International Journal of Community Medicine and Public Health
Setua M et al. Int J Community Med Public Health. 2025 Apr;12(4):1916-1924
http://www.ijcmph.com
pISSN 2394-6032 | eISSN 2394-6040

DOI: https://dx.doi.org/10.18203/2394-6040.ijcmph20250947

Review Article

Tracing tribal development in independent India: analyzing health challenges through five-year plans

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Received: 29 November 2024
Revised: 09 March 2025
Accepted: 11 March 2025

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ABSTRACT

This study examines the efforts made by the Indian government to improve the health and socio-economic conditions of tribal communities through five-year plans, focusing on the challenges and gaps that persist. The subject is India's tribal population, historically marginalized and vulnerable, and the evolving strategies employed to enhance their welfare. The research employs a qualitative approach, analyzing secondary data from government reports, Five-year plan documents, and scholarly literature. Primary data, including expert interviews and field surveys in tribal areas, complement this analysis. A thematic framework evaluates the historical evolution of health interventions, policy impacts, and implementation challenges across various plans. Findings reveal that while substantial progress has been made, tribal communities continue to face significant barriers to health and well-being. Key achievements include disease eradication initiatives, improved health infrastructure, and nutrition programs under integrated tribal development strategies. However, issues such as geographical isolation, inadequate infrastructure, socio-cultural barriers, and limited health literacy persist. Constitutional safeguards and welfare schemes have often fallen short due to ineffective implementation and resource gaps. Seventy-eight years' post-independence, the health disparities among tribal populations remain pronounced. Future development strategies must prioritize inclusive, culturally sensitive policies, strengthen health infrastructure, and actively involve tribal communities in program design. Bridging policy and implementation gaps is essential for achieving equitable development and sustainable health improvements for India's tribal populations.

Keywords: India, Independence, Five-year plans, Tribal development, Health status, Marginalized communities, Policy evolution

INTRODUCTION

After India gained independence in 1947, the country faced immense challenges in organizing a new nation and addressing the needs of its diverse population. Among the most marginalized groups were the tribal communities, who had suffered from years of colonial neglect and exploitation.[1] The Indian government, understanding the importance of equitable development, launched the five-year plans aimed at promoting national economic growth, improving education, enhancing healthcare, and facilitating overall social development.[2]

Special attention was given to the tribal population, which, despite its integral role in the country's socio-cultural fabric, had faced significant disadvantages due to the colonial legacy.[3] Tribes across the country remained largely marginalized, lacking access to basic services such as healthcare, education, and employment.[4] Over the years, successive five-year plans have made provisions for tribal welfare, with varying strategies and outcomes. From focusing on economic development to addressing health issues, the plans have evolved to better understand the unique needs of the tribal population.[5]

According to the census of India 2011, the scheduled tribes (ST) population in India numbers 104 million, comprising 8.6% of the country's total population. These communities are spread across 705 distinct tribes, with nearly 90% residing in rural areas that are often geographically isolated and lack adequate access to basic healthcare and services.[6] Recognizing the unique vulnerabilities of tribal populations, the Indian Constitution grants them special protections under Schedules V and VI, which focus on safeguarding their rights, land, and cultural identity while promoting their social and economic development.[7]

Despite these constitutional provisions and decades of planning, tribal communities in India continue to face significant challenges.[8] Poor health outcomes, inadequate infrastructure, economic hardships, and environmental degradation remain persistent issues.[9] Contributing factors include isolation, difficult terrain, ecological vulnerabilities, poverty, illiteracy, and a long history of social and economic marginalization.[10] The Indian Government has implemented numerous schemes and policies aimed at tribal welfare since independence, informed by a range of perspectives and recommendations from various committees and social scientists.[11]

The discourse on tribal development and integration has been shaped by three primary schools of thought. The Elwin school advocated for isolating and protecting tribal communities to preserve their unique identity.[12] In contrast, Ghurye's perspective emphasized total assimilation into the national mainstream.[13] A middle-ground approach emerged, advocating for gradual integration while safeguarding tribal cultural heritage. This balanced view, supported by leaders like Jawaharlal Nehru, called for promoting development while protecting tribal areas from exploitation.[14] Nehru emphasized a careful approach that respected tribal customs and traditions, suggesting that development efforts should be led by tribal communities themselves rather than imposed by external forces.

