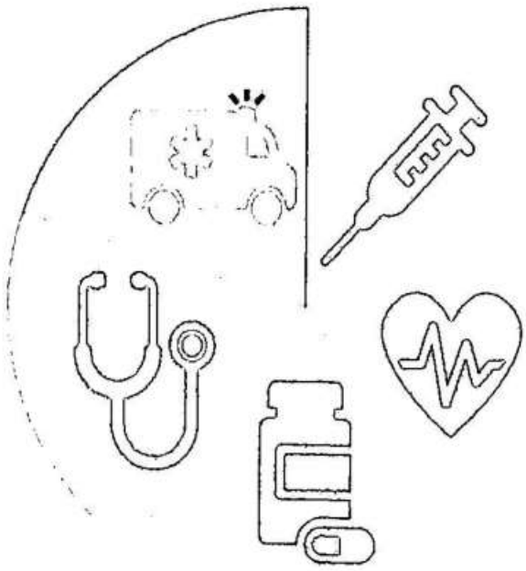
REPORT ON HEALTH-CARE STATUS OF THE INDIGENOUS ASSAMESE MUSLIM COMMUNITY



THE SUB COMMITTEE ON HEALTH FOR INDIGENOUS ASSAMESE MUSLIM COMMUNITY

CONSTITUTED BY
THE WELFARE OF MINORITIES AND DEVELOPMENT DEPARTMENT,
GOVERNMENT OF ASSAM

HEALTH-CARE STATUS OF THE INDIGENOUS ASSAMESE MUSLIM COMMUNITY

REPORT BY THE SUB COMMITTEE ON HEALTH FOR INDIGENOUS ASSAMESE MUSLIM COMMUNITY

CONSTITUTED BY
THE WELFARE OF MINORITIES AND DEVELOPMENT DEPARTMENT,
GOVERNMENT OF ASSAM

Vide Notification No. WMD.62/2021/Pt/7 Dated 31st July 2021.

Dr. Syed IFTIKAR Ahmed
(Chairman)

Dr. Javed Ali
(Member)

Dr. Aftab Ali Ahmed
(Member)

S.M. Zahid Chistie, ACS
(Member-Secretary)

To

Dr Himanta Biswa Sarma,
Hon'ble Chief Minister, Assam,
Janata Bhavan, Dispur, Guwahati-6

Dated: 24th of February, 2022.

Dear Sir,

Kindly find herewith the Report of the Sub-Committee on 'Health' that was constituted by the Welfare of Minorities and Development Department, Government of Assam to carry out a thorough study on the status of Health-Care of the Indigenous Assamese Muslim Community of Assam. The sub-committee was constituted in pursuance of the decision taken at the 'Alaap Alochana' (Interactive Session) held on 4th July, 2021 at Assam Administrative Staff College, Guwahati.

The report seeks to bring out a holistic overview of the Health-care status of the Indigenous Assamese Muslim Community residing across Assam. While acknowledging its shortcoming of not been able to visit all the districts of the state, the sub-committee sincerely believes that the recommendations in the report would cover all relevant health-care issues faced by the Indigenous Assamese Muslim Community of the state.

The Sub-Committee is hopeful that the report and its recommendations would receive your kind consideration and that of the Government of Assam. Its acceptance would go a long way in alleviating the human development status, in general and the health status, in particular of the Indigenous Assamese Muslim Community residing in Assam.

Yours Sincerely,

(Dr. Syed IFTIKAR Ahmed)
Chairman, Sub-Committee on Health
For Indigenous Assamese Muslim Community

Acknowledgement

The Sub-Committee would first like to thank the Hon'ble Chief Minister Assam, Dr Himanta Biswa Sarma, for his unprecedented initiative of reaching out to the Indigenous Assamese Muslim Community residing all across Assam through the 'Alaap Alochana' interactive programme and for constituting the sub-committees for undertaking thorough studies on various aspects of the community.

We are very grateful to the District Administration and the District Health Authorities of Golaghat, Dibrugarh, Kamrup, Goalpara and Dhubri for their excellent cooperation in organising the interactive sessions in their districts and in providing necessary support during our visit.

We are also very much grateful to the Welfare of Minorities & Development Department and Char Area Development Board for arranging the logistics to carry out the study and to prepare the report.

TABLE OF CONTENT:

I. INTRODUCTION

With the objective of overall development of the Indigenous Assamese Muslim Community of Assam, an interactive session - " Alaap Alochana" was organised by the Govt of Assam at Assam Administrative Staff College, Khanapara, Guwahati on 04-07-2021. In the session, the Hon'ble Chief Minister of Assam, Dr Himanta Biswa Sarma, informed of his decision to form 7 (Seven) Sub Groups/ Committees to undertake detailed studies on different issues confronting the Indigenous Assamese Muslim Community of Assam and submit reports with recommendations to the Government.

One such sub-committee was formed on "Health" as per Notification issued by the Welfare of Minorities Development Department, Govt of Assam on 31st July, 2021 with the following members (Annexure I) :

1. Dr Syed Iftikar Ahmed, Anti-AIDS Campaigner & Social Activist - Chairman
2. Dr Javed Ali, Former Professor & HOD, TMCH, Tezpur - Member
3. Dr Aftab Ali Ahmed, Assistant Professor, Jorhat Medical College - Member
4. Syed Md Zahid Chistie ACS, Joint Secretary to the Govt of Assam, Personnel Department - Member Secretary.

The committee was tasked to carry out a thorough study on the Health-Care status of the community.

The existing data on Health of the Muslim population paints a poor picture on the health care status of the community. Both the UNDP sponsored Assam Human Development Report, 2014 and the latest National Family Health Survey (NHFS-5) of 2019-20 points to a poorer human development status of the Muslim population. Although, the Indigenous Assamese Muslims constitute only about 25-30% of the total Muslim population of the state, the data provided by the 2 reports gives an indication of the comparative health-care status of the Indigenous Assamese Muslim community.

A comparative statement of key indictors between Hindus and Muslims of Assam on Maternal and Child Health, social status of women and access to health-care facilities as available in the NFHS-5 is shown in Table I. An overview of the data in Table-I, suggest that the Muslim population, especially Women and Child have poorer health status than the Hindu population and have been able to avail lesser health-care facilities. This comparative deprivation extends to Maternity-care, infant-care, child-care, support from Anganwadi Centres, health and hygiene awareness and access to Government financial support and health insurance.

This study shall seek to examine whether those comparative Health-care deficiencies of the Muslim population of Assam also extends to the Indigenous Assamese Muslim community. The recommendation of this report shall lay down ways to overcome those deficiencies, if they exist among the community.

Table I: A comparative statement of Health and Health-care status of Hindu and Muslim population in the state of Assam as per NFHS-5 (2019-20)

Sl No	Indicator	Hindu	Muslim
1	Total Fertility Rate	1.59	2.38
2	% of teenage(15yrs-19yrs) girls with live birth	4.4	12.6
3	% with birth order of 4 or more in preceding 3 years	4.5	14.9
4	% receiving Ante Natal Care(ANC) from a doctor	67.9	48.9
5	% receiving ANC from a skilled provider	89.8	78.9
6	% receiving 4 or more ANM visits	58.2	41.1
7	% undergoing ultrasound Test during pregnancies	76.3	69.1
8	% of births in a Health facility	90.5	76.6
9	% of births assisted by health personnel	93.5	81.8
10	% receiving postnatal check	76.9	67.8
11	% receiving financial benefit under JSY	47.7	43.4
12	% of babies with post-natal check within 3 hrs	71.1	58.7
13	% of babies with no post-natal check	20.2	31.8
14	% of babies with all basic vaccination	70.6	61.8
15	% of children under 5 with symptoms ARI	2	3.2
16	% of children under 5 with fever	16.8	18.8
17	% of children under 5 with Diarrhoea	4.7	6.4
18	% of Under 6 receiving any service from Anganwadi Centres (AWC)	68.1	64.8
19	% of Under 6 receiving counselling after weighing from AWC	66.4	59.9
20	% of mothers receiving any service during pregnancy from AWC	70.4	64
21	% of mothers receiving any service during breastfeeding from AWC	66.7	60.5
22	Median duration of breastfeeding in months	5	3.5
23	% of anaemia 6-59 months	35.6	36.7
24	% of women with knowledge of AIDS	95.4	91.5
25	% of men with knowledge of AIDS	98.5	96.6
26	% of women with knowledge of TB	95.3	93.3
27	% of men with knowledge of TB	94.2	88
28	% of women covered by health insurance/ finance scheme	54.9	49.8
29	% of men covered by health insurance/ finance scheme	56.4	49.7
30	% of women using hygienic method of menstrual protection	73.4	57.3
31	% of women facing violence during pregnancy	2	2.7
32	% of women facing emotional, physical or sexual violence	31.6	38.2

II. METHODOLOGY

The Sub Committee on Health proceeded with their activities based on the following methodology.

