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Health and Nutrition: Accessibility to Infrastructure and Welfare Measures for Scheduled Tribes in KBK Region

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Abstract

It is a fact that health and nutrition are co-related to each other. Women's health consist of "emotional, social, cultural, spiritual and physical wellbeing, is determined by the social, political, cultural and economic context of women's lives. Every woman should be provided with the opportunity to achieve, sustain and maintain health, as defined by the woman herself, to her full potential. Health care is predominantly related in improving socio- economic and cultural life style of every human. Both central and state government has been providing various need based health welfare programmes exclusively for last two decades.. There are lot of challenges relating to access, on time services delivery and affordability of health care system which has played an important role towards implementation of the schemes effectively. In this context, this paper reflects analytical views on availability, accessibility and utility of health care infrastructure. All the relevant information has been captured by the researchers from the secondary sources of both central and state government to substantiate ground picture into reality".

Keywords: Women, healthcare, availability, accessibility, marginalised, communities.

I. INTRODUCTION

Health and nutrition of women in general and tribal women in particular is a "major concern for all welfare agencies today. It is a fact that health and nutrition are complimentary to each other. The health of women refers to emotional, social, cultural, spiritual and physical well-being. It is determined by the social, political, cultural and economic conditions of women. This description recognizes the validity of women's life, her belief, experiences and perception of health. Every woman should be provided with the opportunity to achieve, sustain and maintain health as defined by the woman herself, to her full potential (Phillips, S. CMAJ 1995). Health care is predominantly related to improving socio-economic and cultural life style of every human".

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Both Central and State governments "have been providing various need-based health welfare programs exclusively for the last two decades. There are a lot of challenges relating to access, on time services delivery and affordability of health care system that has played an important role towards implementation of the schemes effectively. The State Government makes consistent initiatives to reduce the prevailing regional disparities and gaps in the access to safe drinking water, public and private health care infrastructure, rural health care infrastructure, access to preventive and medical care, public hygiene, information system on health care and nutrition, skilled manpower etc. The outcome was quite visible between 2000 and 2017. Quality and adequate health care services lead to better learning ability, nutritional retention, capability enhancement and longevity and standard of living and better sense of well-being of people. It helps in limiting family size, improving basic amenities and reducing poverty significantly". The government of Odisha has demarcated three categories of "health indicators like outcomes (Infant Mortality Rate etc.), process

(institutional delivery etc.) and input (infrastructure, public expenditure, National Health Mission etc.) to describe the progress of health sector in the State" (Economic Survey 2017-18, GoO).

II. METHODOLOGY

In health and nutrition sector, generally underprivileged groups scheduled castes and scheduled tribes (ST and SC) and people of backward areas (undivided Koraput, Bolangir and Kalahandi (KBK) districts) have lesser accessibility than other parts of Odisha (Reference needed) . "The area is wide spread and communities inhabiting the area are widely scattered and fragmented. The tribes in KBK region are unorganised economic force, highly stratified on caste and community considerations. They are usually subjected to indebtedness and bondage and their meagre income cannot meet their livelihood requirements leaving aside health needs. Tribal's are marginalised in relation to health and nutrition in comparison to rest of the society. It has been reported many a times that women and children receive poor health care and nutrition facilities. Providing better health and nutrition services for tribal people still is a major concern and challenge to the State. Particularly in tribal community wide spread habitation, disconnected from service delivery point and their dialects mostly stand as huddle to address the right beneficiary". Exploratory research design is the key instrument of the study where the authors have used both secondary and primary sources of data. With the application of non probability sampling procedure, the primary sources of data were collected through structured interview schedule". In case of secondary both 2001 and 2011 census data have been analysed as per need and importance referring to nutrition and tribal health aspects. However, "the proactive support of the State government in terms of ensuring better health care facilities at the grassroots level expected to have changed the scenario at present. In this context, this paper would reflect analytical views on availability, accessibility and utility of health care infrastructure. All the relevant information have been captured from the secondary sources of both Central and State Government to substantiate ground picture into reality.

Objective

- To address health and nutrition status of the state from the year 2000 to 2017
- To explore the welfare and social security (Health and Nutrition) provisions for the underprivileged and marginalised communities.
- To suggest some strategic measures to solve the problem of women and children of marginalised communities.

