine lakh were women and 3.5 lakh were children. Let me focus on some of the real issues. The main issue is the huge communication problem. Most of the areas are inaccessible. Communication is a major area of concern. Then, most of the medical units like PHCs etc., are non-functional. There is a lack of doctors, lack of other staff, lack of medicines, lack of everything. If you have to really improve the health of tribal women, it cannot be addressed separately. There should be a comprehensive approach. If there is total development, inclusive work, then only it is possible. Probably strengthening self-help groups may be a good idea. If they are totally involved, if health forms part of the total graph, then only it will happen. Otherwise, exclusively addressing them for health only might not be a very good idea.

Many of the NGOs involved can be made more active. Some of the PHCs, etc., can even be given to them on experimental basis to see how they handle it because they have direct connection with the organisations and tribal population at the grassroot level.

I have always been advocating this. A lot more mobile medical services can be provided. Directly setting up facilities in tribal areas is difficult. If mobile medical services, on which we have done quite a lot, can be strengthened, probably that will help in the tribal areas.

Many of the NGOs are really struggling hard as far as grants are concerned. Because it is a State subject, you have to always get the recommendation from the State. But it takes time. Also, many of the things which have been made online, like the helplines, are not functioning. All the online facilities are only for namesake. When you set up an online helpline, the most important thing is that it should function. They do not function at all. So, probably if some of these issues can be addressed, then overall improvement is possible. "

1.94 NGOs Ramakrishna Mission and ASHA also gave valuable inputs on malnutrition and anemia among the tribal people, mental health condition of tribal women, communication issues at the ground level etc.

(xxii) Funds for Focused Interventions for STs

1.95 The Committee understand that Tribal Sub Plan(TSP) / Scheduled Tribe Component (STC) funds are dedicated source of fund for tribal development. Under Tribal Sub Plan (TSP) mechanism, all States and Central Ministries/ Departments have been mandated for earmarking of funds as Schedule Tribe Component (STC) as per stipulated rates. STC is a multi-pronged strategy which includes support for education, health, sanitation, water supply, livelihood etc. Major part of infrastructure development in tribal dominated areas and provision of basic amenities to tribal people in the country is carried out through various schemes / programmes of concerned Central Ministries/Departments and the State Governments. Overall about two lakh crore is earmarked in a year for overall tribal development including health out of which 70 to 85% rests with the State Government, 15-25% with the Central Ministries and 2-4% with the Ministry of Tribal Affairs.

1.96 The Committee have found that the mandate of the Ministry of Tribal Affairs as per Business Rules is as follows:

"MINISTRY OF TRIBAL AFFAIRS (JANJATIYA KARYA MANTRALAYA)

1. Social security and social insurance with respect to the Scheduled Tribes.
2. Tribal Welfare: Tribal welfare planning, project formulation, research, evaluation, statistics and training.
3. Promotion and development of voluntary efforts on tribal welfare.
4. Scheduled Tribes, including scholarship to students belonging to such tribes.
5. Development of Scheduled Tribes.

1. A. All matters including legislation relating to the rights of forest dwelling Scheduled Tribes on forest lands.

NOTE: -The Ministry of Tribal Affairs shall be the nodal Ministry for overall policy, planning and coordination of programmes of development for the Scheduled Tribes. In regard to sectoral programmes and schemes of development of these community's policy, planning, monitoring, evaluation etc. as also their coordination will be the responsibility of the concerned Central Ministries/ Departments, State Governmentsand Union Territory Administrations. Each Central Ministry/Department will be the nodal Ministry or Department concerning its sector.

6. (a) Scheduled Areas;2(b) regulations framed by the Governors of States for Scheduled Areas.

7. (a) Commission to report on the administration of Scheduled Areas and the welfare of the Scheduled Tribes; and(b) issue of directions regarding the drawing up and execution of schemes essential for the welfare of the Scheduled Tribes in any State.

8. The National Commission for Scheduled Tribes. "

9. Implementation of the Protection of Civil Rights Act, 1955 (22 of 1955) and the Scheduled Castes and the Scheduled Tribes (Prevention of Atrocities) Act, 1989 (33 of 1989), excluding administration of criminal justice in regard to offences in so far as they relate to Scheduled Tribes.

10. Monitoring of Tribal Sub-Plan, based on the framework and mechanism designed by NITI Aayog."

1.97 The mandate given in Business rules is also reflected in allocation of funds to MoTA and line Ministries. In 2021-22, out of total earmarked under STC / TSP for tribal development was about Rs 2.72 lakh crore, out of which, about 68% rested with the State Government, 29% of with the Central Ministries and Ministry of Tribal Affairs (MoTA) gets merely 2%. The same position is replicated in allocation of State TSPs, where the State Tribal Welfare gets only 4-5% of State TSP and rest is available with Sectoral Ministries. The position of allocation of funds during last five years is given in the table below for ready reference: **(MoTA - pg.4 Prlm. Lop replies to Q.5)**

Allocation/Expenditure of STC/TSP in (crores)

TSP Component	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Central Ministries	15,604.65	15,552.40	16,161.44	25,044.09	29,397.99	38,685.68	42,622.43	79,804.01	79,177.74
State Component	86,075.00	1,00,558.00	1,11,295.00	1,33,999.10	1,52,002.10	1,59,052.79	1,64,542.41	1,85,814.96	93448.24*
Funds under MoTA	3,832.20	4,472.26	4,793.96	5,285.67	5,954.78	7,170.72	5,461.67	6,126.46	8,406.92
Total	**1,05,511.85**	**1,20,582.66**	**1,32,250.40**	**1,64,328.86**	**1,87,354.87**	**2,04,909.19**	**2,12,626.51**	**2,71,745.43**	**1,81,032.90**

Note: Funds under Central Ministries and MoTA are actual for the year 2014-15 to 2020-21, 2021-22 (RE) and 2022-23 (BE).

* Provisional (as on 24.08.2022)

(xxiii) Coordination between Ministries and State Governments

1.98 With regard to the coordination between Ministry of Tribal Affairs and Ministry of Health and Family Welfare, the following written reply has been furnished by the Ministry of Health and Family Welfare:

"Recognizing the need for a roadmap for tribal health that is based on an

understanding of the health situation of the tribal people, their needs, aspirations and rights, the Ministry of Health and Family Welfare (MoHFW) and the Ministry of Tribal Affairs (MoTA) in October 2013, jointly constituted the Expert Committee on Tribal Health, under the Chairmanship of Dr Abhay Bang.

A Memorandum of Understanding (MoU) was signed between Ministry of Health & Family Welfare (MoHFW) and Ministry of Tribal Affairs (MoTA), in 2018 for cooperation between the two Ministries for sensitizing the principals and training to teachers each of all functional EMRSs, Ashram Schools and other Schools supported by MoTA in the country using the existing infrastructure of MoTA in the states. The MoU covered various activities including extending all aspects of the School Health Program viz., providing weekly Iron and Folic Acid Supplementation, bi-annual de-worming, basic first aid and health promotion activities through teachers designated as Health and Wellness Ambassadors at the school level in all functional EMRSs, Ashram Schools and other Schools supported by MoTA in the states.

Some of the initiatives of the Ministry of Health in this regard are-

- Under National Health Mission (NHM), guidance has been given to the states that the district health action plans (DHAP) need to have a dedicated plan for their tribal population.
- Under NHM there is a separate component in the project implementation plan (PIP) for tribal health. States have flexibility to indicate their requirements specific to tribal population under this component.
- Planning include malnutrition, gender issues, limited access to health care services, specific conditions like sickle cell anemia and malaria and special needs of Particularly Vulnerable Tribal Groups.
- All tribal and LWE affected districts which are below the state's average of composite health index have also been included as high priority districts. Such districts/areas receive higher per capita resource allocations as appropriate.
- Relaxation in the population norms for establishing health facilities in tribal areas. For e.g. for general areas, CHCs can be established for 1,20,000 populations, whereas the same for tribal population is 80,000.
- Similarly, PHCs for tribal population can be for 20,000 instead of 30,000 in other areas and Sub Center can be established for a population of 3000 instead of 5000 in other areas.
- In addition to the above for tribal, hilly and sparsely located population Health facilities can be established based on time to care approach.
- The ASHAs in tribal area can be selected for a 500 population instead of 1000 in other areas. Moreover, if there are sparsely located hamlets then one ASHA can be selected for such hamlets also.
- Mobile Medical Units(MMU) are being sanctioned with prioritization of tribal and hilly/sparsely/remotely located population. Expanding MMU (relaxing the cap of 5 MMU per districts), telemedicine, alternate HR strategies are key in providing health care services delivery.
- Under NHM, States have also been given flexibility to hire doctors including specialists

with higher remuneration and incentives for health facilities including those located in tribal area.

MOTA has also prepared a concept note & action plan on tribal health to mitigate the gaps in health infrastructure and other health services in the tribal dominated areas. The Tribal Health Plan has already been shared with NITI Aayog and circulated among stakeholders for appropriate action including Ministry of Health and Family Welfare, Ministry of AYUSH and State Governments. Secretary (Health) and Secretary (Tribal Affairs) had taken a video conference with State Health and Tribal Welfare Secretaries in the month of December, 2019 for taking appropriate action for implementation of the interventions envisaged in the Concept Note. The major interventions proposed in the Concept Note areas under:

i. Preservation and promotion of duly validated and certified traditional medicine and medicinal practices along with age-old tribal healing techniques.
ii. Establishment of Tribal Medical Colleges in one of the three tribal dominated Districts with tribal population more than 50% in line with the aspirations of Hon'ble Prime Ministry expressed during his Independence Day speech 2019.
iii. Establishment of new Tribal CHCs and PHCs where there is deficit
iv. Renovation and Modernization of existing PHCs
v. Creation of pool of tribal health personnel including doctors, paramedics, pathologists, lab technicians, nurses, midwives, and other associated personnel.
vi. Networking of tribal villages with Motorcycle Ambulances.
vii. Introduction of Tele Medicinal Services.
viii. Prevention and Management of sickle cell Anemia including diagnosis kits for screening and management of patients with multiple VOC
ix. TB elimination by supporting required equipment's
x. NCD prevention and Management

Apart from the above, MoTA and MoHFW have been taking part in MoWCD's Poshan Abhiyaan vigorously by promoting the importance of nutrition among tribals especially tribal women and children. "

1.99 The Ministry of Tribal Affairs also stated during the Oral Evidence as follows:

"But we have to do some convergence, we have to sit with States also because Health, as you know, is finally a State Subject and all our action plans are coming originally from the States. So, we have been in touch with the Ministry of Health and I propose that when they make their State-specific PIPs, I have requested the Health Ministry colleagues that they should involve our Ministry's representatives when they give the green signal to the PIP of a particular State so that we can see that the requirements of Primary Health Centres and Sub Centres are met."

