

TRIBAL HEALTH INFRASTRUCTURE AND PERFORMANCE IN ODISHA: A CRITICAL ANALYSIS

Prasant Kumar Sahoo * Kalandi Singh * *

Introduction

Since the earliest civilization, talks on health have been on the forefront. Be it Plato's 'Dialogue' on harmonization of individual and community interests, or Hippocrates' positive health, or the philosophical discussions on body and soul of Hellenism or the ancient Indian concepts such as Pindar's 'health as harmonious functioning of organs' - all these emphasized different dimensions of health, though mainly on physical one (Svalastog et al, 2017). But with health being construed as a bio-psycho-social construction, it has taken the centre stage of every development agenda. It is indeed correlated with the levels or status of growth and development in the modern-day economy. It is in this context the definition of WHO (1948) is dovetailed perfectly which is defined as "health is a state of complete physical, mental, and social wellbeing and not merely absence of disease or infirmity". However, later the very concept of WHO definition was denigrated on ground of being medicalization of society and the increasing incidence of chronic diseases. So the 'complete wellbeing' is a misnomer. Consequently, the Ottawa Charter from the 1st International Conference on Health Promotion, 1986 says that 'health is created in the context of everyday life and environment, where people live, love, work, and play' (Svalastog et al, 2017). The Dutch Conference too stressed on the concept of 'the ability to adapt and to self-manage' (Huber et al. 2011). Accordingly, the concept of health was taking on the pretext of 'wholeness'. Thus, Svalastog et al (2017) emphasized that 'health is a relative state in which one is able to function well physically, mentally, socially, and spiritually to express the full range of one's unique potentialities within the environment in which one lives', adding the spiritual wellbeing of the individuals.

It is in accordance that this paper is talking about the tribal health of Odisha - whether they are fulfilling the criteria of the above definitions and whether they are on a state of complete or partial wellbeing. Odisha is geographically placed in the eastern coast of India, covering around 155,707 sq. km. Amounting to 3.47 % of the country's total population,

* Asst. Professor of Anthropology, F. M Autonomous College, Balaosre, Odisha

* * Research Assistant, SCSTRIT, Bhubaneswar

it stands distinct as the state with highest number of Scheduled Tribe (STs) at 64. The state also contains the highest number of particularly vulnerable tribal groups (PVTGs) at 13 who happen to be the most primitive and backward in the social strata. Odisha has the second highest tribal concentration in India and ranks next to Madhya Pradesh. According to Census 2011, out of a total population of 419,74,218, STs number around 9,590,756 accounting to 22.85 % of state's population and more than 10 % of the country's total tribal population. In the Indian context, the term 'tribe' refers to the indigenous Janas. They are commonly designated as Adivasi (original settlers), Girijan (hill-dwellers), Vanyajati (forest caste), Adimjati (primitive castes), JanJati (folk communities), Anusuchit Jan Jati (Scheduled Tribes) etc. (Ota & Mohanty, 2018). At present the term Adivasi is commonly used for the tribes.

Review of literature

Majhi & Mallick (2018) discussed the health infrastructure of tribal districts of Odisha assigning different indices such as the district-wise Composite of Health Infrastructure Index with rank across various time periods where they found that Mayurbhanj has performed well while districts like Gajapati, Nuapada, Jharsuguda and Deogarh show a very poor performance throughout. They suggest that health is a significant social and physical infrastructure for a community. Therefore, they recommend sufficient healthcare facilities and easy access to health services is indispensable for overall human development of the region.

Dehury (2021) in his study for tribal maternal healthcare infrastructure of Balasore, Odisha has found that there is lack of provisioning of health services in healthcare facilities. Both the district hospital and sub-district hospitals lack basic services recommended by World Health Organization for taking care of women. In their study among the STs of KBK districts of Odisha, Priyabadini et al (2022) endorses the view that woman should be provided with the opportunity to achieve, sustain and maintain health, as defined by the woman herself, to her full potential. Pointing to various welfare measures in health sector they stressed upon a special comprehensive policy specifically for health and nutrition needs of tribal women to ensure their health security and uplift them from marginalization.