- Several meetings were organised among the members to formulate the strategies to move forward to achieve the set goals within 3 months.
- Without any specific data on the population distribution of the Indigenous Assamese Muslim Community of Assam, the sub-committee had to initially depend on a published document –the district and sub-district wise (approximately revenue circle-wise) population of Muslims of Assam as given in the 2011 Census, which gave a rough idea of the region-wise population. Still challenges would remain.
- The Sub Committee suggested two options to the Welfare of Minorities& Development (WMD) Department for the process of identifying the target population.
  - Requesting the district administration to identify the indigenous Assamese Muslim population in each district through Circle Officers.
  - Using the survey carried out by civil society organizations as a draft and updating it through public scrutiny and hearing at the district level.
- After the target population were identified, interaction would be carried out in the field for 'Situational' and 'Need' analysis at district level.
- It was contemplated that data on the following health-related issues would be collected through the proposed district level interactions. The data collected would be cross-checked with those available with District Health Society collected through other sources.
  - i) General status of health, i.e., IMR, MMR etc
  - ii) Prevalence of communicable and non-communicable diseases.
  - iii) Access to government health facilities- distance, accessibility, opening hours etc
  - iv) Availability of lab facilities- cost thereof.
  - v) Deficiencies in the Government healthcare facilities
  - vi) Expectation of the public from Government health facilities, in general
  - vii) Availability of private healthcare facilities- cost thereof
  - viii) Representation of local population in health training, awareness creation and service delivery systems.

  However, the sub-committee expected that clear guidelines would be issued by the Government regarding the deliverables that is expected of it.
- Chairman and all members were firm on their opinion from the start that Health is a universal issue for Humanity and Health planning or care cannot be planned on any specific community as Health do not discriminate any caste, creed, colour, language or

religion. However, certain section of the population, including the Indigenous Assamese Muslim Community of Assam could have certain health care issues because of their demographic distribution in the state, socio economic conditions, education, accessibility etc.

- The Sub Committee decided to carry on the Qualitative Community Health Need Assessment (QCHNA), proposed on the line of a time bound RNA (Rapid Need Assessment) of groups of sub population which were clearly defined.

- One-day interaction with the stakeholders were planned for few districts of Assam and 3(three) activities in each meeting were proposed to be conducted:

  i) Questionnaire- with three parts (Annexure II)

     Part I : Information from the stakeholders

     Part II : Information from the District Health Officials

     Part III : Observations from the Stakeholders

  ii) Focus Group Discussion.

  iii) Interaction and Direct response on the health needs of the stakeholders.

Under Part III of the proposed questionnaires, provisions were made for attaching all observations, Studies, Data, FGDs (Focus Group Discussions), NFHS documents etc. Issues like Non-Communicable Diseases & Communicable diseases, behavioural perception of the beneficiaries from service providers, Insurance, Health Cards etc were also included in the questionnaire. It was expected that the representatives of the District Administration, the Joint Director of Health Services (H & FW Deptt) and the National Health Mission would participate in the interaction.

The RNA was expected to elicit adequate quantity of responses and information. The conclusions and recommendations were to be drawn by the committee after analysing the information provided in the questionnaires.

CONSTRAINTS:

While preparing the report, the sub-committee was constrained in the following ways.

1. There are no published authentic data or documents on the demographic status of the Indigenous Assamese Muslim Community of Assam.

2. One day sessions are too short a period for in-depth analysis as it is not possible to gather and examine all relevant information within that period.

3. Not all districts of the state nor all sub-groups within the community could be covered. Hence the analysis, observations and recommendation of this report is only indicative in nature.

IV. ANALYSIS AND OBSERVATIONS:

The primary source of data for the analysis were the information received through the questionnaires and the verbal presentation of the focussed group discussions in the five district-level one-day interactions. The written representations submitted by community organisations served as our secondary source.

Information was received through questionnaires on the health status of 115 Nos of villages inhabited by indigenous Assamese Muslim Community in 5 districts. The district-wise break-up of the 115 villages areas follows:

i) Golaghat: 21
ii) Dibrugarh: 24
iii) Kamrup: 18
iv) Goalpara: 27
v) Dhubri: 25

The names of the villages are given in Annexure IV.
Written representations (Annexures V-A to V-E) were submitted by 3(three) community organisations and 2(two) individuals. The names of the organisation/individuals are as follows:

i) Sadou Asom Goria Moria Deshi Jatiya Parishad
ii) Sadou Asom Goria Jatiya Parishad
iii) Deshi Janagosthiya Manch,Assam
iv) Abdul Haque Ahmed, Dhupdhara
v) Syed Khairul Islam, Rangia(By e-mail).

Based on the analysis of the data and other information received through the questionnaires, representations, focus group discussions and inter-actions with village/community representatives, the following key observations are recorded.

1) Lack of demographic data: In Assam, the smallest unit for published census data and most other socio-economic data is a revenue village. As the indigenous Assamese Muslim community resides in revenue villages having mixed population, it is difficult to specifically delineate the health status and related socio-economic issues of the community from the existing census and other published official data.

2) Lack of adequate health care services/centres: A common problem facing the Indigenous Assamese Muslim Community is unavailability of Government Health services/centres within easily accessible distances or at villages level. There are only a few specialist services in the Block, sub-division or district level hospitals forcing the referral patients to go to the nearest Medical College Hospital at great personal expense.

3) Inadequate transportation facilities: Lack of adequate transport facilities for carrying patients to Health Care Centres is another common problem faced by the Indigenous Assamese Muslim Community. Such problem becomes acute during floods in remote areas. There are instances, where people living in border areas within 10 Kms of

III. ACTIVITIES

The following activities were carried out by the committee while preparing the report.

1) Studying available data of NHFS studies including NHFS- 5 of Assam
2) Holding meetings of the sub-group for preliminary discussions and setting of datelines.
3) Establishing initial contact with sub-groups of Indigenous Assamese Muslim Community of Assam.
4) Contacting District Administration for field visits-The district administrations were requested to invite the following persons to the district level interactions.
5) At least 3 representatives of indigenous Assamese Muslim community from each revenue village inhabited by members of the community
6) Community leaders, NGOs etc working with sub-groups of the community.
7) Service providers / community workers from the Health and Family Welfare Department.
8) Field visits – One-day interactive sessions were held in the months of October and November 2021 with various representatives of Indigenous Assamese Muslim Community and health officials identified and invited by the District Administration in District Headquarters. Photographs displaying the inter-active sessions are given at Annexure III.
9) A brief details of the district-level one-day interactions are given below.

Sl	Date	District	Location	No of participants
1	6/10/2021	Golaghat	Conference Hall, DC's Office, Golaghat	71
2	7/10/2021	Dibrugarh	Jagriti Hall, DRDA, Dibrugarh	63
3	18/11/2021	Kamrup	Conference Hall, DC's Office, Amingaon	70
4	23/11/2021	Goalpara	Conference Hall, DC's Office, Goalpara	58
5	24/11/2021	Dhubri	Conference Hall, DC's Office, Dhubri	38

10) Analysing the information collected through the Questionnaire, Focus Group Discussion, Interactions and Health status Report from District Health Authorities and Submitting the Report with recommendations.

international border need special pass even for transportation of pregnant women, seriously ill patients, trauma and accident patients leading to loss of valuable time.