1.100 When the Committee desired to know about the coordination of Ministry of Health and Family Welfare with the State governments in the implementation of various health

schemes and whether they monitor the progress achieved by States in implementing the centrally sponsored health programmes and other relevant schemes, the Ministry of Health and Family Welfare furnished the following written reply:

"Under National Health Mission (NHM), support is provided to States/ UTs for strengthening of their healthcare system based on their proposals in State Programme Implementation Plans (PIPs). PIPs are envisaged to be an aggregate of the district/city health action plans, and include activities to be carried out at the state level. District Health Action Plans developed (DHAP) through district based planning utilizing locally generatedservice data, civil registration etc. is a key pillar under NHM.

In this regard, Ministry has already directed the States:

- To include the suggestions of local tribal community before finalizing DHAP under NHM, particularly the TSP component.
- This is more warranted in tribal districts and districts having vast tribal population and inSchedule IV and V areas of the Constitution."

1.101 Regarding States that have poor infrastructure in the health sector for tribals, especially in terms of hospitals, doctors, paramedics, necessary drugs, ambulance services, etc., Ministry of Health and Family Welfare submitted the following written reply :

"Health infrastructure –There are 11 states which have the highest population of tribal health and also have gaps in infrastructure in the health sector. These are Chhattisgarh, HP,J&K, Jharkhand, MP, Odisha, Rajasthan, Andhra Pradesh, Telangana, Gujarat and Maharashtra".

1.102 On the monitoring of various schemes and their outcomes, the Ministry of Health and Family Welfare submitted the following:

"Regular monitoring

Supervision and evaluation of health initiatives, programmes and infrastructure are important ways of creating a knowledge pool regarding Tribal Health. While there is already a web based HMIS in place to monitor the health outcomes of communities, thereare other mechanisms including:

- Annual Common Review Mission
- NPCC meetings with States and UTs
- Quarterly Review Meetings
- Regional reviews
- State reviews
- NHM & MIS regular review Monitoring through Health Surveys (NFHS):
- The NFHS have ST disaggregated data. Community Monitoring by VHSNCs:

- Advisory Group of community Action has implemented "Community Action for health" which includes, Community Health Planning, Community Action and Community Monitoring.

Triangulation of the above three data give a better understanding of the status of tribal health."

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PART- II

OBSERVATIONS/RECOMMENDATIONS

NEED TO DEVELOP TRIBAL SPECIFIC DATA BASE

1. The Committee's report on 'Health Facilities for Tribal Women' assumes significance as in their opinion this is a very vital subject not only for the health of tribal women but in securing a healthy generation yet to be born. The Committee's examination is based on the material and information provided by the Ministries of Tribal Affairs, Health and Family Welfare (Department of Health and Family Welfare) and Women and Child Development. The Committee also took oral evidence on the subject for deeper understanding and probe. The Committee, after the examination of all the facts brought before them arrive at the conclusion that a lot needs to be done for the betterment of health facilities for tribal women. Their findings and recommendations are contained in the succeeding paragraphs.

(i) The Committee are of the view that being the nodal Ministry meant for the welfare of specific percentage of tribal population in the country, the Ministry of Tribal Affairs should be having separate database on the health aspects of the tribal people as good health is an important index to assess the welfare of any community. The Committee feel that the practice of subsuming tribal data in rural healthcare data has resulted in creating ineffective conclusions on the implementation of available health programmes among the tribal people. As complicated problems cannot be solved without an in-depth understanding of the

root causes, the Committee, recommend that the Ministry of Tribal Affairs should work in tandem with the Ministry of Health and Family Welfare to generate tribal disaggregated health data with separate classifications like girl children, adolescent girls, women of various age groups and women senior citizens to help in evolving custom made health interventions to suit the unique healthcare requirements of the tribal people, especially tribal women and girl children.

(ii) The Committee note that Ministry of Tribal Affairs has recognized Piramal Swasthya as a Centre of Excellence(CoE) for Knowledge Management in Health and Nutrition. One of the core mandates of this CoE is to address the data gaps/ challenges specific to tribal health and nutrition by creating an online repository of all tribal health and nutrition related data in close coordination with the Ministry of Women and Child Development and Ministry of Health and Family Welfare and State Governments. While appreciating this step taken by the Ministry, the Committee recommend to the Ministry of Tribal Affairs to link the Swasthya Portal through application programming interface (APIs) to various other government database such as Health Management Information Systems (HMIs), POSHAN Tracker, Swachh Bharat Mission Dashboard etc. to have a clear picture of the status of service delivery in the 177 tribal districts, on priority basis.

(iii) The Committee understand that the Swasthya Portal contains tribal disaggregated data for 177 tribal districts of the country. Presently, the Centre of Excellence for Knowledge Management in Health and Nutrition is examining the data from time-to-time. However, the Committee feel that there is a need to examine this data on the Portal periodically at the level of the Government also in

order to check the authenticity of the data. The Committee, therefore, recommend the Ministry of Tribal Affairs to devise a mechanism at the earliest to examine and assess the data available on the Portal periodically and review the same at the national level.

(iv) The Committee note that District Factsheets using the National Family Health Survey-4 has already been created. Since the data of National Family Health Survey-5 is available with the Ministry of Health and Family Welfare and International Institute for Population Sciences (IIPs), the Committee recommend that tribal population sub-sample data may be collected using the NFHS-5 data so that changes in the health and nutrition status of the tribal communities can be tracked easily and shortcomings can be addressed effectively in time. In fact, such sub-samples can be collected in various other national surveys including subsequent NFHS to understand the improvements in the tribal regions and study the changes in the social determinants of health.

NEED FOR FOCUSSED EFFORTS TO ADDRESS MALNUTRITION AND ANAEMIA AMONG TRIBAL WOMEN AND GIRLS

2. The Committee observe that malnutrition among tribal people is much higher than that of all groups taken together. Malnutrition and anaemia is a multi-dimensional issue caused by multiple factors such as poverty, inadequate and improper food consumption, multiple pregnancies, poor sanitary and environmental conditions, restricted access to quality health, education and social care services. As per the estimates of National Family Health Survey 5, almost two children out of five, under five years of age, suffer from chronic under nutrition

and is underweight and one in every fourth child is wasted. More than half of the tribal children and women in the reproductive age groups are anaemic and almost 41.6% out of every 1000 children die before they complete the first year of their life. It has been understood that only 50 percent of the anaemia is due to nutritional causes such as iron, folic acid and vitamin B-12. Other non-nutritional factors leading to high prevalence of anaemia among women in tribal areas are malaria endemicity and prevalence of sickle-cell anaemia and fluorosis. The Committee find various interventions by the Government like Anganwadi Services and Pradhan Mantri Matru Vandana Yojana (PMMVY) under Integrated Child Services Scheme, POSHAN Abhiyaan, and other interventions under National Health Mission like 'the Mothers' Absolute Affection (MAA) programme, Anemia Mukt Bharat Programme etc. to reduce malnutrition across the life cycle of the people in the country including the tribals. The Committee also observe that 25.5% of tribal women are underweight as compared to 18 percent of non tribal women in the country and prevalence of anaemia in tribal women is 64.6 percent as compared to 56 per cent in non-tribal population. In view of the above, the Committee recommend the following:

(i) The Committee are happy to note that as per NFHS -5, there is considerable improvement in the nutritional status of tribal women and children. The Committee are of the view that in order to effectively address the malnutrition and anaemia among the tribal women and children, the government should focus on 'prevention is better than cure' formula. It has been observed that many government health measures begin when the damage has already taken place.

This practice needs to be changed and focus should be on effectively taking health measures at the right time.

(ii) A child born to an undernourished tribal mother faces a high risk of restricted foetal growth and death. Those who survive are likely to be stunted with a high probability of transmitting their poor nutrition status to their next generation. Hence, effective action may be taken under the Integrated Child Development Scheme to ensure nutritional meals, immunization and health check-up to every tribal child under the age of 6 years. The Committee while desiring the government not to dilute the quality and quantity of the services provided to the tribal children recommend that a social audit be conducted on the performance of Anganwadi centres in the tribal areas.

(iii) Presently, most of the health and nutrition campaigns of the Government are uniform for the tribal and rural communities. However, the Committee opine that in order to obtain optimum results, it is essential to delineate the tribal and the rural population and plan customised health and nutrition campaigns for the tribal groups, addressing the regional challenges and promoting behaviours and practices which do not directly challenge their norms and customs. Since the tribal population have a strong sense of community built amongst them, the Committee are of the view that community influencer groups and tribal leaders must also be engaged to instil behavioural changes among the tribal community for better health and nutrition outcomes. Though many of the government programmes are focussing on this approach currently, the Committee would urge upon the Government to reinforce this approach for maximising the impact of such

campaigns among the tribal community so that desired results are achieved.

URGENT INTERVENTIONS FOR SICKLE CELL ANEMIA AMONG TRIBALS

3. The Committee note that sickle cell anemia or Sickle Cell Disease (SCD) continues to be a daunting challenge in the healthcare of the tribal people. Sickle cell anemia is a genetic disorder that cannot be cured. Its prevalence is found to be higher amongst the tribal groups in Central, Western and Southern India. About 1 in 86 births among Scheduled Tribe (ST) population have SCD and the percentage of Sickle cell carriers among different tribal groups vary from 1 to 40. The Committee found from available data that out of approximate 1.5 cr. tribals who were tested for SCD, 10.5 lakh were found to be carriers of SCD and 50,000 had SCD. In view of the above, the Committee recommend the following:

(i) Recently the Government has started the screening of new born babies and school students for sickle cell disorders as a strategy to tackle SCD which in the opinion of the Committee is a right step in the right direction. As the Committee in this regard infer that in the absence of any effective treatment for SCD, the disease burden can only be reduced with appropriate state-of-the-art diagnostics/ intervention strategies which are primarily dependent on reliable data and hence they, in no uncertain words, recommend that the government should complete the screening of all tribals for SCD from newborn to the old, with emphasis on the adolescents and antenatal women in a time bound manner so that the next generation of the tribal people are free from this disease. The Committee may be apprised about the timelines proposed for completion of this nationwide screening and the status of the same, State-wise, while furnishing the action taken replies

to the Committee.

(ii) The Committee have been given to understand that if one parent has Sickle Cell Disease and the other is normal, all of the children will have Sickle Cell Trait. If one parent has Sickle Cell Disease and the other has Sickle Cell Trait, there is a 50% chance of each child having either sickle cell disease or sickle cell trait. When both parents have Sickle Cell Trait, each of their children has a 25% chance of having sickle cell disease. The Committee understand that colour coded health cards are also being provided to tribal people indicating their SCD status with a view to providing counseling and treatment. Since awareness creation and counseling can really go a long way in arresting the spread of the disease, the Committee recommend to the Ministry to strengthen such strategies through regular awareness drives, marriage counseling and education through school curricula so that effective awareness is created among the tribal people about SCD and the risks involved in getting married to a carrier or an affected person is obviated.