Dash and Mahanta (2018) studied some blocks in Keonjhar and found that half of the villages do not have medical facilities within a distance of 5 km. In Banspal block, 90 % of children are malnourished. The absence of transport connectivity, shortage of doctors and lack of other health infrastructure in the tribal areas has created adverse condition in efficient health care delivery. Majority of tribal people take the help of witchcraft method to cure diseases. He prioritised awareness creation among the tribal, proper monitoring and

supervision of the health programmes, and PPP mode of health care.

Kankar et al (2023) reviewed the health issues of the indigenous communities especially the PVTGs of Odisha. They highlighted the epidemiological transition among the tribes due to migration and urbanization. Due to this, along with the traditional malnutrition, the tribes of the region are suffering from the dual burden of both infectious and life style diseases. The review recommends that taking pin-pointed goals more action-oriented ground level research can address the health needs of the indigenous populations at a micro level.

Methodology

The current research was undertaken to critically analyse and review the state of health infrastructure and health performances in the tribal districts of Odisha. Therefore, it has tried to compare the indicators of health and nutrition among the districts of the state. As a result, it employed the secondary sources using the rigorous content analysis method. It has collected around twenty peer-reviewed papers and selected seven papers based on empirical works. Along with that the authors have gone through several reports of the central and state govt. Most importantly, the method of grounded theory was heavily applied as new ideas and concepts were being generated from various reviews. Besides, numerous online sources were consulted for clarity.

Results and discussion

The state of tribal health infrastructure and performances has been very miserable as found in previous surveys. The current study too supports the earlier researches done indicating that the welfare measures initiated by the respective administration has not been reaching to the grass root level. Out of total 341 blocks in Odisha, 119 tribal development blocks which has been receiving grants from various schemes such as the tribal sub-plan (TSP) and other line departments have fared very badly. Table 1 shows the total number of sub-centres (SCs), primary health centres (PHCs), community health centres (CHCs) and sub-divisional hospitals (SDHs) for the 5th scheduled areas. It is seen that the health infrastructure at the village and semi-urban areas in tribal blocks are much skewed towards tribal and more PHCs/SCs are found in the non-tribal areas. It may be due to the low population density in the TSP areas. But this impacts the health care facilities very negatively. For example, in Kalahandi district having two tribal blocks has a total of 52 health centres out of 297 such centres. This can create regional disparities among the areas of district. As already the tribal population are suffering from manifold socio-economic depravities, the weak budgetary allotments and poor implementation of measures could further affect the development of the people and region.

Table 1: Demographic details of tribal population along with health centres

Sl no.	Districts	Total population	Tribal population	% of total population of Dist.	Total blocks	Tribal blocks	Health centers (SC/PHC/CHC/SDH)in the Dist.	Health centers(SC/PHC/CHC/SDH)in tribal blocks
1.	Angul	1273821	179603	14.10	8			
2.	Bolangir	1648997	347164	21.05	14			
3.	Balasore	2320529	275678	11.88	12	1	80	7
4.	Bargarh	1481255	281135	18.98	12			
5.	Bhadrak	1506337	30428	2.02	7			
6.	Boudh	441162	55364	12.55	3			
7.	Cuttack	2624470	93745	3.57	14			
8.	Deogarh	312520	110400	35.33	3	1	51	15
9.	Dhenkanal	1192811	162056	13.59	8			
10.	Gajapati	577817	313714	54.29	7	5	164	127
11.	Ganjam	3529031	118928	3.37	22			
12.	Jagatsinghpur	1136971	7862	0.69	8			
13.	Jajpur	1827192	151432	8.29	10			
14.	Jharsuguda	579505	176758	30.50	5			
15.	Kalahandi	1576869	449456	28.50	13	2	297	52
16.	Kandhamal	733110	392820	53.58	12	12		
17.	Kendrapara	1440361	9484	0.66	9			
18.	Keonjhar	1801733	818878	45.45	13	10	430	353
19.	Khurda	2251673	115051	5.11	10			
20.	Koraput	1379647	697583	50.56	14	14		
21.	Malkangiri	613192	354614	57.83	7	7		
22.	Mayurbhanj	2519738	1479576	58.72	26	26		
23.	Nawrangpur	1220946	681173	55.79	10	10		
24.	Nayagarh	962789	58691	6.10	8			
25.	Nuapada	610382	206327	33.80	5			
26.	Puri	1698730	6129	0.36	11			
27.	Rayagada	967,911	541905	55.99	11	11		
28.	Sambalpur	1041099	355261	34.12	9	3	207	95
29.	Sonepur	610183	57192	9.37	6			
30.	Sundargarh	2093437	1062349	50.75	17	17		
31.	Odisha	41974218	9590756 (22.85)		314	119		