LITERATURE REVIEW

The development and integration of India's tribal populations have been a focus of scholarly research and policy analysis since the country's independence in 1947. Several studies have examined the socio-economic and health conditions of tribal communities and the effectiveness of various governmental initiatives aimed at their upliftment.[1] This literature review highlights key findings from existing research, providing a foundation for understanding the successes and limitations of development policies targeted at these marginalized groups.[3]

Research highlights that the marginalization of India's tribal communities stems from a colonial legacy that disrupted their traditional rights and societal structures through land alienation and resource exploitation.[5] Scholars like Bipan Chandra and Ramachandra Guha note that colonial policies of isolation left lasting effects, which post-independence policies have struggled to fully address.[4] India's planned economic model initially focused on rural development, and targeted tribal welfare measures came later but faced implementation challenges, as discussed by Nirmal Sengupta and K. S. Singh.[9]

The five-year plans have been central to this process. According to Bipan Chandra's India since independence, 2008, the first five-year plans focused on modernizing the economy and included provisions for tribal welfare, yet the results were uneven. The tribal sub-plan initiative, introduced in the fifth five-year plan, was a significant policy shift aimed at addressing the specific needs of tribal populations, but studies such as those by Xaxa, 1999 show that issues such as inadequate health infrastructure, cultural insensitivity, and bureaucratic inefficiency have continued to impede progress.

Additionally, Ramachandra Guha in This Fissured Land, 1992 discusses the tensions between conservation and development, particularly in relation to forest policies, which are integral to tribal livelihoods. He argues that while the British colonial policies were exploitative, post-independence policies did not always effectively balance tribal rights with national interests, especially regarding forest use and land alienation.

The evolving strategies for tribal integration, influenced by various schools of thought, such as the Elwin School (which emphasized isolation) and the Ghurye School (which favored assimilation), have been debated in several works. Sengupta, 1987 critiques these early policies and emphasizes the need for an approach that integrates tribal development while preserving their cultural uniqueness.[5]

Furthermore, Virginius Xaxa, 1999 offers a critical view on the implementation of constitutional safeguards and argues that while legal frameworks for tribal protection exist, the gap in actual implementation continues to hinder their socio-economic progress.[4] The need for greater attention to the "scheduled areas" under the Indian constitution, particularly in terms of land rights and health access, is also highlighted in the reports of the tribal welfare committees.

Further studies by Setua and Islam, 2021 highlight the socio-economic transformations among the Lodha tribes due to globalization.[15] Setua, 2019 explores how geographical factors influence the health and hygiene of Jangalmahal's tribal communities, emphasizing the interplay between environment and well-being.[16] Additionally, Setua and Islam, 2024 discuss contemporary challenges in tribal health management, underlining the necessity for holistic and culturally sensitive healthcare approaches.[17]

Despite progress, tribes remain marginalized, facing industrial displacement, livelihood loss, and poorly executed welfare schemes.[18] Studies, including those by Amartya Sen, emphasize the need for an inclusive, sustainable development approach that addresses structural inequalities.[11]

The literature underscores both the progress made and the significant challenges that continue to affect tribal populations in India. While the five-year plans have brought about some improvements, the complex interplay of socio-economic, geographical, and political factors has meant that tribal communities remain marginalized. Despite the constitutional protections, the gap between policy and implementation, particularly in the areas of healthcare, education, and economic opportunities, remains wide. In conclusion, while tribal welfare policies in India have evolved significantly over the past 78 years, there remains much to be done to address the socio-economic and health disparities faced by these communities. Future development strategies must be more inclusive, culturally sensitive, and better implemented to ensure that tribal populations can fully benefit from India's growth and progress.

The present study showed analysis of the evolution of India's five-year plans in addressing health needs of tribal populations and to assess the impact of different five-year plans initiatives on tribal health.

