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PARLIAMENT OF INDIA
LOK SABHA

COMMITTEE ON EMPOWERMENT OF WOMEN
(2025-2026)

(EIGHTEENTH LOK SABHA)

SECOND REPORT

'HEALTH FACILITIES FOR TRIBAL WOMEN'

[Action Taken by the Government on the Observations/Recommendations contained in the Seventh Report (Seventeenth Lok Sabha) of the Committee on Empowerment of Women (2022-23) on the subject 'Health Facilities for Tribal Women']

LOK SABHA SECRETARIAT
NEW DELHI

30 July, 2025/08 Shravana, 1947 (Saka)

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Presented to Lok Sabha on 30th July, 2025

Laid in Rajya Sabha on 30th July*, 2025*

LOK SABHA SECRETARIAT
NEW DELHI

30 July, 2025/08 Shravana, 1947 (Saka)

E.W.C. No. ---.

PRICE: Rs._____

Published under ……

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Lok Sabha

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1. Smt. Jyochnamayi Sinha - Joint Secretary
2. Smt Neena Juneja - Director
3. Shri Yogesh Verma - Assistant Executive Officer

INTRODUCTION

I, the Chairperson, Committee on Empowerment of Women, having been authorized by the Committee to submit the Report on their behalf, present this Second Report (Eighteenth Lok Sabha) on the action taken by the Government on the Observations/Recommendations contained in their Seventh Report (Seventeenth Lok Sabha) on 'Health Facilities for Tribal Women'.

2. The Seventh Report of the Committee on Empowerment of Women was presented to Lok Sabha and laid in Rajya Sabha on 8th August, 2023. The Ministry of Tribal Affairs, Ministry of Health & Family Welfare and Ministry of Women and Child Development have furnished the action taken replies to all the Observations/Recommendations contained in the Report.

3. The Committee on Empowerment of Women (2025-26) considered and adopted the draft Action Taken Report at their sitting held on 21st July, 2025. Minutes of the sitting are given in Appendix I.

4. An analysis of the action taken by the Government on the Observations/Recommendations contained in the Seventh Report (Seventeenth Lok Sabha) of the Committee is given in Appendix II.

5. For facility of reference and convenience, the Observations/Recommendations of the Committee have been printed in bold letters in the body of the Report.

NEW DELHI;
30 July , 2025
08 Shravana , 1947 (Saka)

Dr. D. PURANDESWARI,
CHAIRPERSON,
COMMITTEE ON EMPOWERMENT OF WOMEN

CHAPTER I

REPORT

This Report of the Committee deals with the action taken by the Government on the observations/recommendations contained in the 7th Report (Seventeenth Lok Sabha) of the Committee on Empowerment of Women on the subject 'Health Facilities for Tribal Women' pertaining to the Ministry of Tribal Affairs, Ministry of Health & Family Welfare and Ministry of Women & Child Development.

2. The 7th Report of the Committee was presented to Lok Sabha on 8th August, 2023 and was simultaneously laid in Rajya Sabha on the same day.

3. Action Taken Replies in respect of all the 22 observation/recommendations contained in the Report have been received from the Government. These have been categorized as follows: -

(i) Observations/Recommendations which have been accepted by the Government:

Recommendation Para Nos: **1,2,3,4,7,8,9, 10,11,12,16, 18, 19,20,21 and 22**

Total: 16
Chapter – II

(ii) Observations/Recommendations which the Committee do not desire to pursue in view of the replies of the Government:

Recommendations Para Nos.: **5 and 15**

Total : 02
Chapter : III

(iii) Observations/Recommendations in respect of which replies of the Government have not been accepted by the Committee and which require reiteration:

Recommendation Para Nos: **6,13,14 and 17**

Total :04
Chapter : IV

(iv) Observation/Recommendations in respect of which the Government have furnished interim replies :

Recommendation Para Nos: **NIL**

Total : Nil
Chapter : V

4. The Committee trust that utmost importance would be given by the Government to the implementation of their recommendations. In case where it is not possible for the Government

to implement the recommendations in letter and spirit for any reason, the matter should be reported to the Committee with reasons for non-implementation. The Committee further desire that the Action Taken Notes on the observations/recommendations contained in Chapter-I of this Report be furnished to the Committee within three months of the presentation of this Report.

5. The Committee will now deal with those action taken replies of the Government, which need reiteration or merit comments.

A. NEED TO DEVELOP TRIBAL SPECIFIC DATA BASE

Recommendation Para No.1

6. The Committee in their Original Report recommended as under:

> "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 a specific percentage of tribal population in the country, the Ministry of Tribal Affairs should be having a 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 the 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 dose 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 Fact sheets 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 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."

7. Ministry of Tribal Affairs in its action taken reply on the above mentioned recommendation has stated as under:-

"Reply to (i), (ii) and (iii): – The Ministry of Tribal Affairs is 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 communities, policy, planning, monitoring, evaluation etc. as also their coordination, implementation will be the responsibility of the concerned Central Ministries/ Departments, State Governments and Union Territory Administrations. Each Central Ministry/Department will be the nodal Ministry or Department concerning its sector. Thus, the Ministry of Health and Family Welfare, the Ministry of Women and Child Development and the Ministry of AYUSH are the nodal Ministries with respect to their respective domains in the matter of tribal health, including of tribal women. The specific replies to the recommendations of the Committee are as follows:

Reply to (i): At present, there is no centralized repository as well as mechanism for collection or storage data pertaining to the health of tribal women as mostly the tribal

related data is gender neutral. However, Ministry of Tribal Affairs has taken note of the recommendation to inform the Ministry of Health and Family Welfare/ Ministry of WCD and other Government Ministries/agencies 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.

Reply to (ii): **Ministry of Tribal** have already taken up the matter with MoH&FW and MoWCD to provide access to the required data through an Application Programming Interface (APIs) for the selected indicators related to the Tribal Districts. The recommendation with reference to the API linkages with the Swasthya Portal has been noted.

Reply to (iii): The **Ministry of Tribal Affairs** has requested the MoHFW to undertake periodic reviews of the Swasthaya Portal. Nonetheless, the recommendations are noted.

Reply to (iv): The **Ministry of Tribal Affairs** has requested to MoHFW for collecting the sample data in NFHS 6 related to Health & Nutrition in Tribal communities. However in reply MoHFW has informed that MoTA may take up this issue separately with IIPS or any other agency."

Comments of the Committee

8. While expressing concern about the practice of subsuming tribal data in rural healthcare data which led to creation of ineffective conclusions on the implementation of available health programmes among the tribal people, the Committee in their original Report had recommended the Ministry of Tribal Affairs to work in tandem with the Ministry of Health and Family welfare to generate tribal disaggregated health data for evolving custom made health intervention to suit unique requirements of the tribal people especially women and children. The Committee note from the Action Taken Replies of the Ministry that it has simply taken note of the recommendation to inform the Ministry of Health and Family Welfare/ Ministry of WCD and other Government Ministries/agencies to generate tribal disaggregated health data. The Replies of the Ministry is vague and it is not clear whether the matter has been taken up or not. The Ministry of Tribal Affair, being the nodal Ministry for overall policy planning and coordination of programmes for the development and welfare of tribals, needs to take concerted steps in a focused manner to yield the desired results in a reasonable time frame in close coordination with all other Ministries/Departments and stakeholders concerned. The Committee, therefore, desire the Ministry of Tribal Affairs to take a proactive role by collaborating with the Ministry of Health and Family Welfare (MoHFW) and the Ministry of Women and Child Development (MoWCD) to ensure generation of tribal disaggregated health data, regular updation and utilization of the same for evolving custom made health intervention to suit unique requirements of the tribal people especially women and children in a stipulated time frame and apprise the Committee on the concrete action taken in this regard. The Committee are of the view that formation of a Task Force or Working Group involving representatives from these Ministries and Data Experts and in partnerships with academic institutions and NGOs in the tribal healthcare sector, if required, could help in designing a mechanism to fill this data gap.

While appreciating the step taken by the Ministry of Tribal Affairs for recognizing Piramal Swasthya as a Centre of Excellence(COE) for knowledge Management in Health and Nutrition to address the data gaps/ challenges specifics to tribal health and nutrition by creating an on line repository of all tribal health and nutrition in coordination with the Ministry of Women and Child Development and Ministry of Health and Family Welfare and State Governments, the Committee had recommended 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. This will facilitate to have a clear picture of the status of service delivery in the 177 tribal districts, on priority basis. The Committee note from the Action Taken Replies that the Ministry of Tribal have already taken up the matter with MoH&FW and MoWCD to provide access to the required data through an Application Programming Interface (APIs). However, the replies remain silent on the plan of action and time-line for ensuring the linkages, of APIS in the absence of which, there is a risk of delay or non-implementation of the recommendation of the Committee. The Committee, while, imploring for implementation of the recommendations, desire that the Ministry of Tribal Affairs should delineate a time period for database integration via APIs and bring together technical teams from the concerned Ministries to expedite the process. The Ministry must ensure timely User testing and regular reviews so that the data are seamlessly accessible for policymakers. The Committee may be apprised of the action taken in this regard.

Further, the Committee in their original Report had observed that the Centre of Excellence- for Knowledge Management in Health and Nutrition is examining the data of Swasthya Portal which contains tribal disaggregated data for 177 tribal districts of the country from time-to-time. They felt that the Ministry of Tribal Affairs being the nodal Ministry, should devise a mechanism to periodically examine and assess this data on the Portal in order

to check the authenticity of the data. The Ministry has stated that "The Ministry of Tribal Affairs has requested the MoHFW to undertake periodic reviews of the Swasthaya Portal. Nonetheless, the recommendations are noted" The Committee are of the strong view that the Ministry should refrain from furnishing such type of replies to the recommendations of the Committee. They desired that actual action taken with respect to the recommendations should be furnished to them with in three months of presentation of this Report.

So far as collecting tribal population sub-sample data, the Committee in their original Report had recommended to do the same by using the NFHS-5 so that the changes in the health and nutrition status of the tribal communities can be tracked and timely and effective redressal of shortcomings can be carried out. They also had recommended that 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. The Committee are concerned to note that till the furnishing of Action Taken Replies, no action has been taken. The responsibilities are being shifted from one Ministry to other. The Committee, therefore, reiterate their earlier recommendation that concerted efforts need to be taken by Ministry of Tribal Affairs and the Ministry of Health and Family Welfare for periodic review of the Swasthya Portal and the collection of the requisite data in NFHS 6 so that the same can be properly analyzed and utilized. To achieve this, an internal review mechanism may be established for periodic analysis of tribal health data, which shall form a part of an annual or biannual tracking of healthcare delivery progress of tribal communities. Further, the Ministry of Tribal Affairs should directly engage with the International Institute for Population Sciences (IIPS) to ensure tribal-specific data collection in future NFHS surveys, formalizing this collaboration through a Memorandum of

Understanding (MoU). The Committee also feel that the Ministry needs to provide the healthcare facilities and services to the tribal communities in a far effective manner by creating a dedicated Tribal Health Data Coordination Unit within the Ministry and building the technical capacity of tribal health officials and frontline workers.

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

Recommendation Para No. 2:

9. The Committee in their Original Report recommended as under:

> "The Committee observe that malnutrition among tribal people is much higher than that of all groups taken together. Malnutrition and anemia 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 anemic 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 anemia is due to nutritional causes such as iron, folic acid and vitamin B-12. Other non-nutritional factors leading to high prevalence of anemia among women in tribal areas are malaria endemicity and prevalence of sickle-cell anemia 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 Anemia 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 anemia 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 behaviors 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 instill behavioral changes among the tribal community for better health and nutrition outcomes. Though many of the government programmes are focusing on this approach currently, the Committee would urge upon the Government to reinforce this approach for maximizing the impact of such campaigns among the tribal community so that desired results are achieved."

10. The Ministry of Tribal Affairs in its action taken reply on the above mentioned recommendation has stated as under:-

"Reply (i) to (iii): Ministry of Women and Child Development has stated that it is committed towards eradication of malnutrition and is implementing Mission Saksham Anganwadi and Poshan 2.0 (Poshan 2.0), which is a holistic nutrition support programme, and consists of POSHAN Abhiyaan, Anganwadi Services, and Scheme for Adolescent Girls that collectively focus on addressing malnutrition. Other schemes like Pradhan Mantri Matru Vandana Yojana (PMMVY) under 'Mission Shakti' of MoWCD also contribute towards the same. Mission Poshan 2.0 and PMMVY schemes are implemented at Pan India level covering all 36 States/UTs, all districts including 112 aspirational districts and 177 tribal districts, while Scheme for Adolscent Girls (SAG) is implemented in aspirational districts and all districts of North East States including Assam. The MoWCD has further given the following information:

Anganwadi services Scheme and Scheme for Adolescent Girls:

(a) The Anganwadi Services Scheme encompasses six services namely- supplementary nutrition, pre-school non-formal education, nutrition and health education, immunization, health check-up and referral services. The responsibility of delivery of these services is partly

shared by MoWCD, National Health Mission (NHM) and Public Health Infrastructure. The scheme adopts a holistic approach (preventive, promotive, curative and sensitization) to effectively address the challenges of malnutrition and Anaemia. Besides nutrition intervention, it seeks to embrace practices that nurture health, wellness and immunity.

(b) The existing Supplementary Nutrition Programme (SNP) is reinvigorated and converged under 'Saksham Anganwadi and Poshan 2.0'. It seeks to address the dual burden of malnutrition i.e., under-nutrition and micronutrient deficiency by bridging the gap between Recommended Dietary Allowances (RDA) and the Average Daily Intake (ADI). It provides nutrition support to the children (including severely malnourished children) up to the age of 6 years, pregnant women, lactating mothers, and adolescent girls (14-18 years) in the aspirational districts and all districts of North-Eastern States. Under this programme, take home ration (THR) and hot cooked meal (HCM) is given as per the designated nutritional norms of energy and protein.

(c) In order to prevent micronutrient deficiency and provide good quality proteins, special emphasis has been laid on incorporation of dietary diversity, use of locally produced fresh green leafy vegetables, fruits, medicinal plants and herbs, fortified rice, millets, nuts & oilseeds. Under Mission Poshan 2.0, only fortified rice is being allocated to States/UTs.

(d) More emphasis is on the use of millets as they have higher nutrient content which includes protein, essential fatty acid, dietary fibre, B-Vitamins, minerals such as calcium, iron, zinc, folic acid and other micro-nutrients, thus helping to tackle Anaemia and other micro-nutrient deficiencies in women and children. Hence, government is focusing on incorporating millets in the Hot Cooked Meals (HCM) and Take Home Ration (THR) provided to pregnant women & lactating mothers (PW&LMs), and children below 6 years under SNP. In line with the United Nations General Assembly's resolution declaring 2023 as the 'International Year of Millets', Government took the initiative to encourage the adoption of millets across the country through Jan Andolan. In Poshan Pakhwada 2023, one crore activities were carried out for popularization of millets, health benefits of millets and their suitability for cultivation in challenging climates. An exemplary initiative taken by the District Asifabad in Telangana under Project Sampoorna was also awarded with the Hon'ble PM's Award for Excellence in Public Administration in 2022 for promotion of Jan Bhagidari in Poshan Abhiyaan for Millet promotion.

(e) Children are vaccinated against disease-causing micro-organisms. Pregnant women are also given two shots of tetanus vaccine.

(f) Early detection of children with underweight, stunting, severe acute malnutrition (SAM) and moderate acute malnutrition (MAM) status through periodic growth monitoring is undertaken. Regular growth monitoring is essential for early identification of malnourished children and timely interventions. In this direction, close to 7 crore children at Anganwadi Centres were measured in September 2023. The results captured on the Poshan Tracker show substantially lower malnutrition (wasting) levels in comparison to NFHS-5 findings (2021 – 2023). Only 6.6% were found to be wasted, as compared to 19.3% under NFHS-5. (M/WCD)

(g) In a national event held on 10th October 2023, the protocol for Community Management of Malnutrition (CMAM) was released jointly by the Ministry of Women & Child Development and Ministry of Health & Family Welfare to prevent and treat severe acute

malnutrition (SAM) thereby reducing associated morbidity and mortality. The community-based approach involves timely detection and screening of children with severe acute malnutrition in the community, management for those without medical complications with wholesome, local nutritious foods at home and supportive medical care. Those malnourished children which have medical complications are referred for facility-based care. The protocol will help to provide uniform standardized care to the malnourished children across all State/UTs.

(h) Besides Nutrition support, the adolescent girls under SAG are also supported with IFA (Iron and Folic Acid) supplementation, health check-ups, referral services and Nutrition & health Education. Close to 22.7 lakh adolescent girls (14-18 years) from North east and Aspirational districts are registered on the Poshan Tracker as part of the Scheme for Adolescent Girls.

(i) A key initiative of the POSHAN Abhiyaan, to enable the right kind of nourishment, is the Poshan Vatikas or Nutri-gardens that are being set up across the country at or near an Anganwadi Centre to provide a fresh, affordable and regular supply of locally produced fruits, vegetables and medicinal plants to women and children. To encourage diet-diversity and consumption of wholesome local produce, more than 6 lakh Poshan Vatikas have been developed at AWCs. Also, more than 1 lakh medicinal plants were planted in 21 districts of 6 States namely Uttar Pradesh, Madhya Pradesh, Maharashtra, Gujarat, Himachal Pradesh, and Mizoram during Poshan Pakhwada 2021. Poshan Vatikas are a good example of convergent action on-ground which will reduce external dependency and make communities Atmanirbhar for their nutritional security.

Poshan Abhiyaan:

(a) Behavior change interventions also lay a key foundation in preventing malnutrition at the household and the community level. Under these, community-based events are being organized twice per month at the Anganwadi centers to engage community and empower beneficiaries for bringing positive behavior change towards nutrition. Further, for making 'Malnutrition free India' a national move, Poshan Maah and Poshan Pakhwada are celebrated annually in the month of September and March respectively as nutrition-centric Jan Andolans. Poshan Maah is a month long celebration and Poshan Pakhwada is observed for 15 days wherein theme-based sensitization activities are conducted by the community and within the community evoking behavioral change through the process of community mobilization. Over the years, themes have included overall nutrition, hygiene, water and sanitation, Anaemia prevention, importance of breast-feeding, growth monitoring, role of Poshan Panchayats, AYUSH for Well-being, 'Back to Basics – Yoga for Health', importance of Poshan Vatikas for cultivation of local vegetables, medicinal plants/herbs and fruits at the community level, Poshan ke Paanch Sutra, promoting tribal foods, Water conservation through rainwater harvesting, Millet promotion etc. More than 90 crore Jan Andolan activities have been conducted across the country from September 2018 onwards. In the last three years, more than 2 crores tribal focused sensitization activities have been conducted under Jan Andolan.

(b) Amalgamation of AYUSH systems with Poshan 2.0 has also been emphasized upon to stimulate health and nourishment in the community with a focus on prevention of diseases and promotion of wellness through Yoga, cultivation of medicinal herbs in Poshan Vatikas, and preparation of AYUSH formulations to address conditions like Anaemia.

Similarly, the Ministry of Health and Family Welfare implements the Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition (RMNCAH+N) strategy in a life cycle approach under National Health Mission (NHM). This includes the following interventions across the country, including the tribal areas:

- **Mothers' Absolute Affection (MAA)** to improve breastfeeding coverage which includes early initiation of breastfeeding and exclusive breastfeeding for first six months followed by age-appropriate complementary feeding practices.

- Under **Home Based New-born Care (HBNC) and Home-Based Care of Young Children (HBYC)** program, home visits are performed by ASHAs to improve child rearing practices and to identify sick new-born and young children including tribal children in the community and advise appropriate referral.

- **Anaemia Mukt Bharat (AMB)** strategy is implemented to reduce anaemia among six beneficiaries age group - children (6-59 months), children (5-9 years), adolescents (10-19 years), pregnant and lactating women and in women of reproductive age group (15-49 years) in life cycle approach through implementation of six interventions via robust institutional mechanism across India including for the tribal areas.

- Under **National Deworming Day (NDD)** albendazole tablets are administered in a single fixed day approach via schools and anganwadicentres in two rounds (February and August) to reduce the soil transmitted helminth (STH) infestation among all children and adolescents (1-19 years) and to pregnant mothers all over the country.

- **Intensified Diarrhoea Control Fortnight** initiative is implemented for promoting ORS and Zinc use, for reducing diarrhoeal deaths and associated malnutrition among children.

- **Social Awareness and Actions to Neutralize Pneumonia Successfully (SAANS) initiative** is implemented for reduction of Childhood morbidity and mortality due to Pneumonia.

- **Universal Immunization Programme (UIP**) is implemented to provide vaccination to children against life threatening diseases from birth up to 5 years.

- **Rashtriya Bal Swasthya Karyakaram (RBSK)** covers children from 0 to 18 years of age in schools and Aanganwadicentres to screen for 4Ds viz; Diseases, Deficiencies, Defects and Developmental delays to support early detection, management and support improved child survival.

- **Village Health Sanitation and Nutrition Days (VHSNDs)** are observed for provision of regular maternal and child health services and creating awareness on health care including nutrition in convergence with Ministry of Women and Child Development cross the country.

- **Nutrition Rehabilitation Centres (NRCs)** are set up at public health facilities to provide in-patient medical and nutritional care to Severe Acute Malnourished (SAM) children under 5 years of age with medical complications.

Ministry of Tribal Affairs has taken the following initiatives:

i. In collaboration with the Ministry of Ayush, Poshan Vatikas have been created in a few EMRS schools
ii. Funding of Voluntary Organizations for undertaking health initiatives
iii. Taking up health projects through funding of research and projects.

These initiatives are however of a limited nature, and are merely additive to and not in lieu of or even in supplementation of the efforts of the MoHFW and the MoWCD, which are the domain Ministries responsible for tribal health in general."

Comments of the Committee

11. The Committee are concerned to note that while they had recommended for specific measures to be taken to address a serious and multi-dimensional issue i.e malnutrition and anemia among tribal women and girls i.e. by focusing on the formula of 'prevention is better than cure', ensuring nutritional meals, immunization and health checks for every tribal child under the age of 6 years; conducting social audit of the performance of the Anganwadi Centres in tribal areas; planning customized health and nutrition campaign for the tribal groups; the Ministry has simply cited the overall scenario of the various programmes undertaken by the Ministry of Women and Child Development, Ministry of Health and Family Welfare; and three initiatives of the Ministry of Tribal Affairs of limited nature confining to a few places in regard to addressing malnutrition and anemia among women and girls. The Ministry has not reported the specific outcome of these measures. This reflects lack of seriousness on the part of the Ministry to take concerted action to address the issues as per the recommendation of the Committee. Therefore, the Committee are of the strong view that the due seriousness may be taken and specific outcome of the measures may be intimated to them within three months of the presentation of this report.