(iii) The Committee note that the Ministry of Health & Family Welfare gives financial assistance to BPL patients under Rashtriya Arogya Nidhi and also under Health Minister's discretionary grant for bone marrow transplant for SCD patients. Considering the effectiveness of bone marrow treatment in SCD, the Committee desire the government to make the financial assistance/grant easily accessible to the tribals. Dissemination of information on the availability of such a grant/ financial assistance may also be imparted to the tribal people through IEC campaigns so that SCD affected tribal patients can make good use of such

government aids/funds.

(iv) The Committee are aware that access to care for SCD in the tribal regions is limited due to inadequate health infrastructure and shortage of healthcare personnel. However, the Committee are of the strong opinion that the shortage of health infrastructure or healthcare personnel in tribal areas should not stand as a constraint in the way of ensuring quality treatment for SCD patients. Hence, the Committee recommend to establish a specialty wing with state-of-the-art technology to screen and treat sickle cell patients in select hospitals in tribal areas with high prevalence of SCD.

(v) The Committee find that as a part of research initiatives in the effective treatment of SCD, the Indian Council of Medical Research (ICMR) under its Tribal Health Research Forum (THRF) activities as well as under the National Rural Health Mission (NRHM) have initiated programmes to enable advances in genetics to reach the tribal communities. The Committee while recommending the Ministry to strengthen their research initiatives on SCD, also recommend that the possibility of testing for sickle cell genes before the birth of a child may also be explored so that suitable remedial action can be taken consequently.

(vi) The Committee note that in order to create awareness, a sickle cell support corner has been created (scdcorner.in) by the Ministry of Tribal Affairs which also has a deposited knowledge of repository. The Sickle Cell Corner aims to create a self-registration system for people with Sickle Cell Disease and Sickle Cell Trait. The registration is voluntary. The Committee fail to understand the relevance of this self registration mechanism in the portal as most of the tribal people may lack

in computer literacy and the chance of them doing this registration on their own is very feeble. The Ministry themselves has stated that the registration is voluntary and this data is not recommended to be referrred to for programme planning and research purposes. The Committee while wanting to know from the Ministry about the relevance of a self registration mechanism on the portal, recommend the Ministry to develop the portal into a data repository on SCD by collecting and uploading authentic official data from all available sources and from the nation-wide screening of tribals. The Committee also recommend that at every District level specially at the subdivision Tehsil and Block level a help-desk be set up where the willing persons may be assisted by creating a help-desk where interested persons may register themselves for this support.

(vii) The Committee note that the Ministry of Social Justice and Empowerment has taken note of the challenges faced by SCD patients and have increased the validity of Disability Certificate from 1 year to 3 years. However, the Committee feel that since sickle cell disease is a lifelong illness and a blood and bone marrow transplant is currently the only cure for it which very few people, specially amongst the tribal population can undertake, the Government may consider giving a Disability Certificate with lifelong validity to those SCD patients who are more than 5 years of age and fulfill the stipulated criteria instead of a certificate with 3 year validity. If giving a lifelong disability certificate to SCD patients is not feasible, the Government may consider giving it for five years at a stretch and then keep renewing it.

INTERVENTIONS TO PREVENT EARLY CHILD MARRIAGES

4. The Committee are perturbed to note that as per the data provided to the Committee, 30% tribal women in the age group of 20-24 years are married before the age of 18. Teen age pregnancy is highest among tribals in all social groups. Early marriage and the resultant pregnancy combined with anaemia is causing 46% of maternal deaths among tribals. The Committee observe that under the Reproductive, Maternal, Newborn, Child and Adolescent Health, (RMNCH+A) Programme , the government has employed effective strategies for health gains in maternal health. States like Rajasthan, Madhya Pradesh and Jharkhand have special programmes to intervene in early child marriages. As per the findings of National Family Health Survey-5 available for 26 States, 17 States have shown improvement in arresting teen age pregnancies. However, the Committee are not confident about this finding as the family of the girl often misrepresents the girl's age in the tribal areas and it is very difficult to determine exact/right age of a girl in the absence of a robust and accurate birth registration system. The Committee are not oblivious of the fact that Child marriage is a violation of human rights and every child has the right to be protected from this harmful practice, the Committee recommend as under:

(i) Until and unless proper awareness is created among the tribal population especially about the health risks involved in early marriage and the resultant pregnancy, desired results cannot be achieved. Therefore, the Government should focus on creating awareness among the tribal population about the necessity to avoid early marriage of girls, the need to have spacing between

children and the importance of educating girls with the help of community leaders, ASHAs, Anganwadi workers and other functionaries at the ground level in tribal areas.

(ii) The Ministry of Tribal Affairs in coordination with States/UTs with high tribal population may devise suitable intervention strategies to prevent early marriage of girl children as is being done in the States of Rajasthan, Madhya Pradesh and Jharkhand so that tribal girls who are already bearing the brunt of malnutrition and anaemia are not exposed to further health risks through child marriage. The Government should also impress upon State Governments to undertake rigorous awareness programs and also employ stringent measures to ensure that tribal girls are not married off before the legal age of marriage in the country for girls.

(iii) The Committee are aware that keeping girls in school and reaching out to those who are out of school is vital in the fight against child marriage, recommend that the Ministry of Tribal Affairs in coordination with the Ministry of Education should devise special action plan to retain tribal girl children in schools, facilitate their higher education and develop alternate learning programmes for 'out of school' girl children.

PROMOTING FAMILY PLANNING AND CONTRACEPTION METHODS AMONG TRIBALS

5. The Committee have been informed that currently 55.17 percent tribal women use modern contraceptive methods and 14% use spacing methods for family planning. According to National Family Health Survey (NFHS)-5, the

demand for contraceptives satisfied through modern methods in tribal areas is 74.8%. The Committee also note that 24.4% of tribal men are using contraceptive methods as compared to the national level of 25.8%. Though it is the right of every man and woman to make their own reproductive choices, the Committee feel that since the tribal women suffer from malnutrition and are subjected to early marriage, family planning is important for them to avoid teenage pregnancy. Since family planning services have the potential to improve the health of the mother, which in turn assists social and economic upliftment of the family, the Committee recommend the Ministry of Tribal Affairs to focus on educating women and their respective husbands about the proper use and benefits of modern contraceptives. The Committee also recommend to the Ministry to organise special drives to promote male contraceptives among tribal men and to burst the myths around male contraception so that family planning responsibility is shared between husband and wife.

URGENT NEED TO GENERATE ACCURATE PAN INDIA DATA ON THE MMR AMONG THE TRIBALS

6. The Committee find that Maternal Mortality Ratio (MMR) of India has reduced from 130 per 100,000 live births in 2014-16 to 113 per 100,000 live births in 2016-18 and to 103 in 2017-19 as per the Sample Registration System (SRS) report by Registrar General of India (RGI). However, they note with concern that neither the Ministry of Tribal Affairs nor the Ministry of Health and Family Welfare have any separate data on Maternal Mortality Rate (MMR) among

the tribals. This is because the Sample Registration System (SRS) does not capture category-wise, disaggregated information on MMR. The Committee fail to understand how the line Ministries have so far evolved policies or are going to chalk out any action plan to secure maternal and infant health among the tribals without having proper MMR data. It is a fact that despite having better sex ratio of 990 as compared to India's average of 943, child marriage, early motherhood, low Body Mass Index (BMI) and high incidence of anemia are causing high rates of mortality among tribal women. Hence, the Committee recommend to the Ministry of Tribal Affairs to compile and collate the MMR data among the tribal population from numerous independent research studies conducted by individuals/organizations till the time a proper mechanism is put in place to generate accurate pan India data on the MMR among the tribal population. The Committee would be apprised about the timelines for the same.

INTERVENTIONS FOR POSITIVE BIRTHING EXPERIENCE TO TRIBAL WOMEN

7. The Committee note that various interventions like Janani Suraksha Yojana, Janani Shishu Suraksha Karyakaram (JSSK) and 'Surakshit Matritva Aashwasan' (SUMAN) are put in place by the Government to provide a positive birthing experience to women including the tribal women. These schemes are in place with the objective of reducing maternal and neonatal mortality rate and to promote institutional delivery among pregnant women especially with weak socio-economic status i.e. women from Scheduled Castes, Scheduled Tribes and BPL households. Under JSY, cash assistance is provided to the beneficiaries and JSSK and SUMAN ensure free of cost healthcare for the mother and the child. The

Committee are surprised to note that despite the existence of so many interventions by the Government, the maternal mortality rate and neo-mortality rate are still high among the tribals. Further, they note that the Government does not have a separate data on tribal beneficiaries of any of these schemes as it is clubbed with BPL and SCs also. Further, many of the tribal women prefer to deliver at home due to various reasons. In view of the above, the Committee recommend the following:

(i) The Committee are aware that in tribal communities, pregnancy and childbirth is treated as part of a natural process not requiring external intervention. They have a well-established practice of birthing. In this scenario, we need to be responsive to the requirements of tribal women, cater to their cultural needs, reorient maternal health services by providing support to domiciliary deliveries and preserve beneficial traditional practices. While emphasizing that the focus may be on safe delivery, the Committee recommend that along with incentives to motivate women for institutional delivery, the traditional 'Dais' in whom the tribal communities have unquestionable trust with respect to deliveries should be trained and integrated into the health system. It is needless to point here that they should be imparted training from time to time and kept abreast with the medical developments taking place in order to enable them to effectively use them in field.

(ii) The Committee find that in tribal areas the ANMs (Auxiliary Nursing Midwife) are given Skilled Birth Attendant (SBA) training in addition to institutional delivery and ASHAs are being oriented about safe delivery practices.

In this training, the primary focus is on early detection of complications and provision of immediate care along with transport facilities to the nearest equipped health centre if need arises. Since tribal communities also recognize the need for health system interventions in case of high-risk births or complications, the Committee recommend that the health care system should ensure all support and assistance through ANMs and ASHA workers in transferring the pregnant women to the institutional facility in time to ensure safe delivery in high-risk cases. The Committee also recommend that a standard protocol for high risk pregnancies should be made for admission at Tertiary Health Centres/Institutional facilities for tribal women especially in areas where it is difficult for pregnant women to reach hospital in time.