Source: Compiled by author from Census, 2011 (only some selected districts chosen for highlighting the no. of healthcare centers)

Out 30 districts, 13 districts have TSP blocks in the state. However these blocks tell a different story. The density of health centers in the coastal areas having better connectivity and awareness is higher (Table 2). The skewed health infrastructure too is manifested in the poor infant mortality rates (IMR) and under-nutrition cases (Table 3). All the tribal districts

have very low levels of nutrition status including high levels of IMR. While the state average IMR is 59, maximum of tribal districts have the IMR more than the state average.

Table 2: A detailed account of healthcare facilities in tribal areas of Odisha

Sl. No.	Tribal concentrated Districts	Blocks		SCs		PHCs		CHCs		SDHs	
		Total	Tribal	Total	Tribal	Total	Tribal	Total	Tribal	Total	Tribal
1.	Balasore	12	1	**	**	70	6	9	0	1	1
2.	Deogarh	3	1	42	12	7	3	2	0	0	0
3.	Gajapati	7	5	136	106	20	15	8	6	0	0
4.	Kalahandi	13	2	242	44	38	5	16	3	1	0
5.	Kandhamal	12	12	**	**	36	36	14	14	1	1
6.	Keonjhar	13	10	351	306	60	39	17	7	2	1
7.	Koraput	14	14	307	307	48	48	16	16	1	1
8.	Malkangiri	7	7	158	158	24	24	8	8	0	0
9.	Mayurbhanj	26	26	**	**	84	84	17	17	3	3
12.	Sambalpur	9	3	167	82	30	9	9	3	1	1

Source: compiled by authors (from DoHFW, Govt. of Odisha)

Table 3: Nutritional status of tribal children of Odisha

Sl. No.	Districts	IMR	Stunted	Wasted	Under weight
1.	Rayagada	65	43.5	23.1	42.4
2.	Kandhamala	88	38.4	23.1	43.1
3.	Malakangiri	55	45.7	32.5	51.8
4.	Boudh	64	42.2	22.5	43.5
5.	Koraput	56	40.3	28.5	44.4
6.	Kalahandi	59	36.6	24.8	39.7
7.	Nuapada	56	37.6	26.4	40
8.	Gajapati	65	32.5	18.4	32.1
9.	Nawarangpur	54	45.8	36	51
10.	Bolangir	100	44.4	26.1	44.7
11.	Deogarh	58	33.4	19.9	37.5
12.	Keonjhar	58	44.6	19	44.3
13.	Ganjam	61	28.9	16.4	21.3
14.	Nayagarh	67	28	17.5	25.4
15.	Sonepur	54	47.5	22.3	43
16.	Dhenkanal	76	26.1	19	29.2
17.	Mayurbhanj	53	43.5	17.2	43.8
18.	Sambalpur	56	40.2	28.6	45.3
19.	Sundargarh	55	37.2	31.4	44.2
20.	Anugul	50	31.8	21.6	35.3
21.	Khurdha	76	24.7	13.8	20.3

23.	Puri	80	16.1	12.1	17.2
24.	Kendrapada	64	26.9	12.3	24.1
25.	Bhadrak	55	34.9	15.3	28.2
26.	Cuttack	63	15.3	9.1	17.1
27.	Jajpur	53	30.3	16.5	30
28.	Jagatsighpur	56	19.5	12.6	16.5
29.	Jharsuguda	51	34.9	24.8	36.5
30.	Balasore	49	33.2	18	33.7
31.	Odisha	59			
32.	India	44			

Source: NFHS-4, 2015-16

When we compare the health indicators of Odisha with other states and at national levels, it is found that it performs better in some aspects while fares very poorly in other dimensions. For instance, in Table 3, it is seen that among the similarly-based economies, Odisha has acute shortfall of health centers. Among the ten 5th Scheduled Areas given here, only Andhra Pradesh, Chhattisgarh, Himachal Pradesh and Gujarat have performed satisfactorily. Most importantly, Odisha has a deep shortfall of 309 SCs which has direct bearing upon the natives at the local level and for minor ailments. Sometimes, due to unavailability of SCs, minor sickness turn out to be bigger ones leading to district headquarter hospitals.

