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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

Executive Summary and Recommendations

Ministry of Health and Family Welfare
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The Expert Committee on Tribal Health

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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

Contents

The Expert Committee on Tribal Health *ii*

Preface *v*

List of Abbreviations *vii*

State of Tribal Health in India **1**

1. Introduction 1
2. Scheduled Tribes in India 2
3. State of Health and Health Care in Tribal Areas 4
4. Diagnosis of Tribal Health 14

Recommendations **17**

1. Principles of Health Care for the Tribal People 17
2. Goals: 18
3. Organization of service delivery 19
4. Human Resources for Tribal Health 23
5. Addressing The Ten Special Problems in Tribal Health 26
6. Integrating Traditional Tribal Medicine into Primary Health Care 27
7. Knowledge, Research and Data on Tribal Health 29
8. Governance and Participation 31
9. Financing Tribal Health 35

List of Figures

Figure 1: Concentration of ST population across various states (as % of total population of the state) 3

Figure 2: Time trend of IMR in ST population 6

Figure 3: Comparison of Under-five mortality in STs and Others* during past 25 years 6

Figure 4: % Surplus/deficit in tribal areas of ten states 12

Figure 5: Primary Health Care Pyramid for Tribal Area 20

Figure 6: Proposed Governance Structure of Tribal Health 34

List of Tables

Table 1: Expanded Functions and expected work load of ASHA in tribal village/hamlet with 250 population 24

Table 2: Expected allocations for Tribal health in the health budget (as per TSP guidelines) by the States and the Centre 36

Preface

The Expert Committee on Tribal Health was constituted jointly by the Ministry of Health & Family Welfare and the Ministry of Tribal Affairs, Government of India in 2013. Why?

The Constitution of India recognizes the special status of tribal people – the Scheduled Tribes – and provides safeguards to protect their rights and culture. However, despite their large number, (104 million according the Census, 2011), tribal people have remained marginal – geographically, socio-economically, politically, and therefore, in the national psyche. For the mainstream population, the tribals are 'those semi-naked wild people who live somewhere in the forests and mountains, and who sometimes appear in the news because their children are malnourished'.

Though it has long been suspected that tribal people have poor health and unmet needs, health care for tribal people remained subsumed in rural health care. It was assumed that tribal people have same health problems, similar needs and hence the uniform national pattern of rural health care would be applicable to them as well, albeit with some alteration in population: provider ratio. The different terrain and environment in which they live, different social systems, different culture and hence different health care needs were not addressed. Not surprisingly 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.

It is creditable that the two ministries of 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. Hence 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 Expert Committee on Tribal Health has approached this task in four stages.

- What is the evidence and experience on the present status of health of the tribal people and health care, leading to formulation of Diagnosis of Tribal Health.
- What should be the principles and goals of tribal healthcare?
- How should the health care delivery and human resources be organized in tribal areas?
- The finances, governance and knowledge required to support the above.

It proved to be a most challenging work. To our dismay we found that not only separate data on tribal population's health, health care, and finances were not available, even the institutional mechanisms to generate such data did not exist or did not function. The darkness of information was astounding. For example, nobody knew what was Infant Mortality Rate in tribal population or how much money was spent on tribal health.

This report succeeds in collating such information hidden in various databases or studies, analyzing and interpreting it and constructing the first comprehensive picture of tribal health and health care in India. Though several gaps remain, what has been accomplished is valuable and eye opener. We found that the tribal people suffer from a 'triple burden of disease'. Their health status has significantly improved over the past 25 years, and yet, it is worst as compared to other social groups. We found that the health care services in tribal areas, apart from being deficient in number, quality and resources, suffer from major

design problems of inappropriateness to tribal society and lack of participation. Part one of the report is devoted to this inquiry, culminating in to the Diagnosis of Tribal Health.

Part two presents the solutions and roadmap for the future. Through a consultative process – with the experts, officers, researchers, civil society organizations, and with the representatives of tribal people, and by organizing a national workshop to identify potential solutions, by inviting suggestions online, by reviewing the evidence from other countries and finally, by searching for ideas and examples from the ongoing work of NGOs in tribal areas and other reports, we have formulated a roadmap for the future. Beginning with identifying the principles of tribal healthcare we propose the goal that the health status of tribal people in India should be brought on par with the rest of the population in the next ten years.

Universal Health Care (UHC) and Universal Health Assurance (UHA) are now accepted principles of India's government policy. We propose that, in the spirit of *Antyodaya* and the constitutional promise to tribal people, the implementation of UHC or UHA in India should urgently begin with the tribal populations. We have suggested a health care delivery pattern and a governance structure. We also visualise the necessary human and financial resources and the way to mobilize. The good news is that within the limits of the national guidelines of Tribal Sub Plan and of the National Health Policy (2016), it is possible to finance tribal health care.

This report is an output of four years of work of the Committee. I must say that this Committee included individuals of exceptional quality with expertise, experience, authority and diversity. This report is a product made possible due to pooling of their efforts.

I wish to thank the Ministry of Health and Family Welfare, Government of India, for supporting, actively participating and enabling this committee in several ways, and the Ministry of Tribal Affairs, for providing very useful information and participation in the deliberations.

All the invited experts, government officers, and the tribal and civil society representatives have made this report possible by way of their valuable contributions.

I wish to specially thank the member secretary of the Committee, Mr. Manoj Jhalani, (Additional Secretary, Health, and the Mission Director, NHM, Govt. of India). His sustained administrative support as well as participation with insights and openness were a great asset.

Special thanks to the National Health Systems Resource Centre (NHSRC) and its team for acting as the secretariat, and to Ms Gunjan Veda, consultant, for very ably assisting in the enormous work of writing.

Dr Neeru Singh, then the director of National Institute of Research on Tribal Health ICMR, who had spent decades of her life for tribal health research was a very active member of the Committee. We lost her due to cancer when the report was in the final stage. This report is dedicated to the tribal people of India and to her.

I hope that this report will prove to be a milestone in realizing the aim of health and health care to the tribal people of India.

Abhay Bang
Chairman, Expert Committee on Tribal health

List of Abbreviations

ACT	Artemisinin based Combination Therapy
AHS	Annual Health Surveys
AIDS	Acquired Immune Deficiency Syndrome
AIR	Age-Adjusted incidence Rate
ANC	Ante-Natal Care
ANM	Auxiliary Nurse Midwifery
API	Annual Parasite Incidence
ARI	Acute Respiratory Infection
ASHA	Accredited Social Health Activist
ATSP	Additional Tribal Sub-Plan
AWC	Anganwadi Centre
AWW	Anganwadi Worker
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy
BCC	Behaviour Change Communication
BHO	Block Health Officer
BMI	Body Mass Index
BPL	Below Poverty Line
CAG	Comptroller and Auditor General
CBGA	Centre for Budget and Governance Accountability
CBPR	Community Based Participatory Research
CDU	Central Diagnostic Unit
CED	Chronic Energy Deficiency
CES	Coverage Evaluation Survey
CHC	Community Health Centre
CHD	Coronary Heart Disease
CHW	Community Health Worker
CMR	Child Mortality Rate
CNS	Central Nervous System
CPHM	Comprehensive Primary Healthcare Management
CSIR	Council of Scientific and Industrial Research
CSR	Corporate Social Responsibility
CSSM	Child Survival and Safe Motherhood
DBT	Department of Bio-Technology
DGHS	Directorate General of Health Services
DH	District Hospital
DHO	District Health Officer
DHR	Department of Health Research
DLHS	District Level Household and facility Survey

DPC	District Planning Committee
EAG	Empowered Action Group
EAP	Externally-Aided Projects
ECHO	Extension for Community Health Outcomes
EmOC	Emergency Obstetric Care
EMR	Electronic Medical Record
EMRI	Emergency Management and Research Institute
FP	Family Planning
FRLHT	Foundation for Revitalisation of Local Health Traditions
FY	Financial Year
G6PD	Glucose-6-phosphate dehydrogenase
GNM	General Nursing and Midwifery
GoI	Government of India
HBNCC	Home Based New-born and Child Care
HbS	Sickle Haemoglobin
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HLEG	High-Level Expert Group
HMIS	Health Management Information Systems
HR	Human Resource
HRA	House Rent Allowance
HRH	Human Resources in Health
HSC	Health Sub-Centre
ICDS	Integrated Child Development Services
ICMR	Indian Council of Medical Research
ICT	Information and Communications Technology
IDA	Iron Deficiency Anaemia
IDSP	Integrated Disease Surveillance Programme
IEC	Information, Education and Communication
IHDS	Indian Human Development Survey
IIPS	International Institute for Population Sciences
IIT	Indian Institute of Technology
IMA	Indian Medical Association
IMFL	Indian-made Foreign Liquor
IMR	Infant Mortality Rate
IPD	In-Patient Department
IPHS	Indian Public Health Standards
IRS	Indoor Residual Spray
ISFR	Indian State of Forest Report
ITDA	Integrated Tribal Development Agency
ITDP	Integrated Tribal Development Projects
ITNs	Insecticide Treated Bednets
JE	Japanese Encephalitis

JSS	Jan SwasthyaSahyog
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
KAP	Knowledge, Attitude and Practice
LASI	Longitudinal Ageing Survey in India
LE	Life Expectancy
LFT	Liver Function Test
LHV	Lady Health Visitor
LLINs	Long Lasting Insecticide Treated Nets
LWE	Left-Wing Extremism
MADA	Modified Area Development Approach
MANSI	Maternal and New-born Survival Initiative
MATIND	Maternal Health India
MCI	Medical Council of India
MCTS	Mother and Child Tracking System
MIS	Management Information System
MMU	Mobile Medical Unit
MNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MO	Medical Officer
MoEF	Ministry of Environment and Forests
MoHFW	Minsitry of Health and Family Welfare
MoTA	Ministry of Tribal Affairs
MPH	Masters in Public Health
MPLAD	Member of Parliament Local Area Development
MPW	Multipurpose Workers
NACO	National AIDS Control Organization
NCD	Non-Communicable Diseases
NE	North-East
NFHS	National Family Health Survey
NGO	Non-Governmental Organisation
NHM	National Health Mission
NHSRC	National Health Systems Resource Centre
NIN	National Institute of Nutrition
NIRTH	National Institute for Research in Tribal Health
NLEP	National Leprosy Eradication Programme
NMR	Neonatal Mortality Rate
NNMB	National Nutrition Monitoring Bureau
NPR	National Population Register
NREGA	National Rural Employment Guarantee Act
NRHM	National Rural Health Mission
NSSO	National Sample Survey Office
NTHC	National Tribal Health Council
NVBDCP	National Vector Borne Disease Control Programme

OBC	Other Backward Class
OBG	Obstetrician and Gynaecologist
OCAP	Ownership, Control, Access and Possession
OOPE	Out-of-Pocket Expenditure
OPD	Out-Patient Department
OT	Operation Theatre
OTTET	Odisha Trust for Technical Education and Training
PDS	Public Distribution System
PESA	Panchayat (Extension to Scheduled Areas)
PHC	Primary Health Centre
PHFI	Public Health Foundation of India
PHU	Public Health Unit
PID	Pelvic Inflammatory Disease
PMTHF	Prime Minister Tribal Health Fellows
PNC	Post-Natal Care
PPP	Public-Private Partnership
PRI	Panchayati Raj Institutions
PTB	Pulmonary Tuberculosis
PVTGs	Particularly Vulnerable Tribal Groups
RAC	Regional Autonomous Councils
RBSK	Rashtriya Bal SwasthyaKaryakram
RCH	Reproductive and Child Health
RDA	Recommended Daily Allowance
RDT	Rapid Diagnostic Test
RFT	Renal Function Test
RHS	Rural Health Statistics
RMNCHA	Reproductive, Maternal, New-born, Child and Adolescent Health
RNTCP	Revised National Tuberculosis Control Program
RSBY	Rashtriya Swasthya Bima Yojana
RSOC	Rapid Survey on Children
RTI	Reproductive Tract Infections
SAGE	Study on Global Ageing and Adult Health
SAM	Severe Acute Malnutrition
SC	Scheduled Caste
SCA	Sickle Cell Anaemia
SCA	Special Central Assistance
SCD	Sickle Cell Disease
SCP	Special Component Plan
SEARCH	Society for Education, Action and Research in Community Health
SHGs	Self-Help Groups
SRS	Sample Registration System
ST	Scheduled Tribe
STI	Sexually Transmitted Infection

TB	Tuberculosis
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
THD	Tribal Health Directorate
THO	Tribal Health Officer
THRC	Tribal Health Research Cell
THWC	Tribal Health and Wellness Centres
TM	Traditional Medicine
TRI	Tribal Research Institute
TSP	Tribal Sub-Plan
U5MR	Under-five Mortality Rate
UNDP	United Nations Development Programme
UT	Union Territory
VAW	Violence Against Women
VHSNCs	Village Health, Sanitation and Nutrition Committee
WASH	Water, Sanitation and Hygiene
WHIMS	Wireless Health Incident Monitoring System
WHO	World Health Organization
YLDs	Years Lived with Disability
YLL	Years of Life Lost

State of Tribal Health in India



1. Introduction

Over 104 million tribal people live in India. Spread across 705 tribes, they account for 8.6% of the country's population. Cognizant of the distinct socio-cultural structures and way of life in these communities,the Government of India has laid down the three landmark policy expressions- the Constitution of India, the Panchsheel Principles and the PESA act- for the protection and development of tribal communities.

