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MAPPING HEALTH CONSEQUENCE OF WORKING-CLASS POPULATION IN KBK DISTRICTS IN ODISHA

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Abstract

Health remains a key issue in the contemporary society. Particularly in the working-class population is concerned, there is a serious challenge in life without access to proper health care facility. As poverty remains a key issue which causes multiple vulnerability when an individual unable to take care of himself or his family because of lack of money. Thus, in a particular case of KBK region in Odisha which witnesses a historic cause of poverty, underdevelopment, and health problem since long past is a case to understand social reality. So, this paper will be discussing on social health of people in the KBK region with specific focus on poverty, under-development and marginalization of various poor marginalized communities across the region. Although various curative measures have been taking by the state's mechanism since the independence, but persistence of poverty and health problem remain as key factor of under-development in this region.

Key Words: - Health, Poverty, Underdevelopment, KBK region, Social Policy

Introduction

Good health is an important factor for the provision of regular supply of labour as it avoids the disruptions caused by sickness. Good health not only promotes high moral and labour productivity but also produce positive environment for the economic growth. Health has been declared as a fundamental human right. This implies that the state has the responsibility for the health of its people. National Governments all over the world are working towards expanding and improving the health care services for their citizens. As economic growth and national development relies on good health, ability and social wellbeing of its populations, so all over the world, good health and social wellbeing became a new prospective life for everyone (Ritu Priya, John Porter, Unnikrishnan Payyappallimana, Liz Maria Kuriakose: 2013; Ritu Priya: 2014). So, in this context, this paper will be discussing on health issue particularly in the case of working class population in the KBK (Kalanadi-Balangir-Koraput) district in Odisha.

Health is the most basic and primary need of an individual which enable a nation towards progress in the socio-economic, scientific, literary and cultural spheres. A long life and good health are the greatest blessing which makes human life better. In fact health is an important input in any progress and development. As the health problems in the people in KBK districts is a serious matter, particularly in the case of working class population thus this paper will be discussing the fundamental issue of health problem in this region by highlighting poverty is a major cause of underdevelopment and health problem.

The KBK refers to the erstwhile undivided districts of Koraput, Bolangir and Kalahandi comprising of 80 blocks and 1,437 gram panchayats. Based on the National Sample Survey data (1999-2000), 87.14 per cent of the population in the region involving nearly 12 lakh families were living below poverty line with sad history of deforestation, land degradation and recurring droughts. Abysmally low return on agriculture led to migration of labour. Incidence of malnutrition as well as malaria was high among the people of all ages. The area lacked basic infrastructure like road connectivity and drinking water. The KBK districts accounted for about 20 per cent population covering over 30 per cent geographical area of the State. According to the 2001 census around 38 and 16 per cent of the total population of the KBK region constitute tribal and scheduled caste communities respectively and 90 per cent of the people live in villages (Das: 2007; Parida: 2012; Pnadey,Das & Mishra: 2008).

There is a large number of populations those are facing health problem because of various reasons. KBK districts come under the under-developed part of Odisha, which is very neglected in terms of health infrastructures and better opportunities. KBK districts in Odisha is a classic case where high level of poverty, malnutrition and starvation are common

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phenomena in people lives. Lack of job opportunities and destabilization of rural economy make them more vulnerable. Forced migration to urban areas and searching job in informal sector becomes a way of life. There is no job security in the urban areas which causes social distress, destitute and hunger life in urban slums but, still people continue to rely on out-migration. In this scenario, health problem make them double vulnerable and bring more hardship in their life. Thus, poor citizens have no social protection over basic survival of livelihood despite of every citizens have law for right to life and survival (Currie: 200; Jayal: 1999; Mohanty: 2005; Sainath: 1996).

The health is both input and output and link with the development of human beings. So this should not be an isolated phenomena from overall goal of development. However, every society has unhealthy human beings. So the promotion and protection to them should be first priority and essential work. It should be a national objectives to provide better health care services to its citizens. Good health is a pre-requisite to human productivity and development process. A healthy community constitutes the infrastructure needed for building an economically viable society. The World Health Organization defines health as "A state of complete physical, mental and social wellbeing and not merely an absence of disease or infirmity." Health has found an important place in the constitution of all countries. Of the thirty articles of the Universal Declaration of Human Rights, Article 25 is particularly concerned with the right to health. A healthy society is a strong society. Therefore, the progress of any nation depends on its efficient healthcare management system (Ramanujam, 2009).

