

## **Health Care Issues and Challenges of Indigenous People in Mayurbhanj District of Odisha**

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### **Abstract**

Along with the Northeastern states of India, Odisha has a large indigenous population. For a long time, the indigenous community has been one of the most marginalized, with the highest rates of human health and well-being problems. Lack of efficient communication is a key impediment to their development as well as a crucial aspect in dealing with Maoist threats regularly. Superstition has been deeply established in their belief system as a result of a lack of education, locking them in hopeless grief and creating disease in their families. The present research paper mainly attempts to collect the knowledge of the indigenous people relating to the health care issues and challenges to develop the socio-economic condition of the study areas. According to the findings of the study, there is a link between negative behaviors such as intoxication and traditional belief practices such as traditional medicine and superstitions, as well as between government health programs and respondents' financial well-being.

**Keywords:** Health; Intoxicant; Insurance policy; Government program; financial well-being; Santal tribe.

## Introduction

Odisha treasures many indigenous communities and they have many traditions which are still being carried out today. Odisha has a large indigenous population along with the northeastern states (Nagaland, Meghalaya, Manipur, and Tripura). There are many constraints towards socio-economic development such as lower income, illiteracy, poor health care facilities, etc. Health is the asset of all human beings so its care and challenges are necessary for physical and psychological fitness. The state has approx. 25, 19,738 population. Where the sex ratio is 936 and the literacy rate is 63.17% (Male 73.76%, Female 52.71%), (Census 2011). Odisha is placed eighth from the bottom in a newly released NITI Aayog study, 'National Multidimensional Poverty Index (MPI) 2021 – Baseline Report,' with 29.35 percent of the state's population being multidimensionally poor.

There are 62 types of tribes including thirteen primitive indigenous categories spread in the different districts in Odisha. There are 8.15 million people in the state. Mayurbhanj, which is the largest district in Odisha in terms of area, has its headquarter in Baripada. Majorly, in this locality, the Santal tribe exists which is one of the richest communities in the district. There are around 6, 38,104 numbers of Santal population in the district (Census 2011). The district is where forest dwellers dominate indigenous groups. They thrived in a wide range of habitats, climates, and biological niches. Illiteracy, ignorance, poverty, unfamiliarity, and apprehension are some of the factors that prevent individuals from visiting local dispensaries and health clinics. All people need to maintain good health standards.

## Literature Reviews

Chandana et.al. (2020) determined indigenous women's health status, reaching health & Medi-care services, to shed light on the needs necessary to improve their health and welfare. In elderly women, there was a low rate of chronic disease. RMPs were chosen over government health institutions for regular visits. ASHAs played a critical role in reaching out to indigenous women with health information. Pradhan et.al. (2020) argued that indigenous populations make up 5% of the total global population, but 15% of the total indigenous population is found to be poor. Indigenous are being pushed out of their natural habitat as a result of displacement caused by development projects. Women are unaware of their child spacing options and the unmet need for family planning. Chauhan et.al. (2020) studied the factors that influence the use of healthcare and Medicare and focused on maternal facilities in India's three indigenous populous states which are the central Indian states of Madhya Pradesh, Jharkhand, and the state of Chhatisgarh. They found that in these three states studied, there was a larger socioeconomic disparity while availing health facilities and medical services. According to the regression results, indigenous people were less likely than other caste groups to use maternity and child health care facilities. Saikia et.al. (2020) reported two Assamese indigenous communities encountered modern healthcare issues. On the demand side, the biggest impediments to getting healthcare services were related financial concerns, travel distance to health facilities, bad transportation facilities, evidence of the previously unfriendly attitude of healthcare employees, and a lack of healthcare facilities. Due to a lack of human resources, physicians and nurses at government health institutions were overworked. Despite national government attempts to enhance rural healthcare, our qualitative research demonstrates that these initiatives have failed to improve rural healthcare in the study region. Negi et.al. (2018), Investigated indigenous Indians' health and healthcare beliefs which explored their deplorable condition of health. Furthermore, the data shows that indigenous reliance on traditional medicine and healthcare is waning, but contemporary healthcare institutions have yet to catch up. The indigenous people

of the nation have the majority of traditional health knowledge; thus, in the face of globalization and fast societal change, it must preserve and document this traditional pool of knowledge for future use.