(iii) The Committee also note that lack of road connectivity in tribal areas causes hindrance in transferring women to hospitals. In this context, the Committee would like to highlight the utility of 'Pradhan Mantri Gram Sadak Yojana '(PMGSY)', the objective of which in respect of hill states, desert areas (as identified in the Desert Development Programme) as well as the Tribal (Schedule-V) areas, is to connect habitations with a population of 250 persons and above with all weather roads. The Committee urge upon the Ministry of Tribal Affairs to make use of this Yojana in coordination with the Ministry of Rural Development for building all weather roads in tribal areas so that the tribal population including pregnant women can access healthcare facilities in time. The Committee also recommend that all habitations with a population of 250 in hilly and tribal areas should be covered under PMGSY and all weather roads should be made to improve

connectivity in such rural areas.

(iv) The Committee would like the Government to evaluate the efficacy of Janani Suraksha Yojana '(JSY), Janani Shishu Suraksha Karyakram (JSSK) Surakshit Matritva Aashwasan (SUMAN) identify the bottlenecks in the outreach of the Schemes to the eligible beneficiaries with special reference to tribal women. The Committee may also be apprised about the number of tribal women who have been the beneficiaries of these schemes during the last three years, scheme and State -wise.

(v) Further, as most of the tribal mothers work in informal sector, the Committee would urge the Government to explore the possibilities of establishing crèches in anganwadi centres where the tribal mothers can leave their children free of cost.

POST NATAL CARE FOR TRIBAL WOMEN

8. The Committee note that as per National Family Health Survey-5, 61.7% and 79 % of lactating tribal mothers and new born babies had postnatal check up respectively. The Committee observe that interventions like Janani Suraksha Yojana, Janani Shishu SurakshaKaryakaram (JSSK) and 'Surakshit Matritva Aashwasan' (SUMAN) have various components to ensure post-natal care for the mother and the child. Since, a lot of tribal women prefer to deliver at home, Home Based Newborn Care (HBNC) programme is also being implemented across the country which stipulates 6-7 visits by ASHAs during the post-natal period to provide essential new born care and appropriate care and referral support to the mother. Taking note of the fact that the World Health Organisation has underlined

that the first 24 to 48 hours are the most crucial period for postpartum woman and the new born, the Committee recommend the Ministry to amplify their post-natal care interventions to scale up the coverage of post natal care among the tribal population. Further, as motivation by health workers seems to be the most important contributing factor for better utilization of health services, they recommend that in the skill upgradation and capacity building of ASHA workers, special motivational modules may be included for better communication about the need for availing medical services for lactating mothers and new borns.

COMMUNICABLE DISEASES AMONG TRIBAL WOMEN

9. The Committee find that despite having dedicated programmes for each and every communicable and non-communicable diseases, tribal people continue to bear a disproportionate burden of such diseases. In the light of the above, the Committee recommend the following:

(i) The Committee are glad to note that the Government has made praiseworthy strides in the reduction of malaria in tribal areas. As per the data provided to the Committee, among 177 tribal districts, there has been 86.6% reduction in malaria morbidity and 83.4% reduction in malaria mortality between 2015 and 2020. The Committee understand that the National framework for Malaria Elimination (2016) aims for elimination of malaria throughout the country by 2030. In order to achieve this target, Committee are of the view that there is a need to implement this programme with right earnest in the tribal areas and effective monitoring of the same needs to be ensured. The Committee,

therefore, recommend to the Government to revamp the activities of National Vector Borne Disease Control Programme (NVBDCP), identify its shortfalls and design new strategies albeit custom made for tribal areas so that malaria can be effectively controlled among the tribal population.

(ii) During their examination of the subject, the Committee find that the proportion of tuberculosis patients among the tribals is high and that there does not exist any mechanism on the part of the Government or the healthcare system to follow up on these patients as to whether they are completing the course of TB treatment or not. Hence, the Committee recommend that the Government should take measures to make the tribal population aware about the importance of getting treated for TB and the need for undergoing the full course of treatment for effective controlling of TB.

(iii) The Committee have been informed that as per the National Leprosy Eradication Programme (NLEP) reports submitted by States/UTs for the year 2019-20, a total 21,469 cases (18.76%) have been reported from Scheduled Tribes (ST) population wherein women patients constitute 39.21% of the total leprosy cases. It has further been informed that it is estimated that approximately 8418 number of tribal women would be the leprosy cases in the year 2019-20. For the year 2020-21, a total of 13,117 cases, (20.12 per cent) have been reported from ST population including both tribal men and women. Further, as per the Report, women patients constitute 36.44 per cent of the total leprosy cases in 2020-21, which is approximately 5266 in numbers. While noticing that there is a reduction in the number of female leprosy patients among tribal population, the

Committee fail to understand how leprosy continues to be concentrated amongst the Tribes despite the targets set in the National Health Policy 2002 and official declarations of achieving statistical elimination of leprosy at the national level long back in 2005. Keeping this in the background, the Committee feel that the implementation of Leprosy elimination programmes since independence has resulted in decrease in the number of leprosy cases among tribal community but still the country is a long way from eliminating leprosy at the state or district levels. Taking cognizance of the recent strides in the healthcare system in the country, the Committee look forward to Ayushman Bharat as an opportunity for streamlining case detection and treatment as 150,000 Health and Wellness Centres are being built across the country under the initiative which will offer screening for leprosy among other diseases. It is also learnt that the provision of reconstructive surgery for leprosy patients is also a part of the care package of the Pradhan Mantri Jan Aarogya Yojna (PMJAY), which is the insurance arm of the Ayushman Bharat scheme. The Committee, therefore, recommend that the provisions under Ayushman Bharat initiative should reach every person living with this disease, especially the tribals and let Ayushman Bharat be a true beginning. Eventually, keeping this maxim in mind 'there is light at the end of the tunnel', the Committee would like to see a day when leprosy is completely eliminated from amongst the tribal population.

MENTAL HEALTH OF TRIBAL WOMEN

10. The Committee note that due to the changing times, tribal people have been exposed to several existential threats and mental stress. Since they are a marginalized community and live in relative social isolation with poorer health indices, the mental health issues among the tribals, especially tribal women, often go unnoticed or unattended. Further, lack of data and research on the mental health issues faced by tribals, especially tribal women, makes it difficult to charter a custom made treatment plan for the tribal mental health issues. The Committee also find there is less awareness among tribals about mental health issues/ mental health services. Even though treatment is available under National Mental Health Programme, access to such treatments is limited due to remoteness of many of the tribal villages. Moreover, the preference for traditional faith healers also acts as a deterrent. The Committee, therefore, recommend that the government should primarily focus on creating awareness among tribals about mental health issues, encourage them to avail medical facilities and increase the access to mental health services.

SUBSTANCE ABUSE AMONG TRIBAL WOMEN

11. The Committee note that alcohol and tobacco abuse among the tribals, including tribal women, poses a serious threat to their health and productive lives. Though the Ministry has admitted that there is a link between addiction disorders and intimate partner or gender- based violence, needless to say, they have not maintained any separate data at the central level regarding substance use

disorders among tribals or the magnitude of substance addiction among tribal women. The Ministry has not provided any updated data in this regard either. However, the Committee note that use of alcohol is a part of the life style of many tribal people and both men and women tend to drink alcohol which adversely affects the health of tribal women, especially during pregnancies. Considering the poor maternal and child health indicators among the tribal population, the Committee, in no uncertain words recommend the government to assess the magnitude of alcohol and substance abuse among tribal women and put in place suitable remedial measures like providing counselling and establishing de-addiction ,centres/treatment facilities for alcohol substance abuse related disorders in tribal areas where such facilities are not in place. The Committee also recommend the Government to make use of Village Health and Nutrition Day (VHND) to provide community counselling and create awareness among the tribal population about the adverse effects of substance abuse among tribal women.

HEALTH CARE INFRASTRUCTURE IN TRIBAL AREAS

12. The Committee note that over 50-60 per cent of the tribal population depend on the public health system for their healthcare needs. Despite this huge demand for healthcare, tribal areas experience a shortfall in public healthcare infrastructure and human resource for health. According to regional health Survey 2020-21, tribal areas experience an overall deficit of 25.4 per cent Sub-Centres, 29.2% Primary Health Centres, and 27.9% Community Health Centres. In order to address these shortcomings, various steps have been taken by the Government as a result of which there has been a 73 percent increase in the

health facilities in tribal areas compared to a 10 per cent increase all-India in 2020. The Committee also observe that the Ministry of Tribal Affairs has a robust health action plan involving three levels of comprehensive tribal primary health care model. In this context, the Committee make the following recommendation:

(i) The Committee are concerned about the gaps still existing in healthcare infrastructure in tribal areas though the concerted efforts of the Government have brought in 73 per cent increase in the health facilities in tribal areas as compared to a 10 per cent increase all-India. While lauding the Government for their efforts, the Committee recommend that as a part of strengthening the healthcare infrastructure in tribal areas, the Government should ensure, in coordination with the state governments, that health centre buildings are in good condition equipped with proper electricity , drinking water, sanitation, labour room, operation room and other required facilities and the increase should not be in mere numbers.

(ii) While stating about the efforts to plug the gaps in physical infrastructure, the Committee learn that the Ministry of Tribal Affairs has developed a concept of "Comprehensive Primary Health Care in Tribal Blocks" which do not have Primary Health Centres (PHC) / Community Health Centres (CHC) facilities and can be mapped with "Comprehensive Tribal Primary Health Care Model" on Public-Private-Partnership (PPP) basis. This model has at level 1, a Tertiary Health Care Facility, i.e a Medical College Hospital , at level 2, a Tribal Primary Health Centre (TPHC) and at level 3, community/village health services. The Tertiary Hospital ought to provide necessary support to Primary Health Centre by telemedicine

centres. TPHC, the first contact point with Arogya Bank and Arogya Mitra (Female) & Traditional Tribal Healer (Male) will be extending its services through Mobile Medical & MCH clinic and motorbike ambulance-cum-health clinics. The Government has informed that their concept is based on the model which is being successfully implemented by Pravara Institute of Medical Sciences, deemed to be university, Loni and the comprehensive health action plan will be implemented by revising the guidelines of NGO schemes of the Ministry of Tribal Affairs which is under process. While appreciating the Ministry for developing this commendable health action plan, the Committee hope that once implemented this model would be able to address the health concerns of the tribal people to a great extent. The Committee, therefore, recommend that effective implementation of this health action plan should be ensured by the Ministry and the success of Pravara model may be analysed thoroughly before revising the guidelines of NGO schemes of Ministry of Tribal Affairs.

(iii) The Committee note that in the new comprehensive tribal health plan, Tertiary Hospital will provide necessary support to Primary Health Centre by telemedicine centres. The Committee understand that health-tech solutions like telemedicine and health helplines bridge the gap between quality healthcare and the one in need of medical aid. However, for seamlessly conducting telemedicine activities, a telemedicine centre and the receptive Primary Health Centre require necessary apparatus including strong wi-fi or data connectivity and trained manpower. The Committee in this context recommend the Government to ensure the availability of necessary apparatus and trained manpower in telemedicine

centres and the receptive primary health centre in order to ensure their effective functioning.

