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Drivers of Primary Healthcare and Elementary Education Initiatives in Odisha (2014–2024)

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Abbreviations

AAY	Antyodaya Anna Yojana
AFHC	Adolescent Friendly Health Centre
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ANMOL	Auxiliary Nurse Midwife Online
ANWESHA	Assistance to Needy Women & Eminent Scholars Through Holistic Action
APF	Azim Premji Foundation
ASER	Annual Status of Education Report
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homoeopathy
B.Ed	Bachelor of Education
BCG	Bacillus Calmette-Guérin
BE	Budget Estimate
BEO	Block Education Officer
BIMARU	Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh
BJD	Biju Janata Dal
BKKY	Biju Krushak Kalyan Yojana
BLS	Basic Life Support
BPL	Below Poverty Line
BSKY	Biju Swasthya Kalyan Yojana
CAG	Comptroller and Auditor General
CBO	Community-Based Organisation
CBSE	Central Board of Secondary Education
CHC	Community Health Centres
CM	Chief Minister
CMO	Chief Minister's Office
CMS	Centre for Media Studies
CRCC	Cluster Resource Centre Coordinator
CSO	Civil Society Organisation
CSR	Corporate Social Responsibility
CT	Computed Tomography
CWSN	Children With Special Needs
DAMaN	Durgama Anchalare Malaria Nirakaran
DBT	Direct Benefit Transfer
DEO	District Education Officer
DHH	District Headquarter Hospital
DHO	District Health Officer

DHS	District Health Society
DIET	District Institute of Education and Training
DIKSHA	Digital Infrastructure for Knowledge Sharing
DMC	Designated Microscopy Centre
DMF	District Mineral Foundation
DMHP	District Mental Health Programme
DMLT	Diploma in Medical Laboratory Technology
DOT	Directly Observed Treatment
DPT	Diphtheria, Pertussis, and Tetanus
ECCE	Early Childhood Care and Education
EDL	Essential Drug List
EMAS	Emergency Medical Ambulance Service
EMRS	Eklavya Model Residential Schools
ENT	Ear, Nose, and Throat
ESI	Employees State Insurance
FBNC	Facility-Based Newborn Care
FHI	Fiscal Health Index
FID	Fixed Immunisation Day
FLN	Foundational Literacy and Numeracy
FRU	First Referral Unit
FY	Financial Year
GBV	Gender-Based Violence
GJAY	Gopabandhu Jan Arogya Yojana
GNM	General Nursing and Midwifery
GoO	Government of Odisha
GSDP	Gross State Domestic Product
H&FW	Health and Family Welfare
H&UDD	Housing and Urban Development Department
HBNC	Home-Based Newborn Care
HCES	Household Consumption Expenditure Survey
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	Human Resource
HRH	Human Resources for Health
HWC	Health and Wellness Centre
IAPPD	Intensified Action Plan for Pneumonia and Diarrhoea
ICDD	Intensive Case Detection Drive
ICDS	Integrated Child Development Services
ICT	Information and Communications Technology
ICTC	Integrated Counselling and Testing Centre
IDCF	Intensified Diarrhoea Control Fortnight
IDD	Iodine Deficiency Disorder
IFA	Iron and Folic Acid

IMNCI	Integrated Management of Neonatal and Childhood Illness
IMR	Infant Mortality Rate
INAP	India Newborn Action Plan
IPD	In-Patient Department
IPHS	Indian Public Health Standards
ITI	Industrial Training Institute
IYCF	Infant and Young Child Feeding
JSA	Jan Swasthya Abhiyan
JSSK	Janani Sishu Surakshya Karyakrama
JSY	Janani Suraksha Yojana
KBK+	Kalahandi–Bolangir–Koraput plus
KGBV	Kasturba Gandhi Balika Vidyalaya
KII	Key Informant Interview
KMC	Kangaroo Mother Care
LBW	Low Birth Weight
LEP	Learning Enhancement Programme
LHV	Lady Health Visitor
LLIN	Long-Lasting Insecticidal Net
LR	Labour Room
LTRMO	Leave Training Reserve Medical Officer
MAMATA	Mamata Conditional Cash Transfer Scheme
MAS	Mahila Arogya Samiti
MBBS	Bachelor of Medicine, Bachelor of Surgery
MCH	Maternal and Child Health
MD	Doctor of Medicine
MDA	Mass Drug Administration
MDM	Mid-Day Meal
MDMS	Mid-Day Meal Scheme
MIS	Management Information System
MLA	Member of the Legislative Assembly
MLAD	MLA Local Area Development
MLE	Multilingual Education
MMR	Maternal Mortality Ratio
MNH	Maternal and Neonatal Health
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare
MoSPI	Ministry of Statistics and Programme Implementation
MoU	Memorandum of Understanding
MPCE	Monthly Per Capita Expenditure
MPI	Multidimensional Poverty Index
MPLAD	Member of Parliament Local Area Development Scheme
MRI	Magnetic Resonance Imaging
MWH	Maternity Waiting Home
NACP	National AIDS Control Programme

