

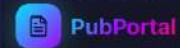
Sociology of Trust: Navigating Traditional Medicine and Government Healthcare in Tribal Communities

ABSTRACT

The Scheduled Tribes (ST), also known as tribal populations, still face serious health inequalities despite the visible improvement of several indicators. As an illustration, the National Family Health Survey 5 (2019-21) suggests that, relative to NFHS-3, institutional deliveries, and child immunisation rates among ST groups have significantly improved. However, the problem that is disproportionately high among these communities is malnutrition, anaemia, and maternal mortality (Ministry of Health and Family Welfare, 2021). To some degree, these inequities are structural in nature: the healthcare infrastructure in the districts where tribal populations are concentrated is still inadequate, the number of functioning sub-centres is low, and the number of medical workers is also lower than the national average (MoHFW, Rural Health Statistics, 2021). This paper explores the sociological foundation of trust in health-seeking behaviour among tribal communities with particular focus on distribution of trust in traditional healers and indigenous medical systems (folkloric and AYUSH CAM) as opposed to formal biomedical services offered by the state. The empirical evidence that was obtained with the help of the National Sample Survey Office 75th round of social consumption of health and the MOSPI survey of AYUSH demonstrate that in tribal regions consumers turn to local healers and AYUSH modalities more often, which is explained by the considerations of accessibility and is also preconditioned by the cultural meanings (MOSPI, 2020). According to the Report of the Expert Committee on Tribal Health (2018), it is common among tribal populations that the government health facilities are viewed as distant, culturally alien, and unreliable, whereas traditional practitioners continue to be trusted by the population in their daily life because of the essential part they play in tribal life.

KEYWORDS: *Tribal health, Scheduled Tribes (ST), medical pluralism, traditional medicine, AYUSH, healthcare access, trust, health-seeking behaviour, rural health infrastructure*

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Introduction

Trust can be described as the social lubricant of healthcare; it is what dictates whether or not individuals pursue care, accept diagnoses, follow through on treatment regimes, and whether they will pursue participate in public health programmes (Luhmann, 1979; Giddens, 1990). Patterns of trust and medical pluralism play a vital role in health equity, as well as in the national progress toward the Sustainable Development Goals, in tribal India, a demographically distinct and geographically heterogeneous group of about 104 million people in the 2011 Census (Registrar General of India, 2011). A multi-modal therapeutic repertoire that involves traditional healers, home remedies, AYUSH systems (Ayurveda, Yoga, Unani, Siddha, Homeopathy), and even formal government biomedical services is usually used by indigenous communities (MOSPI, NSS 75th Round, 2020; Ministry of AYUSH, 2021). The empirical data and policy reviews accentuate the fact that decisions are not solely determined by the availability of services but relational trust, cultural interpretations, and perceived risk-benefit considerations are also influential (Kleinman, 1980; Expert Committee on Tribal Health, 2018).

This paper synthesises government data, such as NFHS-5 (2019-21), Rural Health Statistics (2021) data and peer-reviewed sources in order to document tribal health facts, gaps in infrastructure, and lived experience of trust in an empirical mapping of the two. The discussion has shown that trust is a mediating variable between structural disadvantage and therapeutic choice that highlights its central role as a sociological issue in the promotion of tribal health equity (Citizen's Health, 2022; PIB, 2023).

Theoretically speaking, the given research relies on both national and international frameworks:

Social Capital Theory (Putnam, 2000; Coleman, 1988). The confidence in medical professionals and peer networks is one of the major components of the social capital. Intense bonding among tribal groups leads to sharing of information about traditional and mainstream healthcare services, whereas the social capital acts as a bridge that links the tribal people to government programmes and the AYUSH/biomedical services.

Health Belief Model (Rosenstock, 1974; Becker, 1974). This model explains the health-seeking behaviour using perceived susceptibility, severity, benefits and barriers. The perceived benefits of treatments and adherence of biomedical interventions over traditional remedies depend on such trust in different providers in tribal India.

The Behavioral Model of Health Services Use created by Andersen (Andersen, 1995). The model focuses on predisposing, enabling, and need variables in the service utilisation. In the case of tribal populations, predisposing factors are cultural beliefs, enabling factors are the distance to main health facilities or AYUSH healthcare providers, and need factors are the severity of illness or health burden in the family.

Tribal Health Equity Approach Nationally Relevant Framework (Ministry of Health & Family Welfare, India, 2018). This model acknowledges cultural competence, trust-building, and community involvement as the key to successful service delivery to tribal populations, which is consistent with the /National Rural Health Mission initiatives.

Health Landscape in India.

