National Conclave

Nourishing India’s Tribal Children

Voices of frontliners, promising practices and policy implications

Synthesis of deliberations and recommendations

15-16 January 2015
Mayfair Convention, Bhubaneswar, Odisha, India
National Conclave

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National Conclave: Nourishing India’s Tribal Children
Stunting in children is a measure of chronic undernutrition, with irreversible, profound and lifelong consequences. A stunted child is significantly less tall than would be expected for his or her age. Stunting contributes to one third of under-five deaths globally, and adversely affects a child’s health, cognitive capacity, school performance and productivity in adulthood.

According to the National Family Healthy Survey (NFHS) 2005-2006, 48 per cent of Indian children under five are stunted. The prevalence of stunting is highest (54 per cent) among children of India’s tribal peoples. In terms of numbers, 6.2 million out of 11.5 million tribal children aged under five in India are stunted. Nine tribal dominated states of central India collectively house 4.7 million of these stunted children: Andhra Pradesh, Chhattisgarh, Gujarat, Jharkhand, Madhya Pradesh, Maharashtra, Odisha, Rajasthan and Telengana.

Stunting in tribal children is severe and influenced by multiple interrelated factors. These include household poverty and food insecurity, maternal nutrition before and during pregnancy, poor complementary feeding practices in the first two years of life, and poor access to water, health and sanitation services.

At least six ministries have a role to play to ensure tribal children are well nourished. These include (i) Ministry of Rural Development; (ii) Ministry of Public Distribution and Civil Supplies; (iii) Ministry of Health and Family Welfare (MoHFW); (iv) Ministry of Women and Child Development (MWCD); (v) Ministry of Drinking Water and Sanitation; and (vi) Ministry of Tribal Affairs (MoTA).

The Ministry of Tribal Affairs, being the nodal ministry for welfare, development and protection of tribal children, has the mandate to convene, coordinate and synergize efforts of line ministries to reduce undernutrition in tribal children. However, its role for ‘nutrition’ remains untapped.

In order to accelerate synergistic multi-sector actions to reduce stunting in tribal children of central India, a two-day national conclave to draw attention to stunting among tribal children across the nine states of central India was held on 15-16 January, 2015, in Bhubaneswar, Odisha, India.

The conclave was jointly organized by the Ministry of Tribal Affairs and UNICEF, in collaboration with the Ministries of Women and Child Development, and Health and Family Welfare. It was hosted by Odisha’s Scheduled Tribes and Scheduled Castes Development Department, Research Training Institute and UNICEF Odisha.
The national conclave on tribal nutrition had two main objectives:

1. Identify challenges and promising practices [‘what works and how’] for improving food, livelihood, Integrated Child Development Services (ICDS), health and sanitation services for tribal children in the nine states of central India.

2. Deliberate how government departments in these states can coordinate, contribute and commit to reducing stunting in India’s tribal children by involving frontliners, practitioners and various government departments in the nine states.
Delegates

The conclave brought together 297 delegates from state and district Scheduled Tribes and Scheduled Castes Departments; Tribal Research Institutes; Commissioners of State Departments of Women and Child Development, Health and Family Welfare, and Drinking Water and Sanitation; national representation from five ministries – Tribal Affairs, Health and Family Welfare, Women and Child Development, Drinking Water and Sanitation, and Rural Development; and the Prime Minister’s Office (PMO).

Representatives from non-governmental organizations (NGOs), academia, print and electronic media, and UNICEF offices at national and state level were also in attendance.
The first two plenary sessions set the context and provided a platform for national government officials and key stakeholders to affirm their commitment to improve nutrition of tribal children. This was followed by six parallel sessions, which focused on sharing state-level promising practices ‘what works and how’ through presentations by practitioners and identifying the challenges and recommendations through group work.

The six thematic sessions covered all underlying and basic determinants of undernutrition in tribal children:

- Improving household food and livelihood security
- Improving Integrated Child Development Services in tribal areas
- Improving tribal health outreach and referral services
- Improving drinking water and sanitation services/commodities in tribal areas
• Tribal budgets, governance and coordination for nutrition
• Role of academic institutes and NGOs in improving nutrition services in tribal areas

Each parallel session was led by a government official and moderated by a reputed media personality.

To ensure that voices of frontliners were adequately captured, an additional special parallel session was organized with tribal community members. This session was moderated by Ministry of Tribal Affairs representatives. Similarly, a special session was held for media representatives for their interaction with experts. See Annex for the conclave agenda.

Market stalls of select NGOs working in tribal areas displayed descriptions of their ongoing nutrition related development work. Furthermore, stalls of uncultivated forest foods were showcased by nine tribal community federations/community-based organizations associated with five NGOs, which was a special highlight of the two-day event.

A synthesis of recommendations emerging from the parallel sessions were presented during a concluding plenary session, with reflections by senior government officials from the Prime Minister’s Office, Ministry of Rural Development and Ministry of Tribal Affairs on the way forward.

The UNICEF 2014 report – Nourishing India’s Tribal Children – which presented an analysis of existing data on the determinants of stunting among tribal children, documentation of 12 promising practices and affirmative actions as well as a supporting pack of 11 films were circulated to all participants.

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1 Development Research Communication and Service Centre, Digital Green, Gramvikas, Living Farms, MS Swaminathan Research Foundation, Reach India and Sewa Rural.
2 Abhiyakti Foundation, Development Research Communication and Service Centre, KIRDTI, Living Farms and SACAL.
3 UNICEF, Nourishing India’s Tribal Children: The nutrition situation of children of India’s scheduled tribes, 2014.
The inaugural session reiterated commitment towards India’s tribal children, which began with lighting of the lamp by panel members. While delivering the welcoming note, Yumi Bae, UNICEF Chief of Office, Odisha, invited delegates to use the conclave for mutual learning and understanding on how different sectors could pool resources, time and expertise to nourish tribal children.

Surendra Kumar, Indian Administrative Service, Secretary, Scheduled Tribes and Scheduled Castes Development Department, Government of Odisha, highlighted that this conclave was the culmination of a year-long dialogue with UNICEF to ensure that the best evidence and practitioners across the nine states and six line departments could come together to discuss the multiplicity of issues and
solutions to end undernutrition in tribal children.

Louis-Georges Arsenaught, UNICEF India Representative, emphasized the need to focus on inter-ministerial coordination, nutrition of tribal women during preconception, and to ensure food and livelihood security linkage with nutrition promotion. He also emphasized the importance of listening to the voices of frontliners, at which point a film produced by UNICEF was shown.

The film captured recommendations from frontline workers across five states on the actions needed to reduce undernutrition in tribal children. These included promoting indigenous food forests, improving access to livelihood and universalization of public funded crèches in tribal areas, strengthening quality and monitoring of anganwadi centres (AWCs), and better enforcement of community forest rights.

Baijayanta (Jay) Panda, Member of Parliament and member of Citizens’ Alliance against Malnutrition, emphasized the importance of addressing anaemia in the mother, early and repeated pregnancy, early child care and feeding practices, gender and traditional taboos. He apprised the delegates of the Citizens’ Alliance Against Malnutrition – a bipartisan alliance of members of parliament, which has potential to lead and initiate change for nourishing tribal children.

Sudam Marndi, Minister of State, Tribal Welfare, Odisha, stressed the need to contextualize channels of communication in order to effectively communicate with tribal peoples, and to work with them as partners of change. He highlighted the importance of documenting promising practices to ensure cross-fertilization of ideas.

Lal Bihari Himirika, Minister, Scheduled Tribes and Scheduled Castes Development Department, Odisha, and chief guest, inaugurated the event. He stated that a better nutritional outcome requires not only food security but also adequate access to health, clean drinking water and other basic amenities. He highlighted a state initiative, Mamata, which provides conditional cash to pregnant women to promote access to antenatal and postnatal care. He concluded by stating that national progress would remain incomplete without taking the needs and aspirations of the tribal population into account as they contribute to the bulk of undernourished Indian children.
During Plenary 2, panellists highlighted the severity of child stunting in tribal areas and the perspectives of five different ministries on the ongoing efforts to improve nutrition services in tribal areas. Presentations were made by Saba Mebrahtu, Child Development and Nutrition Section, UNICEF India; Gopal Sadhwani, Ministry of Tribal Affairs; Manoj Jhalani, Ministry of Health and Family Welfare; Gulshan Lal, Ministry of Women and Child Development; Urvashi Prasad, Ministry of Drinking Water and Sanitation; Nita Kejrewal, Ministry of Rural Development; and S.B. Agnihotri, Cabinet Secretariat. Key messages from this session are summarized in this section.
1. **Focus on districts contributing to maximum burden and deliver proven interventions at scale**

Globally, 10 proven interventions, if delivered at scale, can reduce undernutrition among children, including tribal children (see Figure).