These policy safeguards notwithstanding, the elected representatives from tribal areas frequently voice the problem of poor health and health services. Numerous media reports show, that the tribal population continues to suffer from lack of infrastructure, development facilities and services. Malnutrition, child mortality and diseases like malaria are disproportionately high amongst these areas.

The questions are:

- Nearly seven decades after independence, do the tribal people still suffer from the inequity in health and health care compared to others? If yes, why?
- How can this gap be bridged rapidly?

Recognising the need for a roadmap for tribal health that is based on an understanding of the health situation of the tribal people, their needs, aspirations and rights, the Ministry of Health and Family Welfare (MoHFW) and the Ministry of Tribal Affairs (MoTA), in October 2013, jointly constituted the **Expert Committee on Tribal Health**, under the Chairmanship of Dr Abhay Bang. It had as its member's prominent academicians, civil society members and policy makers who have long been working with the tribal people.

The Objective was to develop a national framework and roadmap to improve the appropriateness, access, content, quality and utilization of the health services among the tribal population, particularly those living in scheduled areas. It was tasked to review the existing situation of health in tribal areas, suggest interventions, formulate strategic guidelines for states and make recommendations on the requirement of additional resources.

The report is based on committee meetings,expert consultations, nine thematic working groups, in-depth situation analysis through secondary data, field visits, consultation with stakeholders and a best practices workshop. This probably is the first such comprehensive report on tribal health in India.

The work of the Committee was made difficult by severe lack of segregated data on tribal people in general and on tribal health in particular. Moreover, though tribal health is heavily dependent on socio-economic and environmental factors, due to its specific scope, the Committee largely focused on health and health care only.

The Committee hopes that this report will provide a policy framework for bridging the gap.

2. Scheduled Tribes in India

i) **Who is tribal?:** Article 342 of the Indian Constitution defines "Scheduled Tribes" as the "tribes or tribal communities or parts of or groups within tribal communities which the President of India may specify by public notification.

ii) **Where are they located ?:** The 705 scheduled tribes in the country can be divided into four major categories namely,
- Tribal people living in Schedule V areas and in tribal dominated blocks and districts,
- Tribal population in North- East India,
- Particularly vulnerable tribal groups, and,
- Tribal people living outside Scheduled areas.

Numerically, Madhya Pradesh has the largest ST population (15 million), followed by Maharashtra (10 million), Odisha (9 million), and Rajasthan (9 million). In fact, more than two thirds of the ST population lives in the 7 states of MP, Chhattisgarh, Jharkhand, Odisha, Maharashtra, Gujarat and Rajasthan. However, the concentration of tribal population is highest amongst the North Eastern states.

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.

The tribal population of the country continues to live pre-dominantly in hilly and forested areas and together account for almost 60% of the forest cover in the country. The common understanding and experience of working in tribal areas shows that tribal habitations are scattered across large areas, resulting in a low density of population. During 1951-1990, almost 40% of the 2.13 crore people displaced due to dams, mines, industries etc belonged to Scheduled Tribes.

iii) **Population growth and fertility:** On the whole, the ST population within the total population of India increased from 8.2 per cent in 2001 to 8.6 per cent in 2011. Recent estimates by the IIPS, based on the NFHS-4, of the TFR for STs is 2.5. Thus, the fertility rate in tribal population is declining and is within reasonable limits. At 990 per 1000 males, the Sex Ratio among STs is much better than the All India average of 933. However, the Child Sex Ratio among STs has declined from 972 in 2001 to 957 in 2011.

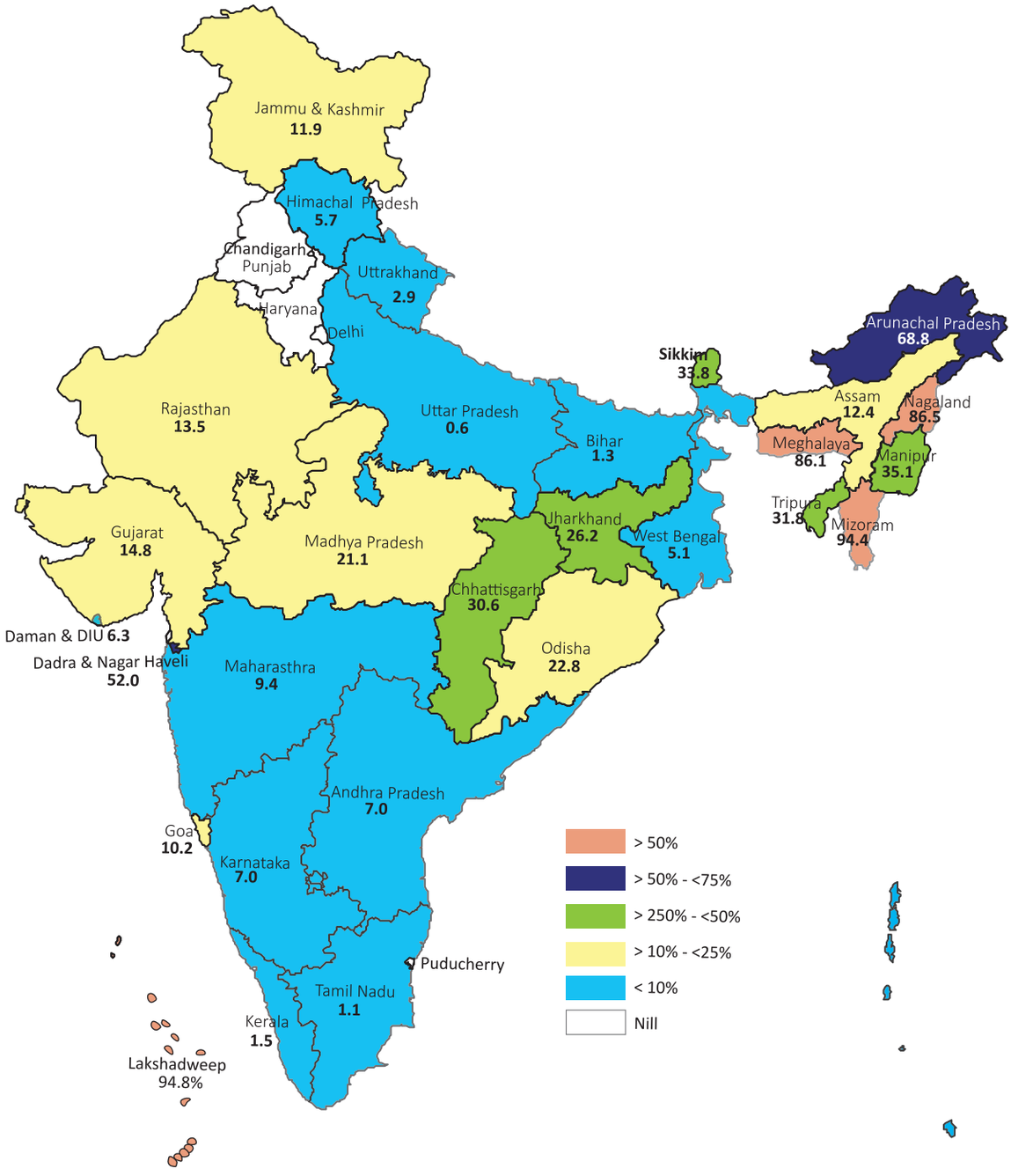
iv) **Socio-Economic Status:** A large proportion of Scheduled Tribes are collectors of forest produce, hunter-gatherers, shifting cultivators, pastoralists and nomadic herders, and artisans. Over two-thirds of the tribal population is working in the primary sector (as against 43% of the non -tribal population), and is heavily dependent on agriculture either as cultivators or as agricultural labourers.

The poor economic status: Overall, 40.6% ST population lived below poverty line as against 20.5% of the non-tribal population in the country.

Access to amenities: Only 10.7% of the tribal population has access to tap water as against 28.5 % of the non-ST population.Three out of every four tribal people (74.7%) continue to defecate in the open. Use of clean cooking fuels among non-STs is more than three times compared to STs.

Education: About 41 per cent of the ST population in India is illiterate as compared to 31 per cent of the non-ST population While 35% tribal people had attained primary education, less than 2% had received higher education. Nationally, only 6.7% of ST population above 18 years of age have completed 12 years of education.

Figure 1: Concentration of ST population across various states (as % of total population of the state)



Source: Primary Census Abstract for Total population, Scheduled Castes and Scheduled Tribes, 2011; Office of the Registrar General & Census Commissioner, India

v) **Special Governance Mechanisms for Tribal Development**

a) The Constitution of India created two distinct administrative arrangements. These are the Fifth and Sixth Schedules that provided protection to the tribal population through separate laws for Scheduled Areas.

b) The provisions of the Fifth Schedule have seen further legal and administrative reinforcement in the form of Provisions of Panchayats (Extension to Scheduled Areas) Act, 1996, which empowers Gram Sabhas.

c) In 1999, a separate Ministry of Tribal Affairs was created to ensure the socio-economic development of Scheduled Tribes in an integrated, planned and coordinated manner.

d) The Scheduled Tribes and Other Traditional Forest Dwellers (Recognition of Forest Rights) Act 2006 was introduced to redress the "historical injustice" committed against forest dwellers and restore their right to land and forest produce.

Ministry of Tribal Affairs (MoTA) is the nodal agency for planning and safeguarding the welfare of tribal people. But currently, the committee could not find any comprehensive plan for the development of tribal people, including health at the national level. Similarly, MoHFW or NHM did not actively consider for tribal health. Health of the most vulnerable was left out by both the ministries.

There never was a dedicated mechanism for looking at Tribal Health.

vi) **Planning and Financing:** The **Tribal Sub-Plan** is a major instrument of inclusion for the ST population. The basic objective of the Tribal Sub-Plan (TSP) is to channelize the flow of funds and benefits from the general sectors in the Ministries/Departments for the development of Schedules Tribes, at least in proportion to their population, both in physical and financial terms.

Planning Commission guidelines clearly state 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.

The availability of funds under TSP during the last three years shows that, on an average, per capita availability of fund per year was around Rs. 8,000. During the current year, it is around Rs. 10,000. However, often the percentage expenditure shown under TSP is a mere accounting exercise. This is because various Ministries show under TSP, the regular services that they would in any case have to provide in tribal areas. The additional expenditure in these areas, which is the mandate of the TSP, remains unstated. There is no consolidated data available on TSP expenditure, at the state and centre level.

3. State of Health and Health Care in Tribal Areas

The problem of lower health status of tribal people is global. A recent international review revealed that health and social outcomes compared on 9 indicators were poorer for tribal people than for the rest of the population in most of the countries. However, it is not nature's inviolable law. Life expectancy among indigenous people is more than 70 years in the high-income countries. Infant mortality rate for indigenous people is less than ten in the high-income countries. Nearer home, it is 6.6 in Thailand. In India during the comparable period, it was 74!

The tribal people in India form a heterogeneous group with a huge diversity. Yet, the one commonality among tribal communities in India is that they have poorer health indicators, greater burden of morbidity and mortality and very limited access to healthcare services.

There is also a near complete absence of data on the health situation of different tribal communities. In the absence of a comprehensive picture of tribal health in the country, policy measures and

government programs are often ad-hoc. This committee therefore spent a considerable amount of time in trying to piece together the picture of tribal health in the country.

1) **Life expectancy:** The estimates published in the Lancet 2016, show that Life Expectancy at birth for ST population in India is 63.9 years, as against 67 years for the general population. This life expectancy for tribal people is likely to be an overestimate because child deaths are under reported amongst tribals more often than in general population.