III. OVERALL HEALTH STATUS OF ODISHA

According to the Census, 2001 nearly 85% of the total population lives in rural areas. Scheduled Castes and Scheduled Tribes population in the State, as per 2001 Census, was 60.82lakh and 81.45lakh respectively. STs with 62 tribes account for 22.21% and that of SCs with 95[1] castes make-up 16.12% of the total population of the State. Odisha has the largest percentage of tribal population among the Indian States barring the north-eastern States viz. Nagaland, Meghalaya, Manipur and Tripura. The poverty ratio among the STs is exorbitantly high across all regions in the State followed by SCs. Thus, STs followed by SCs from the economic point of view are highly vulnerable groups in Odisha". The number of infant deaths in rural Odisha is staggering high at 73 as compared to 52 infant deaths per 1000 live births in the urban areas of the state.

[1] *List of Scheduled Castes notified (after addition/deletion)as per the Constitution (Scheduled Castes) Order, 1950, as amended vide Modification Order 1956, Amendment Act, 1976 and the Constitution (Scheduled Castes) Order (Amendment) Act 2002 No. 25 dated 27.5.2002. of Ministry of Law, Justice and Company Affairs, read with The Constitution (SCs) Order (Second Amendment) Act, 2002 No. 61 of 2002 dated 18.12.2002 of Ministry of Law & Justice republished vide Notification No. 7797-I- Legis-5/2002-L dated 7.6.2003 of*

Law Deptt, Govt. of Orissa and, vide Gazette of India No.381dt.30.8.2007, Gazette of India No.40 dt.18.12.2014, Gazette of India No.7 dt.23.03.2015, Gazette of India No 27 dt 9.05.2016& Gazette of India No 17 dt 01.05.2017.

http://stscodisha.gov.in/pdf/ScheduledCast_List.pdf, accessed on 24th September 2020

Besides such high infant mortality, "the under-five mortality rate in the state is also accounted to be very high which stands at 90.6 under five deaths per 1000 live births. Especially among the STs, the under-five mortality is astoundingly high at 136.3 per 1000 live births as compared to 91.8 among SCs, 83.5 among OBCs and 64.2 among other castes. Whether it is neonatal, postnatal, infant, child and under five, the mortality rate among STs is higher than any other caste groups followed by SCs and then the OBCs.

As per 2011 census, districts in Odisha have the highest NMR (71 deaths per 1,000 live births in Bolangir), IMR (97 deaths per 1,000 live births in Bolangir) and UFMR (139 deaths per 1,000 live births in Kandhamal). It is revealed that larger reduction in mortality rate is experienced when districts are at higher levels whereas small and increasingly divergent reductions are observed at lower levels. There are significant social, regional and gender disparities in accessing public health in Odisha. Interior regions in general and tribal districts in particular have poor physical and economic access to health services. Institutional deliveries are lower in case of tribal woman. Post-natal care of mothers and infants also needs greater attention. These regions also bear the brunt of resource crunch both in terms of health budget deficit and neglected public health institutions. There is however, some improvement in past ten years".

Health Indicators of Odisha 2010-2011

Crude Birth Rate(per 1000 population)	20.1
Crude Death Rate (per 1000 population)	8.5
Infant Mortality Rate (per 1000 live birth)	53
Under 5 Mortality Rate	79
Maternal Mortality Ratio (per 100000 live birth)	250
Total Fertility Rate (%)	2.4
Children fully Vaccinated (%)	74
Institutional Delivery (%)	56.0
Sex Ratio at birth	903

Source: Annual Health Survey Bulletin 2011-12, Census Commissioner, Govt. of India. Sample Registration Bulletin, Register General of India, 2012, Central Bureau of health Intelligence, Govt. of India, National Health profile, 2012, Economic Survey of Odisha 2012-13, Annual Activity Report, Health and Welfare Department, Odisha