The following steps for a strategic approach were highlighted:

(i) Map the districts within the nine states contributing to the highest burden of stunted children in terms of numbers.

(ii) Identify the gaps in access to the 10 interventions for each of these high burden districts, which could be contributing to the high levels of stunting. Where data permit, this analysis to be done at the block for developing context-specific strategic plans.

(iii) Select key priority departments to come together in support of identified priority interventions, and provide results-based incentives to achieve the specific targets, given that each of these interventions are not necessarily handled by one sectoral ministry. Evidence exists in Latin America (Brazil and Peru) and Asia (Bangladesh) showing that such a multi-sectoral approach can yield impressive results. Nepal has successfully brought together key line ministries to develop an evidence-informed and results-based multi-sector nutrition plan, and is in the process of implementing it in select high burden areas.

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**Figure: Ten proven interventions to reduce undernutrition in children**

**Care for women before and during pregnancy**

1. Prevent pregnancies – too early, too many and too soon.
2. Adequate micronutrients, food, care and support for women pre-conceptually, during pregnancy and between pregnancies.

**Infant and young child feeding practices**

3. Initiation of breastfeeding within one hour of birth.
4. Exclusive breastfeeding during the first six months of life.
5. Timely introduction of complementary foods at six months of age.
6. Age-appropriate foods for children aged six months to two years.

**Access to health, water and sanitation services/commodities**

7. Immunization and bi-annual vitamin A supplementation with deworming.
8. Appropriate feeding for children during and after illness.
9. Therapeutic feeding for children with severe acute malnutrition in facility and community.
10. Improve access to safe drinking water and sanitation commodities.
2. **Vanbandhu Kalyan Yojana paves the way to demonstrate multi-sectoral change in tribal areas**

The Ministry of Tribal Affairs does not have a vertical implementing cadre. It depends on 28 sectoral ministries, and their respective line departments in the states, for the provision of basic civic and welfare services to tribal peoples according to their state plan and tribal sub-plan (TSP). MoTA provides top-up grants to its state scheduled tribe departments, under special central assistance (SCA) and provisions under Article 275 (1) of the Constitution, for special projects to be undertaken in tribal sub-plan blocks. MoTA has very little control over the implementation of the TSP.

On 28 October, 2014, MoTA launched the Vandbandhu Kalyan Yojana⁴ to improve infrastructure and human development indices on a pilot basis in one block among the lowest literacy blocks in the scheduled V states⁵ of the Indian Constitution. Towards this end, INR 1 million has been allocated to each block, which may be used to demonstrate multi-sectoral nutrition programmes for tribal children.

3. **Tackle major infections such as malaria and tuberculosis**

Child mortality and undernutrition indicators are well known to be high in tribal areas. A probable key contributing factor is the fact that tribal children are less likely to receive immediate referral care. Health issues, such as malaria, sickle cell anaemia, tuberculosis, various skin infections (e.g., scabies and fungal infections) and snake bites are common among the tribal population. Chhattisgarh, Jharkhand, Madhya Pradesh and Odisha are among the major contributors of the high burden of malarial disease. Alcoholism and tobacco use are also common, which can further aggravate the already poor health conditions of the tribal population.

4. **Tribal and other marginalized areas require more effort to reduce existing health inequities**

Tribal blocks, marginalized and hard-to-reach populations are prioritized in the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A)⁶ framework, as well as in the vector and malaria control programme. The MoHFW has also constituted a national tribal health task force. For the tribal dominated high burden districts, there is provision for relaxed norms; mobile services; incentives for infrastructure, human resources and accredited social health activist (ASHA) recruitment; enhanced financial allocation; flexibility; and dedicated budget lines for tribal reproductive child health (RCH) to tackle the specific constraints and bottlenecks being faced in these areas.

There is renewed focus on strengthening health sub-centres in tribal blocks as the ‘first port of call’ with increased human resource. Some state innovations include: partnership with NGOs for service delivery in civil strife affected districts (e.g., Chhattisgarh); birth waiting rooms, provision of long lasting insecticide treated

² Vanbandhu Kalyan Yojana, implemented by MoTA, seeks to bring the tribal population at par with other social groups and include them in the overall progress of the country.

⁵ These states are same as the nine states with the highest burden of stunting among tribal children discussed at this conclave.

⁶ RMNCH+A is a national programme that addresses the major causes of mortality among women and children as well as the delays in accessing and utilizing health care and services.
nets and use of the geographic information system (GIS) for planning and monitoring (Odisha); boat clinics (Assam); indigenous transport (Gujarat, Himachal Pradesh); bed grant scheme (Tamil Nadu); and a tribal coordination cell in district hospitals (Maharashtra).

5. ICDS restructuring could serve as a good platform to improve reach and coverage in tribal areas

There are 7,076 projects and 1.4 million AWCs approved under the ICDS. Out of these, 2,544 projects and 535,499 AWCs are in rural/tribal areas of the nine states. The ICDS projects in Attapady, Thane and Melghat have made strides in strengthening AWCs in tribal areas. Provisions for additional anganwadi workers (AWWs), setting up of crèches in 5 per cent of AWCs, AWC extension counters, and services using a cluster approach are available under ICDS restructuring in the 200 high burden districts, many of which are tribal dominated.

6. Promising practices exist for improving access to water and sanitation

There are valuable state experiences in improving access to water and sanitation in tribal areas across some of the nine states. Some of these include: training local youth on basic geo-hydrology and water resource engineering to support development of village water security plans (Gujarat); and community group led and managed total sanitation systems, wherein credit linkages with banks, monetary financial institutions (MFIs) and self-help groups (SHGs) were made for toilet construction, and women self-help groups have set up systems of waste management in rural areas (Tamil Nadu). In Chhattisgarh, possessing a household toilet at home is included in the eligibility criteria for contesting local elections.

7. Vulnerability Reduction Fund provides opportunity to layer nutrition interventions in Aajeevika

Aajeevika, the National Rural Livelihoods Mission, presently works with 100 million poor households organized into 7-9 million self-help groups and their federations at village and cluster level. It provides handholding support to enable them to come out of abject poverty and strengthens existing livelihoods. Aajeevika as an entity is exploring various gender, anti-human trafficking, sanitation and nutrition promotion interventions to layer in voluntary organization (VO) mandates where VO s are mature (1-2 years work experience and have received and managed other grants such as the Community Investment Fund).

Such models within Aajeevika have been seen in some State Rural Livelihood Missions such as the health risk fund and food security fund (Bihar), homestead kitchen gardens (Odisha), and hot cooked meals and counselling for pregnant and lactating women (‘one full meal’ scheme in Andhra Pradesh and three paid meals in Bihar and Andhra Pradesh). It is envisaged that the Vulnerability Reduction Fund can be used for such layering of interventions.

8. Do not let the middle order collapse: right interventions and team effort needed

The task of eliminating child undernutrition is like chasing a given target of runs in a cricket match. The entire team has to contribute to achieve it. An important factor is healthy mothers, best indicated by the proportion of adolescent girls with body mass index (BMI) above 18. Mother’s weight gain during pregnancy is the next important parameter followed by proportion of low birth weight (LBW) babies. After this, the nutritional
status of the child in the first six months is important, as it is an indication of the prevalence of early breastfeeding initiation and exclusive breastfeeding.

The trouble usually begins in the 7-36 month age groups. Children in these age groups – 7-12, 13-24 and 25-36 months – usually show a rapid decline in nutritional status. There is a mild recovery in the 37-72 month age group, but it is not enough to compensate for the decline seen between 7-36 months. In addition, losses in brain and physical development during this early period of life are never recovered. This pattern can best be described as the ‘collapse of the middle order’ in cricketing language. The batting performance of the team also depends on the conditions of the outfield – immunization coverage, extent of open defecation and the like. To elaborate, therefore, while chasing a given target, the performance in the ‘middle order’, i.e., 7-36 months, is the most important component.

