

Sustainable Development Goals (SDGs) and Health of Scheduled Tribes in India: A New Era or a Missed Opportunity?

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Abstract:

Background: Health status is shaped by diverse, interrelated factors that produce inequities in health interventions and outcomes. Despite India's promising social inclusion agenda, unequal power relations and social inequalities leave scheduled tribe (ST) populations largely excluded. The Sustainable Development Goals (SDGs), with their principle of 'leaving no one behind', place social justice and equity at the centre of universal health coverage. This paper examines (i) the health status and access to reproductive health care of STs using an equity lens, and (ii) identifies policy gaps and public health strategies to achieve the SDG targets by 2030. **Methods:** Select health and nutrition indicators from NFHS-5 (2019-21) were analysed, comparing STs against the aggregate non-ST population, to highlight relative marginalization. **Results:** Findings reveal persistent, and on several indicators stagnant, disparities in child and maternal health between STs and non-STs, alongside inadequacies in multi-sectoral implementation and arbitrary program convergence that continue to widen these gaps. **Conclusion:** To progress on the SDGs, India must assess the specific needs of tribal populations and design integrated, rights-based health services that address systemic inequities. Strategies to close these gaps are proposed.

Key words: Sustainable Development Goals, Tribals, Healthcare, Equity, Multi-sectoral

Introduction: Despite India's substantial progress in health and social development indicators during the post-independence period, tribals (also known as adivasis/scheduled tribes/indigenous population, and used synonymously in the literature; the term 'tribal' is used here for consistency) continue to experience far worse health and nutrition outcomes than the rest of the population. The process of globalization has led to the systematic dismantling of programs and policies directed towards vulnerable groups, accentuating their poverty, morbidity, and mortality. Socially excluded communities like tribals disproportionately experience morbidity and mortality, both in scale and intensity (Coburn, Restivo, & Shandra, 2015; Thomson et al., 2017). India, with 8.6 percent of its population being scheduled tribes, has the world's second largest tribal population (Office of the Registrar General & Census Commissioner, 2011). Although the Constitution of India protects the rights of tribals through special provisions for scheduled tribes, centuries of exploitation, marginalization, and neglect still resonate in their lives. Tribals in India mostly live in difficult-to-access terrains, facing a range of inequalities in terms of land alienation, access to health care, nutritional services, educational facilities, and other social sector schemes due to poor policy responses, resulting in malnutrition, hunger, and increased mortality and morbidity (King, Smith, & Gracey, 2009; Xaxa, 2014).

The Sustainable Development Goals (SDGs) were introduced by the United Nations in 2015, expanding the Millennium Development Goals (MDGs) with a comprehensive set of new targets under the principle of 'leaving no one behind'. The SDGs seek to achieve their agenda by 2030 through a people-centric approach, employing the principles of accountability, transparency, and participation. One of the SDGs is devoted to health (Goal 3), making health a priority area of sustainable development. Although only two of the 169 SDG targets specifically mention tribals (indigenous people), the framework nevertheless provides a structure for inclusive development (Martinez & Lizama, 2019). There is therefore a need for an analysis that accounts for the historical vulnerabilities and marginalization of tribal populations and develops an analytical trajectory for policy directives to address tribal health, especially of women and children under five, in India.

Given this context, the paper explores (i) the extent to which India has advanced towards universal health care coverage for the tribal population, examining their health status and access

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to reproductive health care through select indicators using an equity lens, and (ii) identifies policy gaps and public health strategies to achieve the SDG targets by 2030.

Methods and Procedures: The National Family Health Survey (NFHS) provides state and national-level estimates on key indicators of child and maternal health, drawing on a multistage stratified sample representing individuals from all major social groups in India. Select health and nutrition indicators, especially those relevant to SDG child and maternal health targets, from the last round of NFHS-5 (2019-21) were used for this analysis. Data on scheduled tribes were compared against the aggregate non-ST population (comprising General, OBC, and SC categories) to highlight the relative marginalization of tribal populations. An equity lens approach was adopted to understand how multiple interacting social and economic factors contribute to the social exclusion and discrimination faced by tribal populations in accessing health care, and how this may affect India's ability to achieve its SDG health targets. Descriptive statistics, in the form of percentages and ratios, are used to present disparities between the tribal and non-tribal groups.