Table 4:

A comparative account of health centers in the 5th Scheduled Areas of country

Sl. No.	5 th Scheduled States	Tribal population in rural areas	SCs			PHCs			CHCs		
			R	P	S	R	P	S	R	P	S
1.	Andhra Pradesh	2293102	764	804	**	114	155	**	28	19	9
2.	Chhattisgarh	7231082	2410	2804	**	361	392	**	90	80	10
3.	Gujarat	8021848	2673	2775	**	401	406	**	100	92	8
4.	Himachal Pradesh	374392	124	104	20	18	43	**	4	8	**
5.	Jharkhand	7868150	2622	2465	157	393	165	228	98	104	**
6.	MP	14276874	4758	2952	1806	713	332	381	178	104	74
7.	Maharashtra	9006077	3002	2057	945	450	315	135	112	67	45
8.	Odisha	8994967	2998	2689	309	449	425	24	112	132	**
9.	Rajasthan	8693123	2897	1658	1239	434	209	225	108	65	43
10.	Telangana	2939027	979	698	281	146	93	53	36	23	13
11.	All India	93819162	31273	28200	6503	4690	4024	1240	1172	1028	273

(Source: Rural Health Statistics, 2017, M/o health & Family Welfare)(As on 31st March, 2017)

[Notes: The requirement is calculated using the prescribed norms on the basis of rural population from Census, 2011. R: Required; P: In Position; S: Shortfall; **: Surplus]

Table 5 depicts a mixed state of affairs in health care services in the tribal areas of state. The number of non-technical health workers like Axillary Nurse Mid-wife (ANMs) at the village level is more than required while the number of doctors is less than needed. This has led to many PHCs without any doctors and unfortunately the nurse or even the peon serves as the role of the doctor.

Table 5: Some health parameters of Odisha

Sl. No.	Health parameters	Required (R)	Sanctioned (S)	Position (P)	Vacant (S-P)	Shortfall (R-P)
1.	Health Worker [Female] / ANM at Sub Centres & PHCs in Tribal Areas	3114	3089	3193	**	**
2.	Nursing Staff at PHCs & CHCs in Tribal Areas	1349	318	615	**	734
3.	Doctors at Primary Health Centres (PHCs) in Tribal Areas	425	425	335	90	90

(Source: Rural Health Statistics, 2017, M/o health & Family Welfare, as on 31st March, 2017) [** surplus]

Way ahead

While health parameter is a major problem area, in many PVTG settlements, inaccessible geography and communication hampers the healthcare services. Some 127 of the total 541 PVTG habitations are completely inaccessible, according to data accessed from Odisha PVTG Empowerment and Livelihoods Improvement Programme (Mohanty, 2023). Mobile healthcare, regular health check-up, nutrition supplement, round the year memorable road, telemedicine. Community health officers (CHOs) can be appointed from within the region like the ASHAs/ANMs. But due to population criteria, this facility is not being done at most of the remote areas. Hence it is necessary to relax population criteria to facilitate such provisions. Proper training to youths having secondary pass certificated can be enrolled and they can be certified as the *arogya-mitras* as done in other states. They can better make the fellow members understand and educate the primary health and sanitation issues in their native language. It could only be allowed to dispense medicines and not for prescription or to diagnose chronic diseases. But the villagers travel to the local weekly markets every week that has become our meeting point. As per standard norms,

one Sub-centre is required for every 5000 population in plain areas (3000 population in hilly/tribal/desert areas). It is observed that not a single of the nine tribal dominated districts is fulfilling this criterion (Mohan et al, 2023).