Strategies for the 0-36 month age group would consist of: (i) complete coverage of essential nutrition services for children aged 7-36 months; (ii) 90 per cent or above weighing efficiency; (iii) timely reporting of the nutritional status; (iv) preventive measures like deworming and immunization coupled with remedial treatment measures; (v) sanitation measures; and (vi) special measures for specific groups.

This should be backed up by a better score by the openers, i.e., better nutritional status in the 0-6 month age group and no/low incident of LBW. Important factors to achieve this are (i) adequate weight gain by the mother; (ii) timely antenatal care; (iii) tetanus toxoid vaccine for the mother; and (iv) identification of mothers at risk. If there is a low incidence of BMI below 18 among adolescent girls and higher age at first pregnancy, it is equivalent to winning the toss.

9. Find the undernutrition-free districts

It is important to strike a balance between projecting the states and districts contributing to the highest burden of malnutrition in absolute numbers and prioritizing these for corrective strategic actions, and locating the leading districts – those that are closest to becoming undernutrition free. Incentives can be provided at the district level for good performance and for better results.

10. Marry NFHS data on National Sample Survey Office regional platforms

A solution needs to be found for various regional levels instead of the ‘one size fits all’ central planning. For this, it is urgently necessary to bring the NFHS, District Level Household and Facility Survey (DLHS) and the National Sample Survey Office (NSSO) data (and other similar databases) on the 88 NSSO regional platform for use in research and policy decisions and strategic actions.
Parallel sessions

Challenges, promising practices and recommendations
Parallel session 1: Improving household food and livelihood security

Challenges

The following challenges constraining improvement of household food and livelihood security in tribal areas were highlighted during the parallel session:

1. Access to food is limited due to poor market access and purchasing power. Income security has been adversely affected by losses in productive resources (rights to forest or agricultural lands coupled with low amounts or utilization of compensation). Debts are one of the main coping strategies to help cover expenditures, which are usually repaid to the village money lender in services or periodical bonded labour, resulting in a hand-to-mouth existence for those affected.

2. Access to public distribution system (PDS) entitlements is constrained by poor definition of ‘below poverty line’, coupled with limited to negligible awareness on where and how to access ration cards and entitlements. PDS supply items also do not include traditional foods consumed by tribal groups, who often do not eat the cereals provided through PDS.

3. Poor banking penetration and banking literacy pose a challenge to the transfer of conditional cash benefit to the tribal population; furthermore, banking correspondents are few in these areas.

4. Vocational training is often not suited to the needs/culture of tribal peoples. For instance, a hotel management training course resulted in limited benefits with trainees managing only to obtain low paying jobs such as cleaning/sweeping in hotels.

5. The average number of days of work of a tribal person under the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) was 49 days during 2013-2014. Children of working parents are the worst affected as there are no crèches at MGNREGA sites.

6. Indigenous seeds and methods, and mixed cropping are not used to make agriculture nutrition-sensitive; they are neither promoted nor incentivized. The forest is not recognized as a food producing habitat. Planted trees are often not fruit/food producing. Uncultivated yet nutritious tribal foods are considered unfashionable by communities themselves.

7. Other challenges include: reliance on rain-irrigated agriculture, which is increasingly unreliable or unpredictable due to climate change; use of traditional practices of production and technologies; depleting natural resource base; distress migration for basic survival and livelihood; and use of pesticides in agriculture, adversely affecting the health of the mother and child in the womb.

Promising practices

The following promising practices were presented and discussed during the parallel session:

*MGNREGA is designed to provide a job guarantee of at least 100 days of unskilled work for adults in rural areas.*
1. Nutrition promotion and early child care linked to food security and livelihood support

Three models were presented and discussed on this topic. The first model relates to the ‘one hot cooked meal scheme’ in Andhra Pradesh and Telengana, wherein pregnant and lactating women are provided one cooked afternoon meal each day, at the cost of INR 15 per meal. Raw materials are purchased by village organizations under Aajeevika with funds from the Department of Women and Child Development. Anganwadi workers serve the meal, administer iron folic acid (IFA) tablets, monitor weight and provide counselling while health workers conduct health check-ups.

The second model involves crèches run by mothers’ groups in Chhattisgarh with funds provided through the Village Health and Sanitation Committee, which are routed through panchayats. It aims to support tribal women as most are engaged in productive work outside home.

The third model uses a participatory learning cycle to link agriculture-based livelihood and nutrition through behaviour change communication, promotion of indigenous foods, mixed cropping pattern and methods, and gender-equity focus implemented by two NGOs, Living Farms and Ekjut.

2. Khariff, or monsoon crop, yield enhanced by System of Rice Intensification

Pradan – an NGO working across seven states in India – shared their agriculture and nutrition development experience covering 12 districts in Chhattisgarh. Their intervention, which uses an innovative technique called System of Rice Intensification, includes enhancing productivity of land, water and agriculture through the organization of women-led self-help groups and building their capacities in soil health improvement, stabilization of paddy yields and incorporation of nutritious crops in the overall cropping plan, e.g., vegetables, millets and pulses, to ensure food sufficiency for 9-12 months.

3. Online PDS portal to reach the most vulnerable

Samagra, a social security programme run by the Madhya Pradesh government, is supporting identification, verification, updates and categorization of all individuals within families by respective local bodies and linking households to their respective Fair Price Shops (FPSs) electronically. Authentic, accurate and monthly FPS shop-wise allocations of food grain are generated from the State PDS Portal. Instead of inclusion criteria, exclusion criteria have been ensured to reach out to the most vulnerable and marginalized. The Madhya Pradesh government has provided an additional co-financing of INR 6 billion.

4. Using technologies to improve livelihoods and quality of life for tribal communities

BAIF Development Research Foundation has been designated a centre of excellence by the Ministry of Tribal Affairs since March 2008. Technologies produced by BAIF include WADI, a farming system approach combining agri-horti-forestry with required in-situ soil and water conservation works, integration of crop diversification practices, intensification, skill-oriented training for good production systems and integration of animal husbandry, and continuous on-field support using just 0.4 hectares of land.

These practices are coupled with interweaving quality of life actions, e.g., women development through the SHG federation, drudgery reduction measures, clean drinking water, and health, nutrition
and sanitation actions. Another technology involves capacity building for mixed cropping, and promotion of small plot vegetables, water resource management and forward marketing linkages.

**Recommendations**

The group work discussions held after this parallel session generated the following recommendations, which have been classified into immediate-, medium- and long-term actions.

**Ministry of Civil Supplies**

1. **Evaluate online portal in (immediate to medium term)**

Evaluate Samagra online portal in Madhya Pradesh for sharing and adapting in other states.

2. **Include nutrient-dense foods in PDS (medium to long term)**

States to consider including nutrient-dense foods, double fortified salt, fortified cereals, fortified edible oils, nutritious and culturally appropriate forest foods in PDS.

**Ministry of Rural Development**

3. **Strengthen links between livelihood support and nutrition promotion (immediate to medium term)**

Strengthen links between livelihood support and nutrition promotion and build capacity to do so through Aajeevika (National Rural Livelihood Mission). Practices such as the one full meal scheme, which should include women of reproductive age, and WADI may be replicated. Such practices should include covering the service cost to the voluntary organization so that nutrition promotion is also a business enterprise.

In addition, mature village organizations under Aajeevika’s resource blocks may also be provided a livelihood option to run ‘one stop shop’ for services and entitlements. They could be trained using participatory learning methods to layer nutrition in discussions in their weekly self-help group meetings as done by Ekjut. It would also be useful to mainstream nutrition into the curriculum of the National Institute of Rural Development and State Institutes of Rural Development so that allied sectors become nutrition-sensitive.

4. **Promote and provide incentives for System of Rice Intensification (medium to long term)**

Promote and provide incentives for the System of Rice Intensification, uncultivated nutrient-rich forest foods, and local manure under Rashtriya Krishi Vikas Yojana and Nutri-rich Program.

5. **Ensure universal access to unconditional maternity entitlements (long term)**

Ensure universal access to unconditional maternity entitlements for tribal mothers. The business correspondent, or local bank representative, model has worked best for financial inclusion by linking women groups, which would ensure livelihood opportunity in their locality.