Shabber et.al. (2017) examined the health conditions of eight major indigenous peoples in Kerala and found that there were significant differences and inequities among communities. Communities such as Mala, Arayan, Kurichiyar, and Kuruman were discovered to be more fortunate than others. Despite this, the indigenous Kerala population has outstanding demographic and socioeconomic characteristics. The most common reported condition was unexplained fever, followed by high/low blood pressure. For indigenous groups as a whole, the yearly hospitalization rate is 0.5 per thousand. The Kuruman indigenous community has the greatest rate, while the Muthuvan indigenous tribe has the lowest. The majority of indigenous households have modest healthcare needs. Simultaneously, more than half of indigenous were perceived to be in high or very good health, indicating the prevalence of perception bias. Jose et. al, (2014) argued on the same topic that early pregnancy registration, awareness about healthcare and medical services for women, and economical, convenient, and better care in Kerala's PHS (Public Health System) were the predictors of maternal care service consumption among indigenous women. Lack of transportation facilities was a major issue in indigenous women's underutilization, along with a lack of knowledge and financial restrictions. In indigenous women, the factors of usage were general knowledge, cost, convenience, as well as mental motivation from medical or health experts. In comparison to non-indigenous women, indigenous prenatal women used maternal health care services at a rate of 85 percent. Education and a shortage in transportation means were major attributes leading to indigenous women's underutilization. Verma et.al. (2014) have developed a health care system for indigenous people related to culture, tradition, and environment based on their ethnic knowledge. Although contemporary medical methods have remained inaccessible to the impoverished tribe, they have undoubtedly found a place in their indigenous health care system. Traditional medicinal traditions, which are constantly being eroded, continue to be the primary source of health care, which the government must supplement with modern medical facilities. From a socio-cultural standpoint, Islary (2014) reported on indigenous community health challenges and status, as well as health-seeking behavior. The idea of health was regarded among indigenous communities in functional rather than clinical ways. It is associated with the environment, and habitat, as well as socio-cultural and magico-religious ideas and rituals. The biggest quandary that an indigenous member usually faces is the decision between traditional practices and beliefs and the contemporary system. Dash (2013) the indigenous population's health has not improved in the intended manner. To treat the ailments, they continue to use traditional medicine. The delivery of services in healthcare was still inadequate. This study clearly shows the need of the hour to raise knowledge, awareness, and competence among indigenous peoples to address healthcare and medical-related issues. Community engagement, as well as mutual contact between service providers and recipients, was critical to the success of health-related development programs in indigenous communities. To meet the aim in the field of health development, geographic accessibility, awareness, and cost of contemporary health care methods must be increased in indigenous communities. Agrawal (2013) added that there was a significant disparity in literacy rates, productive age, underweight, anemia, and vaccination between tribal and non-tribal women and their children. There was a high requirement for the execution of specialized health & Medicare care programs to reduce health and nutritional disparities. Lal (2011), the study discovered that in indigenous communities, common ailments such as the common cold, dengue, malaria, diarrhea, anemia, typhoid, and jaundice are more prevalent. As a result, the