(iv) The Committee further note that the Tertiary Health Centre will also maintain data base of each tribal linked with Aadhar and Aayushman Bharat card and the data will be shared centrally with MoTA through a dedicated portal. Applauding this laudable initiative, the Committee recommend that while linking tribal data with Aadhar and Ayushman Bharat, the Government should also take steps to ensure that the tribal data is not being misused and the privacy of the tribals are not compromised in any manner.

AMBULANCES AND EMERGENCY TRANSPORTATION IN TRIBAL AREAS

13. The Committee note that currently under National Health Mission, all States are given support for provision of free ambulance services through two models, namely, Dial 108 for Advance Life Support (ALS) and Basic life Support (BLS) and Dial 102 for patient transport services. The Committee also note that while one ALS ambulance with ventilator is supported for an average population of five Lakh, one BLS without ventilator Ambulance is supported for over one lakh population. There is also a provision for allocating one ambulance per 50,000 population in the plains/densely populated areas. The Committee further note that under Janani Shishu Suraksha Karyakaram (JSSK) and 'Surakshit Matritva Aashwasan' (SUMAN) every pregnant woman including tribal women are entitled for free referral and transport. Under National Health Mission (NHM), there is also

provision for technical and financial support for emergency medical services in States/UTs through a functional National Ambulance Service (NAS) network linked with centralized toll free number 102/108. Moreover, for ensuring better access to ambulances particularly in NE region, an expert group has been constituted to examine and recommend the type of vehicle and ambulance in North East which has predominantly the tribal population. The Committee also note that motor bike ambulances are proving to be a life saving boon for the people of Chhatisgarh region, bridging the last mile to health care. In view of the above, the Committee recommend as under:

(i) The Committee are of the view that ambulance services are not just mere transporting vehicles for a patient but life saving units. The Ministry has stated that there is an effective mechanism in the tribal areas to ensure the availability of ambulances within 15-20 minutes of the distress call. However, the Committee also observe that at ground level, the time taken is often more than 15-20 minutes and in difficult terrains the time could extend to any length of hours. Further, there is no implicit mechanism at the ground level for coordination of engaging the ambulances or for registering any grievance with regard to the same. The Committee hence recommend the Ministry to employ strict monitoring measures in the functioning of ambulance services under NHM, ensure adequacy of ambulances and drivers to run them, fix individual responsibility for the smooth functioning of the services including the maintenance of the ambulances and lay out a well designed availability coordination and complaint registration system with regard to the same. The Committee further recommend the Ministry

to relax the norms of ALS and BLS for average population from 5 lakh to 1 lakh and from 1 lakh to 20 thousand respectively.

(ii) The Committee note that the tribal women who live mostly in hilly, forest and remote areas, often find it arduous to access healthcare facilities due to geographical difficulties of the regions. Similarly, the non-motorable terrain in the remote tribal hamlets often cause hindrance to ambulances in reaching the needy tribals in time. The Committee further note that one commutation method that has emerged for the tribal patients is motorcycle ambulances which have been used by States like Chhattisgarh and Jharkhand to ferry patients including pregnant women and infants from remote areas to the nearest primary and Community Health Centers. In this regard, the Committee recommend that the Ministry concerned may work out the guidelines and modalities with regard to this including and custom made design of the motor bike ambulance suitable to every region in coordination with the various stake holders concerned.

(iii) The Committee observe that often tribals refrain from seeking healthcare due to non-availability of ambulances or other free mode of commutation. The out of the pocket expenses that they incur in emergency situations by choosing private mode of commutation fall heavy on their already economically weakened self and deter them from seeking further healthcare. The Committee feel that in order to encourage tribals to access healthcare facilities, it is necessary to reduce the burden of these out of the pocket expenses on them. They, therefore, recommend the Ministry to explore the means to reimburse the travel expenses of the tribals to healthcare centres if they choose to avail any private mode of

commutation and take steps to implement the same without delay.

MOBILE MEDICAL UNITS

14. The Committee note that despite notable gains in health care, especially when India is moving towards achieving Universal Health Coverage, reaching out to the tribal populace in the remote and geographically difficult terrains remains a constant challenge. In this daunting scenario, a Mobile Medical Unit (MMU) is an effective means to deliver optimum healthcare services to the tribal population living in the remote areas of the country. From providing comprehensive primary care to specialized care like bone density check up, ophthalmic check-ups, immunization, dental checkups, cardiac units for coronary care, cancer screening or multiphase screening etc. at the doorsteps of the tribals, MMUs can accelerate the inclusion of tribals in the formal healthcare system. Further, MMUs with all the life-sustaining facilities and adequate healthcare staff can not only reduce the pressure on health centres/ hospitals but also help in saving lives with timely intervention. The Committee, therefore, recommend that the Government should do all out efforts so that a parallel health delivery mechanism through MMUs may also be boosted by providing adequate funding to the States/UTs as per their requirement in support of MMUs. The Committee feel that constraints of fund should not stand as a barrier in the way of providing region specific and need based MMU healthcare service to the tribals in various States. The Committee also note that one major disadvantage of mobile units is the lack of continuous care for patients by the medical personnel. The Committee feel that this can be addressed

by a judicious mix of the services of health-centres and MMUs and proper follow up of the patients. The Committee also recommend that GPS tracker should be installed in the bike ambulances, ALS, BLS and MMUs so that effective monitoring can be done.

ADEQUACY OF HEALTHCARE PROFESSIONALS AND MEDICINES IN TRIBAL AREAS

15. (i) The Committee note that the healthcare sector in tribal areas is fraught with lack of availability of health centres, quality healthcare and human resources for health. According to Rural Health Statistics 2020-21 (RHS), there is a shortage of 69 General Duty Medical Officers (GDMOs), 3186 Specialists, 1340 Lab Technicians (LTs) and 607 Staff nurse in the tribal States in India. The difficult terrain of tribal areas and the propensity to regard postings in tribal areas as demotivating/ punishment postings by healthcare professionals have long been serious challenges for the public health system in ensuring quality healthcare for tribal people . Further, it is a matter of concern for the Committee to learn that despite a slew of efforts taken under NHM to attract and retain doctors and specialists, tribal areas are still reeling under lack of quality healthcare and the efforts of the Government have not shown any concrete results at the ground level. The Committee understand that the Expert Committee on Tribal Health has proposed measures like enhancing the salary of Medical Officers by 30%, performance based incentives, well equipped housing facilities, preference for selection in post graduate courses, flexible recruitment and contracting norms to attract and retain doctors, specialists and other healthcare professionals in tribal areas. This Committee is in agreement with the suggestions made by the Expert

Committee and hence, desire the Government to implement the recommendations of the Expert Committee in letter and spirit so that a dedicated healthcare force is made available for the tribal people in the near future.

(ii) In order to increase the smooth accessibility of medicines through Jan Aushadhi Kendras for the tribal population, the Committee further desire that the Government should explore the possibility of opening Jan Aushadhi Kendras in Primary Health Centres also. Tribal people may also be made aware of the concept of expiry of medicines so that no expired medicines are administered to them. It would be in fitness of things, if medicines with long shelf life are supplied to tribal health care centers. The steps initiated/taken in regard to above observation of the Committee may be spelt out in detail while submitting to the action taken report on this Report.

ASHA AND ANGANWADI WORKERS

16. The Committee note that Accredited Social Health Activist (ASHAs) have been the back bone of National Health Mission (erstwhile NRHM) since 2005. They have played a pivotal role in increasing institutional deliveries, utilization of antenatal care services and skilled birth attendance across various demographic groups and have succeeded in reaching out to groups that are typically left out of the formal health care system, especially the tribal people. Similarly, the Anganwadi workers have been the building blocks of Integrated Child Development Scheme (ICDS), the world's largest community based outreach programme which offers a package of health, nutrition and education services to the children below six years and also pregnant/ nursing mothers across the

country including the tribal areas. The Committee are not oblivious of the fact that the contribution of ASHA and Anganwadi workers are crucial in securing good health for the tribal people, especially tribal women and children. In the light of these facts, the Committee recommend the following:

(i) There are around 13 lakh Anganwadi workers, 11.5 lakh Anganwadi helpers and 9.6 lakh ASHA workers in rural areas in the country. The Committee consider them as the foot soldiers on ground who shoulder a spectrum of health related activities and carry to the doorsteps of people many other services whenever there are unforeseen emergencies. The Committee understand that the Ministries concerned had made efforts to get them recognized as 'frontline workers' though the efforts did not yield positive results. The Committee are of the strong view that the Contribution of ASHA and Anganwadi workers to the healthcare system in the rural and tribal areas is not only priceless but imperative. During the COVID-19 pandemic, they fared high risk conditions and rendered exemplary service to the people. The Committee, therefore, recommend that the Ministry of Health and Family Welfare and Ministry of Women and Child Development should take necessary steps to get ASHA and Anganwadi Workers recognized as frontline workers. Government may make provision for periodic enhancement of the honourarium paid to them.

(ii) Taking into consideration the fact that ASHA and Anganwadi workers play a vital role in the healthcare of people in inaccessible and far flung tribal and rural areas in the absence of no or insufficient public transport facilities, the Committee recommend that they may be provided with two wheelers for catering to a larger

population in an effective manner. The Committee further recommend that the Government should consider providing two wheelers to other front line medical personnel like ANMs (Auxiliary Nurse Midwife workers) and MPWs (Multipurpose Health Workers) also working in tribal and rural areas in order to ensure effective health coverage.

(iii) The ASHA worker and the Anganwadi Sevika work side-by-side to implement various health and nutrition related programmes of the Government. ASHAs support the Anganwadi workers in mobilizing pregnant and lactating women and infants for nutrition supplement take initiative for bringing the beneficiaries from the village on specific days of immunization/, health checkups to Anganwadi Centres etc. However, the Committee observe that at the ground level that the pregnant tribal women who register themselves with Anganwadi workers many a time fail to register themselves with ASHA workers which results in those tribal women not receiving adequate health check-ups and nutritional supplements. This also creates a discrepancy in the data of total number of pregnant women among tribal population. Hence, the Committee recommend to the Government to take steps to ensure that effective coordination is maintained between Anganwadi and ASHA workers at the ground level, especially in tribal areas in order to ensure the effective reach of various nutritional programmes of the Government among tribal population and also ensure that timely registration of pregnant mothers at the PHC is done for regular health check up during ANC period. This will help in generating accurate health data of tribal women and children in the respective areas.