**Ministry of Environment, Forest and Climate Change**

6. **Protect community forests and promote cultivation of food yielding trees (medium to long term)**

Protect community forests by setting minimum proportion of land to remain as forestland for protection of indigenous livelihood as well as the environment; and promote cultivation and planting of trees that yield food or have traditional medicinal values.
Parallel session 2: Improving Integrated Child Development Services in tribal areas

Challenges

The following challenges constraining improvement of ICDS services in tribal areas were highlighted during the parallel session:

1. Household care practices, especially during the vulnerable periods of preconception, pregnancy and infants in the 6-36 months period, have remained suboptimal. There is also suboptimal/ negligible use of take-home rations by pregnant women and children provided under the ICDS supplementary nutrition programme. Health education and kitchen gardens only are having a limited impact.

2. Children aged under 36 months need to be transported to the AWCs; they require frequent feeding with nutrient-dense foods, and to be cleaned before meals and after using the toilet. They need a ‘safe’ place to learn and play, with attention to age-appropriate learning needs. It is exhausting for the AWW, who manages more children than the optimum 1:10 worker:child ratio. With more tribal mothers having to go out to work to earn a living, older siblings often are forced to drop out of school to take care of younger children.

3. There are poor monitoring visits in tribal pockets. There are tribal villages where no government officer has ever visited an AWC, even in areas not affected by civil strife. There is also an issue of non-tribal workers looking down on tribal workers.

4. Most TSP budget items are focused on infrastructure and even then it remains untapped for improving the infrastructure of AWCs, or for establishing Nutrition Rehabilitation Centres (NRCs), or for providing crèches with safe water supply and toilets in remote tribal areas.

5. Planning is still done population-wise while hamlet-based population norms are needed in tribal areas. ICDS data coverage, allocations and expenditures for tribal pockets are still not available and if so, are often unreliable. There is no separate chapter for tribal ICDS under the ICDS Project Implementation Plan (PIP) and/or National Nutrition Mission. Many faith-based and civil society organizations exist, but they do not work together to deliver outreach ICDS services in tribal areas affected by civil strife. Often, procedures to engage with such partners are tedious, political and non-transparent.

Promising practices

The following promising practices were presented and discussed during the parallel session:

1. Decentralized ICDS supplementary nutrition programme led by women’s groups

In Odisha, self-help groups provide hot cooked meals and a morning snack to children at the anganwadi centre. Mechanisms have been put in place for procuring grains and food from the Food Corporation of India, selecting self-help groups, ensuring quality checks and accounting, which is jointly done with support of the AWW and elected ward member. Menus are also locally contextualized. However, adherence to food safety guidelines remain a challenge. The model still needs to be evaluated for impact.
and whether livelihood generation and nutrition have been ably linked.

2. Trained paid workers in hamlet-based crèches in tribal areas

In Chhattisgarh, NGO Jan Swasthya Sahyog (JSS) has demonstrated the feasibility, continuity and effectiveness of hamlet-based crèches for children aged 6-36 months for the last seven years in forest fringe areas and forest villages of rural Bilaspur. JSS has also developed the operational requirements, costing, training materials and stationery needs, and a troubleshooting guide for running such a programme at scale. In addition to JSS, a consortium (Action Against Malnutrition and mobile crèches) is working on a similar approach in Bihar, Jharkhand, Madhya Pradesh and Maharashtra.

3. Self-help groups run nutrition counselling and feeding centres

Mainstreaming feeding and nutrition promotion through women self-help federations engaged in thrift and credit, and livelihood initiatives has been carried out since 2007 across 4,200 villages of the state of Andhra Pradesh (before bifurcation). These federations provide pregnant and lactating women two hot cooked meals a day in their community-managed nutrition cum day care centres set up for every 1,000 persons.

Each centre receives a one-time grant of INR300,000 (US$5,000) and a recurring annual grant as partial cost for the meals. About one third of the cost of the meal is paid for by the women (INR10 (US$0.16) of INR35 per person per day). To ensure they can pay this amount, they are encouraged to join the network of self-help groups and undertake safe livelihood activities, which enable them to earn about INR800-1,000 per month (US$13-16).

Presently, the Andhra Pradesh government has adapted this model and started a free ‘one full meal’ scheme, a free noon meal provided through a partnership between Aaajevika and the Department of Social Welfare, which covers the service cost to self-help groups.

**Recommendations**

The group work discussions held under this parallel session generated the following recommendations, which have been classified into immediate-, medium-, and long-term actions.

1. Set up Nutrition Rehabilitation Centres close to tribal communities (immediate term)

Set up NRCs close to tribal communities in partnership with NGOs working in tribal areas. Children with severe acute malnutrition (SAM) and with medical complications have specific medical treatment needs to enhance their survival, and cannot be provided only supplementary food through the Sneha Shivirs scheme, a community based approach for prevention and management of moderate and severe malnutrition. Underweight and severe acute malnutrition are different problems and need to be acted upon differently.

2. Set up special scheme for preconception women and at-risk pregnant women (immediate to medium term)

Low pre-pregnancy weight and lack of weight gain monitoring in pregnancy are important drivers of intrauterine growth retardation. Hence, the package for preconception women should be expanded beyond Nutrition and Health Education.

It is crucial to conduct periodic nutrition assessments of newly wed and pregnant
women during nutrition and health outreach sessions, followed by instituting corrective measures for those women identified as ‘at risk’ (along the lines of Sneha Shivirs for children). These measures could include enrolling undernourished women for special feeding, behaviour promotion and family planning sessions. Emphasize information on various schemes and entitlements and delaying age at marriage in these sessions.

3. **Take into account tribal considerations within ICDS (medium to long term)**

Hamlet-based planning and provision of cluster or AWC extension counters should be considered in tribal areas. ICDS food items for tribal areas should include tribal uncultivated forest foods.

There should be separate review of tribal ICDS with a separate tribal nutrition coordination cell at national and state levels to monitor implementation progress of tribal related schemes, at least within the departments of Women and Child Development and Health to begin with.

As in RCH, a separate PIP for tribal ICDS/mission should be considered. Learning from promising practices is important, e.g., projects in Attapady, Thane and Melghat.

4. **Universalize public funded crèches through trained paid workers in tribal areas (medium to long term)**

In addition to home visits by frontline workers, crèches for tribal children aged 6-36 months should be universalized rather than putting a ceiling of using only 5 per cent of AWCs as crèches and only one additional link AWW who can potentially be a crèche worker. The following requirements should be ensured:

- Community driven rather than thrust upon externally.
- Open 8 hours a day, 26 days a month, timings according to local work schedule.
- Run by adequately trained crèche workers from the same hamlet (need not be literate).
- Caretakers should be paid a regular wage, not on voluntary basis.
- At least three large feeds, a minimum of 75 per cent calories (at least 750 calories out of 1,000) and all protein needs of the child in this age group be met by these three feeds; highly desirable to have some animal proteins such as from milk or eggs.
- Iron supplements daily and three monthly albendazole (deworming).
- Early child education.
- Safe water and mosquito proof interiors.
- Growth and illness monitoring.

Inter-sectoral financial budget pooling is possible among the departments of Women and Child Development (wages, food, monitoring), Rural Development (MGNREGA, space, toilets), Health (ASHA, drug supplies, bed nets) and the panchayat raj (community monitoring and infrastructure support).
Parallel session 3: Improving tribal health outreach and referral services

Challenges

The following challenges constraining improvement of nutrition outreach and referral services in tribal areas were highlighted during the parallel session:

1. Access to government health outreach and referral services is constrained by geographical, linguistic, cultural and social barriers, as well as opportunity cost (loss of wages, cost of travel time to the facility and medicines). This is also one of the core reasons for reliance on traditional medicine and spiritual healers.

2. Health outreach communication in the local state official language cannot be understood by tribal peoples, given that each tribe has a language of its own and also because illiteracy is quite high.

3. Shortage of skilled human resource, high staff turnover and absenteeism are major problems in tribal areas, particularly in areas of conflict. While tribal peoples are preferred, it is difficult to find those who match the qualification criteria. Postings in tribal areas are perceived, generally, as ‘punishment postings’ that are assigned to non-performers. Community health services managed by nurses remain untapped.