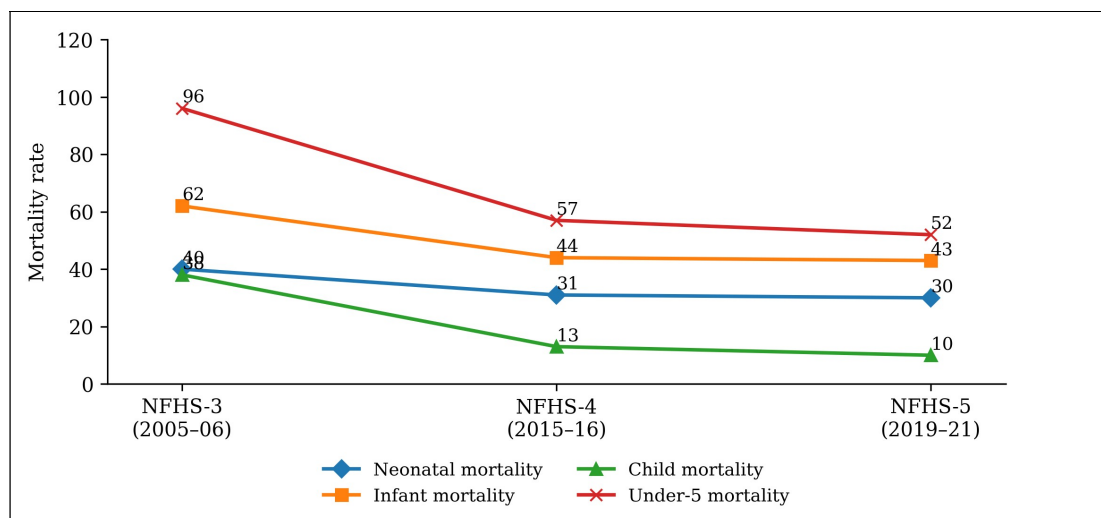
Results: This section analyses the health of tribal populations with a focus on SDG indicators for children under five years and women of reproductive age, since they are the most vulnerable, benchmarked against inequities between tribals and non-tribals in India.

Health status of tribal population

Child health

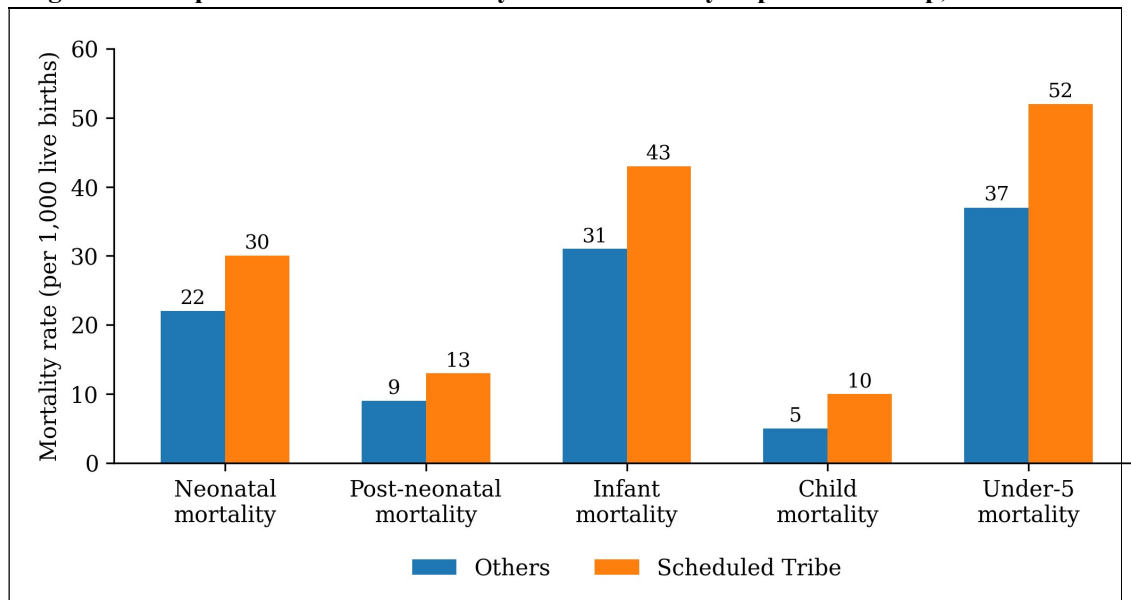
Mortality rates among children are a critical output indicator for child health. An analysis of National Family Health Surveys (IIPS, 2007, 2017, 2021) (Fig. 1) shows the levels and trends of components of under-five mortality among tribal children from 2005 to 2021. The magnitude of decline has varied across components of under-five mortality, and the decline between 2015-16 and 2019-21 is marginal. Although under-5 mortality reduced from 96 deaths per 1000 live births in 2004-05 to 52 deaths in 2019-21, neonatal mortality, an important indicator of care quality and nutritional status, has remained more or less stagnant over the years.

Figure 1: Trends in mortality rates among tribal children in India across NFHS rounds (2005-2021).