(iv) The Committee note that the Expert Committee on tribal health has recommended that there should be one ASHA per 50 households or 250 populations in tribal areas as against the present norm of 300 to 500 population. This Committee could not agree with them more since it is laborious for one ASHA worker to cover a population of 300 to 500 people in tribal areas as the tribal settlements are scattered in difficult geographical terrains. Hence, the Committee recommend that one ASHA per 50 households or 250 populations may be made the norm at the earliest so that effective coverage of health and nutrition can be achieved in tribal areas. Further, considering the difficult working conditions of ASHA and Anganwadi workers, the Committee also recommend that the Government may explore the possibility of providing difficult area allowance to them in tribal areas.

TRADITIONAL MEDICINES AND HEALERS IN TRIBAL COMMUNITIES

17. The Committee note that even today many tribal communities have undisputable trust on their traditional herbal and indigenous systems of medicine. The Committee also note that under the comprehensive health care model being provided by the Ministry of Tribal Affairs there are provisions for providing traditional tribal systems of medicine facilities along with Ayurveda in Arogya Banks. Since the tribal people have implicit faith on their traditional medicines, the Committee recommend that accessibility to these medicines in Arogya Banks may be facilitated efficaciously along with dissemination of information on modern medicine. The Committee also recommend that while encouraging them

to take to modern medicine, they may also be given the freedom to choose the traditional form of medicine in a given situation as per their preference.

(ii) The Committee further note that tribal communities repose absolute trust and faith on their traditional healers with whom they share a deep cultural bond. These healers are available to the tribal communities round-the-clock, provide home-visits and prescribe traditional medicines whenever necessary. Since the tribal communities are more at ease with these traditional healers, the Committee feel that it is essential for the public health care system to engage with the traditional healers and integrate them into the larger public health system without compromising on scientific methods and principles. The Committee, therefore, recommend the Ministry of Tribal Affairs to devise a larger plan to integrate traditional healers into the public health system and apprise the Committee about the same.

RESEARCH AND DATA ON TRIBAL COMMUNITY AND THEIR TRADITIONAL MEDICINES

18. The Committee note that in order to protect preserve the vast traditional and medicinal knowledge of the tribals, Patanjali Research Institute has been given a pilot project for research on tribal healers and medicinal plants in Uttarakhand. Similar projects have been given to AIIMS-Jodhpur, Pravara Institute of Medical Science and Mata Amritanandamayi Institute for Rajasthan, Maharashtra and Kerala respectively. Tribal Research Institute, Uttarakhand has been made the nodal centre for coordination of research works on tribal medicine and an integrated centre for AYUSH has also been set up in Uttarakhand with World

Health Organisation (WHO) support. While appreciating these steps taken by the Ministry, the Committee recommend to the Government to document, research and examine traditional tribal healing practices, customs and medicines with a view to preserving the ancient traditional medicine systems as well as making the scientific community aware of the utility of the traditional medicines. The research on unique healthcare needs of the tribal people, especially on genetic diseases like sickle cell anemia may be prioritised and specific findings on tribal women/girls may be figured as an integral part of the research wherever applicable. The Committee recommend that the Ministry of Tribal Affairs must work in coordination with AYUSH Ministry to devise larger plan to integrate with traditional healers. The Committee further recommend that the Government should take effective steps not only to encourage plantation of medicinal herbs used by the tribal communities but also provide conclusive environment for expanding the cultivation of such herbs.

SOCIAL DETERMINANTS OF HEALTH

19. The Committee understand that most tribal people live in remote rural hamlets in hilly, forested or desert areas. The difficult environment along with lack of proper roads, heavy rains and floods, lack of healthcare facilities, potable water, schools, personal hygiene and sanitation, regular means of income, job opportunities and malnutrition make them more vulnerable to diseases as a result of which their health indicators stand worse in comparison to the general population. In this regard, the Committee feel that special programmes and

policies by the concerned Ministries/Departments may mitigate the social determinant of health gaps persisting in the tribal areas. The Committee, therefore, urge the Ministry of Tribal Affairs to coordinate with the other Ministries concerned for addressing the infrastructural gaps existing in the tribal areas and pursue the concerns of the tribal people relentlessly so that social determinants of health become better in the tribal areas.

ROLE OF NGOS IN THE WELFARE OF TRIBAL POPULATION

20. Voluntary Organisations (VOs) and Non Governmental Organisations (NGOs) play a major role in enhancing the reach of various government schemes and filling the critical gaps in service deficient tribal areas. There is no dearth of success stories in the country to prove that effective use of NGOs in various programmes of the government can leverage the output and lend support in terms of human resource, technical skills and financial assistance. The Committee, therefore, recommend to the Government to consider implementing the following measures for securing good health for the tribal population:

(i) Anganwadis may be delegated to NGOs with adequate Grant-in-aid on pilot basis, particularly in areas where malnutrition, anemia, maternal mortality rate,etc. are on a higher side and their performance may be evaluated periodically to decide whether to continue with the provision or not.

(ii) Steps may be taken to ensure that NGOs who perform well and fulfill the laid down criteria are provided with funds in time.

(iii) The Committee also recommend that MMUs should be attached to renowned

NGOs to ensure last mile delivery of healthcare services in the tribal areas.

FUNDS FOR FOCUSSED INTERVENTIONS FOR SCHEDULED TRIBES

21. The Committee note that on the one hand, as per 'Allocation of Business Rules', the Ministry of Tribal Affairs is responsible for overall planning, project formulation and monitoring, especially monitoring of Tribal Sub-Plan, whereas on the other hand, policy, planning, monitoring and evaluation of sectoral programmes and schemes for development of these communities shall be the responsibility of the Central Ministry / Department concerned.

In view of the above, the Committee recommend the following:

(i) The Committee reiterate that the needs and requirements of Tribals are different from other population due to their culture, locations, remoteness and psychology. Therefore, schemes formulated by sectoral ministries without keeping in mind, the unique requirements of tribals may not be of much utility. The Committee fail to understand how the Ministry of Tribal Affairs can strive to achieve the welfare of the tribal population, especially tribal women and children with only limited funds in hand. The Committee feel that there is a need to review the allocation of business rules with reference to Ministry of Tribal Affairs with a view to empowering the hands of the Ministry of Tribal Affairs in such a way that substantial funds are made available to them for making area specific, sector specific and group specific schemes especially in the sectors of livelihood, education, skill development, nutrition and health. They, therefore, unequivocally recommend that all possible avenues be looked into and a concrete plan be drawn

in this direction. Once this in place, the Committee believe that the funds will be utilized effectively for the overall development of the tribal people in its true sense. The Committee would like to be intimated on the tangible progress made in this regard at the time of furnishing Action Taken Replies.

(ii) In order to bridge the gaps existing between tribal population and others there is a need to revamp mechanism for utlization of TSP/STC funds. Since health is an outcome of various social determinants, the Committee recommend that sector specific programme should be implemented in a mission mode in Education, Health, Livelihood, Skill Development and Nutrition. The Committee further recommend that ministries like Telecom, Road and Transport, Commerce, Electronics and Information Technology and Education should chalk out schemes for tribal areas in consultation with the Ministry of Tribal Affairs based on Infrastructural Gap Analysis.

(iii) In order to mitigate the various socio-economic gaps existing amidst the tribal population in comparison to the other general population, Tribal Sub Plan (TSP) was introduced to mandate a spending on the tribal community in proportion to their population percentage. TSP was visualised as an additional spending over and above the regular programmatic spending by the Ministries/Departments in the tribal areas. Currently, funds are allocated every year to different Ministries to be spent on the welfare of the tribal people. Here, the Committee would like to emphasise and recommend that a mechanism be created to track the exclusive spending *vis a vis* notional spending or assess the actual benefits received by the tribal communities out of this additional budget.

The Committee also recommend to the Ministry of Tribal Affairs to implement a mechanism for effectively tracking the spending of TSP funds by various Ministries exclusively on the tribal population and periodically assessing the actual benefits received by them out of TSP funds in the 177 tribal districts with special focus on the health, nutrition, education of tribal women and children.

COORDINATION BETWEEN MINISTRIES AND STATE GOVERNMENTS

22. The Committee find that so far tribal healthcare was subsumed in rural health care under the assumption that tribal people have same health problems and similar needs as others. The Committee feel that their different geographical locations and their unique socio-culture situations should be taken into account while formulating policies and programmes for their healthcare. Further, they are of the opinion that good health can't ever be achieved among tribals without necessary progress in developmental parametres which fall under the purview of various Ministries. As far as health is concerned, Ministry of Health and Family Welfare and Ministry of AYUSH are responsible for the health care of the tribal people and Ministry of Tribal Affairs is responsible for their overall development. Nutrition, which is a major component of the health is taken care of by the Ministry of Women and Child Development. In this backdrop, the Committee recommend the following:

(i) The Ministry of Tribal Affairs was set up in 1999 with the objective of providing more focused approach on the integrated socio-economic development of the Scheduled Tribes who are the most underprivileged in the Indian society.

The Committee feel that all the programmes and special schemes by various Ministries/Departments meant for the tribal people be implemented effectively so as the majority of the tribal people should not continue to be under poverty line and lacking in crucial health and social parametres. The Committee, therefore recommend the Ministry of Tribal Affairs to maintain effective coordination with the line Ministries concerned by fine tuning their programmes under Tribal Sub Plan with a tribal perspective, constantly following up with analysis of various welfare programmes for the tribals; identifying the shortcomings in the programmes and taking them up with the Ministries concerned for filling up critical gaps.

(ii) The Committee note that understanding the health situation of the tribal people, their aspirations and rights, the Ministry of Health and Family Welfare and the Ministry of Tribal Affairs had jointly constituted the Expert Committee on Tribal health under the chairmanship of Dr. Abhay Bhang. A Memorandum of Understanding (MoU) has also been signed for cooperation between both the Ministries. However, health is a state subject and all the action plans are coming originally from the States. The Committee, therefore, recommend that while chalking out state specific Programme Implementation Plans (PIPs), the Ministry of Health and Family Welfare should ensure the involvement of the representatives of the Ministry of Tribal Affairs so that the Ministry of Tribal Affairs can also give their inputs based on specific requirements. Also priority must be given to the tribal areas while making PIPs. The Committee also desire that inputs from the representatives of the public, including Members of

Parliament, may also be taken while State specific and district level PIPs are prepared.

(iii) The Committee further note that the Ministry of Health and Family Welfare monitor the health outcomes of tribal communities through various mechanisms including annual common review mission, National Programme Coordination Committee (NPCC) meetings with States and Union Territories as well as regional reviews etc. While appreciating the efforts taken by the Ministry, the Committee would like to put on record that it is not the lack of health programmes but the effective implementation of the programmes that cause hindrance in achieving desired results and it can be ensured only through strict monitoring of the programmes. The Committee, therefore, recommend the Ministry of Health and Family Welfare to make all out efforts to ensure that effective monitoring of the health programmes in the tribal areas is carried out in coordination with the state governments.

