Health & Nutrition in Odisha: Distance Is a Diagnosis

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B sector-primer Health & Nutrition

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> "*In the absence of healthcare services and lack of transportation, vulnerable tribes are deprived of timely healthcare facilities.*" — Government of India Expert Committee on Tribal Health, 2017

She walked four hours to reach the Primary Health Centre. When she arrived, the doctor was absent. The auxiliary nurse midwife who was supposed to cover was managing three other emergencies in a building without running water. The woman had walked four hours while in early labour because the ASHA in her village had told her: you must deliver in a facility. The policy was right. The system that was supposed to make that policy real was not.

This is the central narrative of health in Odisha's tribal districts. Not a story of absent intent — the National Health Mission, the Janani Suraksha Yojana, the Ayushman Bharat programme all represent genuine and substantial government commitment to improving health outcomes for the poorest. It is a story about the distance between policy and what a woman in the second trimester experiences in a PVTG hamlet in Malkangiri.

The distance is sometimes literal — the three-hour walk to a health facility that is a documented, persistent reality for communities in remote tribal blocks. And sometimes it is structural — the cultural distance between a healthcare system designed in Bhubaneswar or Delhi and the lived health realities of 62 tribal communities speaking languages the system does not accommodate, holding health beliefs the system does not engage, eating foods the system does not recognise as medicine.

Odisha's health statistics contain both progress and stubborn failure. Understanding both — in specific, honest detail — is what allows NGOs and CSR programmes to intervene where they will matter most.

Part One: Odisha's Health Landscape — The Numbers Behind the Headlines

Odisha has made measurable progress on several key indicators. Institutional deliveries have increased substantially — NFHS-5 (2019–21) shows 94% of mothers in Odisha having a postnatal check after their last birth. The state's childhood immunisation coverage has risen. Infant mortality rate and under-five mortality rate have both declined, tracking the national improvement trend.

But the headline numbers conceal dramatic geographic and demographic variation. Among Scheduled Tribes across India, neonatal mortality declined to 28.8 per 1,000 live births — still higher than the national average of 24.9. One in 20 tribal children nationally died before the age of five, compared to one in 25 across India. A systematic review published in 2025 covering 67 studies on the health status of Odisha's 13 PVTGs found that undernutrition, anaemia, and preventable infectious disease remain pervasive across all groups.

The 2024–25 Odisha Tribal Family Health Survey — covering 9,711 households across 14 tribal-dominated districts, the first comprehensive tribe-specific health survey of its kind in India — found that health outcomes for tribal populations lag significantly

behind national averages, with high malnutrition rates exacerbated by limited healthcare access, geographical isolation, and socio-economic marginalisation. In 2021, 81 out of 129 health metrics measured in national surveys showed non-Scheduled Tribe populations faring better than ST populations, who still suffered from higher mortality rates, widespread malnutrition, and increasing prevalence of hypertension and diabetes.

Anaemia is a defining indicator of this gap. NFHS-5 reports 57% of women aged 15–49 in Odisha as anaemic. For tribal women in remote districts, the rate is higher still. Anaemia is not merely a haematological problem — it is a proxy indicator for chronic food insecurity, inadequate dietary diversity, the gendered patterns of food distribution within households, and the accumulated health burden of repeated pregnancy without adequate recovery. Anaemic mothers have more anaemic infants, and the cycle compounds across generations.

Obstetric morbidity in eastern India — including Odisha — remains high. A NFHS-4 to NFHS-5 comparative study of the eastern region found that while obstetric morbidity decreased by 6.79% between the two survey rounds, Odisha consistently showed higher prevalence than the regional average. Factors contributing to obstetric morbidity — younger age of women at first birth, higher birth order, lack of toilet facilities, rural residence — all cluster in tribal districts.

Mental health is the most systematically neglected dimension of health in tribal Odisha. Tribal communities carrying the cumulative burden of displacement, poverty, marginalisation, and exposure to conflict have high rates of psychological distress that the public health system almost entirely fails to address. The ASHA programme is expanding into mental health screening, but knowledge and capacity remain limited — studies find that while ASHAs trained in mental health are more able to identify depression and have less stigmatising outlooks on mental illness, the training is inconsistent and the referral pathways remain inadequate.

The rising burden of non-communicable diseases — hypertension, diabetes, cardiovascular disease — adds a third layer of complexity. Tribal communities are experiencing a nutrition transition: traditional diets high in micronutrients (millets, forest produce, leafy vegetables) are being replaced by cheaper, lower-nutrition alternatives as market integration deepens. Simultaneously, alcohol consumption among tribal populations — particularly men — is high and documented as a contributor to both physical and mental health burden. The health system was designed primarily for infectious disease and maternal health. It is not ready for the NCD transition.

