Frontiers in Health Informatics
ISSN-Online: 2676-7104
www.healthinformaticsjournal.com
2024; Vol 13: Issue 8
Open Access

Healthcare Access and Utilization Among Migrant Tribal Populations in Urban Fringe Areas

[1]Dr. Sampriti Panda,[2]Mr. Laxmikant Bal
[1]Assistant Professor, Department of Anthropology, B.J.B. Autonomous College, Bhubaneswar
[2]Project Assistant, OURIIP 2022, B.J.B. Autonomous College, Bhubaneswar

Cite this paper as: Dr. Sampriti Panda,Mr. Laxmikant Bal (2024). Healthcare Access and Utilization Among Migrant Tribal Populations in Urban Fringe Areas. *Frontiers in Health Informatics*, *13 (8) 1935-1942*

ABSTRACT
Healthcare disparities among tribal populations in India have been a persistent challenge despite various governmental initiatives. This study explores the healthcare needs and coping strategies of migrated tribals in peri-urban settings, focusing on Odisha, a state with a significant tribal population. The research examines the existing health infrastructure and utilization patterns among tribal communities, highlighting the socio-cultural factors influencing health-seeking behaviors. Utilizing a mixed-method approach, including surveys and qualitative interviews, the study aims to uncover the complexities of medical pluralism and syncretism among migrated tribals, analyzing their integration of traditional and modern healthcare systems. By identifying effective coping strategies, the study contributes to understanding healthcare accessibility and adaptation in marginalized tribal communities facing urbanization pressures. This Project is funded by Odisha State Higher Education Council, Govt, of Odisha.
Keywords: coping strategies, healthcare, migrated tribals, peri-urban.

Introduction

According to *WHO*, Health is a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1948)"[1]. According to *World Development Report 1993*, "Improved health contributes to economic growth in four ways. It reduces production losses caused by worker illness, it permits the use of natural resources that had been totally or nearly inaccessible because of diseases, it increases the enrolment of children in schools and makes them better able to learn and it frees alternative uses resources that would otherwise have to be spent on treating illness (World Development Report, 1993)"[2].

Health care is the delivery of services aimed at enhancing people's health. Health care is defined as everything that promotes improved health, such as wholesome food, clean air, exercise, medical intervention, etc. Health care infrastructure means an optimum mix of physical structure and human resources as both are required to deliver the desired health services (Vij, 2019)[3].

Because of their distinct topography, geography, and climate, the tribal people have distinct cultural, social, and environmental characteristics. The distinctions are significant since they all have an impact on health and medical care.

[1] World Health Organization. (1948). Health. In *Constitution.* https://www.who.int/about/governance/constitution
[2] World Development Report. (1993). Investing in Health. Published for the World Bank, Oxford University Press.

[3] Vij, D.D. (2019). Health Care Infrastructure in India: Need for Reallocation and Regulation. *Research Review International Journal of Multidisciplinary,* Volume 4, Issue 3, Pp. 289-296.

The main problems with tribal healthcare include inadequate planning and policy, a dearth of contemporary medical services in these places, and limited use of the treatments that are provided. The tribal people have immense faith on traditional healers and large knowledge gap related to diseases and management (Bhatia & Behera, 2017)[4].

There are hundreds of tribal villages spread out over the nation, but some of them are comparatively more remote, primitive, fragile, underdeveloped, and backward. Living in small, dispersed habitats in isolated, inaccessible places, these indigenous communities are the most disadvantaged. Because the more powerful tribal and non-tribal groups have throughout time encroached on the resources that they once owned and relied on for existence, their livelihoods are particularly at risk. The outcomes of the many government initiatives to mainstream these communities have not lived up to expectations. They were first identified based on specific criteria and designated as Primitive Tribal Groups (PTGs) when the country adopted the Tribal Sub Plan (TSP) approach in the 5th Five Year Plan. The Government of India recently re-designated them as Particularly Vulnerable Tribal Groups (PVTGs) in order to give them special attention for their overall development. There are 13 *PVTGs*[5] located in Odisha (SCSTRTI, accessed on July 3, 2024)[6].
The main objective of this study is to identify existing coping strategies utilized by migrated tribals to address healthcare needs in peri-urban environments.

Health and Tribes in India

It is difficult to bridge the healthcare divide between tribal and non-tribal groups in India, where 8.6% of the population is tribal. Tribal population suffers *triple burden*[7] of disease; in fact it is quadruple complicated by poor health seeking behaviour (Kumar, Pathak & Ruikar, 2020)[8].