Note: Mortality rates are expressed as deaths per 1,000 live births. Data are presented for neonatal, infant, child (1-4 years), and under-five mortality across NFHS-3 (2005-06), NFHS-4 (2015-16), and NFHS-5 (2019-21). The figure demonstrates a consistent decline in all mortality indicators over time.

Figure 2: Components of Child Mortality Rates in India by Population Group, 2019-21.



Note. Fig 2: Components of child mortality, tribal vs non-tribal. Mortality rates are expressed as deaths per 1,000 live births. The figure compares neonatal, post-neonatal, infant, child (1-4 years), and under-five mortality rates between the general population (Others) and Scheduled Tribe (ST) children in India based on NFHS-5 (2019-21). Mortality rates were consistently higher among Scheduled Tribe children across all mortality indicators, highlighting persistent disparities in child health outcomes.

Figure 2 compares child mortality rates between Scheduled Tribe (ST) children and children from other population groups in India using NFHS-5 (2019-21) data. Across all mortality indicators, ST children experienced consistently higher mortality rates than their counterparts. The largest disparity was observed in under-five mortality (52 vs. 37 deaths per 1,000 live births), followed by infant mortality (43 vs. 31), neonatal mortality (30 vs. 22), post-neonatal mortality (13 vs. 9), and child mortality (10 vs. 5). These findings indicate persistent inequalities in child survival among tribal populations, underscoring the need for targeted maternal and child health interventions in tribal communities.

Child nutritional status:

Malnutrition is widely recognized as a manifestation of social and economic inequality, which often widens disparities in health outcomes. There is unacceptably high prevalence of malnutrition-stunting, wasting, underweight and anemia among tribal population as compared to the other group (Fig.3)

Maternal health

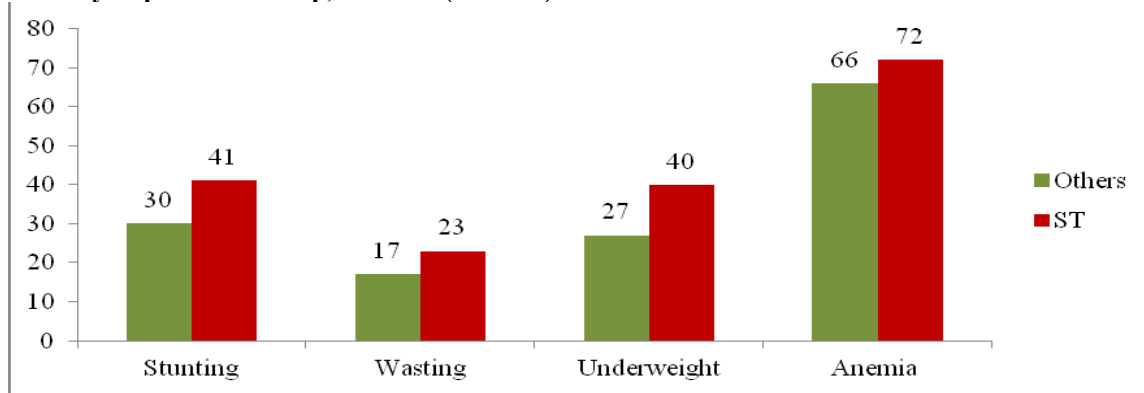
There is no large-scale data available on maternal mortality among tribal women; the Sample Registration System (SRS) Bulletin on maternal mortality in India (2018-20) does not provide disaggregated data by social group. Though, it is well known that early childbearing, low body mass index (BMI), and high incidence of anemia are critical risk factors for maternal mortality, and these are disproportionately prevalent among tribal women. According to NFHS-5, nine percent of teenage tribal girls had already begun childbearing, the highest among all social groups. The prevalence of low BMI was 11 percent among tribal women (compared to 6 percent among non-tribal women), and anemia affected 65 percent of tribal women (compared to 56 percent among non-tribal women).

Access to health care

Ninety percent of the tribal population lives in rural areas, and around 60 percent face various dimensions of poverty (Alkire, Oldiges, & Kanagaratnam, 2021), limiting their ability to access quality health care. Over the years, government spending on health has declined (Duggal, 2009;

Haakenstad et al., 2022), while policy measures have encouraged the growth of the private sector, so that India today has one of the largest, and least regulated, private health care sectors in the world (Sengupta & Nundy, 2005; Baranidharan, 2023), affordable mostly to the upper echelons of society. Evidence from across the country indicates that access to health care has declined sharply for marginalized groups since the advent of globalization (Barik & Thorat, 2015; Dash & Mohanty, 2019). Universal health coverage is a key SDG target, yet findings from NFHS-5 reveal a dismal picture for the tribal population (Fig. 4 and Fig. 5).

Figure 3: Comparison of Nutritional Status Indicators Among Children Under 5 Years in India by Population Group, NFHS-5 (2019-21).