2) **Reproductive, Maternal, New born, Child Health and Adolescents (RMNCH+A):**

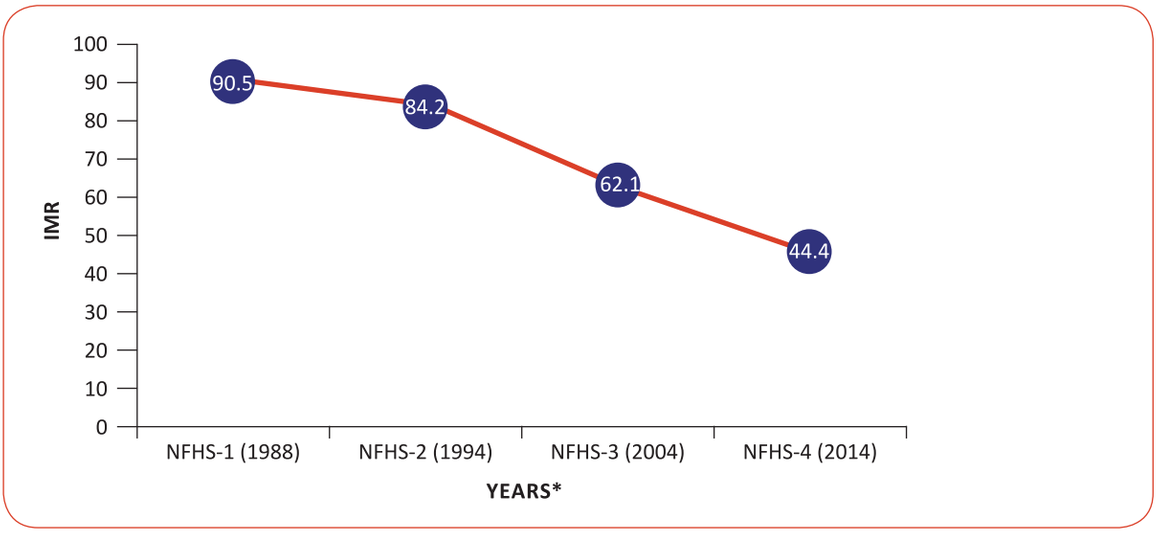
i) **Maternal Health:**

- No recent estimates for maternal mortality among the tribal women are available. Early marriage, early child birth, low BMI and high incidence of anaemia are known critical reasons for high maternal mortality.
- Alarmingly almost 50% adolescent ST girls between the ages of 15 and 19 years are underweight or have a BMI of less than 18.5.
- NFHS 3 shows that 65% tribal women in the 15-49 years age group suffer from anaemia as against 46.9% other (non-SC, ST) women.
- The full ANC coverage remains poor, particularly for the tribal women. RSoC data shows that while 81.8% ST women had received at least one ANC, only 15% had received full ANC, the lowest among all social groups.
- At 70.1%, the rate of institutional delivery is the lowest among tribal women. However, it is a big increase from 18% in NFHS 3 (2005-06) and 57% in CES 2009. Recent RSoC data shows that as many as 54.7% tribal women benefitted from JSY- the highest among all the social groups.
- Cost of institutional delivery, distance and lack of transport continue to be deterrents. NSSO 2014 data reveals that average expenditure on childbirth at a health centre is still approximately Rs. 4000 – way more than the costs covered by schemes like JSY.
- 27% tribal women still deliver at home, the highest among all population groups. This could in part be attributed to the unfriendly attitude of health workers, language and understanding gap and the lack of trust in an alien system. Maternal health services provided by the government are often not in tune with the health beliefs and practices of the tribal people.
- Coverage of post-natal care remains poor. Only about 37% tribal women reported receiving any PNC within 48 hours of delivery.

ii) **Child Mortality:**

- Indirect estimate based on the Census 2011, providing the IMR pertaining to the year 2008 showed that, the tribal IMR was 74 as against the 62 for rest of the population in India.
- The ST IMR in India was highest in the world among the indigenous populations, next only to the Federally Administered Area in Pakistan. India cannot be proud of this.
- As per NFHS 4, the estimated IMR for ST population in 2014 was 44.4, the 1-4 year mortality rate was 13.4, and the under-five MR was 57.2 per 1000 live births. This is significantly less than the Census based estimate of IMR of 74 for the year 2008.
- The time trend analysis 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.

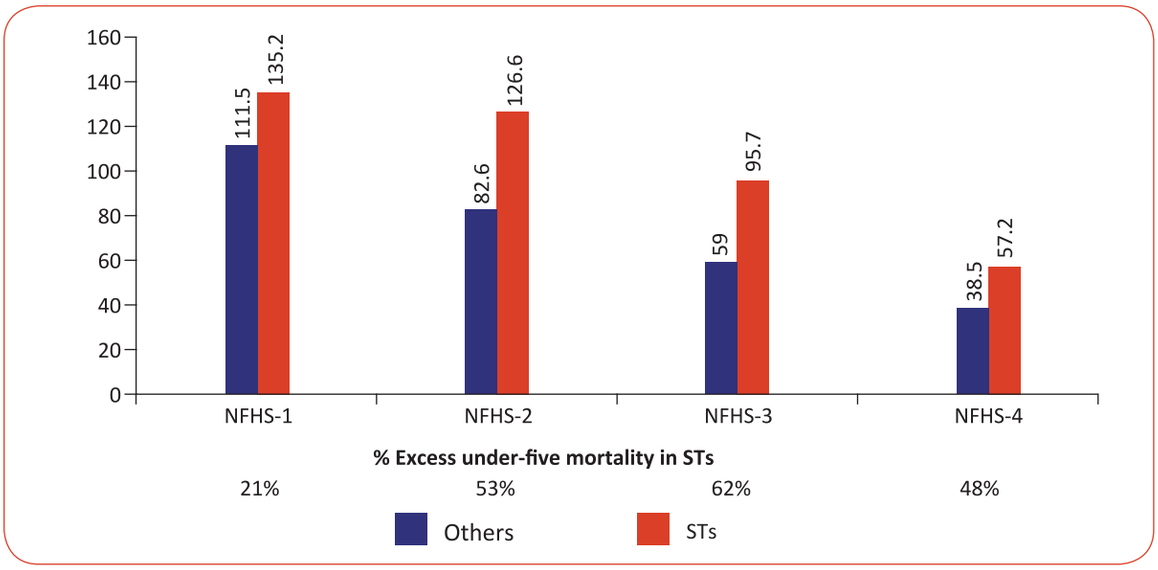
Figure 2: Time trend of IMR in ST population



*The IMR estimated by NFHS pertains to the midpoint of the period of inquiry.That midpoint year is provided here.

- But the annual rate of reduction in tribal IMR after peaking in 2004, declined during the last ten years of 2004-14.
- When compared to other populations it was observed that, though the absolute level of IMR in tribal population in India has nearly halved over a quarter century, the gap with the favourable social groups has widened from 10% to 38%.
- The under-five MR shows a 58 % reduction in tribal areas, from 135 (in 1988) to 57 (in 2014). Percentage of excess of under-five mortality in ST when compared to others has widened from 21% to 48 %. As late as in 2014, in some of the states with large ST population, the ST U5MR was two to three times higher than in others.
- As late as 2011, nearly 146,000 under-five tribal child deaths occurred annually in India, (estimated on the basis of NFHS and the Census 2011).

Figure 3: Comparison of Under-five mortality in STs and Others* during past 25 years



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

iii) **Other Child Health Indicators**

- The Rapid Survey of Children (2013-14) showed that the highest percentage of children with low birth weight (less than 2.5kg) was found among the tribal population.
- However, early breastfeeding practices were best among ST women.
- Despite the high rates of infant and child mortality in tribal areas and the heavy burden of diseases, full immunization coverage remains consistently low among the ST population across states, 56% as against 72% among all other social groups.

Thus, with some exceptions (such as breast feeding in 0-23 months or JSY benefits), on most of the indicators of health care coverage or health status, the ST population is uniformly worse by 10-25% as compared to others but by upto 50% (38 Vs 57) in the case of Under 5 Mortality (U5MR).

iv) **Family Welfare**

- Contraceptive use among the ST population at an all India level has been close to the non-ST population (41% vs 49%). While the TFR for STs at 3.1 was higher than the general population (2.4) in NFHS-3, the NFHS-4 data revealed that the TFR for ST had come down to 2.5, close to the replacement level of 2.1.

3) **Burden of Disease:** *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.*

Currently, there is no single source of data available on tribal population to create a countrywide disease burden profile. The NSSO data shows that while the infections still constitute the larger proportion, (40%), the reported proportion of non-communicable diseases like Cancer, Diabetes and Cardiac ailments, though lower among the tribal population (10%) in comparison to the other population groups (25%), it is sizable and needs attention. Alarmingly, tribal people report a high proportion of respiratory (18%), mental/ neurological (5%) and musculo-skeletal (10%) conditions. The obstetric ailments were three times the national average.

Epidemiologic transition is emerging, Most importantly, the health care needs of tribal people are not RMNCHA alone, but broader.

NIRTH calculated that there would be 65,000 adults (15 years or older) per lakh population in tribal areas. Among them, fever (8743), syndromic STI cases (8255), herpes simplex (8032), ARI (6695) and pelvic inflammatory diseases (PID) (5298) would be the most common diseases. Among nutritional disorder/ deficiencies, there would be about 39,000 cases of malnutrition, 25,000 cases of anaemia, 4000 cases of conjunctival xerosis and 3000 cases of dental carries. These estimated numbers provide a rough idea about the need of health care and the huge quantum of workload for primary care.

4) **Communicable Diseases:** The tribal population bears a disproportionate burden of communicable diseases. These include malaria, tuberculosis, skin infections, sexually transmitted diseases, HIV, typhoid, cholera, diarrhoeal diseases, hepatitis, and viral fevers.

i) **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 reflects an economic burden of staggering Rs. 6000 crores per year. Yet only 10% of the budget of the NVBDCP is marked for TSP. The National Framework for Malaria Elimination (2016) aims

to eliminate malaria throughout the country by 2030. Clearly, this goal cannot be met unless tribal health is prioritized as the majority of malaria cases and deaths occur in tribal areas.

ii) **Tuberculosis:** The estimated prevalence of pulmonary Tuberculosis in tribal community is significantly higher than rest of the country- 703 against 256 per 100,000. Current reporting status of smear positive suggests that only 11% of pulmonary TB cases in tribal population get treated.

iii) **Leprosy:** Though the proportion of ST population in India is 8·6%, during 2012, the proportion of new leprosy cases among ST population was found to be 18·5%, revealing a disproportionate burden of leprosy among the tribal population. Since leprosy treatment is integrated with the general health services, identifying leprosy cases is not going to be easy in these settings and they remain as endemic reservoirs, unless greater efforts are made to reach them.

5) **Non-Communicable Diseases:** Unexpectedly, evidence of an early epidemiologic transition in tribal areas and associated increase in the incidence of non-communicable diseases is being observed.

i) **Hypertension:** O*ne out of every four tribal adults sufferfrom hypertension.* Further the prevalence of hypertension increased significantly with age, consumption of tobacco, alcohol and a sedentary lifestyle. Yet two out three tribal adult men and women did not know the signs and symptoms of the ailment. *More worryingly, only 5 per cent men and 9 per cent women suffering from hypertension knew their hypertensive status.*

6) **Genetic Disorders:** The prevalence of **Sickle Cell Disease** (anemia and trait together) and thalassemia – another genetic disorder – varies between 1-40 percent in different tribal communities. However, most of the prevalence is due to the heterozygous form of disease. Sickle cell anemia,the more serious form, is prevalent 1 in 86 births among tribal communities,in central India.

There are two views with respect to the sickle cell disease (SCD) program. The first points out that most of the studies on morbidity and mortality due to SCD are hospital-based where only severely affected cases reach. Hence it might be premature and even unethical to launch mass screening, identify and label asymptomatic individuals in the community- especially when proper health care is not provided to them. The second view holds that mass screening and management of SCD is important to ensure greater life expectancy and quality of life for the tribal people. The Government of India has taken the second view, and started an extensive program for screening 3 crore people for sickle cell trait. Largely, the focus has been on screening with a view to identifying carriers and couples in their reproductive years, providing counselling to prevent the spread of the disease. However, in the absence of any cure and treatment, just identifying carriers may lead to stigma and social ostracism.

Another genetic disease prevalent in many tribal groups in India is the **G6PD deficiency**. Among the 14 primitive tribal populations from four different States showing a high frequency of sickle gene, the prevalence of G6PD deficiency varied from 0.7 to 15.6 per cent.

7) **Nutrition**

i) **Daily nutrient Intake:**

a) The third round of the National Nutrition Monitoring Bureau (NNMB) survey completed in 2008-09 found that the mean intake of most foodstuffs and nutrients by tribal people continued to be below the Recommended Daily Allowances (RDA) by the Indian Council of Medical Research and had in fact reduced over the years, across all age groups and for both genders. This is worrisome and maybe indicative of a rising food insecurity or a change in dietary habits.

b) On an average, intake of cereals and millets decreased by about 50 g/CU/day between the second (1988-90) and the third NNMB surveys (2008-09) in tribal areas. The average daily intake of proteins decreased by about 3 g/CU/day and of Vitamin A by about 117 µg/CU/day. The average intake of energy decreased by about 150 kcal/CU/day.

c) Only about 29-32% of children of different age groups and 63-74% among adult men and women were consuming diets that were adequate in both protein and energy.

d) Only about 25% pregnant and lactating women had adequate intakes of both protein and calories. This leads to undernourished mothers and children and risk-prone pregnancies.

ii) **Malnutrition:**

a) There are huge disparities between the nutritional status of tribal children and those belonging to non-tribals, except in the northeastern states.

b) 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.

c) As in the general child population, under-nutrition among tribal children in fact increases with age. The prevalence of underweight and stunting was higher among preschool children as compared to infants.

d) The time trend (NNMB 2 and 3 followed by the RSoC) show some welcome decrease in the prevalence of malnutrition in tribal children. However, 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. The nature and the reasons for these tragic spurts need to be identified and suitable measures instituted. Since such episodes are reported mostly during rainy seasons, they may be caused by a seasonal food scarcity, increased infections (malaria, diarrhoea) and a breakdown of access to health care during the rainy season.

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.

iii) **Micronutrient deficiencies**

a) About two-third of the preschool children were consuming **iron** below 50% of Recommended Dietary Allowances (RDA), which is the major cause for high levels of anaemia among these people. Mothers of young children reportedly revealed that only 4.2% had received iron supplements within the past one week.

b) **Anemia:** Maternal malnutrition is quite common among the tribal women, especially those who have closely spaced pregnancies. NFHS 3 shows that 65% tribal women in the 15-49 years age group suffer from anemia as against 55.7% SC and 46.9% other women. The prevalence

of anemia among children (6-59 months) is also notably higher among ST children compared to children of other social groups. According to NFHS 3, about 77% ST children were anaemic compared to about 64% other category children.

