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Research Article

## Human Rights and Access to Healthcare in KBK Districts of Odisha

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### Abstract

The eight districts of the KBK region of Odisha, namely Koraput, Bolangir, Kalahandi, Nabarangpur, Nuapada, Rayagada, Malkangiri, and Kandhamal, represent one of the most acutely underdeveloped geographic zones in India. Despite decades of special development initiatives, healthcare indicators in the KBK region continue to lag far behind both State and national averages. This article examines healthcare access in the KBK districts through the lens of international and constitutional human rights law, treating access to healthcare not as a charitable benefit but as a justiciable entitlement. Drawing on primary data collected from 600 respondents across the eight KBK districts, supplemented by secondary data from government health reports, NHRC records, and census databases, the study identifies structural, institutional, and socio-cultural barriers that prevent the people of the KBK region, particularly women, children, and Scheduled Tribe communities, from realising their right to health. The article situates these findings within the framework of Article 21 of the Constitution, the Directive Principles, and relevant international instruments, including the International Covenant on Economic, Social and Cultural Rights (ICESCR). It concludes with a set of targeted policy recommendations aimed at transforming the existing healthcare landscape in the KBK region into one that is rights-based, community-centred, and institutionally accountable.

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**KEYWORDS:** Right to health, KBK districts, Odisha, tribal healthcare, human rights, access to justice, maternal health, infant mortality, ICESCR, Article 21.

## 1. INTRODUCTION

The Kalahandi, Bolangir, and Koraput (KBK) region of Odisha has occupied a place of dark distinction in India's development narrative for well over five decades. First drawing national attention through the famine deaths and distress grain sales of the 1980s, the KBK region today comprises eight districts, namely Koraput, Bolangir, Kalahandi, Nabarangpur, Nuapada, Rayagada, Malkangiri, and Kandhamal, encompassing a combined area of over 72,000 square kilometres and a population of approximately 1.21 crore persons. The region is characterised by a high proportion of Scheduled Tribe communities, dense forest cover, rugged terrain, limited road connectivity, and pervasive poverty.

The healthcare situation in KBK is a microcosm of a larger crisis: the failure of the Indian state to treat the right to health as a genuine, enforceable legal entitlement for its most marginalised citizens. Infant mortality rates in the KBK districts remain among the highest in India. Maternal mortality is disturbingly elevated. Malnutrition among children under five is endemic. Tuberculosis, malaria, sickle cell anaemia, and waterborne diseases impose a chronic disease burden that overwhelms the region's skeletal health infrastructure. Meanwhile, healthcare facilities are understaffed, under-equipped, and physically inaccessible to large swaths of the population.

This article approaches these realities not as development statistics but as human rights violations. The right to health is not merely aspirational in the Indian constitutional framework. It has been consistently recognised by the Supreme Court of India as an integral component of the right to life under Article 21 of the Constitution. The State's failure to ensure adequate healthcare to the people of the KBK region constitutes, on this analysis, a continuing and systemic violation of a fundamental right. This framing has profound implications for legal accountability, institutional design, and the direction of public policy.

The article proceeds as follows. Section 2 establishes the legal and normative framework for the right to health under Indian constitutional law and international human rights law. Section 3 presents the socio economic and demographic profile of the KBK region. Section 4 details the methodology of the primary study. Section 5 presents the empirical findings on healthcare access and violations. Section 6 analyses the institutional mechanisms for redressal and their limitations. Section 7 provides a comparative perspective. Section 8 discusses the key findings. Section 9 advances policy recommendations, and Section 10 concludes.

## 2. The Right to Health: Legal and Normative Framework

### 2.1 Constitutional Provisions

The Constitution of India does not expressly enumerate a right to health as a fundamental right. However, a series of landmark decisions by the Supreme Court has firmly established that the right to health is an integral and inalienable component of the right to life under Article 21. In *Consumer Education and Research Centre v. Union of India* (1995), the Supreme Court held that the right to health and medical care is a fundamental right under Article 21 read with Articles 39(e), 41, and 43. In *Paschim Banga Khet Mazdoor Samity v. State of West Bengal* (1996), the Court held that the State's failure to provide adequate medical facilities violated the right to life. These decisions establish a constitutional duty on the State to maintain and expand health infrastructure commensurate with the needs of its population.