The Ministry in its action taken replies has mentioned about Anemia Mukt Bharat initiative but hasn't specified any tribal-centric strategies to tackle the unique causes of wide spread anemia in tribal areas. Therefore, the Committee wish to reiterate their earlier recommendation that the Ministry of Tribal Affairs in coordination with the Ministry of Health and Family Welfare ought to have made concerted efforts to develop area specific targeted interventions for these health issues, which disproportionately affect tribal populations, including enhanced screening for the causes of anemia besides devising their treatment and prevention strategies. The Ministry of Tribal Affairs should play a more proactive role in

coordinating with the Ministry of Women and Child Development and the Ministry of Health and Family Welfare to review the progress of nutrition-related schemes periodically and specifically in tribal regions, setting clear targets for reducing malnutrition and Anemia, tracking progress against those targets and fine tuning the methods of the implementation.

Further, the Committee's recommendation for a social audit of Anganwadi Centres in tribal areas has not been addressed clearly in the Ministry's reply. The Committee desire that the Ministry should implement a systematic mechanism for regular and independent evaluation including social audit of anganwadi services/centres, with special focus on tribal districts to monitor the quality and delivery of services.

The Committee had specifically recommended for developing customized campaigns for tribal communities that consider their unique socio-cultural practices and regional challenges and by involving tribal leaders and influencers. While the reply of the Ministry acknowledges the role of tribal leaders and community groups in behavior change initiatives, it needs to be more explicit about how they are being mobilized and involved. For achieving better results the Ministry of Tribal Affairs is also required to outline a concrete strategy for training local influencers, village health workers, and community leaders to create a robust health awareness network. Further, more collaboration with the Ministry of Health and Family Welfare and the Ministry of Women and Child Development for developing focused health solutions in tribal regions is required. The Committee, therefore recommend that the Ministry of Tribal Affairs should draw a road map for holding regular consultations and joint action plans with the Ministry of Health and Family Welfare and the Ministry of Women and Child Development to tackle interconnected issues of malnutrition, maternal health, and child mortality.

The Committee may be apprised of the action taken on the above recommendations and the outcome of such measures.

C. URGENT INTERVENTIONS FOR SICKLE CELL ANAEMIA AMONG TRIBALS

Recommendation Para No.3:

12. The Committee in their Original Report recommended as under:

"The Committee note that Sickle Cell Anaemia or Sickle Cell Disease (SCD) continues to be a daunting challenge in the healthcare of the tribal people. Sickle Cell Anaemia 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 be 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 counselling and treatment. Since awareness creation and counselling 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 counselling 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 on 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 is 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 referred 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 nationwide 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 were 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 dire 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."

13. The Ministry of Health & Family Welfare in its action taken reply on the above mentioned recommendation has stated as under:

"Reply to (i): The National Sickle Cell Anaemia Elimination Mission was launched by Hon'ble Prime Minister on 1st July 2023 at Shahdol, Madhya Pradesh. The program is being carried out in a mission mode for screening, prevention, and management of sickle cell Anaemia in all tribal and other high prevalent states/UTs.The target for screening for FY 2023-2024 is 2,50,00,000. As per data from NHM (MoH&FW), till 19 March 2023, a number of 2,64,49,913 population in the 17 identified states have been screened. The total number of sickle cell cards distributed is 10470609.

Reply to (ii) : Under the National Sickle Cell Anaemia Elimination Mission, color coded sickle cell id cards are being distributed to all screened population. Counsellors at the primary health care centers shall be using sickle cell cards for the purpose of pre-marital and pre-conceptional counselling by matching the cards of prospective matches. Matching of the cards will show the chances of their children being born with SCD or SCT. The card will show the status of the individual viz, Normal, Carrier or Diseased. The cards are color coded separately for male (blue) and female (pink). Based on the card's status, the individual will receive treatment and counselling services. Total No of Sickle cell id cards distributed till 08 October 2023 are **16,05,245**. The states are encouraged to conduct awareness drives, pre marriage and pre-natal counseling.

Sickle cell activities are also being carried out by MoTA as per the assigned role by MoHFW. The following have been initiated by MoTA:

a. Strategic plan for Information, Education and Communication in respect of Sickle Cell Anaemia Mission has been made ready. Consultation with all endemic states has been done once.

b. Modules on Awareness and Counselling got prepared through an expert technical committee and were vetted by the MoHFW and thereafter approved

c. The Awareness and counselling modules and Training of Trainers module for medical service providers were released on 01.07.2023 by Hon'ble Prime Minister at the Launch of the Mission at Sehdol, MP.

d. Hindi translation of awareness and counselling modules has been completed. Pamphlets have been translated in Hindi, English, Telegu, Gujrati, Marathi, Odia, Kannada, Malayalam, Assamese, Bengali completed and into the Tribal languages of Advasi, Odia, Kui, Koya, Bhili, Konkani, Dehvali, Mundari, Santhali, Kurkhu, Ho, Kolami, Gondi, Korku, Mandiya, Kuvi, Desia, Soura, Koraga, Jenu Nudi, Soliga, Paniyan, Mullukurma, Kurumba, Santhali, Nepali. An audio-video clip has been prepared and translated into Konda, Koya, Savara, Kuvi, Odia and Gondi. Translation of Awareness & counselling modules in Hindi, English, Gujrati, Kannada, Malayalam, Gondi, Korku, Bangani has been done.

e. Launch of awareness training programmes of first State level master trainers on 28 August 2023 by Hon'ble Minister Tribal Affairs.

f. Engagement with the stakeholders like IMA, IPA, FOGSI, patients' group and other relevant stake holders has been commenced.

g. Advocacy and support with link Ministries/Departments to raise awareness and garner support for effective implementation has commenced.

h. Sensitization of VDVKs and EMRSs has been initiated.

Reply to (iii): Financial assistance is provided by the Ministry of Health and Family Welfare under the Umbrella Scheme of Rashtriya Arogya Nidhi (RAN) & Health Minister's Discretionary Grant (HMDG) based on defined eligibility criteria (including income status) of relevant guidelines. Under the Umbrella Scheme of RAN, financial assistance is provided to patients living below State/UT-wise threshold poverty line for medical treatment of identified life-threatening diseases at Super Specialty Government Hospitals/Institutes across the country. Under HMDG, financial assistance is provided to poor patients suffering from life threatening diseases to cover apart of expenditure on treatment/hospitalization in all Government Hospitals/Institutes.

Ministry of Health & Family Welfare is already in the process of giving wide publicity of both the Schemes to create awareness amongst the citizens of (including tribal people) of the country.

Reply to (iv): The NHM (MoHFW) has mentioned that Health being a state subject, the issue is being encouraged to be taken up by respective States. Budgetary support, as needed and justified by the States, will be made available by the Ministry of Health, as per priorities.

Reply to (v): NHM (MoHFW) has stated that tertiary hospitals in various states have already established facilities to conduct chorionic villous sampling (CVS) and other advanced diagnostics. National Health Mission focusses mainly on the screening and management of the disease. MoTA has been given a responsibility of developing the center of competence in AIIMs and other tertiary care units in regard to sickle cell disease which will work as a referral center where the prenatal diagnosis services will be a part of it.

Reply to (vi): Ministry has noted the recommendations of the Committee. However, the Swasthaya Portal is now a repository of all the concerned IEC material related to Sickle cell Disease. Awareness & Counselling modules, SCD Management modules have been prepared and disseminated to states. The awareness & counselling modules have been translated into state and tribal languages, which all may be seen at Swasthaya Portal.

Reply to (vii): MoTA has taken the initiative and has written to the Department of Social Justice regarding the permanent disability for the blood disorders patients. Taking the cognizance of the permanent disability the Department of Social justice has constituted a committee, where MoTA member is a special invitee. The committee has given its report. The gazette notification dated 14 March 2024 has been published which provides for grant of permanent disability certificate for SCD patients as per the conditions in the Notification."

Comments of the Committee

14. (i) The Committee appreciate that the National Sickle Cell Anemia Elimination Mission which was launched on 01 July, 2023 is being carried out in a mission mode for Screening, Prevention and Management of Sickle Cell Anemia in all tribal and other high prevalent States/UTs as nation-wide efforts to curb and minimize the spread of Sickle Cell Anemia. Against the target of screening 2,50,00,000 during the year 2023-24, till March, 2023 , a number of 2,64,49,913 population in the 17 identified States have been screened. The total number of sickle Cell card distributed is 10470609.However, as desired by the Committee in their original Report, the Ministry has not furnished the proposed timeline for completion of screening in each State. In order to make it more productive, the Committee desire that the Ministry of Tribal Affairs in coordination with the Ministry of Health and Family Welfare should work upon for vigorous implementation of Screening for detection of Sickle Cell Anemia under the National Sickle Cell Anemia Elimination Mission and chalk out State-wise time-line for screening and inform the Committee about the progress made thereon.

(ii) With regard to strengthening Counseling and Awareness Strategies to arrest the chance of spreading of SCD, the Committee note that along with the distribution of color-coded health cards, categorized by gender and SCD status (Normal, Carrier, Diseased), the Ministry of Tribal Affairs has also carried out Sickle cell activities as per the assigned role by MoHFW viz:

- **a. Strategic plan for Information, Education and Communication in respect of Sickle Cell Anaemia Mission has been made ready. Consultation with all endemic States has been done once.**
- **b. Modules on Awareness and Counselling got prepared through an expert technical committee and were vetted by the MoHFW and thereafter approved**

c. **The Awareness and counselling modules and Training of Trainers module for medical service providers were released on 01.07.2023 by Hon'ble Prime Minister at the Launch of the Mission at Sehdol, MP.**

d. **Hindi translation of awareness and counselling modules has been completed. Pamphlets have been translated in Hindi, English, Telegu, Gujrati, Marathi, Odia, Kannada, Malayalam, Assamese, Bengali completed and into the Tribal languages of Advasi, Odia, Kui, Koya, Bhili, Konkani, Dehvali, Mundari, Santhali, Kurkhu, Ho, Kolami, Gondi, Korku, Mandiya, Kuvi, Desia, Soura, Koraga, Jenu Nudi, Soliga, Paniyan, Mullukurma, Kurumba, Santhali, Nepali. An audio-video clip has been prepared and translated into Konda, Koya, Savara, Kuvi, Odia and Gondi. Translation of Awareness & counselling modules in Hindi, English, Gujrati, Kannada, Malayalam, Gondi, Korku, Bangani has been done.**

e. **Launch of awareness training programmes of first State level master trainers on 28 August 2023 by Hon'ble Minister Tribal Affairs.**

f. **Engagement with the stakeholders like IMA, IPA, FOGSI, patients' group and other relevant stake holders has been commenced.**

g. **Advocacy and support with link Ministries/Departments to raise awareness and garner support for effective implementation has commenced.**

h. **Sensitization of VDVKs and EMRSs has been initiated.**

Appreciating the efforts undertaken by the Ministry, the Committee wish to emphasize that the Ministry should augment all the implementation activities at the earliest without losing further time and desired that they may be updated about results yielded thereon.

(iii) Financial Assistance for SCD Treatment: The Committee while appreciating the move of the Ministry of Tribal Affairs to grant such financial aids to poor/BPL Tribal Person, desire the Ministry to make these procedures as simple as possible to assist the tribals in getting aid from these schemes. The Committee would also like the Ministry to set up *dedicated outreach*

programmes **within tribal areas to disseminate information about these grants and to assist the eligible patients in applying for the aid. This may involve engaging community health workers and local leaders to bridge the gap in information dissemination.**

(iv) Healthcare Infrastructure and Personnel: The Ministry of Tribal Affairs in its action taken reply has given the statement of the National Health Mission (Ministry of Health and Family Welfare) which mentions that" health being a state subject, the issue is being encouraged to be taken up by respective States. Budgetary support, as needed and justified by the States, will be made available by the Ministry of Health and Family Welfare, as per the priorities". The Committee feel that there is a dire need for more central intervention in establishing specialty wings for SCD treatment in tribal areas with high prevalence of SCD. The Committee, therefore, would like the Ministry of Tribal Affairs to take up the matter at the highest levels with the Ministry of Health and Family Welfare and the States concerned to set up state-of-the-art diagnostic centers and encourage the States to submit comprehensive proposals to get adequate assistance and funds from the Centre. Further, the Committee desire that there should be a focus on *incentivizing healthcare personnel* to serve in these tribal areas to alleviate personnel shortages.

(v) Prenatal Screening and Advanced Diagnostics: The Committee had recommended for strengthening research initiatives on SCD and exploring the possibility of testing for sickle cell genes before birth of a child so that remedial action could be taken. The reply of the Ministry highlights that tertiary hospitals in some States have the facilities for prenatal diagnostics such as Chorionic Villous Sampling (CVS) and other advanced diagnostics. The Committee urge the Ministry of Tribal Affairs, the nodal Ministry to step up coordination with the Ministry of Health and Family Welfare to increase the number of accessible, prenatal diagnostic centers in all tertiary hospitals in tribal dominated States. As awareness and access to these facilities

remain a challenge for tribal populations, the publicity of these services should be intensified through focused campaigns so that the tribals get information about the existence of all these services so that they will avail these facilities. Information regarding the implementation of the above recommendations and their results may be communicated to the Committee.

(vi) Self-Registration Mechanism and Data Repository: The Committee in their original report had felt that the Ministry's reliance on self-registration on the Sickle Cell Corner Portal (scdcorner.in) might not be sufficient as tribal population may lack the required digital literacy. Therefore, the Committee felt for developing alternative methods to ensure comprehensive data collection *e.g.* health workers could assist in Manual Registration during Screening Processes, and a dedicated Help Desk at local Health Centers could support Registration and provide relevant information to tribal populations. The Committee note from the action taken replies that Swasthaya Portal is now a repository of all the concerned IEC material related to Sickle cell Disease. Awareness & Counselling modules, SCD Management modules have been prepared and disseminated to states and the awareness & counselling modules have been translated into state and tribal languages, which all may be seen at Swasthaya Portal. The Ministry has not answered to the recommendation of the Committee about setting up of dedicated Help Desk at local Health Centers at Sub division Tehsil and Block level to assist the tribal population. While taking a serious view on this approach of the Ministry, the Committee strongly desire for setting up of the help desk at the earliest and apprise them of the same in the Action Taken statement.

(vii) Disability Certification for SCD Patients: The Committee are happy to note that the Ministry of Tribal Affairs has taken the initiatives with the Department of Social Justice to provide lifelong disability certificate to the SCD Patients. The Ministry has informed that Gazette Notification dated 14th March, 2024 has been published which provides for grant of

permanent disability certificate for SCD patients as per condition notified in the Gazette. The Committee may be apprised of the clear terms and conditions for grant of permanent disability certificate for SCD patients.

The Committee also desire that the nodal Ministry i.e Ministry of Tribal Affairs should regularly provide periodic updates on the implementation of the Sickle Cell Anemia Elimination Mission in tribal areas with specific milestones, Progress Reports, and challenges faced and remedial measures taken there on.

D. INTERVENTIONS TO PREVENT EARLY CHILD MARRIAGES

Recommendation Para No.4:

15. The Committee in their Original Report recommended as under:

> "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 clone in the States of Rajasthan, Madhya Pradesh and Uttarakhand 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."

16. Ministry of Tribal Affairs in its action taken reply on the above mentioned recommendation has stated as under:

"Reply to (i) to (iii): Ministry of Tribal Affairs is implementing the Central Sector Scheme of Eklavya Model Residential School (EMRS) to provide quality education to the tribal children in their own environment. State Governments/UTs/ State Societies are given instructions to ensure safety of the schools, including its girl children and women staff, by ensuring necessary precautionary measures. As per EMRS guidelines, the following facilities are ensured while setting up an EMRS:

i. Medical facilities including telemedicine and tie up with prominent hospitals in the vicinity.

ii. Facilities for diagnostic and remedial

iii. Medical needs of tribal children (e.g. Sickle Cell Anaemia, Tuberculosis, Malaria etc.) are ensured wherever possible.

iv. Special nutritional requirement and provisions for menstrual hygiene (sanitary pads, incinerator, etc.) of girl students.

v. The number of seats for boys and girls are equal.

vi. Hostel facility: Dormitories for Girls (Capacity of minimum 240).

As on 22.11.2023, 694 EMRSs have been sanctioned (with 409 functional schools) across the country. A total number of 118982 students have been enrolled during the year 2023-24, out of which, number of girls enrolled are 60318 (50.7%).

Steps taken by Ministry of Women and Child Development (WCD):

The Ministry of Women and Child Development is the apex body of Government of India for formulation and administration of regulations and laws related to welfare and development of women and children in the country. MWCD has declared 24 January as the 'National Girl Child Day'. It aimed at empowering the adolescent girl child, improving their nutritional and health status and providing them various life skills.

The Ministry has been taking pro-active measures to eliminate the social evil of child marriage. The Prohibition of Child Marriage Act, 2006 has been enacted to punish those who promote, perform and abet child marriages. The States/ UTs from time to time are being requested to oversee the effective implementation of the Prohibition of Child Marriage Act, 2006.

Prevention of child marriage and protection of girl child are prominent parts of the National Plan of Action for Children, 2016. Some of the efforts of Ministry towards prevention of child marriage include

i. Communications with the State Governments requesting them to take special initiative to delay marriage by coordinated efforts on special festivals such as Akshya Tritiya/Akha Teej— the traditional day for such marriages.

ii. To educate people about the issue of child marriage, awareness has been created through advertisements in the press and electronic media.

iii. Platforms such as the Beti Bachao Beti Padhao (BBBP), International Women's Day and the National Girl Child Day are used to create awareness and bring focus on issues related to women such as child marriage to the centre-stage.

iv. As per announcement in the Budget 2020-21, a Task Force was constituted to examine the correlation of age of motherhood with (i) health, medical well-being and nutritional status of mother and neonate/infant/ child, during pregnancy, birth and thereafter; (ii) key parameters like Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR), Total Fertility Rate (TFR), Sex Ratio at Birth (SRB), Child Sex Ratio (CSR), etc. and (iii) any other relevant points pertaining to health and nutrition in this context.

v. After taking into account the recommendations of the Task Force and other aspects, the Ministry of Women and Child Development has introduced 'The Prohibition of Child Marriage (Amendment) Bill, 2021' in the Parliament on 21.12.2021 for raising the minimum age of marriage of women to 21 years to make it at par with that of men. The amendment also proposes to amend the relevant provisions of various acts viz the Indian Christian Marriage Act, 1872; the Parsi Marriage and Divorce Act, 1936; the Muslim Personal Law (Shariat) Application Act, 1937; the Special Marriage Act, 1954; the Hindu Marriage Act, 1955; and the Foreign Marriage Act, 1969 to universalize the minimum age of marriage in

India. The aforesaid Bill has been referred to the Parliamentary Standing Committee on Education, Women, Children, Youth and Sports (EWCY&S).

vi. The National Commission for Protection of Child Rights (NCPCR) also undertakes awareness programs and consultations with stakeholders from time to time in this regard. In addition, Government of India has introduced CHILDLINE with short code 1098, a 24X7 telephone emergency outreach service for children in crisis which responds with suitable interventions to call for any form of assistance which a child requires, including for prevention of child marriages in coordination with police, Child Marriage Protection Officers (CMPOs), District Child Protection Units etc.

vii. Section 16 of Prohibition of Child Marriage Act (PCMA) authorizes the State Government to appoint for the whole State, or such part there of as may be specified, an officer or officers to be known as the 'Child Marriage Prohibition Officers (CMPO)' having jurisdiction over the area or areas specified in the notification. This section also specifies the functions to be discharged by CMPOs, which also include preventing solemnization of child marriages by taking such action as they may deem fit; to collect evidence for the effective prosecution of persons contravening the provisions of the Act; to advise the individuals or counsel the residents of the locality not to indulge in promoting, helping, aiding or allowing the solemnization of child marriages; to create awareness about the ill effects of child marriages; and to sensitize the community on the issue of child marriages. These authorities function under the respective State Governments/ UT Administrations. As such, implementation of the provisions of the Act lies with them. (e): The National Crime Records Bureau (NCRB) compiles and publishes the data on the number of cases of child marriage registered under 'the Prohibition of Child Marriage Act (PCMA), 2006' in its publication 'Crime in India'.”

Comments of the Committee

17. The Committee feel that focused efforts are required to prevent early marriages. Though the Ministry of Tribal Affairs has taken a significant step by establishing Eklavya Model Residential Schools (EMRS) in partnership with State Governments, the Committee are of the view that broader and more tailored initiatives as done in the States of Rajasthan, Madhya Pradesh and Uttarakhand are essential to make an impact at the grassroots level. The efforts of the Ministry should not solely focus on school-based interventions but also extend to community awareness by involving community leaders, Accredited Social Health Activists (ASHAs), and Anganwadi workers in campaigns and workshops about the health risks associated with early marriages and pregnancies.

Further, a more Robust Information, Education, and Communication (IEC) campaign is needed, using local media, traditional forms of communication, social media and social influencers within the tribal communities to shift social norms that support early marriages. Additionally, integrating the risks of child marriage into school curricula for both girls and boys could foster long-term behavioral changes. The Committee may be apprised of the pointed action taken as per their recommendations and the outcome thereon.

Another challenge highlighted by the Committee that has not been reflected in the Ministry's reply is the misrepresentation of the age of tribal girls, often due to unreliable birth registration systems. For this, the Ministry of Tribal Affairs, in collaboration with the Ministry of Home Affairs and State Governments, needs to improve mechanism relating to birth registration in tribal areas such as mobile registration units in remote regions. The Ministry may apprise the Committee about the action taken in this regard.

E. URGENT NEED TO GENERATE ACCURATE PAN INDIA DATA ON THE MATERNAL MORTALITY RATIO (MMR) AMONG THE TRIBALS

Recommendation Para No.6:

18. The Committee in their Original Report recommended as under:

> "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 (SPS) report by Registrar General of India (RG1). 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 Anaemia 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 wrong the tribal population. The Committee would be apprised about the timelines for the same."

19. Ministry of Tribal Affairs in its action taken reply on the above mentioned recommendation has stated as under:

> **"Reply:** According to information gathered with MoH&FW, the Sample Registration System (SRS) Report of Registrar General of India (RGI), the Maternal Mortality Rate (MMR) has reduced from 8.1 in 2015-17 to 7.3 in 2016-18 at National Level. The Status of MMR at National level and State level as per SRS 2015-17 and 2016-18 are as follows:

Status of Maternal Mortality Rate (MMR)		
India/ States	**2015-17**	**2016-18**
ALL INDIA	**8.1**	**7.3**
Andhra Pradesh	3.6	3.6
Assam	15.2	14.0
Bihar	16.9	15.1
Jharkhand	6.1	5.6
Gujarat	6.0	5.1
Haryana	7.7	7.0
Karnataka	7.3	4.9
Kerala	1.9	2.1
Madhya Pradesh	17.5	15.9
Chhattisgarh	11.0	12.1
Maharashtra	3.3	2.6
Odisha	11.1	9.7
Punjab	6.8	7.0
Rajasthan	16.8	14.5
Tamil Nadu	4.8	3.2
Telangana	3.8	3.6
Uttar Pradesh	20.1	17.8
Uttarakhand	5.9	6.4
West Bengal	5.0	5.0
Other States	4.7	4.5
Source: Sample Registration System (SRS) of Registrar General of India (RGI)		

In order to bring down Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR), the Ministry of Health and Family Welfare (MoHFW) is supporting all States/UTs in implementation of Reproductive, Maternal, New-born, Child, Adolescent health and Nutrition (RMNCAH+N) strategy under National Health Mission (NHM) based on the Annual Program Implementation Plan (APIP) submitted by States/ UTs. The interventions taken up by Govt. are:

Interventions for improving Maternal Mortality Rate (MMR):

- **Janani Suraksha Yojana (JSY),** a demand promotion and conditional cash transfer scheme was launched in April 2005 with the objective of reducing Maternal and Infant Mortality by promoting institutional delivery among pregnant women.