Note. Values represent the percentage of children under 5 years affected by each nutritional indicator based on NFHS-5 (2019-21). ST = Scheduled Tribe. Higher percentages indicate a greater prevalence of malnutrition and anaemia. Across all indicators, ST children experienced a higher burden of undernutrition than children from other population groups.

Figure 4: Nutritional status of children (%) under age 5 years, NFHS 2019-21.

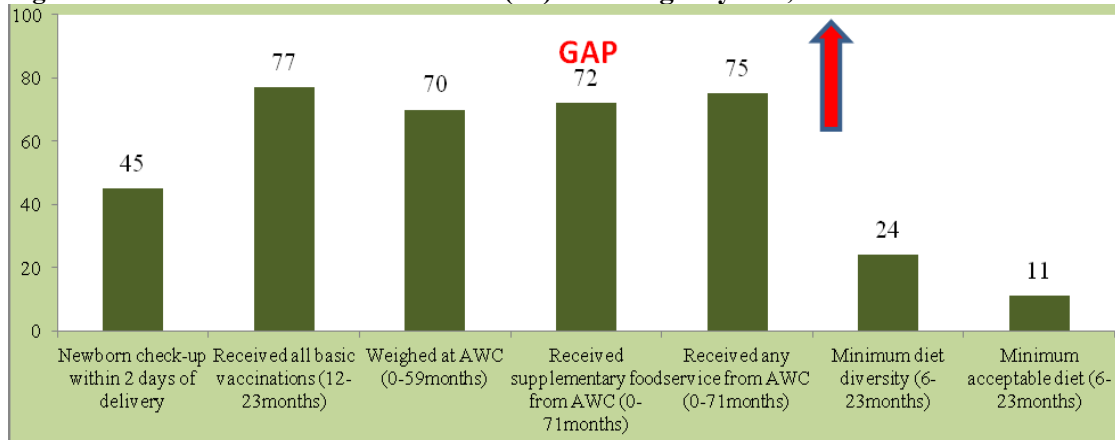


Fig 4: Access to health care services, tribal vs non-tribal

The Ministry of Health and Family Welfare recommends that all newborns receive a health check within the first 48 hours of birth (GOI, 2014); only 45 percent of tribal children received a postnatal checkup as per NFHS-5, consistent with the near-stagnant decline in neonatal mortality among tribal children over the last two decades. 'Minimum acceptable diet', a composite indicator incorporating meal frequency and dietary diversity, was met by only 11 percent of tribal children, highlighting persistent food insecurity. Even two decades after the launch of the National Rural Health Mission (NRHM), large proportions of tribal children continue to lack basic services such as vaccination and growth monitoring. NRHM, now renamed the National Health Mission (NHM), recognizes that child survival cannot be addressed in isolation, as it is intricately linked with maternal health, and thus adopts a 'continuum of care' approach through its Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A) strategy. Fig. 5 reveals that although some improvements have been made, significant gaps remain: more than 40 percent of

tribal women lack the WHO-recommended minimum of four antenatal care (ANC) visits, and gaps also persist in other aspects of ANC and postnatal care (PNC), such as consumption of iron-folic acid (IFA) tablets.

Figure 5: Coverage of Antenatal Care (ANC) and Postnatal Care (PNC) Services Received by Tribal Women in India, NFHS-5 (2019-21)

