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REPORT OF THE EXPERT COMMITTEE ON TRIBAL HEALTH

Tribal Health in India

Bridging the Gap and a Roadmap for the Future

Policy Brief

Ministry of Health and Family Welfare
Government of India

&

Ministry of Tribal Affairs
Government of India

Report of the Expert Committee on Tribal Health

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Bridging the Gap and a Roadmap for the Future

1. Why the Committee?

- Over 104 million tribal people live in India. Spread across 705 tribes, they account for 8.6% of the country's population. Tribal people have remained marginal – geographically, socio-economically, politically, and therefore, in the national psyche. Health and healthcare in tribal areas remained unsolved problems.
- But how would the nation know? No separate data on tribal health were maintained. That permitted a blissful unawareness of tribal health. Government of India recognized that sixty six years after independence and after eleven five year plans, we need to view tribal people's health as a serious and special concern.
- This committee, the first such endeavour, was constituted to answer two questions 1) What is the present status of health and health care in tribal areas and why the gap? 2) What should be the roadmap for the future to bridge this gap rapidly ?
- The Ministry of Health and Family Welfare (MoHFW) and the Ministry of Tribal Affairs (MoTA), in October 2013, jointly constituted the **Expert Committee on Tribal Health**, under the Chairmanship of **Dr Abhay Bang**. It had as its members prominent academicians, civil society members and policy makers who have long been working with the tribal people.
- This probably is the first such comprehensive report on tribal health in India.

2. The Present Status of Tribal Health and Health Care in India

2.1. Where are the tribal people located?

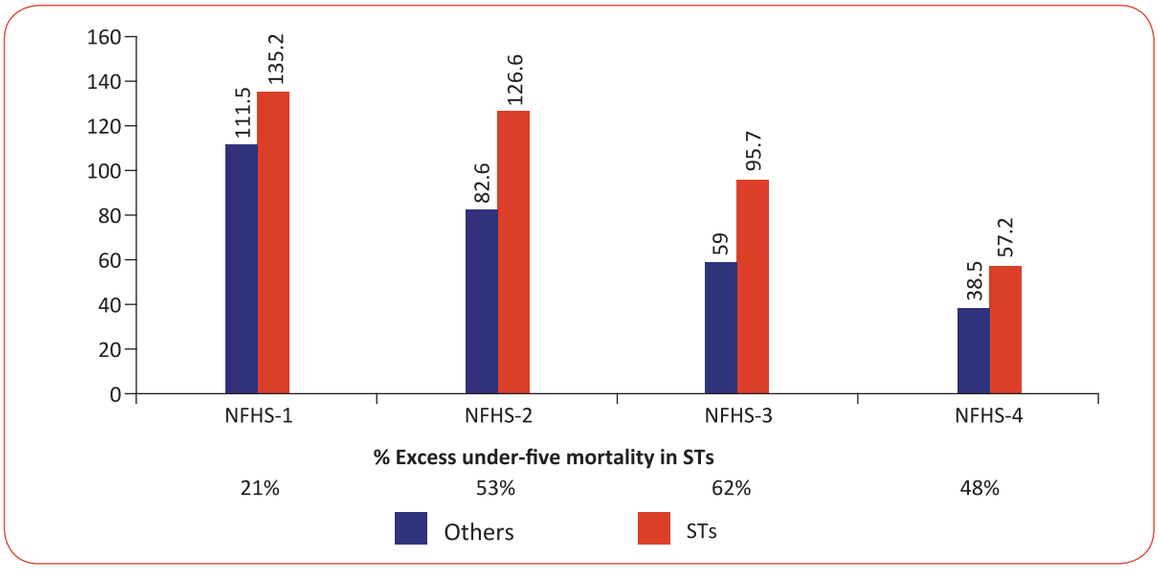
The 104 million tribal people in India are largely concentrated in ten states and in the North-East. Almost 90% of the tribal population of the country lives in rural areas. There are 90 districts or 809 blocks with more than 50% tribal population and they account for nearly 45% of the ST population in the country. In other words, almost 55% of the tribal population lives outside these 809 tribal majority blocks. They too need attention.

Tribal people rank lowest on various economic and educational indicators and on access to social amenities.

2.2. Child Mortality:

- The time trend analysis (NFHS 1 to 4) shows that the tribal IMR over the period of 26 years (1988 – 2014) has halved, reduced from 90 to 44. This is certainly a major improvement.
- However the gap with the favourable social groups has widened from 10% to 38%.
- The under-five mortality rate (U5 MR) shows a 58 % reduction in tribal areas, from 135 (in 1988) to 57 (in 2014). However, the excess of under-five mortality in Scheduled Tribes (ST) when compared to others has widened from 21% to 48 % (Fig.1). As late as in 2014, in some of the

Figure 1: Comparison of Under-five mortality in STs and Others* during past 25 years



* Others comparise the population excluding STs, SCs and OBCs.

states with large ST population, the ST U5MR was two to three times higher than in others.