- **Janani Shishu Suraksha Karyakram (JSSK)** aims to eliminate out-of-pocket expenses for pregnant women and sick infants by entitling them to free delivery including caesarean section, free transport, diagnostics, medicines, other consumables, diet and blood in public health institutions.

- **Surakshit Matratva Ashwasan (SUMAN)** aims 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 to end all preventable maternal and newborn deaths.

- **Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)** provides pregnant women fixed day, free of cost assured and quality Antenatal Care on the 9thday of every month.

- **LaQshya** aims to improve the quality of care in labour room and maternity operation theatres to ensure that pregnant women receive respectful and quality care during delivery and immediate post-partum period.

- **Comprehensive Abortion Care services** are strengthened through training of health care providers, supply of drugs, equipment, Information Education and Communication (IEC) etc.

- **Midwifery programme** is launched to create a cadre for Nurse Practitioners in Midwifery who are skilled in accordance with International Confederation of Midwives (ICM) competencies and capable of providing compassionate women-centred, reproductive, maternal and new-born health care services.

- **Delivery Points:** Over 25,000 'Delivery Points' across the country are strengthened in terms of infrastructure, equipment, and trained manpower for provision of comprehensive RMNCAH+N services.

- Functionalization of **First Referral Units (FRUs)** by ensuring manpower, blood storage units, referral linkages etc.

- Setting up of **Maternal and Child Health (MCH) Wings** at high caseload facilities to improve the quality of care provided to mothers and children.

- Operationalization of **Obstetric ICU/HDU** at high case load tertiary care facilities across country to handle complicated pregnancies.

- **Capacity building** is undertaken for MBBS doctors in Anesthesia (LSAS) and Obstetric Care including C-section (EmOC) skills to overcome the shortage of specialists in these disciplines, particularly in rural areas.

- **Maternal Death Surveillance Review** (MDSR) is implemented both at facilities and at the community level. The purpose is to take corrective action at appropriate levels and improve the quality of obstetric care.

- Monthly **Village Health, Sanitation and Nutrition Day (VHSND)** is an outreach activity for provision of maternal and child care including nutrition.

- Regular IEC/BCC activities are conducted for early registration of ANC, regular ANC, institutional delivery, nutrition, and care during pregnancy etc.

- **Mother and Child Protection (MCP) Card and Safe Motherhood Booklet** are distributed to the pregnant women for educating them on diet, rest, danger signs of pregnancy, benefit schemes and institutional deliveries.

- Ministry of Tribal Affairs in association with Ministry of Health & M/o.WCD occasionally organizes awareness programmes in the regional languages to make them aware about severe Anaemia, sickle cell Anaemia, Nutrition, TB, reproductive health & Hygiene, which helps in reducing MMR gradually. IEC activities along with the health camps are being organized in the states to overcome the issue of MMR. Poshan Abhiyaan along with TRIFED are being organized to sensitize VDVKs run by tribal women for Nutrition on the occasions of Poshan Maah and Poshan Pakhwada."

Comments of the Committee

20. The reply given by the Ministry does not address the tribal-specific MMR data as recommended by the Committee. The lack of data for tribal areas, where healthcare challenges—like high rates of anemia, malnutrition, early marriage, and limited healthcare access—are prevalent , make it difficult to implement customised programme. To address these gaps, the Committee reiterate their recommendation that the Ministry of Tribal Affairs, in collaboration with the Ministry of Health and Family Welfare should create a mechanism to collect accurate, tribal-specific MMR data on pan India basis in a time bound manner and intimate the concrete action taken in this regard.

F. MENTAL HEALTH OF TRIBAL WOMEN

Recommendation Para No.10:

21. The Committee in their Original Report recommended as under:

> "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 service. Even through 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."

22. The Ministry of Tribal Affairs in its action taken reply on the above mentioned recommendation has stated as under:

> "The recommendation is noted."

Comments of the Committee

23. The Committee expresses deep concern over the Ministry's cursory response—merely stating, *"the recommendation is noted"*—in relation to the pressing issue of mental health among tribal women, many of whom face severe existential challenges and psychological distress. Such a minimal reply not only undermines the gravity of the situation but also fails to meet the Committee's expectations. Addressing a crisis of this magnitude requires more than acknowledgment; it demands a concrete roadmap for intervention. The Committee urges the Ministry to formulate and present a comprehensive action plan outlining targeted measures to mitigate mental health challenges within tribal communities, with particular attention to the needs of women.

Further, the Committee had pointed out that access to mental health services under the National Mental Health Programme (NMHP) is limited due to the remoteness of many tribal villages. The Ministry has not outlined any specific steps to overcome this accessibility issue, which is crucial for addressing mental health challenges in tribal areas. Therefore, the Committee desire that the Ministry, needs to increase accessibility of mental health services in tribal regions by expanding mobile health units that can provide mental health services in remote tribal areas and establishing telemedicine facilities that offer virtual consultations for mental health in areas where access to physical healthcare facilities is limited.

The Committee had also highlighted the fact that many tribal communities still rely on traditional faith healers for health-related issues, which can act as a deterrent to seeking professional mental health treatment. The Ministry has not addressed the need for culturally sensitive approaches to encourage tribals to access formal and contemporary mental health services. In this regard, the Ministry should develop culturally sensitive mental health

programmes that respect tribal traditions while promoting access to modern healthcare by engaging traditional healers and tribal leaders in mental health awareness campaigns to help bridge the gap and forge synergies between traditional practices and modern medicine. The Ministry also needs to create public awareness materials in local languages that are culturally appropriate and resonate with tribal values and beliefs and train local healthcare workers in tribal areas to act as intermediaries between tribal communities and formal and contemporary mental health services so as to build trust and reduce stigma around mental health issues. It is imperative for the Ministry of Tribal Affairs to work in coordination with the Ministry of Health and Family Welfare to develop and implement joint mental health strategies focused on tribal populations for ensuring that mental health services under the National Mental Health Programme are adapted and scaled up to reach tribal communities effectively. The Committee urge the ministry to treat this matter with the seriousness it deserves and provide a substantive response at the earliest.

G. SUBSTANCE ABUSE AMONG TRIBAL WOMEN

Recommendation Para No.11:

24. The Committee in their Original Report recommended as under:

> "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 counseling 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 counseling and create awareness among the tribal population about the adverse effects of substance abuse among tribal women."

25. Ministry of Tribal Affairs in its action taken reply on the above mentioned recommendation has stated as under:

"The recommendation has been noted."

Comments of the Committee

26. The Committee, in its original report, had taken note of the Ministry's acknowledgment regarding the link between addiction disorders and intimate partner or gender-based violence. However, it remains deeply concerning that the Ministry has not maintained any disaggregated data at the central level on substance use disorders among tribal populations—particularly tribal women.

Given the persistently poor maternal and child health indicators among tribal communities and the prevalent use of alcohol in their daily lives, the Committee had strongly recommended a thorough assessment of substance abuse, especially among women. This should be followed by the establishment of targeted interventions such as counselling services and dedicated de-addiction centers in tribal regions where such infrastructure is currently absent.

Furthermore, the Committee advised leveraging Village Health and Nutrition Day (VHND) as a platform for community-level counselling and awareness initiatives, aimed at curbing substance misuse and informing tribal communities of its adverse effects—especially on women.

In response to these significant and nuanced recommendations, the Ministry's reply—merely stating *"the recommendation has been noted"*—is both inadequate and disappointing. It fails to outline any remedial action, awareness strategy, data collection framework, or plans for setting up treatment facilities. The Committee therefore urges the Ministry to avoid perfunctory replies in future and instead respond with substantive commitments.

Of particular concern is the Ministry's omission in recognizing the correlation between substance abuse and gender-based violence in tribal areas—a connection that further entrenches the marginalization of tribal women. The Committee reiterates its recommendation for an integrated support approach that combines de-addiction counselling with survivor assistance mechanisms.

Health workers, in coordination with local leaders, should engage communities where substance abuse fuels domestic violence. This multi-layered, culturally-sensitive strategy—reinforced by awareness efforts—will be instrumental in reducing both addiction and its social ramifications among tribal women.

The Committee expects to be apprised of concrete, actionable steps taken by the Ministry in this regard.

H. HEALTH CARE INFRASTRUCTURE IN TRIBAL AREAS

Recommendation Para No.12:

27. The Committee in their Original Report recommended as under:

> "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 (P1-1C) / 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 in the 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 the health action plan should be ensured by the Ministry and the success of Pravara model may be analyzed 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 anti 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."

28. Ministry of Tribal Affairs in its action taken reply on the above mentioned recommendation has stated as under:

"Reply to (i): The MoHFW informed that Public Health and Hospital is a state subject and its implementation primarily lies with the State Government. The NHM provides technical and financial support to the States/UTs to strengthen their health care systems including setting-up/upgrading public health facilities and augmenting health human resource for provision of equitable, affordable healthcare to rural marginalized population based on requirements proposed in the PIPs by the States/UTs.

For effective and quality delivery of comprehensive healthcare services, the Indian Public Health Standards (IPHS norms 2022) for Sub-Centres Health & Wellness Centres, Primary Health Centres-Health & Wellness Centres, Community Health Centres, Sub-District and District Hospitals, are followed. While establishing or upgrading infrastructures the IPHS 2022 also focuses special attention to human resource, drugs, diagnostics, equipment, quality and governance requirements for delivering health services at these facilities.

The revised IPHS guidelines 2022 provides guidance on the health system components such as:

a. The basis for establishing the health facilities, infrastructure requirement and the general appearance and upkeep of the facilities;
b. Prescribed norms to be followed for illumination, fire safety, disaster and emergency preparedness, water and sanitation and power backup;
c. Standard protocol to be adopted for better service delivery;
d. HRH requirement for ensuring service availability, conduct and behavior standards and safety measures to be adopted for the HRH;
e. Essential medicines to be available free of cost in the health facilities under 'Free Drug Service Initiative' of GoI;
f. Essential diagnostics to be provided in the health facilities;
g. Equipment required for providing the services being offered through the facilities;
h. Quality Assurance Protocol to be adopted including a road map for healthcare facilities to achieve NQAS certification;
i. Ensuring accountability and governance in service delivery.

Reply to (ii): As per NHM (MoHFW) the health action plan should be in accordance with the Indian Public Health Standards (IPHS) and National Quality Assurance Standards (NQAS) to ensure infrastructural adequacy in healthcare facilities. These standards, endorsed by the National Health Mission (NHM) based on state-submitted proposals, encompass vital amenities like electricity, drinking water, sanitation, labour room, and operation theatre,

which are crucial for delivering quality healthcare services. The guidelines can be accessed on the IPHS and NQAS websites.

Reply to (iii): NHM (MoHFW) stated that under the Telemedicine programme, which is being implemented under the e-Sanjeevani initiative, systems have been augmented, and all necessary equipment has been put in place to ensure seamless connectivity between the Telemedicine Centre and the Primary Health Centre, as per the guidelines and provisions under the programme. The erstwhile Ayushman Bharat-Health & Wellness Centres now renamed as Ayushman Arogya Mandir ensure continuity of care by appropriate referrals and optimal home and community follow-up. AAMs provide teleconsultation services, wherein every level of service provider, from Community Health Officers to Medical Officers, can access higher-level consultation, including with specialists in secondary and tertiary centres. This minimizes the physical travel of patients, resulting in reduced costs and potential hardships for the patients.

The Ayushman Bharat Digital Mission (ABDM) aims to develop the backbone necessary to support the integrated digital health infrastructure of the country. It will bridge the existing gap among different stakeholders of the healthcare ecosystem through digital highways by integrating digital health infrastructure, ensuring access, equity and CoC with citizens as data owners, leveraging IT and associated technologies and supporting existing health systems in a 'citizen-centric' approach. The digital ecosystem creates health records based on the ABHA ID. This 14-digit number will uniquely identify a participant in India's digital healthcare ecosystem that healthcare providers and payers nationwide will accept.

Reply to (iv): The NHM (MoHFW) stated that the Digital Personal Data Protection (DPDP) Act 2023 declares the right to information privacy as a fundamental right. It intends to protect the privacy, confidentiality, security, and standardizations of Electronic Health Records. It imposes several obligations on entities collecting personal data—to provide notice and take consent from individuals, to store accurate data securely, and to use it only for purposes listed in the notice. Ministry of Health and Family Welfare, under all its programs, promotes and adopts e-health standards, enforces privacy and security measures for electronic health data, and regulates the storage and exchange of EHRs."

Comments of the Committee

29. The Committee feel that despite Ministry's commendable strides i.e. 73 per cent increase in healthcare infrastructure in tribal areas, several critical gaps still remain unaddressed. The Committee had emphasized in its Original Report that improvements in healthcare infrastructure should not be in "mere numbers" but the Ministry should ensure that the requisite infrastructure are fully operational with all the facilities such as electricity, drinking water, sanitation, labor rooms and operation rooms. The Ministry's reply acknowledges these needs, referencing the IPHS guidelines, but does not address how will they ensure that existing healthcare infrastructure meets these standards or that future infrastructure facilities will be up to the mark. Further, the Ministry's Comprehensive Tribal Primary Health Care Model aims to address the lack of PHC and CHC facilities in tribal blocks, using a Public-Private Partnership (PPP) model. However, the reply is silent on how this model will be scaled up or rolled out across different tribal areas and whether the guidelines of NGO schemes of the Ministry have been raised after analyzing the success of Pravara model. The Committee deem it appropriate for the Ministry to conduct pilot study on the Comprehensive Tribal Health Care Model in a few regions to assess its feasibility and effectiveness before wider implementation. The Ministry should also establish monitoring and evaluation frameworks to ensure that the PPP model is delivering results, including patient satisfaction and access to services. Further, the Ministry in collaboration with NGOs and local community organizations needs to ensure that the model is culturally sensitive and well-received by tribal communities.

The Committee had also raised various concerns about lack of infrastructure/facilities in telemedicine centres and the need for reliable infrastructure (Wi-Fi, data connectivity, and trained manpower) to ensure its success. The Ministry's reply emphasizes that necessary

systems and equipment have been put in place under the e-Sanjeevani initiative. However, in many remote tribal areas, internet network connectivity is still unreliable, and the deployment of trained personnel may be challenging. The Committee, therefore, recommend the Ministry to work with the Department of Telecommunications to improve the internet connectivity in remote tribal areas which is a prerequisite for successful Telemedicine Services. Awareness and training in Tribal areas for use of telemedicine system would enhance the benefits from the system.

The Committee may be kept informed about the actions implemented following the above recommendations and the effectiveness of those measures.

I. AMBULANCES AND EMERGENCY TRANSPORTATION IN TRIBAL AREAS

Recommendation Para No.13:

30. The Committee in their Original Report recommended as under:

> "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 women 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 (NA) 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 Chhattisgarh 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.1 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 it 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 from1 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 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."

31. The Ministry of Tribal Affairs in its action taken reply on the above mentioned recommendation has stated as under:

"The NHM (MoHFW) has provided the following comments –

• The Record of Proceedings of NPCC (RoP of NPCC) imposes important conditions when approving funds for ambulance services.
• The states are required to closely monitor functionality, maintain records of upkeep, and obtain monthly reports from service providers.

• Additionally, the MoHFW guidelines on Grievance Redressal & Health Helpline facilitates a structured process for registering and resolving grievances, although its implementation varies across states.
• The proposal to reconsider population norms for ambulance allocation is a crucial policy decision that warrants careful deliberation at the Mission Steering Group (MSG) level. This decision needs to take into account the performance of existing ambulance services and the specific requirements or requests put forth by the States."

Comments of the Committee

32. The Committee are not satisfied with the casual and evasive reply furnished by the Ministry which lacks the substantive and specific actions necessary to improve ambulance services in tribal areas. The Ministry has simply stated some advisories or guidelines and no action taken or clear plan for implementation of the recommendation has been delineated.

The Committee had also observed that at ground level, the time taken in availing ambulance services is often more than 15-20 minutes and in difficult terrains, the time could extend to any length of hours. Further, no implicit mechanism exists at the ground level to coordinate availability of ambulances or for registering any grievance with regard to the same. With no action taken in this regard by the Ministry, the Committee reiterate their recommendation for 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 coordination and complaint registration system with regard to the same in tribal areas. Further, while the Committee had recommended the Ministry to relax the norms of ALS and BLS-for average population from 5 lakh to 1 lakh and from1 lakh to 20 thousand respectively, the Ministry has replied that changes in these norms are a "policy decision" requiring further deliberation at the level of Mission Steering Group (MSG). The Committee desire that matter may be expedited at the earliest under intimation to them.

Regarding the deployment of motor bike ambulance in other tribal areas though the same has been successful in States like Chandigarh and Jharkhand, the Ministry is non-responsive on the recommendations of the Committee. The Committee would like to know the details and modalities of the same.

The Ministry's reply is also completely silent on the Committee's recommendation for reimbursement of out-of-pocket expenses for tribal populations when they use private transport to reach healthcare centers, ignoring a crucial issue that affects access to healthcare for the economically weaker tribal population. The Committee reiterate their recommendation and desire that the Ministry should draw a reimbursement scheme for out-of-pocket expenses, using either direct benefit transfers (DBT) or voucher systems.

The Committee desire that a report on the actions taken in line with the above recommendations and the resulting outcomes may be shared with them.

J. MOBILE MEDICAL UNITS

Recommendation Para No.14:

33. The Committee in their Original Report recommended as under:

> "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 MU 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."

34. The Ministry of Tribal Affairs in its action taken reply on the above mentioned recommendation has stated as under:

"It has been stated by the NHM (MoHFW) that the implementation of Health and Wellness Centers marks a significant step towards strengthening healthcare provision to the most remote areas. MMUs continue to hold relevance for areas that are remote, inaccessible, or challenging to reach, where Health and Wellness Centers may not be adequate. However, States needs to ensure provisions of high quality services through adequate and appropriate HR in these MMUs. Any future expansion of MMUs should be carefully assessed in light of the increasing coverage of Health and Wellness Centers and the overarching objective of ensuring healthcare access for everyone."

Comments of the Committee

35. The Committee are not satisfied with the incomplete reply of the Ministry which lacks action points on their recommendation for boosting, augmenting and monitoring of MMUs. The reply of the Ministry is devoid of crucial aspects such as adequate funding, patient follow-up systems, GPS tracking, and specialized care for tribal populations. To ensure effective functioning of MMUs, the Ministry needs to enhance funding and operational plans for MMUs, develop integrated care models to ensure patient follow-up and continuity of care, implement GPS tracking systems for better monitoring and accountability. Therefore, the Committee while reiterating their earlier recommendation, desire the Ministry of Tribal Affairs to coordinate with the Ministry of Health and Family Welfare and States and develop specialized MMU models equipped to provide health services including specialized services catering to the specific needs of tribal populations. The Committee may be intimated about the steps taken on the recommendations and the results achieved thereon.

K. ASHA AND ANGANWADI WORKERS

Recommendation Para No.16:

36. The Committee in their Original Report recommended as under:

> "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 (ICEIS), 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 latch 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 honorarium 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 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 Anynawadi 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. The Committee could not agree with them more since it is labourious 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."

Reply of the Government

37. The Ministry of Tribal Affairs in its action taken reply on the above mentioned recommendation has stated the following reply of the Ministry of Women and Child Development:

"Reply to (i) to (iv): Mission Poshan 2.0 is a centrally sponsored scheme with a designated cost-sharing ratio between Centre and State. Government of India enhances the honorarium of AWWs/ AWHs from time to time. Lastly, Government of India has enhanced the honorarium of AWWs at main-AWCs 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 ₹250/- per month to AWHs and ₹500/- to AWWs w.e.f. 1st October, 2018. In addition, States/UTs are also paying additional monetary incentives/honorarium to these functionaries from their own resources which may vary from State to State.

POSHAN Abhiyaan showcases one of the finest and most practical examples of Convergence at the implementation level. The AAAA&LS (Anganwadi Worker, Anganwadi Helper, Accredited Social Health Activist, Auxiliary Nurse and Midwife & Lady Supervisor) model was being recognised for awards under which the effective contributions of field functionaries namely AAAA&LS were recognised through a monetary award of ₹50,000 each for synergizing their efforts during various activities like counselling during home visits, Community Based Events and Village Health Sanitation and Nutrition Day etc. During 2018-19, 237 field functionaries comprising of Anganwadi Workers, Anganwadi Helpers, Lady Supervisors, Accredited Social Health Activist (ASHA) and Auxiliary Nurse and Midwives (ANM) were given cash prize of₹50,000 each, a certificate and a medal for exemplary services.

In a national event held on 10th October 2023, the protocol for Community Management of Malnutrition (CMAM) was released jointly by the Ministry of Women & Child Development and Ministry of Health & Family Welfare. The protocol is representative of the convergent and coordinated efforts of the field functionaries of the two Ministries i.e., Anganwadi Workers, Anganwadi Helpers, Accredited Social Health Activist and Auxiliary Nurse and Midwives who will work in tandem to address and treat severe acute malnutrition in India.

The NHM (MoHFW) stated that ASHAs are envisaged to be community health volunteers and are entitled to task/activity based incentives. ASHAs receive a fixed monthly incentive of Rs. 2000 per month for routine and recurring activities and the details are placed at **Annexure-I**. Additionally, they are provided performance-based incentives for a varied set of activities under various National Health Programmes, placed at **Annexure-II**. States/UTs in their programme implementation plans have also been given flexibility to provide a range of monetary incentives to the ASHAs and the details are placed at **Annexure-III**.

After the launch of the Ayushman Bharat scheme with operationalization of AAMs, ASHAs are now additionally eligible for Team Based Incentives (TBIs) along with ANMs based on monitored performance indicators (up to Rs. 1000 per month).

In the year 2018, the ASHA benefit package was introduced acknowledging significant contribution and commitment of ASHAs. The package providing coverage for:

Pradhan Mantri Jeevan Jyoti Beema Yojana (PMJJBY) with a benefit Rs. 2.00 Lakh in case of death of the insured (annual premium contributed by GOI).
Pradhan Mantri Suraksha Beema Yojana (PMSBY) with a benefit of Rs.2.00 lakh for accidental death or permanent disability; Rs. 1.00 lakh for partial disability (annual premium contributed by GOI).

In Addition, Pradhan Mantri Shram Yogi Maan Dhan (PM-SYM) with pension benefit of Rs. 3000 pm after age of 60 years (50% contribution of premium by GOI and 50% by beneficiaries) is also available for ASHA workers.