Nutritional Status of Odisha

Almost half of the children "under five in Odisha are stunted or chronically malnourished (45%) and Underweight (40.7%). About 19.5% children are wasting or acutely malnourished. Very high percentages of children belonging to ST and SC communities are malnourished. Particularly, the higher incidence of wasting or acutely malnourished in STs (27.6%) is of major concern. Among young children, the anaemia percentage of Odisha (65.0%) is just below the national average (69.5%) but far from states like Goa (38.2%), Manipur (41.1%) and Kerala (44.5%). As compared to other caste groups, the percentage of anaemia among ST adults is highest i.e. 53.6%. Highest percentages of people in rural (78.8%) and urban (62.2%) areas are dependent on public medical sector followed by private medical sector (19.9% in rural areas and 37.3% in urban areas). In tribal dominated districts like Malkangiri, Bolangir, Kandhmal and Koraput lowest percentages of mothers had at least 3 ANC visits where as the districts in the coastal part of the state viz. Jagatsinghpur, Khurda and Cuttack more percentages of mothers had three ANC visits. As low as 11.7% births in STs take place in health facilities and 17.3% of their births are likely to be assisted by health personnel as compared to 60.4% and 66.9% in

case of other castes respectively. The institutional birth in districts which are demarcated by the constitution of India as scheduled area viz. Malkangiri, Nabarangpur, Koraput, Rayagada and Gajapati is below 20% where as in district like Jagatsinghpur almost 80% institutional birth was recorded. The percentage of delivery at home & other places assisted by a Doctor/ Nurse/ LHV/ ANM in districts viz. Malkangiri, Nabarangpur, Koraput, Rayagada, Mayurbhanj, etc. is even below 5% which clearly portrays the in equitable health care delivery system in the state. Likewise ST children (30.4%) are less likely to be vaccinated as compared to children from OBC (59.4%) and other caste group (58%). In districts like Rayagada, Malkangiri and Nabarangpur the percentage of fully immunised children stands at only 26.8%, 35.1% and 38.2% respectively. In respect to nutritional status of the children in Odisha it was recorded that highest stunted (height-for- age) was 57.2 among scheduled tribe communities, followed by scheduled caste i.e.49.7, Other Backward Castes 40.8 and others 33.6". The underweight status also shows highest among ST 54.4 in comparison to other caste group like SC 44.4, Other Backward Caste 38.1 and others 26.4.

Health Indicator Status (SRS-2013, NFHS-4)

- "The IMR of Odisha is 40 per 1000 live births.
- The MMR of Odisha is 222 per 1 lakh population
- Child Mortality Rate is 49 per 1000 live births
- Children under 5 years who are under weight is 34.4%
- Children under 5 years who are stunted is 34.1%
- The severely wasted children rate under 5 years is 6.4%
- Wasted children under 5 years percentage is 20.4%
- Total children of age 6-23 months are receiving an adequate diet is 8.5%
- The percentage of children age 6-59 months who are anaemic is 44.6%
- Non pregnant women age 15-49 years who are anaemic is 47.6%"

Healthcare Infrastructure in the state

Health Facility	**Number**	
	2015-16	**2017-18**
Medical College and Hospitals	3	3
District Hospitals (30 districts + Capital Hospital, BBSR & R.G.H, RKL)	32	32
Sub-Divisional Hospitals	27	27
Community Health Centres	377	377
Other Hospitals	79	79
Infectious Disease Hospitals	5	5
Training Centres	5	5
Primary Health Centres (N) & others	1228	1226
Sub Centres	6688	6688
A.N.M. Training Schools	16	19
G.N.M. Training School	8	8
M.P.H.W.(Male) Training School	3	3
Ayurvedic Hospitals	2	2
Ayurvedic College & Hospitals	3	3
Ayurvedic Dispensaries	619	619
Homoeopathic College & Hospitals	4	4
Homoeopathic Dispensaries	560	561
Unani Dispensaries	9	9
Medical College – Private	3	3

Source: Economic Survey of Odisha, 2015-16 & 2017-18

Public health infrastructure, "is an area of concern for govt. and other associated agencies. Although the state did not have adequate infrastructure but in the last 15 years the situation has improved significantly. In fact, in comparison to 2015-16 and 2017-18 economic survey, the health infrastructure is almost remaining same but only 3 new ANM training centres opened with the objective of increasing a greater number of skilled human resources. According to the need and demand of health care services a greater number of medical

colleges and trained medical as well as para-medical professionals are highly essential. Medical colleges in each district would be an advantage for providing better health care services to the rural and tribal people. However, quality aspect should not be neglected or ignored under any circumstances".