Article 47 of the Constitution, a Directive Principle, specifically imposes on the State the duty to raise the level of nutrition and the standard of living of its people and to improve public health. Article 39(e) directs the State to protect the health and strength of workers and children. Article 41 obliges the State to make effective provision for securing the right to public assistance in cases of sickness and disablement. Article 42 mandates the State to make provision for maternity relief. Together, these provisions constitute a comprehensive constitutional mandate for the State to ensure universal, equitable, and adequate healthcare.

### 2.2 International Human Rights Standards

At the international level, the right to health is most comprehensively articulated in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which India ratified in 1979. Article 12 recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The UN Committee on Economic, Social and Cultural Rights, in its General Comment No. 14 (2000), elaborated that the right to health requires healthcare to be available, accessible, acceptable, and of adequate quality. The accessibility dimension includes physical accessibility, economic affordability, and non-discrimination.

For tribal and indigenous communities specifically, the UN Declaration on the Rights of Indigenous Peoples (UNDRIP), adopted in 2007, recognises in Article 24 the right of indigenous peoples to their traditional medicines and the right of access to all social and health services without discrimination. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) imposes specific obligations with respect to maternal healthcare. India's compliance with these international instruments must be evaluated against the healthcare reality of communities such as those in the KBK districts.

**Table 1:** Legal Framework Governing the Right to Healthcare in KBK Districts

Legal Instrument	Key Provision	Relevance to KBK Healthcare
Article 21, Constitution of India	Right to life includes right to health	Foundational right enforceable in courts
Article 47, Constitution of India	State duty to raise nutrition and	Directive for government healthcare investment

	public health	
National Health Mission (NHM)	Universal healthcare in rural areas	Primary implementation framework in KBK
Clinical Establishments Act 2010	Regulation of healthcare facilities	Standards applicable to private providers in KBK
Pre Conception and Pre Natal Diagnostic Techniques Act 1994	Prohibition of sex selection	Maternal health and gender rights protection
PESA Act 1996	Gram Sabha powers in scheduled areas	Community governance of health services in tribal areas
Janani Suraksha Yojana (JSY)	Cash incentives for institutional delivery	Maternal healthcare entitlement in KBK districts
National Food Security Act 2013	Right to food and nutrition	Malnutrition and child health in KBK

Source: Author's compilation from constitutional provisions and statutory instruments.

### 3. Socio-Economic and Demographic Profile of the KBK Region

The KBK region presents a development paradox: it is rich in natural resources, including forests, minerals, and river systems, yet its human development indicators are among the lowest in the country. The region contains significant iron ore, bauxite, and chromite deposits, and its forests constitute a significant portion of Odisha's biodiversity wealth. However, the communities that inhabit these resource rich landscapes have historically been excluded from the benefits of resource extraction while bearing its social and environmental costs.

The Scheduled Tribe population constitutes between 28 and 58 per cent of the population in different KBK districts. The literacy rate in the region ranges from approximately 39 per cent in Malkangiri, the lowest in Odisha, to 67 per cent in Bolangir. Per capita income in the KBK districts is significantly below the Odisha average. Agriculture and forest produce collection are the predominant livelihoods, with seasonal migration to urban areas being a significant survival strategy for many families. The region is served by a network of Primary Health Centres (PHCs), Community Health Centres (CHCs), and district hospitals that are chronically understaffed and under-equipped.

Table 2: Socio-Economic and Healthcare Profile of KBK Districts (2023)

District	ST Pop. %	Literacy %	IMR (2023)	PHC Availability
Koraput	49.8	51.4	42	1 per 38,000 pop.
Nabarangpur	55.9	44.7	47	1 per 44,000 pop.
Bolangir	28.4	67.3	36	1 per 29,000 pop.
Kalahandi	29.1	60.8	38	1 per 32,000 pop.
Nuapada	31.2	52.6	51	1 per 48,000 pop.
Rayagada	56.1	47.2	44	1 per 41,000 pop.
Malkangiri	58.1	39.6	55	1 per 52,000 pop.
Kandhamal	51.5	52.7	46	1 per 43,000 pop.

Source: NHM Odisha District Health Action Plans 2023; Registrar General of India; Census 2011.

The health infrastructure in the KBK region is characterised by severe shortfalls against both normative and national standards. The Indian Public Health Standards (IPHS) prescribe one PHC for every 30,000 population in tribal areas. In Malkangiri, the ratio is approximately one PHC for every 52,000 persons. In Nuapada, it stands at one per 48,000. Even where health facilities exist, they are frequently non-functional due to staff absenteeism, drug stockouts, broken equipment, and lack of reliable electricity and water supply. The 2022 Rural Health Statistics report found that specialist vacancies in the KBK districts exceeded 70 per cent in several categories.