Village people have been facing more crisis comparatively urban people. As working class population are unaware and uneducated, so without better health care facilities in local area these population unable to travel long distance for health care treatment. The people in KBK region predominantly live in villages and depend on various working activities such as daily wage labour, agriculture, non-manufacturing and small scale farming work for their livelihood. So, the workers both in rural as well as urban areas work here for their livelihoods. These working class populations work hard by investing their physical labour to meet their income. “The workers work all day along, but they don’t take care of their bodies or take time to rest.” So these are some basic problems which affect their life. Due to this, many people are facing various health problems. Obesity, malnutrition, lack of access to clean water, and lack of proper sanitation are the main causes (Field Work: 2025-26). So in this context this research study has been carried out in the KBK districts to discuss various issues related to health problem of working class populations in the KBK region.

Health and poverty vice versa poverty and health are closely related to each other. If poverty is eliminated, health problem can be easily elevated. Deprivation means something taken away from people, in this context of deprivation from access of resources leads to poverty and health problem (Amartya Sen: 1981). Similarly health problem is an issue continues to exist because of socio-economic deprivation of working class population from access of resources and better life. To break or overcome such situation particularly for the poor sections, the intervention of the government is very essential to ensure higher provisioning for health and education sectors for securing decent and quality life. So in this scenario of economic distress and illness due to hard work and poverty is a major cause of health problem.

Health is an important determinant of economic and social development because ill-health creates a vicious circle by depleting human energy leading to low productivity and earning capacity. Therefore, a nation ought to give adequate attention to the healthcare of its people. Health is an important aspect of human resource development. Good healthcare facilities and services are essential for creating healthy citizens and society that can effectively contribute to social and economic development. With increased urbanization, industrialization and the changing environment, health related issues and problems are being emphasized and have become a great concern for the contemporary world but the hardship of life among working class population remains an issue of continuous suffering.

In the KBK region, many people earn their living by doing daily wage work, such as manual work, building construction, and brick kiln work etc. A respondent replied by saying this “I do this work every day, come home in the evening, and when I get some money, I spend it on food. This is not only because I work hard all day, but also because I have other problems in the body (Field Work: 2026). So, in this context, economic growth of people and nation is affected by poor health quality of its population. If there is no availability of good health care service than it will impact for the

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larger context of long term plan. Health is not only the absence of illnesses; it is also the ability of people to develop their potential during their entire lives. In that sense, health is an asset the individuals possess, which has intrinsic value (being healthy is a very important source of well-being) as well as instrumental value. In instrumental terms, health impacts economic growth in a number of ways. For example, it reduces production losses due to worker illness, it increases the productivity of adult as a result of better nutrition, and it lowers absenteeism rates and improves learning among school children.

Eight KBK districts comprise 14 Sub-divisions, 37 Tahsils, 80 Community Development Blocks, 1,437 Gram Panchayats and 12,104 villages. As per the 1997 Census of families below poverty line (BPL), conducted by the State Panchayati Raj Department, about 71.40% households in this region live below poverty line. Further, an analysis of NSSO 55th Round unit level data from Consumption Expenditure Survey, 1999 2000 indicates that about 78% of the rural people of these districts are poor (Government of Odisha: 2002).

Table 1.1 Below Poverty Line of People In KBK Region

SL. No	District	Blocks (Number)		1992 Census (Lakh Families)			1997 Census (Lakh Families)		
		Total	TSP	Total	BPL	Percentage	Total	BPL	Percentage
1.	Kalahandi	13	2	2.41	2.07	85.77	3.08	1.93	62.71
2.	Nawapara	5	-	0.94	0.79	83.64	1.27	0.99	78.31
3.	Balangir	14	-	2.39	1.81	75.82	3.30	2.01	61.06
4.	Sonepur	6	-	0.92	0.57	62.29	1.10	0.80	73.02
5.	Koraput	14	14	1.88	1.63	86.59	2.65	2.22	83.81
6.	Malkangiri	7	7	0.80	0.68	84.81	1.09	0.89	81.88
7.	Nawrangpur	10	10	1.52	1.38	90.56	2.15	1.59	73.66
8.	Rayagada	11	11	1.42	1.22	86.04	1.88	1.36	72.03
	Total	80	44	12.28	10.14	82.60	16.52	11.79	71.40

Source: Census data from Panchayati raj Department, Govt.of Odisha & Tribal Sub Plan Blocks