In summation, consequent to sifting of all the information and material gathered by the Committee, they aver with certitude that the subject 'Health Facilities for Tribal Women' assumes significance as far as the wellbeing of the tribal population across India is concerned. They, in no uncertain words would like to infer that unless a tribal women is healthy and free of diseases, at least the ones which could be steered away by precautionary treatment/early detection or the ones which could be clinically cured subsequently, their future generations yet to be born would also not be healthy. Therefore, they recommend that all the

three Ministries viz. Ministry of Tribal Affairs, Ministry of Health and Family Welfare as well as the Ministry of Women and Child Development undertake all out concerted efforts based on the recommendations of this Report so that a propitious conditions are developed and eventually, within the prescribed time frame the recommendations are implemented in letter and spirit.

NEW DELHI
21 July, 2023
Ashadha 25, 1945, (Saka)

DR. HEENA VIJAYKUMAR GAVIT
Chairperson,
Committee on Empowerment of Women

Annexure I

Tribal Dominated Village wise infrastructure gap analysis - All India			
S. No	**Village wise Infrastructure Details**		**No. of villages out of Tribal Dominated Villages (117047 Total Villages)**
1	Availability of banks in the village		10945
	Bank not available, the distance where facility is available	< 1 km	1674
		1-2km	5785
		2-5km	24751
		5-10Km	34106
		>10Km	39786
2	If bank not available in the village Availability Of bank/Business Correspondent with internet connectivity		12639
3	Availability of ATM		8173
4	Whether the village is connected to All weather road		77551
5	Whether village has an internal cc/ brick road		67531
6	Availability of Public Transport	Bus	33009
		Van	13978
		Auto	34144
		None	34999
7	Availability of Internet Cafe/Common Service Centre		19979
8	Availability of electricity for domestic use	1-4 hrs	7868
		5-8 hrs	19586
		9-12 hrs	35010
		>12 hrs	47407
		No electricity	7176
9	Availability of Public Distribution System (PDS)		58068
10	Availability of markets	Mandis	2989
		Regular market	5631
		weekly haat	18327
		None	90100
11	Availability of Piped tap water	100%	12150

		50-100%	17658
		< 50% habitation covered	18647
		Only one habitation is covered	6936
		not covered	61656
12	Availability of telephone services	Landline	1012
		Mobile	87650
		Both	10847
		None	17538
13	Total no of household using clean energy (LPG/Biogas)	Total Household – 21444823	9359939
14	No of household with kuccha wall and kuccha roof	Total Household – 21444823	9114133
15	Availability of Post office/Sub-Post office		22808
16	Availability of school	Primary	61230
		Middle School	26155
		High School	10642
		>Senior Secondary school	5519
		No school	13501
17	Availability of Vocational Educational center/ITI/RSETI/DDU-GKY		9366
18	Availability of Sub center	PHC	3453
		CHC	7114
		Sub Centre	18185
		None	88295
	If Sub Centre >not available in the village, distance of the nearest place where facility is available	< 1 km	2164
		1-2km	7110
		2-5km	23365
		5-10Km	25144
		>10Km	28031
19	Availability of Veterinary Clinic Hospital		15654
20	If Veterinary Clinic not available in the village, distance of the nearest place where facility is available	< 1 km	1379
		1-2km	4844

		2-5km	21356
		5-10Km	31518
		>10Km	42412
21	Availability of drainage facilities	Closed drainage	5247
		open pucca drainage covered with tiles slab	3270
		open pucca drainage uncovered	16585
		open kuccha drainage	33882
		no drainage	58063
Source: Census 2011 & Mission Antyodaya			
Note: There are about 145000 villages in all India with more that 25% of Tribal population out of which Mission Antyodaya infrastructure gap data is available only for 117064 villages			

Access to Tap Water, sanitation and clean energy

S. No	Indicators	% ST population	% Non-ST population
1	% Household with Access to Tap water	10.7	28.5
2	Prevalence of open defecation	74.7	47.2
3	% Household with separate kitchen	53.7	62.1
4	% Household using clean cooking fuel	9.5	31.1

Census-2011

COMMITTEE ON EMPOWERMENT OF WOMEN (2020-21)
MINUTES OF THE THIRD SITTING OF THE COMMITTEE HELD ON TUESDAY, THE 23rd FEBRUARY, 2021

The Committee sat from 1100 hrs. to 1350 hrs. in Committee Room 'E', Parliament House Annexe, New Delhi.

PRESENT

Dr. Heena Vijaykumar Gavit - **Chairperson**

MEMBERS

LOK SABHA

2. Smt. Sangeeta Kumari Singh Deo
3. Smt. Annpurna Devi
4. Smt. Navneet Ravi Rana
5. Smt. Satabdi Roy (Banerjee)

RAJYA SABHA

6. Smt. Vandana Chavan
7. Smt. Shanta Chhetri
8. Ms. Saroj Pandey
9. Smt. Chhaya Verma

SECRETARIAT

1. Smt. Kalpana Sharma - Additional Secretary
2. Smt. Maya Lingi - Director
3. Smt. Reena Gopalakrishnan - Additional Director

Representatives of the Ministry of Tribal Affairs

1. Shri Naval Jit Kapoor - Joint Secretary,

Representatives of the Ministry of Health and Family Welfare (Department of Family Welfare)

1. Shri Vikas Sheel - Joint Secretary,
2. Dr. N. Yuvaraj - Director

Representatives of the Ministry of Women and Child Development

1. Shri Drijesh Kumar Tiwari - Statistical Advisor

2. At the outset, the Chairperson welcomed the members of the Committee to the sitting convened to have a briefing by the representatives of the Ministry of Tribal Affairs, Ministry of Health and Family Welfare (Department of Health and Family Welfare) and Ministry of Women and Child Development in connection with the examination of the subject 'Health Facilities for Tribal Women'.

[Witnesses were then called in]

3. After welcoming the witnesses, the Chairperson, in her initial remarks, expressed concern over the persisting issues relating to tribal health despite a spate of health schemes in place for them. She stressed on the need to achieve significant changes in various tribal health issues and requested the Ministries concerned to throw light upon the various activities conducted by them to secure good health for tribal women. She also read out Direction 55, regarding the confidentiality of the proceedings. After that, the representatives of the Ministry of Tribal Affairs and the Ministry of Health and Family Welfare , through their power point presentation, briefed the Committee about the multifarious Schemes, interventions, Tribal Action Plans and other measures/programmes in place to ensure tribal health.

4. After the Power Point presentation by both the Ministries, the Committee discussed about various health related aspects like opening of Health Centres by State Governments, State health Missions, funding in High Priority Districts, availability of fund from District Mineral Development Funds for health schemes in tribal areas, the imperativeness to reduce infant mortality rate and maternal mortality rate, the need to eliminate leprosy, reduce instances of malaria, controlling dengue fever etc. The Committee also stressed upon the need to have adequate ambulance services in tribal areas, the urgency to devise a smoother and easier mechanism to make ambulance services available to the needy tribals, provision of a mechanism to register complaints about improper functioning of ambulance services and reimbursement of private vehicle transportation expenses incurred during emergency visit to hospitals in the tribal areas.

5. The Committee further discussed about mobile medical units, bike ambulance service in tribal areas, facilities available under Janani Shishu Suraksha Yojana including free pick and drop facility for the new born and the mother, role of ASHA workers in creating awareness about the various health schemes and facilities available for tribal women, need to increase the incentives/remuneration to ASHA workers, different norms prevailing in different States with regard to the incentive given to ASHA workers, benefits available under Pradhan Mantri Matru Vandana Yojana, the modus operandi adopted to handle high risk deliveries in tribal areas including finding the ways and means to reduce the travel time involved in reaching District Medical Hospitals, percentage of TB amongst tribal population,

health measures in place to treat and eradicate TB, the necessity to make the TB patients resort to full course of TB treatment, the need to give as much importance to treatment of diseases like TB, leprosy etc. as given to other programmes under National health Mission, anaemia among tribal women, need for a dedicated TB officer in the districts, availability of TrueNat and CBNAAT testing in tribal districts, awareness about various diseases among tribals and the need to educate them about the health facilities available for them, addiction related issues among tribal women, provision of clean drinking water, schemes to tackle sickle cell and aplastic anaemia and thallassemia, death rate among tribals due to sickle cell anaemia, schemes for bone marrow transplant treatment, CSR initiative of Coal India Limited for bone marrow transplant treatment, grants sanctioned under Rashtriya Aarogya Nidhi etc. The Members also sought specific information on state-wise number of ASHA workers engaged in COVID duty and the amount paid to the ASHAs.

6. Thereafter, the Ministry of Women and Child Development briefly apprised the Committee about the major schemes undertaken by them for the welfare of tribal women like Beti Bachao, Beti Padhao Scheme, Anganwadi services , Pradhanmantri mathru vandana yojana and Scheme for Adolescent Girls.

7. After that, the Committee further discussed about lack of good infrastructure in tribal areas , the need to focus on the health of tribal women and girls, the need to conduct check-ups in schools to identify sickle cell anaemia patients at a very young age and provide required counselling, the need for institutional deliveries etc. The Members also raised questions about the pitiable health conditions of tribals despite a plethora of programmes being in place for them, the progress achieved over the years in tribal health care, the level of coordination between the three Ministries, efficacy of Special Central Assistance to Tribal Sub-Plan Scheme, need for coordination between ASHA worker and Anganwadi sevika at the ground level, whether Anganwadi centres are available across all the tribal areas and the efficacy of Anganwadi scheme in addressing malnutrition amidst tribal children, adolescent girls and women, contraceptive methods amongst tribals, shortage of doctors and paramedics in tribal areas, the budget expenditure for tribals by all the three Ministries, need for proper implementation of tribal health schemes and ensuring that the benefit is reaching every deserved tribal, the dedicated tracking portals created by the Ministries etc. The Committee also sought information from the Ministries about the number and percentage of deaths among tribal women and the causes for the deaths. The Ministries

answered the various questions raised by the Members. They were requested to furnish written replies on those points on which answers were not readily available with them to the Lok Sabha Secretariat within a week's time.

[The witnesses then withdrew]

8. Thereafter, the Committee also decided to undertake a study tour during the last week of April, 2021 and authorized the Chairperson to finalize the tour programme.

9 A verbatim record of the proceedings has been kept.

The Committee then adjourned.

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COMMITTEE ON EMPOWERMENT OF WOMEN (2020-2021)

MINUTES OF THE SIXTH SITTING OF THE COMMITTEE HELD ON TUESDAY, THE 27th JULY, 2021

The Committee sat from 1500 hrs. to 1725 hrs. in Committee Room No. 2, First Floor, Block 'A', Extension to Parliament House Annexe, New Delhi.