Tribal health has been the subject of ongoing discussion and consideration for a while. One of the most neglected and vulnerable groups in the nation is the tribal community, which has long been ignorant and careless. The socioeconomic condition along with poor health and sanitation condition makes it more vulnerable and susceptible to disaster and change (Negi & Singh, 2019)[9].

There is Tribal Development Ministry, at the Centre and in the States, and exclusive Tribal Sub-plan (TSP), administered by single-window tribal development departments, based on Nehru's *Tribal 'Panchsheel'*[10] (Mutatkar, 2022)[11].

A relatively limited data set available on the health conditions and disease profile of the tribal groups across the

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4 Bhatia, V., & Behera, P. (2017). Tribal Health Care: The Unaddressed Aspect in Indian Health System. *Indian Journal of Community & Family Medicine*, Volume 3, Issue 2, Pp. 2-3.

5 **13 PVTGs** of Odisha namely- Birhor, Bondo, Chuktia Bhunjia, Didayi, Juang, Kharia, Dongria Kondh, Lanjia Saora, Lodha, Mankidia, Paudi Bhuyan and Saora. The present study is being conducted on migrated tribes of Odisha settled in peri-urban areas and focuses on health coping strategies.

7 SCSTRTI. PVTGs of Odisha. Available at: https://www.scstrti.in/index.php/communities/pvtg [accessed on July 3, 2024].

7 **Triple burden disease** earlier includes – communicable disease, non-communicable disease and malnutrition. But now it is more likely to be quadruple with one extra disease i.e. mental health and addiction.

8 Kumar, M.M., Pathak, V.K., & Ruikar, M. (2020). Tribal population in India: A public health challenge and road to future. *Journal of Family Medicine and Primary Care*, Volume 9, Issue 2, Pp. 508-512. https://doi.org/10.4103/jfmpc.jfmpc_992_19

9 Negi, D.P. & Singh, M.M. (2019). Tribal Health in India: A Need for a Comprehensive Health Policy. *International Journal of Health Sciences & Research, 9(3),* pp. 299-305.

10 Jawaharlal Nehru had advocated '**Panchsheel** or five principles' for Tribal development in 1957 to address issues of tribal justice.

11 Mutatkar, R.K. (2022). Tribal health issues: need of tribal health policy. *Indian Journal of Medical Research, 156(2)*, pp. 182-185. https://doi.org/10.4103/ijmr.ijmr_3217_21

13 Basu, S. (2000). Dimensions of tribal health in India. *Health and Population perspectives and Issues*, Volume 23, Issue 2, Pp. 61-70.

country shows that the diseases affecting tribal population vary from area to area, depending on the environmental and social conditions and cultural practices prevalent in each area (Basu, 2000)[12].

Health and Tribes in Odisha

One of India's most diverse and largest tribal populations is found in Odisha. In India, tribes are among the most marginalized groups. The general health of India's tribal population is in a terrible situation and is egregiously ignored. Although, observations as well as newspaper reports do indicate the poor state of health in Koraput, Bolangir, and Kandhamal (KBK) Districts i.e. districts with highest tribal concentration in Odisha (Satpathy, Satpathy & Acharya, 2018)[13].

About 22% of the population of Odisha is made up of scheduled tribe members, who reside in practically every district of the state. With the exception of the northeastern states, it has the highest proportion of tribal residents among all Indian states. Nine of the thirty districts are dominated by indigenous people. The state has about 47 percent of its area under Scheduled area where more than 50 percent of the population is ST. Access to healthcare by the tribals is important not only for human development, but also for inclusive development in the state of Odisha (Dash & Mahanta, 2018)[14].

Approximately 55% of the nation's native people currently live outside of their ancestral lands. It is well known that there has been a rise in tribal population migration, which is increasingly motivated by despair. "There is a movement of tribal people from tribal to non-tribal areas, possibly in search of livelihood and educational opportunities," says the report. But it is insistent on a livelihood crisis that is triggering this exodus (Mahapatra, 2018)[15].

Health Seeking Behaviour and Coping Strategies

The rising globalisation has changed people's *health-seeking practices*[16]. Various technological innovations have made easier for people to access a range of prescriptions and over-the-counter drugs, as well as traditional, complementary and alternative medicines (TCAM), without needing a prescription from a qualified professional (Brijnath *et al.,* 2015)[17].

Islary (2014) made a study on health seeking behaviour among the tribal communities in India and his study was based on review of secondary literatures and attempted to develop a model of health seeking behaviour among the tribals. According to him people seek health services from various health care systems when one's capability to perform ones expected role in life is impeded either partially or completely[18].