The Government has also approved a cash award of Rs. 20,000/- and a citation to ASHAs who leave the programme after working as ASHAs for minimum of 10 years, as acknowledgement of their contribution."

Comments of the Committee

38. The reply of the Ministry confines to overall scenario of payment/enhancement of honorarium, incentives, prizes, awards, benefit packages to Anganwadi and ASHA workers and is silent on the Committee's recommendations for recognizing ASHA and Anganwadi workers as frontline workers; providing two wheelers to other frontline medical personnel like Auxiliary Nurse and Midwives (ANMs) and Multipurpose Health Workers (MPWs) working in tribal and rural areas; revision of household and population norms for deployment of ASHA and Anganwadi workers and providing difficult area allowance to them in tribal areas. The reply also mentions about the release of the protocol for community management of malnutrition (CMAM) on 10 October, 2023 jointly by the Ministry of Women and Child Development and the Ministry of Health and Family Welfare, which is claimed to be representative of the convergent and coordinated efforts of Anganwadi and ASHA workers. However, information about the system/mechanism put in place for ensuring effective coordination between Anganwadi and ASHA workers has not been furnished to the Committee in the action Taken replies. The Ministry needs to act on the following areas to fully align with the Committee's vision:

(i) ASHA and Anganwadi workers should be recognized as frontline workers for their pivotal role in healthcare delivery, particularly in rural and tribal areas. This recognition could enhance their benefits, insurance coverage, and working conditions, commensurate with the risks they undertake, especially during pandemics.

(ii) The Committee desire that there should be a mechanism for increasing the honorarium and incentives for ASHA and Anganwadi workers periodically based on the increasing workload and inflation. The honorarium was last revised in 2018 as ₹4,500/month for Anganwadi workers, ₹3,500/month for mini-Anganwadi workers, and ₹2,250/month for

Anganwadi helpers. ASHAs receive a fixed ₹2,000/month along with performance-based incentives. The last increment was hiked about six years ago in 2018, and given inflation, and rising cost of living, another revision is overdue. The Ministry of Women and Child Development should consider annual reviews of these honorarium and incentives with an inflation-adjusted mechanism. Honorarium and incentives also need to match the expanding roles of ASHA and Anganwadi workers under schemes like Ayushman Bharat and Poshan 2.0 for ensuring adequate financial motivation.

(iii) The Committee reiterate their earlier recommendation that two-wheelers should be provided to healthcare workers like ANMs (Auxiliary Nurse Midwife workers) and MPWs (Multipurpose Health Workers) for effective outreach in rural and tribal areas. This will improve accessibility and efficiency, particularly in remote areas with difficult terrain.

(iv) Coordination between ASHA and Anganwadi workers still needs to be strengthened to ensure that tribal women receive proper health and nutrition services without duplication or exclusion. The Ministry has emphasized convergence under Poshan Abhiyaan and highlighted the release of the CMAM protocol (Community Management of Malnutrition) involving these workers.

(v) In view of the ground realities prevailing in different areas, the Ministry needs to review/reduce the minimum household and population norms for deployment of ASHA and Anganwadi workers in tribal areas from 1:300-500 to 1:250 or 50 households to ensure better outreach. In addition, considering the remoteness and difficult terrain of tribal areas, the Committee reiterate their earlier recommendation urging the Government to explore the feasibility of providing difficult area allowance to them.

The Committee may be apprised of the status of implementation of the above recommendations on ground.

L. TRADITIONAL MEDICINES AND HEALERS IN TRIBAL COMMUNITIES

Recommendation Para No.17:

39. The Committee in their Original Report recommended as under:

> "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 Ministry of Tribal Affairs there are provisions for providing traditional tribal systems of medicine facilities along with Ayuveda 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 of 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 healer into the public health system and apprise the Committee about the same."

40. The Ministry of Tribal Affairs in its action taken reply on the above mentioned recommendation has stated as under:

> "NHM (MoH&FW) stated that under AAM, initiatives are already being taken to build synergy and integration of the traditional systems of medicine, particularly Ayurveda and Yoga, with the public health system, especially with Health Promotion – preventive and promotive – interventions.
>
> Action taken:

- Free Siddha Medical Camp under Swasthya Rakshaan Programme was conducted for the Kaani Tribals. Every month Free Siddha Medical Camp will be organized at the Kaani Tribal Settlement with the help of KalakadMundanthurai Tiger Reserve officials. Free Siddha Consultation and Free medicine was given to the tribal people and documented.

- As per the direction from Ministry of Ayush, all the peripheral institutes/units of Central Council for Research in Siddha (CCRS, Chennai) observed Janjatiya Gaurav Diwas from 15-11-2023 to 26-11-2023 inclusive of medical consultation, blood examination and distribution of medicine"

Comments of the Committee

41. The Committee had recommended improving access to traditional tribal systems of medicine through Arogya Banks along with information about modern medicines; engaging traditional healers; and devising a more comprehensive approach involving integration of traditional healers into the public healthcare system. However, the Ministry's reply focuses primarily on organizing Siddha medical camps and observing Janjatiya Gaurav Diwas for tribal communities. It does not mention any concrete steps taken or being taken to strengthen the functioning of Arogya Banks to make traditional medicine accessible or how both forms of medicine will be made equally available and acceptable within the existing healthcare framework. Further, the Ministry has missed the Committee's recommendation for engaging traditional healers and integrating them into public healthcare without compromising scientific principles as no information has been provided on these issues crucial for extending healthcare services to tribals. The Committee desire that a comprehensive framework involving integration of public health systems with traditional healing system engagement of both healers and modern practitioners; and spread of awareness about the modern medical practices and medicines amongst the tribals. The Committee may be informed of the actions undertaken in response to the above recommendations and their outcomes thereon

M. RESEARCH AND DATA ON TRIBAL COMMUNITY AND THEIR TRADITIONAL MEDICINES

<u>Recommendation Para No.18</u>:

42. The Committee in their Original Report recommended as under:

"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 u 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 Anaemia 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"

43. The Ministry of Tribal Affairs in its action taken reply on the above mentioned recommendation has stated as under:

"AYUSH stated that the Central Council for Research in Siddha (CCRS, Chennai) have initiated steps to preserve effective health practices/ traditional medicines used by local tribal people in different parts of the country through IMR project and documentation of medicinal plant for the treatment of various diseases.

Siddha Medicinal Plants Garden (SMPG) at Mettur Dam, Salem dt. Tamil Nadu is one among the wings of Central Council for Research in Siddha (CCRS), Chennai to promote, propagate, conserve and cultivate medicinal plants along with Medico Ethno Botanical study on medicinal plants of Tamil Nadu .

In the last 5 years Siddha Medicinal Plants Garden (SMPG), Mettur Dam functioning under Central Council for Research in Siddha (CCRS, Chennai) has conducted three Intra Mural Project funded by CCRS, Chennai to conduct Medico-ethnobotanical Survey to document the medicinal plants used by the tribal and non-tribal inhabitants of Tiruppur District, Palamalai hills, Salem (Completed), and in Dharmapuri District (Tamil Nadu) which is on-going.

1. Medico ethnobotanical studies of Palamalai, Salem, (Rs.36,78,800/-) – study completed
2. A survey on the ethno-medicinally important plants for common ailments in Tiruppur District Tamil Nadu,– Rs,49,18,800/.- study completed

3. Survey on the traditional and common uses of Medicinal plants from Dharmapuri District, Tamil Nadu , Rs.47, 86,940/- - study in progress

Project 1:
Siddha Medicinal Plants Garden, Mettur dam of CCRS conducted medico-ethnobotanical study at Palamalai Hills under IMR Project during the period of 2016 to 2019.

The inhabitants of the study area claim that they have been originated from Irulars and have settled at Palamalai before 18th Century BC. The survey team made surveys in the following hamlets such as Patthiramadivu, Sundaikadu, Hemmampatti, Ramanpatti, Sothankadu, Periyaelaikadu, etc. Documentation of traditional knowledge of Medicinal plants (104 folklore claims) and flora (604) of the study areas are documented.72 raw drugs and 609 herbarium sheets have been documented.

No. of Informants interviewed 18 Nos – from Tribal settlement.

Details of publications are:

Research article entitled "Selected Folklore Claims of Malayali Tribes of Palamalai Hills, Salem District, Tamil Nadu, India" authored by M. Padma Sorna Subramanian, R. Lakshmanan and M. Thiruvalluvar was published in the European Journal of Biomedical and Pharmaceutical Sciences. EJBPS, 2018, Vol.5 (3): 830-835, ISSN 2349-8870.

- Research article entitled "A Study on the diversity of Medicinal plants in Palamalai hills, Salem district, Tamil Nadu" authored by R. Lakshmanan, M. Thiruvalluvar, M.Subramanian and A. SaravanaGanthi was published in the European Journal of Biomedical and Pharmaceutical Sciences. EJBPS, 2018, Vol.5(4): 294-303, ISSN 2349-8870.
- Research article entitled "Impact of Anthropogenic Pressure on the Phytodiversity of Palamalai Hills, Salem District, Tamil Nadu" authored by R. Lakshmanan, M.Thiruvalluvar and M. Padma Sorna Subramanian was published in the proceedings of National Conference on Climate change and Sustainable Environment on March 15,16;2018 at St. Xavier's College (Autonomous), Palayamkottai, Tirunelveli -2.Pp. 83-86. ISBN: 978-93-5300-509-2

Project 2:

A survey on the ethnomedicinally important plants for common ailments in Tiruppur District, Tamil Nadu under IMR Project.

The survey was carried out in Kodanthur (Anaimalais) and Thirumoorthy hills of Western Ghats as a pioneer study. The research work focused on the uses of traditional plant resources with reference to the common ailments such as cold, cough, fever, skin diseases, poison bite, jaundice, leucorrhoea etc. Frequent field survey was conducted during the period of December 2017 to December 2020 in five blocks (Udumalpet, Tiruppur, Avinashi, Palladam and Pongalur).

1. The survey was carried out in Kodanthur (Anaimalais) and Thirumoorthy hills of Western Ghats. Anaimalais and Thirumoorthy hills ranges have been home to indigenous

communities of different ethnic groups such as Kadar, Muthuvar, Malasars, Malai Malasars, Pulaiyars and Eravalars. There are fifteen settlements in Udumalpet range in Tiruppur District such as Amaravathinagar, Arugampatti, Balrimalai, Easalthittu, ElumayanKoil, etc. The total population of the tribes in Udumalpet range is 1090 and Thirumoorthi hills is 314. Interviewed 292 informants from Rural and Tribal Settlement of Tiruppur District/

- Documentation of traditional knowledge of Medicinal plants (148) was documented.
- About 478 plants were documented in the fruiting and flowering conditions and folklore of 288 species of medicinal plants uses were documented.
- About 346 of raw drugs specimens (214 taxa) were collected
- 255 Herbarium sheets from 1478 vouchers specimens were prepared and deposited for further studies.

Details of publications are:

1. "Ethno-gynaecological knowledge on medicinal plants among the rural communities of Tirrupur district, Tamil Nadu, Radha .P et al, Medicinal plants, vol. 12, (4), December 2020,656- 665
2. Radha, P., Nagaraj, R., Udhayavani, C., &Sivaranjani, K. (2020). A survey on the floral diversity of rural areas in Udumalpet Taluk, Tiruppur District, Tamil Nadu, India. Bangladesh Journal of Plant Taxonomy, 27(1), 137-152.

Project 3:

Survey on the traditional and common uses of medicinal plants from Dharmapuri District, Tamil Nadu/

Investigation and documentation of the folklore and traditional medicinal uses of plants from Dharmapuri District, Tamil Nadu.

- Proposed to interview on the both Tribal and Non-tribal of Dharmapuri District.

About 75 informants interviewed till date.

Digitalization of Herbarium, Museum and compilation of folklore claims of Siddha Medicinal Plant Unit (SMPU), Palayamkottai, Tamil Nadu.

The outcomes of nearly four-decade long studies pertaining to medico-ethno botanical folklore claims have been documented for the benefit of future generations.

In this regard, from the year 1971 to 2008, SMPU-S have accomplished 400 Medico-ethno botanical study tours and has completed 10025 field collections and 7700 herbariums, a good source of ethno-botanical data representing 1836 species. As an outcome of this IMR project, this book is the compilation of 663 medico ethno botanical folklore along with their colour photographs for authenticity under the title "Digitization of Herbarium and Compilation of Folklore claims" and the same published by CCRS, Chennai.

Books published related to Ethno-botanical survey:

- Herbal wealth of Agasthiyamalai – A pictorial Guide
- Herbarium catalogue of Survey of Medicinal Plants Unit-Siddha (SMPU), Palayamkottai
- A Pictorial Guide of Siddha Medicinal Plants (Part I)
- Compilation of Medico ethno botanical folklores

NMPB-RCFC Project:

An NMPB-RCFC Project (One year) entitled Production and Distribution of QPMs of Andrographis paniculata, Indigofera tinctoria, Senna alexandrina and Aegle marmelos has sanctioned to promote the medicinal plants cultivation among farmer's clusters. One among the four farmers cluster selected for this project is at the tribal settlement of Palamalai, Salem District."

Comments of the Committee

44. The Committee appreciate the Ministry's positive response and taking initiatives in documenting tribal medicinal knowledge and promoting herb cultivation. However, a more collaborative framework between the Ministry of Tribal Affairs and the Ministry of AYUSH is crucial for realizing the Committee's objectives. The involvement of prestigious institutes and the establishment of nodal centers like the Tribal Research Institute in Uttarakhand, highlight a multi-disciplinary and structured approach. Efforts such as comprehensive documentation and promotion of medicinal plant cultivation, including collaborations with farmers' clusters, are commendable. However, the Committee feel that the limited geographic coverage of these efforts with a focus only on States like Tamil Nadu and Uttarakhand, neglects other vast tribal regions such as the Northeast and Central India having abundant vegetation/forests and possess huge potential for herbal cultivation. The Committee recommend for expanding research to these areas having huge potential for large scale plantation of medicinal plants which could lead to a more inclusive approach and will benefit the local tribals economically also. As the reply is also devoid of emphasis on research on critical tribal health issues. The Committee desire that the Ministry to prioritize them for taking appropriate action and carrying out strategic enhancements to address the gaps. Information regarding the implementation of the above recommendations and their results may be communicated to the Committee.

N. FUNDS FOR FOCUSSED INTERVENTIONS FOR SCHEDULED TRIBES

Recommendation Para No.21:

45. The Committee in their Original Report recommended as under:

> "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 the 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 utilization 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 ids a v/s 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."

46. The Ministry of Tribal Affairs in its action taken reply on the above mentioned recommendation has stated as under:

> "At MoTA for utilization of TSP/STC funds, regular meetings are being conducted for better outcome of various social determinants, in the field of Education Health Livelihood, Skill Development and Nutrition. Further, the expenditure on the various schemes is monitored through a dedicated portal. Further, the PM-JANMAN and the PMAAGY are both schemes which are envisaged to be implemented in a convergence mode with other major Ministries/Departments by utilization of the funds under their respective schemes under STC."

Comments of the Committee

47. The Committee in their recommendation had highlighted various issues on focused allocation and utilization of funds for tribals. One primary issue is the Ministry of Tribal Affair's limited control over a significant quantum of funds and its reliance on other Ministries for implementing tribal welfare schemes. Meetings and Inter-Ministerial Cooperation alone are insufficient to empower the Ministry of Tribal Affair to achieve the intended objectives. The Committee are of the view that the Ministry of Tribal Affair needs to be given direct or greater authority to design and implement sector-specific, location-specific, and group-specific schemes for tribal development.

The Committee also feel the need for a clear mechanism to track actual versus notional spending under TSP to ensure that the benefits of the funds percolate down to tribal populations directly. Although the Ministry of Tribal Affair has a portal for monitoring TSP expenditure, the current response lacks details on its transparency and real-time accountability. The Committee recommend that spending should be monitored along with utilization certificate.

The Committee further recommend the Ministry to conduct an infrastructure gap analysis and form inter-Ministerial task forces to align schemes with tribal needs more effectively. Further, a more strategic and time bound approach is needed to empower the Ministry of Tribal Affair, improve TSP fund tracking, implement sector-specific interventions, and coordinate with other Ministries effectively. Addressing these areas would strengthen the Ministry of Tribal Affair's role in achieving sustainable and meaningful development for tribal communities.

The Committee may be updated on the actions taken on the above recommendations and the outcome thereon.

O. COORDINATION BETWEEN MINISTRIES AND STATE GOVERNMENTS

Recommendation Para No.22:

48. The Committee in their Original Report recommended as under:

"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 parameters which fall under the purview of various Ministries. As far as health is concerned, the Ministry of Health and Family Welfare and Ministry of MUSH 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 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 anuual common review mission, National Programme Coordination Committee (NPCC) meeting 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 government.

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 inter that unless a tribal women is healthy and free of diseases, at least the ones which could be steered away be 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."

49. The Ministry of Tribal Affairs in its action taken reply on the above mentioned recommendation has stated as under:

"The suggestions have been taken note of."

Comments of the Committee

50. Underscoring the necessity for customized healthcare policies for tribal populations, considering their unique geographical and socio-cultural contexts, the Committee had highlighted the importance of coordinated efforts among various Ministries, including the Ministry of Tribal Affairs, the Ministry of Health and Family Welfare, and the Ministry of Women and Child Development, to address the health and developmental needs of tribal communities. The Committee had also desired that the Ministry of Health and Family Welfare should involve the Ministry of Tribal Affairs in state-specific health plans to fulfill tribal needs.

However, the Ministry's reply that the suggestions have been noted is not acceptable and they should refrain from furnishing this type of casual replies to the recommendation of the Committee. Moreover, the Committee's recommendation for the Ministry of Health and Family Welfare to involve representatives from the Ministry of Tribal Affairs and public representatives including Members of Parliament in State-Specific Health Plans is not acknowledged in the reply. Moreover, there is a requirement of inter-ministerial task force for looking after the needs of the tribal population.

The Committee, while reiterating their recommendations in the Original Report, desire that time bound action plan be taken to implement the recommendations with the larger objective of providing adequate health services to the tribals while ensuring accountability and transparency.

CHAPTER II

OBSERVATION/RECOMMENDATIONS WHICH HAVE BEEN ACCEPTED BY THE GOVERNMENT

Recommendation No.1:

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 dose 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 Fact sheets 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 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 NFFIS to understand the improvements in the tribal regions and study the changes in the social determinants of health.

Reply of the Government

Reply to (i), (ii) and (iii): **Ministry of Tribal Affairs** – The Ministry of Tribal Affairs is 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 communities, policy, planning, monitoring, evaluation etc. as also their coordination , implementation will be the responsibility of the concerned Central Ministries/ Departments, State Governments and Union Territory Administrations. Each Central Ministry/Department will be the nodal Ministry or Department concerning its sector. Thus, the Ministry of Health and Family Welfare, the Ministry of Women and Child Development and the Ministry of AYUSH are the nodal Ministries with respect to their respective domains in the matter of tribal health, including of tribal women. The specific replies to the recommendations of the Committee are as follows:

Reply to (i): At present, there is no centralized repository as well as mechanism for collection or storage data pertaining to the health of tribal women as mostly the tribal related data is gender neutral. However, Ministry of Tribal Affairs has taken note of the recommendation to inform the Ministry of Health and Family Welfare/ Ministry of WCD and other Government Ministries/agencies 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.

Reply to (ii): **Ministry of Tribal** have already taken up the matter with MoH&FW and MoWCD to provide access to the required data through an Application Programming Interface (APIs) for the

selected indicators related to the Tribal Districts. The recommendation with reference to the API linkages with the Swasthya Portal has been noted.

Reply to (iii): The **Ministry of Tribal Affairs** has requested the MoHFW to undertake periodic reviews of the Swasthaya Portal. Nonetheless, the recommendations are noted.

Reply to (iv): The **Ministry of Tribal Affairs** has requested to MoHFW for collecting the sample data in NFHS 6 related to Health & Nutrition in Tribal communities. However in reply MoHFW has informed that MoTA may take up this issue separately with IIPS or any other agency.

[Ministry of Tribal Affairs (Tribal Health) OM No. 42/1/2023-THC(e-file No. 26374) dated 2nd July, 2024]

Comments of the Committee

(Please *see* para-8 of Chapter-I of the Report)

Recommendation No.2:

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, Anaemia 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 behaviors 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.

Reply of the Government

Reply (i) to (iii): The **Ministry of Women and Child Development** (MoWCD) has stated that it is committed towards eradication of malnutrition and is implementing Mission Saksham Anganwadi and Poshan 2.0 (Poshan 2.0), which is a holistic nutrition support programme, and consists of POSHAN Abhiyaan, Anganwadi Services, and Scheme for Adolescent Girls that collectively focus on addressing malnutrition. Other schemes like Pradhan Mantri Matru Vandana Yojana (PMMVY) under 'Mission Shakti' of MoWCD also contribute towards the same. Mission Poshan 2.0 and PMMVY schemes are implemented at Pan India level covering all 36 States/UTs, all districts including 112 aspirational districts and 177 tribal districts, while Scheme for Adolscent Girls (SAG) is implemented in aspirational districts and all districts of North East States including Assam. The MoWCD has further given the following information:

Anganwadi services Scheme and Scheme for Adolescent Girls:

(a) The Anganwadi Services Scheme encompasses six services namely- supplementary nutrition, pre-school non-formal education, nutrition and health education, immunization, health check-up and referral services. The responsibility of delivery of these services is partly shared by MoWCD, National Health Mission (NHM) and Public Health Infrastructure. The scheme adopts a holistic approach (preventive, promotive, curative and sensitization) to effectively address the challenges of

malnutrition and Anaemia. Besides nutrition intervention, it seeks to embrace practices that nurture health, wellness and immunity.

(b) The existing Supplementary Nutrition Programme (SNP) is reinvigorated and converged under 'Saksham Anganwadi and Poshan 2.0'. It seeks to address the dual burden of malnutrition i.e., under-nutrition and micronutrient deficiency by bridging the gap between Recommended Dietary Allowances (RDA) and the Average Daily Intake (ADI). It provides nutrition support to the children (including severely malnourished children) up to the age of 6 years, pregnant women, lactating mothers, and adolescent girls (14-18 years) in the aspirational districts and all districts of North-Eastern States. Under this programme, take home ration (THR) and hot cooked meal (HCM) is given as per the designated nutritional norms of energy and protein.

(c) In order to prevent micronutrient deficiency and provide good quality proteins, special emphasis has been laid on incorporation of dietary diversity, use of locally produced fresh green leafy vegetables, fruits, medicinal plants and herbs, fortified rice, millets, nuts & oilseeds. Under Mission Poshan 2.0, only fortified rice is being allocated to States/UTs.