NAS	National Achievement Survey
NBCC	Newborn Care Corner
NBSU	Newborn Stabilisation Unit
NCD	Non-Communicable Disease
NEP	National Education Policy
NFCP	National Filaria Control Programme
NFHS	National Family Health Survey
NFSA	National Food Security Act
NGO	Non-Government Organisation
NHA	National Health Accounts
NHED	Nutrition and Health Education
NHM	National Health Mission
NIDDCP	National Iodine Deficiency Disorders Control Programme
NIMHANS	National Institute of Mental Health and Neurosciences
NIUA	National Institute of Urban Affairs
NLEP	National Leprosy Elimination Programme
NNMR	Neonatal Mortality Rate
NP-NCD	National Programme for Prevention and Control of Non-Communicable Diseases
NPCB	National Programme for Control of Blindness
NPEGEL	National Programme for Education of Girls at Elementary Level
NQAS	National Quality Assurance Standards
NRC	Nutrition Rehabilitation Centre
NRHM	National Rural Health Mission
NSSO	National Sample Survey Office
NUHM	National Urban Health Mission
NVBDCP	National Vector Borne Disease Control Programme
O&G	Obstetrics and Gynaecology
OAV	Odisha Adarsha Vidyalaya
OAVS	Odisha Adarsha Vidyalaya Sangathan
OGIP	Odisha Girls' Incentive Programme
OOPE	Out-of-Pocket Expenditure
OOSC	Out-of-School Children
OPD	Outpatient Department
ORS	Oral Rehydration Solution
OSMC	Odisha State Medical Corporation
OSTF	Odisha State Treatment Fund
OT	Operation Theatre
PAB	Project Approval Board
PCI	Per Capita Income
PHC	Primary Health Centre
PIP	Programme Implementation Plan Report
PM-ABHIM	Pradhan Mantri Ayushman Bharat-Health Infrastructure Mission

PMSMA	Pradhan Mantri Surakshit Matritva Abhiyan
PNC	Postnatal Care
PPP	Public–Private Partnership
PRI	Panchayati Raj Institution
PRS	Policy Research Studies
PTR	Pupil Teacher Ratio
PVTG	Particularly Vulnerable Tribal Group
RBSK	Rashtriya Bal Swasthya Karyakram
RHS	Rural Health Statistics
RKSK	Rashtriya Kishor Swasthya Karyakrama
RNTCP	Revised National Tuberculosis Control Programme
ROP	Record of Proceedings
RSBY	Rashtriya Swasthya Bima Yojana
RTE	Right to Education
S&ME	School and Mass Education
SAB	Skilled Birth Attendant
SC	Scheduled Caste
SCB	Srirama Chandra Bhanja
SCPCR	State Commission for Protection of Child Rights
SDH	Sub-Divisional Hospital
SFSS	State Food Security Scheme
SHG	Self-Help Group
SMC	School Management Committee
SMDC	School Management and Development Committee
SNCU	Sick Newborn Care Unit
SNP	Supplementary Nutrition Programme
SRS	Sample Registration System
SSA	Samagra Shiksha Abhiyaan
ST	Scheduled Tribe
TB	Tuberculosis
TSP	Tribal Sub-Plan
TT	Tetanus Toxoid
U-AAM	Urban Ayushman Arogya Mandir
U-DISE	Unified District Information System for Education
U5MR	Under-5 Mortality Rate
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UPHC	Urban Primary Health Centre
VHND	Village Health and Nutrition Day
VHSND	Village Health, Sanitation, and Nutrition Day
WIFS	Weekly Iron and Folic Acid Supplementation
WSHG	Women's Self-Help Group

Project Summary

This paper is part of a three-state study on the drivers of state-level initiatives in primary healthcare and elementary education in urban areas during the decade of 2014–2024. The selected states are Karnataka, Rajasthan, and Odisha.

The states were selected to represent three different types of contexts regarding state-level initiatives. The first is a well-resourced state (indicated by per capita income) with health and education indicators above the national average (Karnataka). The second is a poorly resourced state that has improved health and education outcomes to reach above the national average (Rajasthan). The third is also a poorly resourced state, but one that has rapidly improved its fiscal position and some health and education outcomes (Odisha).