- As late as 2011, estimated 146,000 under-five tribal child deaths occurred annually in India, (estimated on the basis of NFHS and the Census 2011).

2.3. Disease Burden:

The tribal population in the country faces a triple burden of diseases. While malnutrition and communicable diseases like malaria and tuberculosis continue to be rampant, rapid urbanization, environmental distress and changing lifestyles have resulted in a rise in the prevalence of non-communicable diseases like cancer, hypertension and diabetes. To add to this is the third burden of mental illnesses, especially the addiction.

Malaria: Although tribal communities constitute only about 8% of the national population, they account for about 30% of all cases of malaria, more than 60% of P. falciparum, and as much as 50% of the mortality associated with malaria. This results in an economic burden of staggering Rs. 6000 crores per year.

Tuberculosis: The estimated prevalence of pulmonary Tuberculosis in tribal community is significantly higher than rest of the country- 703 against 256 per 100,000.

Evidence of an early **epidemiologic transition** in tribal areas and associated increase in the incidence of non-communicable diseases is being observed. One out of every four tribal adults suffer from **hypertension**

2.4. Malnutrition:

The percentage of ST children underweight has reduced from 54.5% in NFHS-3 (2005-6) to 42% in NFHS-4 (2015-16) However, compared to other social groups, tribal children continue to be the most malnourished. The prevalence of underweight is almost one and half times in tribal children than in the 'other' castes.

Time and again, **episodes of increased malnutrition and child deaths** are reported in tribal pockets (Melghat, Nandurbar, Thane) by the media and in the state legislatures.

Paradox of tribal nutrition

1. Malnutrition (stunting among children, and low BMI among adults) in tribal people is more than among the non-tribal population, and is unacceptably high.
2. The food intake and the intake of various nutrients such as proteins, calories, vitamins have decreased in the last decade in the tribal population.

3. Yet, the prevalence of clinical malnutrition in children or low BMI in adults has, to some extent decreased in a decade, probably because of reduced physical activity, and decrease in nutritional wastage due to infections.

2.5. Mental Health and Addictions:

Almost 72% of the tribal men in the 15-54 years age group use tobacco as compared to 56% non-tribal men. Slightly above half of ST men consume some form of alcohol at the national level. This is higher than the consumption among non-ST men (30%).

3. Healthcare Seeking

Nearly 50 percent of the outpatient visits by tribal people are to public health institutions and more than two third of the indoor hospitalization of tribal population is in government health services. These proportions in 'other' caste group are 18.5% and 34.5% respectively. Thus, tribal people, when they seek external health care, they heavily depend on public health care. What it does signal is the need to strengthen public health facilities in tribal areas and to ensure that these facilities are run by qualified and sensitive health functionaries who treat the tribal people with respect. Unfortunately such is not the case.

3.1. Health Care Infrastructure: TBA

In nearly half of the states the healthcare institutions in tribal areas were deficient in numbers as compared to the present norms – subcentres by 27%, PHCs by 40% and CHCs by 31%.

3.2. Human Resources for Health:

i. The situation is summarized in the Fig 2.

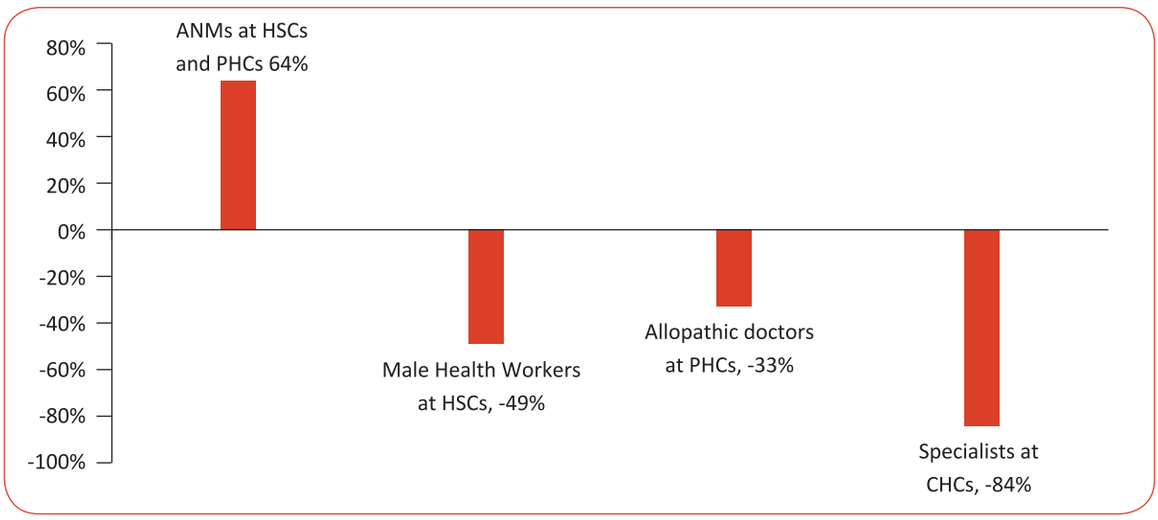
ii. This paradox of the huge number of vacant posts of doctors and specialists in the PHCs and CHCs in tribal areas, and the non-enforcement of service bond on the 90% doctors is surprising and tragic!