The simultaneous presence of multiple medical systems in a community is known as ***Medical pluralism***[19] . The

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13 Satpathy, M., Satpathy, S.R., & Acharya, J. (2018). Tribal Health and Wellbeing in Odisha-A Health Systems Communication Perspective. *ResearchGate*. Available at: https://www.researchgate.net/publication/323825694

14 Dash, L.N., & Mahanta, L.M. (2018). The State of Tribal Health in Odisha. *The Tribal Tribune,* Volume 5, Issue 3. Available at: https://www.etribaltribune.com

15 Mahapatra, R. (2018). More than 50% of India's tribal population has moved out of traditional habitats. *DownToEarth*. Available at: https://www.downtoearth.org.in/news/health/more-than-50-of-india-s-tribal-population-has-moved-out-of-traditional-habitats-62208

16 **Health seeking practices** vary from person to person in the current study. Some access healthcare facilities while some follow traditional methods of healing.

17 Brijnath, B., Antoniades, J., & Adams, J. (2015). Investigating Patient Perspectives on Medical Returns and Buying Medicines Online in Two Communities in Melbourne, Australia: Results from a Qualitative Study. *The Patient-Patient-Centered Outcomes Research, 8,* pp. 229-238. https://doi.org/10.1007/s40271-014-0082-z

18 Islary, J. (2014). Health and Health Seeking Behaviour among tribal Communities in India: A Socio-Cultural Perspective. *Journal of Tribal Intellectual Collective India, Vol 2,* Issue 1, Pp. 1-16. http://www.daltrijournals.org/ITICI/recent_issue.html

19 **Medical pluralism** refers to the coexistence of differing medical traditions and practices. In current study among the migrated tribes, it varies from Ayurvedic to modern methods of treatment of ailments.

availability of various medical procedures, therapies, and establishments for people to utilize when seeking health care is referred to as medical pluralism. For instance, fusing biomedicine with alternative or so-called traditional medicine. Medical pluralism lies at the heart of the discipline of medical anthropology, which owes its birth to the study of non-western medical traditions and their encounters with biomedicine (Khalikova, 2021)[20].

To investigate the morbidity status and treatment-seeking behaviors of tribal groups, a primary survey was carried out among 300 rural tribal households in the Bijadandi block of the Mandla district of Madhya Pradesh. Households were chosen using a non-random selection technique in order to gather data on treatment history, location of therapy, and cause for non-treatment for morbidity. To gather information, a planned interview schedule was also employed. Nearly three-fifths of the women in this study, who were generally over 60, had less than a primary education, were farmers, housewives, widowed, or both, experienced morbidities for at least a year. 90% of patients received therapy when unwell, and fever and cough were more common. Two-fifths received treatment from public healthcare centres and three-fifths received from private healthcare centres (Prasad *et al.*, 2023)[21].

Chaturvedi *et al.* (2023) have attempted to put forth insights into using traditional medicine systems to achieve Universal Health Coverage (UHC), where they are aware of the popular use of traditional medicine systems like - Ayurveda, Yoga, Unani, Siddha along with Homeopathy, now termed as the *AYUSH*[22] systems. According to them efficacy and costs are the important criteria in people's choice of medical systems, especially for chronic ailments but the growing concern about the side effects of biomedical treatments resulted into people's diverse preferences, which is called medical pluralism. To them, medical pluralism exists in other parts of the world as well[23].

A study was conducted using mixed-method approach to explore the contestation between the public healthcare and indigenous healthcare system among the tribals of West Bengal. An attempt was made to understand social ecology where surrounding forest was always part of their healthcare system. In-depth interviews were also done with Janguru (*Healer*) and Sardars (*Chieftains*) of 'Santhals' of Ausgram block of Purba Bardhaman district. It was resulted that contestation was mainly of two kinds, firstly between public and traditional system of healthcare, secondly imbalance of ecology. And due to the progressive social ecology, Santhals were far away better than the non-tribals in terms of various demographic health indicators; like in 1881, out of 100 females in the age group of 20-24, unmarried females in the Santhals society was 13 comparing 7 in the non-tribal society. Child sex ratio was also higher among the tribals. In this study, healthcare is used as an analytical framework to understand the larger question of 'contested territories' of environment, state and tribal society. In current times, only 4% of the households have faith on the indigenous system and disassociation of the tribals from their traditional ecology and role of state to promote western medicine has been observed widely (Mondal *et al.*, 2023)[24].