METHODOLOGY USED

This study adopts a retrospective, qualitative research methodology to analyze the efforts and outcomes of the five-year plans in improving the health and well-being of India's tribal populations.[8] The research aims to evaluate the development initiatives, explore the impact of these initiatives on tribal health, and assess the socio-economic, geographical, and infrastructural challenges that continue to affect tribal communities.[19]

Research design

The study uses a descriptive and analytical approach, focusing on both historical and contemporary developments within the five-year plans as they relate to tribal health. The analysis is structured to understand how various policies, health interventions, and welfare measures evolved over time and their success or limitations in improving tribal health.

Secondary data

Government documents and reports: Key documents such as the official five-year plan reports, reports from the ministry of tribal affairs, and other related government publications will be analyzed to understand policy changes, budget allocations, and the implementation of health programs for tribal communities.

Published literature: The study will review academic research, books, and articles from scholars such as Bipan Chandra, Virginius Xaxa, and other experts on tribal development. Previous studies on tribal health, infrastructure, and welfare programs will help frame the study's context.

Policy analysis: A detailed examination of health policies, particularly the integrated tribal development projects (ITDP), national malaria eradication program (NMEP), and national family welfare program, will be included.

Primary data

Interviews with experts: Qualitative interviews with policymakers, health experts, and administrators who were directly involved in the implementation of tribal health and welfare initiatives.

Focus groups: Discussions with tribal leaders, health workers, and community members to gather qualitative data on the current health situation and perceptions of government programs.

Sampling

The study has focused on tribal areas from different regions in India, especially those that have seen significant intervention under the five-year plans. Purposive sampling has been used to identify areas where health initiatives such as mobile dispensaries, community health centres, and health education programs were introduced. These regions haveprovided diverse perspectives on the implementation and impact of the health programs.

Data analysis

Content and thematic analysis: The qualitative data gathered from government reports, interviews, and field visits have been analyzed using content analysis to identify recurring themes related to tribal health issues, program success, and implementation challenges.

Comparative analysis: A comparative approachhas been used to analyze the differences in health outcomes between different five-year plans. This has involve comparing changes in health indicators such as maternal and infant mortality rates (IMRs), disease eradication (e.g., smallpox, malaria), and improvements in sanitation and nutrition.

HEALTH INFRASTRUCTURE EXPANSION

Over various five-year plans, health infrastructure for tribal communities, such as sub-centers, primary health centers (PHCs), and community health centers (CHCs), has increased.[20] Notable achievements include:

First five-year plan (1951-1956)

The first five-year plan emphasized the health and well-being of all Indians, including tribal communities. Special attention was given to addressing the health challenges faced by tribals.

Health and hygiene in tribal areas were key concerns during this period. The lack of healthcare services in rural and remote regions, coupled with difficult communication and scattered populations, made medical assistance scarce. Common diseases affecting tribal communities included yaws, malaria, scabies, smallpox, venereal diseases, leprosy, trachoma, tuberculosis, glaucoma, and elephantiasis.[21] Additionally, malnutrition, poor sanitation, exposure to harsh climates, contaminated water, and certain social customs contributed to the high prevalence of diseases.

It was observed that many tribal communities attributed illnesses to supernatural causes and spirit possession. To address these challenges, the Plan proposed health education initiatives supported by mobile dispensaries. A gradual introduction of balanced medical services and scientific approaches was also recommended to improve healthcare delivery.

The plan further suggested conducting continuous health surveys in identified tribal areas. These surveys would cover aspects such as diet, health practices and beliefs, the causes and prevalence of diseases, folk medicine, and traditional healing methods. If any scientific or medicinal value was found in tribal healing practices, the Government pledged to recognize and incorporate them into healthcare strategies.

Second five-year plan (1956-1961)

The second five-year plan introduced special measures to improve the well-being of tribal communities. Although tribals lived close to nature, their overall health and physical condition remained poor. They suffered from various diseases, including smallpox, tuberculosis, malaria, and eye and skin infections. The high prevalence of these illnesses was primarily due to inadequate access to safe drinking water, poor nutrition, and insufficient protection against extreme climatic conditions.