8) **Mental Health and Addictions:**

a) Tribal people world over are known to be easy prey to these addictive substances. In addition, tribal people during the modern time have been exposed to several existential threats and the mental stress.

b) **Prevalence:** According to NFHS 3, almost 72% of the tribal men in the 15-54 years age group were using 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%).

c) **Tobacco and Alcohol in Gadchiroli:** The more recent district sample surveys by SEARCH (2015) in Gadchiroli found that-

- Prevalence of alcohol use among men (above 15 years) was 41%. The annual out of pocket expense on alcohol was Rs. 79 crore in the district.
- The next annual district sample survey in 2016 showed the prevalence of tobacco use (all age groups) was 44%, and money spent was annually Rs 298 Cr.
- Thus, annually the out-of-pocket money spent by people on alcohol and tobacco together was Rs. 377 crores. This was more than twice the size of Annual District Plan in the previous year (Rs 157 crores). This is indeed alarming.

d) **Tobacco, alcohol and drugs threaten the tribal people in five ways:**

- Harm health and increase the incidence of serious diseases and mortality;
- Reduce productivity and increase poverty;
- Disrupt family and community harmony;
- Generate law and order problems;
- Constitute a major out of pocket expense and adversely affect the family economy.

Thus, these substances are anti-health, anti-harmony and anti-development. They might be partly responsible for the increasing incidence of non-communicable diseases like hypertension and cancers among the tribal population.

e) **Excise Policy for Tribal Areas**

Recognising the harmful impact of alcohol on the tribal communities, the Ministry of Home Affairs, Government of India promulgated the Excise Policy for Tribal areas in 1976. According to this policy:

- No commercial sale of alcohol is permitted in scheduled areas.
- Tribal people are permitted to consume traditional, home made alcoholic beverages under the community control.
- Vigorous educational efforts should be made by way of schools, colleges, civil society, tribal leaders to wean away tribal people from drinking.

Yet, this policy is often being violated by the states – either in letter or in spirit. No agency is monitoring implementation of this policy.

9) **Animal Attacks and Violence in Conflict Areas**

As tribal areas are often surrounded by forests, animal bites from snakes, dogs and scorpions are common. India has highest snakebite mortality in the world -between 45,000 to 50,000 annually, ie about 125 people per day.

As the conflict between man and environment intensifies and boundaries are constantly redefined, it is the tribal people, living in environmentally sensitive areas with rich natural resources and forests who bear the wrath of animals and nature alike.

10) **Health Care seeking in Tribal Areas**

- Rural Health Statistics (RHS) reveals huge gaps in the health infrastructure and resources in tribal areas due to serious geographical and socio-economic challenges. Access to health services becomes difficult as the roads are poor or restricted. Poor availability of health personnel, lack of adequate equipment, language and social barriers, waiting time at health centres and poverty also add to problems of access.
- Nearly 50 percent of the outpatient visits by tribal people are to public hospitals 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.

11) **Health Care Infrastructure**

As per the present norms, tribal and hilly areas should have one Health Sub-centre (HSC) per 3000 population, one Primary Health Center (PHC) per 20,000 population, and a Community Health Centre (CHC) per 80,000 population.

Data on 'required versus shortfall' of Sub-centres, PHCs and CHCs in tribal areas of 18 states and three UTs was studied. Data in 18 States showed:

Sub-centres: In seven states no shortfall in number of HSCs against the required number was observed. In the remaining 11 states, a shortfall of 4996 sub-centres i.e. 27% of the required numbers in these states was noted.

PHCs: No shortfall existed in 11 states. In the remaining seven deficient states a shortfall was noted of 1023 PHCs which was 40% of the required number in these states.

CHCs: In eight states, there was no shortfall. In the remaining 10 states a shortfall of 209 was observed. The shortfall accounted for 31% of the required number of CHCs in these states.

Among the UTs an 8% shortfall in Sub-centres and of 1 CHC (against the requirement of 1) was reported from Dadra and Nagar Haveli. No other shortfall was noted at any level.

Thus in about half of the states, the health institutions in tribal areas were deficient in number by 27 to 40 percent as compared to the present norms.

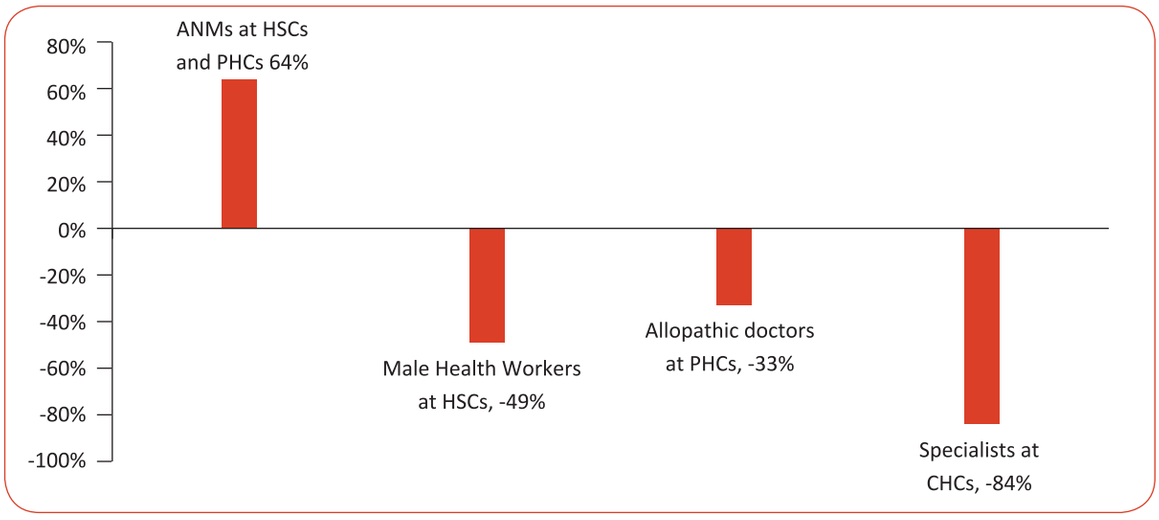
12) **Health Human Resource (HRH)**

i) The huge gap in human resources in health centres in tribal areas is attributed to reasons such as limited scope for professional interaction or growth for the staff, a feeling of social and professional isolation, weak human resource policies, poor working conditions and environment in the government health institutions, limited social infrastructure, etc**.** Various states have tried different measures to overcome this shortage of doctors, but the problem persists.

ii) Maharashtra and several other states have introduced a bond for compulsory rural service, but it is flouted by most of the doctors completing MBBS. The medical education and the health departments seem unwilling or unable to enforce the execution of the bond.

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

Figure 4: % 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.

iii) With respect to front line workers, no numbers are available as to the density of ASHAs in tribal areas or the average number of people covered by them. In tribal areas where the public health systems suffer from problems of acceptability, these workers can play a very crucial role.

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.

iv) The total surplus of ANMs in tribal areas in 10 states was 64% of the required number. This 'surplus' may reflect the real need of ANMs posts. *In fact, such deployment, probably dictated by the need, indicates that one ANM is required for 2000 people.*

v) There is a severe shortage of nursing staff. The highest shortfall is reported in Himachal Pradesh (77%) followed by Jharkhand (56%) and Odisha (54%).

vi) Further, the quality of care offered by the existing health personnel also remains questionable due to lack of motivation, understanding and mutual respect.

13) **Health culture and Health Literacy:**

i) In most tribal communities, there is a wealth of folklore related to health. Tribal people and forest dwellers collect a variety of leaves, fruits, seeds, and nuts, with medicinal value and use it for treatment. Traditional healers act as the medium between man, nature and the supernatural entity, providing spiritual security to the tribal people. Often, they are the port of first call for the tribal population when they experience sickness. On the one hand, the influence of traditional healers is becoming more limited. On the other, the lack of emotional content and spiritual security in the modern health care system continues to keep the tribal people away from the public health facilities. Awareness about and acceptability of the Indian Systems of Medicine (like Ayurveda and Unani) is also low, particularly in the north-east and in states like Jharkhand.

ii) Tribal societies have remained away from scientific knowledge about the causation of disease (nutrition, micro-organisms) or the ways to prevent (sanitation, personal hygiene, nutrition, immunization, etc) and treat them. Awareness about good health practices and symptoms of diseases continues to be poor. Awareness of all the forms of distress among infants was also found poorest among the tribal mothers.

14) **Health Planning:**

Policy measures towards improvement in tribal health have often been limited to relaxation in norms for tribal areas within the existing schemes and targeted implementation of particular schemes in tribal areas. Recognizing the distinct problems of tribal health, the National Health Policy of 2002 provided for the state governments to tailor implementation of strategies according to the need in tribal areas. However, state-level interventions that are adapted to tribal settings are few and far in between. Where such initiatives do exist, there is a complete lack of monitoring and evaluation to gauge their impact.

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.

15) **Financing of Tribal Health:**

- Tribal Sub-Plan was initiated because the benefits of the general plan designed for the overall development did not fully reach the tribal communities.
- Under the revised guidelines on TSP, the Ministry of Women and Child Development and the Department of Health & Family Welfare are required to earmark between 7.5 to 8.2% of their Plan Outlays for the tribal sub-plan.
- An analysis of the budget of all state governments for the FY 2012-13, revealed that only seven states – Andhra Pradesh, Himachal Pradesh, Gujarat, Odisha, Rajasthan, Tamil Nadu and West Bengal – had allocated money for health under the TSP. However, 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.
- Despite the Planning Commission guidelines in this respect, the Ministry of Tribal Affairs itself does not have information on the TSP allocations made by different states or the allocations to health made under the TSP budget of different states.
- Utilization of funds was found to be near complete in most of the states however no data was available with the states or MOTA on the proportion of TSP funds spent on health. It is generally felt that the sizeable proportion of the claimed expenditure in tribal areas is an accounting jugglery. Due to lack of transparent accounting and data it is usually not possible to assess how much was actually spent in tribal areas, particularly on health.

16) **Tribal Health in North-East India:**

The tribal people of the eight states of North East India comprise about 12 per cent or one eighth of the total tribal population of the country. Forty-eight of the total 86 districts in these eight states have more than 50% ST population. There are 145 tribes of which 78 are large, each with a population of more than 5000.

i) The **Disease Patterns** among the tribal communities in north-east India are in some ways different from those in the rest of the country.
   - Incidence of Non-communicable disease is high.
   - A high incidence of cancer.
   - Mental health problems, drug abuse and consumption of tobacco and alcohol is particularly high.
   - A high incidence of HIV/AIDS in the region, primarily due to drug abuse.
   - Malaria continues to be a major problem in the north-eastern states, with API greater than 5 in almost all the tribal regions.

ii) **Nutritional state** of these communities is much better than that of the tribal population in the rest of the country. Only Meghalaya and Mizoram have a higher incidence of stunting among children in their tribal population than the national average for Scheduled Tribes.

iii) **RMNCH**:

- The maternal health indicators for the tribal people are worse than the non-tribal population even in the north-eastern states**.** Coverage of full ANC remains poor**.** Prevalence of anaemia is more than 50% in all the NE states except for Tripura.
- NFHS 3 shows that the infant mortality amongst the tribal population is higher than the total state average in Arunachal Pradesh, Manipur and Meghalaya. Immunisation coverage is less than 50 % in majority of the districts. Unlike the rest of the country.
- The Total Fertility Rate amongst the tribal communities in the north-east is high**.**

iv) **The health infrastructure** in the north-eastern states seems to be better than the rest of the country, as far as the norms are concerned. However, this does not necessarily mean greater access to healthcare for the population because the terrain in most of the north-eastern states is mountainous and habitations are few and far in between. Further when it comes to secondary care and the presence of CHCs, there is a huge deficit. As in the rest of the country, there are huge gaps in availability of health functionaries across all levels in the North-eastern states. The position with respect to availability of doctors and specialists is particularly bad, and much worse than the national average.

17) **Health Situation among Particularly Vulnerable Tribal Groups:**

At present, there are 75 tribal groups identified and categorized as Particularly Vulnerable Tribal Groups (PVTGs), (earlier known as Primitive Tribal Groups) The issues and strategies for the smaller tribal groups i.e. 'vanishing tribes' need further emphasis and warrant higher importance and urgency.

Among tribal health, the health of PVTG groups is worse-off and poorly documented. In some of the PVTGs, there is a severe neglect of maternal and child health services. In many of these groups, expectant mothers do not even receive a single dose of tetanus toxoid vaccination. Restrictions in family planning services currently apply for some groups hindering their reproductive rights, while others are in need of infertility care and/or safe abortion services. Further, there is a huge lack of data regarding social determinants and health aspects of these communities as evaluation research and policy research in these areas are scarce.

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. This is associated with a high prevalence of hypertension (24%) among ST adults and use of addictive substances by many tribal communities. Rapid exposure to media and modern lifestyle, without proper health education has accentuated these problems.

Diagnosis of Tribal Health therefore reveals that almost seven decades after Independence and despite many constitutional provisions to safeguard their interests, the tribal population continues to suffer disproportionately from health problems, compounded by problems of healthcare access and quality. Yet the Public health system including infrastructure, human resources and governance in the tribal areas remain inadequate. In more than half of the states with sizable tribal population, the health care infrastructure was 27 to 40 percent deficient in numbers compared to the NRHM population norms. The shortfall of male MPWs (49%), PHC doctors (33%) and specialists at CHCs (84%) in tribal areas is deplorable. Our current health care delivery system is incompatible with tribal cultural and belief systems, leading to low rate of acceptance. The organization of public health service delivery in tribal areas suffers from serious design flaws that affect its efficiency, efficacy and uptake.

In conclusion, it can be said that 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.

This means two things. One, that the health situation of the tribal population can be improved and two, that as things stand today, a lot of work needs to be done. There is need for urgent action.