Mudi *et al.* (2023) have carried out one study on the menstrual health and hygiene among the Juang women in Odisha to provide an insight into the sensitive issue of their mode of practices. 360 recently married women participated in a cross-sectional study using a mixed methodology, which included 15 focus groups and 15 in-depth interviews with

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20 Khalikova, V. (2021). Medical Pluralism. In *The Open Encyclopaedia of Anthropology,* edited by Felix Stein. http://doi.org/10.29164/21medplural.

21 Prasad, S., Raushan, R., & Tiwari, R. (2023). Health Status and Healthcare Care-seeking Behavior: A Study of Tribal Communities in Bijadandi block in Mandla District. *International Journal of Health Science and research, 13(9)*. https://doi.org/10.52403/ijhsr.20230925

22 **AYUSH** is an acronym for Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy. The present study with the help of multidimensional interviews show that people are more into modern health care services instead of social and cultural practices, which often lead them to pluralistic care.

23 Chaturvedi, S., Porter, J., Gopalakrishna Pillai, G.K., Abraham, L., Shankar, D., & Patwardhan, B. (2023). India and its pluralistic health system - a new philosophy for Universal Health Coverage. *The Lancet regional health. Southeast Asia, Vol 10*, Issue 100136. https://doi.org/10.1016/j.lansea.2022.100136

24 Mondal, P., Mondal, S., & Mondal, M. (2023). The Contested Medical Pluralism; Environment, State and the Indigenous Healthcare in West Bengal.

Juang women to learn more about their customs, cultural beliefs, menstrual issues, and treatment-seeking behavior related to menstruation and its management. They discovered that 71% of women had menstrual issues, 85% were prohibited from engaging in any religious activities, 94% avoided social events, and 85% utilized old clothing as absorbents during their periods. Of these, barely one-third sought treatment for their issues.[25].

An exploratory study in Rayagada district of Odisha was carried out by Contractor *et al.* (2018) to understand tribal women's maternity care and their interactions with the formal health care system. To learn more about their chosen practices and health-seeking behaviors, they conducted in-depth interviews with women, traditional healers, and official healthcare professionals. Their exploration resulted that, tribal women perform natural practices for their treatment and do not like to seek for any external interventions[26].

A study was carried out in a migratory tribal community in Bhubaneswar, Odisha, to investigate treatment-seeking behavior and out-of-pocket costs associated with treating childhood illnesses. Total 175 households with children aged 0-14 years were selected from tribal dominated slums and who had migrated within the last 12 years. Mothers were interviewed regarding their children's illness. Of which, 78.8% had at least one episode of illness. Just 16.5% of people used government health care, and private health care was favored. Additionally, out-of-pocket expenses were borne by 89% of homes with boys and 87% of households with girls. Female child, mother's education and type of illness were significantly associated with total out-of-pocket expenditure (Mishra *et al.,* 2017)[27].

In the present world, medical syncretism—the practice of healers combining or blending various treatment approaches and explanatory models—is common. Padmawati et al. (2014) conducted a study on health system changes and ethics among private practitioners in a poor neighborhood in Yogyakarta, using 30 medical facilities and 29 families as informants. According to the findings of their investigation, some medical professionals were integrating herbal remedies, acupuncture, Traditional Chinese Medicine (TCM), bekam, prayers, reiki, and acupuncture with their therapies. Their shared goal in integrating the system was to assist patients in healing from their ailments as traditional and alternative medicines were safer in the hands of biomedical professionals.[28].

Muela *et al.* (2002) have had explored a new information on health related to malaria in Ifakara, a community in South-eastern Tanzania, where population has had been in contact with biomedicine for many decades. They carried out their study mainly among the mothers (n=81) of children under five with in-depth interviews and illustrated how biomedical knowledge got transmitted, co-existed, interacted and merged with local pre-existing ideas and logics. According to their investigation, the medical syncretic model showed that even if people understood health messages correctly, their interpretations might not be. Hausman (2022) discussed three methods of combining biomedicine with traditional medicine in pre-independence Madras state in India, with comparative examples drawn from ethnographic studies in South India in the 1990s. With the goal of creating a universal and synthetic textbook that covers all medical systems on an equal basis, Srinivasamurti experimented in the 1930s with a cooperative approach involving clinical practitioners of ayurveda, siddha, and unani and allopathic medical registrars. Additionally, in the 1940s, the Government Hospital of Indian Medicine in Madras allowed a traditional practitioner to do bone setting. These examples all highlight

25 Mudi, P.K., Pradhan, M.R., & Meher, T. (2023). Menstrual health and hygiene among Juang women: a particularly vulnerable tribal group in Odisha, India. *Reproductive Health, Vol 20,* Issue 55. https://doi.org/10.1186/s12978-023-01603-1