By the end of the first five-year plan, 3,144 dispensaries and mobile health units had been established in tribal areas. Additionally, large-scale efforts were undertaken to construct drinking water wells in various locations. The central and state governments collaborated to conduct health surveys across multiple states to assess disease prevalence and study traditional treatment methods. These surveys indicated that mobile medical units were particularly effective in serving tribal populations.

Under the second five-year plan, the government aimed to establish an additional 600 dispensaries and mobile health units, along with the construction of 15,000 drinking water wells in tribal regions. Moreover, specialized training programs were introduced for tribal nurses and midwives to enhance healthcare delivery.

The budget allocation for tribal welfare under this plan increased significantly to ₹47 crores, compared to ₹25 crores in the first five-year plan. The funds were distributed across various sectors as follows:

Table 1: Tribal welfare program.

Sectors	Allocation (in crore)
Communications	11
Development of the tribal economy	12
Education and culture	8
Public health, medical, and water supply	8
Housing and rehabilitation	5
Others	3
Total	47

This plan marked a significant step toward improving healthcare, infrastructure, and overall welfare in tribal areas.

Third five-year plan (1961-1966)

The third five-year plan introduced specific programs aimed at enhancing public health and healthcare infrastructure. These initiatives focused on improving environmental sanitation, controlling epidemic diseases, expanding rural and urban water supply programs, and strengthening institutional health facilities. Additionally, significant emphasis was placed on training medical personnel, promoting health education, improving nutrition, and advancing maternal and child welfare services.

The malaria prevention measures implemented during the second five-year plan had led to a noticeable decline in the disease's incidence. Building on this progress, the third five-year plan aimed to eradicate malaria from the country entirely. Efforts were also intensified to combat other diseases such as tuberculosis, leprosy, filariasis, and venereal diseases.

As a result of these efforts, there was a substantial increase in the number of dispensaries and hospitals. The Plan also introduced a Tribal Health Scheme, focusing on providing safe drinking water in tribal areas. Additionally, the government allocated funds to improve housing conditions for tribal communities and established a dedicated department to oversee these initiatives. Healthcare infrastructure in tribal regions was further enhanced through improvements in dispensaries, mother and child healthcare centers, and mobile health units.

Fourth five-year plan (1969-1974)

The fourth five-year plan introduced various health programs aimed at eradicating and controlling infectious diseases, particularly in rural and remote areas. A key initiative was the establishment of PHCs in each development block to provide both preventive and curative healthcare services. Additionally, paramedical and medical personnel training programs were expanded to strengthen the healthcare workforce. These initiatives were guided by the 1961 health survey and the planning committee's recommendations.

During this period, efforts were made to reinforce PHCs and establish rural organizations to manage projects aimed at epidemic prevention and family planning. The fight against infectious diseases intensified, with major national health programs being extended: The NMEP, initially scheduled for completion in 1968, was extended to 1975. The national smallpox eradication project was launched in 1962 as a three-year initiative, after which smallpox cases were expected to decline significantly. It was anticipated that smallpox control would eventually become part of routine healthcare services. Chemotherapy gained national importance under the Madras project, demonstrating its effectiveness in treating specific diseases.

The national leprosy control project also expanded significantly before the fourth five-year plan, with 1,136 surveys and 182 control units established for patient treatment and examination. Under this Plan, leprosy control efforts targeted both early detection and drug treatment, as well as segregation measures for highly infectious cases.

To prevent waterborne diseases like cholera, the plan also prioritized safe drinking water initiatives and the proper disposal of sewage. Furthermore, a new direction was set for medical research, with numerous medical colleges launching studies in microbiology, immunology, and animal diseases.

India's growing population during this period placed a strong emphasis on family planning programs. Additionally, the leprosy mission control project played a crucial role in tribal areas, significantly improving health awareness and access to healthcare for tribal communities.

Fifth five-year plan (1974-1979)

The health initiatives introduced in the fourth five-year plan were continued and expanded in the fifth five-year plan. The government increased funding for centrally sponsored programs, particularly the NMEP, to strengthen disease control efforts. Recognizing the need for enhanced disease prevention, additional provisions were made to improve the effectiveness of the national leprosy control program.