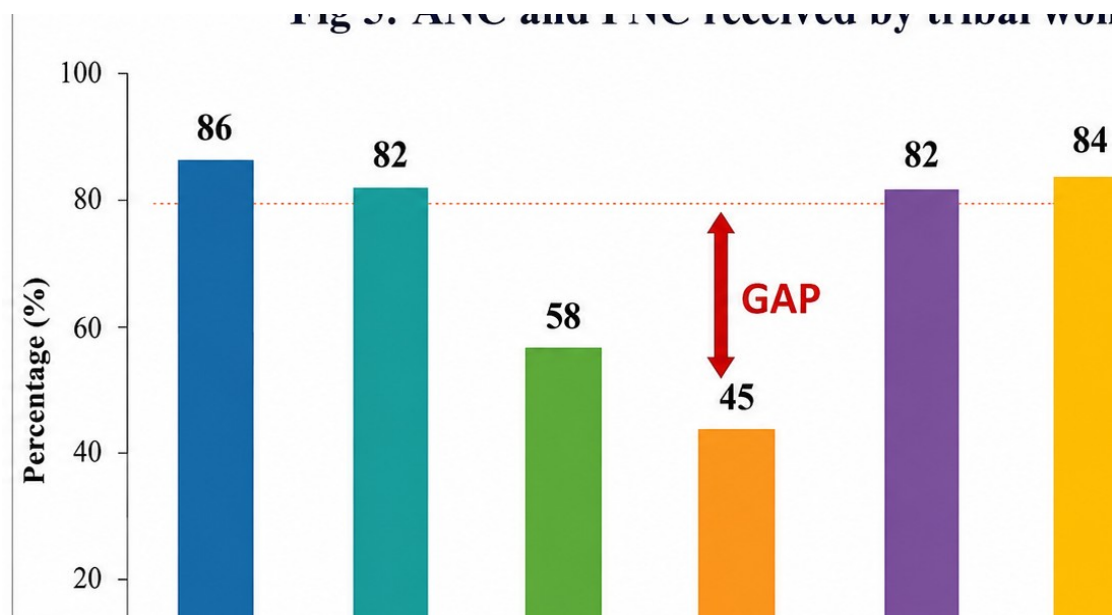


Fig 5: Antenatal and postnatal care coverage, tribal vs non-tribal. Note. ANC = Antenatal Care; PNC = Postnatal Care; IFA = Iron-Folic Acid. Values represent the percentage of tribal women who received each maternal healthcare service during pregnancy and the postnatal period. The red arrow highlights the substantial gap between completion of four ANC visits (58%) and consumption of IFA tablets for more than 100 days (45%), indicating a critical shortfall in maternal nutrition compliance. Source: National Family Health Survey (NFHS-5), India, 2019-21.

Determinants of health

Health is an outcome of the complex interaction of structural factors that persist across the life course. This section briefly addresses three such factors that shape the context in which tribal people in India seek health care.

Poverty and livelihood: Despite substantial progress in poverty reduction, India still has the largest number of poor people in the world. An analysis of multidimensional poverty trends between 2005-06 and 2015-16 (UNDP & OPHI, 2022) shows that poverty is not uniform, but correlates strongly with discrimination and disproportionately affects socially excluded groups like tribals. Tribal areas are rich in natural resources, yet tribals have experienced deprivation through large-scale displacement and inadequate rehabilitation as these areas were exploited in the name of development. More than three-fourths of tribal households were either landless or held less than one hectare of land in 2011-12 (NSSO, 2015), and traditional rights over Common Property Resources such as forests, land, and rivers are routinely denied. Nearly 85 lakh tribal persons were displaced by mega-development projects up to 1990 (Singh Negi & Ganguly, 2011; Salve, 2014), a number that has likely risen substantially since 1991 (Jaysawal & Saha, 2014), with the heaviest toll on women and children's right to life and health.

Living environment: Access to improved sanitation and water has a direct impact on health status, and SDG target 6 calls for universal and equitable access to drinking water and sanitation. Since the NFHS-5 survey does not provide disaggregated data by social category for living conditions, Census 2011 data were used for this analysis (Table 1). The data reveal that a majority

of the tribal population in India struggles to access basic facilities, contributing to high morbidity and mortality among the tribal population.

Table 1: Comparison of access to living environment, Census 2011

Indicator of living environment	ST (%)	Non-ST (%)
Improved sanitary facility	17	44
Availability of tap water	11	28
Clean cooking fuel	10	31

Government policies and programs: Government policies and programs play a decisive role in addressing health inequalities and social determinants of health. India has several constitutional and legal provisions, such as the Provisions of Panchayats (Extension to Scheduled Areas) Act (PESA) of 1996 and the Scheduled Tribes and Other Traditional Forest Dwellers (Recognition of Forest Rights) Act (FRA) of 2006, enacted to safeguard tribal rights, yet these policies have failed to protect tribals from continued deprivation. Policies implementing structural adjustment programs, alongside forest and wildlife conservation laws like the Wildlife Protection Act of 1972 and the Forest Conservation Act of 1980, have enhanced the deprivation of forest-dwelling tribals by alienating land and curtailing their livelihood and survival, overlooking their dependence on forests (Thresia et al., 2022). These discriminative policies have institutionalized social, cultural, and economic inequities, pushing tribals further to the margins. Even recent targeted interventions, such as the Aspirational Districts Programme launched in 2018, which focuses heavily on health and nutrition in districts with high tribal populations, have struggled to achieve sustained convergence at the grassroots level due to chronic understaffing and administrative bottlenecks.

Discussion:

The challenges in achieving SDG targets

India's 1978 signing of the Alma Ata declaration paved the way for a large public health infrastructure (Rifkin, 2018), and the 1983 National Health Policy committed to increased spending and a three-tier system of sub-centres, primary health centres, and community health centres. Though, since 1991, structural adjustment programs administered by international financial institutions like the IMF, World Bank, and regional development banks have typically set the fiscal parameters within which developmental policies, including health, operate in developing countries, including India. With large-scale economic restructuring, public health care became a casualty, with a significant reduction in public expenditure on health (Ghosh, 2010). There exists a clear contradiction between the principles of public health and neo-liberal economic theory (Fisk, 2000), and the findings of this paper highlight the negative consequences this has had on the lives of the tribal population in India.