### 4. RESEARCH METHODOLOGY

This study adopts a mixed methods research design combining a household survey with qualitative data collection. The primary survey was conducted across all eight KBK districts between February and May 2024. A total of 600 respondents were interviewed using a structured questionnaire covering healthcare access, awareness of health entitlements, experience of rights violations, and interaction with grievance redressal mechanisms. The sample was stratified by district, gender, and

tribal or non tribal status, with over representation of Scheduled Tribe respondents in proportion to their share of the district populations.

Within each district, three blocks were selected by purposive sampling to include one relatively accessible block and two remote or interior blocks. Within each block, four villages were selected by random sampling, and households were selected through systematic random sampling. One adult member per household was interviewed, with a specific effort to interview women respondents wherever possible, given the particular salience of maternal and reproductive health issues in the study. In total, 327 female and 273 male respondents were interviewed.

Qualitative data were collected through 16 focus group discussions (two per district), one with women of reproductive age and one with mixed community members including local health workers, village headpersons, and community leaders. Twenty eight key informant interviews were conducted with ASHA workers, ANMs, PHC medical officers, DLSA officials, NGO representatives, and elected Gram Panchayat members. All qualitative data were recorded with participant consent and

transcribed in Odia or the relevant tribal language before thematic analysis.

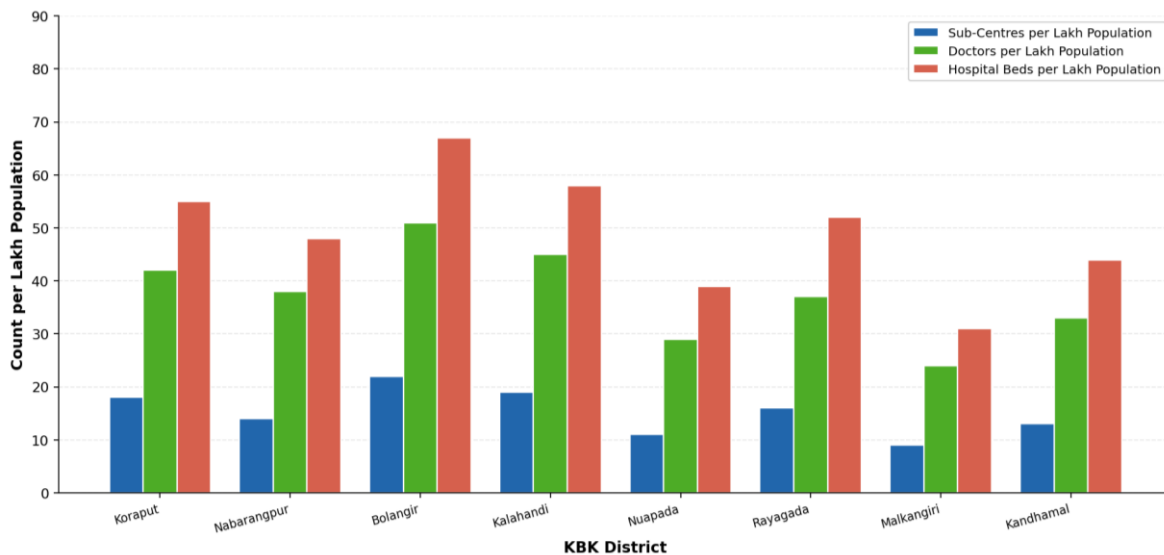
## 5. EMPIRICAL FINDINGS

### 5.1 Healthcare Infrastructure: District wise Disparities

The survey findings on healthcare access confirm and extend the pattern revealed by official statistics. Across the full sample, only 38 per cent of respondents reported that a functional PHC was reachable within one hour by foot or locally available transport. In Malkangiri and Nabarangpur, this proportion fell to 24 and 29 per cent respectively. Physical distance is compounded by the near total absence of reliable all

weather roads connecting interior villages to healthcare facilities. In several villages in the interior blocks of Malkangiri and Koraput surveyed for this study, the nearest PHC was more than three hours away on foot and required crossing seasonal rivers.

The district wise comparison of healthcare infrastructure indicators against national norms reveals a persistent and serious gap across all KBK districts, as illustrated in Figure 1. Malkangiri and Nabarangpur record the lowest figures across all three infrastructure indicators, reflecting their status as the most geographically remote and administratively challenged districts in the region.