Applying the principles of Equity and Antyodaya, this committee has no hesitation in saying that tribal health must receive the first and the highest attention.

Recommendations



1. Principles of Health Care for the Tribal People

Designing and planning of health care for tribal people need to be guided by the following principles:

1) **Justice and responsibility:** It is the constitutional and moral responsibility of the government and of the society to do justice to this vulnerable segment of the population. Provision of health care to the tribal people cannot be derived from the market principle of financial returns or profit, but should be only on the principles of justice, rights and equity.
2) **Appropriateness**: A uniform and rigid model of health care is definitely inappropriate. The health care delivery and content must be appropriate to the needs and culture of each tribe and its locality.
3) **Autonomy**: Tribal people want to be autonomous so as to be able to preserve their identity, their way of life. Autonomy is also necessary to ensure that the health care designed or planned for the tribal people is appropriate to their needs and culture.
4) **Decentralized planning and administration**: This means more role and power to the basic units such as the Gram Sabha, the Panchayat institutions and the district. However, enormous capacity building efforts will be required to enable these units perform better.
5) **Acceptable and Culture sensitive:** A contentious, but important issue is how to accommodate the indigenous medical system – the providers and the therapies– without sacrificing the scientific principles and methods of public health.
6) **Universality**: All tribal people living in the scheduled areas or outside, should be covered by appropriate health care models. For those living in non-scheduled areas (with rural population), special provisions must be made at the household level.
7) **Accessible**: In view of the problem of distance – physical and cultural – access to health care is of paramount importance. Health care must be designed and delivered to ensure access for all. This will mean that infrastructure, human resource and service delivery should be as near as possible. Access can be ensured in several ways:
    i) **Health care institutions** should be more in number, at a lower population ratio. For this, we will have to move beyond the IPHS in tribal areas.
    ii) **Human Resources:** They should be more in number and placed at a short, walk-able distance. This means, each tribal village and hamlet should have a trained community health worker and volunteers. This would also mean that majority of these workers must be from within the community, and community-based.
    iii) **Outreach service and mobile care**:
    iv) **Knowledge and Skills Transfer:** Health literacy among tribal people is low. Behaviour change communication and health education are important. These should be done in a culturally sensitive manner,
    v) **Technology**: Use of information technology and mobile phones can bypass the distance and enable a quantum jump in access to knowledge.

The principle of accessibility places the primary responsibility of ensuring access on the health care services, thereby making community-based care and outreach services the backbone of health care in tribal areas.

8) **Comprehensiveness**.
9) **Adequacy**: The quantity and quality of health care must be adequate. The optimum levels must be stated, monitored and safeguarded.
10) **Integration to address the social determinants:** Several initiatives of various ministries aim to mitigate this gap by planning various schemes and programmes. Better health outcomes will result if multi-dimensional development is pursued. The health initiatives need to collaborate with other programmes such as the schools, ICDS, water and sanitation, MNREGA, PDS, Roads, Forest rights, PESA, Excise policy, telecommunication etc.
11) **Empowerment**: Several of the above principles can be best practiced not by a patronizing model of provided care but by the empowerment model. Empowering tribal people can be accomplished in several ways.
    i) Knowledge transfer and training – a massive effort to import health literacy and the basic scientific information necessary for taking care of health.
    ii) Local and community-based human resource
    iii) Delegation of medical roles and skills.
    iv) Local leadership development
    v) Local planning, management and accountability.
    vi) Financial and administrative powers.
    vii) Use of enabling technologies.
12) **Flexible and dynamic:** Tribal health care should be designed not with a fixed rigid template, but should offer a flexible framework. The details, such as health care priorities and goals, must be chosen locally. This also means the health care solutions offered must take the form of a wider menu from which the states and the districts will opt for what is appropriate for them. Moreover, the design must be dynamic to allow for the rapid changes in the tribal society and the changing disease pattern to be equally rapidly addressed.
13) **Financial Resources:** To bridge the health status deficit in tribal areas and to overcome the handicaps and difficulties, more per capita financial resources will be needed in tribal areas. These should come largely from:
    i) The regular health care budget of the state including the Central schemes. As per the guidelines of the erstwhile Planning Commission of India, each line department (Health and Family Welfare) must spend a proportion of its planned and non-plan budget in the tribal areas at least equal to the proportion of tribal population in the state population.
    ii) ST component of the state plan:At least 15 per cent of the ST component of the state's plan must be earmarked and made available for health care to tribal people.
    iii) Special provisions for tribal health from the Central component.
    iv) The mines, the forest department and the public and private sector companies located in or drawing raw material from tribal areas may also be charged a cess as the share of the local tribal people.
    v) In addition, a smaller component may also be mobilized from the civil society and the CSR.

2. Goals:

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.

The **sub-goals** should be:

1. To create a functioning, sustainable and universal system of health care for the tribal people, consistent with the above general principles, in the next five years, by 2022.
2. To design and create the following components essential for health care for the tribal people:
    - An administrative structure for local participation, planning and management, especially a greater role to the Gram Sabhas empowered under the PESA Act
    - Focus on comprehensive primary health care delivered closer to the community

- More human resource for health
- Health education and knowledge dissemination plans.
- Measurement and monitoring system
- Special Financial system.
- Research: bio-medical, epidemiological and operational research to provide appropriate solutions for the existing problems.

3. 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. This comes to roughly 2.5% of the per capita GDP, which is in line with the suggestions of the HLEG and the new National Health Policy (2016). MoTA should also spend 15% of its own funds and the funds available under TSP on Tribal Health.
4. 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.

3. Organization of service delivery

1. *The promise of Universal Health Assurance, as proposed in the new National Health Policy (2016), and the Universal Health Coverage as recommended by the HLEG (2011) should begin with the tribal areas.*
2. *This committee recommends that the government should focus 70% of its resources for tribal health on provision of primary care in tribal areas. This* Comprehensive primary health care should include preventive, promotive, curative and rehabilitative care.
3. This universal primary care shoud 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.
4. *There is aneed to shift the emphasis of health care to making a larger basket of services available, and matching this with adequate human resources and infrastructure.*

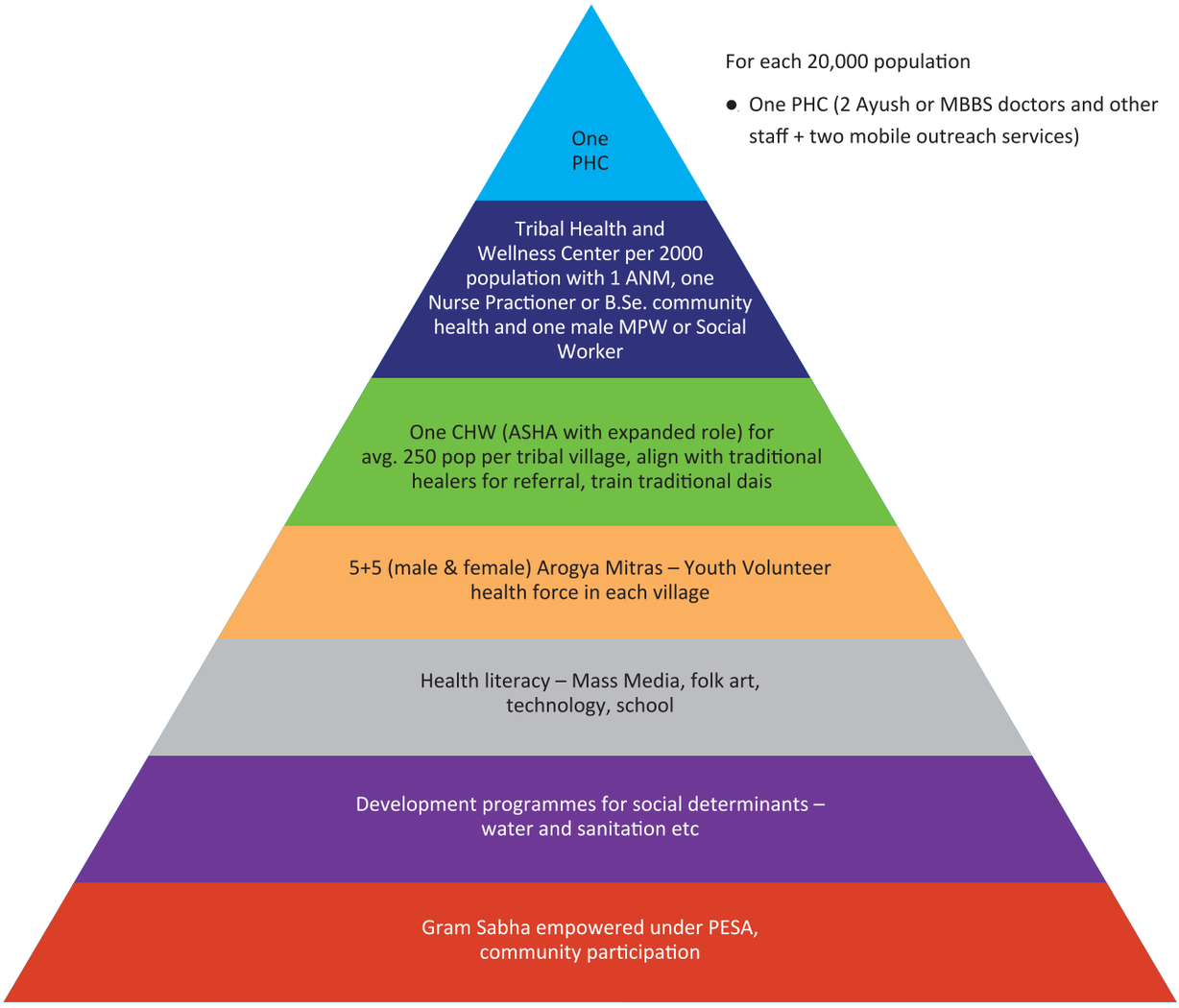
A. **Primary Health Care:** The Expert Committee would like to suggest the following structure for delivery of primary health care in tribal areas.

This structure visualises three distinct layers for the delivery of primary health care in tribal areas:

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.*
   i) At the base of this proposed structure would be the Gram Sabha
   ii) The village specific health needs will be decided by them and mediated through an annual Tribal Health Assembly and VHSNC per hamlet.
   iii) To bridge the knowledge gap, a massive Health Literacy drive through mass media, folk media, schools etc would need to be undertaken in local tribal dialects and using local cultural symbols.
   iv) This drive would be supported by trained ArogyaMitras. These would be volunteers -5 boys and 5 girls- from every tribal hamlet (per 250 people) who would spread awareness about health and good health practices, after due training and capacity building.
   v) The topmost rung at the community level would be the community health workers: empowered ASHA. This committee recommends that there should be one ASHA per 50 households or 250 population in tribal areas. She may be less educated and should be trained for expanded functions

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.

Figure 5: Primary Health Care Pyramid for Tribal Area



At least half of her total payment, that is the fixed component, should be routed through the Gram Sabha or the VHSNC.

The ASHA will be guided/supported by the Tribal Health and Wellness Centre. The ANM and Social Worker there will be her supervisors. She will be IT empowered.

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 in accordance with the proposed Health and Wellness centres, offer a much broader range of 15 types of preventive, promotive, curative and rehabilitative services.

This committee recommends strengthening these sub-centres to become THWCs. Once that is achieved 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.*
- It would have an ANM, one Male health worker/social worker for managing, health education and social mobilization and one attendant for the support functions. In addition to this a mid-level health care practitioner- a trained Ayurvedic doctor or Nurse/Practitioner would be stationed here to provide basic curative health care.
- Appropriate technology would be used to connect these mid-level practitioners to MBBS doctors to facilitate proper diagnosis and timely referrals.

3. **Primary Health Centre:**
   - At the apex of the Primary Health care pyramid in tribal areas would be the Primary Health Centre. This centre is currently for a population of 20,000 i.e. approximately 80 villages/hamlets. *The ten THWCs per PHC, strengthened with Ayurvedic doctors will be able to take provision of care closer to the people thereby reducing distance between tribal villages and health care services.*
   - All PHCs, CHCs and District Hospitals should have a help desk to support tribal patients.
   - All PHCs should have oral hygienist, ophthalmic assistant and a mental health counsellor.
   - **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.

This proposed structure for primary health care delivery in tribal areas would involve 1 to 2 per cent of the population in tribal areas in health care delivery as health workers (excluding volunteers). *It will empower the tribal people manage their own health.* At the same time, it will ensure the timely and efficient delivery of quality primary health care.

- Given the paucity of specialists, super-specialists and surgeons in tribal areas, **periodic diagnostic and surgical camps** need to be organized, for chronic surgical, gynaecological and ophthalmic problems The specialist doctors deployed at CHCs, district hospitals and medical colleges, should visit PHCs on a regular basis. ICT tools should be deployed to create a dynamic database of such doctors and an annual camp rooster should be created. There is a need to put in place strict guidelines for such camps to ensure quality of service provided.
- **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 eg ANMs and MPWs to ensure that they are able to cover maximum ground in minimum time. Government can, through banks, make available personal loans to these workers.
- India needs to innovate more **point of care diagnostic technologies**; to develop frugal and rugged technologies that can work with ease in the peripheral health facilities and with community health volunteers. We need to adapt or adopt good service delivery models, demonstrated by others in the tribal populations.