4) Lack of adequate health care personnel: There is a lack of adequate number of health care workers including ANM, GNM, Lab Tech, Radiologist, Doctors, Ayush and others in the areas inhabited in remote places by Indigenous Assamese Muslim Community. The situation is aggravated by rampant absenteeism, frequent transfers and lack of accommodation for staff. As a result, non-availability of health staff is frequently observed leading to serious situation during disasters like floods, disease outbreaks etc.

5) Poor quality of drinking water: Poor Water quality having excess component of Fluorosis and Arsenic is creating additional health problems in areas inhabited by the Indigenous Assamese Muslim Community. Further, pesticides, insecticides, harmful chemicals used legally or illegally for enhancing both vegetable and animal growth are also contaminating drinking water sources.

6) Lack of awareness: Awareness level on Health issues among the Indigenous Assamese Muslim Community is very low. Further there is a lack of knowledge about government health programmes meant for the benefit of the common people. This has led to a situation where traditional healers, fake medical practitioners, self-medication, un-scientific health myths and mis-conceptions have gained pre-dominance in the areas inhabited by the community. Non-adherence to prescribed medical treatment includes non-completion of iron tablet course during pregnancy, non-completion of four mandatory antenatal visits and non-completion of vaccination doses, which have serious public health outcomes.

7) Social evils impacting health: There are some social problems rampant within the community which are having a bearing on the health of the community. Drugs and Alcohol use among the youths and adolescents, teen pregnancy, early marriage, multiple marriages, abortion as mode of family planning, domestic violence are some of the common social evils.

8) Presence of illegal health services: Untrained persons dispensing Medicines through local pharmacies and even spurious drugs from unrecognized and unlicensed manufacturers are common in areas inhabited by the community.

9) Deficiency in government health insurance delivery: There appears to be widespread shortfall both in awareness and delivery of Government Health Insurance programmes like Atal Amrit Card and Ayushman Cards. There is a general opinion that the present system of delivery of Government health insurance cards keeps out a large section of the community from its benefits. The application process and the document requirements discourage a lot of potential beneficiaries from applying.

The above observations indicates that the Indigenous Assamese Muslims faces similar nature of deficiencies in Health-care as the general Muslim population of the state, enumerated in Table-I (Page 9). However, without clear identification of the Indigenous Assamese Muslim community it would be fallacious to assume that the same degree of deficiency in health-care exists in the community as the general Muslim population.

V. RECOMMENDATIONS:

The key observations identify the issues that are relevant for the improvement of health care for the indigenous Assamese Muslim community. After taking into account the existing government health care services in the state and also the spatial distribution of the indigenous Assamese Muslim community, the following actions are recommended with regards to each of the key observation.

1) Lack of demographic data: Detailed revenue village wise mapping of the indigenous Assamese Muslim Community is needed to identify the geographical areas inhabited by the community. For this, officials of the revenue circles may be utilised by the district administration to identify all revenue villages inhabited by the community and provide a tentative estimate of population of the community in each of the village along with relevant socio-economic data.

2) Lack of adequate health care services/centres: This problem is probably faced commonly by other communities living near the Indigenous Assamese Muslim Communities. Hence, it is recommended that medical facilities from sub-centres to 200-bedded hospitals be established as per existing government guidelines covering all the population of the state.

   All peripheral level health facilities need to be upgraded to Ayushmann Bharat Health and Wellness Centres with the assurance of the availability of the expanded packages of services including RCH, CDs, NCDs and management of common ailments with assured referral linkages for secondary and tertiary level care.

3) Inadequate transportation facilities for patients: It is also a problem commonly shared by other communities living near the Indigenous Assamese Muslim Communities. It is recommended that Mobile Clinics, Mobile Medical Vans, Ambulances, Boat Clinics etc be provided in adequate quantities to cater to the need of the communities living in remote areas. The specific difficulty of the community living in border areas needs to be addressed which may require coordination with local law enforcement agencies.

4) Lack of adequate health care personnel: It is recommended that in the recruitment of lower-level health care workers, like ASHA workers, ANM, GNM, Pharmacist, Lab Technicians etc, priority may be given to local residents as they would have greater commitment to work in their own area. This is likely to reduce shortages of health care workers in remote areas inhabited by Indigenous Assamese Muslim Communities.

   Moreover, dissemination of critical medical/ family planning information to women becomes much easier if communicated in the local dialect. Hence, priority may also be given for training of para-medical personnel from the local population so that the communities in remote areas are better catered to.A separate public health cadre may be introduced in the state health services. This would enable planning for healthcare interventions at district/blocks based on local disease profile and socio-economic conditions.

5) Poor quality of drinking water: The District Health authorities should ensure regular testing of water quality in collaboration with the Public Health Engineering Department in such areas.

6) Lack of awareness: Targeted awareness campaign on health issues and Government health programmes may be organised in villages inhabited by the Indigenous Assamese Muslim Communities. The campaign should be carried out in the local dialect, as far as possible. For this local NGOs, having both male and female members, be specifically trained and engaged for awareness creation.

7) Social evils impacting health: The Health & FW department and the Social Welfare Department should tackle the issues head-on in partnership with the indigenous Muslim community organisations, local women groups, religious leaders and the local panchayat representatives. Targeted IEC activities using local dialects would strengthen such efforts.

8) Presence of illegal health services: It is a common problem for all communities inhabiting the areas. All such activities need to be strictly monitored by the Drug Controller authority at the District level.

9) Deficiency in government health insurance delivery: The awareness and delivery of Government health insurance services needs to be strengthened by the district health authority in areas inhabited by the Assamese Muslim community.

10) Need for effective monitoring mechanism: To effectively implement upon the above recommendations, there would be a need to have a system in place to monitor the activities of different departments related to above issues and to receive regular feedback from the Assamese Muslim community.

Hence, it is strongly recommended that a platform be formed in every district where the representatives of the Indigenous Assamese Muslim Community of the District may meet with the District Administration and District Health Officials and draw their plan to follow up the healthcare activities, including awareness creation, to be undertaken in their respective districts. The forum should be convened periodically (preferably every 3 months) by the district administration and should be broad-based.

VI. CONCLUSION :

On embarking upon this mission, we had to undertake huge scientific research ourselves. We had to examine a huge lot of available documents in a very scientific approach - Religious Demographic breakup analysis of Assam, NFHS Studies since last 5 years, comparison charts on health indices of Assam and other Indian States etc, formulation of Questionnaires to be used among our indigenous communities like Goriya, Moriya, Desi, Joloha etc on their health needs. This was felt essential in order to come to a scientific conclusion with recommendations to the Government.

The data deprived from the NFHS-5 data of 2019-20 indicated that the Muslim population of the state suffers from a poorer Health status and from a comparative deprivation in health-care. The sub-committee examined the data and information gathered in course of study through questionnaires and interactions with the community. The study clearly indicated that the Indigenous Assamese Muslim community also suffers from deficiencies as that of the general Muslim population. However, without enumeration of the Indigenous Assamese Muslim community, the study could not conclude that the same degree of deficiency exists in the community as the general Muslim population. The recommendation based on the observations were made after giving due to consideration to the above constraint.

Most of the recommendations made in this report are general in nature. The Indigenous Assamese Muslim community have been found to be residing as a mixed population with other communities in different villages and towns of the state. If the recommendations are accepted, they are likely to benefit a much broader population who face the same health-care issues as that of the Indigenous Assamese Muslims.