The health issues facing tribal populations in India are unique, and the survey conducted by the Ministry of Health & Family Welfare, NFHS 5 (2021) records a limited access to formal healthcare services, widespread malnutrition, and a high prevalence of communicable and non-communicable diseases. The National Health Policy of 2017 clearly identifies the tribal and socially vulnerable populations as having special health needs, mandating situation-specific interventions to the provisioning and delivery of care (MoHFW, 2017).

In spite of those challenges, a concerted effort has been witnessed to increase healthcare access to tribal communities. The (NHM) was initially called the National Rural Health Mission (NRHM), which aims to strengthen the rural health infrastructure through a three-level continuum of Sub-centres (SCs), Primary Health Centres (PHCs) and Community Health Centres (CHCs) (MoHFW, 2021). However, the number of facilities in tribal areas is not always up to standards. The Rural Health Statistics (RHS) is 2021-22 which indicates that the normative facility level of one Sub-Centre per every 5,000 citizens (one per 3,000 in tribal/ hilly areas) indicates that, despite the persistence of inequity in the access to health services, tribal districts have a clear deficit in the number of Sub-Centres, PHCs, and CHCs (MoHFW, RHS 2022).

Table 1: Health Indicators for Scheduled Tribes (ST) vs. Non-Scheduled Tribes (Non-ST) in India (NFHS-5, 2019-21)

Indicator	ST (%)	Non-ST (%)
Under-5 Mortality Rate (per 1,000 live births)	50	41
Stunting (Children under 5)	40+	35
Institutional Deliveries	78	89
Full Immunization (12-23 months)	71	77
Anemia Prevalence (Women 15-49)	59	53

Source: NFHS-5, 2021

Pluralism of Medicine among Tribal Communities.

Ethnographically, healthcare in tribal areas does not only exist within the framework of biomedical practice only. The indigenous populations regularly use the combination of traditional healers, home-made treatments, AYUSH, and the state-based medical care. This is a hybrid methodology, which is called medical pluralism, a reflection of a functional reaction to the unequal availability and access to care options (MOSPI, NSS 75th Round, 2020; Ministry of AYUSH, 2021). An example of rural Meghalaya, in which, similar to the majority of states in North-Eastern India, the population is predominantly tribal, demonstrated that despite the high level of public health awareness, a significant percentage of households still preferred non-biomedical modalities, which highlights the timeless nature of non-biomedical modalities in health-seeking behaviour (Bamon et al., 2018, MoHFW, 2021).

Healthcare Utilization and Trust.

Trust is a critical determinant of healthcare usage amongst tribal people. The levels of trust, which in turn determine the choice of health services, are the results of cultural beliefs, lingual issues, and past experiences with medical personnel (Kleinman, 1980; Luhmann, 1979). Expert Committee on Tribal Health, which is a collective of the Ministry of Health and Family Welfare and Ministry of Tribal Affairs has emphasized the need to develop culturally sensitive and community-based models of delivery that build trust and promote better health outcomes among tribal communities (MoHFW and MoTA, 2018).

Table 2: Healthcare Infrastructure in Tribal Areas (Rural Health Statistics, 2022–23)

Facility Type	Number in Tribal Areas	Coverage Norm (Tribal Areas)
Sub-Centres	28,660	1 SC per 3,000 population
Primary Health Centres	4,158	1 PHC per 20,000 population
Community Health Centres	1,035	1 CHC per 80,000 population

Source: PIB, 2024

Objectives

- Examine trends in healthcare use amongst populations of the tribes with a focus on the relationship between trust and medical pluralism.
- Discuss how traditional healers, AYUSH systems and biomedical services influence health-seeking behaviour of tribal communities.
- Estimate the effectiveness of the government programs in increasing the access to healthcare and fostering confidence among tribal communities.

Literature Review: Trust, Medical pluralism and tribal Health Policy.

1. Theoretical Foundations of Trust Sociology.

The concept of trust is the cornerstone of analyzing the health systems and it is especially common when dealing with tribal contexts where the relationships often overlap both traditional and biomedical realms.

Niklas Luhmann theorizes trust as the mechanism that reduces the complexity on the system level, enabling people to trust institutions despite the uncertainty.

Anthony Giddens emphasizes trust as the key of the contemporary world, where the subjects are forced to trust abstract systems and specialists.

Meyer et al. (2008) build on these theories by focusing on the influence of socio-economic status and class on trust.

Indian sociologists like R.K. Mutatkar and V.K. Srivastava have emphasized the need to know the tribal institutions and practices to develop trust in the health systems. Their academics also suggest that the health interventions should be resonant with the social organization of the tribes in order to be effective.