(d) More emphasis is on the use of millets as they have higher nutrient content which includes protein, essential fatty acid, dietary fibre, B-Vitamins, minerals such as calcium, iron, zinc, folic acid and other micro-nutrients, thus helping to tackle Anaemia and other micro-nutrient deficiencies in women and children. Hence, government is focusing on incorporating millets in the Hot Cooked Meals (HCM) and Take Home Ration (THR) provided to pregnant women & lactating mothers (PW&LMs), and children below 6 years under SNP. In line with the United Nations General Assembly's resolution declaring 2023 as the 'International Year of Millets', Government took the initiative to encourage the adoption of millets across the country through Jan Andolan. In Poshan Pakhwada 2023, one crore activities were carried out for popularization of millets, health benefits of millets and their suitability for cultivation in challenging climates. An exemplary initiative taken by the District Asifabad in Telangana under Project Sampoorna was also awarded with the Hon'ble PM's Award for Excellence in Public Administration in 2022 for promotion of Jan Bhagidari in Poshan Abhiyaan for Millet promotion.

(e) Children are vaccinated against disease-causing micro-organisms. Pregnant women are also given two shots of tetanus vaccine.

(f) Early detection of children with underweight, stunting, severe acute malnutrition (SAM) and moderate acute malnutrition (MAM) status through periodic growth monitoring is undertaken. Regular growth monitoring is essential for early identification of malnourished children and timely interventions. In this direction, close to 7 crore children at Anganwadi Centres were measured in September 2023. The results captured on the Poshan Tracker show substantially lower malnutrition (wasting) levels in comparison to NFHS-5 findings (2021 – 2023). Only 6.6% were found to be wasted, as compared to 19.3% under NFHS-5. (M/WCD)

(g) In a national event held on 10th October 2023, the protocol for Community Management of Malnutrition (CMAM) was released jointly by the Ministry of Women & Child Development and Ministry of Health & Family Welfare to prevent and treat severe acute malnutrition (SAM) thereby reducing associated morbidity and mortality. The community-based approach involves timely detection and screening of children with severe acute malnutrition in the community, management for those without medical complications with wholesome, local nutritious foods at home and supportive medical care. Those malnourished children which have medical complications are

referred for facility-based care. The protocol will help to provide uniform standardized care to the malnourished children across all State/UTs.

(h) Besides Nutrition support, the adolescent girls under SAG are also supported with IFA (Iron and Folic Acid) supplementation, health check-ups, referral services and Nutrition & health Education. Close to 22.7 lakh adolescent girls (14-18 years) from North east and Aspirational districts are registered on the Poshan Tracker as part of the Scheme for Adolescent Girls.

(i) A key initiative of the POSHAN Abhiyaan, to enable the right kind of nourishment, is the Poshan Vatikas or Nutri-gardens that are being set up across the country at or near an Anganwadi Centre to provide a fresh, affordable and regular supply of locally produced fruits, vegetables and medicinal plants to women and children. To encourage diet-diversity and consumption of wholesome local produce, more than 6 lakh Poshan Vatikas have been developed at AWCs. Also, more than 1 lakh medicinal plants were planted in 21 districts of 6 States namely Uttar Pradesh, Madhya Pradesh, Maharashtra, Gujarat, Himachal Pradesh, and Mizoram during Poshan Pakhwada 2021. Poshan Vatikas are a good example of convergent action on-ground which will reduce external dependency and make communities Atmanirbhar for their nutritional security.

Poshan Abhiyaan:

(a) Behavior change interventions also lay a key foundation in preventing malnutrition at the household and the community level. Under these, community-based events are being organized twice per month at the Anganwadi centers to engage community and empower beneficiaries for bringing positive behavior change towards nutrition. Further, for making 'Malnutrition free India' a national move, Poshan Maah and Poshan Pakhwada are celebrated annually in the month of September and March respectively as nutrition-centric Jan Andolans. Poshan Maah is a month long celebration and Poshan Pakhwada is observed for 15 days wherein theme-based sensitization activities are conducted by the community and within the community evoking behavioral change through the process of community mobilization. Over the years, themes have included overall nutrition, hygiene, water and sanitation, Anaemia prevention, importance of breast-feeding, growth monitoring, role of Poshan Panchayats, AYUSH for Well-being, 'Back to Basics – Yoga for Health', importance of Poshan Vatikas for cultivation of local vegetables, medicinal plants/herbs and fruits at the community level, Poshan ke Paanch Sutra, promoting tribal foods, Water conservation through rainwater harvesting, Millet promotion etc. More than 90 crore Jan Andolan activities have been conducted across the country from September 2018 onwards. In the last three years, more than 2 crores tribal focused sensitization activities have been conducted under Jan Andolan.

(b) Amalgamation of AYUSH systems with Poshan 2.0 has also been emphasized upon to stimulate health and nourishment in the community with a focus on prevention of diseases and promotion of wellness through Yoga, cultivation of medicinal herbs in Poshan Vatikas, and preparation of AYUSH formulations to address conditions like Anaemia.

Similarly, the Ministry of Health and Family Welfare implements the Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition (RMNCAH+N) strategy in a life cycle approach under National Health Mission (NHM). This includes the following interventions across the country, including the tribal areas:

- **Mothers' Absolute Affection (MAA)** to improve breastfeeding coverage which includes early initiation of breastfeeding and exclusive breastfeeding

for first six months followed by age-appropriate complementary feeding practices.

- Under **Home Based New-born Care (HBNC) and Home-Based Care of Young Children (HBYC)** program, home visits are performed by ASHAs to improve child rearing practices and to identify sick new-born and young children including tribal children in the community and advise appropriate referral.

- **Anaemia Mukt Bharat (AMB)** strategy is implemented to reduce anaemia among six beneficiaries age group - children (6-59 months), children (5-9 years), adolescents (10-19 years), pregnant and lactating women and in women of reproductive age group (15-49 years) in life cycle approach through implementation of six interventions via robust institutional mechanism across India including for the tribal areas.

- Under **National Deworming Day (NDD)** albendazole tablets are administered in a single fixed day approach via schools and anganwadicentres in two rounds (February and August) to reduce the soil transmitted helminth (STH) infestation among all children and adolescents (1-19 years) and to pregnant mothers all over the country.

- **Intensified Diarrhoea Control Fortnight** initiative is implemented for promoting ORS and Zinc use, for reducing diarrhoeal deaths and associated malnutrition among children.

- **Social Awareness and Actions to Neutralize Pneumonia Successfully (SAANS) initiative** is implemented for reduction of Childhood morbidity and mortality due to Pneumonia.

- **Universal Immunization Programme (UIP**) is implemented to provide vaccination to children against life threatening diseases from birth up to 5 years.

- **Rashtriya Bal Swasthya Karyakaram (RBSK)** covers children from 0 to 18 years of age in schools and Aanganwadicentres to screen for 4Ds viz; Diseases, Deficiencies, Defects and Developmental delays to support early detection, management and support improved child survival.

- **Village Health Sanitation and Nutrition Days (VHSNDs)** are observed for provision of regular maternal and child health services and creating awareness on health care including nutrition in convergence with Ministry of Women and Child Development cross the country.

- **Nutrition Rehabilitation Centres (NRCs)** are set up at public health facilities to provide in-patient medical and nutritional care to Severe Acute Malnourished (SAM) children under 5 years of age with medical complications.

Ministry of Tribal Affairs has taken the following initatives:

i. In collaboration with the Ministry of Ayush, Poshan Vatikas have been created in a few EMRS schools
ii. Funding of Voluntary Organizations for undertaking health initiatives
iii. Taking up health projects through funding of research and projects.

These initiatives are however of a limited nature, and are merely additive to and not in lieu of or even in supplementation of the efforts of the MoHFW and the MoWCD, which are the domain Ministries responsible for tribal health in general.

[Ministry of Tribal Affairs (Tribal Health) OM No. 42/1/2023-THC(e-file No. 26374) dated 2nd July, 2024]

Comments of the Committee

(Please *see* para-11 of Chapter-I of the Report)

Recommendation No.3:

URGENT INTERVENTIONS FOR SICKLE CELL ANAEMIA AMONG TRIBALS

3. The committee note that Sickle Cell Anaemia or Sickle Cell Disease (SCD) continues to be a daunting challenge in the healthcare of the tribal people. Sickle cell Anaemia 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 be 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 counselling and treatment. Since awareness creation and counselling 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 counselling 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 on 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 is 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 referred 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 nationwide 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 were 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 dire 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.

Reply of the Government

Reply to (i): The National Sickle Cell Anaemia Elimination Mission was launched by Hon'ble Prime Minister on 1st July 2023 at Shahdol, Madhya Pradesh. The program is being carried out in a mission mode for screening, prevention, and management of sickle cell Anaemia in all tribal and other high prevalent states/UTs.The target for screening for FY 2023-2024 is 2,50,00,000. As per data from NHM (MoH&FW), till 19 March 2023, a number of 2,64,49,913 population in the 17 identified states have been screened. The total number of sickle cell cards distributed is 10470609.

Reply to (ii) : Under the National Sickle Cell Anaemia Elimination Mission, color coded sickle cell id cards are being distributed to all screened population. Counsellors at the primary health care centers shall be using sickle cell cards for the purpose of pre-marital and pre-conceptional counselling by matching the cards of prospective matches. Matching of the cards will show the chances of their children being born with SCD or SCT. The card will show the status of the individual viz, Normal, Carrier or Diseased. The cards are color coded separately for male (blue) and female (pink). Based on the card's status, the individual will receive treatment and counselling services. Total No of Sickle cell id cards distributed till 08 October 2023 are **16,05,245**. The states are encouraged to conduct awareness drives, pre marriage and pre-natal counseling.

Sickle cell activities are also being carried out by MoTA as per the assigned role by MoHFW. The following have been initiated by MoTA:

a. Strategic plan for Information, Education and Communication in respect of Sickle Cell Anaemia Mission has been made ready. Consultation with all endemic states has been done once.

b. Modules on Awareness and Counselling got prepared through an expert technical committee and were vetted by the MoHFW and thereafter approved

c. The Awareness and counselling modules and Training of Trainers module for medical service providers were released on 01.07.2023 by Hon'ble Prime Minister at the Launch of the Mission at Sehdol, MP.

d. Hindi translation of awareness and counselling modules has been completed. Pamphlets have been translated in Hindi, English, Telegu, Gujrati, Marathi, Odia, Kannada, Malayalam, Assamese, Bengali completed and into the Tribal languages of Advasi, Odia, Kui, Koya, Bhili, Konkani, Dehvali, Mundari, Santhali, Kurkhu, Ho, Kolami, Gondi, Korku, Mandiya, Kuvi, Desia, Soura, Koraga, Jenu Nudi, Soliga, Paniyan, Mullukurma, Kurumba, Santhali, Nepali. An audio-video clip has been prepared and translated into Konda, Koya, Savara, Kuvi, Odia and Gondi. Translation of Awareness & counselling modules in Hindi, English, Gujrati, Kannada, Malayalam, Gondi, Korku, Bangani has been done.

e. Launch of awareness training programmes of first State level master trainers on 28 August 2023 by Hon'ble Minister Tribal Affairs.

f. Engagement with the stakeholders like IMA, IPA, FOGSI, patients' group and other relevant stake holders has been commenced.

g. Advocacy and support with link Ministries/Departments to raise awareness and garner support for effective implementation has commenced.

h. Sensitization of VDVKs and EMRSs has been initiated.

Reply to (iii): Financial assistance is provided by the Ministry of Health and Family Welfare under the Umbrella Scheme of Rashtriya Arogya Nidhi (RAN) & Health Minister's Discretionary Grant (HMDG) based on defined eligibility criteria (including income status) of relevant guidelines. Under the Umbrella Scheme of RAN, financial assistance is provided to patients living below State/UT-wise threshold poverty line for medical treatment of identified life-threatening diseases at Super Specialty Government Hospitals/Institutes across the country. Under HMDG, financial assistance is provided to poor patients suffering from life threatening diseases to cover apart of expenditure on treatment/hospitalization in all Government Hospitals/Institutes.

Ministry of Health & Family Welfare is already in the process of giving wide publicity of both the Schemes to create awareness amongst the citizens of (including tribal people) of the country.

Reply to (iv): The NHM (MoHFW) has mentioned that Health being a state subject, the issue is being encouraged to be taken up by respective States. Budgetary support, as needed and justified by the States, will be made available by the Ministry of Health, as per priorities.

Reply to (v): NHM (MoHFW) has stated that tertiary hospitals in various states have already established facilities to conduct chorionic villous sampling (CVS) and other advanced diagnostics. National Health Mission focusses mainly on the screening and management of the disease. MoTA

has been given a responsibility of developing the center of competence in AIIMs and other tertiary care units in regard to sickle cell disease which will work as a referral center where the prenatal diagnosis services will be a part of it.

Reply to (vi): Ministry has noted the recommendations of the Committee. However, the Swasthaya Portal is now a repository of all the concerned IEC material related to Sickle cell Disease. Awareness & Counselling modules, SCD Management modules have been prepared and disseminated to states. The awareness & counselling modules have been translated into state and tribal languages, which all may be seen at Swasthaya Portal.

Reply to (vii): MoTA has taken the initiative and has written to the Department of Social Justice regarding the permanent disability for the blood disorders patients. Taking the cognizance of the permanent disability the Department of Social justice has constituted a committee, where MoTA member is a special invitee. The committee has given its report. The gazette notification dated 14 March 2024 has been published which provides for grant of permanent disability certificate for SCD patients as per the conditions in the Notification..

[Ministry of Tribal Affairs (Tribal Health) OM No. 42/1/2023-THC(e-file No. 26374) dated 2nd July, 2024]

Comments of the Committee

(Please *see* para-14 of Chapter-I of the Report)

Recommendation No.4:

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 crested.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 clone in the States of Rajasthan, Madhya Pradesh and 5harkhand 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.

Reply of the Government

Reply to (i) to (iii): Ministry of Tribal Affairs is implementing the Central Sector Scheme of Eklavya Model Residential School (EMRS) to provide quality education to the tribal children in their own environment. State Governments/UTs/ State Societies are given instructions to ensure safety of the schools, including its girl children and women staff, by ensuring necessary precautionary measures. As per EMRS guidelines, the following facilities are ensured while setting up an EMRS:

i. Medical facilities including telemedicine and tie up with prominent hospitals in the vicinity.

ii. Facilities for diagnostic and remedial

iii. Medical needs of tribal children (e.g. Sickle Cell Anaemia, Tuberculosis, Malaria etc.) are ensured wherever possible.

iv. Special nutritional requirement and provisions for menstrual hygiene (sanitary pads, incinerator, etc.) of girl students.

v. The number of seats for boys and girls are equal.

vi. Hostel facility: Dormitories for Girls (Capacity of minimum 240).

As on 22.11.2023, 694 EMRSs have been sanctioned (with 409 functional schools) across the country. A total number of 118982 students have been enrolled during the year 2023-24, out of which, number of girls enrolled are 60318 (50.7%).

Steps taken by Ministry of Women and Child Development (WCD):

The Ministry of Women and Child Development is the apex body of Government of India for formulation and administration of regulations and laws related to welfare and development of women and children in the country. WCD Ministry, has declared 24 January as the 'National Girl Child Day'. It aimed at empowering the adolescent girl child, improving their nutritional and health status and providing them various life skills.

The Ministry has been taking pro-active measures to eliminate the social evil of child marriage. The Prohibition of Child Marriage Act, 2006 has been enacted to punish those who promote, perform and abet child marriages. The States/ UTs from time to time are being requested to oversee the effective implementation of the Prohibition of Child Marriage Act, 2006.

Prevention of child marriage and protection of girl child are prominent parts of the National Plan of Action for Children, 2016. Some of the efforts of Ministry towards prevention of child marriage include

1.Communications with the State Governments requesting them to take special initiative to delay marriage by coordinated efforts on special festivals such as Akshya Tritiya/Akha Teej— the traditional day for such marriages.

2.To educate people about the issue of child marriage, awareness has been created through advertisements in the press and electronic media.

3.Platforms such as the Beti Bachao Beti Padhao (BBBP), International Women's Day and the National Girl Child Day are used to create awareness and bring focus on issues related to women such as child marriage to the centre-stage.

4. As per announcement in the Budget 2020-21, a Task Force was constituted to examine the correlation of age of motherhood with (i) health, medical well-being and nutritional status of mother and neonate/infant/ child, during pregnancy, birth and thereafter; (ii) key parameters like Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR), Total Fertility Rate (TFR), Sex Ratio at Birth (SRB), Child Sex Ratio (CSR), etc. and (iii) any other relevant points pertaining to health and nutrition in this context.

5. After taking into account the recommendations of the Task Force and other aspects, the Ministry of Women and Child Development has introduced 'The Prohibition of Child Marriage (Amendment) Bill, 2021' in the Parliament on 21.12.2021 for raising the minimum age of marriage of women to 21 years to make it at par with that of men. The amendment also proposes to amend the relevant provisions of various acts viz the Indian Christian Marriage Act, 1872; the Parsi Marriage and Divorce Act, 1936; the Muslim Personal Law (Shariat) Application Act, 1937; the Special Marriage Act, 1954; the Hindu Marriage Act, 1955; and the Foreign Marriage Act, 1969 to universalize the minimum age of marriage in India. The aforesaid Bill has been referred to the Parliamentary Standing Committee on Education, Women, Children, Youth and Sports (EWCY&S).

6. The National Commission for Protection of Child Rights (NCPCR) also undertakes awareness programs and consultations with stakeholders from time to time in this regard. In addition, Government of India has introduced CHILDLINE with short code 1098, a 24X7 telephone emergency outreach service for children in crisis which responds with suitable interventions to call for any form of assistance which a child requires, including for prevention of child marriages in coordination with police, Child Marriage Protection Officers (CMPOs), District Child Protection Units etc.

7. Section 16 of Prohibition of Child Marriage Act (PCMA) authorizes the State Government to appoint for the whole State, or such part there of as may be specified, an officer or officers to be known as the 'Child Marriage Prohibition Officers (CMPO)' having jurisdiction over the area or areas specified in the notification. This section also specifies the functions to be discharged by CMPOs, which also include preventing solemnization of child marriages by taking such action as they may deem fit; to collect evidence for the effective prosecution of persons contravening the provisions of the Act; to advise the individuals or counsel the residents of the locality not to indulge in promoting, helping, aiding or allowing the solemnization of child marriages; to create awareness about the ill effects of child marriages; and to sensitize the community on the issue of child marriages. These authorities function under the respective State Governments/ UT Administrations. As such, implementation of the provisions of the Act lies with them. (e): The National Crime Records Bureau (NCRB) compiles and publishes the data on the number of cases of child marriage registered under 'the Prohibition of Child Marriage Act (PCMA), 2006' in its publication 'Crime in India'.[Ministry of Tribal Affairs (Tribal Health) OM No. 42/1/2023-THC(e-file No. 26374) dated 2nd July, 2024]

Comments of the Committee

(Please *see* para-17 of Chapter-I of the Report)

Recommendation No.7:

INTERVENTIONS FOR POSITIVE BIRTHING EXPERIENCE TO TRIBAL WOMEN

7. The Committee note that various interventions like Janani Suraksha Yojana (JSY), Janani Shishu Suraksha Karyakararn (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 creches in anganwadi centres where the tribal mothers can leave their children free of cost.

Reply of the Government

Reply to (i): As per MoH&F, tThe tribal regions have a presence of traditional healers and Dais who provide services at the grassroot level. To ensure the quality and respectful maternal healthcare services, it is imperative to integrate these traditional healthcare providers into the ongoing Government of India initiatives. It can help bridge the gap in healthcare delivery and improve maternal and infant outcomes in these underserved regions through their inclusion as:

- **SUMAN Volunteer:** Under SUMAN initiative, SUMAN volunteers are individuals who are empowered and respected within their communities, such as PRI (Panchayati Raj Institutions) representatives, influential community leaders, school teachers, civil society representatives, members of Self-Help Groups (SHGs), etc provided they are committed to the cause and are willing to devote time for the same.

Recognizing the valuable experience, community acceptance, and local knowledge possessed by traditional healers and Dais in their respective villages, they may be designated as SUMAN Volunteers. Upon their identification as SUMAN Volunteers, they undergo comprehensive training in all essential GoI Maternal Health Flagship programs. Their roles as volunteers encompass:

- Serve as a intermediaries/bridge between the healthcare system and the local community.
- Facilitate early registration of all pregnant women during their first trimester and ensure institutional deliveries.
- Participate in VHSNC/Panchayat/MAS meetings and orient members on various entitlements for pregnant women.
- Engage/support in generating community awareness about various entitlements for the pregnant women i.e. JSY, JSSK, PMMVY etc.
- In case of emergencies, ensure that pregnant women have access to referral transportation and reach appropriate healthcare facilities in time.

- Soliciting feedback from pregnant women regarding their care experiences and documenting and sharing this feedback with MO, ANM, ASHA, AWW, etc.
- Coordinating with ASHA and ANM to ensure the availability of all service provisions provided by the GoI.

- **SUMAN Champion:** Once identified as SUMAN Volunteers, they may be acknowledged as SUMAN Champions contingent upon their performance, and they may be recognized from the local administration for their exemplary work in saving lives of pregnant women and newborns.

- **Primary Informant:** They may also be recognized as primary informants for community maternal deaths.

Midwifery Initiative:

Introduction of **Midwifery Services in India** (2018) is another significant initiative that has been taken by MoHFW to:

- Promote **physiological birthing** process and ensure a **positive child birth** experience for women, including tribal women, with respect and dignity
- Creation of a new cadre **"Nurse Practitioner in Midwifery"** who will be stationed in high case load delivery points and will promote physiological birthing.
- There is a provision of posting the midwives (NPM) in 24X7 PHCs/ Urban PHCs remote locations with high home deliveries after serving at Medical Colleges/DG/SDH/CHC for three years initially.
- Establishment of **Midwifery Led Care Units**, which are underway at high case

Reply to (ii): Considering the need for health system interventions in case of a high-risk pregnancy, the MoHFW, Government of India launched **Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)** in June 2016. It envisages to improve the quality and coverage of Antenatal Care (ANC) including diagnostics and counselling services as part of the Reproductive Maternal Neonatal Child and Adolescent Health (RMNCH+A) Strategy.

Its objective is to provide fixed-day, assured, comprehensive and quality antenatal care on the 9th of every month, to all pregnant women, including tribal pregnant women, in 2nd and 3rd trimester of pregnancy. The IEC/BCC activities are extensively taken up for sensitizing the community for availing services. The key features of PMSMA include:

- A minimum package of antenatal care services (including investigations and drugs) is provided to all pregnant women by OBGY specialists/ medical officer in addition to the routine ANC visits attended by the woman.

- Special efforts are made to reach out the left out/drop out/missed ANC cases as well as high risk pregnant women.
- Enrolment of private OBGY specialists/physicians to provide voluntary services at public health facilities.
- One of its critical components is the identification and follow up of High-Risk Pregnancies (HRP).
- Further, it is mandatory that all identified high-risk cases must be linked with facilities for their routine /periodic care and timely admission for delivery.