Part Two: What the Global Evidence Says

The ASHA Programme: Strong Concept, Variable Delivery

India's ASHA (Accredited Social Health Activist) programme is one of the world's largest community health worker initiatives — over 1.05 million ASHAs placed across rural India. The concept is evidence-based: the global literature consistently shows that community health workers who come from the communities they serve, speak the local language, and are trusted by community members produce better health-seeking behaviour outcomes than external health workers visiting periodically.

A systematic review of the ASHA programme found that special interventions evaluated under controlled conditions showed overwhelmingly positive results. However, the routine ASHA programme showed mixed findings in 55% of studies and negative findings in 23% — reflecting the gap between the programme's potential and the system constraints that limit its real-world functioning.

The constraints are documented and specific: inadequate and delayed incentive payments; drug kit refills that are slow or incomplete; poor supervision and coaching relationships with ANMs; and a remuneration structure that is performance-incentive based, creating pressure to generate facility-based deliveries even when home-based care might be more appropriate for the family's situation.

In tribal areas of Jharkhand and Odisha specifically, a 2025 systematic review notes logistical challenges, language barriers, and limited community trust as particularly acute constraints on ASHA effectiveness. An ASHA who does not speak the community's language cannot provide the culturally grounded health education that the programme is designed around. In Bonda communities in Malkangiri, in Didayi villages in Nabarangpur, the language gap between ASHA and community is not an edge case — it is routine.

What this means for Odisha NGOs: Supporting ASHA effectiveness — through supervision, drug kit supply, language capacity, and connection to block-level health systems — is one of the highest-leverage health interventions available to civil society. An ASHA who is properly equipped, incentivised, and supervised produces measurably better maternal and child health outcomes than one who is not. NGOs that work with block medical officers to improve ASHA support systems, rather than setting up parallel health worker cadres, produce more sustainable impact.

Mobile Health Clinics: Reaching What the Fixed System Cannot

The evidence on mobile health interventions in remote areas is consistent: when fixed-facility healthcare cannot reach populations because of geographic distance, bringing healthcare to communities produces significant uptake improvements. Mobile Medical Units operating regular, predictable circuits in remote blocks dramatically increase the proportion of pregnant women who receive antenatal care, the proportion of sick children who receive early treatment, and the proportion of community members who receive routine preventive services.

The design elements that determine whether mobile clinics work: regularity and predictability of visits (communities that can rely on a clinic arriving on the third Tuesday of every month can plan around it; unpredictable visits generate mistrust); integration with community health workers who pre-register and prepare community members before the clinic arrives; and follow-up mechanisms that ensure patients

who need referral to higher-level facilities actually reach them.

Odisha has Mobile Medical Units deployed under the National Health Mission, particularly in PVTG areas. The challenge — documented across multiple evaluations — is the regularity and quality of those visits. An MMU that visits a block twelve times a year instead of monthly, or that arrives without drugs because supply chains failed, is not the evidence-based intervention it was designed to be.

What this means for Odisha NGOs: Civil society organisations have a specific role in monitoring MMU performance in their operational districts — tracking whether visits are happening on schedule, whether drug availability is adequate, and whether community mobilisation before visits is generating the uptake that makes the visits worthwhile. This monitoring and advocacy role is unglamorous but directly connected to health outcomes.

Traditional Health Beliefs and the Integration Question

Research on tribal communities in Odisha and comparable contexts globally consistently shows that health-seeking behaviour is mediated by cultural beliefs about illness causation, by trust in traditional healers, and by experiences of the formal health system that range from respectful to actively harmful. A study among tribal women in Odisha found that only 6% solely opted for allopathic medical treatments. The majority use a combination of traditional and formal healthcare — approaching traditional healers first, and moving to the formal system when traditional treatment fails or when the condition is severe.

This is not ignorance. It is rational behaviour in a context where formal healthcare is geographically distant, culturally alien, and associated with poor experiences. The global evidence on improving health outcomes in indigenous communities is clear on one point: programmes that work with traditional health knowledge rather than against it produce better outcomes than those that dismiss it. The WHO's traditional medicine strategy explicitly recognises this. The practical implication for Odisha is that

health programmes need to engage traditional healers — not to replace them, but to work alongside them; ensuring they refer severe cases to formal facilities rather than managing them with practices that can be harmful; and using them as trusted community entry points for health education.