- **Public-Private Non-profit Partnerships** should be explored in a flexible way with good service NGOs and under the CSR.
- **Tele-medicine:** Tele-medicine can be used for assisting the doctors and health workers at the PHCs and the THWCs with expert advice.
- **Data collection:** Collection of data and monitoring is a huge problem across the country, but particularly in tribal areas. Local health workers in tribal areas can be empowered with mobile and tablet connectivity to record and share data and problems via sms or internet.

B) Secondary, Tertiary care and referral in the tribal areas,

- Given the paucity of specialists and doctors in tribal areas, hospitals in a district may be organized as a cluster and a team of specialists be ensured in each cluster.
- For tertiary care, medical colleges in tribal areas should take direct responsibility.
- This committee sees tele-medicine as providing a systematic back up to all PHCs and CHCs in tribal areas- mainly for discussing and finalizing treatment plans in chronic illness
- Tribal Help Desks should be set up in CHCs and DHs to ensure that no user fee is levied. There is strong evidence to show that user fees reduce utilization of health services.
- All existing government insurance programmes should be monitored for the percentage of ST beneficiaries for financial protection.
- Diagnostics, medicines and food should be free.
- For tribal areas the norms for 108 Ambulance services need to be relaxed. Alternatively, localised solutions through empanelled private vehicles run by local youth and women's SHGs.
- There should be emergency blood storage units or blood banks at all CHCs and DHs in tribal areas.

C) 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.

D) To ensure access to **Essential Medicines and Diagnostics**, 'e-Aushadhi', a web based application and a Central Diagnostic Unit (CDU) for every 20 Health and Wellness Centres is the recommendation. The Mobile Outreach Services attached to each PHC should have a mobile lab with it and a lab technician to reach essential lab facilities to the doorstep, especially for chronic diseases.

E) 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. Some health literacy strategies are targeted mass communication (wall paintings, posters, media); Health science exhibitions on mobile vans eg 'video rath'; folk media (folk theatre, street plays, cultural groups, health education courses and activities in schools; every contact with health system (ASHA, ANM, PHC, MMU) must be accompanied by a five-minute health education; Information Technology (tablets, mobile phones; village volunteers and VHSNCs.

F) 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. In Maharashtra alone there are 4.5 lakh tribal children in 1100 Ashram schools. These schools can be used to inculcate good health practices, disseminate information, monitor health and nutritional status, provide health care and train boys and girls to become frontline health workers.

G) **Cultural compatibility** is required to improve the utilization of health services by making hospitals more tribal friendly,having helpdesks, sensitization of health workers to tribal culture and language and designing culturally appropriate communication strategy and material.

H) Recommendations for Provision of Healthcare for Tribal people living Outside 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 (Integrated Tribal Development Project) areas and MADA clusters. But such strategy leaves out a large number of ST population.
- Trends from census 2011 suggest that the tribal population in the country is getting increasingly dispersed. Estimates IIPS based on the Census 2011 data show that in India, less than 45% of the tribal people live in 809 tribal majority blocks (with over 50% tribal population). Conversely, nearly 55% ST population (5.78 Cr) lives outside the tribal majority blocks. All 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 would like to suggest the following **Nine Steps** for tribal people living outside scheduled areas or tribal majority areas.

1. Population enumeration, and preparing village/town wise lists of ST families living outside the Scheduled Areas.
2. **ST sub-sample in National surveys:** such as NFHS, SRS, NSSO, DHS etc to enable independent assessment of the coverage and outcomes for STs living outside.
3. **Tribal Health Cell:** A tribal health cell should be created at the state and district level to monitor the health status, outcomes and coverage of health services for tribal people, including those living outside scheduled areas.
4. **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.
5. **Targeted Health communications:** provide targeted health communications to these families to fill the big information gap that exists.
6. **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.
7. **Health Insurance:** It is important to ensure that all tribal people are covered under public health insurance schemes. If the state does not have a medical insurance scheme, an AadivasiAarogyaBimaYojana should be introduced with special provisions tailored to the morbidity and causes of death pattern and healthcare needs among the tribal population.
8. **Provision of primary care:** All frontline health workers and the health care institutions (ASHA, ANMs, AWW, PHCs) and the disease control programmes and schemes should be given ST specific coverage targets depending up on the ST population in their work area.
9. **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.

4. Human Resources for Tribal Health

- The health workforce in our tribal areas is inadequate, demotivated, ill-equipped and without leadership. Health personnel view a tenure in tribal areas as a punishment. It is vital to "reposition" postings in tribal areas and make them more lucrative through a mix of financial and non-monetary incentives.
- 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.

The Committee makes following recommendations on human resources for tribal health

1. **Tribal youth**, who are literate, local and often with free time, are a good human resource for Tribal Health. Instead of importing unwilling medical personnel from outside, the more feasible and sustainable long-term solution will be to select, train and deploy local boys and girls from tribal areas as *ArogyaMitra,* trained birth attendants, ASHAs, paramedics and allied health professionals - staff nurses, lab technicians and pharmacists.
2. The role of **traditional healers** in the community should be recognized, and they should be offered training and encouraged to adopt a referral role, especially for animal bites, TB, malaria and other serious ailments. Similarly, the government needs to undertake training of traditional birth attendants/ dais with appropriate skill transfer and certification. Dais should be provided with delivery kits, and linking them to the nearest ASHA and the ANM.
3. 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*
   - A long term process of training, 25 days per year, provided through multiple-short duration workshops to progressively build as well as refresh her capabilities.
   - A sustained training system with two dedicated trainers in each block (for 320 ASHAs)
   - The ASHA workers should be encouraged to upgrade their skills through multi-skilling bridge courses so that they can be upgraded to the role of ANMs.
4. To bridge the gap in the provision of care created by the absence of a dedicated health work force, **Mid-level care providers**should be created through bridge courses and placed at the subcentres.

Table 1: Expanded Functions and expected work load of ASHA in tribal village/hamlet with 250 population

	Functions (and expected beneficiaries per month)	Approximate time Per month (in hours)
1	Treatment of illnesses. • Community based treatment (50) • Taken to MMU (10) • Assistance in referral (2)	15
2	Reproductive, sexual, adolescent health and FP (15-50 yrs, 150 persons)	15
3	Maternal – newborn – child health (6 deliveries/yr + 30 under-five children)	15
4	Communicable diseases + Sanitation	15
5	NCDs. (40 persons with NCDs)	15
6	Health promotion, mental health & addiction	15
7	Vital statistics, record keeping, reporting to the supervisors	15
8	Monthly Training	15
	Total	**120 (4 hours/day)**

5. **Three year courses** in B.SC Community Medicine or Rural Health should be started or reintroduced.
6. **Multi-skilling** and task-shifting with CHWs to do work, normally expected of nurses and paramedics. Then nurses and paramedics can become mid-level care providers, and doctors can be multi-skilled and work as basic specialists.
7. To **attract specialists, doctors** and other health functionaries to tribal areas and to ensure that they stay:
    - The total salary of MOs needs to substantially increase, by 30% and monthly performance linked bonus added. If the salary of all other cadres remains unchanged, then the total state health salary budget will barely increase by about 5%.
    - Their authority to take decisions along with the ability to "do good" and "make a difference" is a powerful inducement.
    - This needs to be coupled with incentives like well-equipped housing facilities through group housing schemes, preference for selection in post graduate courses, avenues for professional participation and networking through support groups.
    - Compulsory posting of Medical officers in tribal areas, for a period of 3-5 years, staggered or together, over the course of their entire service- normally 30 years in span- is another option.
8. Appointment of **'Prime Minister's Tribal Health Fellows'** is another solution worth exploring. These PMTHFs should be selected though a special process and be appointed for a period of 5 years. (Further elaborated later on)
9. Positions in tribal areas should be **empanelled** making them coveted postings through flexible recruitment and contracting norms.
10. **Flexible recruitment and contracting norms** may be set by states for the tribal areas.
11. Professional isolation and stagnation is often a primary concern of functionaries posted in tribal and difficult areas. **Avenues forprofessional growth** and career advancement need to be planned.
12. MBBS doctors with clinical responsibilities do not like look after administrative and public health responsibilities. In Africa, an ANM or GNM has been provided additional training as a **public health practitioner** to undertake the routine public health functions. Though this would lead to a bifurcation of curative and preventive functions, both services would still be available under a single roof and ensure performance of "in position" functionaries.
13. Under the PESA act, the *'Gram Sabha'* in tribal village has been empowered to guide the social sector and the health programmes and schemes. Hence, the health care staff must seek both, the guidance on the needs, and feedback on its services, from the *'Gram Sabha'*.
14. The committee recommends **creation ofdedicated medical colleges in tribal districts**, exclusively for tribal students in the scheduled areas in the state, on a priority basis. Serving in tribal areas should be made compulsory for those graduating from these colleges. This can be done through a legal bond. In view of the aim of this degree, the curriculum should be appropriate to produce doctors.This may require a bold departure from the current MBBS curriculum. A special Task Force might be constituted for deciding the training objectives and the curriculum.
15. **Reservation of seats for tribal people willing to serve in tribal areas**: Each medical college in the states with a sizable tribal population should have some seats reserved for tribal candidates from tribal areas, who are bound to return and work only in the tribal areas.

5. Addressing The Ten Special Problems in Tribal Health

There are ten health problems that affect the tribal people disproportionately

1. Controlling Malaria in the tribal population

The 124 districts with only 8 per cent of the country's total population but 49 per cent of its tribal population, accounted for 46 per cent of the total malaria cases, 70 per cent of the Plasmodium falciparum cases and about 47 per cent of the malaria deaths in the country. Yet only 10% of the budget of the NVBDCP is marked for TSP.

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

1. The objective of the TMAP is to reduce the annual parasite incidence to less than 1 API in Tribal districts.
2. It proposes to do so by undertaking a seven point strategy:
   - i) Ensure Adequate Human Resources.
   - ii) Introduce Surveillance system.
   - iii) Ensure Malaria protection at Ashramshalas.
   - iv) Introduce special and emergency care for Falciparum malaria.
   - v) Check the spread of vector through abandoned mines.
   - vi) Health education and BCC in tribal areas.
   - vii) Support research.

2. 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.
2. Use of local foods.
3. Strengthening of ICDS.
4. Nutrition counselling of mothers, built on the knowledge of local foods and food habits.
5. 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.
6. Prevention and treatment of infections.
7. Management of severe Malnutrition.

3. Reducing Child Mortality among the tribal population.

As described in the chapter on Status of Tribal Health, IMR, U5MR and malnutrition are unacceptably high among tribal children. Neonatal causes, pneumonia, diarrhoea and malaria remain the main medical reasons behind high child mortality. The committee recommends the following:

i) Recording and Measuring Child mortality-completely and correctly.

ii) Home-based Newborn and Child Care (HBNCC): several policy and operational gapsremain, especially in tribal areas. These need to be plugged urgently.
   - Clear goals and targets should be fixed for various indicators of HBNCC.
   - NMR, IMR and CMR:30% reduction in 3 years and 50% reduction in 5 years

4. Ensuring Safe Motherhood and health of the women from tribal communities

i) Focus on Safe deliveries, not institutional deliveries:
   - In addition to institutional delivery, it is imperative to train the traditional birth attendants and dais and equip them with TBA (trained birth attendant) kits.
   - Tribal women should be given the choice to decide where they want to give birth, and both the places be made safe.

ii) Round-the-clock Emergency Obstetrics care: There should be at least one place with Emergency Obstetrics Care per 2 lakh population and within one hour vehicular journey from a primary care site.

iii) Accommodation near health centres.

iv) ANC and PNC care.

v) Emergency transport for maternal complications.

vi) Special measures for Particularly vulnerable tribal groups.

vii) Timely payment.

viii) A comprehensive plan for women's health.

5. Providing Family Planning Services and Infertility care

The current TFR in ST population has reduced to 2.5 (NFHS-4)

This committee firmly believes that it is important to recognise the right of every man and woman, including those belonging to PVTGs to make their own reproductive choices.

i) Determining the true TFR: MoHFW should collaborate with the Census Commissioner to establish the true fertility rates for all tribal communities and to adopt individual and case- appropriate solutions for population stabilization.
ii) Availability of Family Planning information and services: Where a tribe has a total fertility rate of more than 2.1, the government should ensure the availability of safe family planning methods under the RCH programmes.
iii) Culturally sensitive Infertility care.

6. Controlling the use of addictive substances and providing de–addiction and mental health service.

i) Map the magnitude of the problem.
ii) Implement the Excise Policy for Schedule Areas.
iii) Restrict the supply of Tobacco.
iv) Effective IEC campaign.
v) Establish a network of responsive De-addiction centres.
iv) Community based strategies and support groups.
vii) Culturally appropriate mental health support.
viii) Timely screening of mental health problems.

7. Sickle Cell Disease

Currently, there are two views on SCD in India

While the current campaign has created a mechanism for screening people for the sickle cell trait, there is no plan of action for people with the serious form of disease. Therefore this committee believes that providing good quality care for those with clinically severe Sickle Cell Anaemia must be the first priority. In the absence of an evidence of the need and effectiveness of marriage counselling, the whole program of mass screening may prove to be a futile exercise of shadow chasing.

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

8. Ensuring timely treatment for Animal Bites, and Accidents

1. Development of a comprehensive system for the management of animal bitesand the trauma.
2. Institute a Snake Bite Management system.

9. Health Literacy in Tribal areas

Knowledge is the best pill and best vaccine. Therefore massive health literacy drives for continuous health education of women, men, youth and children are needed. Detailed ways of doing so are included in the Chapter on Organization of Service Delivery.