PRESENT

Dr. Heena Vijaykumar Gavit - Chairperson

MEMBERS

Lok Sabha

2. Smt. Locket Chatterjee
3. Smt. Sangeeta Kumari Singh Deo
4. Ms. Ramya Haridas
5. Smt. Raksha Nikhil Khadse
6. Smt. Queen Oja
7. Smt. Shardaben Anilbhai Patel
8. Smt. Riti Pathak
9. Smt. Navneet Ravi Rana
10. Smt. Gomati Sai
11. Smt. Sarmistha Sethi
12. Smt. Geetha Viswanath Vanga

Rajya Sabha

13. Smt. Vandana Chavan
14. Smt. Shanta Chhetri
15. Smt. Mamata Mohanta

SECRETARIAT

1. Smt. Kalpana Sharma - Additional Secretary
2. Smt. Maya Lingi - Director
3. Smt. Reena Gopalakrishnan - Additional Director

Representatives of the Ministry of Tribal Affairs

1. Shri Anil Kumar Jha - Secretary
2. Shri Naval Jit Kapoor - Joint Secretary

Representatives of the Ministry of Health and Family Welfare

1. Ms. Vandana Gurnani - Additional Secretary & MD
2. Sh. Vishal Chauhan - Joint Secretary
3. Dr. N. Yuvaraj - Director

Representatives of the Ministry of Women and Child Development

1. Shri Indevar Pandey - Secretary

2. Shri Ashish Srivastava	-	Additional Secretary
3. Ms. Pallavi Agarwal	-	Joint Secretary

2. At the outset, the Chairperson welcomed the Members of the Committee to the sitting convened to take oral evidence of the representatives of the Ministry of Tribal Affairs, Ministry of Health and Family Welfare (Department of Health and Family Welfare) and Ministry of Women and Child Development on the subject 'Health Facilities for Tribal Women'.

[Witnesses were then called in]

3. After welcoming the witnesses, the Chairperson, in the initial remarks, expressed her concern over having no desegregated data on tribal health. While pointing out the high prevalence of malnutrition, sickle cell disease, malaria, leprosy, TB etc. among the tribal population and the shortage of health infrastructure and healthcare personnel in tribal areas, the Chairperson wished to know about the reasons for the lack of development at the ground level in tribal areas despite spending crores of rupees under Scheduled Tribe Component by various Central Ministries on multiple tribal welfare schemes including schemes on health. During the initial remarks itself, the Chairperson further raised pertinent questions to the Ministries about the efforts taken to address the COVID-19 concerns in tribal areas, vaccination status of the tribal people etc. and also read out Direction 55 regarding the confidentiality of the proceedings.

4. Thereafter, the Ministries apprised the Committee about the multifarious Schemes and new interventions taken by them to address the varied healthcare issues of the tribal people, especially tribal women. The Committee, then, through the questions raised by the Members, discussed about issues like the lower percentage of institutional delivery among the tribals, the need to strengthen Primary Health Centres, Sub Centres and Community Health Centres to fortify the healthcare of tribal women and children, the need for more coordination and interaction with State Governments to ensure better healthcare for the tribals as 'health' is ultimately a 'State subject', the necessity to involve the representatives of the Ministry of Tribal Affairs by the Ministry of Health and Family Welfare when they approve project implementation plan of the States under National Health Mission, provision for relaxation of norms in tribal areas for establishing health centres, having ambulance, ASHA workers etc.

5. Discussion was also held at length regarding Ayushman Bharat Health and Wellness Centres through which teachers are trained to become health ambassadors and also the accessibility of the Centres to the tribal community, healthcare under Pradhan Mantri Jan Arogya Yojana and the efforts of the Government to reduce maternal mortality rate and infant mortality rate among the tribals.

6. The Committee also deliberated upon the importance of Mission Indradhanush programmes which aims at reaching the last mile and covering the uncovered, new vaccine for prevention of pneumococcal pneumonia, setting up of birth waiting rooms under Surakshit Matritva Abhiyan and Mission Parivar Vikas, improvement in institutional delivery, improvement in ante-natal care, growth in the modern contraceptive usage among tribal women, increase in the hygienic methods for protection during the menstrual period among tribal women, 'active case detection of leprosy ' in tribal areas etc.

7. Focussing specifically on the issues of malnutrition among the tribal people, the Ministry informed about the initiatives under 'Anaemia Mukt Bharat Programme' to address

malnutrition related issues amongst the tribals, the importance of shifting attention from calories to micronutrients to address malnutrition, provision of fortified rice through Anganwadis, provision of supplementary nutrition from anganwadi centres to girls between 14-18 years of age, introduction of Poshan Tracker App to get the data of all the children who are coming to the Anganwadi Centre, the efforts to track beneficiaries through Aadhar enabled system, Covd-19 vaccination status among the tribals , screening of new born children for sickle cell disorders etc.

8. During the discussion, the Committee Members while appreciating the Poshan Tracker App, specifically pointed out to the Ministry about how the tribal areas are lacking in good data or wifi connectivity and how it can affect the efficient recording of data through the App and the relevance of educational qualification of the Anganwadi workers in ensuring the accuracy of the data. The Members further raised concerns over discontinuation of Integrated Action Plan Scheme, vacancies of healthcare professionals at the ground level and the need to fill them at the earliest, constitution of National Tribal Health Council, Tribal Health Directorate and a Tribal Health Research Cell, allocation and utilisation of funds for tribal healthcare.

9. The Committee also specifically dwelled upon the contribution of ASHA and Anganwadi workers in the healthcare of tribal people, especially during the COVID time, the need to ensure coordination between ASHA and anganwadi workers and the importance of maintaining accurate data by both of them, ways and means to encourage tribal women to access healthcare facilities, system of registration at the sickle cell corner portal created by the Ministry of Tribal Affairs, health interventions by the Government at school level, provision of permanent Disability Certificate to sickle cell disease patients, monitoring and tracking of various welfare programmes by the Ministries, appointment and retention of healthcare professionals in tribal areas, compulsory posting of PG doctors as Interns in District Hospitals to meet the demand of doctors in tribal areas,

10. Most of the issues raised by the Chairperson and the Members were replied to by the representatives of the Ministries concerned. However, on the queries on which the information was not readily available, they were directed to furnish written replies to the Secretariat within a week's time.

(The witnesses then withdrew)

The Committee then decided to undertake a study tour in September, 2021

The Committee then adjourned.

A copy of verbatim record of the proceedings has been kept.

COMMITTEE ON EMPOWERMENT OF WOMEN (2020-21)
MINUTES OF THE EIGHTH SITTING OF THE COMMITTEE HELD ON THURSDAY, THE 05th AUGUST, 2021

The Committee sat from 1500 hrs. to 1625 hours in Committee Room 2, First Floor, Block 'A', Extension to Parliament House Annexe, New Delhi.

PRESENT

Dr. Heena Vijaykumar Gavit - **Chairperson**

MEMBERS

LOK SABHA

2. Smt. Raksha Nikhil Khadse
3. Smt. Jyotsna Charandas Mahant
4. Smt. Queen Oja
5. Smt. Shardaben Anilbhai Patel
6. Smt. Riti Pathak
7. Smt. Navneet Ravi Rana
8. Smt. Sarmistha Sethi

RAJYA SABHA

9. Smt. Jharna Das Baidya
10. Smt. Vandana Chavan
11. Smt. Shanta Chhetri
12. Smt. Mamata Mohanta
13. Smt. Chhaya Verma

SECRETARIAT

1. Smt. Maya Lingi - Director
2. Smt. Reena Gopalakrishnan - Additional Director

REPRESENTATIVES OF 'RAMAKRISHNA MISSION'

Swami Shantatmananda - Secretary

REPRESENTATIVES OF 'PIRAMAL SWASTHYA'

1. Mr. Ashwin Deshmukh - Senior Vice President
2. Dr. Shailendra Hegde - Senior Vice President

REPRESENTATIVES OF 'BHARATIYA LOK KALYAN SANSTHAN'

Shri Chandra Deo Singh - Secretary

REPRESENTATIVES OF THE 'ASSOCIATION FOR SOCIAL AND HUMAN AWARENESS' (ASHA)

1. Ms. Punam Toppo - Chairperson
2. Shri Ajay Kumar Jaiswal - Founder ASHA

2. At the outset, the Chairperson welcomed the members of the Committee to the sitting convened to have an interaction with the representatives of the NGOs 'Ramakrishna Mission', Piramal Swasthya', 'Bharatiya Lok Kalyan Sansthan' and 'Association for Social and Human Awareness' (ASHA) in connection with the examination of the subject 'Health

Facilities for Tribal Women'.

[Witnesses were then called in]

3. After welcoming the witnesses, the Chairperson, in her initial remarks, expressed concern over the persisting healthcare issues among the tribal people despite a plethora of health schemes in place for them. While stressing upon the need to achieve significant progress in various tribal health parameters, she requested the NGOs to express their views and suggestions on securing good health for the tribal people, especially tribal women. The Chairperson also read out Direction 55, regarding the confidentiality of the proceedings.

4. Thereafter, the representatives of ASHA and Bharatiya Lok Kalyan Sansthan briefed the Committee about their activities through Power Point presentations. After that, both Ramakrishna Mission and Piramal Swasthya apprised the Committee about their activities among tribal communities. Subsequently, the Committee discussed with the NGOs about lack of data about tribal people, malnutrition issues among the tribals, lack of health infrastructure and human resource in tribal healthcare, the need for convergence amongst the Ministries of Health and Family Welfare, Tribal Affairs, Women and Child Development and Rural Development.

5. The Committee were also apprised about the urgency to set up a National Council on Tribal Health and launch a Tribal Health Mission, the need to engage with the tribal community in letter and spirit, communication issues in tribal areas, the necessity to strengthen tribal Self Help Groups for the overall growth of the tribal people, the need to explore the feasibility of entrusting NGOs with the running of Primary Health Centres on trial basis and increasing mobile medical services in tribal areas, streamlining of online services and enhancing their functionality, etc.

6. During the discussion, the Members raised questions about the working of ASHA and Anganwadi workers, the data gap in tribal healthcare, the means and methods to ensure the authenticity and accuracy of tribal data, spending of Tribal Sub Plan funds, telemedicine projects, methods to address malnutrition, encouraging male participation in family planning, rising cases of sexually transmitted diseases among tribal women, response time for an ambulance service in tribal areas, treatment of sickle cell disease, the utility results of bone marrow transplant schemes at the ground level etc. The NGOs answered the various questions raised by the Members. However, they were requested to furnish written replies on those points on which answers were not readily available with them to the Lok Sabha Secretariat.

[The witnesses then withdrew]

7. A verbatim record of the proceedings has been kept.

The Committee then adjourned.

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