A new national initiative was launched to prevent vision loss and blindness, reflecting a growing focus on public health. Additionally, a pilot research project was introduced to develop a strategy for filaria control in rural areas, aiming to address endemic parasitic infections. By 1977-79, several laboratories were established to test food and drugs, ensuring better quality control in public health. Central support was also provided to existing food and drug laboratories in various states.

The family planning program was a key priority of the Plan, emphasizing population control and reproductive health. To improve accessibility, 288 new rural family welfare planning centers were established in different development blocks. Special focus was placed on research for new family planning methods, integrating maternal and child healthcare services into the broader health strategy.

In addition to general health programs, the plan introduced the integrated tribal development project, which combined health and welfare services for tribal communities. This initiative aimed to improve healthcare accessibility for marginalized populations while addressing broader socio-economic challenges.

Overall, the fifth five-year plan reinforced a comprehensive and research-driven approach to healthcare, expanding disease control programs, family welfare initiatives, and healthcare facilities to promote better public health outcomes.

Sixth five-year plan (1980-1985)

Over the past three decades, sustained efforts to improve healthcare services resulted in significant advancements in public health. A major milestone was India's declaration as a smallpox-free nation in April 1977. The NMEP effectively reduced casualties and deaths, while national programs for tuberculosis, leprosy, filaria, and blindness contributed to lowering mortality rates.

The government also expanded immunization programs, including the widespread tetanus vaccination drive for newborns and mothers, alongside initiatives emphasizing the role of vitamins in overall health.

A key focus of the plan was rural health development, aligning with India's adoption of the "health for All by 2000 A.D." goal from the Alma Ata declaration (1977). This long-term strategy aimed to stabilize population growth by reducing the net reproduction rate (NRR), requiring a restructured and reoriented healthcare system.

The plan recognized the environment as a significant factor in disease prevention, leading to discussions and policy adjustments addressing environmental health concerns. A working group on population policy was appointed to further these goals.

Population control and nutrition programs

The government implemented various initiatives to control population growth. A key target was to reduce the average family size from 4.2 to 2.3 children, lowering the birth rate from 33 to 21 per 1,000 people.

Nutrition was another major priority, with several new programs introduced. The special nutrition program (SNP) provided supplementary nutrition to pregnant women, preschool children, and nursing mothers through 600 ICDS centers. This initiative significantly improved nutritional access for rural women and children.

The ICDS program was also restructured to integrate welfare and healthcare services, ensuring better overall support for maternal and child health. Additionally, the existing mid-day meal program for school-going children was reviewed and expanded, incorporating health inputs, access to purified drinking water, clean kitchens, and horticultural gardens to enhance nutritional benefits.

Infrastructure and community development

To improve living standards in marginalized communities, the plan focused on developing community assets and facilities. Key initiatives included: community centers for social and welfare activities. Improved water supply sources for better hygiene and health. Streetlights and other minimum needs programs specifically targeted at SCs and STs.

Overall, the sixth five-year plan emphasized disease eradication, immunization, environmental health, population control, and nutrition enhancement, laying the foundation for long-term health and the development goals.

Seventh five-year plan (1985-1990)

The Indian government prioritized health development in alignment with the Alma Ata declaration (1978), which set the goal of achieving health for all by 2000 A.D. Building on the progress of previous plans, significant advancements were made in tackling infectious diseases and improving rural healthcare infrastructure.

A major milestone during this period was the passage of the national health policy (NHP) by both houses of parliament, which led to the restructuring and reorientation of health programs. The policy emphasized expanding healthcare services at the village level by strengthening PHCs, CHCs, and sub-centers.

Key initiatives included: Upgrading sub-district hospitals into CHCs. Converting maternity and child rural dispensaries into PHCs. Integrating family welfare, health, and maternity and child health (MCH) programs for a more holistic approach to healthcare.

Strengthening rural and tribal health programs

The minimum needs program (MNP) was further expanded at the state level to improve access to basic healthcare services in rural areas. To support this, the village health guide program was introduced, and additional sub-centers were established.