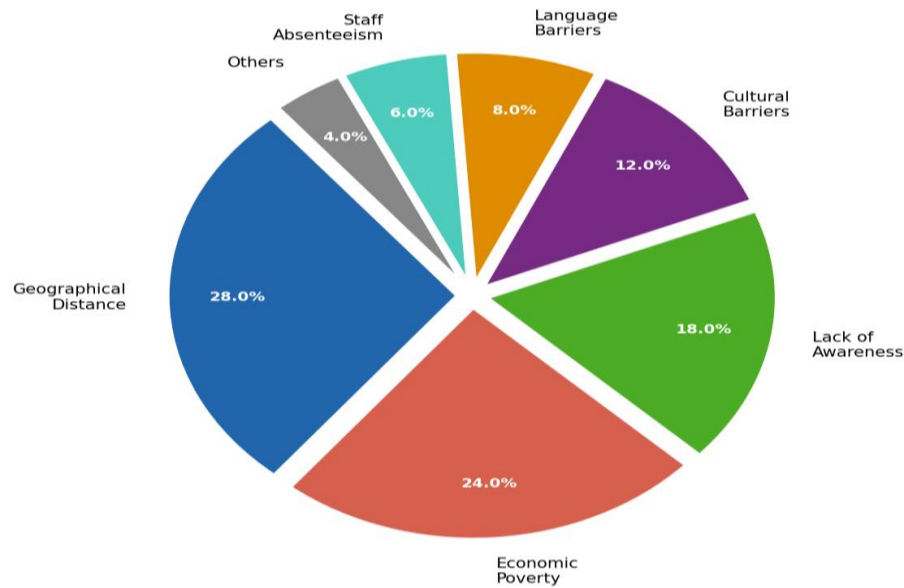
Source: NHM Odisha, Primary Survey

Figure 1: Healthcare Infrastructure Indicators across KBK Districts (2023)

### 5.2 Barriers to Healthcare Access

Respondents were asked to identify the primary reasons for not accessing available healthcare facilities. Geographical distance was the most commonly cited barrier at 28 per cent of responses, reflecting the terrain challenges described above. Economic poverty was the second most significant barrier at 24 per cent, cited even in the context of ostensibly free public healthcare, because the indirect costs of accessing care,

including transportation, lost wages, and informal payments demanded at facilities, impose a heavy burden on poor households. Lack of awareness of available services and entitlements was cited by 18 per cent, cultural barriers including gender norms and traditional health beliefs by 12 per cent, and language barriers by 8 per cent. Staff absenteeism at health facilities was specifically cited by 6 per cent.