Effective social welfare depends on how well existing programmes are implemented as well as on how strongly governance systems function and are prioritised by the state and national governments. This includes education, health, sanitation, water, and nutrition. Prioritisation is reflected in increased budget allocation, mission-mode implementation, or new initiatives targeting specific challenges. In certain instances, such prioritisation shapes the commitment of political leaders, bureaucrats, civil society actors, and professional associations. Mission mode implementation—when clear, time-bound targets are set with accountability frameworks—commands the highest levels of political and bureaucratic commitment (Kapur et al., 2010, p. 39). This is widely understood among practitioners and researchers.

Understanding how social welfare is prioritised requires tracing the pathways through which new initiatives emerge. This project aims to highlight these pathways. The overarching study question is why and when a state undertakes new initiatives in primary healthcare and elementary education in urban areas. This question is examined across the three study states in separate state reports. This will be followed by an overarching synthesis (paper) in which we will analyse the common drivers of the initiatives across all three states. We also examine whether the nature of initiatives varies across states depending on their drivers. Lastly, we will examine if the initiatives address the critical ground-level challenges facing elementary education and primary health. For example, would the introduction of the English medium of instruction address the low uptake of urban primary schools? Would the provision of free medicines make government primary care facilities in urban areas preferable to private clinics? The project does not attempt to do an evaluation of new programmes. It aims to see if the solutions proposed by the initiatives are sufficient to solve ground-level challenges.

This paper focuses on the third state in the study, Odisha. The first state, Karnataka, is held up as a progressive state with strong social indicators and high per capita income. However, gaps exist in both the performance and provision of elementary schools and primary health facilities. There has been a reduced policy focus on

health and education in Karnataka. On the other hand, Rajasthan is a large state with low per capita income, but it has significantly improved its performance in health and education. It had strong civil-society-led movements for progressive legislation in health and education, the most recent of which has been the Right to Health Act. Odisha, also a state with low per capita income, presents an interesting case—it has remarkably improved key health and education indicators over the past two decades, notably in maternal and child health. Unlike most Indian states, Odisha has witnessed unique circumstances of political continuity and bureaucratic stability, with long tenures in the state bureaucracy during our study period. Odisha has transitioned from being in a difficult financial situation in the early 2000s to maintaining a revenue surplus since 2005–2006. Since 2015, owing to a dramatic increase in state revenue from non-budget sources such as the District Mineral Foundation, it has enhanced its capacity to fund social welfare. Despite being predominantly poor and rural, Odisha has focused on urban areas—notably through land-title grants for the urban poor and slum upgradation under the Jaga Mission. Odisha is an interesting state to understand how this emerging focus on urban has translated to areas of health and education.

The overall findings will highlight what drives state-level policymaking in diverse settings and who the key stakeholders are. It will tell us whether there is something inherent in the nature and process of state-level policymaking that leads some states to adopt active and engaged roles in making social welfare policies aligned with grassroots-level realities, while others do not. Broadly, across the three states, the project employs the following methods:

a) Analysis of key government policy documents and knowledge reports, such as the state's economic survey reports and finance commission reports.

b) Key Informant Interviews (KIIs) with bureaucrats at the state, district, and facility levels (schools and Primary Health Centres [PHCs]), civil society leaders, researchers, academics, journalists, and engaged citizens.

c) Analysis of health and education datasets, which include the Unified District Information System for Education (U-DISE), National Achievement Survey (NAS), Sample Registration System (SRS), and National Family Health Survey (NFHS).

Executive Summary

Context and Research Objectives

This study examines the drivers of state-level initiatives in primary healthcare and elementary education in Odisha during 2014–2024, with a focus on urban areas and on the early stages of the policy life cycle: impetus and initiation, and conceptualisation and design.

Odisha has achieved noteworthy progress in poverty reduction and expanding access to social welfare. This is evident in improvements in maternal and child health (MCH) indicators, including infant mortality rate (IMR), maternal mortality ratio (MMR), institutional deliveries in public facilities, and child vaccinations. In elementary education, Odisha's performance in the NAS 2021 surpassed the Indian average in several subjects. These achievements are significant given Odisha's income disparities, fiscal history, and previously poor health and education outcomes.

Odisha is important for this study for three reasons. First, it has witnessed unusual continuity in both the political regime and bureaucracy, with some tenures spanning a decade. This makes it a useful case for asking how political stability can be an enabling factor for progressive social welfare provisioning. Scholars have commented that political leadership in Odisha has been welfare-oriented. How did this stability translate into a focus on urban primary health and elementary education, which stakeholders drove policy initiatives, and which ideas did they prioritise? Second, Odisha's financial position has improved sharply over the past two decades. It has maintained a revenue surplus since 2005–2006, and since 2015, higher non-tax revenue has strengthened domestic resources. This allows us to ask how greater fiscal space shapes social welfare provisioning and what receives attention once resources become available.