26 Contractor, S.Q., Das, A., Dasgupta, J., & Belle, S.V. (2018). Beyond the template: the needs of tribal women and their experiences with maternity services in Odisha, India. *International Journal for Equity in Health, Vol 17,* Issue 134, Pp. 1-13. https://doi.org/10.1186/s12939-018-0850-9

27 Mishra, S., Kusuma, Y.S., & Babu, B.V. (2017). Treatment-seeking and out-of-pocket expenditure on childhood illness in a migrant tribal community in Bhubaneswar, Odisha State, India. *Paediatrics and International Child health, 37(3),* pp. 181-187. https://doi.org/10.1018/20469047.2016.1245031

28 Padmawati, R.S., Seeberg, J., & Trisnantoro, L. (2014). Medical syncretism in Yogyakarta: what do the practitioners get?. *BMC Public Health, 14(1).* https://doi.org/10.1186/1471-2458-14-S1-032

aspects of the unbalanced relationship between traditional and contemporary medicine in India in the 20th and 21st centuries.

Tatum (2020) has stated that the business of ***medical tourism***[29] has had collapsed in 2020 and 2021 due to COVID-19 pandemic. The conditions that lead to transnational therapeutic mobilities from wealthy countries to low-income countries with traditional treatment systems have been studied using a narrative method. Transnational therapeutic excursions from Europe to Indian Ayurvedic clinics should be seen as a frantic and committed response to unsatisfactory therapeutic experiences and the absence of answers in biomedicine, according to people's sickness narratives. Their research demonstrated that in addition to financial, human, and social resources, specific patient-subjectivities are required to mobilize them across borders and healing systems.

Gilbert *et al.* (2019) in their paper demonstrated on a larger study into depression and health-seeking among Indian-Australians and Anglo-Australians. In Melbourne, Australia, focus groups were conducted with members of the Indian-Australian community to find out how the general public views mental health and seeking medical attention. Thirteen males and twenty-one women, with a mean age of 57.7 years and an average of 13.8 years of residency in Australia, made up the total of 34 Indian-Australian individuals they studied. Because consumers implicitly assume that healthcare providers and systems act in their best interests when they seek treatment, medical care offers a striking illustration of trust. Additionally, they discovered that the symbolic use of "strong medication" and the instillation of "hope" in patients are the means by which trust is mediated in Indian healthcare encounters.

Kaspar *et al.* (2023) have made their focus on global market of healthcare system and the transnational practices of people with chronic conditions who travel to India for Ayurveda treatment out of dissatisfaction with local biomedical healthcare facilities. For better and more affordable care, hospitals in low- and middle-income nations draw patients from all over the world.

Conclusion

The *health disparities*[30] faced by tribal populations in India, particularly in regions like Odisha, highlight profound challenges that persist despite decades of policy efforts. The foundational definition of health by the WHO underscores the holistic nature of well-being, encompassing physical, mental, and social dimensions, which remains largely unmet among tribal communities due to systemic neglect and socioeconomic marginalization. The fact that there are Particularly Vulnerable Tribal Groups (PVTGs) highlights how serious the problem is, and their vulnerability is exacerbated by a lack of access to contemporary medical treatments and an inadequate healthcare infrastructure.

Efforts to bridge these gaps through initiatives such as the Tribal Sub Plan (TSP) have fallen short of expectations, leaving a significant portion of the tribal population without essential healthcare services. Moreover, the phenomenon of migration among tribal communities, driven by economic and educational aspirations, introduces additional complexities to healthcare access in peri-urban environments. The adaptive strategies employed by migrants, often relying on a blend of traditional and modern healthcare practices, underscore the resilience and resourcefulness of these communities in navigating their healthcare needs.

Moving forward, addressing these healthcare disparities demands a comprehensive approach that integrates indigenous knowledge systems with mainstream healthcare services, fostering medical pluralism and cultural sensitivity. Sustainable improvements will require not only targeted healthcare interventions but also broader socio-economic development initiatives that empower tribal communities and recognize their unique health challenges within the broader context of

[29] **Medical tourism** is the practice of travelling abroad to obtain medical treatment. In the present study, no such cases on health tourism has been witnessed but people from far places have come to the study area for their treatment. Mostly when it is traditional healing practices.

[30] **Health disparities** refers to differences in health outcomes or burden of disease between groups of people. Factors like socioeconomic status, race, gender, age, sexual orientation, disability status, geographic location etc. influences the difference in health outcomes.

national healthcare strategies. Efforts towards achieving health equity must prioritize inclusivity, community engagement, and policy coherence to ensure that no tribe or community is left behind in the pursuit of health and well-being for all.

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