iii. There is powerful evidence that ASHA is a very appropriate, feasible and effective way of bridging some of the health care gap in tribal areas. Yet, this committee in its visits to tribal states found either the lack of appreciation of this fact or inability to manage this solution in the State Health Missions.

3.3. Planning and Finances:

i. Lack of population level data and near absence of local tribal communities in the agenda setting and implementation of health programmes are some of the key challenges in the planning process.

Figure 2: Human Resources for Health % Surplus/deficit in tribal areas of ten states*



Source: *Calculations based on the RHS data 2017*

* Ten states with sizeable ST population – Andhra Pradesh, Chhattisgarh, Gujarat, Himachal Pradesh, Jammu and Kashmir, Jharkhand, Madhya Pradesh, Maharashtra, Odisha and Rajasthan.

ii. The Departments of Health & Family Welfare are required to earmark a proportion of their Plan Outlays for the tribal sub-plan. However, only seven states had allocated money for health under the TSP. None of these seven states followed the guideline of earmarking funds under TSP from the outlays, at least in proportion to the percentage of ST population in the State.

4. Diagnosis of Tribal Health

Tribal health in India suffers from following ten burdens:

1. Communicable diseases, maternal and child health problems and malnutrition continue to prevail;
2. Non-communicable diseases including mental stress and addiction are rapidly increasing.
3. Injuries due to accidents, snake and animal bites and violence in conflict situations;
4. Difficult natural conditions arising due to geographic terrain, distances and harsh environments;
5. Worse social-economic determinants, especially in education, income, housing, connectivity, water and sanitation.
6. Poor quality and inappropriate health care services with low access and coverage, low outputs and outcomes;
7. Severe constrains in health human resource at all levels; the professionals from outside are unwilling to serve in tribal areas, and the local potential human resource is not trained and utilized by the health system.
8. The legitimate and needed financial share for tribal health is not allocated or used in most of the states. There is lack of transparent accounting of the actual expenditure on tribal health.
9. Lack of data, monitoring and evaluation that masks all the above-mentioned problems;
10. Political disempowerment of tribal people– from the individual to the national level - that exacerbates these problems. There is little inclusion of tribal people in the planning, priority setting and in execution.

Yet, over the decades, **significant improvements** have taken place. This can be seen by comparing the fertility rates, IMR and CMR, and malnutrition in children in the NFHS II, III, IV and RSoC, or the series of nutritional surveys of tribal population by the NNMB.

While the tribal communities continue to suffer from the huge burden of malnutrition, communicable diseases, maternal and child health problems, there is evidence of early **epidemiologic transition** among the tribal population.

Conclusion: Tribal people have the poorest health status and they carry a triple burden of disease. Moreover, despite the high reliance of the tribal people on the public health care system in Scheduled Areas, it continues to be characterized by low output, low quality and low outcome delivery system, often targeting wrong priorities. An important reason behind this is the near complete absence of community participation in the planning, design and implementation of health services. Therefore, restructuring and strengthening of the public health care system, in accordance with the needs and aspirations of the tribal communities, and with their full participation, should be the highest priority for the Ministries of Health and Family Welfare, both at the Centre and in the states.

5. Goal

The overarching goal of health care for the tribal people should be to bridge the current gap in the health status of the tribal people and to bring the health coverage and outcome indicators at par with the state's average latest by the year 2027.

Sub–goals

i. To create a functioning, sustainable and universal system of health care for the tribal people, in the next five years, by 2022.
ii. To allocate and spend on tribal health a budget equal to 8.6% of the total health budget, over and above the amount spent as per capita health expenditure. MoTA should also spend 15% of its own funds and the funds available under TSP on Tribal Health.
iii. To establish at the Central and the state level new bodies called Tribal Health Council and Directorate for Tribal Health, with system for

generation of data, monitoring and reviewing, and to ensure finances.