indigenous faced a significant financial burden as well as a loss of work. Balgir (2011) the indigenous population is plagued by both communicable and non-communicable illnesses. Nutritional deficits were widespread. Indigenous people are absorbed in superstitions and place their trust in traditional healers who perform magico-religious ceremonies as well as indigenous herbal remedies for common maladies. Traditional folk medicine and health culture have a big influence on indigenous society. Sonowal (2010) According to the study, indigenous people faced health and nutritional difficulties as a result of a deficit in agricultural or forest resources, a shortage of local labor skills, and knowledge about non-indigenous domains. According to the study's findings, the notion of health and health care was linked to several elements among indigenous cultures. Traditional ideas, in addition to physical and economic restraints, were frequently determining factors in health-seeking behavior. Such instances, however, were not previously thought to be so widespread. According to one survey, 66 percent of indigenous groups had less than two acres of cropland. Meher (2008) analyzed the income and livelihood patterns and hygiene conditions of Odisha's indigenous peoples, as well as the concomitant morbidity and conditions of health & Medicare care services in the state's indigenous populous regions. This study particularly evaluates the state's present health & Medicare policy, its efficacy along with its impact on the indigenous people in light of financial and economic developments, and the state's departure from subsidized health care services. He further found that poverty is widespread among Odisha's indigenous' peoples not only because of increased natural resources vulnerability but also a shortage in occupational opportunities, it was because indigenous individual's hygiene practices were poor, resulting in increased poverty as a result of lost income and an increasing debt burden. Balgir (2006) studied poverty, illiteracy, malnutrition, and other issues that contribute to poor health among Odisha's indigenous populations. Governmental organizations, bureaucrats, officers, administrators, and other contractual organizations hired by the government face several problems in improving indigenous communities in the Eastern Ghats. Lack of access to clean water to drink and hygienic conditions, inadequate maternity and children's healthcare, and insufficient coverage of national health and nutritional programs were some of the key challenges. Agrawal et. al, (2005) found from the (NFHS: National Family Health Survey-2), which was surveyed in the year 1998-1999, compares indigenous women's health care and health conditions to non-indigenous women in Jharkhand state. Non-indigenous women outperformed indigenous women compared to a few components like living standard, education level of individuals, and other factors like sociological and demographic characteristics. This research identifies significant gaps in the literature by describing the prenatal, birth, and postnatal period of indigenous and non-indigenous women, as well as child-delivery and postpartum care, awareness and usage of contraceptives. Furthermore, indigenous women in Jharkhand were vulnerable to anemia. Indigenous women in Jharkhand used maternity health care at a much lower rate than non-indigenous women. In the state of Jharkhand, indigenous women used maternity health care at less cost compared to non-indigenous women. Usage of contemporary contraceptive techniques is likewise lesser among indigenous women than non-indigenous women.

### ***Research Gaps***

With the review of the literature, it has been found that the majority of the researchers conducted research on indigenous and non-indigenous health care comparisons, as well as literacy, nutritional issues, and modern health care status across different regions of the country. Limited research has been conducted on the 'Santal tribes' in the Mayurbhanj area. A few researchers have studied the health and hygiene factors that influence the indigenous community's various economic factors and living standards. Hence the current study aims to

explore healthcare practices, hygiene-ness, nutrition, sanitation practices, and overall financial well-being of Santal tribe in Mayurbhanj district of Odisha.

## Research Objectives

- To understand the bad habit's connection concerning their financial well-being.
- To know the belief and practices relationship concerning their financial well-being.
- To explore the government programmes relationship concerning their financial well-being.

### *Hypothesis*

**H1<sub>0</sub>**- There is no relationship between bad habits and financial well-being.

**H1<sub>1</sub>**-There is a relationship between bad habits and financial well-being.

**H2<sub>0</sub>**-There is no relationship between belief practices and financial well-being.

**H2<sub>1</sub>**-There is a relationship between belief practices and financial well-being.

**H3<sub>0</sub>**-There is no relationship between govt. program and financial well-being.

**H3<sub>1</sub>**-There is a relationship between govt. program and financial well-being.

## Research Methodology

The research is both qualitative and quantitative. It is a basic tool for scientifically gathering data from respondents. This exploratory study is an analytical approach, and it is based on a closed-ended questionnaire. A total of 400 samples were collected from the respondents from four villages of Patsanipur Gram Panchayat (G.P) of Mayurbhanj, Odisha. The sample taken for the study is those who have been married. The research is based on both primary and secondary data. The statistical data are analyzed with statistical tools such as Chi-square. Phi and Cramer's V by the use of IBM SPSS statistic 25.

## Data Analysis

### *Relationship between bad habits and financial well-being*

**H1<sub>0</sub>**- There is no relationship between bad habits and financial well-being.

**H1<sub>1</sub>**-There is a relationship between bad habits and financial well-being.

In the present study, bad habits (relating to health) are considered as taking intoxicants (smoking, alcohol, rice beer, etc).

**Table.1** Measure the relationship between intoxicant consumption and respondents' income.

		Income							
		0 to 1L		1L to 2L		2L to 3L		Total	
		F	%	F	%	F	%	F	%
Consumption of Intoxicant	Yes	148	71.8	86	49.1	8	44.4	242	60.7
	No	58	28.2	89	50.9	10	55.6	157	39.3
	Total	206	51.6	175	43.9	18	4.5	399	100

**Source:** Primary survey

Table No. 1 shows that respondents with incomes between 0 and 1 lakh and 1–2 lakh consume more intoxicants, while those with incomes between 2 and 3 lakhs consume very less.