4. Few professionals would like to work in these areas due to poor integrated housing facilities, lack of recreational facilities, poor roads and power supply, electricity problems, centralized human resource policies that often do not specify the duration of tribal postings, and insufficient hardship allowances for serving in difficult terrains (such as transportation, board and lodging, and promotions/dual degree incentives).

5. TSP funds remain untapped for establishing Nutrition Rehabilitation Centres in remote tribal areas.

6. Tuberculosis, malaria and sickle cell anaemia are major health problems and need deserved attention.

7. Tobacco and alcoholism are major problems. Habitual drinkers spend all their earnings and cash benefits received from government schemes on alcohol.

8. There is no integrated tribal health dashboard monitoring system, which combines vector borne diseases and health and nutrition indicators, even though the NFHS, DLHS, Rural Health Statistics and National Nutrition Monitoring Bureau provide tribal health care data. The specific provisions RMNCH+A can offer to tribal peoples should be highlighted and publicized. In addition, while the Indian Council of Medical Research (ICMR) Jabalpur issues a six-monthly bulletin, the Tribal RCH PIP chapter remains the most neglected.

Promising practices

The following promising practices were presented and discussed during the parallel session:

1. Community clinics managed by nurses, complemented by doctor supervision and outreach activities

Such a model of a judicious mix of professionals skills (doctor, nurse and social
work team) and activities (clinic, community mobilization, home counselling and crèches for nutrition support) has been demonstrated in difficult and dispersed tribal catchment areas of Udaipur, Rajasthan, by NGO basic health services. The learning suggests that community clinics led by nurses, nutrition security activities and ambulances capable of going the last mile can work best in partnership with NGOs under a public-private partnership (PPP) model.

2. A good school of nursing could be key

This has been demonstrated by the Christian Hospital, Bissamcuttack, Odisha, where a school of nursing is attached to the hospital. The uniqueness of this school is that professionals from Odisha are trained in nursing for the local population. This is complemented by the Mitra Project in 53 predominantly tribal villages, where primary outreach activities are conducted, including malaria screening and management at community level and a residential tribal school, led and governed by the community.

3. Low cost health care technology and improving logistics of public health

Low cost health care technology and improving logistics of public health, such as rapidly taking malaria slides to laboratories from tribal areas, is important. Jan Swasthya Sahyog in Chhattisgarh has adopted an innovative approach in water purification systems and in keeping newborns warm by using sleeping bags (containing palm oil to retain warmth).

4. States show the way in promising practices

Several states have promising practices that could be adapted or relicated. These include partnership with NGOs (under MoTA) for setting up NRCs in block hospitals run by them in Microeconomic Social Organization zones (Jharkhand); young professionals attracted to support the state level Development Commissioner in tribal districts and work on special projects (Gujarat’s Chief Minister’s Fellowship Programme); tribal coordination cell in district hospitals in tribal districts (Maharashtra); and focus on upgrading tribal district hospital infrastructure, context-specific bed linen and cash transfers to access primary health care facilities (Maharashtra).

Recommendations

The group work discussions held under this parallel session generated the following recommendations, which have been classified into immediate-, medium-, and long-term actions.

1. Provide incentives to NGOs running hospitals to establish Nutrition Rehabilitation Centres (immediate term)

The Ministry of Health and Family Welfare should provide incentives to NGOs running hospitals with MoTA to establish NRCs for management of severely acute malnourished tribal children with complications, coupled with outreach prevention activities. These could eventually be linked to a community branch for treatment of SAM children without complications.

2. Bundle nutrition-specific interventions (immediate to medium term)

Nutrition-specific interventions, such as vitamin A supplementation, and other nutrition-sensitive actions (e.g., indoor residential spraying), should be bundled with
the immunization days/weeks under the newly launched Indradanush, an universal immunization programme, in tribal areas. Advocate for Village Health and Nutrition Days and Indradanush outreach days to be ‘days of peace’ in conflict affected areas to ensure that health service providers are not restricted or questioned.

3. Expand nutrition basket to include women during preconception and at risk of pregnancy (immediate to medium term)

Maternal undernutrition is an important predictor of intrauterine growth, low birth weight, as well as maternal and neonatal mortality. Global literature now clearly establishes that fetal stunting is largely because of overall nutrition and dietary insults in the first trimester, a time often when pregnant women do not reveal they are pregnant. Also, poor preconception nutritional status and poor weight gain during pregnancy are major independent determinants of fetal stunting.

However, in India there is no mechanism in place to identify and provide a package of nutrition interventions to women during preconception or to identify pregnant women at nutrition risk and provide them a special package of care. Nutrition interventions that are a part of the antenatal service package also need strengthening both in terms of inclusion of ‘missing’ interventions, coverage and service provider capacity and monitoring.

4. Integrate malaria and sickle cell prevention with anaemia control programmes (medium term)

For tribal peoples living in malaria endemic areas, national guidelines on malaria prevention and control with links to IFA programmes should be made available.

5. Establish tribal cell in Department of Health and Family Welfare in tribal dominated states (medium to long term)

As in Andhra Pradesh, a tribal cell can play the following roles: (i) liaise with other departments; (ii) monitor tribal budgeting, expenditures in RMNCH+A, tribal RCH and TSP, with specific guidelines on areas/themes to include in the TSP; (iii) link with ICMR on district-level tribal nutrition surveys once every three years; (iv) develop a tribal info-system for disaggregated data using Health Management Information System scorecards; (v) create a platform for sharing replication-worthy practices; and (vi) place young professionals on special tribal projects complemented by a health policy degree.

6. Focus especially on tribal Reproductive and Child Health programme in Ministry of Health and Family Welfare (medium to long term)

MoHFW should take into account tribal considerations in its RCH programmes and consider the following actions: (i) institutionalize weekly haats (markets) for outreach services in tribal areas; (ii) carry out hamlet-based calculations; (iii) provide second ANM/community nurse at health sub-centre in tribal areas; (iv) provide central funds for improving quality services to ashramshalas (residential schools) run by state governments; and (v) test training and engagement methods for traditional healers and relaxing the Leave Travel Concession norms for tribal areas.
Parallel session 4: Improving drinking water and sanitation services/commodities in tribal areas

Challenges

The following challenges constraining improvement of drinking water and sanitation services in tribal areas were highlighted during the parallel session:

1. Water crisis and lack of water purification continues in tribal desert-prone areas, and existing toilets are not often used, as many of them do not have doors and/or water.

2. Although toilets for girls in schools have been constructed, the water crisis makes these toilets unusable.

3. Many anganwadis do not have facilities for handwashing with soap, and often have adult but not child toilets. Swasth Bharat, a national health campaign, does not specifically target health centres and AWCs.

4. While community-based models are promoted, fund flow mechanisms and newer technologies in these models need to be streamlined and percolated to the community.

5. There is still inadequate capacity enhancement and support to panchayat raj institutions to implement and maintain their own water and sanitation systems.

Promising practices

The following promising practices were presented and discussed during the parallel session:

1. Water supply chains and water harvesting improve access to water

‘Unbundling’ of water supply chains, collecting rainwater and water harvesting on hilly areas, along with installing mini pipelines are being carried out in Gujarat.

2. Local youth trained to support water security

In Gujarat, local youth are being trained on basic geo-hydrology and water resource engineering to support development of village water security plans.

3. Community managed sanitation linked to access to credit

In Tamil Nadu, community group led and managed total sanitation systems, wherein credit linkages from banks, MFIs and SHGs are made for toilet construction, and women self-help groups have set up systems of waste management in rural areas.

4. Local election eligibility criteria include possessing household toilet

In Chhattisgarh, eligibility criteria for contesting local elections includes possessing a household toilet at home.

5. Government-NGO partnership models improve water and sanitation infrastructure

The Society for Participatory Research in Asia and NGOs Gramvikas and PRIA help communities and gram panchayats
work together in Chhattisgarh, Odisha and Jharkhand to create and maintain water and sanitation structures and innovate global positioning systems, as well as activate District Planning Committees.

**Recommendations**

The group work discussions held under this parallel session generated the following recommendations, which have been classified into immediate-, medium-, and long-term actions.

1. **Improve facility for handwashing with soap and toilets for children (immediate to medium term)**

   Ensure facilities for handwashing with soap and children’s toilets in anganwadi centres and Nutrition Rehabilitation Centres, improve water and sanitation facilities in ashramshalas, and monitor water and sanitation facilities in health centres for tribal areas.