For further improving the individual HRP tracking and strengthening their follow-up activities, **Extended-PMSMA (E-PMSMA)** has been launched recently. Following are the silent features of the extended PMSMA;

- An additional day of the month is identified (over and above the existing 9th of every month) for organizing the PMSMA clinics, to make up for missed out HRP cases or those requiring frequent follow ups
- Cash-based incentives to ASHA for mobilizing high risk pregnant women to PMSMA session for follow up visit
- Cash-based incentive to Beneficiary towards transportation cost to attend follow up ANC visits

Reply to (iii): The Department of Rural Development (DoRD), Ministry of Rural Development (MoRD) is implementing a number of rural development schemes, namely Mahatma Gandhi National Rural Employment Guarantee Scheme (Mahatma Gandhi NREGS), Pradhan Mantri Awaas Yojana —Gramin (PMAY-G), Pradhan Mantri Grain Sadak Yojana (PMGSY), Deendayal AntyodayaYojana — National Rural Livelihoods Mission (DAY-NRLM), Deen Dayal Upadhayay — Gramin Kaushalya Yojana (DDU-GKY), Rural Self Employment Training Institutes (RSETIs) and National Social Assistance Programme (NSAP), to alleviate poverty and to bring about overall improvement in the quality of life of the people in rural areas including tribal areas of the country, strengthening of livelihood opportunities, providing minimum guaranteed employment, promoting self-employment, skilling of youths in various useful trades and entrepreneurship qualities, infrastructure development and provision of social assistance. Comments of this Department on relevant issues, scheme-wise are as under:

1. Pradhan Mantri Gram Sadak Yojana (PMGSY):

PMGSY was launched in the year 2000 to provide connectivity, by way of an all-weather road to the eligible unconnected habitations in rural areas with a population of 500 and above (as per 2001 census) in plain areas. In respect of special category states (i.e. Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim, Tripura, Himachal Pradesh, Jammu & Kashmir and Uttrakhand), the Desert Areas (as identified in the Desert Development Programme), the Tribal (Schedule V) areas and selected Tribal and Backward District (as identified by the Ministry of Home Affairs and Planning Commission) the objective would be to connect eligible unconnected Habitations with population of 250 persons and above (Census 2001). For Most intensive IAP blocks

as identified by Ministry of Home Affairs the unconnected habitations with population 100 and above (as per 2001 Census) would be eligible to be covered under PMGSY.

The mandate of the scheme was subsequently widened and new interventions viz. PMGSY-II and PMGSY-III were added for up-gradation of the existing rural road network which connect habitations to the various facilities and services.

Against 1,78,184 eligible habitations of 250+ and 500+ population size identified for coverage under the scheme, 16,086 habitations have been provided connectivity by the States out of their own resources and 4,857 habitations have either been dropped or have not been found feasible. Out of the balance 1,57,241 habitations sanctioned for providing connectivity under the PMGSY, 1,56,495 have already been covered. Thus, as on 30th September, 2023, only 738 habitations remain to be saturated.

Under 100-249 population category (LWE areas) 6,245 habitations have been sanctioned for providing all-weather road connectivity out of which 6,036 habitations have been saturated till 30th September, 2023. (Inputs of MoRD at p.611/c.)

Reply to (iv): Disaggregated data is not available in this regard.

Reply to (v): The Ministry of Women & Child Development have informed that active participation and leadership of women are vital for women-led development. Institutionalization of care services is crucial for enhancing female labour force participation. Transformative Care Policies can yield positive economic and gender quality outcomes, leading to better outcomes for women's participation in workforce.

Responding to long standing demands, the Ministry of Women and Child Development in consultation with the Ministry of Labour & Employment has released the National Minimum Standards and Protocol for Crèches (Operation and Management) guidelines which aims to provide guidance to individual/ service agencies/ corporations/ companies/ universities/ hospitals/ care service providers/ government organizations/ non-governmental organizations etc., mandated under various acts and rules of the Government of India for setting up and running of Creches. These Standards and Protocol focus strongly on standardizing and institutionalizing the care economy, contributing significantly to the vision of Women-led Development'.

It may please be noted that these Standards and Protocol are issued in supersession of the earlier guidelines of this Ministry titled 'National Minimum Guidelines for Setting up and Running Creches under Maternity Benefit Act, 2017' issued vide Office Memorandum of even number dated 02.11.2018.

Wide publicity to these Standards and Protocol is been given and they are also circulated to each and every employer/ institution covered under the Ministry/ Department/ State/ UT, thereby empowering them with the requisite know how to set up model creche facilities with adequate provisions. A copy of these Standards and Protocol can also be downloaded from the Ministry's website -https://wcd.nic.in.

[Ministry of Tribal Affairs (Tribal Health) OM No. 42/1/2023-THC(e-file No. 26374) dated 2nd July, 2024]

Recommendation No.8:

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 Suraksha Karyakaram (JSSK) and 'Surakshit Matritva Aashwasani (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.

Reply of the Government

Reply: The Ministry of Health & Family Welfare stated that since 30% of maternal deaths occur in the postnatal period (WHO), a new initiative, **Optimizing Postnatal Care,** complimentary to the existing HBNC program, has been recently launched by MoHFW, for strengthening the quality of postnatal care to all mothers, including the mothers in tribal areas. The key features of the initiative are:

- In order to address the morbidity and mortality in the post-natal period, mothers are being provided high quality care in the form of diligent observation during HBNC visits, screening for danger signs, referrals and appropriate management for those found to have issues by the respective ASHA.
- If the post-natal mother is having any complication and screened as high risk on the basis of danger signs, ASHA will arrange transportation for her visit to

the nearest healthcare facility or designated PMSMA session depending on the urgency and medical condition through 108/102 ambulance network.

- ASHA, ASHA Facilitator, ANM, CHO and others are oriented and extensive IEC/BCC activities are carried out to generate awareness about the initiative.
- Provision of Rs. 250/- per high-risk postnatal mother for the ASHA, on achieving healthy outcome for both mother and the baby is made.

[Ministry of Tribal Affairs (Tribal Health) OM No. 42/1/2023-THC(e-file No. 26374) dated 2nd July, 2024]

Recommendation No.9:

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:

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, these have 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.

i. The Committee are glad to know 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 abeit custom made for tribal areas so that malaria can be effecitively 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 peed 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 (18.7681%) 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 13417 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 Maritri 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.

Reply of the Government

Reply to (i): The MoHFW has informed that Malaria Situation in Tribal Areas of India is as follows

- In 2023, a total of 2,27,564 malaria cases and 83 malaria deaths were reported across the country. Of these, 1,46,978 (64.58%) cases and 57 deaths (68.67%) were reported from 182 tribal predominant districts of India. The list of Tribal district with API is attached at **Annexure-IV**.

- Among 182 tribal districts, there has been 82.29% reduction in malaria morbidity and 77.01% reduction in malaria mortality between 2015 and 2023.
- In 2023, 122 districts in the Country have reported 'zero malaria case' out of which 27 are tribal districts.

Key Strategic approaches of National Strategic Plan (NSP 2023-27):

- Transforming malaria surveillance as a core intervention for malaria elimination.
- Ensuring universal access to malaria diagnosis and treatment by enhancing and optimizing case management-"testing, treating and tracking".
- Ensuring universal access to malaria prevention by enhancing and optimizing vector control
- Accelerating efforts towards elimination and attainment of malaria –free status.
- Promoting research and supporting the generation of strategic information for malaria elimination and prevention of re-establishment of malaria transmission.

Strategies for Prevention & Control of Malaria

- Integrated Vector Management including Indoor Residual Spraying (IRS) in selected high risk areas, Long Lasting Insecticidal Nets (LLINs) in high malaria endemic areas, use of larvivorous fish, anti-larval measures in urban areas including bio-larvicide and minor environmental engineering and source reduction for prevention of breeding.
- Disease Management involving early case detection with active, passive and sentinel surveillance followed by complete and effective treatment, strengthening of referral services, epidemic preparedness and rapid response.
- Supportive Interventions including Behaviour Change Communication (BCC), Inter- Sectoral Convergence and Human Resource Development through capacity building.

Joint Action Plan for Malaria Elimination in Tribal Area

A Joint Action Plan for Malaria Elimination in Tribal Area has been drafted by Ministry of Health & Family Welfare (MoHFW) and the Ministry of Tribal Affairs (MoTA) for implementing appropriate strategies in the 182 tribal dominated district with vision to eliminate malaria in tribal districts in Mission Mode by year 2030.

Key Activities Identified in Joint Action Plan are as follows:

1. **Surveillance: Increase Outreach Service for diagnosis and treatment.**

- Fill up the gap in the existing health facilities
- Mobile dispensary/clinics in remote and hard to reach locations
- Provision of hamlet- wise ASHAs
- Involvement of the local informal and faith healers in malaria identification and referral process

2. **Early Diagnosis & Complete Treatment**

    - Early diagnosis and complete treatment by ensuring 24X 7 availability of RDK and antimalarial with ASHA, ANM and health facilities.
    - Strengthening of PHCs/CHC/DH with quality microscopy facilities & other necessary equipment
    - Intensive training for all relevant cadres of staff in using RDTs and administration of relevant dosage of anti-malarials

3. **Strengthening disease and vector surveillance**

- Expansion and linking of IHIP-VBD portal with MoTA web portal in all identified tribal districts for real-time information
- Use of innovative technologies for vector surveillance especially for mapping of potential breeding sites and receptivity of areas

4. **Integrated Vector Management**

- Identification and prioritization of areas in tribal districts according to degree of risk for Malaria transmission for appropriate vector control measures (IRS/ LLINs or community- owned bed nets with insecticides
- Timely supply and maintenance of adequate stock of insecticides, LLINs or community- owned bed nets with insecticides etc.

5. **Targeted Social and Behaviour Change Communication (SBCC)**

- Advocacy with political leaders, influencers, religious leaders, community leaders etc.
- Involvement of appropriate and relevant health and Non-Health Dept./sector such as Education, PRIs, MNREGA, Rural Development, Drinking water and sanitation, Road and Transport etc. for advocacy and social mobilization and communication
- Specific IEC/BCC activities suited for the tribal areas

- Utilizing the weekly HAAT (market)/folk media for conducting IEC/BCC activities.
- Conducting IEC/ BCC activities during local festivals or VHNDs

Reply to (ii): Under the National TB Elimination Programme (NTEP), the Government is providing financial incentive to volunteers who would act as treatment supporter to a TB patient so that he/ she completes the TB treatment. Nikshay Poshan Yojana (NPY) is another financial support under the programme to support nutrition till TB treatment completion provisioned for a TB patient. Further, 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.

a) Additionally, the Government has initiated the Pradhan Mantri TB Mukt Bharat Abhiyan (PMTBMBA) where nutritional and other support to TB patients with the aim to improve treatment adherence, completion and also for overall well being is being supported by Nikshay Mitras.

b) The Family Care Model has recently been initiated to involve the family members to support treatment adherence, treatment completion and providing home-based care to a TB patient.

c) Apart from these, the Government is using different adherence monitoring mechanisms including digital solutions for monitoring the treatment completion.

d) The Government has also undertaken various campaigns for generating awareness about TB & services available under NTEP with involvement of the Panchayats, HWCs, SHGs, etc.

e) The Government has undertaken special activities like Aashwasan, a joint campaign with the Ministry of Tribal Affairs for active case finding for TB and COVID-19 awareness from January 2022 till October 2022. The campaign aimed at active case finding for TB in tribal and hard-to-reach areas, increasing awareness regarding TB and COV1D-19, and epidemic preparedness by engaging with community influencers. It was implemented across 174 tribal districts, covering 1122 blocks with more than 25% tribal populations (Scheduled tribes). Intensive outreach activities were conducted by community mobilizers and paramedical staff with front-line health workers and community influencers under the guidance of district TB cells for 100 days (each) in each of the 68,413 villages.

Some key highlights include:

i) More than 1,66,77, 804 people were reached out

ii) 1,03,84,538 people were screened for symptoms of TB

iii) 3,82,251 people were identified for presumptive TB

iv) 10,249 persons were diagnosed with TB and 9,588 persons were put on treatment."

Reply to (iii): The recommendation has been noted.

[Ministry of Tribal Affairs (Tribal Health) OM No. 42/1/2023-THC(e-file No. 26374) dated 2nd July, 2024]

Recommendation No.10:

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 service. Even through 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.

Reply of the Government

Reply: The recommendation is noted.

[Ministry of Tribal Affairs (Tribal Health) OM No. 42/1/2023-THC(e-file No. 26374) dated 2nd July, 2024]

Comments of the Committee

(Please *see* para-23 of Chapter-I of the Report)

Recommendation No.11:

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 counseling 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 counseling and create awareness among the tribal population about the adverse effects of substance abuse among tribal women.

Reply of the Government

Reply: The recommendation has been noted.

[Ministry of Tribal Affairs (Tribal Health) OM No. 42/1/2023-THC(e-file No. 26374) dated 2nd July, 2024]

Comments of the Committee

(Please *see* para-26 of Chapter-I of the Report)

Recommendation No.12:

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 (P1-1C) / 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 in the 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 the health action plan should be ensured by the Ministry and the success of Pravara model may be analyzed 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 anti 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.

Reply of the Government

Reply to (i): The MoHFW informed that Public Health and Hospital is a state subject and its implementation primarily lies with the State Government. The NHM provides technical and financial support to the States/UTs to strengthen their health care systems including setting-up/upgrading public health facilities and augmenting health human resource for provision of equitable, affordable healthcare to rural marginalized population based on requirements proposed in the PIPs by the States/UTs.

For effective and quality delivery of comprehensive healthcare services, the Indian Public Health Standards (IPHS norms 2022) for Sub-Centres Health & Wellness Centres, Primary Health Centres-Health & Wellness Centres, Community Health Centres, Sub-District and District Hospitals, are followed. While establishing or upgrading infrastructures the IPHS 2022 also focuses special attention to human resource, drugs, diagnostics, equipment, quality and governance requirements for delivering health services at these facilities.

The revised IPHS guidelines 2022 provides guidance on the health system components such as:

a. The basis for establishing the health facilities, infrastructure requirement and the general appearance and upkeep of the facilities;
b. Prescribed norms to be followed for illumination, fire safety, disaster and emergency preparedness, water and sanitation and power backup;

c. Standard protocol to be adopted for better service delivery;
d. HRH requirement for ensuring service availability, conduct and behavior standards and safety measures to be adopted for the HRH;
e. Essential medicines to be available free of cost in the health facilities under 'Free Drug Service Initiative' of GoI;
f. Essential diagnostics to be provided in the health facilities;
g. Equipment required for providing the services being offered through the facilities;
h. Quality Assurance Protocol to be adopted including a road map for healthcare facilities to achieve NQAS certification;
i. Ensuring accountability and governance in service delivery.

Reply to (ii): As per NHM (MoHFW) the health action plan should be in accordance with the Indian Public Health Standards (IPHS) and National Quality Assurance Standards (NQAS) to ensure infrastructural adequacy in healthcare facilities. These standards, endorsed by the National Health Mission (NHM) based on state-submitted proposals, encompass vital amenities like electricity, drinking water, sanitation, labour room, and operation theatre, which are crucial for delivering quality healthcare services. The guidelines can be accessed on the IPHS and NQAS websites.

Reply to (iii): NHM (MoHFW) stated that under the Telemedicine programme, which is being implemented under the e-Sanjeevani initiative, systems have been augmented, and all necessary equipment has been put in place to ensure seamless connectivity between the Telemedicine Centre and the Primary Health Centre, as per the guidelines and provisions under the programme. The erstwhile Ayushman Bharat-Health & Wellness Centres now renamed as Ayushman Arogya Mandir ensure continuity of care by appropriate referrals and optimal home and community follow-up. AAMs provide teleconsultation services, wherein every level of service provider, from Community Health Officers to Medical Officers, can access higher-level consultation, including with specialists in secondary and tertiary centres. This minimizes the physical travel of patients, resulting in reduced costs and potential hardships for the patients.

The Ayushman Bharat Digital Mission (ABDM) aims to develop the backbone necessary to support the integrated digital health infrastructure of the country. It will bridge the existing gap among different stakeholders of the healthcare ecosystem through digital highways by integrating digital health infrastructure, ensuring access, equity and CoC with citizens as data owners, leveraging IT and associated technologies and supporting existing health systems in a 'citizen-centric' approach. The digital ecosystem creates health records based on the ABHA ID. This 14-digit number will uniquely identify a participant in India's digital healthcare ecosystem that healthcare providers and payers nationwide will accept.

Reply to (iv): The NHM (MoHFW) stated that the Digital Personal Data Protection (DPDP) Act 2023 declares the right to information privacy as a fundamental right. It intends to protect the privacy, confidentiality, security, and standardizations of Electronic Health Records. It imposes several obligations on entities collecting personal data—to provide notice and take consent from individuals, to store accurate data securely, and to use it only for purposes listed in the notice. Ministry of Health and Family Welfare, under all its programs, promotes and adopts e-health standards, enforces privacy and security measures for electronic health data, and regulates the storage and exchange of EHRs.

Comments of the Committee

(Please *see* para-39 of Chapter-I of the Report)

Recommendation No.16:

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 is 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 services 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 honorarium 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 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 Anynawadi 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 fur 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 recommends that the Government may explore the possibility of providing difficult area allowance to them in tribal areas.

Reply of the Government

Reply of M/WCD :

Reply to (i) to (iv): Mission Poshan 2.0 is a centrally sponsored scheme with a designated cost-sharing ratio between Centre and State. Government of India enhances the honorarium of AWWs/ AWHs from time to time. Lastly, Government of India has enhanced the honorarium of AWWs at main-AWCs 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 ₹250/- per month to AWHs and ₹500/- to AWWs w.e.f. 1st October, 2018. In addition, States/UTs are also paying additional monetary incentives/honorarium to these functionaries from their own resources which may vary from State to State.

POSHAN Abhiyaan showcases one of the finest and most practical examples of Convergence at the implementation level. The AAAA&LS (Anganwadi Worker, Anganwadi Helper, Accredited Social Health Activist, Auxiliary Nurse and Midwife & Lady Supervisor) model was being recognised for awards under which the effective contributions of field functionaries namely AAAA&LS were recognised through a monetary award of ₹50,000 each for synergizing their efforts during various activities like counselling during home visits, Community Based Events and Village Health Sanitation and Nutrition Day etc. During 2018-19, 237 field functionaries comprising of Anganwadi Workers, Anganwadi Helpers, Lady Supervisors, Accredited Social

Health Activist (ASHA) and Auxiliary Nurse and Midwives (ANM) were given cash prize of₹50,000 each, a certificate and a medal for exemplary services.

In a national event held on 10th October 2023, the protocol for Community Management of Malnutrition (CMAM) was released jointly by the Ministry of Women & Child Development and Ministry of Health & Family Welfare. The protocol is representative of the convergent and coordinated efforts of the field functionaries of the two Ministries i.e., Anganwadi Workers, Anganwadi Helpers, Accredited Social Health Activist and Auxiliary Nurse and Midwives who will work in tandem to address and treat severe acute malnutrition in India.

The NHM (MoHFW) stated that ASHAs are envisaged to be community health volunteers and are entitled to task/activity based incentives. ASHAs receive a fixed monthly incentive of Rs. 2000 per month for routine and recurring activities and the details are placed at **Annexure-I**. Additionally, they are provided performance-based incentives for a varied set of activities under various National Health Programmes, placed at **Annexure-II**. States/UTs in their programme implementation plans have also been given flexibility to provide a range of monetary incentives to the ASHAs and the details are placed at **Annexure-III**.

After the launch of the Ayushman Bharat scheme with operationalization of AAMs, ASHAs are now additionally eligible for Team Based Incentives (TBIs) along with ANMs based on monitored performance indicators (up to Rs. 1000 per month).

In the year 2018, the ASHA benefit package was introduced acknowledging significant contribution and commitment of ASHAs. The package providing coverage for:

Pradhan Mantri Jeevan Jyoti Beema Yojana (PMJJBY) with a benefit Rs. 2.00 Lakh in case of death of the insured (annual premium contributed by GOI).

Pradhan Mantri Suraksha Beema Yojana (PMSBY) with a benefit of Rs.2.00 lakh for accidental death or permanent disability; Rs. 1.00 lakh for partial disability (annual premium contributed by GOI).

In Addition, Pradhan Mantri Shram Yogi Maan Dhan (PM-SYM) with pension benefit of Rs. 3000 pm after age of 60 years (50% contribution of premium by GOI and 50% by beneficiaries) is also available for ASHA workers.

The Government has also approved a cash award of Rs. 20,000/- and a citation to ASHAs who leave the programme after working as ASHAs for minimum of 10 years, as acknowledgement of their contribution.

[Ministry of Tribal Affairs (Tribal Health) OM No. 42/1/2023-THC(e-file No. 26374) dated 2nd July, 2024]

Comments of the Committee

(Please *see* para-38 of Chapter-I of the Report)

Recommendation No.18:

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 u 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 Anaemia may be prioritised and specific findings on tribal women/girls may be figured as an integral part of the research wherever applicable. The Committee recommends 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

Reply of the Government

Reply: AYUSH stated that the Central Council for Research in Siddha (CCRS, Chennai) have initiated steps to preserve effective health practices/ traditional medicines used by local tribal people in different parts of the country through IMR project and documentation of medicinal plant for the treatment of various diseases.

Siddha Medicinal Plants Garden (SMPG) at Mettur Dam, Salem dt. Tamil Nadu is one among the wings of Central Council for Research in Siddha (CCRS), Chennai to promote, propagate, conserve and cultivate medicinal plants along with Medico Ethno Botanical study on medicinal plants of Tamil Nadu .

In the last 5 years Siddha Medicinal Plants Garden (SMPG), Mettur Dam functioning under Central Council for Research in Siddha (CCRS, Chennai) has conducted three Intra Mural Project funded by CCRS, Chennai to conduct Medico-ethnobotanical Survey to document the medicinal plants used by the tribal and non-tribal inhabitants of Tiruppur District, Palamalai hills, Salem (Completed), and in Dharmapuri District (Tamil Nadu) which is on-going.

1. Medico ethnobotanical studies of Palamalai, Salem, (Rs.36,78,800/-) – study completed

2. A survey on the ethno-medicinally important plants for common ailments in Tiruppur District Tamil Nadu,– Rs,49,18,800/.- study completed
3. Survey on the traditional and common uses of Medicinal plants from Dharmapuri District, Tamil Nadu , Rs.47, 86,940/- - study in progress

Project 1:
Siddha Medicinal Plants Garden, Mettur dam of CCRS conducted medico-ethnobotanical study at Palamalai Hills under IMR Project during the period of 2016 to 2019.

The inhabitants of the study area claim that they have been originated from Irulars and have settled at Palamalai before 18th Century BC. The survey team made surveys in the following hamlets such as Patthiramadivu, Sundaikadu, Hemmampatti, Ramanpatti, Sothankadu, Periyaelaikadu, etc. Documentation of traditional knowledge of Medicinal plants (104 folklore claims) and flora (604) of the study areas are documented.72 raw drugs and 609 herbarium sheets have been documented.

No. of Informants interviewed 18 Nos – from Tribal settlement.