Third, the study focuses on urban areas. Although Odisha remains predominantly rural, its urbanisation is projected to increase in the coming decades (National Institute of Urban Affairs [NIUA], 2022), and more than one-fifth of its urban population is categorised as urban poor. Even if Odisha's urbanisation remains below the Indian average,[1] the concentration of poverty, precarious living conditions, and low per capita incomes in urban areas requires greater public attention. Recent urban initiatives therefore raise an important question: How far do they address health- and education-specific challenges in urban Odisha? We examine this through the following question: Why and when did Odisha undertake state-level initiatives for primary health and elementary education in urban areas during 2014–2024?

[1] SBI's Research Report, 'Precursor to Census 2024' projects a 19% urbanisation rate for Odisha in 2024, which is lower than India's projected average urbanisation rate of 35.4%.

We employed qualitative methods in this study (see Figure ES–1).

Figure ES–1: Methods Used in the Study

Qualitative Research Methods in this Study

1. Key informant interviews

State, district bureaucracy, and frontline-level health and education officers, civil society leaders, academics, policy researchers, journalists, engaged citizens, and ordinary users of health and education facilities.

2. Reviewing government reports

- Economic Survey (2014–2024)
- PAB minutes (2014–2024)
- ROP reports (2014–2024)
- Policy documents (state-level task force reports, CAG reports, Finance Commission reports, etc.).

3. Analysis conducted at four levels

- State-level initiatives
- Selected districts with higher urban demographics and government-run schools/PHC
- Government-run schools/PHCs (school teachers, PHC staff)
- Community/users of PHCs and schools

4. Additional layers to select the district

- Narrowed this down to a capital, an older urban centre (unplanned as compared with the capital) with a dense population and a coastal urban area across three districts.
- Selection of these sites with varying resource availability, proximity to the centre of power, and differences in composition of the population.

Source: Authors' illustration.

Sectoral Findings and Policy Mismatches

Our study is organised in three parts. First, we examine the number and nature of initiatives. We selected initiatives that have been either funded and/or ideated by the state. We also took stock of the trends in the budget allocation to the health and education sectors during the study period. Second, we examine the objectives and the strategy of these initiatives and whether they align with the ground-level challenges faced by urban primary health centres (UPHCs) and elementary schools. Third, we examine the actors and pathways that drove state-level primary health and elementary education initiatives.

Our findings highlight that the state's overall focus has been greater on health than on education. Within health, however, the emphasis has been stronger on tertiary care and opening hospitals than on primary care. The state's flagship health programme during this decade was the health insurance scheme, Biju Swasthya Kalyan Yojana (BSKY). At the same time, Odisha did take note of some challenges specific to urban health, including shortages of specialists in UPHCs, public–private partnership (PPP) arrangements for staffing, and gaps in UPHC management in urban areas. Interestingly, the state has also focused on rising mental health concerns and the growing burden of non-communicable diseases (NCDs) in urban areas.

In education, the dominant focus has been on infrastructure, notably digital infrastructure under the 5T High School Transformation Programme. Major initiatives focused on alumni donations for school development through the Mo School Abhiyaan, model schools, school mergers, and free textbooks and uniforms. Elementary education received much less attention, and we identified only one clearly urban-specific initiative: the Anwesha scholarship for Scheduled Castes and Scheduled Tribes (SCs/STs) students studying in English-medium private schools in urban areas.

Our analysis of the alignment between the studied initiatives and ground realities highlights two types of mismatches: a) a problem–prioritisation mismatch, where problems that impact the uptake of UPHCs and urban elementary schools do not consistently receive adequate attention and b) a solution–challenge mismatch, where the solutions proposed by initiatives either fail to fully achieve their intended objectives or fall short of advancing the broader goal of improving uptake.

In health, despite increased budgets and policy attention, initiatives have not addressed key shortages in the health workforce and primary care infrastructure in urban areas, which manifest differently than those in rural settings. For instance, the Ama Clinic seeks to meet the demand for specialist services through weekly visits to UPHCs, but its effectiveness is limited when specialist shortages persist. Secondary studies also find that budget utilisation remains persistently low, highlighting the state's limited spending capacity.

In education, the focus on infrastructure upgradation has not been matched by efforts to address teacher shortages or to train teachers to use digital tools effectively. Urban school governance also faces several unique constraints. Despite improvements in many health outcomes, we find reversals in some health and education indicators, including MMR, urban IMR, and government-school enrolment in Class 1. These indicate a weak capacity to sustain gains and a lack of robust monitoring systems.

Actors and Pathways in Policymaking

To understand why Odisha has focused on policy problems and the actors involved, our findings highlight the key drivers of initiatives during this decade.