**Table. 1.1-** *Analysis of “Pearson Chi-square test”.*

Pearson Chi-Square Value	D.F	P-Value
22.508	2	.000

Table 1.1 shows the result of the Pearson Chi-square test where the Pearson Chi-Square score is .000, indicating a degree of significance less than 5%. If the P-value is less than 0.05, the null hypothesis is rejected and the alternative hypothesis is accepted. So, based on the findings, we reject the null hypothesis and accept the alternative hypothesis, i.e., we may infer that there is a link between intoxicant usage and respondents' financial well-being.

**Table. 1.2-** *Result of “Phi and Cramer's V”*

“Nominal by Nominal”	P-value	Significance
*Phi	.238	.000
*Cramer's V	.238	.000

Table no 1.2 shows the result of Phi and Cramer's V. This is done to test the reliability and validity of the output so that the research can be more robust. The rule says that, if the value of the output is less than 0.25, it means the relationship is not strong, and greater than the value of 0.75 implies the relationship is strong. The p-value between 0.25 and 0.75 means the association is moderate and acceptable. So, according to the rule, Phi and Cramer's V value is .258 i.e the relationship is not strong between the variables.

***Relationship between belief practices (relating to health) and financial well-being***

In the present study, belief practices (relating to health) are considered as beliefs in superstition and traditional healing methods.

**H20-** There is no relationship between belief practices and financial well-being.

**H21-** There is a relationship between belief practices and financial well-being.

**Table.2** *Measure the relationship between belief in superstition and the respondent's income.*

		Income							
		0 to 1L		1L to 2L		2L to 3L		Total	
		F	%	F	%	F	%	F	%
Belief in superstition	Yes	112	54.4	52	29.7	4	22.2	168	42.1
	No	94	45.6	123	70.3	14	77.8	231	57.9
healing method Total		206	51.6	175	43.9	18	4.5	399	100

**Source:** *Primary survey*

Table no. 2 shows the association between belief in superstition healing practices and the income of the respondents. According to the table, the majority of respondents believe in superstitious healing practices if their income is less than one lakh rupees. The respondents had an income range of Rs. 2 lakhs to 3 lakhs and did not believe in superstition as a healing method. For those with incomes ranging from Rs.1 to 2 lakhs, very few respondents believed in superstition-healing practices

**Table 2.1-** *Result of Pearson Chi-square test.*

Pearson Chi-Square Value	D.F	P-Value
26.651	2	.000

Table 2.1 shows the result of the Pearson Chi-square test at a 5% level of significance. The Pearson “Chi-square” value shown in the above table is .000, which is less than the.05 level of significance. As a result, we discard the null hypothesis and accept the alternative hypothesis, i.e there is an association between financial well-being and superstitious healing practiced by respondents.

**Table 2.2-** *Result of “Phi and Cramer's V”*

“Nominal by Nominal”	P-value	Significance
*Phi	.258	.000
*Cramer's V	.258	.000

Table no. 2.2 shows the result of Phi and Cramer's V where the value is.258 which is more than.25. So according to the rule, the association is a moderate relationship between the variables.

**Table. 3** *Measure the relationship between traditional healing practices and respondents' income.*

		Income							
		0 to 1L		1L to 2L		2L to 3L		Total	
		F	%	F	%	F	%	F	%
<b>Belief in traditional healing method</b>	Yes	86	41.7	38	21.7	0	0.0	124	31.1
	No	120	58.3	137	78.3	18	100	275	68.9
	Total	206	51.6	175	43.9	18	4.5	399	100

**Source:** *Primary survey*

Table no. 3 shows the association between belief in traditional healing practices and the income of the respondents. The result of the tables shows that very few respondents practice the traditional healing method of those having an income category of Rs. 0–1 lakh. The respondents, between Rs. 1 lakh and Rs. 3 lakh, spent less on practicing traditional healing methods. They mostly depend on modern medicine.

**Table 3.1-** *Result of “Pearson Chi-square test”*

Pearson Chi-Square Value	D.F	P-Value
<b>26.228</b>	2	.000

Table 3.1 shows the result of the Pearson Chi-square test at a 5% level of significance. The “Pearson Chi-square” value in the table is.000, which is less than the.05 level of significance. As a result, it fails to accept null-hypothesis which indicates that there is a link between respondents' financial well-being and traditional healing practices.