To address the shortage of trained medical personnel, foundational training programs for para-professionals and paramedical staff were initiated. These efforts contributed to improving rural healthcare delivery and disease control.

Although there is a lack of specific records on tribal health improvements, it is evident that tribal communities benefited from the newly structured health schemes and policies implemented all across the India during this period.

Eighth five-year plan (1992-1997)

The eighth five-year plan recognized health as a fundamental aspect of human development and a key component of national progress. India reaffirmed its commitment to the 1983 NHP, which aimed to achieve "Health for All by 2000 A.D." Primary healthcare was emphasized as the foundation for this goal, building upon the successes of previous plans.

By this time, significant achievements had been made: Smallpox was eradicated, the number of plague cases dropped drastically, malaria, cholera, and tuberculosis saw a decline in mortality rates, IMR and crude birth rate (CBR) had also decreased,

The primary objectives of the eighth plan were: Population control and improved healthcare access, expansion of healthcare services to cover the entire population and combating emerging health threats.

While continuing efforts to control chronic diseases, the Plan expanded its scope to tackle new health challenges, including:

Kala-azar and Japanese encephalitis: These diseases became major public health concerns, leading to intensive insecticide spraying and vaccination campaigns.

Leprosy: A multidrug therapy program was implemented for effective treatment.

AIDS: The AIDS control program, initiated in 1986, was strengthened with targeted prevention, community monitoring, and blood bank regulations.

Diabetes: The national diabetes control program, launched in 1987, was expanded to address the growing impact of the disease.

Rural and tribal healthcare

Efforts were made to align tribal healthcare facilities with national health policies and programs to ensure equal access to medical services. Additionally, the national rural health mission (NRHM) was introduced toward the end of this period, marking a significant step in improving healthcare accessibility in rural areas.

Ninth five-year plan (1997-2002)

India has been a pioneer in health service planning, with a strong focus on primary healthcare. Since the Bhore Committee's recommendations in 1946, the country's health system has evolved significantly through successive five-year plans. The ninth five-year plan introduced key initiatives aimed at strengthening healthcare management, enhancing human resources, and integrating health programs with non-communicable disease prevention.

The ninth plan emphasized: Developing a robust health management information system. Providing continuous training for healthcare professionals. Integrating healthcare initiatives with programs targeting non-communicable diseases. Improving tribal healthcare services and infrastructure.

Tribal healthcare: challenges and solutions

A major highlight of this plan was the extensive discussion on tribal health issues. Several factors contributing to the poor health of India's tribal population (8.08% of the total population as per the 1991 Census) were identified, including: Malnutrition and poverty, poor sanitation and lack of safe drinking water, limited awareness of available health services, socio-economic barriers restricting healthcare access and higher predisposition to genetic and endemic diseases (e.g., G6PD deficiency, yaws). To address these issues, the plan documented existing health facilities and identified gaps in healthcare infrastructure for tribal areas:

Table 2: Healthcare facility and existing centers.

Healthcare facility	Existing centers
Sub-centers	20,097
PHCs	3,260
CHCs	446
Modern medicine dispensaries	1,122
Hospitals (modern medicine)	120
Mobile clinics (modern medicine)	78
Ayurveda dispensaries	1,106
Ayurveda hospitals	24
Homeopathy dispensaries	251
Homeopathy hospitals	28
Unani dispensaries	42
Siddha dispensaries	7

(Source: B.W.B. Planning Commission)

Government initiatives and strategies

Several schemes were launched to improve tribal healthcare, including: Enhancing healthcare workforce and infrastructure in tribal areas. Defining priority areas for reproductive and child health (RCH) programs. Providing central funding for the NMEP. Prioritizing family welfare programs with a focus on maternal and child health.

The ninth plan reinforced the government's commitment to making healthcare accessible, effective, and inclusive, particularly for vulnerable tribal communities.