First, there has been a strong central government push for major initiatives, including school mergers and UPHC extension clinics. Second, the state bureaucracy has played an engaged and dominant role. Senior bureaucrats in Odisha, led by the Chief Secretary, have shaped decision-making in health and education. With stable tenures and political support, they have had the space to select problems, design interventions, and drive implementation. At the same time, bureaucrats have faced pressure to address clearly defined problems in ways that are visible to the electorate.

The implication of this was a fractured health and education agenda, where targeted issues are addressed with limited coherence and connection. In Odisha, the prominent role of the bureaucracy in governing health and education is a consequence of a highly

centralised political culture. Historically, the chief minister has been the primary political authority and the visible champion for these sectors. This dynamic, coupled with the near absence of oppositional politics (including from within the party), has created a governance model in which the focus of social welfare initiatives often prioritises generating positive public perception and political support.

During this decade, other pathways for policymaking in urban primary healthcare and elementary education, such as civil society organisations (CSOs), social movements, professional associations, and community-based organisations (CBOs), have remained muted. This is notable because Odisha has a large number of CBOs created by the government, such as active self-help groups (SHGs) and slum development committees.

Policy Recommendations

We propose four policy recommendations that can address these implications. The focus is on widening the diversity of ideas, actors, and incentives driving policy initiatives.

First, to address the limited range of initiatives in urban areas, particularly in education, we recommend creating a stakeholder-wide body at the district level. This body would identify issues and recommend amendments to existing initiatives in line with urban challenges. It would focus specifically on policy ideation for 'urban issues' and include all relevant stakeholders across school education and primary health: District Education/Health Officers, local CSOs, CBOs such as SHGs, donor bodies, representatives of frontline professional organisations (teachers' unions and doctors' unions), research professionals, activists, and select retired members of the district-level health and education bureaucracy (such as former DHOs and DEOs). These bodies should be established in all urban-dominant districts and report to a consultative panel created at the state level. Currently, alignment between top-down policy prescriptions and the ground challenges in urban areas is weak. Creating a district-level body to identify issues and suggest implementable solutions can lead to greater ownership. Given the expected increase in Odisha's urban demographic in the coming decades, such mechanisms are needed to develop an urban agenda for health and education.

Second, we recommend creating a consultative panel at the state level that brings together the state bureaucracy and community-based CSOs, donor bodies, state-level CSOs, pan-India CSOs working in Odisha, technical assistance bodies, and consulting firms. This platform would focus on identifying key issues and focus areas, with the district-level bodies reporting to it. Such panels have previously functioned in Odisha. They were able to identify critical ground-level challenges, and several initiatives across sectors benefited from CSOs' strong connection with the communities. Reintroducing these pathways into the policymaking ecosystem would ensure the inclusion of community perspectives in policy ideation at the state level.

Third, to address challenges in sustaining improvements across key health and education outcomes, we recommend reinvigorating third-party audits and programme monitoring as system-level checks. This body already exists within the state bureaucracy in Odisha as an entity independent of line departments, with dedicated funding and personnel. Its position within the state bureaucracy and independence from the social welfare (or spending departments) are its strengths: It allows for impartial access to government information, while also enabling an understanding of internal constraints in implementation. It can also ensure that findings from such studies reach the right audience. However, this monitoring unit has not been effectively used by welfare departments. Regular audits of government programmes and schemes in health and education are critical to highlighting the strengths and limitations of ongoing programmes, creating legitimacy on the ground for government initiatives, and mobilising stakeholders.

Lastly, to address the low engagement of elected political representatives in health and education, we recommend a biannual conference of Members of the Legislative Assembly (MLAs) focused on social welfare, including these sectors. The conference could be modelled on earlier annual conferences of state education ministers at the national level (for example, during the 1980s, the annual education ministers' conference produced reports that shaped the 1986 National Education Policy). These events generated useful public reports that helped initiate systemic changes. Currently, political engagement in health and education remains limited. Greater formal involvement of MLAs can help highlight salient constituency-level challenges, strengthen ownership, and mobilise public awareness around issues in health and education.

1. The Problem

As illustrated in Figure 1, the standard policy life cycle involves five stages: (a) impetus and initiation, (b) conceptualisation and design, (c) implementation, (d) correction, and (e) systems for sustainability. This paper provides a targeted analysis of the initial two phases as they relate to the state of Odisha. While a prominent focus of policy research and popular writings have been on the drivers of public spending and budgets (Govinda & Choudhury, 2012), implementation, outcomes, performance, and evolution of schemes and initiatives (Bajpai & Goyal, 2004; Bali & Ramesh, 2015; Gopalan et al., 2012; Gouroumourty et al., 2025; Little, 2010; Mangla, 2017), less is known about the politics–bureaucracy–economy dynamics which shape the prioritisation of policy problems and solutions.

Figure 1: Stages of a Policy Life Cycle

Phase 1: Impetus and Initiation
The starting point where the need for a policy is identified and triggered.