6. Organization of service delivery

- The promise of Universal Health Assurance, as proposed in the new National Health Policy (2017), and the Universal Health Coverage as recommended by the HLEG (2011) should begin with the tribal areas.
- This committee recommends that the government should focus 70% of its resources for tribal health on provision of primary care in tribal areas, to be achieved by way of a) Empowering the tribal people for health (increasing the health literacy, and building in the community a capacity for health care i.e. tribal human resource) and b) by moving the centre of gravity for provision of health care closer to the community.
- Health care basket should include a larger number of services, and matching this with adequate human resources and infrastructure.

6.1. Primary Health Care:

The Expert Committee would like to suggest the following structure for delivery of primary health care in tribal areas.

6.1.1 **Primary care in the community** through trained local tribal youth volunteers called Arogya Mitras, trained traditional dais and ASHAs, with the active support and participation of the Gram Sabha and the key community influencers.

This committee recommends that there should be one **ASHA** per 50 households or 250 population in tribal areas. This committee recommends that the ASHA in tribal areas should be paid a fixed 50% of their honorarium per month for retention and non-quantifiable work. The remaining 50% should be performance-linked payment. At least half of her total payment, that is the fixed component, should be routed through the Gram Sabha or the VHSNC.

6.1.2 **Primary care at the Tribal Health and Wellness Centre**

- The health sub centre in tribal areas should be renamed as the Tribal Health and Wellness Centre (THWC) and offer a much broader range of 15 types of preventive, promotive, curative and rehabilitative services.

  After strengthening these sub-centres to become THWCs in 3-5 years, the committee recommends increasing the total number of THWCs to 40000 (i.e. 1 THWC per 2,000 population).

- This THWC would be the centre of gravity for Tribal Health and would cover a population of 3000 initially but then eventually 2000, usually within a radius of 5 Km.

- A trained Ayurvedic doctor or Nurse/ Practitioner would be stationed here to provide basic curative health care.

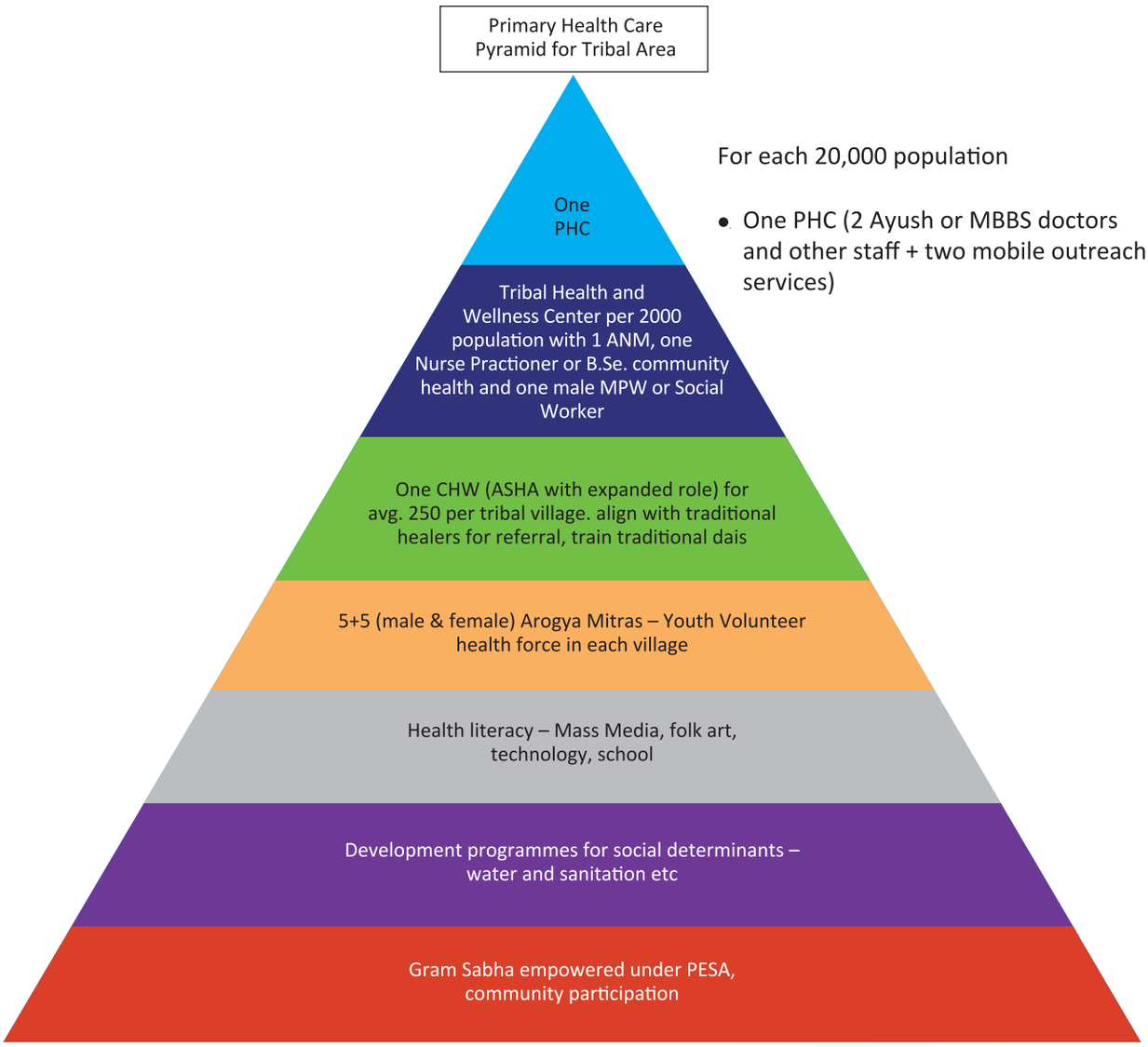
6.1.3 **Primary Health Centres** – Each PHC should have