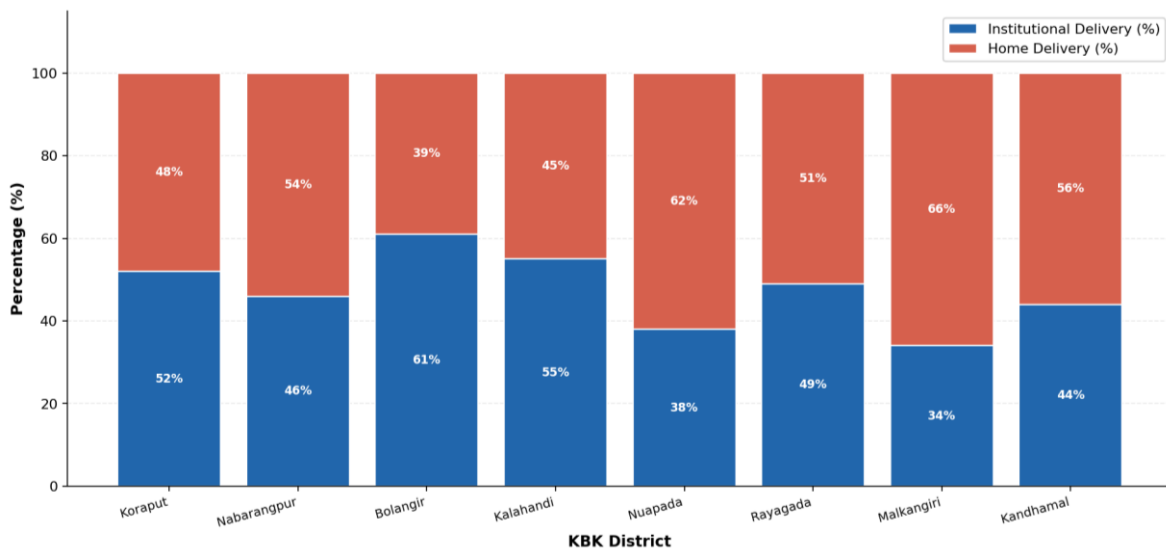
Source: Primary Survey, 2024

Figure 2: Primary Barriers to Healthcare Access in KBK Districts

### 5.3 Maternal Health: A Rights Crisis

The state of maternal health in the KBK districts represents perhaps the most acute dimension of the healthcare rights crisis in the region. The study found an average institutional delivery rate of 47 per cent across the eight districts, compared to the Odisha State average of 79 per cent and the national target of 100 per cent. Malkangiri recorded the lowest institutional delivery rate in the sample at 34 per cent. The consequences are devastating: home deliveries conducted without skilled assistance carry significantly higher risks of maternal and neonatal mortality, haemorrhage, infection, and birth asphyxia.

The Janani Suraksha Yojana (JSY), which provides cash incentives to women for institutional delivery, has had a measurable impact on institutional delivery rates across rural India. However, the study found that only 33 per cent of female respondents in the KBK districts were fully aware of their JSY entitlement. Only 58 per cent of those who were aware had actually received the cash transfer, with delay and partial payment being the most common complaints. The failure of the JSY to fully penetrate the KBK region reflects broader implementation deficits that plague social protection programmes in remote tribal areas.



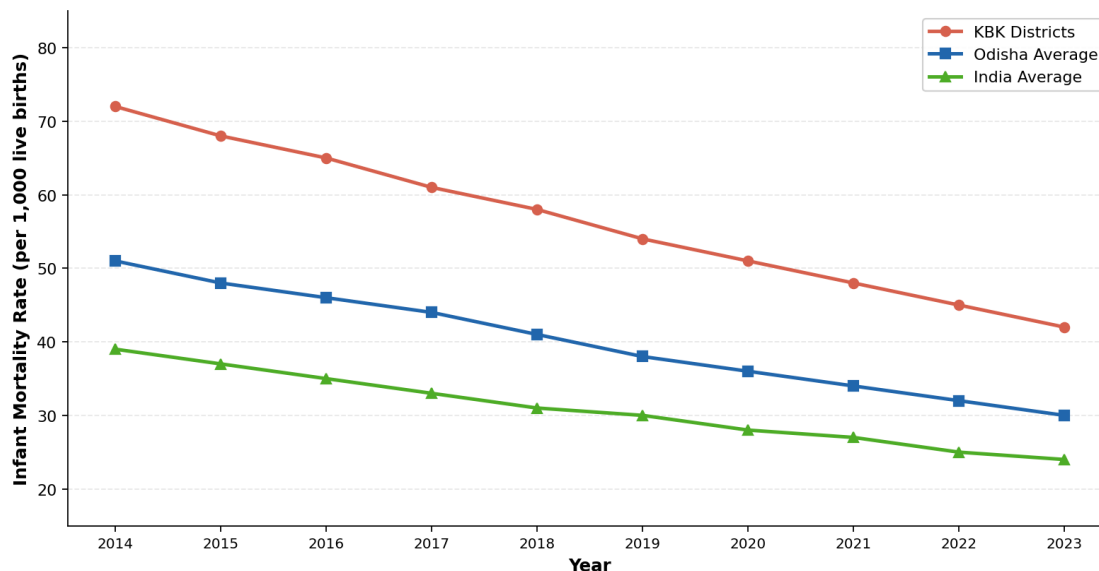
Source: HMIS 2023 24, Primary Survey

Figure 3: Institutional vs. Home Delivery Rates in KBK Districts

### 5.4 Infant and Child Health

Infant mortality rates in the KBK region have declined over the past decade, reflecting some positive impact of the National Health Mission. However, they remain significantly above both State and national averages, as shown in the trend analysis in

Figure 4. In 2023, the estimated IMR for the KBK districts ranged from 42 per 1,000 live births in Koraput to 55 in Malkangiri, compared to the Odisha average of 30 and the national average of 24.