2. **Design and disseminate focused communication messages targeting tribal areas (immediate to medium term)**

   Enhance awareness of toilet use through focused communication messages, while setting up mechanisms to ensure water is available for toilet maintenance and facility for handwashing with soap.

3. **Ensure water security (medium to long term)**

   Under the Vanbandhu Kalyan Yojana, devise and manage water security plans/systems, mini-pipe water supply schemes, rooftop rain water harvesting and water regeneration plantation.

4. **Motivate graduates to work in tribal areas (medium to long term).**

   Open invitation and funding opportunities should be provided to young rural management and Indian Institutes of Technology (IIT) graduates to work in tribal areas for IT-based/low cost water and sanitation solutions.
Parallel session 5: Tribal budgets, governance and coordination for nutrition

Challenges

The following challenges constraining improvement of pro-tribal nutrition budgeting, plans and coordination were highlighted during the parallel session:

1. Challenges in tribal sub-plans include:
   (i) ‘food subsidy’ being treated as non-plan expenditure, which has led to minuscule TSP allocation to PDS;
   (ii) not all ministries and state plans apportion recommended funds for TSPs; the only state to legalize apportioning funds to TSP is Andhra Pradesh;
   (iii) earmarking of funds is done without considering priorities, purpose or track of its usage;
   (iv) most TSP budget items focus on infrastructure and miss out on soft components, such as basic outreach services. On the other hand, the TSP infrastructure budget remains untapped for establishing or improving Primary Health Care Centres, Nutrition Rehabilitation Centres, crèches, and AWCs with adequate water and sanitation facilities in remote tribal areas; and
   (v) TSP is based on the assumption that spending money will automatically lead to development of tribal peoples, which underplays the role of ensuring effective delivery of essential services and enforcement of legislations to protect their social and economic rights. In addition, there are problems of poor access to basic amenities, absence of staff quarters for teachers, poor toilet facilities for girls and absence of life skills and vocational education in ashramshalas (residential schools).

2. The proportion of the special central assistance allocation to TSP by the central government has been less than 5 per cent of the total TSP allocation for most states, coupled with huge paper work. Although meant for critical gap-filling, the critical gaps are not identified and the SCA is transferred to the state scheduled tribe finance and development corporations for providing subsidy to the bank-linked income generating schemes, which are not linked with the sectoral schemes being implemented by the state governments under the TSP.

3. Evidence-based planning of programmes for tribal children is hindered by absence of or dated disaggregated data by social groups for schemes as well as the lack of data analysis of social determinants of poor health and undernutrition in tribal populations. There is limited publicly available data necessary for reliably tracking programme budgetary allocation and expenditure for tribal peoples.

4. Institutions like the Integrated Tribal Development Agency (ITDA) require technical staffing to enable the government to effectively coordinate rather than just accepting tasks and achievement numbers given to them. Vandbandhu Kalyan Yojana provides a platform to test innovations to strengthen ITDA capacity.
Promising practices

The following promising practices were presented and discussed during the parallel session:

1. **TSP legislation implemented to improve accountability and planning**

   Andhra Pradesh has improved accountability, decentralization and inclusive planning in the implementation of TSP. The state council for development of scheduled castes and scheduled tribes is the nodal agency for TSP and has an administrative support unit and institutional mechanism for monitoring and liaising with other departments. Importantly, there is a single line administration in tribal areas – the ITDA is mandated with autonomous bodies, complemented by Tribal Program Monitoring Units under the National Rural Health Mission (NRHM), Sarva Shiksha Abhiyan, MGNREGA and Rural Development. Improving infrastructure and civic amenities in tribal areas has been the focus in many initiatives, as well as teaching and using learning materials in tribal dialects.

2. **Nutrition Mission a platform for convening inter-sectoral action for nutrition of tribal children**

   Maharashtra has specific pro-poor and pro-tribal strategies. For example, filling supply and payment backlogs at AWCs in tribal areas, with special drives to: (i) fill vacant posts at all levels across the Department for Women and Child Development and Department for Health and Family Welfare; (ii) relax recruitment norms and improve training of functionaries; (iii) encourage regular government visits to remote and unvisited villages; (iv) organize pre-monsoon camps for health checks and nutrition counselling by all doctors; (v) set up NRCs at block and primary health centre level; and (vi) ensure doorstep direct delivery of PDS to village from block level godowns.

3. **Initiatives to improve nutrition focus on tribal communities**

   In Gujarat, some initiatives in tribal domains include Doodh Sanjeevani Yojana, a programme providing milk in all primary schools; e-coupons in the PDS system; partnership with cooperatives and NGOs for delivery of services and presence of an autonomous body, Development Support Agency of Gujarat, under Vanbandhu Kalyan Yojana, which has administrative and institutional autonomy.

Recommendations

The group work discussions held under this parallel session generated the following recommendations, which have been classified into immediate-, medium-, and long-term actions.

**Ministry of Tribal Affairs**

1. **Generate disaggregated data for tribal peoples (immediate term)**

   Mandate a Planning and Monitoring Unit within MoTA to allow generating and utilizing tribal disaggregated data for planning, monitoring and liaising with other departments at the state and ITDA levels.

2. **Include nutrition as an agenda item in project level inter-ministerial meetings (immediate to medium term)**

   Include nutrition as an agenda point in project level inter-ministerial coordination committee meetings convened by MoTA.
3. **Replicate good practices (medium to long term)**

Explore replication of the Andhra Pradesh administrative model in tribal areas, and with ITDA as single line administration and responsible for service delivery in tribal areas. It would also be useful to establish a tribal programme management unit within key line departments (as in Andhra Pradesh under NRHM) with a designated tribal programme officer and tribal PIP.

4. **Expand provisions under TSP to include nutrition items (medium to long term)**

Expand TSP to: (i) be needs-based; (ii) include gender and nutrition interventions; (iii) encourage budgetary provisions for new infrastructure and maintenance, targeting institutions providing essential social services, AWCs, crèches and NRCs; and (iv) provide fellowships of one to two years to young contractual professionals, supported by grants, towards enhancing ITDAs on special projects.

5. **Map districts with high burden of stunted children (immediate term)**

Map districts contributing to the burden of stunted children in terms of numbers; identify which of the 10 nutrition interventions to reduce the burden to be implemented within each district and by block; and accordingly develop context responsive plans and provide results-based incentives.

6. **Implement dashboard monitoring (immediate to medium term)**

Implement periodic block-centric dashboard monitoring of a few actionable indicators.

7. **Incorporate targets in Result Framework Document (immediate to medium term)**


8. **Ensure transparency of allocation and use of TSP resources (medium to long term)**

The allocation and utilization of resources under TSP as well as other government programmes should be open to public scrutiny through social and IT-based tracking mechanisms.

9. **Advocate for food fortification (medium to long term)**

Advocate for food fortification with MoHFW and civil supplies to begin with in tribal areas, given the high burden of multiple micronutrient deficiencies in these areas.

10. **Establish Nutrition Coordination Cell in PMO (medium to long term)**

Establish a Nutrition Coordination Cell at PMO level with special focus on tribal peoples to accelerate coordinated action in all the key sectors.
Parallel session 6: Role of academic institutes and NGOs in improving nutrition services in tribal areas

Challenges

The following challenges constraining improvement of partnerships to address tribal nutrition problems were highlighted during the parallel session:

1. Gaps in research on tribal data include: (i) tribal research and ICMR regional tribal centres remain untapped for periodic evaluation and dashboard monitoring of basic schemes; (ii) ICMR National Nutrition Monitoring Bureau reports on tribal population currently provide information only on select nutrition indicators and is limited to select states; (iii) the sample size in large-scale surveys representing tribal peoples is often not large enough, thereby increasing the margin of error when disaggregating data for tribal children; and (iv) there is no independent report on the nutritive value of forest foods, which are rich in nutrients.

2. There are only a few alliances and organizations working to raise issues related to nutrition of tribal peoples. Forums in which scheduled castes and scheduled tribes are represented together inherently favour scheduled castes because of their stronger collective voice and larger numbers. Federations of organizations working for tribals have not been as strong, unlike federations for other social groups. Most civil society organizations working in tribal areas are led by non-tribal leaders (though many invest in tribal youth leadership), reiterating the lack of tribal leadership and collective voice.