Phase 2: Conceptualisation and Design
The stage where the policy framework and strategy are formally developed.

Phases 3–5: Implementation to Sustainability
Covers execution, correction, and building systems for long-term viability.

Study Focus & Scope

- **Primary focus area:** Investigates initiatives in primary healthcare and elementary education.
- **Temporal & geographic scope:** Covers urban initiatives in Odisha during the 2014–2024 period.
- **Analytical lens:** Concentrates specifically on the first two stages of the policy cycle.

Source: Authors' illustration.

Odisha is an important case for this exploration because it represents three distinctive characteristics discussed in the following sections: its political and bureaucratic culture, its economic history and recent transformation, and its health and education challenges.

This paper (and the overall three-state project) highlights that the role of the state in improving citizens' well-being, dignity, and agency depends on more than programme implementation, the right initiatives, or spending levels. Improving welfare through government policy initiatives is fundamentally about which problems are chosen, under what circumstances, when, and through what process. By focusing on this piece of the welfare policy puzzle, we recognise that policymaking is defined by difficult choices. Ground-level challenges do not automatically trigger policy response; processes, actors, contexts, and incentives must align for that to happen. The manner in which problems are prioritised shapes the nature and extent of the social welfare delivered.

Odisha has been widely recognised as a welfare-oriented state. In several areas, such as poverty reduction and maternal and child health and nutrition, it has shown marked improvements (Thomas et al., 2015). Yet, despite the improvements from previous years, several of Odisha's health and education outcomes remain poor, with some indicators facing reversals in recent years as indicated by changes from NFHS-4 to NFHS-5,[2] particularly in urban areas. Odisha is predominantly a rural state, but its urban areas require particular attention. The poor constitute over one-fifth of urban Odisha's population (National Urban Health Mission [NUHM] Odisha, 2023), and Odisha's urban poor are among the poorest in India.[3] With Odisha's urban population set to increase in the coming decades (NIUA, 2022), the need for targeted urban health and education provision is urgent.[4] Despite many enabling conditions, such as revenue surpluses and political and bureaucratic stability, Odisha has not managed to achieve higher and sustained improvement in health and education. Why is this the case? We examine this puzzle in the context of urban primary health and elementary education through our research question: Why and when did Odisha undertake new initiatives for urban primary care and elementary education during 2014–2024? By analysing the pathways and drivers for new initiatives in two of the foundational areas of human development, we aim to shed light on the roadblocks to improving health and education in the state.

Odisha's progress in reducing poverty and enhancing access to social welfare, particularly for its vulnerable populations, since the early 2000s, has been impressive. The state recorded the highest poverty reduction among major states in India (Planning and Coordination Department, Directorate of Economics and Statistics, Government of Odisha).[5] More recently, NITI Aayog's Multidimensional Poverty Index (MPI) (2023) shows one of the steepest declines in the number of MPI poor (NITI Aayog, 2023). Nevertheless, Odisha remains below national averages, and stark inequalities persist. The state's average monthly per capita expenditure (MPCE) is well below the national average—₹3,357 in rural areas (India—₹4,122) and ₹5,825 in urban areas (India—₹6,996) (Ministry of Statistics and Programme Implementation [MoSPI], 2025a). Income disparities are particularly stark between industrial and non-industrial areas.[6]

[2] The National Family Health Survey (NFHS)-6 report 2023–2024 was released on May 29, 2026. At the time of publication, detailed state reports are yet to be released. For all states, key indicators released in the main report include population and household profile, marriage and fertility, family planning methods, and maternal and child health (antenatal care, delivery care, postnatal care, child vaccinations, child feeding practices, nutritional status of children and adults, NCDs, women's empowerment and gender-based violence, and tobacco use). Data on indicators such as IMR, NMR, and U5MR are not included in the current report and are expected to be released as part of detailed state reports. The paper will be updated once this has been released.

[3] Odisha's average MPCE for casual labour in urban areas at ₹3,923 (majority of whom make up the urban poor) is among the bottom two states in India (MoSPI, 2025a).

[4] Odisha is among the urban states in India that have had historically low rates of urbanisation. As per SBI projections for 2024, Odisha's urbanisation is 19%, an increase of 2.3 percentage points from the 2011 census figures. While this is lower than the average urbanisation rate in India, Odisha's change in urbanisation (%) is higher than states like Rajasthan, Bihar, Himachal Pradesh, Uttar Pradesh, and Assam. Further, even though Odisha continues to be predominantly a rural state, its urban poor make up a prominent segment of the urban population, with heightened precarity and low MPCE.

[5] Poverty in Odisha declined to 24.6 percentage points from 57.2% in 2004–2006 to 32.6% in 2011–2012 (Odisha Economic Survey 2014–2015).