Details of publications are:

Research article entitled "Selected Folklore Claims of Malayali Tribes of Palamalai Hills, Salem District, Tamil Nadu, India" authored by M. Padma Sorna Subramanian, R. Lakshmanan and M. Thiruvalluvar was published in the European Journal of Biomedical and Pharmaceutical Sciences. EJBPS, 2018, Vol.5 (3): 830-835, ISSN 2349-8870.

- Research article entitled "A Study on the diversity of Medicinal plants in Palamalai hills, Salem district, Tamil Nadu" authored by R. Lakshmanan, M. Thiruvalluvar, M.Subramanian and A. SaravanaGanthi was published in the European Journal of Biomedical and Pharmaceutical Sciences. EJBPS, 2018, Vol.5(4): 294-303, ISSN 2349-8870.
- Research article entitled "Impact of Anthropogenic Pressure on the Phytodiversity of Palamalai Hills, Salem District, Tamil Nadu" authored by R. Lakshmanan, M.Thiruvalluvar and M. Padma Sorna Subramanian was published in the proceedings of National Conference on Climate change and Sustainable Environment on March 15,16;2018 at St. Xavier's College (Autonomous), Palayamkottai, Tirunelveli -2.Pp. 83-86. ISBN: 978-93-5300-509-2

Project 2:

A survey on the ethnomedicinally important plants for common ailments in Tiruppur District, Tamil Nadu under IMR Project.

The survey was carried out in Kodanthur (Anaimalais) and Thirumoorthy hills of Western Ghats as a pioneer study. The research work focused on the uses of traditional plant resources with reference to the common ailments such as cold, cough, fever, skin diseases, poison bite, jaundice, leucorrhoea etc. Frequent field survey was conducted during the period of December 2017 to December 2020 in five blocks (Udumalpet, Tiruppur, Avinashi, Palladam and Pongalur).

1. The survey was carried out in Kodanthur (Anaimalais) and Thirumoorthy hills of Western Ghats. Anaimalais and Thirumoorthy hills ranges have been home to indigenous communities of different ethnic groups such as Kadar, Muthuvar, Malasars, Malai Malasars, Pulaiyars and Eravalars. There are fifteen settlements in

Udumalpet range in Tiruppur District such as Amaravathinagar, Arugampatti, Balrimalai, Easalthittu, ElumayanKoil, etc. The total population of the tribes in Udumalpet range is 1090 and Thirumoorthi hills is 314. Interviewed 292 informants from Rural and Tribal Settlement of Tiruppur District/

- Documentation of traditional knowledge of Medicinal plants (148) was documented.
- About 478 plants were documented in the fruiting and flowering conditions and folklore of 288 species of medicinal plants uses were documented.
- About 346 of raw drugs specimens (214 taxa) were collected
- 255 Herbarium sheets from 1478 vouchers specimens were prepared and deposited for further studies.

Details of publications are:

1. "Ethno-gynaecological knowledge on medicinal plants among the rural communities of Tirrupur district, Tamil Nadu, Radha .P et al, Medicinal plants, vol. 12, (4), December 2020,656- 665
2. Radha, P., Nagaraj, R., Udhayavani, C., &Sivaranjani, K. (2020). A survey on the floral diversity of rural areas in Udumalpet Taluk, Tiruppur District, Tamil Nadu, India. Bangladesh Journal of Plant Taxonomy, 27(1), 137-152.

Project 3:

Survey on the traditional and common uses of medicinal plants from Dharmapuri District, Tamil Nadu/

Investigation and documentation of the folklore and traditional medicinal uses of plants from Dharmapuri District, Tamil Nadu.

- Proposed to interview on the both Tribal and Non-tribal of Dharmapuri District.

  About 75 informants interviewed till date.

Digitalization of Herbarium, Museum and compilation of folklore claims of Siddha Medicinal Plant Unit (SMPU), Palayamkottai, Tamil Nadu.

The outcomes of nearly four-decade long studies pertaining to medico-ethno botanical folklore claims have been documented for the benefit of future generations.

In this regard, from the year 1971 to 2008, SMPU-S have accomplished 400 Medico-ethno botanical study tours and has completed 10025 field collections and 7700 herbariums, a good source of ethno-botanical data representing 1836 species. As an outcome of this IMR project, this book is the compilation of 663 medico ethno botanical folklore along with their colour photographs for authenticity under the title "Digitization of Herbarium and Compilation of Folklore claims" and the same published by CCRS, Chennai.

Books published related to Ethno-botanical survey:

- Herbal wealth of Agasthiyamalai – A pictorial Guide
- Herbarium catalogue of Survey of Medicinal Plants Unit-Siddha (SMPU), Palayamkottai
- A Pictorial Guide of Siddha Medicinal Plants (Part I)
- Compilation of Medico ethno botanical folklores

NMPB-RCFC Project:

An NMPB-RCFC Project (One year) entitled Production and Distribution of QPMs of Andrographis paniculata, Indigofera tinctoria, Senna alexandrina and Aegle marmelos has sanctioned to promote the medicinal plants cultivation among farmer's clusters. One among the four farmers cluster selected for this project is at the tribal settlement of Palamalai, Salem District.

[Ministry of Tribal Affairs (Tribal Health) OM No. 42/1/2023-THC(e-file No. 26374) dated 2nd July, 2024]

Comments of the Committee

(Please *see* para-44 of Chapter-I of the Report)

Recommendation No.19:

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.

Reply of the Government

Reply: The recommendations are noted for compliance. In this context, the Ministry has launched PM-JANMAN Mission (Pradhan Mantri Janjati Adivasi Nyaya Maha Abhiyan) on 15th November 2023 at Khunti District of Jharkhand which aimed at targeted development of the Particularly Vulnerable Tribal Groups through convergence amongst 9 key Ministries in 11 critical interventions related to their Ministry.

[Ministry of Tribal Affairs (Tribal Health) OM No. 42/1/2023-THC(e-file No. 26374) dated 2nd July, 2024]

Recommendation No.20:

ROLE OF NGOS IN THE WELFARE OF TRIBAL POPULATION

20. Voluntary Organisations (VOs) and Non-Governmental Organisations (NG0s) 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 counts y 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, Anaemia, 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.

Reply of the Government

Reply to (i) to (iii): Under the PMJANMAN, 10 MMUs per district will be allocated in PVTG areas. Deployment of MMUs in the state has been initiated by MoHFW. MoTA will also support the proposals as and when it comes for the PVTG habitation. Ministry is also having an NGO Scheme. The prime objective of the scheme is to supplement the welfare efforts of the Government and fill the gaps in area of education, health, livelihood etc. by developing a participatory and collaborative mechanism with dedicated NGOs, who have capacity to provide quality services for development of tribal population.

MoTA is supporting 79 NGOs in health sector with 10 bedded hospitals and Mobile medical units (MMUs).

[Ministry of Tribal Affairs (Tribal Health) OM No. 42/1/2023-THC(e-file No. 26374) dated 2nd July, 2024]

Recommendation No.21:

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 reiterates 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 utilization 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 ids a v/s 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.

Reply of the Government

Reply to (i) to (iii):

At MoTA for utilization of TSP/STC funds, regular meetings are being conducted for better outcome of various social determinants, in the field of Education Health Livelihood, Skill Development and Nutrition. Further, the expenditure on the various schemes is monitored through a dedicated portal. Further, the PM-JANMAN and the PMAAGY are both schemes which are envisaged to be implemented in a convergence mode with other major Ministries/Departments by utilization of the funds under their respective schemes under STC.

[Ministry of Tribal Affairs (Tribal Health) OM No. 42/1/2023-THC(e-file No. 26374) dated 2nd July, 2024]

Comments of the Committee

(Please *see* para-47 of Chapter-I of the Report)

<u>Recommendation No.22</u>:

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 parameters which fall under the purview of various Ministries. As far as health is concerned, Ministry of Health and Family Welfare and Ministry of MUSH 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 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 anuual common review mission, National Programme Coordination Committee (NPCC) meeting 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 thelack 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 government.

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 inter that unless a tribal women is healthy and free of diseases, at least the ones which could be steered away be 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.

Reply of the Government

Reply to (i) to (iii): The suggestions have been taken note of.

[Ministry of Tribal Affairs (Tribal Health) OM No. 42/1/2023-THC(e-file No. 26374) dated 2nd July, 2024]

Comments of the Committee

(Please *see* para-50 of Chapter-I of the Report)

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CHAPTER III

OBSERVATIONS/RECOMMENDATIONS WHICH THE COMMITTEE DO NOT DESIRE TO PURSUE IN VIEW OF THE REPLIES OF THE GOVERNMENT

Recommendation No.5:

PROMOTING FAMILY PLANNING AND CONTRACEPTION METHODS AMONG TRIBAL

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 contraceptive among tribal Men to burst the myths around male contraception so that family planning responsibility is shared between husband and wife.

Reply of the Government

Reply: The Ministry of Health and Family Welfare has provided the following information:

All Family Planning services are provided across the country universally for all categories of population of caste and tribe. The Government has undertaken following initiatives under the National Family Planning Programme, key amongst which are as follows:

A. Interventions/ Schemes

I. **Expansion of basket of choice:** The current contraceptive basket comprising of Condoms, Combined Oral Contraceptive pills, Emergency contraceptive pills, intra-uterine contraceptive device (IUCDs), and sterilization is expanded with inclusion of new contraceptives namely Injectable Contraceptive MPA (Antara Programme) and Centchroman (Chhaya) in 2016. Government of India has further expanded the basket of choice in the year, 2023 to include two new contraceptives viz. Injectable Contraceptive

MPA (Sub-Cutaneous) and Sub Dermal Contraceptive Implant (single rod) with selected initial introduction in 22 Districts of 10 States respectively.

II. **Mission Parivar Vikas (MPV):** The Government launched Mission Parivar Vikas (MPV) in 2016 for substantially increasing access to family planning services in 146 high fertility Districts with Total Fertility Rate (TFR) of 3 and above in seven high focus States (Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Chhattisgarh, Jharkhand and Assam). In November 2021, the Scheme was extended to remaining districts of the seven high focus States and all Districts of six North Eastern States (Arunachal Pradesh, Manipur, Meghalaya, Tripura, Nagaland and Mizoram), where the modern contraceptive usage is low and unmet need for Family Planning is high. The scheme aims to improve access to contraceptives, generate awareness through promotional schemes like Nayi Pahal Kit, Saas Bahu Sammelan, Saarthi campaign and ensuring commodity security.

   i. **Nayi Pahel Kit:** FP KITs which comprises of basic things for grooming and FP commodities and information leaflets for creating awareness on FP methods are distributed to the newlywed couples.

   ii. **Saas Bahu Sammelan**: Initiative to hold meetings with daughter in law and their mother-in-Law to initiate the dialogue on family Planning.

   iii. **Saarthi Vahan**: Dedicated vehicle for creating awareness on various methods of Family Planning in the MPV States.

III. **Compensation Scheme for Sterilization services:** Under the scheme, MoHFW provides compensation for loss of wages to the beneficiaries on account of undergoing sterilization. The ompensation Scheme was revised in the year 2014 in high focus States, and further in 2016 for the Mission Parivar Vikas States.

IV. **Post-Pregnancy contraception** in the form of Post-Partum Intra-Uterine Contraceptive Device (PPIUCD), Post-Abortion Intrauterine Contraceptive Device (PAIUCD), Post-Partum Sterilization (PPS) and Post Abortion Sterilization (PAS) are provided to beneficiaries.

V. **Home Delivery of Contraceptives Scheme**: ASHAs deliver contraceptives at the doorstep of the beneficiaries.

VI. **Clinical Outreach teams (COT) Scheme:** The scheme has been launched in Mission Parivar Vikas states for providing Family planning services through mobile teams from accredited organizations in far-flung, under-served and geographically difficult areas.

VII. **Drop Back Scheme:** Scheme for ensuring drop back services to sterilization clients.

VIII. **Scheme for ASHAs to ensure spacing in births:** Under the scheme, services of ASHAs are utilized for counselling newly married couples to ensure delay of 2 years in birth after marriage and couples with 1 child to have

spacing of 3 years after the birth of 1st child and couples with up to two children to adopt permanent FP method.

IX. **Installation of Condom Boxes:** Condom boxes are installed at strategic locations in Heath Facilities which can provide twenty-four-hour access to condoms for couples desirous of accessing these in privacy, thereby improving contraceptive access.

X. **Family Planning Logistics Management Information System (FP-LMIS):** The FP-LMIS was launched in 2017 to manage the distribution of contraceptives and strengthen the supply-chain management system in order to reduce stock-outs and overstocks, and improve the program's effectiveness and contraceptive security.

B. <u>IEC in Family Planning</u>:

I. The following are the initiatives taken up:

I. **Family Planning Media Campaign:** A holistic media campaign including for male engagement, is in place to increase awareness for the Family Planning commodities and services.

II. **Observation of World Population Day/ Campaign (27 June – 24 July):** The World Population Day/Campaign is observed as a step to increase awareness & boost Family Planning efforts all over the country.

III. **Observation of Vasectomy Fortnight (November 21-December 4)**: The Vasectomy Fortnight is observed in an effort to increase Male participation and revitalise the NSV (Non Scalpel Vasectomy) services.

IV. **National Family Planning Helpline (Toll Free No. 1800-11-6555):** The National Helpline was launched in 2008, under the Jansankhya Sthirata Kosh (JSK) (an erstwhile autonomous body under MoHFW), for providing reliable, confidential and authentic information on reproductive and child health issues. Since September 2020, the Helpline is approved to 'Go Live' under the aegis of the Ministry of Health & Family Welfare.

C. <u>State Specific Initiatives</u>:

I. **West Bengal**: The state has initiated a week dedicated to reaching out to community for a mass scale awareness on averting of teenage pregnancy. Emphasis is given on reaching out to adolescents for awareness generation on delaying marriage till 18yrs of age and addressing teenage couples to adopt contraceptives and delay pregnancy till 20 years of age. In the Year 2022-23, West Bengal also initiated distribution of Nayi Pahek Kit in the selected Nine Districts in which Teenage Fertility is high. In the Year 2024-25, the state has proposed to extend the initiative to all the Districts of the State.

II. **Andhra Pradesh**: The state has high teenage fertility and has proposed for Nayi Pahel Kits for creating awareness amongst the newly married couples about the contraceptive methods and delaying the pregnancy till 20 years of age.

III. **Bihar:** As part of MPV initiative the state is organizing Saas, Bahu, Beti Samelan since the year 2022-2023 to create awareness amongst the adolescent girls for the teenage pregnancy and FP methods for averting pregnancy till 20 years of age.

IV. **Uttar Pradesh:** The state of Uttar Pradesh has initiated with Mr. Smart Sammelan from 2022-2023 in 18 divisional districts to increase male participation in Family Planning through discussions in community on Family Planning with active participation of male members.

[Ministry of Tribal Affairs (Tribal Health) OM No. 42/1/2023-THC(e-file No. 26374) dated 2nd July, 2024]

Recommendation No.15:

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 resource for health. According to Rural Health Statistics 2020-21 (RHS), there is a shortage of 69 General Duty Medical Officers (GDMOs), 31B6 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 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 tine. It would be in fitness of things, if medicines with long shelf life are supplied tt 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.

Reply of the Government

Reply: It has been stated by the NHM, MoHFW that these flexibilities are already available under NHM. Further, several mechanisms already exist at state level so as to ensure the reach of health professionals to hardship areas, for example, hardship allowance, choice posting, etc.

Further, under NHM, following types of incentives and honorarium are also provided for encouraging specialist doctors to practice in rural and remote areas of the country:

- Hard area allowance to specialist doctors 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.
- Honorarium to Gynecologists/ Emergency Obstetric Care (EmoC) trained, Pediatricians & Anesthetist/ Life Saving Anaesthesia Skills (LSAS) trained doctors is also provided to increase availability of specialists for conducting Cesarean Sections in rural & remote area.
- Incentives like special incentives for doctors, incentive for ANM for ensuring timely ANC checkup and recording, incentives for conducting Adolescent Reproductive and Sexual Health activities.
- States are also allowed to offer negotiable salary to attract specialist including flexibility in strategies such as "You Quote We Pay".
- 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.
- Multi-skilling of doctors is supported under NHM to overcome the shortage of specialists. Skill upgradation of existing HR is another major strategy under NRHM for achieving improvement in health outcomes.

Furthermore, the States must ensure compliance with current PHMC norms as well as IPHS guidelines as revised in 2022.

[Ministry of Tribal Affairs (Tribal Health) OM No. 42/1/2023-THC(e-file No. 26374) dated 2nd July, 2024]

CHAPTER IV

OBSERVATIONS/RECOMMENDATIONS IN RESPECT OF WHICH THE REPLIES OF THE GOVERNMENT HAVE NOT BEEN ACCEPTED BY THE COMMITTEE

Recommendation No.6:

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 (SPS) report by Registrar General of India (RG1). 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 Anaemia 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 wrong the tribal population. The Committee would be apprised about the timelines for the same.

Reply of the Government

Reply: According to information gathered with MoH&FW, the Sample Registration System (SRS) Report of Registrar General of India (RGI), the Maternal Mortality Rate (MMR) has reduced from 8.1 in 2015-17 to 7.3 in 2016-18 at National Level. The Status of MMR at National level and State level as per SRS 2015-17 and 2016-18 are as follows:

Status of Maternal Mortality Rate (MMR)		
India/ States	**2015-17**	**2016-18**
ALL INDIA	**8.1**	**7.3**
Andhra Pradesh	3.6	3.6
Assam	15.2	14.0
Bihar	16.9	15.1
Jharkhand	6.1	5.6
Gujarat	6.0	5.1
Haryana	7.7	7.0
Karnataka	7.3	4.9
Kerala	1.9	2.1
Madhya Pradesh	17.5	15.9
Chhattisgarh	11.0	12.1
Maharashtra	3.3	2.6
Odisha	11.1	9.7
Punjab	6.8	7.0
Rajasthan	16.8	14.5
Tamil Nadu	4.8	3.2
Telangana	3.8	3.6
Uttar Pradesh	20.1	17.8
Uttarakhand	5.9	6.4
West Bengal	5.0	5.0
Other States	4.7	4.5
Source: Sample Registration System (SRS) of Registrar General of India (RGI)		

In order to bring down Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR), the Ministry of Health and Family Welfare (MoHFW) is supporting all States/UTs in implementation of Reproductive, Maternal, New-born, Child, Adolescent health and Nutrition (RMNCAH+N)

strategy under National Health Mission (NHM) based on the Annual Program Implementation Plan (APIP) submitted by States/ UTs. The interventions taken up by Govt. are:

Interventions for improving Maternal Mortality Rate (MMR):

- **Janani Suraksha Yojana (JSY),** a demand promotion and conditional cash transfer scheme was launched in April 2005 with the objective of reducing Maternal and Infant Mortality by promoting institutional delivery among pregnant women.
- **Janani Shishu Suraksha Karyakram (JSSK)** aims to eliminate out-of-pocket expenses for pregnant women and sick infants by entitling them to free delivery including caesarean section, free transport, diagnostics, medicines, other consumables, diet and blood in public health institutions.
- **Surakshit Matratva Ashwasan (SUMAN)** aims 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 to end all preventable maternal and newborn deaths.
- **Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)** provides pregnant women fixed day, free of cost assured and quality Antenatal Care on the 9thday of every month.
- **LaQshya** aims to improve the quality of care in labour room and maternity operation theatres to ensure that pregnant women receive respectful and quality care during delivery and immediate post-partum period.
- **Comprehensive Abortion Care services** are strengthened through training of health care providers, supply of drugs, equipment, Information Education and Communication (IEC) etc.
- **Midwifery programme** is launched to create a cadre for Nurse Practitioners in Midwifery who are skilled in accordance with International Confederation of Midwives (ICM) competencies and capable of providing compassionate women-centred, reproductive, maternal and new-born health care services.
- **Delivery Points:** Over 25,000 'Delivery Points' across the country are strengthened in terms of infrastructure, equipment, and trained manpower for provision of comprehensive RMNCAH+N services.
- Functionalization of **First Referral Units (FRUs)** by ensuring manpower, blood storage units, referral linkages etc.
- Setting up of **Maternal and Child Health (MCH) Wings** at high caseload facilities to improve the quality of care provided to mothers and children.
- Operationalization of **Obstetric ICU/HDU** at high case load tertiary care facilities across country to handle complicated pregnancies.
- **Capacity building** is undertaken for MBBS doctors in Anesthesia (LSAS) and Obstetric Care including C-section (EmOC) skills to overcome the shortage of specialists in these disciplines, particularly in rural areas.

- **Maternal Death Surveillance Review** (MDSR) is implemented both at facilities and at the community level. The purpose is to take corrective action at appropriate levels and improve the quality of obstetric care.
- Monthly **Village Health, Sanitation and Nutrition Day (VHSND)** is an outreach activity for provision of maternal and child care including nutrition.
- Regular IEC/BCC activities are conducted for early registration of ANC, regular ANC, institutional delivery, nutrition, and care during pregnancy etc.
- **Mother and Child Protection (MCP) Card and Safe Motherhood Booklet** are distributed to the pregnant women for educating them on diet, rest, danger signs of pregnancy, benefit schemes and institutional deliveries.

Ministry of Tribal Affairs in association with Ministry of Health & M/o.WCD occasionally organizes awareness programmes in the regional languages to make them aware about severe Anaemia, sickle cell Anaemia, Nutrition, TB, reproductive health & Hygiene, which helps in reducing MMR gradually. IEC activities along with the health camps are being organized in the states to overcome the issue of MMR. Poshan Abhiyaan along with TRIFED are being organized to sensitize VDVKs run by tribal women for Nutrition on the occasions of Poshan Maah and Poshan Pakhwada.

[Ministry of Tribal Affairs (Tribal Health) OM No. 42/1/2023-THC(e-file No. 26374) dated 2nd July, 2024]

Comments of the Committee

(Please *see* para-20 of Chapter-I of the Report)

<u>Recommendation No.13</u>:

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 women 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 (NA) 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 Chhattisgarh 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.1 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 it 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 from1 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 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.

Reply of the Government

Reply: The NHM (MoHFW) has provided the following comments –

• The Record of Proceedings of NPCC (RoP of NPCC) imposes important conditions when approving funds for ambulance services.
• The states are required to closely monitor functionality, maintain records of upkeep, and obtain monthly reports from service providers.
• Additionally, the MoHFW guidelines on Grievance Redressal & Health Helpline facilitates a structured process for registering and resolving grievances, although its implementation varies across states.
• The proposal to reconsider population norms for ambulance allocation is a crucial policy decision that warrants careful deliberation at the Mission Steering Group (MSG) level. This decision needs to take into account the performance of existing ambulance services and the specific requirements or requests put forth by the States.

[Ministry of Tribal Affairs (Tribal Health) OM No. 42/1/2023-THC(e-file No. 26374) dated 2nd July, 2024]

Comments of the Committee

(Please *see* para-32 of Chapter-I of the Report)

<u>Recommendation No.14</u>:

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 MU 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.