Accessibility Status of health Infrastructure

Indicators	State/District	Total	Rural	Urban
Institutional Delivery	Odisha	71.3	69.2	84.0
Highest	Puri	91.6	91.5	91.7
Lowest	Nabarangpur	31.8	30.1	NA
Delivery at Govt. Institution	Odisha	61.7	62.6	56.0
Highest	Puri	80.7	83.4	66.7
Lowest	Nabarangpur	30.0	28.6	NA
Delivery at private institution	Odisha	9.2	6.2	27.5
Highest	Jharsuguda	20.7	11.7	35.3
Lowest	Malkangiri	0.4	0.2	2.6
Delivery at Home (%)	Odisha	28.1	30.2	15.7
Highest	Nabarangpur	68.1	69.8	NA
Lowest	Puri	8.2	8.1	8.3
Safe delivery	Odisha	75.2	73.3	86.9
Highest	Puri	92.7	92.7	92.9
Lowest	Nabarangpur	35.6	33.9	NA

Source: Economic Survey of Odisha, 2017-18

In the overall perspectives, "tribal districts mostly perform lowest institutional delivery, lowest safe delivery and delivery at home which is not at all a healthy indicator. In this context, accessibility to infrastructure and absence of quality services in these areas are major constraints. Looking into delivery at private hospital, Jharsuguda holds highest position but still Malkangiri and other tribal districts have lowest performance rate. Jharsuguda district is a fully industrialized belt where various companies have been providing health care services within the district. It could have been instructed to the companies to work in other districts also. Private entrepreneurs who give low cost services and are not profit oriented should be encouraged within public infrastructure".

Health Services Accessed in KBK District

Indicators	Bala ngir	Kala handi	Kora put	Malka ngiri	Naw arangpur	Nua pada	Raya gada	Suba rnapur	KBK Total	Odis ha
Institutional birth	87.1	74.5	68.4	67.8	64.3	84.7	71.7	93.3	**76.48**	**85.4**
Institutional birth at public facility	84.9	65.2	67.4	67.7	62.5	82.4	68.5	88.7	**73.41**	**75.9**
Home delivery conducted by skilled health personnel (out of total delivery)	4.3	6.4	5.4	10.6	4.8	4	9	3.3	**5.98**	**3.3**
Births assisted by a Doctor/Nurse/LHV/ANM/o their health personnel	91.4	76.9	73.2	77.5	68.6	87	80.2	94.5	**81.16**	**86.6**
Births delivered by caesarean section	11.6	9.9	4.3	1.6	3.5	6.6	5	14.7	**7.15**	**13.8**
Births in a private health facility delivered	0	18.5	0	0	0	0	0	0	**2.31**	**53.7**

by caesarean section										
Births in a public health facility delivered by caesarean section	12.1	12.5	4.9	2.1	4.3	7	4.6	13.3	**7.6**	**11.5**
Child immunization and vitamin A supplementation									**80.45**	
Children age 12-23 months fully immunized (BCG, measles, and 3 doses of each of polio and DTP)	93	88.2	67.1	76.9	71.5	83.8	71.2	91.9	**80.45**	**78.6**
Children age 12-23 months who have received BCG	100	98.3	89.8	98.3	95.1	94.7	93.1	100	**96.16**	**94.1**
Children age 12-23 months who have received 3 doses of polio	96.3	88.2	78.4	84.6	75.8	87.8	83.1	95.1	**86.16**	**82.8**
Children age 12-23 months who have received 3 doses of DPT vaccine	98.1	94.8	82.5	93.8	87.8	90.5	87.9	98.1	**91.69**	**89.2**
Children age 12-23 months who have received measles vaccine	96.7	98.3	75.6	85.1	86.5	87.8	76.5	96.8	**87.91**	**87.9**
Children age 12-23 months who have received 3 doses of Hepatitis B vaccine	96.3	90.1	77.1	87.3	77.3	85	84.5	96.6	**86.78**	**83.2**
Children age 9-59 months who received a vitamin A dose in last 6 months	49.9	78.1	54	65.4	76.7	58.4	72.4	75.7	**66.33**	**69.1**
Children age 12-23 months who received most of the vaccines in public health facilities	100	98.7	98.5	100	100	100	98.7	100	**99.49**	**98.3**
Children age 12-23 months who received most of the vaccines in private health facility	0	1.3	1.5	0	0	0	1.3	0	**0.51**	**1**