Source: SRS, RGI; NHM Odisha

Figure 4: Infant Mortality Rate Trend — KBK Districts vs. Odisha and India (2014-2023)

Malnutrition is both a cause and a consequence of high infant mortality in the KBK region. The National Family Health Survey 5 (NFHS 5, 2019-21) found that in the KBK districts, between 38 and 52 per cent of children under five were stunted, compared to a national average of 35.5 per cent. Wasting ranged from 18 to 26 per cent. Anaemia was found in over 60

per cent of children under five and over 55 per cent of women of reproductive age in the region. These figures reflect a chronic failure of nutrition and preventive healthcare programmes to reach the most vulnerable communities.

### 5.5 Key Healthcare Access and Rights Indicators: Survey Data

Table 3: Key Healthcare Access Indicators — KBK Districts vs. Odisha Average (Survey Data, 2024)

Indicator	KBK Average (%)	Odisha Average (%)	Gap (Percentage Points)
Institutional delivery	47	79	32 pp deficit
Antenatal care (3+ visits)	38	68	30 pp deficit
Full immunisation coverage	54	78	24 pp deficit
Access to ASHA worker	61	89	28 pp deficit
Households with sanitation	29	64	35 pp deficit
Safe drinking water access	44	72	28 pp deficit
Awareness of JSY entitlement	33	71	38 pp deficit
Awareness of NHM services	26	58	32 pp deficit
Filed a complaint against denial	4	11	7 pp deficit

Source: Primary Survey, 2024; NHM Odisha Health Management Information System (HMIS) 2023-24.

The data in Table 3 reveal a systematic and severe shortfall in every healthcare access indicator for the KBK districts relative to the Odisha average. The most alarming gap is in awareness of the Janani Suraksha Yojana entitlement (38 percentage points below Odisha average), closely followed by access to sanitation (35 percentage points) and awareness of NHM services (32 percentage points). These gaps are not accidents of geography; they are the cumulative product of decades of

inadequate investment, poor implementation of welfare schemes, weak administrative capacity, and the absence of a rights-based accountability framework.

### 5.6 Grievance Redressal and Human Rights Awareness

A particularly alarming finding of the study is the near total absence of rights consciousness in the context of healthcare. Only 4 per cent of respondents who had experienced a denial of

healthcare, whether through facility closure, staff absence, drug unavailability, or outright refusal, had ever filed a formal complaint. The qualitative data shed light on why: most respondents were unaware that they had a legal right to healthcare, let alone that mechanisms existed for its enforcement. The NHRC and SHRC were known to fewer than 8 per cent of respondents. The District Grievance Redressal Officer mechanism under the Consumer Protection Act was known to virtually none.

ASHA workers and ANMs, who serve as the primary interface between the formal health system and tribal communities, themselves exhibited significant gaps in knowledge of the rights framework. In the key informant interviews, several ASHAs reported that they had never received training on legal health entitlements and had no knowledge of how to assist a community member in filing a complaint against a dysfunctional facility or an absentee medical officer.

## 6. Institutional Mechanisms and Their Limitations

### 6.1 National Health Mission

The National Health Mission (NHM), launched in 2013 by merging the National Rural Health Mission and the National Urban Health Mission, constitutes the primary institutional framework for public healthcare delivery in rural India. In the KBK districts, NHM funding has supported the construction of health facilities, the appointment of ASHAs, the JSY programme, and the procurement of drugs and equipment. However, implementation quality is severely constrained by staff vacancies, weak monitoring systems, fund diversion, and a top down approach that fails to engage with the lived realities of tribal communities.

The District Health Action Plans (DHAPs) prepared under NHM are, in theory, community informed planning documents. In practice, the FGD data reveal that most community members had no knowledge of the DHAP process and had never participated in a planning consultation. The disconnect between official planning processes and community needs is a structural feature of healthcare governance in the KBK region that significantly undermines the effectiveness of NHM investments.

### 6.2 National Human Rights Commission and State Human Rights Commission

The NHRC has taken cognisance of healthcare rights in tribal areas in several suo motu cases. Its guidelines on the right to healthcare, issued in 2019, recommend minimum standards of infrastructure, staffing, and medicine availability for public health facilities. However, the NHRC's recommendations are not legally binding and rely on voluntary compliance by State governments. The Odisha SHRC, while possessing the power to investigate complaints and make recommendations, is similarly constrained by its quasi judicial character and the State government's discretion in implementation.

The study found that no respondent from any KBK district had ever filed a complaint with the NHRC or SHRC regarding

healthcare denial. This is not because violations are absent; the survey documented an extensive and alarming range of violations. It is because the mechanisms for complaint are inaccessible, unknown, and perceived as irrelevant to the daily struggles of communities who lack even basic knowledge that they possess enforceable rights.