Reply of the Government

Reply: It has been stated by the NHM (MoHFW) that the implementation of Health and Wellness Centers marks a significant step towards strengthening healthcare provision to the most remote areas. MMUs continue to hold relevance for areas that are remote, inaccessible, or challenging to reach, where Health and Wellness Centers may not be adequate. However, States needs to ensure provisions of high quality services through adequate and appropriate HR in these MMUs. Any future expansion of MMUs should be carefully assessed in light of the increasing coverage of Health and Wellness Centers and the overarching objective of ensuring healthcare access for everyone.

[Ministry of Tribal Affairs (Tribal Health) OM No. 42/1/2023-THC(e-file No. 26374) dated 2nd July, 2024]

Comments of the Committee

(Please *see* para-35 of Chapter-I of the Report)

Recommendation No.17:

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 Ministry of Tribal Affairs there are provisions for providing traditional tribal systems of medicine facilities along with Ayuveda 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 of 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 healer into the public health system and apprise the Committee about the same.

Reply of the Government

Reply : NHM (MoH&FW) stated that under AAM, initiatives are already being taken to build synergy and integration of the traditional systems of medicine, particularly Ayurveda and Yoga, with the public health system, especially with Health Promotion – preventive and promotive – interventions.

Action taken:

- Free Siddha Medical Camp under Swasthya Rakshaan Programme was conducted for the Kaani Tribals. Every month Free Siddha Medical Camp will be organized at the Kaani Tribal Settlement with the help of KalakadMundanthurai Tiger Reserve officials. Free Siddha Consultation and Free medicine was given to the tribal people and documented.

- As per the direction from Ministry of Ayush, all the peripheral institutes/units of Central Council for Research in Siddha (CCRS, Chennai) observed Janjatiya Gaurav Diwas from 15-11-2023 to 26-11-2023 inclusive of medical consultation, blood examination and distribution of medicine

[Ministry of Tribal Affairs (Tribal Health) OM No. 42/1/2023-THC(e-file No. 26374) dated 2nd July, 2024]

Comments of the Committee

(Please *see* para-41 of Chapter-I of the Report)

CHAPTER V

OBSERVATION/RECOMMENDATIONS IN RESPECT OF WHICH THE GOVERNMENT HAVE FURNISHED INTERIM REPLIES

—----------NIL—----------

NEW DELHI; **Dr. D. PURANDESWARI,**

30 July , 2025 **CHAIRPERSON,**

08 Shravana , 1947 (Saka) **COMMITTEE ON EMPOWERMENT OF WOMEN**

Annexure-I

The details of incentives for routine and recurring activities given to ASHAs (Refer to Para 37 of Chapter I of the Report)

S. No.	Incentives	Incentives (from September, 2018)
1	Mobilizing and attending Village Health and Nutrition Days or Urban Health and Nutrition Days	Rs.200/session
2	Conveying and guiding monthly meeting of VHSNC/MAS	Rs. 150
3	Attending monthly meeting at Block PHC/UPHC	Rs. 150
4	Line listing of households done at beginning of the year and updated every six months	Rs. 300
	Maintaining village health register and supporting universal registration of births and deaths to be updated on the monthly basis	Rs. 300
	Preparation of due list of children to be immunized on monthly basis	Rs. 300
	Preparation of list of ANC beneficiaries to be updated on monthly basis	Rs. 300
	Preparation of list of eligible couple on monthly basis	Rs. 300
	Total	**Rs. 2000/-**

Annexure-II

Details of performance-based incentives for a varied set of activities under various National Health Programmes

(Refer to Para 37 of Chapter I of the Report)

	Activities	**Amount in Rs/case**
I	**Maternal Health**	
1	JSY financial package	
a.	For ensuring antenatal care for the woman	Rs.300/Rs.200 (Rural/Urban areas)
b.	For facilitating institutional delivery	Rs. 300/Rs.200 (Rural/Urban areas)
2	Reporting Death of women	Rs. 200 (reporting within 24 hours)
3	For prompt identification and referral of post-natal mother with danger signs during HBNC visits, and after confirmation of a healthy outcome for both mother & the baby after 45thday of delivery	Rs. 250/ per high risk mother
II	**Child Health**	
1	Home Visit-care of the New Born and Post-Partum mother etc.	Rs. 250 /-
2	Quarterly home visit to young infants (up to 15 months) under Home Base Care of Young Child (HBYC) programme	Rs 50/- per visit
3	Referral of SAM children to NRC and follow up of SAM children after discharge from NRC.	Rs. 100/- per child for referring SAM child with medical complication to NRCs Rs. 150/- per child for follow up visits of SAM children discharged from NRC, ASHA incentive (Rs 50 per visit for 1st and 4th visit and Rs 25 per visit for 2nd and 3rd visit). Additional incentive of Rs. 50/- per SAM child for ASHA in case child is declared free of SAM status after completion of all follow ups.

2	**Intensified Diarrhoea Control Fortnight**	
a.	Week-1-ASHA incentive for prophylactic distribution of ORS to families with under-five children	Rs. 1 per ORS packet for 100 under five children
b.	Week-2- ASHA incentive for facilitating growth monitoring of all children in village	Rs. 100 per ASHA for completing at least 80% of household
c.	MAA (Mother's Absolute Affection) Programme	Rs. 100/ASHA/ Quarterly meeting
III	**Immunization**	
1	Full immunization for a child under one year/ up-to two years age	Rs. 100 /Rs. 75
2	Mobilizing children for OPV immunization / DPT Booster	Rs. 100 per day / Rs. 50
IV	**Family Planning**	
1	Ensuring spacing of 2 years/ 3 years after birth of 1st child / permanent limiting method after 2 children after marriage	Rs. 500 / Rs. 500 / Rs. 1000
2	Counselling, motivating and follow up of the cases for Tubectomy	Rs. 200 in 11 with high fertility rates states, Rs.300 in 146 MPV districts, Rs. 150/Rs200 in remaining states
3	Counselling, motivating and follow up of the cases for Vasectomy and NSV and Female Postpartum sterilization	Rs. 300 in 11 states with high fertility rates and Rs. 400 in 146 MPV districts and Rs. 200 in remaining states
Mission Parivar Vikas- In selected 146 districts in six states-(57 in UP, 37 in Bihar, 14 RJS, 9 in Jharkhand, 02 in Chhattisgarh and 2 in Assam)		
4	Injectable Contraceptive MPA (Antara Program) and a non-hormonal weekly centchroman pill (Chhaya) - Incentive to ASHA	Rs. 100 per dose
5	Mission ParivarVikas Campaigns Block level activities	Rs. 150/ ASHA/round

6	NayiPahel - an FP kit for newly weds	Rs. 100/ASHA/NayiPahel kit distribution
7	SaasBahuSammelan- mobilize SaasBahu for the Sammelan- maximum four rounds	Rs. 100/ per meeting
8	Updating of EC survey before each MPV campaign	Rs.150/ASHA/Quarterly round
V	**Adolescent Health**	
1	Sanitary napkins to adolescent girls	Rs. 1/ pack of 6 sanitary napkins
2	Organizing monthly meeting with adolescent girls pertaining to Menstrual Hygiene	Rs. 50/meeting
3	Conducting PLA meetings- 2 meetings per month	Rs. 100/ASHA/per meeting
VI	**Revised National Tuberculosis Control Programme**	
1	For Category I/Category II of TB patients (New cases/ previously treated of Tuberculosis)	Rs. 1000 for 42 contacts / Rs. 1500 for 57 contacts
2	For treatment and support to drug resistant TB patients	Rs. 5000 for completed course of treatment
3	For notification if suspect referred is diagnosed to be TB patient by MO/Lab	Rs.100
4	Provision of Incentive to ASHAs or Community Volunteers for ensuring seeding of bank account details of notified TB patients in Ni-kshayportal within 15 days of treatment initiation for enabling DBT Payments under the National Tuberculosis Elimination Programme (NTEP).	Rs. 50/- per patient
5	Provision to incentive to ASHA / Community Health Volunteer for supporting treatment adherence and completion of TB Preventive Treatment among eligible individuals	Rs. 250/- per individual for successful completion of TB Preventive Treatment.

6	Mobilization of beneficiary through ASHA or other mobilizer for additional adult BCG beneficiaries –per session	Rs. 150/- Per case
7	ASHA incentive for due list preparation (for monthly updating of due list of beneficiaries for adult BCG Vaccination) @ Rs. 100/months for 3 months (if mop-up is required)	Rs 100/-
8	ASHA incentive for house-to-house survey before the campaign Rs. 100/- once during the campaign	Rs. 100/-
VII	**National Leprosy Eradication Programme**	
1	Treatment in pauci-bacillary cases /multi-bacillary cases of Leprosy - for 33 states (except Goa, Chandigarh &Puducherry).	Rs. 250 (for diagnosis) + Rs. 400/Rs.600 (for follow up)
VIII	**National Vector Borne Disease Control Programme**	
1	Malaria–Preparing Blood Slides/complete treatment for RDT or radical treatment of positive Pf cases	Rs. 15 per slide/ Rs. 200 per positive cases
2	Lymphatic Filariasis-Listing of cases	Rs. 200
3	Acute Encephalitis Syndrome/Japanese Encephalitis	
	Referral of AES/JE cases to the nearest CHC/DH/Medical College	Rs. 300 per case
4	Kala Azar elimination	
	Involvement of ASHAs during the spray rounds (IRS) / for referring a suspected case	Rs. 100/- per round / Rs. 500/per notified case
	Provision of incentive to ASHAs for referring Post Kala-Azar Dermal Leishmaniasis (PKDL) case detection	Rs. 500/. per case

	and complete treatment in all 4 Kala-azar endemic states.	(Rs. 200/- at the time of diagnosis and Rs. 300/- after treatment completion)
5	Dengue and Chikungunya	
	Incentive for source reduction & IEC activities for prevention and control of Dengue and Chikungunya in 12 High endemic States.	Rs. 200/- (1 Rupee /House for maximum 200 houses PM for 05 months- during peak season).
6	National Iodine Deficiency Disorders Control Programme	
	ASHA incentive for salt testing	Rs.25/ month (for 50 salt samples)
IX	**Incentives under (CPHC) and Universal NCDs Screening**	
1	Maintaining data validation and collection of additional information	Rs. 5/form/family
2	Filling up of CBAC forms of every individual	Rs. 10/per form/per individual
3	Follow up of patients	Rs. 50/per case/Bi-Annual
4	Delivery of new service packages under CPHC	Rs.1000/ASHA/PM
X	**Drinking water and sanitation**	
1	Motivating Households to construct toilet and promote the use of toilets and for individual tap connections	Rs. 75/ per household
XI	**Certification**	
1	Provision of a cash award to ASHAs and ASHA Facilitators who have successfully been certified in two independent certificates. RMNCHA+N Expanded package of new services from Non-Communicable Diseases to Palliative Care	Rs. 5000/- for each certification
XII	**Creation of ABHA IDs**	

	Provision of incentives for ASHAs for facilitating creation and seeding of ABHA ID in various IT Portals of MoHFW such as CPHC NCD Portal and RCH Portal etc	Rs. 10/- for each ABHA account created and seeded

Annexure-III

State-wise details of monetary incentives provided to the ASHAs
(Refer to Para 37 of Chapter I of the Report)

Sl. No.	Name of States	State Specific Incentives for ASHAs from State Funds
1	Andhra Pradesh	Provides balance amount to match the total incentive of Rs.10, 000/PM/ASHA
2	Arunachal Pradesh	100% top-up, frequency of disbursement quarterly
3	Assam	Rs.1000/PM/ASHA from FY 2018-2019
4	Bihar	Rs. 1000/PM/ASHA for defined indicators related to Immunization, Child Health, Maternal Health, and Family Planning, etc. (for achieving any four out of the six defined indicators)
5	Chhattisgarh	75% of matching- amount of incentives over the above incentives earned by an ASHA as a top-up on an annual
6	Delhi	Rs.3000/PM/ASHA for functional ASHA (against the 12 core activities performed by ASHA)
7	Gujarat	Provides 50% top-up - frequency of disbursement quarterly
8	Haryana	Rs.4000/PM/ASHA and 50% top-up (Excluding Routine recurring incentive) and Rs. 450/- additional linked with performance of 05 Major RCH activities
9	Himachal Pradesh	Rs.2750/PM/ASHA
10	Kerala	Rs.6000/PM/ASHA
11	Karnataka	Rs.5000/PM/ASHA
12	Manipur	Rs. 1000/PM/ASHA recently declared by state FY 2021-22- modalities of payment still to be finalized
13	Madhya Pradesh	100% against 07 specified activities (JSY, HBNC, LBW & SNCU Follow-ups, Iron Sucrose follow-ups of anaemic PW, Early Registration of PW, Full Immunization and Complete Immunization)
14	Meghalaya	Rs.2000/PM/ASHA
15	Maharashtra	Rs.3500/PM/ASHA from FY 2021-22
16	Odisha	Rs.1000 /PM/ASHA from state fund launched on April 1st, 2018
17	Punjab	Rs. 2500/PM/ASHA
18	Rajasthan	Rs. 3564/PM/ASHA
19	Sikkim	Rs. 6000/PM/ASHA
20	Tripura	Provides 100% top-up against 08 specified activities and 33.33% top-up based on other activities.
21	Telangana	Provides balance amount to match the total incentive of Rs. 7500/month
22	Uttarakhand	Rs.5000/year and Rs. 3000/PM/ASHA with 10% top-up

23	Uttar Pradesh	Rs.1500/PM/ASHA linked with proportion of routine incentives to be paid to the ASHAs in the month
24	West Bengal	Rs.4500/PM/ASHA

Annexure – IV

List of 182 Tribal Districts With API in 2023 (Refer to Para 9 of Chapter II of the Report)			
Sl. No	**States/UTs**	**Districts**	**API**
1	Andaman & Nicobar Islands (1)	Nicobar	0.77
2	Andhra Pradesh (3)	Vishakhapatanam	0.05
3		East Godavari	0.00
4		West Godavari	0.00
5	Arunachal Pradesh (16)	Anjaw	0.00
6		Changlang	0.01
7		Dibang Valley	0.00
8		East Kameng	0.00
9		East Siang	0.00
10		Kurung Kumey	0.00
11		Lohit	0.03
12		Lower Dibang Valley	0.05
13		Lower Subansiri	0.00
14		Papum Pare	0.01
15		Tawang	0.00
16		Triap	0.02
17		Upper Siang	0.00
18		Upper Subansiri	0.00
19		West Kameng	0.00
20		West Siang	0.00
21	Assam (7)	Baksa	0.01
22		Chirang	0.09
23		Dhemaji	0.01
24		Dima Hasao	0.02
25		Karbi Anglong	0.00
26		Kokrajhar	0.24
27		Udalguri	0.04
28	Bihar (6)	Aurangabad	0.02
29		Banka	0.02
30		Gaya	0.01
31		Jamui	0.01
32		Muzzafarpur	0.00
33		Nawada	0.05
34	Chhattisgarh (19)	Balod	0.21

35		Balrampur	0.03
36		Bastar	3.81
37		Bijapur	30.83
38		Dentewada	25.67
39		Dhamtari	0.35
40		Gariyaband	1.03
41		Jashpur	0.31
42		Kanker	1.01
43		Kondagaon	2.65
44		Korba	0.09
45		Koriya	0.05
46		Mahasamund	0.03
47		Narayanpur	13.35
48		Raigarh	0.10
49		Rajnandgaon	0.08
50		Sukma	6.51
51		Surajpur	0.02
52		Surguja	0.04
53	Dadar & Nagar Haveli (1)	Dadar & Nagar Haveli	0.16
54	Gujarat (10)	Bharuch	0.02
55		Chhota Udepur	0.01
56		Dahod	0.00
57		Mahisagar	0.02
58		Narmada	0.03
59		Navsari	0.04
60		Panchmahal	0.05
61		Tapi	0.02
62		The Dangs	0.04
63		Valsad	0.01
64	Himachal Pradesh (3)	Chamba	0.00
65		Kinnaur	0.00
66		Lahul & Spiti	0.00
67	Jammu & Kashmir (5)	Kargil	0.03
68		Leh (Ladakh)	0.04
69		Punch	0.01
70		Rajouri	0.01
71		Reasi	0.00
72	Jharkhand (20)	Bokaro	0.03
73		Chatra	0.09
74		Dumka	0.03

75		Garhwa	0.10
76		Giridih	0.07
77		Gumla	0.19
78		Hazaribagh	0.16
79		Jamtara	0.01
80		Khunti	1.15
81		Latehar	0.50
82		Lohardaga	0.41
83		Pakur	3.50
84		Palamu	0.10
85		Pashchimi Singhbum	8.76
86		Purbi Singhbhum	0.90
87		Ramgarh	0.04
88		Ranchi	0.04
89		Sahibganj	0.24
90		Saraikela Kharsawan	0.68
91		Simdega	0.27
92	Lakshadweep (1)	Lakshadweep	0.00
93	Madhya Pradesh (19)	Alirajpur	0.05
94		Anuppur	0.02
95		Barwani	0.00
96		Betul	0.00
97		Burhanpur	0.00
98		Chhindwara	0.04
99		Dhar	0.01
100		Dindori	0.03
101		Harda	0.00
102		Jhabua	0.03
103		Khandwa (East Nimar)	0.00
104		Khargone (West Nimar)	0.00
105		Mandla	0.05
106		Ratlam	0.01
107		Seoni	0.07
108		Shahdol	0.01
109		Sidhi	0.04
110		Singrauli	0.05
111		Umaria	0.01
112	Maharashtra (5)	Dhule	0.00
113		Gadchiroli	4.96
114		Nandurbar	0.00

115		Nashik	0.00
116		Palghar	0.02
117	Manipur (5)	Chandel	0.00
118		Churachandpur	0.02
119		Senapati	0.01
120		Tamenglong	0.00
121		Ukhrul	0.01
122	Meghalaya (7)	East Garo Hills	0.64
123		East Khasi Hills	0.02
124		Jainta Hills	0.02
125		Raibhoi	0.01
126		South Garo Hills	7.41
127		West Garo Hills	0.13
128		West Khasi Hills	0.93
129	Mizoram (8)	Aizwal	0.21
130		Champhai	0.29
131		Kolasib	0.31
132		Lawngtlai	56.22
133		Lunglei	28.02
134		Mamit	33.21
135		Saiha	24.36
136		Serchhip	0.69
137	Nagaland (11)	Dimapur	0.01
138		Kiphire	0.00
139		Kohima	0.00
140		Longleng	0.00
141		Mokokchung	0.01
142		Mon	0.00
143		Peren	0.01
144		Phek	0.00
145		Tuensang	0.00
146		Wokha	0.01
147		Zunheboto	0.01
148	Odisha (14)	Debagarh	0.10
149		Gajapati	1.21
150		Jharsuguda	0.07
151		Kalahandi	4.24
152		Kandhamal	6.00
153		Kendujhar	0.13
154		Koraput	4.51

155		Malkangiri	5.52
156		Mayurbhanj	0.36
157		Nabarangapur	0.48
158		Naupada	0.32
159		Rayagada	8.89
160		Sambalpur	0.15
161		Sundargarh	0.65
162	Rajasthan (6)	Banswara	0.01
163		Dausa	0.01
164		Dungarpur	0.01
165		Pratapgarh	0.09
166		Sirohi	0.01
167		Udaipur	0.08
168	Sikkim (4)	East District (Gangtok)	0.05
169		North District (Mangan)	0.00
170		South District (Namchi)	0.00
171		West District (Gyalshing)	0.00
172	Telangana (4)	Khammam	0.00
173		Kothagudem (Badradri)	0.16
174		Mahabubabad	0.00
175		Mulugu	0.12
176	Tripura (5)	Dhalai	31.19
177		Gomati	3.12
178		Khowai	4.05
179		North Tripura	1.32
180		South Tripura	7.19
181	West Bengal (2)	Alipurduar	0.02
182		Darjiling	0.02

It is also desirable from the M/o TA, H&FW to reply specifically in regard to Recommendation 9(iii) for treatment of leprosy under Ayushman Bharat initiative for complete elimination of leprosy from amongst tribal population.

APPENDIX I

(Vide Para 3 of the Introduction)

COMMITTEE ON EMPOWERMENT OF WOMEN (2025-2026)

MINUTES OF THE EIGHT SITTING OF THE COMMITTEE HELD ON TUESDAY,21st July, 2025

The Committee sat from 1500 hrs. to 1700 hrs. in Committee Room No. '02', Ground Floor, Block - A, Extension Parliament House Annexe, New Delhi.

PRESENT

Dr. D. Purandeswari - **Chairperson**

MEMBERS

LOK SABHA

1. Smt. Lovely Anand
2. Smt. D. K. Aruna
3. Smt. Shobhanaben Mahendrasinh Baraiya
4. Ms. Iqra Choudhary
5. Smt. Kriti Devi Debbbarman
6. Dr. Kadiyam Kavya
7. Smt. Jyotsna Charandas Mahant
8. Smt. Mahima Kumari Mewar
9. Km. Sudha R.
10. Dr Rani Srikumar
11. Smt. Smita Uday Wagh

RAJYA SABHA

12. Dr. Sangeeta Balwant
13. Ms. Swati Maliwal
14. Smt. Sudha Murty
15. Smt. Maya Naroliya
16. Smt. Rajani Ashokrao Patil
17. Smt. Sadhna Singh

SECRETARIAT

1. Smt Jyochnamayi Sinha - Joint Secretary
2. Smt. Neena Juneja - Director
3. Shri Sreekanth S. - Deputy Secretary

At the outset, the Chairperson welcomed the Members to the sitting of the Committee:-

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2. The Committee then took the following draft report for consideration:-

   (i) Draft Action Report of the Committee on the action taken by the Government on the recommendations contained in their 7th Report(17th Lok Sabha) on the Subject " Health Facilities for Tribal Women"

3. After some deliberations, the Committee adopted the Report without modification and authorized the Chairperson to finalize the draft Report and present the same to both the Houses of Parliament.

4. A verbatim record of the sitting of the Committee has been kept.

The Committee then adjourned.

APPENDIX II

(Vide Para 4 of the Introduction)

ANALYSIS OF ACTION TAKEN BY GOVERNMENT ON THE RECOMMENDATIONS CONTAINED IN THE SEVENTH REPORT (SEVENTEENTH LOK SABHA) OF THE COMMITTEE ON EMPOWERMENT OF WOMEN (2022-2023) ON 'HEALTH FACILITIES FOR TRIBAL WOMEN.

(i) Total Number of Recommendations……**22**

(ii) Observations/Recommendations which have been accepted by the Government: Recommendation Para Nos: **1,2,3,4,7,8,9, 10,11,12,16, 18, 19,20,21 and 22**

Total: 16

Percentage:72%

(iii) Observations/Recommendations which the Committee do not desire to pursue in view of the replies of the Government: Recommendations Para Nos.: **5 and 15**

Total : 02

Percentage: 9%

(iv) Observations/Recommendations in respect of which replies of the Government have not been accepted by the Committee and which require reiteration:

Recommendation Para Nos: **6,13,14 and 17**

Total :04

Percentage: 18%

(v) Observation/Recommendations in respect of which the Government have furnished interim replies :

Recommendation Para Nos: **NIL**

Total : Nil

Percentage: 0%