**Table 3.2-** *Result of “Phi and Cramer's V”*

“Nominal by Nominal”	P-value	Significance
*Phi	.256	.000
*Cramer's V	.256	.000

Table no. 3.2 shows the result of Phi and Cramer's V where the value is .256 which is more than .25 So, according to the rule, the reliability and validity of the result have a moderate association between the variables.

***Relationship between govt. program (relating to health) and financial well-being***

In the present study, govt. programs (relating to health) are considered as awareness of health insurance policies and having Life Insurance Corporation (LIC) policy and Biju Swastya Kalyan Yojana (BSKY) Card.

**H3<sub>0</sub>**-There is no relationship between govt. program and financial well-being.

**H3<sub>1</sub>**-There is a relationship between govt. program and financial well-being.

**Table. 4** Measures the relationship between awareness of health insurance policies and respondents' income.

		Income							
		0 to 1L		1L to 2L		2L to 3L		Total	
		F	%	F	%	F	%	F	%
Awareness of Health Insurance Policies	Yes		68	17.7	12	66.7	111	27.8	
	No	138	67.0	144	82.3	6	33.3	288	72.2
	Total	206	51.6	175	43.9	18	4.5	399	100

**Source:** Primary survey

Table no. 4 shows the association between awareness of health insurance policies and the income of the respondents. Of the respondents, very few know about health insurance for those having Rs. 0–1 lakh income category. Around 30% of respondents know about health insurance policies for those having Rs. 1 lakh to 2 lakh income categories.

**Table 4.1-** Result of “Pearson Chi-square test”

Pearson Chi-Square Value	D.F	P-Value
25.191	2	.000

Table no 4.1 shows the result of the Pearson Chi-square test at a 5% level of significance. The “Pearson Chi-square” value in the table is .000, which is less than the .05 level of significance. As a result, it fails to accept the null hypothesis and take the alternative hypothesis, i.e there is a link between financial well-being & respondents' awareness of life insurance.

**Table 4.2-** Result of “Phi and Cramer's V”

“Nominal by Nominal”	P-value	Significance
*Phi	.251	.000
*Cramer's V	.251	.000

Table no. 4.2 shows the result of Phi and Cramer's V where the value is .251 which is more than .25 So, according to the rule, the association is a moderate relationship between the variables.

**Table. 5** Measure the relationship between having an insurance policy and respondents' income.

		Income							
		0 to 1L		1L to 2L		2L to 3L		Total	
		F	%	F	%	F	%	F	%
Having health insurance policy	Yes	24	11.7	30	17.1	10	55.6	64	16.0
	No	182	88.3	145	82.9	8	44.4	335	84.0
	Total	206	51.6	175	43.9	18	4.5	399	100

**Source:** Primary survey



Table no. 5 shows the association between having a health insurance policy and the income of the respondents. Only a few respondents had insurance policies for those who had an income category of Rs. 0 to 1 lakh. 30 and 10 respondents did have their health insurance coverage for those having an income category of Rs. 1 lakh to 2 lakhs and Rs. 2 lakhs to 3 lakhs, respectively.

**Table 5.1-** Result of Pearson Chi-square test

Pearson Chi-Square Value	D.F	P-Value
<b>23.976</b>	2	.000

Table 5.1 shows the result of the Pearson Chi-square test at a 5% level of significance. The “Chi-square” value in the table is.000, which is less than the.05 level of significance. As a result, it fails to accept the null hypothesis and accept the alternative hypothesis, i.e., there is a link between financial well-being and respondents' awareness of life insurance.

**Table 5.2-** Result of “Phi and Cramer's V”

“Nominal by Nominal”	P-value	Significance
*Phi	.245	.000
*Cramer's V	.245	.000

Table no. 5.2 shows the result of Phi and Cramer's V. The value of “Phi and Cramer's V” is .245 which is less than 0.25. So, according to the rule, the association shows there is a weak relationship between the variables.