- **Mobile Outreach Services:** To improve the outreach and access, each PHC would also have two Mobile Outreach Services (MOS) that would visit every village in the catchment area at least once a month and offer basic health care, ANC, diagnostics, medicines for regular and chronic ailments, epidemic control and health education.

- **Ten THWCs and two MOs per PHC** will increase the outreach of PHC taking it closer to the tribal villages.

- **Transportation for Health workers:** Given the distances and scattered populations in tribal areas, it is important to provide local suitable two wheel vehicles to frontline health workers e.g. ANMs and MPWs

Figure 3: Proposed Governance Structure of Tribal Health



to ensure that they are able to cover maximum ground in minimum time. Government can, through banks, make available personal loans to these workers.

6.2. Secondary and Tertiary Care and Financial Protection:

Financial protection through government medical insurance schemes ensuring cashless service, should be provided to the tribal people for seeking secondary and tertiary care. All existing government insurance programmes should be evaluated for the percentage of ST beneficiaries.

6.3. Health literacy

is low among the tribal population. Since, knowledge is the best pill and best vaccine, a massive health literacy drive for continuous health education of women, men, youth and children is a cost-effective intervention.

6.4. School Health Program:

Ensuring provision of health education and healthcare through School Health care Programme can bring in a generational and cultural change in tribal health. Ashram schools and hostels for tribal boys and girls offer such a window of opportunity.

6.5. Health Care for Tribal People Living Outside the Scheduled Areas:

Most of the welfare schemes for ST population, be they for education or health care, have been limited to the people living in scheduled areas or ITDP. Nearly 55% ST population (5.78 Cr) lives outside the tribal majority blocks. This necessitates the need for measures for tribal people living outside tribal areas. These ST families are migrants of sort, dislocated from their natural resources and the community support.

This Committee suggests **Nine Steps** for tribal people living outside scheduled areas or tribal majority areas. Some of these are:

1. **Social Facilitators**: To overcome the isolation, ignorance and diffidence of the ST people living outside, MoTA should appoint one social facilitator per 2000 ST families living outside scheduled areas to periodically visit them, identify health needs, facilitate care seeking and access to health care as well as other government benefits.
2. **ST Health Card**: All tribal people should be provided an ST health card to enable them to avail special benefits like health insurance and to fast track facilitation at health care institutions.
3. **Formation of Health SHGs**: Since PESA won't apply outside scheduled areas, MOTA and the MOHFW should facilitate formation of Self Help Health Groups for scattered ST families for mutual support, information sharing and health care seeking.

7. Human Resource for Tribal Health

- Features of tribal society demand that the health care provider, as far as possible, should be a local tribal. The present health workforce pattern is opposite of this.
- The only way of effecting a vibrant, responsive and accessible health workforce in the tribal areas in a sustained manner, is by ensuring that local tribal people are trained and deployed in the health force.
- It is important to place the centre of gravity of the workforce not at the top – the specialists and doctors - but closer to the communities.

7.1) The **ASHA** in tribal areas should have an expanded role. Eight type of functions and total 4 hours of work per-day is expected from tribal ASHAs

7.2) **Mid-level care providers** should be created through bridge courses and placed at the sub-centres.

7.3) To attract doctors to work in tribal areas, the total salary of MOs needs to substantially increase, by 30% and monthly performance linked bonus added.