Mental Health: The Invisible Epidemic

The global and Indian evidence on mental health in marginalised communities is unambiguous: the burden is high, the system capacity is low, and the treatment gap — the proportion of people with mental health conditions who receive no treatment — is enormous. In India, the treatment gap for mental health disorders is estimated at 70–90%. In tribal Odisha, it is likely higher.

The ASHA programme's extension into mental health — identifying depression, psychosis, and substance use disorders and connecting people to care — is an important development. But it requires systematic training, supervision, and referral pathways to be effective. The evidence from global task-sharing models — where trained community health workers or nurses deliver basic psychological interventions, supported by specialists via supervision — shows that this model can produce meaningful outcomes even in extremely resource-constrained settings. The Sangath model (developed in Goa) is the most rigorously evaluated Indian example of this approach.

What this means for Odisha NGOs: Mental health is not a separate sector from physical health — it is a critical and systematically neglected dimension of health in tribal communities. NGOs working in tribal health that build mental health screening and referral capacity into existing health worker cadres — rather than treating mental health as something that requires a specialist to address — are working with the evidence.

Part Three: Five Organisations Doing This Exceptionally Well

1. Ekjut (Jharkhand and Odisha)

Ekjut — whose name means "together" in Hindi — works specifically in tribal communities in Jharkhand and Odisha on community mobilisation for maternal and newborn health. Their approach is built on women's group participatory action cycles: facilitating community women's groups through a structured process of identifying health priorities, learning about evidence, planning and implementing community responses, and evaluating what worked.

The Ekjut approach has been evaluated through a cluster-randomised controlled trial — one of the strongest types of evidence available in community health research. The trial, published in The Lancet, found significant reductions in neonatal mortality in intervention areas. The mechanism was not a specific medical intervention — it was the process of women collectively understanding their health situation and organising to address it, leading to better health-seeking behaviour, better birth preparation, and better recognition and response to danger signs.

The transferable lesson for Odisha: Women's groups as a health intervention — not just as a social support structure — have rigorous RCT evidence of reducing neonatal mortality in comparable tribal contexts. NGOs working in tribal health that facilitate structured women's group health processes, rather than simply delivering health information through ASHAs, are operating on stronger evidence.

2. Sangath (Goa and multiple states)

Sangath is a Goa-based mental health NGO that has developed and rigorously evaluated a "task-sharing" model for mental health care — where community health workers are trained to deliver basic psychological interventions (counselling for depression, support for substance use disorders) under specialist supervision. Their Healthy Activity Programme for depression, evaluated through an RCT in primary care

settings, showed significant reduction in depression symptoms at twelve-month follow-up.

The significance for Odisha is in the model: you do not need a psychiatrist in every tribal block to address the mental health burden. You need community health workers with the right training, the right tools, and specialist supervision — whether in-person or remote. Sangath has demonstrated this is achievable. Their model is being adapted for ASHA-linked delivery across India.

The transferable lesson for Odisha: Mental health task-sharing is evidence-based and deployable at community level. An NGO that invests in training ASHAs or equivalent community workers in structured depression screening and basic counselling, with regular supervision from a mental health professional (potentially via teleconsultation), can produce measurable mental health outcomes in communities that would otherwise receive no mental health care at all.

3. SEARCH (Society for Education, Action, and Research in Community Health) — Gadchiroli, Maharashtra

SEARCH, founded by Abhay and Rani Bang, has worked in tribal Gadchiroli district for four decades. Their research produced one of the most cited studies in neonatal health globally: a community-based newborn care programme in which village health workers were trained to identify and treat neonatal infections reduced neonatal mortality by 62% in a controlled trial. This finding — that trained community health workers with drug kits can manage conditions that were previously assumed to require hospital-level care — fundamentally changed global neonatal health thinking.

SEARCH's approach is relevant to Odisha for what it demonstrates about the potential scope of community health worker roles. In the right context, with the right training, drugs, and supervision, community-based health workers can manage a substantially larger clinical scope than India's ASHA programme currently allows. SEARCH's model has been adapted in multiple Indian states and in global programmes.

The transferable lesson for Odisha: The ASHA programme, as currently designed, is conservative about what ASHAs are allowed to do clinically. The evidence from SEARCH and comparable programmes globally shows that community health workers with appropriate training can manage neonatal infections, identify obstetric emergencies, and support TB and malaria treatment in ways that dramatically reduce mortality. Advocacy for expanding the ASHA clinical scope in tribal areas — with the training and supervision to support it — is evidence-based advocacy.