We conclude by stating that the Indigenous Assamese Muslim Community of Assam have a lot of expectation from the Government of Assam. During interactions in all the districts that was visited by the Sub-committee, every participant belonging to the community have expressed the same sentiment and was highly appreciative of our Hon'ble Chief Minister for reaching out to them. The Indigenous Assamese Muslim Community of Assam are looking upto the Government and we are extremely confident that positive actions will follow.

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Annexure I

GOVERNMENT OF ASSAM
WELFARE OF MINORITIES AND DEVELOPMENT DEPARTMENT
DISPUR
ORDERS BY THE GOVERNOR OF
ASSAMNOTIFICATION
Dated Dispur the 31st July, 2021

No.**WMD.62/2021/Pt/7**: In partial modification of this Department's earlier Notification No. WMD.62/2021/Pt./6 dated 9th July, 2021, and in pursuance of decision taken in 'Alaap Alochana '(Interactive Session) held on 04/07/2021 at Assam Administrative Staff College, Khanapara, Guwahati-22, the following Sub-Groups/Committee are hereby constituted to undertake thorough studies on Population Stabilisation, Healthcare, Cultural Identity, Education, Financial Inclusion, Skill Development and Women Empowerment of Indigenous Assamese Muslim Community of Assam:

A. Sub-Group/Committee on Population Stabilisation:

Name & Address	Designated as	Contact No
1. Dr Ilias Ali (Padmashree)	Chairman	9864061796
2. Akabor Ali Ahmed , Retd. Professor, BN College, Dhubri	Member	9678109177
3. Dr Tanvir Alam 4. Tezpur Medical College	Member	9706037060
5. Sahabuddin Ahmed Journalist, Mukalmua	Member	8638919139
6. K.J. Hilaly, ACS, CEO, GMDA	Member-Secretary	9435080266

B. Sub-Group/Committee on Health:

Name & Address	Designated as	Contact No
1. Dr Syed Iftikhar Ahmed (Anti-AIDS Campaigner & Social Activist)	Chairman	8723950583
2. Dr Javed Ali, Professor, GMCH.	Member	
3. Dr. Aftab Ali Ahmed (Assistant Professor, Jorhat Medical College)	Member	9957100114
4 . Zahid Chistie, ACS, Joint Secretary to the Govt. of Assam, Personnel Deptt.	Member-Secretary	9435055161

C. Sub-Group/Committee on Cultural Identity :

Name & Address	Designated as	Contact No
1. Wasbir Hussain (Editor-in-Chief, Northeast Live TV & Commentator)	Chairman	9864265980
2. Imran Hussain (Writer and Academic)	Member	9435608844
3. Nurul Sultan (Film producer and Cultural Activist , Dergaon)	Member	9435092888
4. Mahmud Hassan, ACS, Addl. Secretary to the Govt. of Assam, Forest Deptt	Member-Secretary	9435027583

D. Sub-Group/Committee on Education:

Name & Address	Designated as	Contact No
1. Dr Adil Ul Yasin, Retd Prof Dibrugarh University, Political Science	Chairman	9435735840
2. Sheikh Hedayetullah (Prof of English, Ratnapith College, Chapar, Dhubri. President, Deshi Jonogosthiya Mancha, Assam)	Member	9435616079
3. Moinul Haq, Writer & Poet	Member	9957860880
4. Inamul Hussain, ACS, Joint Secretary to the Govt. of Assam, Personnel Deptt.	Member-Secretary	9435023966

E. Sub-Group/Committee on Financial Inclusion:

Name & Address	Designated as	Contact No
1. Ms Nafifa Ahmed, IAS Retd.	Chairperson	7086070962
2. Dr Nissar Ahmed Barua, Prof of Economics, Gauhati University	Member	9864034527
3.Safiur Rahman, Retd Jt Director, Economics & Statistics Dept & P&RD Assam	Member	9207001289
4.Fayek Azad (Deputy General Manager, Assam Financial Corporation)	Member	9435101171 / 9859916509
5. Syed Ishfaqur Rahman, ACS, Secretary to the Govt. of Assam, Finance Deptt.	Member-Secretary	9435156139

F. Sub-Group/Committee on Skill Development:

Name & Address	Designated as	Contact No
1. Mr Mujibur Rahman, Head Mechanical Engineering Dept, Dibrugarh Polytechnic	Chairman	8474074803
2. Dr. Nekib Hussain (Entrepreneur and NGO)	Member	9435017680
3. Md Rashid Arif Hussain, Oil Industry Professional, Technical Expert, NRL.	Member	7053204241
4. Sazzad Alam, ACS, Joint Secretary to the Govt. of Assam, Industries & Commerce Deptt.	Member-Secretary	7002238965

G. Sub-Group/Committee on Women Empowerment:

Name & Address	Designated as	Contact No
1. Dr Nazrana Ahmed, Industrialist & Lawyer	Chairperson	9435031080
2. Dr Naseem Farhin Akhtar, Director, Centre for Womens Studies Dibrugarh University	Member	9435004378
3. Dr (Mrs) Jishan Ahmed, Head, Surgery, Assam Medical College Dibrugarh & Rotarian	Member	
4. Farida Samsul, ACS, Director, Char Area Development Assam	Member-Secretary	9435024034

1. The Sub-Groups/Committee will submit detailed report/Recommendation to the Welfare of Minorities and Development Department within 3 months for taking further necessary action.
2. The Chairman and Members of the Sub-Groups/Committee will be entitled for a sitting allowance of Rs. 2500/-(two thousand five hundred only) each.
3. Each Sub-Group/Committee can undertake tour and meet different stakeholders, if required.

Sd/-
Commissioner & Secretary to the Govt. of
Assam Welfare of Minorities and Development
Department

Annexure II

STUDY ON THE INDIGENOUS ASSAMESE MUSLIM POPULATION IN THE STATE OF ASSAM

HEALTH SUB COMMITTEE

A QUALITATIVE COMMUNITY HEALTH NEED ASSESSMENT

ONE TO GROUP IN-DEPTH INTERVIEW QUESTIONNAIRE

DISTRICT : **DATE :**

VILLAGE: **BLOCK :**

NO. OF PARTICIPANTS : **FULL LIST ATTACHED**

PART I

Information from Primary Stakeholders : Points for Generating Information

1. Sub Groups of Participants :
2. Recent illnesses reported by participants (last 1 year)
   i)
   ii)
   iii))
   iv)
   v)
   vi)
   vii)
3. Type of Illnesses -
   Male
   Female
   Children
4. Where did they go for Treatment? Home Remedy / Traditional Healers / Local Pharmacy / Govt Health Centre / Private Health Centres / Specialists / physiotherapists / AYUSH centres / Referrals if any / Self cure or NO treatment accessed
5. How far distance do they have to travel to get health services ? Do they have public transportation / private to reach them?
6. Were health providers available ? were their timings suitable ?

7. Did they receive free services or did they have to pay for the services , if so how Much ?
8. Did they get free Medicines / Lab Diagnostic Services / X Ray/ USG/ Eye/ Dental/ Skin treatment Services / other medical supplies ?
9. Were they satisfied with prevailing health services with remarks ?
10. What are their perceived needs to better the services ? their Suggestions on improvement of services
11. Human Health Resource Availability from the Locality/ Local Community (Doctors / Nurse, ANMs / Homeopath / Ayurvedic / Ayush / Unani / Physiotherapists/ Yoga centres) ?
12. Any Suggestion to improve Local Health Resources ?
13. What needs to be done to improve the overall health services in the District / Towns / Villages ?
14. Health Insurance – Govt/Private : Atal Amrit Card, Other Health Cards :

PART II

Information from the District Health Authorities

1. The Health Delivery System in the District/ Sub divisions
2. Prevailing Diseases
3. Trained Human Resources
4. Infrastructure
5. Supplies
6. Specialists / Referrals
7. Dermatology/ Eye/ ENT/ Dental/ Orthopaedics/ Accident& Emergency/ Blood Transfusion, Blood Banks
8. Transportation/ Ambulance services /108 services
9. School Health Programmes/ trainings / Home Visits/ Nutrition/ safe Water
10. Health Education/ Alcohol/ drugs etc.