10. Health of Children in Ashramsalas

Alarge number of tribal children reside and study in Ashramshalas. (Nearly 450,000 in Maharashtra alone). However, the living and health conditions there are deplorable.

The Salunke Committee on Health in Tribal Schools provides the recommendations for improving the current scenario. These are also recommended by this committee.

6. Integrating Traditional Tribal Medicine into Primary Health Care

Traditional Medicine or 'people's health culture' is usually an oral tradition of healing techniques and properties of plants and animal substances that is passed from one generation of healers to the next. In many communities, it is the traditional healer, not the AYUSH or allopathic doctor who is approached first. It is not culture alone, but a lack of options that governs the final decision on care seeking.

- The traditional tribal medical system and the modern medicine and public health will continue to co-exist for at least a few generations. The objective is to facilitate a seamless integration where different systems of medicine co-exist to provide the best possible care to the people from tribal communities.

- Most tribal societies believe that diseases are caused by supernatural forces. They view the traditional healer as a medium between man, nature and the supernatural entity who guards their community and provides spiritual security.

The **aim** of the tribal health policy should be three fold:

a) To empower the tribal people to be healthier;
b) To seek and identify effective and safe practices and remedies in tribal medicine;
c) To bring the traditional tribal healer into primary health care in order to increase the access to primary health care by tribal people.

Objective 1: *To study, document and test the tribal health traditions, particularly tribal systems of medicine, of different tribes.*

1. Compendium on Tribal herbal medicines with rigourous testing:
   This Committee recommends the creation of a compendium on Tribal herbal medicines and their scientific assessment.
2. Documentation of Traditional Practices:
   This should be carried out by linking tribal communities to local universities and medical institutions. The data thus collected, should be used for designing appropriate behaviour change communication initiatives.
3. Evidence Based dissemination.

Objective 2: *To integrate tribal medical practitioners into primary health care.*

1. Integrate traditional healers in Primary Health Care:
   a) The first step in the integration of these traditional medicine practitioners is recognizing their traditional position and skill
   b) The identified tribal healers should be offered training and encouraged to adopt a referral role for animal bites, TB, malaria and other serious ailments.
   c) Where the Gram Sabha so desires, local traditional healers may be integrated into the PHC and allowed to treat alongside the doctor and the AYUSH practitioner. The choice of who to consult should lie with the patient. At the same time, all the three medical practitioners should be encouraged to recognise conditions that need referral to another system of medicine and to advise patients accordingly.
   d) Many traditional healers and practitioners are grappling with issues of survival.
   e) Ensuring access to medicinal plants for these healers is important.
2. Train traditional birth attendants.
3. Orient health personnel about local tribal health traditions and medicine.

Objective 3: *To empower the tribal people to adopt healthy practices to enhance their capacity for self care.*

Design effective behaviour change communication campaigns.

a) The promotion of healthy behaviours requires formative research with ethnographic inputs to feed into health education and communication strategies, and to define the content of the communication.
b) Health campaigns must necessarily mix a strong endorsement of good practices inherent in tribal cultures- with a reasoned and sensitive disavowal of the harmful practices.
c) All BCC strategies must recognize the heterogeneity of tribal groups and the need for tribe and region specific interventions, in the local language and dialect.

Objective 4: *To enable the tribal people to enjoy the economic benefits of their traditional knowledge.*

Enable tribal people to cultivate, consume and collectively market validated tribal remedies.

Objective 5: *To encourage the tribal people to access modern healthcare infrastructure*

1. Help Desks at Health centres.
2. Making Hospitals more tribal friendly.
3. Sensitization of health workers.
4. Assembly of tribal health.

7. Knowledge, Research and Data on Tribal Health

- As of date, there is scant data and information on the health culture, systems and health status of the tribal population in the country. The lack of disaggregation at the level of reporting means that there are huge data gaps at all levels.
- A more comprehensive and efficacious policy on tribal health demands a well-developed understanding of the health of tribal people- including but not limited to their knowledge, attitude, practices, health seeking behaviour, epidemiological status, access and availability of health services and the changes therein with the introduction of new measures.

1. **Principles and Approaches to Tribal Health Research**
   a) Respect (for tribal culture)
   b) Relevance (to tribal communities)
   c) Reciprocity (through a two way process of learning and exchange)
   d) Responsibility (empowerment through activate engagement; ensuring that the tribal people face no adverse consequences due to research including denial of access to their traditional knowledge).
2. This committee proposes the following **Five approaches to Research on Tribal Health:**
   a) Multi-disciplinary.
   b) Participatory and community based. Community Based Participatory Research (CBPR) addresses the needs of the community and ensures that the findings of the research are transmitted to and adopted by community members.
   c) Epidemiologic research: state specific and tribe specific epidemiologic research will be the foundation of the tribal health plan.
   d) Implementation Research integrated into policy and programmatic decision-making.
   e) Evaluation Research.
3. **Scope of Tribal Health Research**
   There is a need for a more holistic tribal health research plan that covers the gap in terms of themes, regions and tribes. Research on Tribal Health should encompass:
   a) Studies of the knowledge, attitudes and practices in the tribal people. What do they want? Why?
   b) Study of tribal medicines and practices, and scientific evaluation of the same;
   c) Epidemiological studies: Study of morbidities and mortality that affect tribal populations; the rates and the trends, and the interventions studies.
   d) Healthcare Delivery Systems in Tribal areas: priorities, inputs, coverage, quality, utilization, barriers and bottlenecks, outcomes.
   e) The policy, governance and financing.

Challenge 1: *Undertaking Innovative Solutions Research on* Grand Challenges*in tribal health*

Challenge 2*: To collate and make available existing data on tribal health*

a) Currently, the sampling methodology for many population based surveys eg SRS (Sample Registration System) is not designed to provide information on tribal populations. The Committee recommends that these on-going national surveys be advised to aim to estimate various rates in the tribal population.
b) The existing data on tribal populations in surveys need to be segregated, analysed and made available to researchers and practitioners.
c) The Sample Registration System annually publishes the IMR for the rural, urban and total population in each state. The category of 'Tribal' should be added for the states with sizable tribal population. The tribal specific vital rates- for these states and nationally- should be estimated and published annually.

d) Tribal Health Directorate: The Expert Committee recommends that the task of collating the available data on tribal health and identifying information gaps be entrusted to the special Tribal Health Directorate created within the MoHFW.

e) Dissemination of Data:
   - A State of Tribal Health report should be published every three years and placed before the nation.

Challenge 3: *To generate knowledge and disaggregated data on various aspects of tribal health.*

a) Tribe Specific Surveys:A case can be made for a separate Tribal Health Survey or for large scale tribe specific health surveys.

b) Collection of Tribal Health Data: Standard guidelines for HMIS and Civil registration systems must insist on capturing tribal identity so that these could be analysed subsequently.

c) National survey like NFHS, DLHS, AHS, NSSO, SRS and Census should generate tribe specific estimates.

d) Epidemiological Research:Several community based sentinel surveillance sites need to be established to get disease and morbidity data.

e) Maternal and Child Death Audits.

f) **Tribal Health Research Agenda and Special Cell:** A corresponding Tribal Health Research Cell, headed by a senior officer, needs to be created within the Dept of Health Research (DHR) to oversee all Tribal Health Research and to ensure that the data and knowledge generated therein is systematically transferred.

   The DHR should earmark at least 10% of its budget for Tribal Health Research and this should be entrusted to the Tribal Health Research Cell (THRC).

g) **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.

Challenge 4: *To document and test tribal health traditions, particularly tribal medicine.*

Compendium on Tribal herbal medicine:There is a need for documentation and study of herbal remedies, followed by rigorous scientific evaluation to test its potential.

Challenge 5: *Strengthening the institutional mechanism for Tribal Health Research and allocation of sufficient funds.*

a) **Expansion of the ICMR and TRI networks:** ICMR should develop independent Field Stations in tribal areas of the country. To beginwith, this should be done on a priority basis in districts with more than 50% tribal populations

b) **Tribal Health Research Centres and Demonstration Centres in NGOs:** To avoid duplication and costs, select NGOs already working in the tribal areas and with the capacity to conduct quality research should be encouraged to establish Tribal Health Research Centres or Demonstration centres of excellence. To begin with, 15 such sites should be set up in the country,

c) **Tribal Health Directorate and Tribal Health Research Cell:** A special Tribal Health Directorate needs to be created within the MoHFW to oversee all matters related to Tribal Health (described in detail in the chapter on Governance). A parallel Tribal Health Research Cell (THRC), headed by senior officer, needs to be created within the Department of Health Research.

d) **Budget for Tribal Health Research:** At least 10% of the Budget of DHR should be spent on tribal health research. In addition to this, 5% of the TSP funding on Health should be ear-marked for Health Research to create a special Tribal Health Research Fund

Challenge 6 : *Protecting the Rights and Access to Knowledge for Tribal people and Tribal Communities, by way of* Strengthening Ethics Oversight,
Protecting Knowledge Rights of the Community.

Challenge 7: *Monitoring, Supervision and Impact Evaluation of health programs in tribal areas.*

Regular monitoring, supervision and evaluation of health policies, programmes and infrastructure is an important way of creating Knowledge re Tribal Health. While there is an HMIS already in place to monitor the health outcomes of communities, the system needs to be strengthened to ensure availability of good quality, disaggregated data at all levels for a robust prognosis of tribal health issues and evaluation of measures and policies.

i) **Data on Tribal people within all existing programmes:**All national programme should have data/ information exclusively on tribal people and special provisions should be made to monitor the benefits of the programme for tribal population.
ii) **Monitoring benefits to the tribal population.**
iii) **Policy evaluation:** There is a need to focus on implementation research in Tribal Health and to ensure that the results from it feed into programmes and policies, thereby ensuring maximum gains for tribal health.

8. Governance and Participation

This committee would make the following recommendations to ensure effective health care delivery in tribal areas through a robust governance and participation mechanism:

Challenge 1: *Creating a more responsive and focused governance structure for tribal health, at all levels of governance (Fig-6)*

1. **National Tribal Health Council:** To focus the national attention, resources and efforts for rapidly overcoming the deficit in health status and health care suffered by the 10.4 crore tribal people in India, a National Tribal Health Council should be created. The NTHC will be jointly constituted by MoTA and MoHFW for a time limit of five years and cover health, health care and all the related aspects. It will address all the ST population in the country, living in the scheduled areas or outside it as well.

Scope

i) To design and approve policies for Tribal health
ii) To develop the institutions, human resources and health care delivery systems for the tribal people.
iii) To achieve health outcomes at par with those of the non-tribal general population in the respective states.
iv) To approve a National Roadmap for Tribal Health, incorporating the above three.
v) To approve the budget for Tribal Health.

National Tribal Health Council will be the highest policy making body on Tribal health with inter-ministerial linkages. It will discuss and approve the Tribal Health Plan including the envelope of the resources and the principles of allocation. NTHC will meet annually to review the progress and approve policy decisions.

2. **The National Tribal Health Roadmap:** In light of this committee's report and recommendations, a roadmap should be prepared by the MoHFW. This should act as an operational plan to achieve the first three tasks identified in the scope of work for the NTHC. After discussion and approval by the NTHC, this Roadmap will become a part of the plan of the National Health Mission. The Tribal Health Directorate with the NHM will facilitate and monitor its implementation.

3. **Tribal Health Directorate**: A Tribal Health Directorate (THD) should be established under National Health Mission, both at the national and state level, with a senior bureaucrat at its helm (a Joint Secretary Level officer at the Centre and Additional Director level at the state).
   i) This Directorate will function as the Secretariat of the NTHC, planning and operationalizing its recommendations.
   ii) It should publish a **State of Tribal Health report** every year and place it before the nation.
   iii) It should also maintain an annual **Tribal Health Index.**

iv) This Directorate should therefore be responsible for overseeing the Health Ministry's **budget** for STs and for the TSP allocation towards health.

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

   In order to attract dynamic personnel, posts in tribal areas should be made into empanelled postings.

   It will be the responsibility PMTHFs to
   i) Create the participatory consultative structure described earlier
   ii) Develop the taluka and district tribal health plans and budgets
   iii) Supervise the implementation
   iv) Review and report

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

Ensuring participation of local communities in tribal areas in health planning could be achieved through five institutions:

i) **Tribal health Advisory councils at the national and state level:** (beginning with the nine states with substantial tribal population),
ii) **District level consultative Tribal Health Council.**
iii) **Assembly on tribal health:** Once every year there is a need to organize a block and village level tribal health assembly.
iv) **Village Health, Sanitation and Nutrition Committees:** These VHSNCs should be formed at the hamlet level.
v) **Gram Sabha:** A tribal village/hamlet is a physical and social reality. PESA duly recognizes and empowers the 'Gram Sabha' which is at each village/hamlet, and not at the Gram panchayat level. Under PESA Act, tribal Gram Sabhas have been empowered to guide the social sector programs and plans in the village. The Gram Sabha should be consulted and asked for the health priorities and gaps which need to be covered, feedback on various existing programmes, and suggestions for the next year.

All participatory processes need some template of agenda and review items and the guidelines on the processes. These should be prepared as tools to assist organizing these meetings. Moreover, the scope and limits of their advisory power should be clearly defined. Otherwise suggestions are often ignored by the officials who may find them inconvenient.