4. Jan Swasthya Sahyog (JSS) — Bilaspur, Chhattisgarh

JSS provides comprehensive primary healthcare in tribal Chhattisgarh — including outpatient care, inpatient care, surgical services, and mobile health camps — with a specific focus on communities that cannot reach urban facilities. Their model of genuinely comprehensive, community-integrated, affordable primary healthcare in a tribal district has produced outcomes that demonstrate what is possible when the health system functions well.

JSS combines fee-for-service care with cross-subsidy (wealthier patients subsidise poorer ones), strong community relationships built over many years, and a multi-disciplinary team that includes doctors, nurses, community health workers, and social workers. They also produce rigorous health data for their catchment area, contributing to the evidence base on tribal health in India.

The transferable lesson for Odisha: Comprehensive primary healthcare delivered at community level — not just vertical programmes for specific diseases — produces the best health outcomes in tribal contexts. The JSS model is not easily replicable by a small NGO, but its principles — community integration, comprehensive care, cross-subsidy, long-term presence — should inform how any health programme is designed.

5. NIMHANS — National Institute of Mental Health and Neurosciences (Bangalore) — District Mental Health Programme

NIMHANS provides technical support to district mental health programmes across India, including community-level mental health integration. Their work on task-sharing, community awareness, and stigma reduction in rural and tribal settings is the most authoritative Indian evidence base for mental health at the community level.

Their approach to ASHA mental health training — structured screening tools in local languages, clear referral protocols, regular supervision from district mental health teams — provides a scalable model for expanding mental health services into tribal areas without requiring psychiatrist deployment at the block level.

The transferable lesson for Odisha: Odisha's district mental health programmes exist in all districts but have weak community linkage, particularly in tribal areas. NGOs can bridge this gap by working with district mental health teams to extend DMHP reach through ASHA networks — creating the community screening and referral function that the formal system cannot independently deliver.

Part Four: The Odisha Adaptation

What Transfers Directly

ASHA support and supervision — improving the functionality of the existing community health worker cadre — transfers directly and is the highest-leverage point for NGO health investment. An ASHA who is properly paid on time, has a complete drug kit, speaks the community language, and has a functioning supervision relationship with her ANM produces measurably better health outcomes. NGOs cannot solve the ASHA payment problem, but they can advocate for it, document payment delays, and support district-level accountability.

Women's group participatory health action — the Ekjut model — transfers directly to tribal Odisha contexts, where women's groups already exist through Mission

Shakti. Adding a structured health action cycle to existing SHG infrastructure requires investment in facilitation quality, not in group formation. The evidence from Jharkhand and comparable contexts in Odisha's own districts supports this.

Task-sharing for mental health — the Sangath approach — transfers with adaptation for tribal languages and cultural contexts. The core model of training community workers with structured tools, supervised by specialists, is directly applicable.

What Requires Significant Adaptation

Mobile health clinic design must account for Odisha's specific geographic realities: monsoon season road access, distances that make monthly visits logistically difficult in some blocks, and the need for drug supply chain reliability that is not guaranteed. A mobile clinic model designed for peri-urban Maharashtra will fail in Malkangiri without substantial contextual adaptation.

Traditional healer integration requires deep community trust and long-term relationship — it cannot be designed centrally and delivered as a programme. Organisations that have worked in specific communities for many years have the relationships to make this work. Those arriving new should build the relationships first.

NCD prevention and management in tribal communities requires culturally grounded messaging that connects to existing health beliefs and dietary practices. Anti-tobacco messaging that does not acknowledge how deeply tobacco use is embedded in some tribal cultural practices will not change behaviour. Diabetes management that ignores traditional food systems will produce no dietary change.

What Must Be Built

Health data at the sub-district and tribe-specific level is the most critical evidence gap in Odisha's health system. The Odisha Tribal Family Health Survey (2022–23) represents an important step toward tribe-specific data. But routine health data — collected through the HMIS system — is aggregated at the block level in ways

that obscure which communities and which tribes are experiencing the worst outcomes. NGOs operating in specific tribal blocks can generate and use this data if equipped with the right tools.

Language-appropriate health communication in all 13 PVTG languages and across the broader range of tribal languages spoken in Odisha does not exist in any systematic form. Health education materials in Odia are inaccessible to Bonda or Juang speakers. Building this requires investment in translation, community validation, and distribution that no single NGO can do alone — it requires a collaborative approach.