PART III

OBSERVATIONS & REMARKS FROM THE VARIOUS SUB POPULATION GROUPS

Annexure III

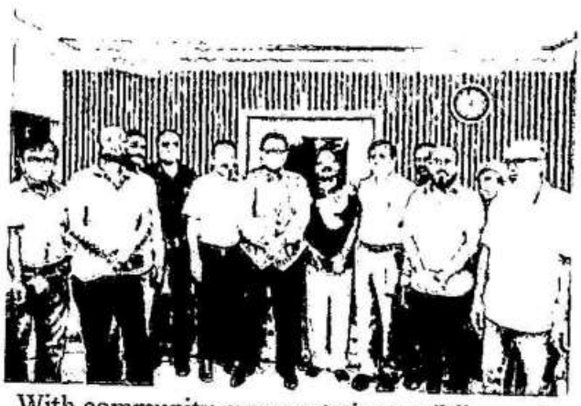
Activities of the Sub-Committee on Health for Indigenous Assamese Muslim Community

Inter-action in progress at Golaghat

Participants filling of Questionnaire at Golaghat

With Health workers at Golaghat

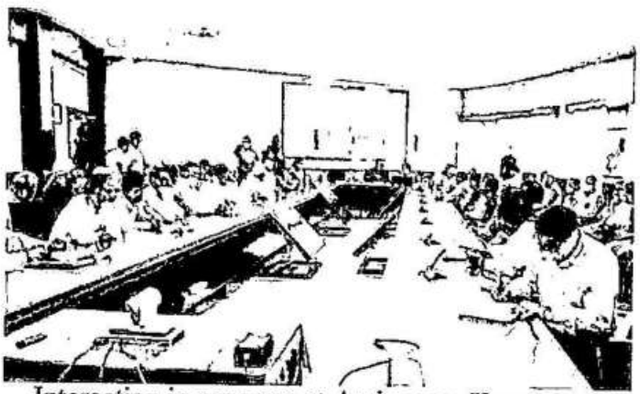
With Health workers at Dibrugarh



With community representatives at Dibrugarh

Inter-action in progress at Dibrugarh

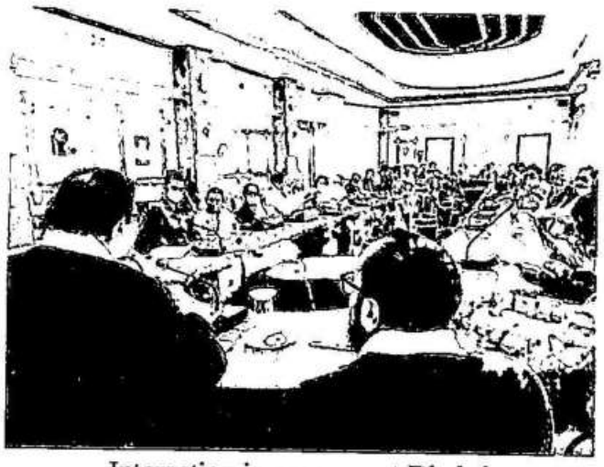
Interaction in progress at Amingaon, Kamrup



Interaction in progress at Amingaon, Kamrup

Addressing the participants at Amingaon

Addressing the participants at Dhubri



Interaction in progress at Dhubri

Interaction in progress at Dhubri

A participant interacting at Goalpara

A participant interacting at Goalpara

Participants at Goalpara

Participant at Goalpara

Annexure IV

LIST OF VILLAGES COVERED BY QUESTIONNAIRES

Sl No	District	Village	Block
1	Golaghat	Naharani	Kakodonga, Kathalguri
2	Golaghat	Batiporia	Kathalguri
3	Golaghat	Mohmaikigaon	Bokakhat
4	Golaghat	Melekhowa	Bokakhat
5	Golaghat	Bohikhowa Dogaon	Bokakhat
6	Golaghat	Balijan	Bokakhat
7	Golaghat	Bokakhat Town	Bokakhat
8	Golaghat	Panikara	Morangi
9	Golaghat	Sarar	Morangi
10	Golaghat	Dhulia	Morangi
11	Golaghat	Halmara toop	Morangi
12	Golaghat	Daigrung	Morangi
13	Golaghat	Falangani	Morangi
14	Golaghat	Murfulani	Morangi
15	Golaghat	Dukhutimukh	Morangi
16	Golaghat	Mowkhowa	Kathalguri
17	Golaghat	Golaghat Town	Golaghat Town
18	Golaghat	Merpani Islampur	Gomariguri
19	Golaghat	Moinapar	Marangi
20	Golaghat	Kacharikhat	Podumoni
21	Golaghat	Goranga	Gamariguri
22	Dibrugarh	Niz Tengakhat	Tengakhat
23	Dibrugarh	Niz Moudumia	Lahoal
24	Dibrugarh	Chungichuk Gaon	Panitola
25	Dibrugarh	Dighali Bari	Panitola
26	Dibrugarh	Chokoli Bhoria	Panitola
27	Dibrugarh	Dibrugarh Town	Dibrugarh Town
28	Dibrugarh	Namrup	Joypur
29	Dibrugarh	Naharkatia	Joypur
30	Dibrugarh	Duliajan Bongali Gaon	Tengakhat

Sl No	District	Village	Block
31	Dibrugarh	No 1 Kokuri Bongaligaon	Tinkhong
32	Dibrugarh	No 2 Chiring Khat	Tengakhat
33	Dibrugarh	Bogibill Lonapathar	Borbaruah
34	Dibrugarh	Hatigarh Balijan	Tengakhat
35	Dibrugarh	Tingrai Chari-Ali	Tengakhat
36	Dibrugarh	Kalakhowa Chari-Ali	Borbaruah
37	Dibrugarh	Chabua Town	Panitola
38	Dibrugarh	Bokul Majgaon	Lahoal
39	Dibrugarh	Bokul Japihojia	Lahoal
40	Dibrugarh	No 2 Dighalia	Tinkhong
41	Dibrugarh	Chaulkhowa Grant Gaon	Lahoal
42	Dibrugarh	Gharbandhichuk	Borbaruah
43	Dibrugarh	Sapkait(Tingkhong)	Tinkhong
44	Dibrugarh	No 2 Nabhakatia Rajgarh	Tinkhong
45	Dibrugarh	Niz Mankata	Borbaruah
46	Kamrup	Saniadi	Hajo
47	Kamrup	Da Mandakata	Bezera
48	Kamrup	Bihdia	Hajo
49	Kamrup	kalitakuchi	Hajo
50	Kamrup	Niz Hajo	Hajo
51	Kamrup	Fakirtola-Hajo	Hajo
52	Kamrup	Guiya	Kamalpur
53	Kamrup	Barijani	Sualkuchi
54	Kamrup	No.1 Dobok	Rangia
55	Kamrup	Udiana	Rangia
56	Kamrup	Madira N.C.	Nagarbera
57	Kamrup	Baregaon	Kamalpur
58	Kamrup	Changsari	Bezera
59	Kamrup	Sila Koraibari	Bezera
60	Kamrup	Hirajani	Hajo
61	Kamrup	No 1 Dhuhi	Rangia
62	Kamrup	No 2 Dhuhi	Rangia
63	Kamrup	Jalah	Bezera