3. The number and geographical coverage of NGOs and faith-based organizations working in tribal areas are limited, which reduces further in civil strife affected areas. Most organizations have focused on mobilization at community and household level and linkage with service providers has not been significant, while relatively very few work with ITDAs on TSP to support such planning.

4. Acquisition of forestland for development by the government is constrained by problems of inadequate compensation and poor resettlement and livelihood arrangements, leading to increasing indebtedness and poverty. The inherent shyness and lack of collective voice of tribal peoples to demand their entitlement(s) mean that they never reach a critical mass to create positive pressure on the government to change the nature of response.

5. Issues of undernutrition among tribal children grab headlines only when there are reported deaths of hunger.

Promising practices

The following promising practices were presented and discussed during this parallel session:

1. Use of participatory learning cycles in women’s groups to reduce neonatal mortality and undernutrition

This promising practice involves running crèches with links to nutrition, national resources and agriculture. It has paved
the way to improve complementary feeding with links to livelihood, agriculture and nutrition. It is supported by Ekjut in collaboration with consortium partners across Chhattisgarh, Jharkhand, Madhya Pradesh and Odisha.

2. Women’s groups engaged to run crèches

Surguja Suposhan Abhiyaan in Chhattisgarh with support of frontliners (mitanin, community health worker) and State Health and Family Welfare (SHRC) share responsibilities wherein communities manage crèches and SHRC plays an important role in training, research and evaluation.

3. NGO workers work with health frontliners

SEWA Rural, an NGO in Gujarat, is linking its NGO workers (1:8 villages) and the ANM/field supervisor (1:15 villages) to support various innovations. The innovations used in this model include: sickle cell anaemia programme; special camps for underweight children; child-wise output and outcome monitoring; and innovative mobile phone technology for community health operation – work plan on mobile phone, tasks completed uploaded immediately, videos for counselling, and tracking children. This PPP model works together with the Government of Gujarat.

4. Mobile-based application to capture ‘real time’ data of each child

NGO Riddhi Foundation is developing a mobile-based application with a voice feature to capture ‘real time’ data of each child, supporting a screening system and sms feedback mechanism. Two mobile telephony applications – one for the child (Jatak) and one for mothers (Janani) – is being developed, which can capture, transmit and process real time data related to expecting/lactating mother and children, covering all aspects of maternal and child healthcare. Riddhi Foundation is working in collaboration with the National Health Mission, Palakkad, Kerala, to develop the Jatak application for the Atappady NRC.

5. Media sensitized on critical issues including nutrition

NGO Jan Samvad working in Madhya Pradesh has been engaging with media to sensitize them on writing about nutrition issues affecting tribal populations.

Recommendations

The group work discussions held under this parallel session generated the following recommendations, which have been classified into immediate-, medium-, and long-term actions according to suggestions made by the panellists in the concluding session:

Academia/research institutes/development agencies

1. Demonstrate feasibility of multi-sectoral nutrition actions (immediate term)

Tap on Bharat Rural Livelihood Missions, Council for Advancement of People’s Action and Rural Technology (CAPART), Vanbandhu Kalyan Yojana, Aajeekiva platforms and Sansad villages to demonstrate feasibility of multi-sectoral nutrition actions to accelerate reduction of undernutrition among tribal children.

2. Enable dashboard monitoring of actionable indicators (immediate to medium term)

Engage IITs and Indian Institutes of Management and related institutes to develop dashboard monitoring, using GIS, of
a few actionable indicators or from centile sites for monitoring outputs and outcomes against inputs (e.g., tracking use of budgets for results).

3. Generate reliable data of extent and nature of undernutrition (medium to long term)

Generate credible data about the extent and nature of undernutrition among tribal children. Expand the scope of ICMR to conduct periodic universal tribal nutrition surveys, at least once in three years.

4. Harmonize key indicators across national surveys (medium to long term)

Build parity and harmonize key indicators across databases of national surveys such as the Census and National Family Health Survey. Extend the NSSO tribal nutrition surveys conducted by ICMR across the country to improve comparability over time and geographic areas.

5. Support food composition analysis of tribal food (medium to long term)

Encourage nutrition departments of home science colleges to support food composition analysis of tribal food (including uncultivated forest foods). Curriculum on tribal nutrition should be layered and enhanced across graduate and postgraduate nutrition curriculum.

Alliances

1. Advocate for special strategies for reducing undernutrition among tribal children in the nine states (immediate to medium term)

Tap into the Parliamentarian Group for Children and Citizens’ Alliance against Malnutrition to advocate for tribal children on the following issues: (i) raise issues of tribal undernutrition in parliament; (ii) meet with concerned authorities and ministers in-charge of provision of basic public services in tribal areas; (iii) collective field visits with concerned officers in tribal villages that have never been visited; (iv) concentrate on demonstrating change in respective constituencies; and (v) advocate for special nutrition gram sabha and social audit of nutrition programmes in tribal areas.

2. Share knowledge on tribal nutrition (medium to long term)

Encourage the Supreme Court office for right to food to examine pertinent issues, publish and highlight special reports, and share findings with line ministries on a periodic basis.

Media

1. Highlight experiences and show disparities (immediate to medium term)

Provide media experiences from the field and highlight disaggregated data that show disparities as well as cross linkages of interventions.

2. Showcase media champions (immediate to medium term)

Showcase media champions from the field at district and sub-district level, who work tirelessly to highlight core tribal concerns in various print and electronic media channels.

3. Create media group to highlight tribal nutrition issues (medium to long term)

Create a digitally connected group of like-minded media that are interested in highlighting issues on tribal nutrition.
There was a separate session with tribal communities to understand their perspectives on the required actions to reduce undernutrition among tribal children. The following recommendations were made by them:

- **Prioritize villages that have not received attention**
  Prioritize the visits of government officials to the villages where they have not been as yet.

- **Stop use of pesticides in farming**
  Pesticide-based farming should cease as it is harmful to children who accompany their mothers working in the fields. Traditional crops and cropping methods should instead be promoted.
**Share information on growth of tribal children**
Anganwadi workers should share data from recorded growth monitoring with the community to enable it to understand the progress made by the children.

**Prevent child marriage and early pregnancy**
One of the key reasons for undernutrition in children is early pregnancy. Efforts to prevent child marriage and early pregnancy should be accelerated.

**Encourage public servants to work in tribal areas**
The duration of tribal postings should be fixed and be on a rotational basis so that public servants are encouraged to work and stay in tribal areas.

**Recognize and promote forest foods**
Forests as a food producing habitat should be recognized and forest foods promoted.

**Include tribal peoples in planning**
Most importantly, include tribal peoples in development of plans. Often, plans and schemes do not consider their needs.
Consolidated recommendations from all six parallel sessions and special session on voices of frontliners were presented during the concluding session. After the presentations, the chairs of this session emphasized the following points:

1. Tap on Bharat Rural Livelihood Missions, CAPART, Vanbandhu Kalyan Yojana, Aajeevika platforms and Sansad villages to demonstrate multi-sectoral nutrition action.

2. Recognize that while SHGs are good service delivery agents and represent community voice, they are not substitutes for the government.

3. Hold state conclaves in each of the nine states to take recommendations forward.
1. The National Institute of Rural Development and Panchayati Raj and UNICEF signed a Memorandum of Understanding on 17 June, 2015, to create and institutionalize a curriculum for multi-sector officials to improve access to nutrition services in rural and tribal areas.

2. The Parliamentarian Group for Children organized its first meeting on 21 July, 2015, with cross-party members to raise awareness of the issues and actions to improve the nutrition of tribal children.

3. Madhya Pradesh has announced a targeted approach, based on several recommendations from the national conclave, to tackle undernutrition in tribal children through state TSP funds and a special plan for tribal children.

4. Jharkhand has announced the formation of a nutrition mission with special focus on tribal pockets.

5. Chhattisgarh has scheduled a high level state conclave to take the deliberations of the national conclave forward through two new schemes under the National Rural Livelihoods Mission.

6. Maharashtra has announced the extension of its nutrition mission (part 3) with a focus on tribal and poor urban areas.