[6] Mahakur and Nayak's (2019) study on *Intrastate Income Inequalities in Odisha* finds "very large differences in per capita income between some of its highly industrialised districts like Jharsuguda and Angul and relatively backward districts like Subarnabur and Deogarh."

The story in health and education is similar. Odisha has significantly improved many health and education indicators over the years. In health, it has particularly improved MCH indicators such as IMR, MMR, and child vaccinations, with the most notable improvements in the decade between 2004–2005 and 2014–2015 (Table 1). In education, there have been improvements in learning levels for particular subjects from 2017 to 2021, as per the NAS scores. But the improvements have not been sufficient, and Odisha remains below the national averages in several outcomes and access indicators.

In health, as Table 1 shows, in several important indicators, such as Neonatal Mortality Rate (NNMR) and urban IMR, where it has demonstrated marked improvements from previous rounds, it still remains below the national average, and in many indicators, such as IMR, there has been a reversal in recent years, particularly for urban areas. Odisha's IMR reduced significantly from NFHS-3 to NFHS-5; yet IMR in urban areas saw an increase from NFHS-4 to NFHS-5 (Table 1).

Table 1: Key Health Indicators: Odisha and India as per the National Family Health Survey

S. No	Indicators	NFHS-3 (2005–2006)	NFHS-4 (2015–2016)	NFHS-5 (2019–2021)	NFHS-6 (2023-2024)	India Average NFHS-5	India Average NFHS-6 (select indicators available)
1	U5MR	91	48.1	41.1	NA	42	NA
2	IMR deaths per 1,000 live births	65	39.6	36.3	NA	35.2	NA
3	Urban IMR	40	21	31	NA	23	NA
4	NNMR deaths per 1,000 live births	45	28.2	27	NA	24.9	NA
5	Children aged 12–23 months who received most of the vaccinations in public health facilities (%)	84.60	98.30	98.10	98.8	94.5	95.6
6	Average OOPE per delivery in public health facility (₹)	NA	4226	4,139	NA	3,245	NA
7	Average OOPE per delivery in public health facilities in urban areas (₹)	NA	4,900	5,066	NA	NA	NA
8	Institutional births at public health facilities (%)	28.8	75.8	78.7	75	61.90	58.6

Source: NFHS-5, NFHS-5 State Fact Sheet Odisha, NFHS-6 (International Institute for Population Sciences, 2021a, 2021b, 2026)

Note: NFHS = National Family Health Survey; U5MR = under-5 mortality rate; IMR = infant mortality rate; NNMR = neonatal mortality rate; OOPE = out-of-pocket expenditure; NA = not available.

Similarly, while Odisha has seen drastic declines in MMR over the years (between 2004 and 2018), there has been a significant increase in MMR since 2019 (Table 2).

Table 2: Maternal Mortality Ratio—Odisha and India—Changes From 2014–2023 as per the Sample Registration System Data

Year	India Average	Change in India	Odisha	Change in Odisha
2014–2016	130		180	
2015–2017	122	-8	168	-12
2016–2018	113	-9	150	-18
2017–2019	103	-10	136	-14
2018–2020	97	-6	119	-17
2019–2021	93	-4	135	**+16**
2020–2022	88	-5	136	**+1**
2021–2023	88	0	153	**+17**

Source: Sample Registration System Special Bulletin on Maternal Mortality in India (Office of the Registrar General, India [2019, 2022, 2025]).

Financing healthcare also continues to be a challenge. OOPE in Odisha reduced from 2019–2020 to 2020–2021. However, for urban areas, there was a parallel increase. Average OOPE per delivery in public health facilities in urban areas (Table 1) increased from ₹4,900 to ₹5,066 between NFHS-4 and NFHS-5.

In terms of health infrastructure and human resources for health (HRH) in primary healthcare, there continue to be salient urban-specific challenges. While there have been notable improvements in the availability of doctors and nursing staff at urban PHCs, there are shortfalls in health infrastructure and human resources in urban areas. These are in the overall number of UPHCs, and the shortfall of health workers (female), pharmacists,[7] and laboratory technicians in UPHCs (Rural Health Statistics [RHS], 2021–2022; Table 3).

[7] The 1% shortage of pharmacists as per the latest RHS 2021–2022 needs to be seen in context of the overall shortage in number of UPHCs in the state.