Sl No	District	Village	Block
64	Goalpara	Sutarpara	Matia
65	Goalpara	Kushthowa Cheehapani Pt II	Rongjuli
66	Goalpara	Gossaindubi Hindupara	Lakhipur
67	Goalpara	Choukatala	Jaleshwar
68	Goalpara	Gaurnagar	Jaleshwar
69	Goalpara	Shauldhowa	Jaleshwar
70	Goalpara	Kheropara	Rongjuli
71	Goalpara	Dakaidol Kodaldhowa	Matia
72	Goalpara	Bhalukdubi	Balijana
73	Goalpara	Karipara	Matia
74	Goalpara	Nayapara	Goalpara Town
75	Goalpara	Bamunpara	Matia
76	Goalpara	Bordal	Rongjuli
77	Goalpara	Garuchatka	Rongjuli
78	Goalpara	Besimari	Rongjuli
79	Goalpara	Medhibari	Rongjuli
80	Goalpara	Padupara	Rongjuli
81	Goalpara	Sachibari	Rongjuli
82	Goalpara	Ghikbari	Rongjuli
83	Goalpara	Chokchoki	Rongjuli
84	Goalpara	Telipara	Rongjuli
85	Goalpara	Dhupdhara	Rongjuli
86	Goalpara	Hatimura	Jaleshwar
87	Goalpara	Kalpani	Balijana
88	Goalpara	Kalpani Chandmari	Balijana
89	Goalpara	Folimari	Lakhipur
90	Goalpara	Rakhalkila	Lakhipur
91	Dhubri	Adabari Pt II	Gauripur
92	Dhubri	Barundanga	Golokganj
93	Dhubri	Salmara Pt-II	Birshing Jarua
94	Dhubri	North Raipur Pt-I	Rupshi
95	Dhubri	Kachuar Khash Pt -I	Gauripur

Sl No	District	Village	Block
96	Dhubri	Sen Nagar	Agamini
97	Dhubri	Silghagri Pt I	Gauripur
98	Dhubri	Birshing	Birshing Jarua
99	Dhubri	Gauripar	Rupshi
100	Dhubri	Matiabag	Desitola
101	Dhubri	Hatipota Pt-I	Chapar-Salkdha
102	Dhubri	Uhita	Rupshi
103	Dhubri	Batuatuli	Rupshi
104	Dhubri	Bamunirvita	Jamadarhat
105	Dhubri	Ward No 10	Dhubri Town
106	Dhubri	Satber	Bilasipara
107	Dhubri	Bangalipara Pt I	Bilasipara
108	Dhubri	Ward No 4	Dhubri Town
109	Dhubri	Ward No 2	Dhubri Town
110	Dhubri	Ward No 13	Dhubri Town
111	Dhubri	Ward No 1	Gauripur Town
112	Dhubri	Ward No 3	Dhubri Town
113	Dhubri	Sharnagar	Agomoni
114	Dhubri	Sindurai Pt-II	Agomoni
115	Dhubri	Rangamati Pt-II	Mahamaya

Annexure V-A

সদৌ অসম গৰিয়া-মৰিয়া-দেশী জাতীয় পৰিষদ
SADOU ASOM GORIA-MORIA-DESHI JATIYA PARISHAD
গোৱালপাৰা জিলা সমিতি
কাৰ্যালয়- টিমলাপাৰা, কলেজ ৰোড, গোৱালপাৰা
জিলা ঃ- গোৱালপাৰা (অসম)

সভাপতি
হাকিব আলী
মোবাইল : ৮৪০০০২২০৮

সম্পাদক
বিহান উল্লা ইতিহাস
মোবাইল : ৯৭০৬২১০১২৫

প্ৰতি,

মাননীয় অধ্যক্ষ মহোদয়,
খিলঞ্জীয়া মুছলমানৰ স্বাস্থ্য উপ-সমিতি, অসম।

তাং: ২৬/১১/২০২১ ইং

মাননীয় মহোদয়,

সংগ্ৰামী অভিনন্দন গ্ৰহণ কৰিব।আজি আমি গোৱালপাৰা জিলা গৰিয়া মৰিয়া দেশী জাতীয় পৰিষদৰ পৰা কিছু মতামত, পৰামৰ্শ আপোনালোকক তলত উল্লেখ কৰা ধৰণে দিব বিচাৰিছোঁ।

পৰামৰ্শ সমূহ হল:

1. আমাৰ প্ৰতি টো জনগোষ্ঠীৰ (গৰিয়া মৰিয়া দেশী) লোক সকলৰ বাবে বিশেষ স্বাস্থ্য বিমাৰ ব্যবস্থা কৰিব লাগে। যাতে সেই বিমাৰ জৰিয়তে বহি ৰাজ্যত বা ৰাজ্যত ব্যক্তিগত চিকিৎসালয় ত বিনামূলীয়া কৈ যি কোনো ধৰণৰ চিকিৎসা সেৱা পাব পাৰে।
2. অতি পিছপৰা আমাৰ জনগোষ্ঠীয় লোক থকা এলেকা সমূহত যি কোনত হস্পিটেল , প্ৰাথমিক চিকিৎসা কেন্দ্ৰ নাই সেই কোৰ ঠাইত হস্পিটেল আদি বনাব লাগে। লগতে একেবাৰে শেষ ঠাইত/ সীমাত থকা লোকৰ স্বাস্থ্যৰ উন্নতিৰ বাবে দিল্লী ৰাজ্যত থকা মাহল্লা ক্লিনিক ৰ দৰে ব্যবস্থা কৰিব লাগে যাতে স্বাস্থ্য সেৱা সহজতে পাবলৈ সক্ষম হয়।
3. ছোৱালী সকলৰ বিশেষ কৈ এনেমিয়া, কম ওজন ৰ সমস্যা হয়। সেয়ে আমাৰ জনগোষ্ঠীয় ছোৱালী যি স্কুল বা কলেজ অধ্যন ৰত তেওঁলোকক স্বাস্থ্য যতন লোৱাৰ বাবে আৰু বিশেষ সেনিতৰী পেড কিনাৰ বাবদ ভেওঁ লোকৰ বেংক একাউণ্ট ত পইচা দিয়াৰ ব্যবস্থা কৰিব লাগে।
4. নৱজাতক ছোৱালীৰ বাবে বেংক এফ.ডী (Fixed Deposit) এটা কৰাই দিব লাগে । যিটো ছোৱালী জনীৰ ১৮ বছৰ পিছত উলিয়াব পৰাৰ ব্যৱস্থা থাকিব লগে।
5. আমাৰ জনগোষ্ঠীয় এলেকা সমূহত থকা গৰ্ভৱতী মহিলা আৰু সদ্য ছোৱালী সকলৰ সুষম আহাৰ কিনাৰ বাবদ ধন একাউণ্ট ত দিয়াৰ ব্যবস্থা কৰিব লাগে।
6. আমাৰ জনগোষ্ঠীয় প্ৰসূতি মহিলা সকলৰ বাবে ২০০০০-২৫০০০ টকাৰ এটা এককলীন ধনৰ ব্যবস্থা কৰি দিব লাগে।সেই ধনেৰে কেঁচুৱা আৰু নিজৰ স্বাস্থ্য ৰ যতন লব পাৰে। এই ব্যবস্থা কেৱল দুই সন্তানৰ বাবে প্ৰযোজ্য হব লাগে।

. আমাৰ জনগোষ্ঠীয় বয়জেষ্ঠ লোক সকলৰ স্বাস্থ্য যতন লোৱাৰ বাবে বিশেষ ধন ডেওঁলোকৰ বেংক একাউণ্ট ত দিয়াৰ ব্যবস্থা কৰিব লাগে।

. আমাৰ জনগোষ্ঠীসমূহৰ লোকৰ কেন্সাৰ, টিবি বা বেলেগ মাৰাত্মক বেমাৰ ৰ চিকিৎসা সম্পূৰ্ণ বিনামূল্যে দিব লাগে। ডেওঁলোকৰ বেমাৰ থকা সময়ত বিশেষ ভাটা দিব লাগে।

. উনুসুচিত জাতি জনজাতিৰ স্বাস্থ উন্নয়নৰ বাবে এম্বুলেন্স আৰণ্টন দিয়া হয় ঠিক তেলেকৈ আমাৰ জনগোষ্ঠীয় এলেকা সমূহত এম্বুলেন্স আৰণ্টন দিব লগে।

0. আমাৰ জনগোষ্ঠীয় এলেকা ত সমূহীয়া আৰু ব্যক্তিগত পকী সৌচাগাৰৰ ব্যৱস্থা কৰিব লাগে।