In tribal societies, trust refers to the inter-personality relations, institutional reliability and compliance with cultural standards; policy prescriptions should thus aim at developing trust by respecting and incorporating indigenous knowledge.

2. Medical Anthropology and Explanatory Models.

The study of how people attribute and perceive illness is essential in designing the effective health interventions.

Arthur Kleinman came up with the concept of explanatory models, which states that illness narratives of patients influence health-seeking behaviour.

Kathakali - The health practices and belief systems of tribal communities of Kerala were pioneered by Indian scholars like L.K. Ananthkrishna Iyer, K. Jose Boban and others. They provide the groundwork in understanding the medical systems of the Southern Indians via their work.

Sharad Dhar Sharma is also the head of a multidisciplinary project sponsored by the Indian Council of Social Science Research (ICSSR), which records traditional medicinal practices of the tribes of Northeast India.

The project aims at studying the indigenous knowledge and social expressions of culture in tribal communities as reported by the Times of India.

3. The Pluralism of Health and Medical Systems.

The concurrent presence of various medical paradigms such as biomedicine, traditional medicine and complementary therapies is an international trend.

The promotes the evidence-based use of Traditional and Complementary Medicine (T&CM) in the integration of health systems where necessary, a strategy that would optimize patient safety and health results by recognizing different medical practices.

Subedi (2024) advocates demographic and democratic medical pluralism, which states that the policies should take into account and unify various medical traditions. His studies play a significant role in explaining the policy impacts of pluralistic medicine.

Indian contributions Although some contributions have been on Indian integration of traditional and modern medical practices, such as by A.K. Kalla and P.C. Joshi in *Tribal Health and Medicines, the pluralistic approach is important in the tribal territories.

The pluralist lens perspective in tribal health policy exhibits opportunities of respectful interaction instead of unilateral substitution of traditional practices. A combination of traditional healing systems and biomedical interventions has the potential to enhance the quality of health, increase patient satisfaction, and preserve cultural heritage.

Implications of policy on Tribal Health.

The incorporation of these theoretical lenses into the tribal family health policy must be well informed by the complexity of the dimensions of trust and cultural validity.

Establishing Trust: It is imperative to realise that trust is a woven web of interpersonal, institutional and relational strands. The principles of transparency, cultural humility, and long-term community involvement should be instilled into the policy frameworks with a view to building trust.

Sharing Cultural Beliefs: Integrating explanatory models of patients into the clinical practice will ensure that cultural assumptions are respected hence improving treatment compliance and attendance.

Fostering Medical Pluralism: The policies should support the harmonistry of traditional and complementary modalities and evidence-based biomedicine through safety, efficacy, and respect to native epistemology.

Community Involvement: Co-designing the health policy with tribal constituencies would be to make sure that interventions are in line with local contexts and would gain wider legitimacy.

Methodology

The research design of this inquiry is descriptive and secondary data researches; and thus, the researchers triangulated government repositories, peer-reviewed literature, and international health reports. No primary field survey was done. The sociological and medical anthropological theories of trust (Luhmann, 1995; Giddens, 1990; Kleinman, 1980) and the WHO medical pluralism framework (WHO, 2014 2023) are the analytical lens. Subsequently, the text challenges patterns of healthcare consumption, trust, and pluralistic practices among tribal people.

The discussion is based on publicly available governmental and international resources:

Census of India, 2011: provides demographic and socioeconomic statistics related to tribal communities, including population levels, literacy, and gender distributions.

(NHM) and Tribal Health Reports: Provides information about the number of Sub -Centres, PHCs and CHCs in tribal districts and operational condition.

Ministry of health and family welfare (MoHFW), 2021: Expert committee on tribal health: It includes information about culturally appropriate service delivery and interventions that build trust.

WHO Traditional Medicine Strategy, 2014-2023: provides international recommendations on how traditional and complementary medicine can be incorporated into the national health system.

Peer-Reviewed Literature: This consists of scholarly articles on the topic of trust, medical pluralism, and tribal patterns of utilisation (e.g., Kleinman, 1980; Sahoo et al., 2020; Garikipati, 2013).

Analytical Approach

Mapping Healthcare Infrastructure: Determines Sub-Centre, PHCs and CHCs coverage with respect to population standards to identify access gaps.

Combination of Trust Indicators: Uses qualitative information of literature and official documents to examine drivers of interpersonal and institutional trust, which include the competence of providers, cultural competence, and previous experiences.

Medical Pluralism Evaluation: Studies the presence of traditional healers, AYUSH services and biomedical centres and is an appraisal of their usage patterns.