Tribals in India are not a homogenous entity, yet large-scale surveys like NFHS, conducted at specific intervals to provide essential health data needed by government and other agencies for policy and program purposes, do not provide disaggregated data for various tribal groups, especially Particularly Vulnerable Tribal Groups (PVTGs), tribal populations of north-east India, and those from scheduled and non-scheduled areas, even though considerable variation exists among the culture and norms of different tribal groups that affects their health status. The SDGs recommend collecting data (SDG 17.18) disaggregated by income, gender, age, race, ethnicity, migratory status, disability, and geographic location in developing countries; NFHS and similar large-scale national surveys should therefore place greater emphasis on uncovering disparities across population groups and understanding the mechanisms and complexities underpinning

them. Despite the lack of disaggregated data, the poor health indicators of tribals compared to non-tribal groups make clear that tribal lives are mired in intersecting axes of inequality rooted in social marginalization, resource alienation, and inadequate policy response, compounded by widespread undernutrition and lack of basic amenities. Recent times have also seen a forced social and cultural transition among tribal people, resulting in lifestyle diseases and a 'double burden of disease' (GOI, 2018). This epidemiological transition means that alongside persistent infectious disease and undernutrition, tribal populations are increasingly vulnerable to non-communicable diseases (NCDs) such as hypertension and diabetes; the existing rural public health infrastructure, already struggling to provide basic maternal and child care, is ill-equipped to screen for or manage this dual burden. Also, the NFHS-5 data collection period (2019-2021) coincided with the COVID-19 pandemic and associated lockdowns, which severely disrupted routine immunization, antenatal care visits, and the functioning of anganwadi centres. It is likely that the pandemic exacerbated already grim health indicators for marginalized groups like tribals, making the achievement of the 2030 SDG targets even more challenging (Saha Sinha, 2022).

Multisectoral action in health: increasing recognition but limited action

The status of health, especially of children and women, offers a clear lens for examining the progress of a country's entire developmental paradigm. Ensuring Universal Health Coverage (UHC) has been termed one of the most powerful social equalizers among all policy options (Al-Mandhari et al., 2019). Child survival gains among tribals have stalled significantly since 2015, and India is likely to fall short of meeting the SDG target for child mortality. Scheduled tribes in India are a socially excluded population facing multi-level barriers in accessing health services, yet programs are often designed and implemented disregarding this context. Health is a well-established outcome indicator of economic, social, and environmental factors (Tangcharoensathien et al., 2017), and therefore requires integrated multi-sectoral action to build a resilient, equitable health system, as envisaged in the SDG declaration. Monitoring, evaluation, and community-based accountability mechanisms are key to building such a system.

The SDGs differ from the MDGs in calling for the integration of various goals with one another (Boidin, 2019); they acknowledge the interdependent nature of proposed targets and place emphasis on collaborative partnerships, policy coordination, and coherence. For tribal health, this interdependence means that SDG 3 (health) cannot be achieved without concurrent progress on SDG 2 (nutrition), SDG 6 (water and sanitation), and SDG 1 (poverty), while SDG 17.18 (disaggregated data) remains essential to making tribal health visible within national monitoring systems. Since independence, successive national health committees have echoed the fact that health outcomes are shaped not only by service delivery but by factors managed across sectors. The Bhore Committee (1946) first linked uncoordinated health, food, and nutrition efforts to high infant and maternal mortality (GOI, 1946), proposing an integrated primary health care system; the Mudaliar, Mukherjee, Jungalwalla, and Kartar Singh committees that followed reiterated the need for greater inter-sectoral coordination. In 2005, the government introduced the National Rural Health Mission (NRHM), now the National Health Mission (NHM), proposing coordination mechanisms across national, state, district, block, sector, and village levels. The National Health Policy of 2017 similarly emphasized intersectoral convergence, yet government review missions and independent surveys have repeatedly found a lack of convergence among departments and functionaries (MoHFW, 2014, 2018; Srivastava et al., 2016; Sangamad & Devagappanavar, 2020), explaining why NFHS-5 continues to reveal such disparities in tribal health status and access to care.