Table (1.1) shows district wise households those come under the Below Poverty Line as per census 1992 and census 1997. The KBK region is considered one of the poorest region in the country because this demographic structure which clearly indicates the level of poverty. Thus, demographically tribal communities dominate this region. About 38.41 percent people in this region belong to Scheduled Tribes including four primitive tribal communities, such as Bondas, Dadai, Langia Sauras and Dangaria kandhas. According to 2001 census survey data this region is socio-economically very backward including literacy rate with 43.33 percent which is much lower than the average state's literacy rate with 63.08 percent. In the same census year 2001 the female literacy rate is 29.10 percent in compare to 50.51 percent of female literacy ration all over the state. In terms of national average of girls marriage below the 18 years is 36.80 percent where as in the KBK region it is 60.60 percent in the census year 2001.

Resources and Livelihood

Land is the major resource, which determines the economic status of households in the rural economy in this region. It is essential to understand the pattern of ownership and distribution of land among different categories of farmers while discussing resources and livelihood of this region. Small and marginal farmers together formed 85 per cent of the farmers but own 46.14 per cent of the total area. The medium farmers constituted 11.90 per cent of the farm households owning 21 per cent of area. By contrast the large farmers constituted 3.14 per cent of farm households but owned 32.85 per cent of total area. Clearly the medium and large farmers have cornered about 54 per cent of area even though they formed about 15 per cent of the total households. Thus the inequality in the landholding is very high in the study villages. It is noteworthy that the large farmers as a group have owned one third of total area land and land owned per household was very high. It

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was nearly 3.5 times higher than that of medium farmers. These two groups dominate in the land market in terms of provision of employment to the other groups as well as in the generation of surplus. Thus agrarian work is the main sources of livelihood for a large number of populations in these districts.

Secondly migration of households to both nearby as well as distant places from the study area is another key finding which suggests that migration is an alternative way of livelihood strategy for livelihood. The nature of migration is mostly of push type in the sense that in the absence of adequate job opportunities even at low wage rate, people try to go elsewhere in search of job for their survival. It is mostly seasonal and circulatory in nature. The prominent destinations of migration are to the towns i.e. Raipur, Rourkela, Hyderabad/Karim Nagar (AP), Mumbai, Surat, Chennai etc. In the case of migration to Andhra Pradesh, Telengana, it is mostly group migration (Families in group travel there and stay there for 5 to 6 months continuously). The migrant workers belong to landless, small/marginal and even in some cases, the medium farmers (Field Work: 2025-26). The migrants mostly belong to backward caste like SC and ST such as Gond, Binjhal, Kondh and other backward caste (OBCs).

Working class population constitutes a significant number in the KBK districts. They have been facing different challenges in the contemporary society because of various problems. The crisis in agrarian sector led to labour migration from the rural agrarian sector to urban unorganized sector is a major issue. Poverty, unemployment, unavailability of work at native place, low productivity from agriculture, indebtedness, ineffectiveness of local governance, flood, drought, cyclone etc main reason behind rural to urban migration. Labourers from mostly poor and deprived sections of the society such as: Schedule Caste (SC), Schedule Tribe (ST) and Other Backward Class (OBC) (Deshingkar: 2010; Ghosh: 2004). Though migration provides livelihood to these population but they remain vulnerable at their workplace. Most of the migrants even don't possess land of their own so they don't have option for cultivation. According to the National Commission on Rural Labour, (NCRL) the majority of seasonal migrants are employed in cultivation and plantations, brick-kilns, quarries and construction sites additionally large numbers of seasonal migrants work (NCRL: 1991).

As working class people in the KBK region is highly rely on migration for their income so they migrate to various states, such as West Bengal, Madhya Pradesh, Kerala, Costal parts of Andhra Pradesh, Telengana, some parts of Maharashtra state, like east and West Parts of Maharashtra, Karnataka, Tamil Nadu and other parts of India. According to (UNESCO & UNICEF: 2012) migration from Odisha to Gujarat and Andhra Pradesh, Bihar to Delhi, Haryana and Punjab, Uttar Pradesh to Maharashtra are commonly visible phenomena. In rural part of India there is unemployment because of disaster of season or absence of assets. Pattern, development and social structure influence migration (NCRL, 1991 & Mosse et al., 2002). National Commission Rural Labour (1991) has highlighted that uneven growth and regional inequality are the main causes of seasonal migration.