ধন্যবাদ

জয় আই অসম।

(ছাইফ উল ইছলাম)
কার্য্যকাৰী সভাপতি

ঃ সদৌ গোৱালপাৰা জিলা গৰীয়া মৰিয়া দেশী জাতীয় পৰিষদ ঃঃ

Annexure V-B

জয় আই অসম

সদৌ অসম গৰীয়া জাতীয় পৰিষদ
Sadou Asom Goria Jatiya Parishad

"স্বদেশ, স্বজাতিৰ স্বাৰ্থত"

মুখ্য কাৰ্যালয় ঃ মইনাপাৰা, গোলাঘাট (অসম), পিন- ৭৮৫৭০২
মাণ্ডলিক কাৰ্যালয় ঃ দিছপুৰ, কামৰূপ (অসম), পিন- ৭৮১০১৯ আৰু চতিয়া, বিশ্বনাথ (অসম), পিন- ৭৮৪১৭৫
Email : aagjpd@gmail.com ■ Whatsapp : 9854546784

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মইনুল ইছলাম সভাপতি	ইমতিয়াজ আহমেদ কাৰ্যকৰী সভাপতি	মীৰ আৰিফ ইকবাল হুছেইন সাধাৰণ সম্পাদক	জেহিৰুল হুছেইন সম্পাদক

প্ৰসঙ্গ- সঅগজপ/২০২১/B- ২৬ দিনাংক-০৬/১০/২০২২

প্ৰতি,
মাননীয় জ্যেষ্ঠ মহোদয়
উপসমিতি স্বাস্থ্য বিভাগ, অসম চৰকাৰ

মহোদয়,

অসম চৰকাৰৰ দ্বাৰা প্ৰতিষ্ঠিত এই উপসমিতিক আমি সন্মান জনাইছোঁ। অসম চৰকাৰে খিলঞ্জীয়া মুছলমান সকলক বিভিন্ন দিশত আগুৱাই নিয়াৰ বাবে যি অভূতপূৰ্ব পদক্ষেপ লৈছে তাৰ বাবে অসমৰ মাননীয় মুখ্যমন্ত্ৰী ডাঙৰীয়াক আন্তৰিক অভিনন্দন আৰু তেওঁৰ আগন্তুক দিনত সুস্বাস্থ্য কামনা কৰিছোঁ। আমি একান্তভাৱে আমাৰ গৰীয়া খিলঞ্জীয়া জনগোষ্ঠীৰ মাজত বিভিন্ন সজাগতা আৰু উন্নয়নৰ দিশত অবিৰতভাৱে কাম কৰি গৈ আছোঁ। আজি সভাত, সভাৰ লক্ষ্য অনুযায়ী কিছু মতামত কথা বা দিহা পৰামৰ্শ লিখিত ভাৱে আপোনাক অৱগত কৰিব ওলাইছোঁ।

(১) গৰীয়া জনগোষ্ঠী প্ৰধান এলেকাবোৰত একোখনকৈ স্বাস্থ্য কেন্দ্ৰ প্ৰতিষ্ঠা কৰক। যাৰ দ্বাৰা আমাৰ সমাজৰ গৰ্ভৱতী মহিলাসকলে সময় অনুযায়ী তেওঁলোকৰ পঞ্জীয়ন আৰু নিয়মীয়া স্বাস্থ্য পৰীক্ষা কৰিব পাৰে, লগতে নৱজাতক শিশুসকলৰ নিয়মীয়া ভেকচিন টীকাকৰণৰ সুযোগ পায়। [illegible]

মূল দাবী– সুকীয়া জাতীপৰ দ্বাৰা চিনাক্ত কৰি ৰাজনৈতিক, অৰ্থনৈতিক আৰু শৈক্ষিক ক্ষেত্ৰত সংৰক্ষণৰ ব্যৱস্থা কৰা

জয় আই অসম

সদৌ অসম গৰীয়া জাতীয় পৰিষদ
Sadou Asom Goria Jatiya Parishad

"স্বদেশ, স্বজাতিৰ স্বাৰ্থত"

মুখ্য কাৰ্যালয় ঃ মইনাপাৰা, গোলাঘাট (অসম), পিন- ৭৮৫৭০২
মাঙলিক কাৰ্যালয় ঃ দিছপুৰ, কামৰূপ (অসম), পিন- ৭৮১০১১ আৰু চতিয়া, বিশ্বনাথ (অসম), পিন- ৭৮৪১৭৫
Email : aagjpd@gmail.com ■ Whatsapp : 9854546784

মইনুল ইছলাম সভাপতি	ইমতিয়াজ আহমেদ কাৰ্যকৰী সভাপতি	মীৰ আবিদ ইকবাল হুছেইন সাধাৰণ সম্পাদক	জেহিৰুল হুছেইন সম্পাদক

প্ৰসংগ- সঅগজাপ/২০২১/B-২৭/ দিনাংক- ০৬/১০/২০২২

স্বাস্থ্য বিভাগত শিক্ষাগত আৰ্হতা অনুযায়ী গৰীয়া জনগোষ্ঠীৰ ছোৱালীক চাকৰিত সংৰক্ষণ কৰাৰ বাবে আহ্বান। ৭%ৰ পৰা ১০% আসন চৰকাৰী সংৰক্ষণৰ ব্যৱস্থা কৰক।

③ গৰীয়া জনগোষ্ঠীৰ যোগ্য সকলো ছোৱালীক পেৰামেডিকেল আৰু মেডিকেল পাঠ্যক্ৰমত ৭%ৰ পৰা ১০% সংৰক্ষণ কৰিব লাগে। (আমাৰ সকলো ছোৱালীবোৰক ANM, GNM, PHARMACIST আৰু B-FARAM পঢ়াৰ ব্যৱস্থা কৰিব লাগে।) অসম চৰকাৰক এই বিষয়ত বহলভাৱে সজাগতা সৃষ্টি কৰিবলৈ অনুৰোধ জনালোঁ।

④ গোলাঘাটত এখন চিকিৎসা মহাবিদ্যালয় হ'ব বুলি অসম চৰকাৰে ঘোষণা কৰিছে। আমাৰ দাবী যে সেই চিকিৎসা মহাবিদ্যালয় খনৰ নাম [illegible] নামেৰে নামাকৰণ কৰা হওঁক।

⑤ গৰীয়া জনগোষ্ঠী জৰীপ অসম চৰকাৰে ক্ষিপ্ৰ গতিত কৰক। সকলো নাই আৰু নোহাৰ সাজুৰি(?)। শেষত আমাৰ চৰকাৰলৈ আহ্বান যে আমাক অসমীয়া মুছলমান বা অসমীয়া খিলঞ্জীয়া মুছলমান নামেৰে নামাকৰণ নকৰি আমাৰ গৰীয়া সম্প্ৰদায়টিক গৰীয়া জনগোষ্ঠী হিচাপে পৰিচয় দিয়াৰ সুবিধা কৰক।

-ভৱদীয়-

মইনুল ইছলাম সভাপতি সদৌ অসম গৰীয়া জাতীয় পৰিষদ তাং 06/10/2022	ইমতিয়াজ আহমেদ কাৰ্যকৰী সভাপতি সদৌ অসম গৰীয়া জাতীয় পৰিষদ তাং 06/10/2022

মূল দাবী– সুকীয়া জৰীপৰ দ্বাৰা চিনাক্ত কৰি ৰাজনৈতিক, অৰ্থনৈতিক আৰু শৈক্ষিক ক্ষেত্ৰত সংৰক্ষণৰ ব্যৱস্থা কৰা

Annexure V-C

OFFICE OF THE
DESHI JANAGOSTHIYA MANCH, ASSAM
CENTRAL COMMITTEE

Reg. No. - RS/KAM(M)263/N/265 of 2016-17

Sheikh Hedayetullah
President
Ph. : 8638011918

Sahidul Islam
General Secretary
Ph. : 9101630419

Ref No. DJG/1/07/2014/21 Date 23-11-2021

The Chairperson,

Sub-Group on Health of Indigenous Muslims, Govt. of Assam.