7.4) To provide doctors dedicated to work in tribal areas, the committee recommends **creation of dedicated medical colleges in tribal districts**, exclusively for tribal students in the scheduled areas.

7.5) **One Thousand Tribal Health Officers:** In all tribal majority districts or districts with 25% tribal population, a **Prime Minister's Tribal Health Fellow (PMTHF)** should be appointed as a District Tribal Health Officer. Similarly, a Taluka Tribal Health Officer, selected from PMTHF should be appointed in the 809 tribal majority blocks.

809 Taluka Tribal health officers+150 District Tribal Health Officers + A few state and national level officer= total 1000 Tribal health Officers should constitute a new empanelled, empowered and effective cadre to operationalise tribal health.

8. Addressing Special Health Problems in Tribal Areas

8.1) This committee strongly recommends the immediate introduction of a new **Tribal Malaria Action Plan** in 91 tribal dominated districts under the National Health Mission.

8.2) The committee recommends **Home-based Newborn and Child Care** (HBNCC) to be strengthened in several ways for rapidly reducing NMR, IMR and CMR (30% reduction in 3 years and 50% reduction in 5 years).

8.3) **Reducing the prevalence of Malnutrition among the tribal population** The origins of malnutrition in tribal people are in a complex web of causes. Hence, the need for inter-sectoral programmes to tackle the problem of malnutrition.

1. Ensuring Food security and the use of local foods.
2. Strengthening of ICDS : The focus of ICDS must shift from a Centre-based service to a home-based reach-out during the period of pregnancy and the first two years of childhood.
   Nutrition counselling of mothers, built on the knowledge of local foods and food habits.
3. Prevention and treatment of infections.

8.4) Controlling the **use of addictive substances** and providing de-addiction and mental health service.

8.5) This Committee recommends a **re-examination of the Sickle Cell Disease programme** and design of a new strategy.

9. Research and Data on Tribal Health

9.1) To study, document and test the tribal health traditions, particularly tribal systems of medicine, of different tribes.

9.2) Committee recommends that the on-going national surveys be advised to aim to estimate various rates in the tribal population. National survey like NFHS, DLHS, AHS, NSSO, SRS and Census should generate scheduled tribe specific estimates.

9.3) **A State of Tribal Health report** should be published every three years and placed before the nation.

9.4) **Tribal Health Index (THI):** To enable the policy makers and people appreciate the health deficit in tribal population and subsequent progress or lack of it, a composite Tribal Health Index should be created to summarily capture the state of tribal health. The Tribal Health Index shall be used to rank the states/districts, to monitor the progress and allocate resources.

9.5) Establish **Tribal Health Research or Demonstration centres of excellence** in NGOs. To begin with, 15 such sites should be set up in the country,