Theoretical Interpretation:** The results are interpreted in terms of the social capital theory, the Health Belief Model, Andersen Behavioural Model and Kleinmans explanatory model, and thus connects the behaviours of trust, culture and utilisation.

Data Findings

Demographic Scale and Heterogeneity: Demographic Scale and Heterogeneity: The tribal population in India is highly heterogeneous.

In 2011, the Scheduled Tribe (ST) populations were enumerated in the Census 2011 at an approximate of 10.4 million and constitute about 8.6 per cent of the population in India. These groups are spread out in many geographies across disproportionate concentration, in rural and forested districts, which is a critical factor in determining access as well as trust dynamics.

Health Status: Stable Gaps with New Improvements.

Comparative NFHS-based analyses reveal that there were small improvements between NFHS-4 (2016) and NFHS-5 (2019-21) on a number of indicators. However, core outcomes, including under-five mortality of under 50 per 1,000 live births compared with 41 amongst non-STs, and more than 40 per cent of ST children under five being stunted in 2019-21, continue to favour non-STs. At the same time, full childhood vaccination and skilled birth attendance coverage among STs also advanced, which is indicative of both positive and negative dynamic trends and structural stagnation.

Healthcare Infrastructure and Norms in Tribal Areas.

The severe conditions in tribal, hilly, and difficult areas are recognized by government norms. As an example, the NHM standard is a sub-centre per 3,000 population (compared to 5,000 in general areas), and PHC per 20,000 (compared to 30,000 in other areas). In spite of normative targets and absolute expansions of 31 March 2023, there were approximately 169,615 Sub-Centres, 31,882 PHCs and 6,359 CHCs nationwide, distributional deficits remain common in most of the tribal districts because of terrain, staffing shortages, and logistical constraints. Such a lopsided allocation weakens availability and, therefore, determines pragmatic trust in emergencies can people feel secure of good biomedical attention?

Awareness and Use of AYUSH and Folk Medicine.

Government surveys have recently found a high level of awareness of AYUSH systems and medicinal plants with about 79% of rural households reporting to know about medicinal plants with similar numbers in the urban areas. Self-reported AYUSH utilisation is high; in fact, some surveys show that almost half of the respondents had used AYUSH services within the past year. Previous national surveys (NSS/NHP, 2014) have reported a lower outpatient AYUSH use (~6.93%), but more recent rounds are reporting increased awareness and utilisation especially in areas where AYUSH services are locally accessible or culturally oriented.

These empirical data suggest that there cannot be an urgency to a pluralistic, culturally sensitive and trust-building approach to tribal health policy, so that the infrastructural expansion, traditional practices, and biomedical services are aligned to work within a framework that honours indigenous knowledge and focuses on proven health outcomes.

Why tribal communities trust traditional healers (empirical mechanisms)?

In ethnographic and community-based literature, there are multiple overlapping causes of why the tribal populations still turn to traditional medicine and healers-causes which cannot be decreased to the inexistence of clinics.

Cultural meaning and explanatory models.

The traditional healers work under the local explanatory illness models that resonate with the tribal cosmologies. Disease can be viewed as relational, spiritual or ecological; a healer offers culturally intelligible diagnosis and rituals which the biomedical staff fail to offer. The framework offered by Kleinman can be used to explain the reasons why such explanatory concordance promotes interpersonal trust and perceived effectiveness.

Immediacy and accessibility.

Traditional healers are incorporated into the community, usually cheap, or in exchange, and offer home-based care. The pragmatic calculus would prefer local healers in remote tribal geographies of PHCs where those are remote, irregular, understaffed or spread unevenly. The number of government infrastructure in such terrains does not necessarily mean access to the functions.

Perceived effectiveness, past experience and social evidence.

Societies also have communal memory concerning what remedies have succeeded in previous generations. Social proof is made in word-of-mouth, observable healing, and family lineage of healing. Biomedical services could be mistrusted in case of poor outcomes, or poor explanation of side-effects. There are multiple qualitative studies on various tribal populations that document that in case of poor biomedical effects or poor communication, traditional medicine was more desirable.

Expense, prestige, and organisational behaviour.

Direct expenses, informal payments and perceived disrespect in the public facilities decrease institutional trust. A nominal free care situation does not increase uptake, as ancillary costs (travel, unavailable medications at the facility) and hostile attitudes decrease uptake. The traditional healers can also be more dignified and culturally respectful.