Education level, land holding, job opportunities and age also are the determinants of migration. According to the 11th five year plan, 2006 estimation there are 27.8% of people who are unable to fulfill their basic needs like food, clothes and shelter in 2004-05. For the first time 55th Round of NSS calculated the number of seasonal migrants in 1999-2000.

Labour migration is considered as a part of temporary migration or seasonal migration. There are two main reasons for rural labour migration such as migration for existence and migration for maintenance. The first reason mentions to the socio- economic distresses faced by the rural labours and the second reason mentions to the need for add on income in order to fill the gaps of seasonal employment. In the Indian history, migration of labour started during the period of British colonial rule (Gill: 1998; Mohapatra: 2005; Mandal: 2005; Gulati: 1979). It was aimed at to meet the necessities of capitalist development both in India and abroad. Gill (1998) also argues that it was structured in the rural areas in such a way that the women and children stayed in the villages while males migrated to the urban areas.

Kalahandi-Bolangir-Koraput (KBK) region of western Odisha are considered as the most backward regions of the state. The districts of Bolangir, Koraput, Kalahandi, and Nuapada etc. of Odisha are famous for seasonal migration. With the arrival of winter season people of western Odisha start their migration journey to outside of Odisha or to the urban areas within Odisha. It is believed that after the drought of 1960 there was such movement happened where people migrate

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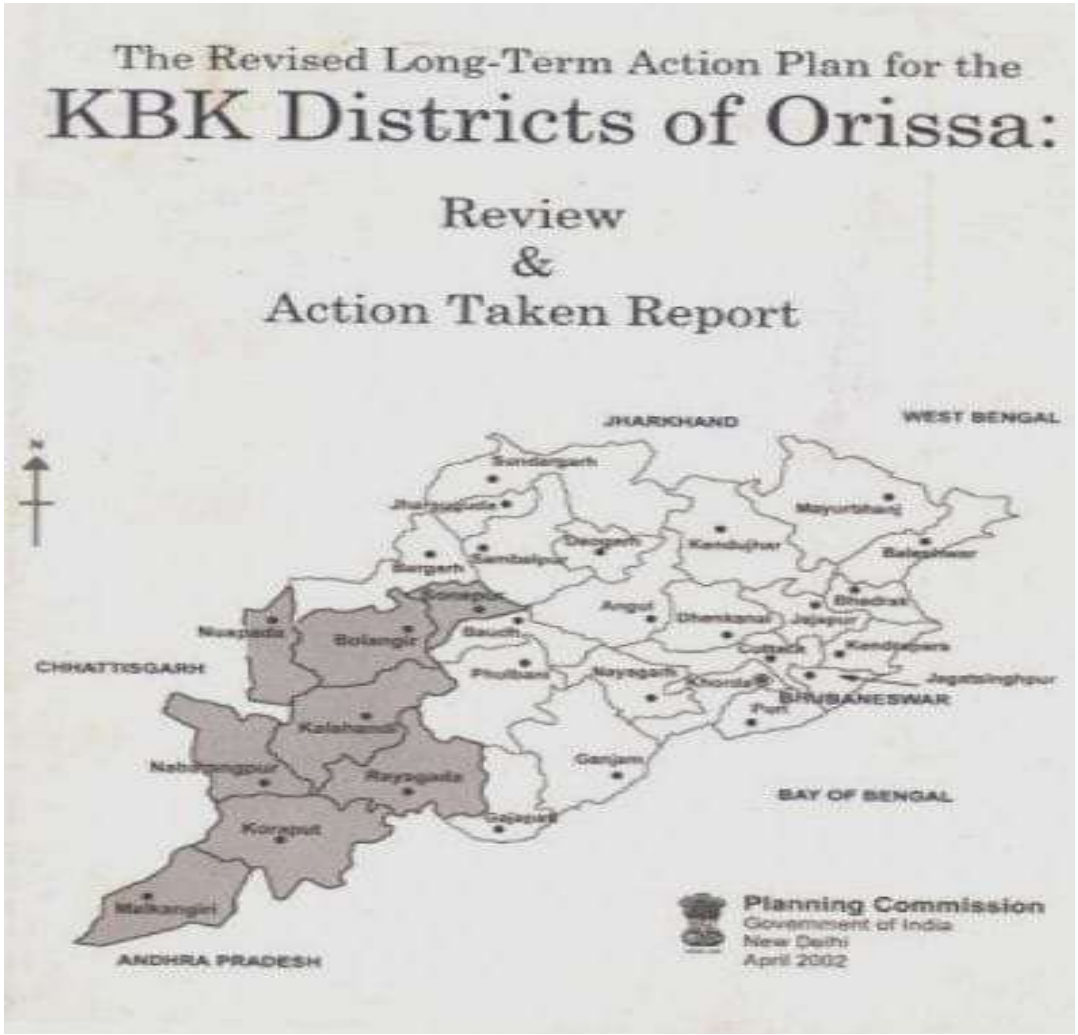
outside. It is a frequent part of life in every year from western Odisha. Comparison to other regions of Odisha, the western region is more backward in terms of socio-economic development. The people who migrates from this area are belongs to the most vulnerable group having small land or landless tribal and dalits.