10. Governance and Participation

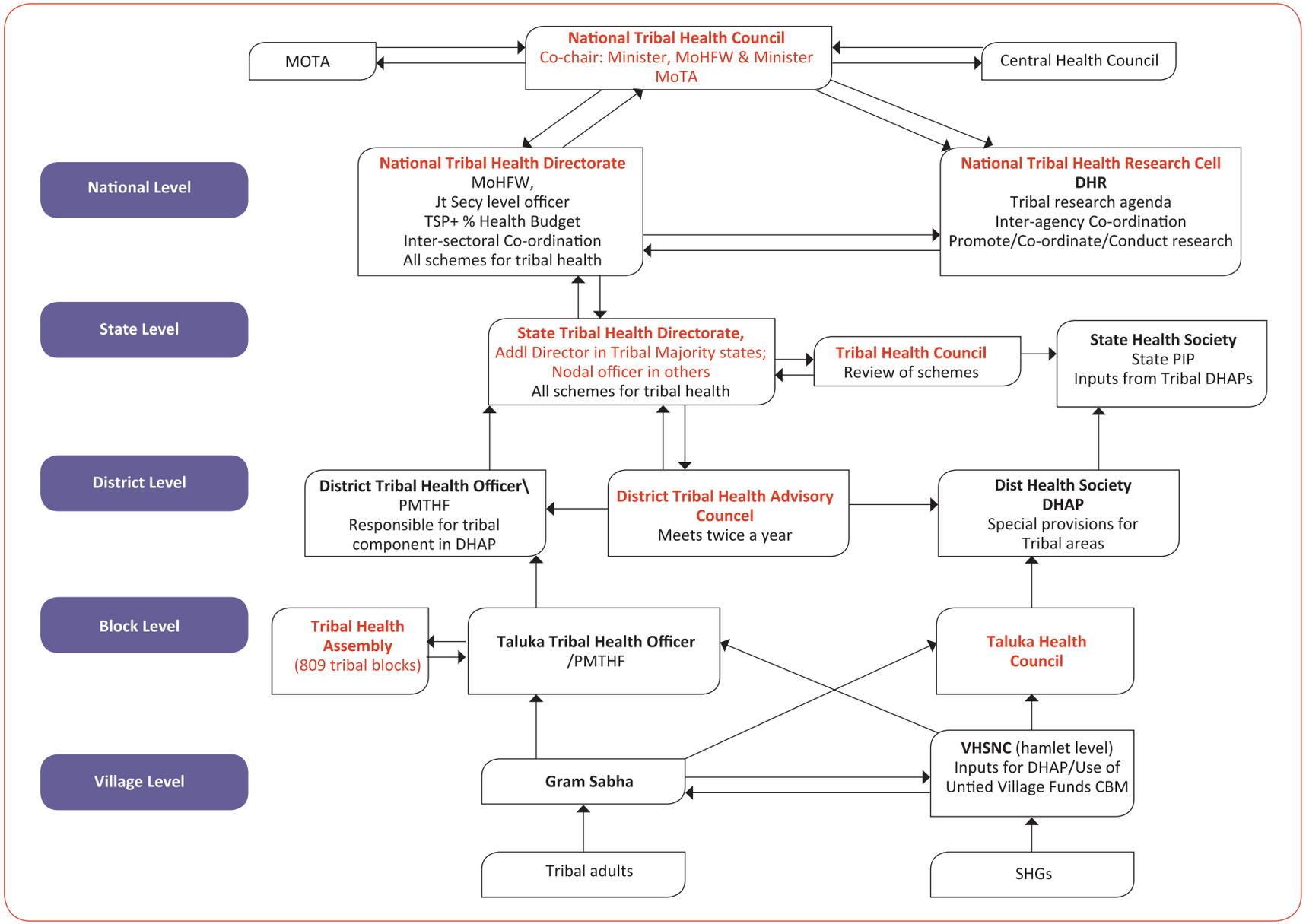
Challenge 1: Creating a more responsive and focused governance structure for tribal health, at all levels of governance (Fig-4) – Following new structures/mechanisms are proposed

1. **National Tribal Health Council** as the apex body
2. **The National Tribal Health Roadmap** to be prepared
3. **Tribal Health Directorate**:
4. **Tribal Health Research Cell (THRC)**, set up within the Department of Health Research
5. The same setup of a Tribal Health Councils, Directorate and Tribal Health Research cell must be duplicated at the state level, at least in the 9 states with large tribal population.
6. **One Thousand Tribal Health Officers**: In all tribal majority districts or districts with 25% tribal population, a **Prime Minister's Tribal Health Fellow (PMTHF)** should be appointed as a District Tribal Health Officer. Similarly, a Taluka Tribal Health Officer, selected from PMTHF should be appointed in the 809 tribal majority blocks

Challenge 2: Enhancing participation of tribal people in shaping policies, plans and services by way of five levels of institutions.

i. Tribal health Advisory councils at the national and state level:
ii. District level consultative Tribal Health Council.
iii. Assembly on tribal health:
iv. Village Health, Sanitation and Nutrition Committees:
v. Gram Sabha:

Figure 4: Proposed Governance Structure of Tribal Health



Challenge 3: Local level planning

Preparing **District Tribal Health Action Plan.** The unit for preparing the Tribal Health Action Plan must be the district, or the sub-district or ITDA

Challenge 4: Need for serving non-tribal people living in the Scheduled Areas

It is neither possible, nor desirable to deny health care services to the almost 2 crore non-tribal population living in tribal blocks. Therefore, funding for tribal areas should be based on the total population (not just the total ST population) of the areas

11. Financing Tribal Health

11.1) **The National Health Policy (2017)** envisages that nationally, atleast 2.5% of GDP be allocated towards health to ensure a functional public health system.

11.2) This will have to be matched by a focused increase **of allocations for tribal health (TSP) to at least 8.6 per cent of the health budget** and implementation of operational processes to increase utilization in the regions dominant with tribal and vulnerable populations.

11.3) **Adhere to TSP guidelines:** Guidelines issued by the Planning Commission in 2013 clearly stipulate that "The expenditure under TSP is meant only for filling the development deficit, as an additional financial support, over and above the normal provisions which should be available to STs, like others, in various schemes, including in flagship programmes."

Here, it is important to note the principle of additionality. It means that the regular activities and expenditure in the tribal areas by the MoHFW are NOT part of the stipulated 8.6 percent under TSP.