Source: National Family Health Survey-4, 2015-16

Health and Nutrition Welfare Programme Measures

*Integrated Child Development Services (ICDS); "*is a crucial program which intends to address nutritional deficiency challenges of the children below 6 years through providing 6 core services. Out of which supplementary Nutrition and immunization services have been providing conducive environment for the women and children towards improvement of qualitative healthy life. This program has covered 47.90 lakh beneficiaries under various categories viz. Children below 6 months- 4.12 lakh, children 6months to 3 years- 19.18 lakh, Children 3 years to6 years- 16.95 lakhs and pregnant and lactating women-7.65 lakhs. In addition to this regular health check-up program has been conducted at the Anganwadi Centre (AWC) level. The women and children who are found malnourished and with serious health issues are referred to govt. hospitals for better care and protection. Looking into the referral service data, it was found that in the year 2016-17 there are 452863 where are as 735156 in 2010-11. Hence, it can be stated that during last 10 years the govt. could reduce 38.39% of malnourished situation after taking continuous effort at the ground level. This significant change could not have been possible without strong governance system at the state level *MAMATA;* this is a maternity entitlement program initiated by the State Government for pregnant and lactating mothers. It is a conditional cash assistance support to the beneficiary in three phases. The objective of providing financial assistance is to utilise the amount for nutritious food consumption". In reality the objective is not accomplished even though the beneficiaries are getting all money as per entitlement. "Still lack of awareness prevails among the people regarding better health care of pregnant and lactating mothers. Inadequate financial supports do not provide much benefits to the beneficiary and this needs to be

enhanced from rupees 6000 to 10000. Instead of direct cash transfer it can be utilised for supplying of nutritious food to the beneficiary by Govt. through *NIRAMAY* at District and Block headquarters".

A) *Mid Day Meal;* is not only enhancing enrolment, retention and attendance but also aims to improve nutrition level among children by serving noon meal in the school. In fact, "the quality of meal is a major concern due to the irrationality in fund allocation per student. As per 2017-18 Mid Day Meal (MDM) report, 66.4 % (3096595) students up to standard 8 availed MDM in 56960 schools. Availability of safe drinking water facility is really a remarkable step taken by the Govt. across all primary and upper primary schools. The coverage of children against enrolment were 90% in primary and 85% in upper primary which is much higher than national average of 76%. During last five years a smaller number of mishap (81%) occurred due to MDM consumption. It is one of the indicators of better service delivery. There are certain unique steps across the country which have been taken into consideration by the state government. Social audit, convergence program, building social capital for demand generation and fully automated supervision & monitoring approach could change the situation and make it the best performing State across the country".

B) *Rajiv Gandhi Scheme for empowerment of Adolescent Girls (SABALA);* With the objectives of improving health and nutrition of adolescent girls and promotion of health, "hygiene, nutrition and sexual health of adolescent girl this program *SABALA* was launched in the year 2011. Adolescent girls of the age group of 11- 18 years would be the beneficiary under the scheme only in 9 selected districts of the state. It is a convergence programme of Department of Health and Family Welfare, Department of Education and Department of Labour and Employment and ESI. The role of each department has been defined and clear-cut guideline has also been communicated to implement the scheme. Starting from health and nutrition to vocational skill development program has been incorporated for overall development of the adolescent girl. While discussing among the beneficiaries, it was reflected that the convergence program has set an exemplary model. Hence, same approach may be replicated in other health and nutrition scheme".