Health Status in KBK Districts

Health status in KBK districts is very low as the area is neglected for years and remained isolated. A large number of populations in this region are from poor and socio-economically marginalized groups. These populations highly rely on agrarian work, daily wage activities and out-migration. The area is covered with 47,646 sq.km, which is located in the Western and Southern part of Odisha covered with part of Eastern Ghat and Deccan Plateau. However health situation in this region remain neglected and underdeveloped.

Odisha Health Sector Plan 2012, stated that "KBK+ districts: Analysis of the wealth index of the 11 KBK+ districts in the south of the State, recognized as the poorest and most vulnerable (with high levels of poverty, high proportion of scheduled tribe communities and high burdens of malaria and malnutrition) provides further evidence of the relative poverty of people in these districts. The percentage of households falling in the low wealth index is double that in other districts" (Odisha Health Sector Plan: 2012).



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KBK is officially declared a drought-prone districts. However it is an underexploited ecological base where average annual rainfall is 1443 mm. Poverty level in these districts are the highest in the country (61.01% as per the Union Planning Commission's estimates, 1999-2000) where one encounters frequent occurrence of starvation deaths, natural disasters like floods and droughts. As a consequence, people in these districts suffers from chronic problems of abject poverty and malnutrition, distress induced migration, food insecurity and even starvation deaths. Majority of households have no satisfactory access to institutional loan and borrowed from a variety of informal sources both from inside and outside the villages.

KBK region is primarily an agrarian economy where technological adoption is at a very low level. Due to lack of suitable irrigation facilities in many places, the success of harvest depends heavily on the monsoon arriving at the appropriate time and in adequate quantity. Perhaps, this remains as the main reason for the lack of application of new biochemical technology in these districts. As a consequence, the occurrence of low yields and crop failures has become a common phenomenon. The growth of non-farm employment is also at a low level in these districts. High level of illiteracy has aggravated the vulnerability of people. The deprivation and poverty on the whole have pushed the majority of people to a corner.

According to the National Family and Health Survey (NFHS-5), there is a clear picture on health status of KBK districts. The data shows way below performing of KBK district in compare to rest of the part of Odisha. See the following table (1.2) below.

Table (1.2) Health Status of Children in KBK districts

Indicator (Children)	Odisha average	KBK- districts
Stunting (Under-5)	31%	43-44%
Wasting (Under-5)	18%	25-28
Full Vaccination (12-23 months children)	90.07%	90-95%
Institutional Deliveries	97%	80-95%

Sources: NFHS-5

The main causes of health vulnerability in the KBK (Kalahandi-Balangir-Koraput) region are those mix of structural poverty, environmental exposure, weak health infrastructure and social exclusion. The region remain historically under-developed and marginalized because of it geographic location and composition of poor marginalized section of populations. Hilly mountainous area with dense forest and jungle remain key components.

It has been reported that migrants in the absence of work during drought period (the lean season) in the village is very high, they have no choice but to migrate even for earning subsistence wages. Further, they have to stay under unhygienic conditions near the field where bricks are made. There is no facility of proper drinking water and they sleep on the field. Many of them have been attacked by diseases during their stay. Many of them have returned home as sick persons (Mandal: 2005; Gulati 1979).

KBK districts which is one of the most backward region in the state recognizes the need of addressing health inequity existing in the state. Since the state has maximum percentage of socio-economically disadvantaged population, the disparities among the different sections of populations are quite prominent. In view of this, the Odisha Health Sector Plan (OHSP) aims to achieve equity in health outcomes and has a key focus on access and utilization of services by vulnerable and marginal groups including women, schedule caste (SC) and schedule tribe (ST) populations. It aims at delivering accountable and responsive health care to reduce maternal mortality; infant and child mortality; reduce the burden from infectious diseases; under-nutrition and nutrition-related diseases and disorders (Odisha Health Sector Plan: 2012).