Dated Goalpara the 23rd Nov/2021

Sub: Suggestions from Deshi Janagoshthiya Mancha, Assam.

Sir,

We welcome the Chairperson of the Sub-Group with his team for taking the trouble to come to Goalpara for interacting us for collecting suggestions and opinions. And we also express our sincere thanks to Dr. Himanta Biswa Sarma, Honble Chief Minister, Assam for taking the great initiative for the upliftment of the Indigenous Muslims of Assam and like to put forward the following suggestions to the Sub-Group.

Our Suggestions:

1. Health is a important criteria of Human Development. But the health care facilities in Indigenous Muslims areas are very low. For example one hospital bed against per 3623 people and number of Doctors one per 10844 peoples in Lower Assam. Though hospital and Doctors should be increased in Indigenous Muslim area of Lower Assam.
2. Maternity and Child care facilities to be increased in Indigenous Muslim Dominated area.
3. Sub-Centres are located in the Indigenous Muslim areas to be upgrade need base as state dispensary.
4. It is a matter of concern that the Indigenous Muslim particularly Deshi Muslims of Lower Assam are deprived of proper Medical Services. As because of no Sub-centre are available located in Indigenous Muslim area. They have go to long distances. So we like to request to Govt. of Assam to establish Sub-Centre in the indigenous Muslim rural and core area for better Medical Service.
5. Ensure provision of reservation in the Medical Services from Nursing to MBBS course for the Indigenous Muslims of Assam.
6. South Salmara-Mankachar District is a very large area. But there is no sufficient Hospital and Sub-Centre. The Common Poor People are suffering lots. So the 100 Bedded Hospital of Hatsingmari shall be upgraded into two hundred beds and a paramedical and Nurse Training Centre to be establish in the same District.
7. Need base special package to the BPL section of Deshi Community through Development council. To do that Deshi Development council to be formed by the Govt. of Assam immediately.

8) Mobile Medical Service Unit during the flood time in Lower Assam.

With Regards

President
Sheikh Hedayetullah
Deshi Janagoshthiya Mancha, Assam.

23/11/21
General Secretary
Sahidul Islam
Deshi Janagoshthiya Mancha, Assam.

Annexure V-D

তাং 26/11/2022 ইং

প্ৰতি
মাননীয় অধ্যক্ষ মহোদয়,
খিলঞ্জীয়া মুছলমানৰ উন্নয়ন স্বাস্থ্য উপ-সমিতি,
অসম চৰকাৰ,

বিষয়: স্বাস্থ্য-সম্পৰ্কীয় প্ৰতিবেদন পৰামৰ্শ।

মহোদয়,

আপোনাৰ অহং গোষ্ঠীৰ বিষয়ত আৰু উল্লেখ কৰা গোষ্ঠী নিৰ্ধাৰণ উদ্দেশ্যে খিলঞ্জীয়া মুছলমান সকলৰ উন্নয়নৰ দিশ-সংক্ৰান্ত গোটো পৰামৰ্শ দিব খুজি উপস্থাপন কৰিছোঁ।

১। অসমত বিভিন্ন সময়ত অনেক জনগোষ্ঠীৰ সৈতে একেলগে থকা থলুৱা-খিলঞ্জীয়া মুছলমান লোকসকলৰ স্বাস্থ্য আৰু শিক্ষা-অৱস্থা জনা-বুজাৰ কাৰণে সমীক্ষা বিশেষ হয়। আমাৰ দেশত বৰ্তমান বহু স্বাস্থ্য বিষয়ক লোকসকলৰ আৰ্থ-সামাজিক উন্নয়ন বিষয়ক পৰিকল্পিত সেৱা নাই। সেয়েহে এনে অন্তৰ্ভুক্তি পৰিকল্পনাত এক সামগ্ৰিক (holistic) উন্নয়ন কৌশলত গুৰুত্ব দি আৰ্থ-সামাজিক-স্বাস্থ্য আৰু শিক্ষাৰ বিকাশ নাই। আৰ্থ-সামাজিক স্বাস্থ্য আৰু-শিক্ষাৰ স্বাস্থ্য-সম্পৰ্কীয় সুবিধা প্ৰদানৰ বাবে এক উদ্যোগ লওক।

2

২. জুবীয়া মোগা নিৰ্বাচিত অঞ্চলৰ গৰ্ভৱতী মহিলাসকল আৰু শিশুসকলক স্বাস্থ্য সুবিধা প্ৰদানৰ ব্যৱস্থা গ্ৰহণ কৰা উচিত হ'ব।

৩. নিৰ্বাচিত অঞ্চল সমূহত বিশেষকৈ স্বাস্থ্য সম্পৰ্কীয় সজাগতা সৃষ্টিৰ কাৰণে কাৰ্যসূচী লৈ নিম্নলিখিত বিষয়সমূহ লৈ প্ৰচাৰ কৰিব লাগে –

ক) কম মূল্যত প্ৰাপ্য কি খাদ্য স্বাস্থ্যকৰ, স্বাস্থ্য-সম্মত; আদি।

খ) সৰু লৰা শিশুৰ পৰিষ্কাৰ পৰিচ্ছন্নতা সম্পৰ্কে।

গ) জনসংখ্যা বৃদ্ধি সম্পৰ্কে

ঘ) অন্য বিষয়ত আৰু ৰোগ সম্পৰ্কীয় বিষয়ত, ইত্যাদি।

৪. নিৰ্বাচিত অঞ্চলত কামত লাগিব পৰা স্বাস্থ্য কৰ্মীসকলক প্ৰশিক্ষণ দিব লাগিব আৰু স্বাস্থ্য সম্পৰ্কীয় সুবিধা দিব লাগিব।

৫. নাৰী সবলীকৰণৰ ব্যৱস্থা গ্ৰহণ কৰিব লাগিব। নাৰী সুৰক্ষা-হেতু বাল্যবিবাহ, বহুবিবাহ আদি বন্ধ কৰিব লাগিব।

৬. চৰকাৰী স্বাস্থ্য বিভাগৰ লগতে NGO ৰ সহযোগত চৰকাৰী স্বাস্থ্য আঁচনি সমূহ অঞ্চলৰ জনসাধাৰণৰ মাজত প্ৰচাৰ কৰিব লাগিব।

ধন্যবাদেৰে
(স্বাক্ষৰ)
ড' ... ; ...
ফোন নং 9435313973.

Annexure V-E

2/10/22, 2:44 AM Gmail - APPEALING FOR HEALTH ISSUE

Gmail

Health Sub-group <wmassam.health@gmail.com>

APPEALING FOR HEALTH ISSUE.
2 messages

KHAIRUL Islam <khairul600071@gmail.com>
To: wmassam.health@gmail.com 15 September 2021 at 10:26

REGARDS,
My name is SYED KHAIRUL ISLAM and im from Rangia kamrup Assam.
Dear sir ,
Now a days i saw many of cancer patient in our local area as you know that north east is a cancer Capital of INDIA.In this time many of middle class ,lower middle class,BPL peole are facing lots of problem because, COST of the treatment is too high ,In our area i saw some of peoples cannot purchase the basic medicine also. So that i appealing to the Honorable Chief DR.H B SHARMA sir too look into the matter in very quick action beacause many of families lost their hopes to live .I appealing through you to Make some task force and spread the awareness programme about cancer and how to tackle and educate the people about this , give some information about new treatment technology etc.

Health Sub-group <wmassam.health@gmail.com>
To: siahmed60@gmail.com 25 September 2021 at 17:42

[Quoted text hidden]

https://mail.google.com/mail/u/1/?ik=05d0a10ed&view=pt&search=all&permthid=thread-f%3A1710942353475782008&simpl=msg-f%3A1710942... 1/1