A rigid and uniform model is unnecessary, especially in the tribal belts. This should be as per the needs and contexts. So that the local based health requirements can be easily met. A decentralised planning and execution in health care services is the need of the hour. Another most vital aspect is that tribal depend and believe in their ethno-medicinal practices most of the time. Therefore, proper models can be developed to integrate both the elements. Though the Govt. is trying towards more health facilities including health insurances, due to lack of awareness, tribal are not taking the benefit of the facilities. All public health institutions can be made mandatory to engage the doctors to serve the tribal areas. Along with these basic health benefits, other auxiliary aspects too should be taken care of such as education for all in tribal area, power and telecommunications connections etc.

Conclusion

Considering the above discussion, it is highly recommended that the lot of the tribal has to be improved on an urgent basis. From diagnostics to delivery, the state has to bear all the responsibility to increase the health parameters of the tribal, especially the women and children. It may invite the private players who can provide healthcare services in PPP mode. The state can learn from other areas that has implemented community based rural healthcare facilities. Community based health services can too be practiced like CHO, community doctors, as they are called. This can inspire and influence the locals to own the resources and responsibility to help and serve them in a better way. Most importantly, the both technical and non-technical medical staff should be placed in a war-footing so that timely and precise healthcare emergencies can be provided to the most margined and weaker sections of the society.

References

1. CYSD.(2019). Inequality &Inequity of Health Services in Odisha. CYSD: Bhubaneswar.
2. Dash, L. N., &Mahanta, L. M. (2018).The State of Tribal Health in Odisha.The Tribal Tribune, 5.From <https://www.tribaltribune.com/index.php/volume-5/mv5i3/the-state-of-tribal-health-in-odisha>.
3. Dehury, R. K. (2021). Assessment of tribal healthcare infrastructure for delivery of maternal health program in balasore district, Odisha, India.Asia Pacific Journal of Health Management 2021; 16(3), 1-9. <https://doi: 10.24083/apjhm.v16i3.999>
4. Huber, M., Knottnerus, J. A., Green, L., Horst, H. V. D., Jadad, A. R., Kromhout, D...Smid, H. (2011). How should we define health?.BMJ. <https:// doi: 10.1136/>

bmj.d4163

5. Kanrar, P., Goswami, M., & Roy, S. (2023). Health issues of the indigenous communities with special reference to the particularly vulnerable tribal groups (PVTGs) of Odisha: A review. *Papers on Anthropology*,XXXII(1), 45-80.
6. Majhi, H. &Mallick, M. (2018).Health infrastructure development in tribal districts of Odisha.*Orissa Economic Journal*, 50 (1 & 2), 128-138.
7. Mohan, P., Jaiswal, S., &Seshadri, D. V. R. (2023). Here are some solutions to address health challenges faced by tribal communities. *DownToEarth*. First published on 06 Feb, 2023
8. Mohanty, A. (2023). Miles to go: In these tribal regions of Odisha, the nearest health clinic is jungles & rivers away. *DownToEarth*.First published on 14 April 2023.
9. MoHFW&MoTA, GoI. (2017). Tribal health in India: Bridging the gap and a roadmap for the future. Report of the expert committee on tribal health.GoI: New Delhi.
10. Ota, A. B., Mohanty, S. C., &Mohanty, B. N. (2018).Demographic Profile of Scheduled Tribes in Odisha (1961 - 2011). SCSTRTI: Bhubaneswar.
11. Priyabadini, S., Padhi, S. &Kar, B. B. (2022). Health and Nutrition: Accessibility to Infrastructure and Welfare Measures for Scheduled Tribes in KBK Region. *Journal of Positive School Psychology*, 6 (7), 901-909.
12. Svalastog AL, Donev D, JahrenKristoffersen N, Gajovi? S. Concepts and definitions of health and health-related values in the knowledge landscapes of the digital society. *Croat Med J*. 2017 Dec 31;58(6):431-435. doi: 10.3325/cmj.2017.58.431. PMID: 29308835; PMCID: PMC5778676.
13. World Health Organization. Global conferences on health promotion - charters, declarations and other documents: Ottawa 1986, Adelaide 1988, Sundsvall 1991, Jakarta 1997, Mexico 2000 and Bangkok 2005. Available at: <http://www.who.int/healthpromotion/conferences/en>. Accessed: December 27, 2017.