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The health of people is determined by two key factors: Firstly, the conditions in which people live and secondly the health care facility that the people get. In the social environment where the people live-in, the following factors could be some of the key determinants of health e.g. housing, education, transportation, access to services, physical environment, socioeconomic status/position etc. Particularly in the context of Odisha, this is one such state in India which is stained with poor socio-economic status of the inhabitants. Lower income, poor housing facility, lack of education and discrimination are some of the factors that contribute to the poor living standard including poor health status of the people in the state.

Thus, health concern of labourers in KBK district is concerned, there is a large number of working class population those have been facing serious health issues through various health diseases. They do hard work in polluted environment without any health safety measure or health insurance plans. Poverty led distress of social life forced them to continue to work even they face health problems. People from poor marginalized section particularly Scheduled Tribes (STs), Scheduled Caste (SCs) and Other Backward Castes (OBCs) constitute large percentage in this working class population. These populations have been facing historical injustices and deprivation and hardship of life without access of resources and good health care services of life since long past. On the other hand their contribution is very significant in terms of national development. So, the state should create adequate number of health infrastructure and provide better health care facilities for these needy sections of population in our society (Field Work: 2025-26).

KBK (Kalahandi–Balangir–Koraput) districts have a long-standing socio-economic disadvantages that translate into significant health burdens. These districts have a relatively high infant mortality rate (45 per 1,000 live births as of 2012–13) and a maternal mortality rate of 198 per 100,000 live births for the same period, indicating fragile maternal child health services. Public health infrastructure is limited, with only about (NFHS: 2012).

Nutrition related problems are a major health consequence in KBK districts. District level nutrition profiles show high rates of under nutrition among children less than five years, including stunting, wasting, and anemia, often above the Odisha state average. A large share of women of reproductive age also suffer from anemia and low body mass index, which increases the risk of low-birth-weight babies, preterm delivery, and poor recovery after childbirth. These conditions contribute to the district's higher burden of preventable morbidity and mortality, especially among infants and young children (ibid).

Infectious diseases remain a key health consequence. Malaria, once very common in the KBK region, has declined sharply in KBK districts from 2011 to 2018, with low growth or even falling case numbers, suggesting some success of control programmes. However, diarrhea illnesses persist as a serious threat; outbreaks of diarrhea have led to deaths, including of adult women, especially in poorly served rural blocks, pointing to inadequate water sanitation and weak primary care response. Similar patterns of diarrhea and acute respiratory infections (ARI) above state averages are documented in district level nutrition and health profiles, highlighting gaps in hygiene, nutrition, and access to oral rehydration therapy and antibiotics (Government of Odisha: 2011).

KBK districts health consequences are shaped not only by poverty and geography but also by strained health system capacity. These districts have a relatively low density of hospital beds and variable access to secondary care, especially in remote blocks, which delays treatment for emergencies, pregnancy complications, and severe infections. A health vulnerability study of KBK districts found that Balangir is less vulnerable than Kalahandi and Koraput when combining exposure (malaria, rainfall shocks) and adaptive capacity indicators, yet it still faces recurrent climate linked disease outbreaks and shocks that strain households already living close to subsistence (Government of Odisha: 2011).

So, particularly in the context of working class population in KBK district, researcher interacted with these following respondents and asked some of these following questions to find the health related answers.

Respondent 1: replied

During construction work, heavy lifting, and heavy lifting, I often experience back pain, neck pain, and fatigue.

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The poor children are not able to eat properly and. They are dependent on their parents, relatives and simple means of livelihood. This leads to problems like weakness and anemia.

In the village areas, There is no clean houses. Due to this, people fall illness with many diseases like tuberculosis, malaria and other diseases. Cleanliness is not impossible, but due to uncleaned environment it is not possible to get rid of the disease.

In the village area, there are some hospitals in the area, but there are also problems such as lack of medicines and lack of doctors. And they said, good hospitals are very expensive, and far away which takes long journey (Field Work: 2025-26).

Respondent-2

Said: I get up at 6 am every day and go to work. I work at the building site, I work in the cement factory, and sometime I work in agricultural sector.

Question? What kind of health problems do you have?

Answer. My back hurts during the day. I also feel pain in my legs. I am tired from the heavy lifting work all day long. I also get tired of working. If I don't work, I don't get money, I get sick, I get sick and I don't get well.