### 6.3 Legal Services Authorities

The National Legal Services Authority (NALSA) and the District Legal Services Authorities (DLSAs) are mandated under the Legal Services Authorities Act 1987 to provide free legal services and promote legal awareness. NALSA has developed schemes specifically addressing the healthcare rights of vulnerable communities. However, in the KBK districts, DLSA outreach to interior tribal villages is extremely limited. The study found that DLSA legal aid camps had been held in only 12 of the 24 surveyed blocks in the preceding year, and none had specifically addressed health rights or the JSY complaint mechanism.

## 7. Comparative Perspective

The KBK situation invites comparison with similarly situated regions in other parts of India and the world. Jharkhand's Sahiya programme, which invested heavily in ASHA training and community mobilisation, achieved a significant increase in institutional delivery rates in Scheduled Area districts over a six year period. The programme's success was attributed to a combination of monetary incentives, regular training, and the creation of a community accountability mechanism through which villages could rate the performance of their ASHA.

Chhattisgarh's Mitadin programme offers another instructive example. By training community health workers drawn from within tribal communities, and by equipping them with knowledge not only of health behaviours but also of legal health entitlements, the Mitadin programme created a cadre of community based advocates capable of navigating the formal health system on behalf of their neighbours. A similar model, adapted to the linguistic and cultural diversity of the KBK region, could significantly improve both healthcare access and rights awareness.

The Brazilian Unified Health System (SUS), which enshrines universal healthcare as a constitutional right enforceable in courts, provides an international reference point. Brazil's experience demonstrates both the transformative potential and the implementation challenges of a rights based approach to healthcare. The extensive public interest litigation on the right to medicines in Brazil has yielded important lessons about the limits and possibilities of juridification of healthcare rights, lessons that are directly relevant to the Indian experience.

In the context of indigenous health rights specifically, the experience of the Maori in New Zealand and the Aboriginal and Torres Strait Islander peoples in Australia demonstrates the critical importance of culturally safe healthcare, meaning healthcare designed and delivered in a manner that affirms and respects the cultural identities of indigenous patients. The cultural safety framework has gained recognition in

international health policy as an essential complement to structural improvements in healthcare infrastructure.

## 8. DISCUSSION

The empirical findings of this study establish beyond reasonable doubt that the people of the KBK region suffer from a systematic and severe denial of the right to health as guaranteed by the Constitution of India and recognised under international human rights law. The denial is not limited to the absence of infrastructure, though that absence is real and serious. It encompasses the failure of existing institutions to perform their mandated functions, the absence of accountability mechanisms accessible to ordinary community members, the invisibility of rights entitlements in the lived experience of the population, and the structural factors, poverty, geography, language, and gender, that prevent access even where services nominally exist.

The gender dimension of the healthcare rights deficit in KBK deserves particular emphasis. Female respondents consistently recorded lower awareness of entitlements, lower rates of healthcare utilisation, and higher rates of experienced violations. The maternal mortality and morbidity data are a direct expression of this gendered exclusion. A healthcare rights framework that does not specifically address the position of women, including the barriers of social norms, mobility restrictions, male gatekeeping of healthcare decisions, and the inadequacy of female friendly infrastructure at health facilities, will necessarily leave the most vulnerable members of the KBK communities unreached.

The role of the private sector in healthcare in the KBK region is also noteworthy. Given the failures of the public system, a significant proportion of respondents reported reliance on informal private providers, including unqualified medical practitioners locally known as quacks. The concentration of qualified private practitioners in district headquarters, inaccessible to interior communities, and the absence of effective regulation of informal providers, creates a situation in which the poorest communities pay out of pocket for the most dangerous care. This market failure in healthcare provision is itself a human rights concern.

The findings also highlight a critical gap in the implementation of the PESA Act 1996 in the healthcare domain. PESA empowers Gram Sabhas in Scheduled Areas to plan and manage social welfare schemes, including health programmes. In theory, this creates a legal framework for community governance of healthcare in the KBK districts. In practice, Gram Sabhas in the region are rarely convened for health planning purposes, their resolutions on healthcare matters are routinely ignored by the district administration, and the PESA provisions relating to health have been poorly operationalised in the State laws and rules of Odisha.