**Table 6.** Measure the association between individuals having BSKY Cards and respondents' income.

		Income						Total	
		0 to 1L		1L to 2L		2L to 3L			
		F	%	F	%	F	%	F	%
Have the BSKY Card	Yes	98	47.6	65	37.1	12	66.7	175	43.9
	No	108	52.4	110	62.9	6	33.3	224	56.1
	Total	206	51.6	175	43.9	18	4.5	399	100

**Source:** Primary survey

Table no. 6 shows the association between having BSKY Cards and the income of the respondents. The result of the table shows that a variable number of respondents have their Biju Swasthya Kalyan (BSKY) Card for all three categories of income respondents. The BSKY Card is a health coverage scheme launched by the Odisha government.

**Table 6.1-** Result of “Pearson Chi-square test”

Pearson Chi-Square Value	D.F	P-Value
<b>8.162</b>	2	.017

Table no 6.1 shows the result of the Pearson Chi-square test at a 5% level of significance. The “Pearson Chi-square” value in the table is.017, which is less than the.05 level of significance. As a result, it fails to accept the null hypothesis and accept the alternative hypothesis, i.e there is a link between financial well-being and owning a BSKY Card.

**Table 6.2-** Result of “Phi and Cramer's V”

“Nominal by Nominal”	P-value	Significance
*Phi	.143	.017
*Cramer's V	.143	.017

Table no. 7.2 shows the result of Phi and Cramer's V where the value is .143, less than 0.25. So, according to the rule, the association of the variables shows a weak relationship between variables.

### *Summary on Hypothesis Measurement*

Hypothesis	Result
<b>H1<sub>0</sub></b> - There is no relationship between bad habits and financial well-being.	Accept the alternative hypothesis
<b>H1<sub>1</sub></b> -There is a relationship between bad habits and financial well-being.	
<b>H2<sub>0</sub></b> -There is no relationship between belief practices and financial well-being.	Accept the alternative hypothesis
<b>H2<sub>1</sub></b> -There is a relationship between belief practices and financial well-being.	
<b>H3<sub>0</sub></b> -There is no relationship between govt. program and financial well-being.	Accept the alternative hypothesis
<b>H3<sub>1</sub></b> -There is a relationship between govt. program and financial well-being.	

## **Results and Discussion**

If people consume intoxicants regularly, it may hurt their health as well as their income. When people's health is good, they have a better possibility of increasing their income and saving. Many respondents argue that excessive intoxication is harmful to their health and that a small amount is beneficial for mental relaxation. Some respondents claimed that consuming rice beer (Handia) is beneficial to their health because it contains no harmful substances. It has medicinal properties. There is a relationship between superstition healing practices and financial well-being. When medicine fails to cure their fever, people sometimes prefer the superstitious healing approach. When they get a fever, some of the respondents turn to witchcraft instead of going to the doctor. Those respondents are mostly from lower socioeconomic groups and believe in superstition healing procedures. Most of the respondents do not have health insurance policies, and very few have life insurance policies. It is observed that only more than one lakh income categories have their life insurance policies, while others do not have insurance policies due to a lack of funds or being unaware. The majority of respondents have obtained the Odisha government's BSKY Card, but they claim that the card is not accepted by private hospital authorities. So, the card is available to them, but it is ineffective when they require it. Some respondents prefer to use traditional treatment methods first before going to the hospital. Some respondents prefer going to the hospital first, and then, if modern medicine does not work, they prefer traditional medicine. During the survey, some respondents were asked to purchase alcohol to answer research questions. The government should run a healthcare training facility to educate people about health issues. People should get treatment with a doctor's prescription so they can reduce unnecessary expenses on health. They should avoid alcohol and smoke daily. At the maximum, people are continuously working hard at work and forgetting about their eating, so they focus on it. For lack of the nearest government hospital or dispensary, they may prefer superstition or traditional healing methods.

If the hospital was available in their village, there would be fewer chances of superstition or traditional healing methods.

## Conclusion

Traditional medicine is still used by the indigenous of the Mayurbhanj area to heal diseases. The health status of the indigenous population has not improved yet as expected so their income may be affected. Healthcare delivery services are still insufficient and must be enhanced if the country's goal of universal health care is to be realized. There is a link between the strange concept of recovering rehearsals and financial success. When people's health is good, they have a better chance of earning more and saving more. The majority of the responders have obtained the Odisha government's BSKY Card, however, they claim that private emergency clinic experts do not accept the card. As a result, the government should investigate the concerns to enhance their income and savings.

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