Table 3: Awareness and Utilization of AYUSH in Rural India (Survey on AYUSH, 2022–23)

Indicator	Rural (%)
Awareness of AYUSH	95
Awareness of Medicinal Plants/Home Remedies	79
Awareness of Folk Medicine/Local Health Traditions	24
Utilization of AYUSH for Treatment/Prevention	46

Source: PIB, 2024

Why tribal communities utilise services of the government (and when trust is lost)

There is no lack of trust in government healthcare. The analyses conducted by NFHS demonstrate an increase in institutional delivery and vaccination rates among STs between 2016 and 2021, which implies that instrumental trust may be established by government programmes and demand-side interventions (e.g., Janani Suraksha Yojana/conditional cash transfer, ASHA outreach). Key motivators to consumption of government services are:

- Perceived clinical need (e.g., problematic delivery or serious sickness).
- Good previous experiences (supportive personnel, effective care).
- Incentives and outreach (cash transfer, door-to-door, free medicine).
- Integration and referral: In which the traditional healers are recognized and incorporated into referral networks.

There are a number of friction points that destabilise trust:

- Diagnoses with no culturally intelligible explanations upon biomedical encounters are a source of suspicion, as they deny the significance of culture.
- Poor quality and discontinuity include: discontinuity in staffing, drug shortages, and workers absenteeism decrease the reliability of institutions.
- Absence of respectful interaction with traditional knowledge, suppression or rejection of indigenous knowledge on top of the hierarchy leads to resentment and opposition.
- Danger of toxic practices- some of the traditional practices can prove ineffective or dangerous and lack of surveillance and documentation which implies that the communities engage in them without protective instructions. This has become a threat to the general health of the population that must be mitigated culturally.

An informed sociological response policy has to respond to both the structural limitation and the meaning-making:

Enhance effective access in tribal regions.

Normative infrastructure and staffing (sub-centres, PHCs) targets in tribal/difficult areas would need to be expedited with incentives on rural placements. Norms in tribal areas have already been differentiated by the government; it is essential to operationalize them (logistics, transport, telemedicine, community health workers) (NHM, MOHFW).

Integrating in a respectful way and two-way referral systems.

Recording ethnomedicinal knowledge Local trust can be preserved by recording ethnomedicinal knowledge, training biomedical staff in cultural competence and creating linkages (traditional healer – PHC – higher centre) to direct emergencies to biomedical services. This is the

recommendation of the Expert Committee on Tribal Health and WHO strategy as well as respectful engagement and not suppression (NHM, MOHFW).

Formal acknowledgment, legislation and networks of AYUSH and folk practitioners.

In case there is evidence of safety/efficacy, quality standards and pharmacovigilance may be combined with AYUSH and folk medicine. The AYUSH survey conducted by MOSPI shows a high level of awareness, and policies should not miss on the opportunity by enhancing better quality, training, and monitoring to mitigate the harm.

Community co-production of services and culturally sensitive communication

The most important subjects of programme design and communication strategies should be community health committees, tribal elders, and ASHAs/Accredited Social Health Activists. Co-created health messages, open grievance redress and demonstration projects with respectful and effective care can help to build trust.

Research, documentation and capacity building.

The systematic record of tribal ethnomedicine, the safety research, and the research of participatory implementation will develop the evidence and enable the selective inclusion of the helpful practices in the context of the public health. The WHO approach is an explicit advocacy of research and regulation as the two support of safety integration.

Limitations

In this paper, secondary information has been synthesised; no primary fieldwork is presented. The government data (NFHS, MOSPI/NSS, RHS) has strong national coverage, but it does not capture within-group heterogeneity: tribal communities are not homogeneous: Northeast system performs worse than central India, and Particularly Vulnerable Tribal Groups (PVTGs) tend to perform worse. The qualitative literature is increasing unevenly across geographies; micro-ethnography is required so that micro-policy can be informed. Lastly, a number of government press summaries and survey fact sheets simplify complicated measures (e.g., household awareness versus individual utilisation); primary datasets should be consulted in order to get exact modelling.

Conclusion

The source of trust in tribal healthcare is multidimensional: cultural concordance, accessibility, perceived competence, and institutional behaviour are the sources of trust. Government biomedical services have achieved quantifiable gains (an increase in institutional deliveries and vaccination coverage among STs) however, due to the inherent gaps in its results and infrastructure and the cultural appeal of traditional healers, the policies cannot replace traditional healers but must bridge them. An integrated approach of both fortifying the existing health infrastructure and standards and humbly incorporating and controlling traditional healers and knowledge is the most viable way to both enhance well-being results and establish sustainable trust. The figures reflect not only something to be concerned about (high under-five mortality and child undernutrition among STs) but also something to be optimistic about (service uptake improvements). The policy should be local, participatory and evidence based.

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