Community participation in health promotion

Good governance advances sustainable development through transparency, accountability, and demand-driven local service delivery (Van Doeveren, 2011). NRHM's Community Based Monitoring and Planning (CBMP) approach, adopted in 2007 and grounded in citizenship, democratization, and rights, was intended to strengthen coordination across social sector programs (Shukla & Saha Sinha, 2014). One of NRHM's major initiatives has been the formation of Village Health and Sanitation Committees (VHSCs), renamed in 2011 as Village Health, Sanitation and Nutrition Committees (VHSNCs) to expand their role to nutrition. Village Health, Sanitation and Nutrition Days (VHSNDs) were conceived as a community-level strategy for convergent action on health, early childhood development, nutrition, and sanitation, and are intended to help achieve various SDGs related to health, nutrition, drinking water, and sanitation, key determinants of health and well-being. Despite being conceptualized and implemented since 2007, this mechanism has not achieved its intended reach: a review by the Common Review Mission (CRM) found that VHSNCs largely operate without regular meetings or proper discussion, and VHSNDs are often held without adequate engagement or coordination (MoHFW, 2021).

Possible Strategies for Achieving SDG Targets

Access to health care: Large proportions of tribals live in remote hamlets, where health infrastructure is inadequate and, during monsoons, virtually inaccessible, leading most communities to rely on traditional medicine. One potential strategy is medical outreach camps with travelling doctors and nurses who visit remote communities regularly. VHSNDs, conceptualized to provide quality ANC, PNC, and child health care at the village level on fixed days, need to be conducted regularly. Institutional arrangements under NHM to improve care quality for mothers and newborns, such as LaQshya (MoHFW, 2017), should be fully implemented alongside thorough monitoring mechanisms, including community-based monitoring. Provision of acceptable, responsive, and non-discriminatory services is critical to social inclusion in health, and training health workers in cultural competency supports responsive, dignified care (Tangcharoensathien et al., 2018).

Access to supplementary nutrition programs: To improve tribal women's and children's access to supplementary nutrition programs initiated under ICDS and now the National Nutrition Mission (NNM), local partnerships with self-help groups are needed to provide culturally appropriate food that improves diet diversity and acceptability. Specific community-based monitoring platforms involving tribal women should be developed to monitor services provided through anganwadi centres, since poor access to these programs is a major factor behind the poor nutritional status of tribal children and women (SAMA, 2018). Proactive disclosure of information about schemes and entitlements should be integral to health and nutrition programs, especially for remote tribal groups. The provision of mini-Anganwadi Centres in hard-to-reach areas, and full utilization of Tribal Sub-Plan (TSP) funds, can help supplement resources in tribal areas.

Access to sanitation and drinking water: While tribal communities maintain specific cultural hygiene practices, open defecation in these areas is rarely a mere 'cultural preference'; it is structurally driven by the denial of traditional rights over common property resources, which has destroyed traditional water sources and left communities without the water needed for toilet maintenance. Standardized toilet designs imposed under schemes like Swachh Bharat often ignore local topography and cultural nuances, leading to underutilization (Jacob et al., 2021). The rights to sanitation and drinking water of tribals are closely linked to their right to habitat and resources; the UN Declaration on the Rights of Indigenous Peoples (UNDRIP) recognizes indigenous peoples' right to improved sanitation (Article 21), but not in isolation from their right

to land, territory, and resources (Article 8). Large tribal lands have been taken for 'developmental projects', displacing communities and disrupting traditional sanitation practices and water resources. Sanitation campaigns need to be designed around tribal communities' own health care and sanitation knowledge, with gram sabhas playing a central role, or toilets built for tribals risk remaining unused.

Conclusions: While the SDG framework offers a robust, multi-sectoral blueprint for achieving health equity, its current implementation in India resembles a 'missed opportunity' for the tribal population. The persistent, and in some cases stagnant, gaps in maternal and child health indicators among STs, rooted in historical land alienation, inadequate data disaggregation, and an increasingly privatized health sector, highlight a systemic failure. To truly embody the central promise of 'leaving no one behind', India must pivot from generic, top-down health missions towards localized, rights-based interventions that address the socio-economic and environmental determinants of tribal health, ensuring that tribal voices are integrated into the design and monitoring of healthcare services. Only then can the SDGs transition from a global mandate into a tangible reality for India's most marginalized communities.

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Conflicts of interest: The authors declare that they have no competing interests.

References:

- Al-Mandhari, A., El-Adawy, M., Khan, W., & Ghaffar, A. (2019). Health for all by all, Pursuing multi-sectoral action on health for SDGs in the WHO Eastern Mediterranean Region. *Globalization and Health*, 15, Article 64. <https://doi.org/10.1186/s12992-019-0504-8>
- Alkire, S., Oldiges, C., & Kanagaratnam, U. (2021). Examining multidimensional poverty reduction in India 2005/6-2015/16: Insights and oversights of the headcount ratio. *World Development*, 142, Article 105454. <https://doi.org/10.1016/j.worlddev.2021.105454>
- Baranidharan, S. (2023). Concerning rise of private healthcare in India. *Economic and Political Weekly*, 58(8).
- Barik, D., & Thorat, A. (2015). Issues of unequal access to public health in India. *Frontiers in Public Health*, 3, Article 245.
- Boidin, B. (2019). Sustainable Development Goals: An opportunity for health in Africa? *Global Health Promotion*, 26(1), 91-94. <https://doi.org/10.1177/1757975916677513>
- Coburn, C., Restivo, M., & Shandra, J. M. (2015). The African Development Bank and infant mortality: A cross-national analysis of structural adjustment and investment lending from 1990 to 2006. *International Journal of Comparative Sociology*, 56(3-4), 275-296. <https://doi.org/10.1177/0020715215610799>
- Dash, A., & Mohanty, S. K. (2019). Do poor people in the poorer states pay more for healthcare in India? *BMC Public Health*, 19, Article 1020. <https://doi.org/10.1186/s12889-019-7342-8>