11.4) **Funds for tribal health**

- Health Budget 2015-16 (States + UTs): Rs 1,26,830 crores
- Central Health Budget 2015-16 (MoHFW): Rs 33,282 crores
- Overall Health Budget 2015-16 (States + UTs + MoHFW): Rs 1,60,112 crores
- Expected TSP allocation from health budgets towards tribal health: Rs 15,676 crores
- The total tribal population in the country: 104 million
- Per capita additional allocation due towards tribal health as per TSP guidelines: ~Rs 1507

The Planning Commission guidelines clearly state that the TSP money is an additionality. **Therefore overall per capita expenditure on tribal health in the country should be a summation of the per capita health expenditure in the country and the per capita allocation for tribal health as per TSP. This is (Rs. 1507 + 940) equal to Rs. 2447 per capita per year.**

Interestingly, if 2.5 per cent of the country's GDP is spent on Health, as per the national health policy, the overall expenditure on health would be Rs 3,39,400 crores, which comes to Rs 2707 per capita. Thus, under the current circumstances, following the TSP guidelines will ensure that at least for the tribal population, the health expenditure is in tandem with National Health Policy and the recommendations of various committees. In other words, till the overall health budget of the country increases, following the TSP guidelines will ensure that at least for the most marginalized sections of society, i.e for the tribal people, per capita health expenditure

is roughly at par with the per capita health expenditure that is needed to ensure universal health coverage. This will not just improve the overall health and well-being of the tribal population, it will take us one step closer to implementing the draft national health policy.

11.5) **Earmark a percentage of Ministry or the Departments of Tribal Welfare's allocation for Health:** that 15% of the district allocation of MOTA or the dept of tribal welfare funds should be spent on health.

11.6) **Provide Health Insurance for all Tribal people:** It is important to ensure that all tribal people – whether they are living inside or outside scheduled areas- are covered under government insurance programmes.

At the same time strict guidelines and vigilance will be needed to ensure that the health care providers do not thrust up on the hapless tribal people unnecessary or excessive medical procedures just to earn money.

Having said this, the committee firmly believes that the insurance system should not be used as a front for the privatization of healthcare services. Private health facilities enrolled under the scheme should not be treated as a substitute for a robust public health system. It is imperative that the public health system be strengthened across the country, particularly in the tribal areas.

11.7) **Tap into Corporate Social Responsibility (CSR) Funds.**

11.8) **Levy a Cess on Extractive industries located in tribal areas.**

11.9) **Financial Data collection and transparency:** Currently, the non-availability of financial data on tribal health stems from poor monitoring of allocation and utilization of funds in tribal areas. This could be addressed by ensuring that the union and state departments follow and maintain strict accounting records for all funds released and utilized and with disaggregated accounting reports on expenditures on tribal populations/districts. This requires to be done not only in the analysis of state and central budgets, but also for the flow of national health mission funds and the funds from publicly financed health insurance schemes.

In conclusion, **the three essentials of financing tribal health** are:

a) Strict adherence to TSP guidelines ensuring additional allocation by Health Ministries (Centre and states) to public health allocation and expenditure in tribal areas, in proportion to the share of ST population, to a total of Rs. 15676 crores, and ensuring that 70% of this is spent on primary health care;

b) Total public expenditure on tribal health is increased to Rs 2447 per capita. This will bring it to the level equivalent to 2.5 percent of national GDP, matching the goal of the new National Health Policy 2016

c) Efficient fund flows from the government matched by transparent accounts, financial monitoring and reliable data.

The Expert Committee on Tribal Health

1.	Dr. Abhay Bang (SEARCH, Gadchiroli)	Chairman
2.	Mr. Manoj Jhalani (AS & MD), Ministry of Health and Family Welfare, Government of India)	Member Secretary
3.	Ms Neidono Angami, Nagaland	Member
4.	Prof H. Beck (Tata Institute of Social Sciences, Mumbai)	Member
5.	Dr Yogesh Jain (Jan Swasthya Sahyog, Bilaspur)	Member
6.	Dr Joseph Marianus Kujur (Tribal Research Institute, Indian Social Institute, New Delhi)	Member
7.	Prof. Dileep Mavalankar (Director, Indian Institute of Public Health, Gandhinagar)	Member
8.	Dr. Faujdar Ram (Director, International Institute of Population Sciences, Mumbai)	Member
9.	(Late) Dr Neeru Singh (Director, National Institute of Research on Tribal Health (ICMR), Jabalpur)	Member
10.	Dr H. Sudarshan (Vivekananda Girijan Kalyan Kendra, Karnataka)	Member
11.	Dr T. Sundaraman/Dr Sanjiv Kumar (Executive Director, NHSRC (National Health Systems Resource Centre) New Delhi)	Member
12.	Joint Secretary, Ministry of Tribal Affairs, Government of India	Member



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