Respondent-3

Question- What is your daily routine like?

Answer - I wake up at 5 am every day. After that, I do some housework and then go to work. We are working in building construction and we also are working in the field. I work all day long but my body gets very tired.

Question- What kind of health problems do you face?

Answer - I have to work hard all day long although my back hurts. I also feel pain in my legs. I also feel weakness and fatigue. But I don't get time to do my work. If I don't work for a day, I don't get enough money, although I get sick and fall sick but I continue to work.

Question- What are the sanitation and hygiene regulations in your village?

Answer- Some time we do not get clean water, when we drink unclean water, we face different kind of diseases.

Question-What is the government's policy on hospitals?

Answer - Even if there are government hospitals, all the facilities would not be available there. The distance from village to hospital is also long. If a person is unwell, he or she will have to go to the hospital or sit down or use other means to get treatment. But in the rural areas, everything is not going well, you can't get good education, you know. The government hospitals are not equipped with doctors and medicines. If you are sick, you can go to the big hospitals in the city or go to the hospital. But you have to spend a lot of money to go there, and it is very difficult for the poor to get treatment. The village is not a village anymore because of ongoing changes (Field work: 2025-26).

Despite working so hard, many problems are still being come in the lives of these people. They are not living on daily wage earners. Some people are not able to find a job. This is how they face a serious problem when their income is not regular.

The living conditions of these working class women are also very simple. Many of the houses are shacks and do not have the facilities like toilets, toilets and good health care. This has a huge impact on the health of the women. Especially the children and the elderly are facing many problems. They do not get a good living environment and there is less security and

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education in their places. This has a negative impact on the physical and mental health of the working class (Field Work: 2025-26).

So, these are common challenges which working class population are facing today. According to the primary survey (2025-26) there have been access to government hospital and health care centres by these working class population. But, the larger question is that they have been facing health problems because of problem in their working site. Working sites are basically polluted and environmentally unhealthy places where these working class populations forced to work without any better opportunity. Thus, health problem of working class population is a serious issue people of this region have been facing since a long past.

State's Policies and Social Development

After the independence, India has been taken some major steps to reduce poverty across the sections. From 1950s to 1990s, focus has been made to help poor section of population through various employment and food distribution schemes. However, poverty scenario in India is a very dynamic, multidimensional which involve socio-cultural and political relations. After the independence, the Government of India has intervened with various planned action to reduce the poverty. Various community development programmes have been implemented over the years since the first planning commission was set up in independent India under the leadership Prime Minister Jawaharlal Nehru.

Poverty alleviation has been implemented through the broader understanding of three dimensions of poverty, such as, lack of income/purchasing power, increasing price of food and inadequacy of social infrastructure. On the basis of these three-poverty alleviation programme also divided into three categories such as, employment programme, housing and others that include National Health Mission and Food Security Mission and National Social Assistance Programme (Thakur, Gautam and Gupta: 2021). Particularly in the poverty stricken region like KBK district "A Revised Long Term Action Plan (RLTAP) was prepared and submitted to the Government of India in 1998. This led to release Rs. 6, 251.06 crore funds for the period of 9 years from 1998-99 to 2006-07 under a specially dedicated plan to the KBK districts. Major source of funds included (i) normal flow of plan funds under Central Plan (CP) and Centrally Sponsored Plan (CDP) (ii) additional funds received from Central Government exclusively for programmes in KBK districts as agreed by Planning Commission, (iii) Central assistance under programmes of Government of India to be implemented in the KBK districts with some relaxation in norms such as accelerated irrigation benefit programme (AIBP) for earmarked irrigation projects. Table (1.3) shows project outlay for RLTAP for KBK districts from 1998-99 to 2006-07.

Table (1.3) Project Outlay for RLTAP for KBK District (1998-99 to 2006-07)

Sl.No.	Scheme	Projected Outlay (Rupees in Crore)			Grand Total (Rupees in Crore)
		Central Plan (CP)	Centrally Plan (CSP)	Sponsored Share	
1.	Agriculture	44.74	30.19	10.01	84.94
2.	Horticulture	66.17	6.35	1.62	74.24
3.	Watershed Development	601.90	194.96	81.42	878.28
4.	Afforestation	347.83	14.11	14.11	376.05
5.	Rural Employment	-	2,235.05	558.76	2,793.81
6.	Irrigation	812.11	-	-	812.11
7.	Health	150.95	-	-	150.95
8.	Emergency Feeding	88.50	-	-	88.50
9.	Drinking Water Supply	-	67.74	67.74	135.48
10.	Rural Connectivity	-	534.70	65.00	599.70
11.	Welfare of ST/SC	257.12	-	-	257.12
	Total	2,369.32	3,083.10	798.66	6,251.06