- Duggal, R. (2009). Sinking flagships and health budgets in India. *Economic and Political Weekly*, 44(33), 14-17.
- Fisk, M. (2000). Neoliberalism and the slow death of public healthcare in Mexico. *Socialism and Democracy*, 14(1), 63-84. <https://doi.org/10.1080/08854300008428251>
- Ghosh, S. (2010). Catastrophic payments and impoverishment due to out-of-pocket health spending: The effects of recent health sector reforms in India (Working Paper No. 15). Asia Health Policy Program, Stanford University.
- Government of India. (1946). Report of the Health Survey and Development Committee, 1946 (Vol. II) [Bhore Committee Report]. Manager of Publication.
- Government of India. (1961). Report of the Health Survey and Planning Committee, 1961 [Mudaliar Committee Report]. Ministry of Health.
- Government of India. (1965). Report of the Committee on Basic Health Services, 1965 [Mukherjee Committee Report]. Ministry of Health.
- Government of India. (1967). Report of the Committee on Integration of Health Services, 1967 [Jungalwalla Committee Report]. Directorate General of Health Services, Ministry of Health.
- Government of India. (1973). Report of the Committee on Multipurpose Workers under Health and Family Planning Programme, 1973 [Kartar Singh Committee Report]. Ministry of Health and Family Planning.
- Government of India, Ministry of Health and Family Welfare. (2014). Home based new born care: Operational guidelines.
- Government of India, Ministry of Health and Family Welfare. (2018). Tribal health in India: Bridging the gap and a roadmap for the future.
- Haakenstad, A., Kalita, A., Bose, B., Cooper, J. E., & Yip, W. (2022). Catastrophic health expenditure on private sector pharmaceuticals: A cross-sectional analysis from the state of Odisha, India. *Health Policy and Planning*, 37(7), 872-884. <https://doi.org/10.1093/heapol/czac035>
- International Institute for Population Sciences, & Macro International. (2007). National Family Health Survey (NFHS-3), 2005-06: India.
- International Institute for Population Sciences, & ICF. (2017). National Family Health Survey (NFHS-4), 2015-16: India.
- International Institute for Population Sciences, & ICF. (2021). National Family Health Survey (NFHS-5), 2019-21: India.
- Jacob, S., Natrajan, B., & Ajay, T. G. (2021). 'Why don't they use the toilet built for them?': Explaining toilet use in Chhattisgarh, Central India. *Contributions to Indian Sociology*, 55(1), 89-115. <https://doi.org/10.1177/0069966720972565>
- Jaysawal, N., & Saha, S. (2014). Marginalisation of tribal communities due to globalization. *Indian Journal of Dalit and Tribal Studies*, 2(2), 37-54.
- King, M., Smith, A., & Gracey, M. (2009). Indigenous health part 2: The underlying causes of the health gap. *The Lancet*, 374(9683), 76-85. [https://doi.org/10.1016/S0140-6736\(09\)60827-8](https://doi.org/10.1016/S0140-6736(09)60827-8)

- Martinez, J. D. O., & Lizama, A. S. (2019). Indigenous peoples and indigenous women in the sustainable development goals. In N. Seth, C. M. D. Barrado, & P. D. Lalaguna (Eds.), *SDGs: Main contributions and challenges* (pp. 71-99). United Nations Institute for Training and Research.
- Ministry of Health and Family Welfare. (2014). *NRHM 8th Common Review Mission report*. Government of India.
- Ministry of Health and Family Welfare. (2017). *Labour room and quality improvement initiative (LaQshya)*. Government of India.
- Ministry of Health and Family Welfare. (2018). *NRHM 12th Common Review Mission report*. Government of India.
- Ministry of Health and Family Welfare. (2021). *NRHM 14th Common Review Mission report*. Government of India.
- National Sample Survey Office. (2015). *NSS 68th round report: Employment and unemployment situation among social groups in India, 2011-12 (Table S3R)*. Ministry of Statistics and Programme Implementation, Government of India.

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