## 9. Policy Recommendations

The analysis presented in this article supports the following recommendations, which are grounded in the empirical findings of the primary survey and informed by the comparative evidence reviewed above. They are directed at the Government of Odisha, the Central Government, the judiciary, legal services authorities, and civil society organisations.

**Table 4:** Policy Recommendations for Realising Healthcare Rights in KBK Districts

Area	Recommended Intervention	Responsible Authority
Infrastructure	Establish 24x7 PHCs in every block of KBK with specialist rotation	State Health Dept / NHM
Human Resources	KBK cadre for doctors with incentive package and mandatory 3 year posting	State Government
Legal Literacy	NALSA led health rights camps in all 80 blocks of KBK districts	DLSA / NALSA
Maternal Health	Door to door JSY enrolment by ASHAs with vernacular IEC material	NHM / District Administration
Nutrition	Convergence of ICDS, MDM, and PM POSHAN in tribal dominated panchayats	WCD / Education Dept
Grievance Redressal	Establish health rights help desks at every CHC in KBK districts	SHRC / State Health Dept
Technology	Telemedicine hubs at block level linked to AIIMS Bhubaneswar and SCB MCH	NHM / IT Dept
Community Governance	Strengthen Gram Sabha health sub-committee under PESA in all scheduled areas	Panchayati Raj Dept

**Source:** Author's recommendations based on primary survey and comparative analysis.

### 9.1 Adopt a Rights Based Approach to KBK Healthcare

The most fundamental recommendation of this study is that healthcare in the KBK region should be reimagined and governed as a justiciable right rather than a discretionary benefit. This requires the enactment of a State level Right to Health Act, as have been adopted by Rajasthan and several other States, which codifies minimum healthcare entitlements, establishes complaint mechanisms, and provides for penalties for denial of care. The Act should specifically address the needs of Scheduled Tribe communities and the KBK region,

with provisions for culturally appropriate care, tribal language services, and community governance.

### 9.2 Emergency Human Resource for Health Mission

The chronic vacancy crisis in healthcare staffing in the KBK region cannot be addressed by ordinary recruitment and posting procedures. An emergency Human Resource for Health Mission, modelled on the Odisha Civil Services reforms but targeted at healthcare workers, should be launched. This should include a dedicated KBK cadre with an attractive incentive

package, compulsory three-year minimum posting, government housing, and career fast tracking for service in the region. Medical and nursing colleges should be established in partnership with CUTM and other institutions within the KBK region to develop locally rooted health professionals.

### 9.3 Legal Literacy for Health Rights

A dedicated Health Rights Legal Literacy Programme should be launched by the Odisha DLSA in partnership with the State NHM. The programme should train a cadre of Health Rights Paralegal Volunteers, drawn from within tribal communities, in the constitutional and statutory framework of health rights, the JSY and NHM entitlements, and the mechanisms for filing complaints with the SHRC and the District Grievance Redressal Officer. All IEC material should be produced in Odia and in the relevant tribal languages.

## 10. CONCLUSION

The people of the KBK region of Odisha have waited too long for the promises of the Constitution to translate into a lived reality of decent healthcare. The empirical findings of this study demonstrate that the gap between constitutional aspiration and ground reality is not narrowing at an adequate pace, and that in critical dimensions of maternal and child health, the region remains in a state of chronic rights deprivation.

The right to health, as embedded in Article 21 of the Constitution and elaborated by the Supreme Court of India over three decades of progressive jurisprudence, is not a slogan. It is an enforceable legal entitlement that imposes concrete duties on the State. The systematic denial of adequate healthcare to the communities of the KBK region, through underfunded infrastructure, vacant positions, inaccessible facilities, dysfunctional schemes, and an absent grievance redressal architecture, constitutes a continuing violation of that right.

Addressing this violation requires not merely incremental improvements in health expenditure or programme implementation. It requires a fundamental reorientation of the State's approach to healthcare in the KBK region, from one premised on charity and discretion to one premised on rights and accountability. It requires placing the communities of the KBK region, particularly its women, its children, its tribal communities, and its most remote inhabitants, at the centre of healthcare planning, governance, and delivery. And it requires investing in the legal literacy and institutional access that would enable these communities to claim and defend their rights.

This article has sought to contribute to that project by providing an empirically grounded, legally informed analysis of the healthcare rights situation in the KBK region. The path from this analysis to policy change is neither short nor straight. But the constitutional mandate is clear, the human cost of inaction is immense, and the moral and legal imperative for urgent, rights-based action is beyond question.

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