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There has been a continues engagement between center and state government at community level to address community level problems adequately. Phase wise implementation of welfare schemes were happened in a planned way. Under this the first phase of the proposed programme envisages a total outlay of Rs.828.10 crore from various sources including SCA under RLTAP and PMGSY grant. The first phase covered all weather connectivity to 607 unconnected habitations with population of 1,000 and 347 unconnected Gram Panchayats irrespective of their population status. Second phase covered with all-weather connectivity to all habitations with population less than 1,000 and up to 500 and restoration of badly damaged arterial roads. Third phase covered all weather connectivity to habitations with population between 250 and 500.

The Planning Commission of India have launched "Backward District Initiative" Programme under Rastriya Sam Vikas Yojana (RSVP) during 2003-04 to accelerate development of identified backward districts. The State Government has formed a Western Odisha Development Council (WODC) which focused on development of ten Western Odisha districts namely, Bargarh, Bolangir, Boudh, Deogarh, Jhasiguda, Kalahandi, Nuapada, Sambalpur, Sonepur and Sundargarh districts. The State Government has provided Rs.50.00 crore to WODC during 2003-04 under this development programmes. Along with that am mount of Rs.25.70 crore has been provided under the constitutional provision under article 275(1) of Indian Constitution under the Tribal Sub-Plan (TSP) Annual Plan 2004-05. And many other plans and scheme have been launched in later phase but the situation remained largely unchanged. Still people in this region rely on out migration for their income. They also travel long distance for their health care and so on (Government of Odisha: 2011).

However, due to economic problems, many children are forced to work from a young age. They either work as maids, agricultural labourers or in the construction industry. Some children are also forced to work as daily wage labourers. The economic condition of the parents is weak and the children are forced to work as maids. This is because the child does not have to go to school or work, and he or she does not have to study or live. This is because the economic problems of working class children are a major obstacle to their education. If the economic situations of the poor are better, then more children would go to school and their future would be brighter (Field Work: 2025-26).

The role of the working class in the development of a society and the economic and moral progress of the country is very important. The working class, through its own hard work and energy, makes various developmental works of the country possible. The contribution of the working class in the construction of houses and buildings, agricultural work, industrial work and other types of work is very high. But despite all this hard work, the working class feels the absence of security and instability in their lives. Thus, it is very necessary to have a system which will provides social security for the workers and the working class. Working class health problem in the KBK region is a major problem where a larger number of populations suffer due to various health diseases. Thus, state's policy should be designed in such a way which could take care of all these issues.

Conclusion

In Conclusion, we have to understand that health care is an essential service of any modern state for its citizens. In many advanced societies health care service is an important aspect of human life.In a healthy society, a good health care service takes care it's all human beings and keeps them healthy. In some societies, health care service also become an exclusive access of rich and elite bureaucratic sections. So, in this context this paper attempted to analysie the core issue of poor health care system in a country like India in a particular case of KBK districts in Odisha where a large number of poor section of populations unable to access better health care services.

Poverty is a main reason of poor health condition for the working class population. When we tress back the inequality and poverty scenario in India then there is large scale of population live Below Poverty Line (BPL) even today. There are 1,392,506, 368 population living in poverty today where 97,697,747 are living under extremely poverty. If we see age group then under 0-4 years are 11,216,926, under 5-9 years are 12,103,639, and under 10-14 years are 13,480,409 living under poverty. However there a simple logic that how can a person meet his/her nutritional needs when he/she lives in poverty. This is a basic obstacle of slow progress in Government Program like "Anemia Mukt Bharat". According to the

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National Family and Health Survey 2019-21, anemia among Children age 6-59 months is 67.1 percent in which rural area shares 68.3 percent and urban area share 64.2 percent.

Health problem in KBK region is concerned there is a close relation between poverty, unemployment and working class health problem. Economic conditions put them under vulnerable conditions. Working hard in unhealthy environment with meager of income and continuous poverty remain a key factor behind large scale of health problem among working class population. Although curative measures are available with health infrastructure, Doctors, nurses, staffs etc but income and economic conditions remain as key factor behind persistent poverty and poor health conditions.

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