DISCUSSIONS REGARDING ASSESSING THE IMPACT OF DIFFERENT FIVE-YEAR PLANS ON TRIBAL HEALTH

India's five-year plans played a significant role in improving tribal health by addressing key challenges such as malnutrition, infectious diseases, poor sanitation, and lack of medical infrastructure. Recognizing the severe health disparities in tribal regions, the government introduced initiatives to establish dispensaries, mobile health units, and PHCs to provide accessible healthcare.[22] Efforts were made to combat diseases like malaria, smallpox, tuberculosis, leprosy, and filariasis through national eradication and control programs, significantly reducing mortality rates.[23] Immunization campaigns were expanded to cover newborns and pregnant women, while supplementary nutrition programs and mid-day meals were introduced to combat malnutrition among children and mothers.[24] The focus also extended to improving sanitation and providing clean drinking water to prevent waterborne diseases like cholera.[25]

To further strengthen healthcare services, specialized training programs were introduced for tribal nurses and midwives, ensuring a skilled workforce to cater to tribal populations.[26] Traditional tribal medicine was also studied for its potential scientific and medicinal value, fostering a blend of modern and indigenous healthcare approaches.[27] As part of broader development efforts, family planning initiatives were introduced to stabilize population growth, recognizing the direct impact of population dynamics on health.[28] Health research institutions and medical colleges were encouraged to conduct studies on microbiology, immunology, and tropical diseases affecting tribal communities, leading to better-targeted interventions.[29] Despite these advancements, challenges such as infrastructure gaps, shortage of trained personnel, and socio-cultural barriers to modern healthcare persisted.[6] The government continued refining its approach, integrating technology through telemedicine, strengthening community participation, and emphasizing preventive healthcare measures.[30] These sustained efforts have significantly contributed to improving tribal health outcomes, though continued policy interventions remain necessary to bridge

remaining disparities and ensure equitable healthcare access for tribal populations.

CONCLUSION

The Indian government's five-year plans have played a crucial role in improving the health and well-being of tribal communities. From the first five-year plan to the Ninth, significant progress has been made in expanding healthcare infrastructure, reducing disease prevalence, and promoting preventive healthcare measures. Establishing PHCs, CHCs, dispensaries, and mobile health units has improved healthcare accessibility in remote tribal areas. National disease eradication and control programs have effectively reduced the incidence of malaria, tuberculosis, leprosy, and smallpox. Additionally, initiatives such as immunization campaigns, nutritional programs, and sanitation efforts have significantly contributed to better health outcomes among tribal populations.

Despite these advancements, persistent challenges remain, including inadequate healthcare infrastructure, shortage of trained personnel, socio-cultural barriers, and limited awareness of modern medical practices among tribal communities. Socioeconomic disparities, poor sanitation, malnutrition, and endemic diseases continue to impact tribal health outcomes. Addressing these challenges requires continued policy interventions, integration of traditional tribal medicine with modern healthcare, and enhanced community participation in health initiatives.

Recommendations

we recommend a comprehensive approach to improving healthcare in tribal regions. Strengthening infrastructure requires expanding PHCs and CHCs with modern facilities and trained personnel, alongside increasing mobile health units for outreach. Enhancing human resources involves specialized training for tribal healthcare workers and incentives to retain medical professionals. Integrating traditional and modern medicine should include research on tribal healing practices and incorporating beneficial knowledge into mainstream healthcare.

Disease prevention efforts must focus on strengthening national programs for endemic diseases like malaria and tuberculosis while expanding vaccination and immunization services. Improving nutrition and sanitation requires expanding programs like the ICDS and ensuring access to clean drinking water and sanitation facilities. Community participation can be strengthened through health education campaigns and by empowering local health workers as intermediaries.

Leveraging technology, including telemedicine and digital health records, will enhance healthcare access and monitoring. Lastly, strong policy and financial support are essential, necessitating increased budget allocations and effective implementation of government health schemes. By adopting an inclusive and technology-driven approach, India can bridge healthcare gaps in tribal regions and improve overall health outcomes.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

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Cite this article as: Setua M, Islam S. Tracing tribal development in independent India: analyzing health challenges through five-year plans. Int J Community Med Public Health 2025;12:1916-24.