Challenge 3: *Ensuring inclusive governance through local level planning, shifting the focus from national to state, and district, finally up to the village level.*

A. **Building institutional capacity for decentralized and participatory planning in the district**

- The unit for preparing the Tribal Health Plan must be the district, or the sub-district or ITDA (since many districts have the tribal and not tribal areas clubbed together).
- The paradox of tribal health planning is that while more flexibility and autonomy is needed in tribal areas, the planning capacity is poorer precisely in the same areas. Hence it is important to build the capacity for planning and management by way of 1) Strengthening the district tribal health council and have a formal linkage to the district health society. 2) Deploying a District Tribal Health Officer – a new specialized cadre, and 3) Preparing District Tribal Health Action Plan that fulfils three criteria- is made in a participatory manner, is technically sound, and is matched by/ matches resource allocation for it.

District Tribal Health Action Plan

- The district tribal health plan must address the specific health issues of tribal population and its different sub-groups in that district.
- Areas: This plan should apply to all scheduled areas in the district and should cover ITDP, tribal majority blocks, MADA and mini-MADA areas.
- **Outcomes of the District Action Plan** will be improvements in.
  a) Tribal Health Index,
  b) Infant, Neonatal, Child mortality, Maternal morbidity, Crude Birth and Death Rate.
  c) Incidence/prevalence of main diseases such as Malaria, Tuberculosis, Leprosy, Filariasis, HIV, Anaemia, Severe Malnutrition, addiction,
  d) Reduction in main risk factors such as mosquito breeding and density, indoor smoke, tobacco and alcohol use, hypertension, open defecation, lack of safe drinking water etc.
  e) Knowledge and behaviour of the people on health and healthcare
  f) Complete and proper allocation and use of finances

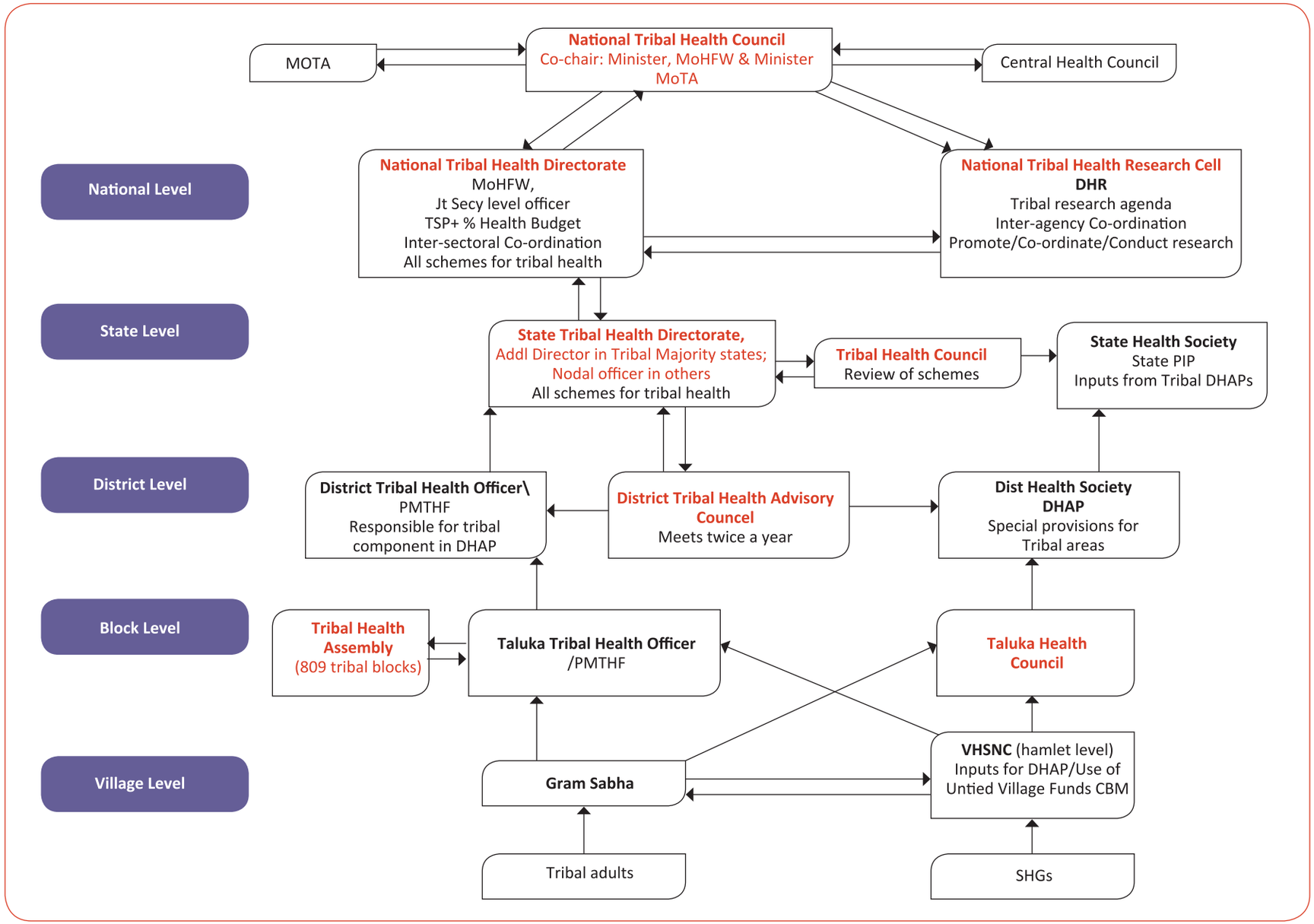
B. **Revising Funding norms:**

It is neither possible, nor desirable to deny health care services to the almost 2 crores 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

Challenge 4: *Ensuring convergence and inter-sectoral co-ordination for tribal health*

The National and State Tribal Health Councils, THD and the THRC suggested above will act as instruments of inter-sectoral collaboration.

Figure 6: Proposed Governance Structure of Tribal Health



9. Financing Tribal Health

- Inclusive policies and programmes for tribal health need to be matched with adequate budgetary provisions. Recognising the gap in the status of the tribal population vis-à-vis the normal population, the Government of India introduced the Tribal Sub-Plan that mandated a spending on the tribal population at least in proportion to their population percentage. The TSP was visualized as an additionality over and above the regular programmatic spending in the tribal areas by departments and ministries.

- However, this provision has not been effective in improving the status of the tribal population primarily because it has been reduced to an exercise in notional allocation at the time of budget presentation and subsequent re-appropriation to ensure timely utilization. Moreover, even in states where actual allocation is made for TSP, very little is earmarked for tribal health.

- Lack of information not only stymies all attempts at effective policy making, it proves a great impediment in determining how much money is actually available to close the healthcare gap between the tribal and non-tribal population.

This committee would like to make the following recommendations to deal with the challenges of financing Tribal Health:

I. Ensure adequate financing for tribal health

There is no getting away from the absolute necessity of increasing public health expenditure in tribal areas and for tribal health. Compensating for distances, lower social, economic and educational levels, lower baselines on health indicators and poorer ability to pay means that the per capita expenditure on public health in tribal areas would need to be much more than the expenditure in non-tribal areas. While the cost-benefit ratio for ensuring tribal health may not be favourable, the cost-equity ratio will be extremely favourable.

1. **Increase the government spending on health and on tribal health:** The National Health Policy (2016) envisages that atleast 2.5% of GDP be allocated towards health to ensure a functional public health system. This is in line with the recommendations of the High Level Expert Group on Universal Health Coverage that suggested that public expenditure on health be increased to 2.5% of the GDP by 2017 and 3% of the GDP by 2022. *This Expert Group feels that increase in public spending on health to at least 2.5% of GDP as recommended by various committees and policies is the starting point for any substantial change in the health status of the people of this country. This will have to be matched by a focused increase of allocations for tribal health 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.*

2. **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.

Table 2: Expected allocations for Tribal health in the health budget (as per TSP guidelines) by the States and the Centre

State/ UT *	% ST Population (A)	Budget Estimates for Health in Rs Crores (2015-16) (B)	Expected Allocation for Tribal Health in proportion to tribal population Rs. Crores (C = A*B)
Jammu and Kashmir	11.90%	2680	319
Himachal Pradesh	5.70%	1776	101
Uttarakhand	2.90%	1782	52
Rajasthan	13.50%	12033	1624
Uttar Pradesh	0.60%	16098	97
Bihar	1.30%	5059	66
Sikkim	34.00%	343	117
Arunachal Pradesh	68.80%	657	452
Nagaland	86.40%	515	445
Manipur	33.20%	487	162
Mizoram	95.00%	487	463
Tripura	31.80%	803	255
Meghalaya	86.20%	633	545
Assam	12.50%	3551	444
West Bengal	5.80%	6346	368
Jharkhand	26.20%	2941	771
Odisha	22.90%	3897	892
Chhattisgarh	30.60%	3282	1004
Madhya Pradesh	21.10%	6091	1285
Gujarat	14.80%	7845	1161
Daman & Diu	6.30%	65	4
Dadar and Nagar Haveli	52.10%	93	49
Maharashtra	9.40%	10090	948
Andhra Pradesh	7.00%	6022	422
Karnataka	7.00%	6321	442
Goa	10.20%	740	75
Lakshadweep	94.90%	60	57
Kerala	1.50%	5643	85
Tamil Nadu	1.10%	8163	90
Andaman and Nicobar Islands	7.50%	262	20
Punjab	0	3214	0
Chandigarh	0	387	0
Haryana	0	3252	0
Puducherry	0	574	0
Delhi	0	4638	0
Total (States)		126830	12814
Union (MoHFW including Ministry of AYUSH)	8.60%	33282	2862
Grand Total		***160112***	***15676***

(Source : Calculations by the NHSRC, 2017)

** According to Census 2011 following states and UTs did not report ST population- Punjab, Chandigarh, Haryana, Delhi, Puducherry*

3. **Estimating the financial allocation due for tribal health**

Table-22 indicates the expected central and state-wise allocations for Tribal Health based on present level of public health expenditure and TSP guidelines. Using these budgetary estimates the following can be inferred:

A)
- 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 (Table-22)
- The total tribal population in the country: 104 million
- Per capita additional allocation due towards tribal health as per TSP guidelines: ~Rs 1507

B) Per capita overall government health expenditure in the country: Rs 1277
Per capita government health expenditure in the country (after deducting expected allocation for TSP and SCP):Rs. 940

C) 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 (minus TSP and SCP allocation) and the per capita allocation for tribal health as per TSP. This is (Rs. 940 + 1507) equal to Rs 2447 per capita ST per year.**

D) Interestingly, if 2.5 per cent of the country's GDP is spent on Health, as per the recommendations of this committee and 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 (as per the HLEG). This will not just improve the overall health and well-bring of the tribal population, it will take us one step closer to implementing the draft national health policy.

4. **Earmark percentage of MOTA's allocation for Health:** It is important for MoTA to clearly bring out guidelines with respect to its expenditure, earmarking a certain percentage for health. There is precedence here. The Department of Tribal Development, Government of Maharashtra has already issued an order stating that 15% of the district allocation of its funds should be spent on health.

5. **Tribal Health Activities which should be considered for financial support from TSP funds by the MOTA** – at the national or the state level.

i) In principle, we recommend that any activity or program which is a part of the regular activities and services of the MoH&FW should not be funded by the MOTA from the TSP funds unless the line department has allocated and used its

own share of the budget for the tribal population in proportion to the share of the total population.

ii) The strategic focus of the TSP funds should be on the initiatives which:
   a) leverage the mobilization or utilization of the funds of the MoHFW
   b) Special problems/needs of the tribal health not likely to be covered by the regular programmes of the MoHFW.

Following are some of such items:

1) Independent data generation on tribal population, health status and health outcomes, IMR and CMR, health care coverage and quality, gaps, barriers etc.
2) Information on Tribal Health Culture
3) Tribal Health Literacy :
4) Designing special programmes for the health care as well as health education of tribal children in Ashram Schools.
5) Developing special human resources for tribal health – their training and deployment. Such personnel could be:
   i) A management cadre of Tribal Health Officers at the Taluka, District, ITDP level.
   ii) Opening special medical college exclusively to produce committed/ bonded doctors from and for the tribal areas.
   iii) Enhancing the number, training and support to ASHAs
6) Specific Disease control in tribal areas (such as Malaria, Child Mortality, Addiction, Snake bites and & animal bites) only to supplement the special projects or innovations.
7) Hard Area Allowances
8) PPP with not for profit organisations, and supporting 15 Centres of Excellence in Tribal Health.
9) Facilitating reach out of National insurance schemes to tribal populations.

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.

This committee strongly believes that the health insurance coverage should be seen as a means of enabling the tribal population to access secondary and tertiary health care, without incurring any additional financial burden. *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.

7. **Encourage Public Private Partnership in Health selectively:** This committee believes that to improve the status of tribal health there is a modest scope of public private partnerships and a high scope for alliance and partnerships with non-government agencies.
8. **Tap into Corporate Social Responsibility (CSR) Funds:**
9. **Levy a Cess on Extractive industries:**
10. **Special Central Assistance to Tribal Areas:**
11. **Tax exemptions:**

II. To ensure optimal utilization of resources and transparent accounting

1. **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.

2. **Single pool of funds:** The current system of fund flows for tribal health is complex. Several ministries and state departments provide funds to these regions/ populations through different mechanisms. A mechanism to consolidate the pool of funds for health for tribal populations /regions could be proposed at district level under the aegis of the district panchayat (or tribal autonomous council where this exists, and the district health society).

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.



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