Part Five: Government Scheme Mapping

National Health Mission (NHM) / ASHA Programme: The ASHA cadre — 1.05 million nationally, with substantial Odisha presence — is the primary community health worker programme. NGO role: ASHA support, supervision advocacy, drug kit monitoring, language capacity support.

Janani Suraksha Yojana: Cash incentive for institutional delivery. NGO role: awareness, documentation support, monitoring of payment delays for tribal beneficiaries.

PM-JAY / Ayushman Bharat: Health insurance covering hospitalisation costs for BPL families. NGO role: enrolment support, claim facilitation, awareness among tribal communities.

Mobile Medical Units (NHM): Government-funded MMUs for remote tribal blocks. NGO role: monitoring visit regularity, community mobilisation before MMU visits, advocacy for improved drug availability.

Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA): Free ANC on the 9th of every month at PHC/CHC level. NGO role: community mobilisation, ASHA support to escort pregnant women.

District Mental Health Programme (DMHP): Every district has a DMHP team. NGO role: bridge between DMHP and community through ASHA networks; stigma reduction; referral facilitation.

Poshan Abhiyaan / ICDS: Supplementary nutrition and ANC support through Anganwadis. NGO role: quality monitoring, linking PVTG communities to Anganwadi entitlements, documenting coverage gaps.

National Programme for NCD Control: Prevention and management of hypertension, diabetes, cancer, cardiovascular disease. NGO role: community screening support, referral facilitation, lifestyle modification messaging.

Part Six: Further Reading

Tribal Health:

- *Health Status of PVTGs of Odisha: A Narrative Review* — Journal of Health, Population and Nutrition (2024): Comprehensive review of health status across all 13 of Odisha's PVTGs. Baseline evidence for any PVTG health programme.
- *A Comprehensive Assessment of Health Indicators Among Tribal Populations in Odisha (OTFHS)* — PMC (2025): The landmark Odisha Tribal Family Health Survey covering 9,711 households. The most current tribe-specific health data available.
- *Why Tribal Indians See Worse Maternal, Child Health* — IndiaSpend (2025): Accessible synthesis of tribal–non-tribal health disparities using NFHS-4 and NFHS-5 comparative analysis.

Community Health Workers:

- *Taking Stock of 10 Years of Published Research on the ASHA Programme* — Health Research Policy and Systems (2019): The most comprehensive synthesis of ASHA programme evidence — what works and where systemic constraints limit impact.

- *Performance and Challenges of ASHAs in Delivering Key MNH Services* — ScienceDirect (2025): Most current systematic review of ASHA maternal and newborn health performance.

Mental Health:

- *The Healthy Activity Programme* — Patel et al., The Lancet (2017): The pivotal RCT of Sangath's task-sharing model for depression in primary care in India. Evidence base for community mental health task-sharing.

Community Mobilisation:

- *Women's Groups and Neonatal Mortality in Tribal India* — Ekjut / The Lancet (2010): RCT evidence for women's group participatory approach to reducing neonatal mortality in tribal Jharkhand and Odisha.

A Final Note: The Long Game

Health in Odisha's tribal districts cannot be fixed with a project. The structural determinants of poor health outcomes — poverty, displacement, dietary change, geographical isolation, the persistent underperformance of a health system that was not designed for the communities it nominally serves — are not addressable in three-year programme cycles.

What can be done in three years: improve ASHA functioning in a specific block; mobilise women's groups into health action; extend mental health screening to communities that have never accessed it; generate and use community-level health data that the formal system does not produce; build the trust that makes communities willing to use formal health services when they need them.

These are not small things. They are the things that, compounded across time and geography, determine whether the next generation of tribal children in Malkangiri has better health outcomes than this one.

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Related Knowledge Commons:

- Practice Note: ASHA Programme — How NGOs Can Strengthen the Last Mile
- Practice Note: Mobile Health Clinics — Design for Remote Tribal Contexts
- Practice Note: Mental Health Task-Sharing at Community Level
- Org Spotlight: Ekjut — Women's Groups and Neonatal Mortality
- Org Spotlight: Sangath — Task-Sharing Mental Health Model
- Sector Primer: Child Welfare (Sector 01) — Nutrition link
- Sector Primer: Women Empowerment (Sector 02) — Maternal health link

Schemes Referenced: NHM / ASHA · Janani Suraksha Yojana · PM-JAY / Ayushman Bharat · MMUs · PMSMA · DMHP · ICDS / Poshan Abhiyaan · NCD Control Programme

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