C) *The National nutrition Mission ;*

As per National Family Health Survey-4, "malnutrition is an acute problem in India which is a high burden for socio economic development of the country where situation in Odisha also is

not an exception in this regards. In fact, stunted, wasted and underweight children of 0-5 years are growing rapidly. Looking into the picture the central government has launched the programme in March 2018 with 9000 crore to *Poshan Abhiyan* which targets to reduce stunting among children up to age of 6 years from 38.4% to 25% by 2022. However, in Odisha, the most vulnerable children are mostly belonging to scheduled tribe and schedule caste mostly. In first phase, Nutritional Operational Plan is devised to implement selected districts viz. Anugul, Bhadark, Balangir, Gajapati, Jharsuguda, Kalahandi, Kandhamal, Keonjhar, Koraput, Malkanagir, Nabarangapur, Nuapada, Rayagarda, Sambalpur and Sundargarh. Strengthening institutional arrangement and result based monitoring and evaluations as well as integrated behavioural change communication are the core intervention strategy. People's participation and community sensitization could have been taken as an alternative in this regard".

Health and Nutrition

Concerning to health and nutritional security of women and girls' subsequent food provision both in terms of quantity and quality is to be ensured.

- "Ensure safe abortion, choice of abortion and family planning services in the selected areas, district is one of them.
- Food preparation for child and pregnant women should be as per the need and requirement.
- Practice of common diet pattern in the family still exists at large scale.
- Promote appropriate time frame as per the comfortability of child along with proper hygiene in each feeding time.
- Referral services through Anganwadi Worker and ASHA worker is implemented for severely affected malnourished children.
- Close monitoring, early detection of problems in implementation and midcourse correction.
- Lower 5-9 FMR indicates an adverse survival conditions faced by the girl child compared to the male children while higher 5 to 9 FMR indicates less female discrimination.
- The life expectancy of females during 2002-06 to present estimate i.e. 2011-15 has increased of 7.7 years within 9 years".

Prevention Against Malnutrition

Looking into tribal children "situation a few suggestive measures can be initiated. These innovative mechanisms are identified based on field experience while interacting with the community people and primary stake holders, the ideas are like;

- Sharing of information related to child and women on regular interval with the community members and about present health status in the locality and services available regarding this aspect. These works are to be facilitated by the Anganwadi Worker, ASHA worker and trained Auxiliary Nurse Midwives (ANM) staff in local dialects".
- "Identification of health issues in the local area and discussion with the parents regarding Severely Under Weight (SUW) and Moderately Under Weight (MUW) children about the causes and preventive methods for reducing inadequate nutritional supports among the tribal children.
- Preservation of extra and additional nutrient food in community house for pregnant and lactating mothers.
- Ensure that all families to cultivate kitchen garden and also facilitate to consume vegetables more in quantity".
- "Skill enhancement of the mother through Anganwadi Centre to plot in Sishu Vikas Chart which is provided through Integrated Child Development Scheme.
- Constant counselling at the individual and family level is highly essential at least during pregnancy regarding food habit. Meantime child health and food consumption pattern can also be initiated accordingly".

Strategic intervention to reduce malnutrition

Over the period, "the government has already been implementing multi developmental programmes to ensure nutritional level and sustainable livelihoods among the tribal communities. In regard to this, there are few innovative strategic interventions through technology being planned out like;

- Information dissemination through electronic and print media regarding nutrition supports knowledge and livelihoods services available at the local level government offices.
- Ensure to practice breast feeding with proper hygiene before and after in between each feeding time.
- Activation of Village Health and Nutrition Day (VHND) programme.
- Development of common app through which updated information relating to better health can be shared accordingly.
- Ensure availability of few health checks up machines and equipment at the village where the villagers and the beneficiaries can be auto user of the services. These are like Blood Pressure instrument, Pregnancy Test Kit etc.

- Develop web portal to track most vulnerable groups for better nutritional health and livelihood status".

IV. CONCLUSION

Benefits like "enhancement of maternity allowance, accident relief, natural death compensation, substantial financial assistance during rainy season and lean period should be provided. Both Central and State Government should formulate umbrella-based policy. The State government has already introduced comprehensive awareness program through or Peoples' Empowerment Enabling Transparency and Enhancing Accountability (PEETHA). This particular program can be articulated in segregating women beneficiaries and whether the schemes have been implemented adequately or not and also to inculcate awareness. This will indubitably improve the current situation in Odisha. Howsoever, it can be deliberated upon and suggested to the Government to introduce a special comprehensive policy specifically for health and nutrition of the tribal women to ensure effectiveness and help in uplifting this marginalised section of the community".

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