Shortly after the conclave, the following actions were carried out:
### Conclave agenda

**Conclave: Nourishing India’s Tribal Children**  
**Voices of frontliners, promising practices and policy implications**  
**15-16 January, 2015: Mayfair Convention, Bhubaneswar**

#### DAY I: 15 January, 2015 (Thursday)

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| **Plenary 1**: Inaugural ceremony by State Government of Odisha  
(Master of Ceremony: Ms. Pamela Philipose) | **Registration and seating before arrival of Hon’ble Ministers, Odisha and Hon'ble Member of Parliament** | **0930-1020** |
| 0930-1020 | Registration and seating before arrival of Hon’ble Ministers, Odisha and Hon'ble Member of Parliament | **0930-1020** |
| 1020-1025 | Welcome                                             | Yumi Bae, Chief, Field Office, UNICEF Odisha                                                                |
| 1025-1030 | Keynote address                                     | Shri Surendra Kumar, IAS, Commissioner cum Secretary, Scheduled Tribes and Scheduled Castes (ST&SC) Development Department, Government of Odisha |
| 1030-1040 | Lighting of lamp                                    | Dignitaries on the Dais                                                                                         |
| 1040-1110 | Speech Commitment for tribal children               | Mr. Louis-Georges Arsenault, UNICEF India Representative                                                        |
|           |                                                     | Shri Baijayanta (Jay) Panda, Hon’ble Member of Parliament, Citizens’ Alliance Against Malnutrition              |
|           |                                                     | Shri Sudam Marandi, Hon’ble Minister of State (Tribal Welfare), Odisha                                         |
|           |                                                     | Shri Lal Bihari Himirika, Hon’ble Minister, ST&SC Development Department, Odisha                               |
| 1110-1115 | Vote of thanks                                      | Shri R. Raghu Prasad, IFS, Director, ST and Additional Secretary ST&SC Development Department, Odisha           |
| 1115-1130 | Inauguration of stalls of NGOs and forest foods corridor | Shri Lal Bihari Himirika, Hon’ble Minister, ST&SC Development Department, Odisha                      |
| 1130-1145 | **TEA-BREAK**                                       | **1130-1145** |
| **Plenary 2**: Context setting  
(Master of Ceremony: Ms. Pamela Philipose) | **MoTA’s food and nutrition security efforts for tribal children**                                              | **1145-1200** |
<p>| 1145-1200 | MoTA’s food and nutrition security efforts for tribal children                                             | Shri Gopal Sindhwani, Ministry of Tribal Affairs (MoTA), Government of India (GoI) |
|           | Importance of a multi-sectoral approach to addressing undernutrition in tribal communities                | Dr. Saba Mebrahtu, UNICEF India                                                                                  |</p>
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<td>1200-1215</td>
<td>Stocktaking of efforts to improve nutrition and health services in tribal areas</td>
<td>Dr. Manoj Jhalani, Ministry of Health and Family Welfare (MoHFW), GoI</td>
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<td>1215-1230</td>
<td>Stocktaking of efforts of Ministry of Women and Child Development to improve ICDS services in tribal areas</td>
<td>Shri Gulshan Lal, Ministry of Women and Child Development (MoWCD), GoI</td>
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<tr>
<td>1245-1300</td>
<td>Linking poverty alleviation and nutrition: Aajeevika experience</td>
<td>Ms. Nita Kejrewal, Director, National Rural Livelihood Promotion Society (NRLPS), Ministry of Rural Development (MoRD), Government of India</td>
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<td>1300-1325</td>
<td>Improving nutrition coordination for tribal children</td>
<td>Dr. S. B. Agnihotri, IAS, Secretary, Coordination and PG, Cabinet Secretariat, GoI</td>
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<td>1325-1330</td>
<td>Announcement for parallel sessions</td>
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**Parallel sessions**

Stirring multi-sectoral action for nourishing tribal children in Central India: what needs to be done and how?

[experiential evidence, field realities and practical solutions]

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<td>Gol representation: Ms. Nita Kejrewal, Director, NRLPS, MoRD, GoI</td>
<td>Gol representation: Shri Gulshan Lal, Director, MoWCD, GoI</td>
<td>Gol representation: Dr. Sila Deb, Deputy Commissioner (Child Health) and Nodal Officer Nutrition, MoHFW, GoI</td>
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<td></td>
<td>Technical lead: Dr. Ajay Parida, Executive Director, M.S. Swaminathan Research Foundation (MSSRF)</td>
<td>Technical lead: Dr. N. C. Saxena, Ex. Supreme Court Commissioner to Right to Food</td>
<td>Technical lead: Ms. Arti Ahuja, IAS, Principal Secretary, DHFW, GoO</td>
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<tr>
<td>1. Ms. Amrapali Kata, IAS, Telangana (One full meal scheme)</td>
<td>1. Shri Saswat Mishra, IAS, Secretary, DWCD, GoO (Decentralized feeding)</td>
<td>1. Dr. Pavitra Mohan, Rajasthan (Outreach services)</td>
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<tr>
<td>2. Dr. Rajeshree Joshi, Dhruba Bharatiya Agro Industries Foundation (BAIF), Gujarat (Food insecurity and initiatives)</td>
<td>2. Shri Sameer Garg, State Health Resource Centre (SHRC), Chhattisgarh (Mitanins)</td>
<td>2. Dr. John Oomen, Odisha (Referral services)</td>
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<td>3. Shri Saroj Mahapatra, Professional Assistance for Development Action (PRADAN), Chhattisgarh (Nutrition-agriculture SRI consortium)</td>
<td>3. Shri Yogesh Jain, (Public funded crèches – issues to consider)</td>
<td>3. Dr. Neeru Singh, Indian Council of Medical Research (ICMR), Jabalpur (VBD)</td>
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<td>4. Dr. Manohar Agnani, IAS, Commissioner, Food and Civil Supplies Madhya Pradesh (NFS implementation in Madhya Pradesh: Improvements in TPDS)</td>
<td>4. Ms. Lakshmi Durga Chava, Director, Society for Elimination of Rural Poverty (SERP), Andhra Pradesh (Nutrition and Day Care Centers) (NDCCs)</td>
<td>4. Dr. Suhas Kadam, Jan Swasthya Sahyog (JSS), Chhattisgarh (Improving tribal health, outreach and referral service/ JSS experience)</td>
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<td>5. Swami Yogishwarananda, Ramakrishna Mission (RKM), Chhattisgarh (Conflict and ICDS)</td>
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<td>2000-2200</td>
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<td><em>Mayfair Lagoon</em></td>
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<td>0930-1000</td>
<td>Summary of previous day and schematics for the Day II [Master of Ceremony: Ms. Pamela Philipose]</td>
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<td>1000-1100</td>
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<td>2. Ms. Deepshikha Kumari, Jharkhand (Lack of sanitation commodities)</td>
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<td>Tribal budgets, governance and coordination for nutrition</td>
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<td>Technical lead: Ms. Sona Mitra, Senior Research Officer, Centre for Budget and Governance Accountability (CBGA)</td>
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<td>2. Ms. Vandana Krishna, IAS, Govt. of Maharashtra (Nutrition Mission)</td>
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<td>3. Shri Banchhanedhi Pani, IAS, Govt. of Gujarat (Planning)</td>
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<td>Role of academic institutes and NGOs in improving nutrition services in tribal areas</td>
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<td>Presenters: Shri R. Prasana, IAS, Chhattisgarh (Fulwari)</td>
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<td>Dr. Dhiren Modi, Gujarat, Self-employed Women’s Association (Sewa - Rural experience)</td>
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<td>Shri K. K. Pal and State government Kerala (Use of GIS in tribal areas)</td>
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<td><strong>Recommendations of all parallel sessions:</strong></td>
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<td>• Dr. S. B. Agnihotri, IAS, Secretary, Coordination and PG, Cabinet</td>
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<td>• Shri S. M. Vijayanand, IAS, Special Secretary, Ministry of Rural</td>
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There are 6.2 million tribal children aged under five in India who are stunted, 4.7 million of whom live in just nine states, according to the National Family Health Survey 2005-2006. A two-day national conclave, attended by 297 delegates, to draw attention to stunting among tribal children across the nine states was held on 15-16 January, 2015, in Bhubaneswar, Odisha, India. This publication synthesizes the deliberations and recommendations on the way forward to prevent undernutrition in India’s tribal children.