Table 3: Shortfalls in Urban Primary Health Centres and Human Resources for Health—Urban Odisha Indicators as per Rural Health Statistics

Reference Year	PHCs in Urban Areas (%)	Health Worker (Female)/ ANM At PHCs in Urban Areas (%)	Doctors at PHCs in Urban Areas (%)	Total Specialists at CHCs in Urban Areas (%)	Pharmacists at PHCs in Urban Areas (%)	Laboratory Technicians at PHCs in Urban Areas (%)	Nursing Staff (Staff Nurse) at PHCs in Urban Areas (%)
2018–2019	45	54.02	**surplus = 25.28% (109 doctors against 87) required	**surplus = 50% (42 specialists against 28) required	5.7 (82 against 87 required)	100 (0 against 87 required)	**surplus = 41.3% (123 nursing staff against 87 required)
2019–2020	47	**surplus = 11.9% (498 health workers against 445 required)	2.24	**surplus = 25% (35 specialists against 28 required)	9.92 (83 against 89 required)	20.2 (71 against 89 required)	** surplus = 59.5% (142 against 89 required)
2020–2021	46	**surplus = 4.6% (476 health workers against 455 required)	**surplus = 3.29% (94 doctors against 91) required	14	1 (90 against 91 required)	14.2 (78 against 91 required)	**surplus = 61.5% (147 nursing staff against 91) required
2021–2022	39	50	**surplus = 1.9% (107 against 105 required)	17	1 (90 against 91 required)	14.2 (78 against 91 required)	**surplus = 65.71% (174 nursing staff against 105) required

Source: Rural Health Statistics (2018–2019, 2019–2020, 2020–2021, and 2021–2022); Ministry of Health and Family Welfare, Government of India.

Note: PHC = primary health centre; ANM = auxiliary nurse midwife; CHC = community health centre.

In education, learning levels data show mixed results: While English scores for Class 10 and Languages scores for Class 3 and 5 improved from NAS 2017 to 2021, Mathematics performance across Classes 3, 5, 8, and 10 worsened. Parallelly, India's average performance from NAS 2017 to 2021 declined in Language and Mathematics for Classes 3, 5, and 8, and in Mathematics for Class 10. Between 2017 and 2021, the drop in India's average scores was much steeper than Odisha's. By 2021, Odisha's performance was slightly better than India's across many subjects (Table 4). Yet, an important caveat is that this period coincided with the COVID-19 learning losses, which had a role to play in worsening learning levels across the country.

Table 4: National Achievement Survey 2017 and 2021: Performance for Classes 3, 5, 8, and 10 for Odisha and India

Class	Subject	Performance 2017 in Odisha (%)	Performance 2017 in India (average) (%)	Performance 2021 in Odisha (%)	Performance 2021 in India (average) (%)	% Change from NAS 2017–NAS 2021 (Odisha)	% Change from NAS 2017–NAS 2021 (India average)
Class 3	Language	64	68	65	62	1	**-6**
	Mathematics	62	64	60	57	**-2**	**-7**
Class 5	Language	51	58	54	55	3	**-3**
	Mathematics	55	53	47	44	**-8**	**-9**
Class 8	Language	53	57	53	53	0	**-4**
	Mathematics	44	42	38	36	**-6**	**-6**

Source: National Achievement Survey 2017 and 2021 State Report Card for Odisha; National Achievement Survey Scores for India.

Note: NAS = National Achievement Survey.

In elementary education, government provisioning has fallen short. While data indicate the availability of schools within 1 km of a habitation, urban areas continue to face challenges. While 93.1% of households across urban and rural districts in Odisha have their nearest school with primary level classes within 1 km, the percentage for urban areas is only 86% as per the NSS Report No. 585: Household Social Consumption on Education in India. The shortfall in availability and quality of schooling is a visible proxy indicator for private school uptake in urban areas.

In terms of the number of schools and enrolment figures, between 2012 and 2022, there was a visible drop in total government schools and total enrolment in Class 1 in government schools, and a parallel increase in private unaided school enrolment in Class 1—an increase of 708.1% (U-DISE 2012–2013; U-DISE 2022–2023; Table 5).

Table 5: Enrolments in Government and Private Schools as per Unified District Information System for Education 2012–2013 and 2022–2023

S. No.	Data Point	U-DISE 2012–2013	U-DISE 2022–2023	% Change
1	Total Government Schools	53,193	48,767	-8.32
2	Total Enrolment in Class 1	8,92,989	34,54,392	286.83
3	Total Enrolment in Class 1 in Government School	43,41,046	27,41,180	-36.85
4	Total Enrolment in Class 1 in Private Unaided School	77,803	6,28,725	708.10

Source: Ministry of Education, Government of India: Unified District Information System for Education 2012–2013 and 2022–2023.

Note: U-DISE = Unified District Information System for Education.

Odisha has three enabling conditions that could aid the development of health and education initiatives. First is the availability of fiscal resources. Odisha has been a revenue surplus state since 2005–2006 (NCCDS, 2013). It has also improved its fiscal resources since 2021–2022 through non-tax revenue sources, particularly mining royalties from the District Mineral Fund (DMF). Odisha topped NITI Aayog's Fiscal Health Index (FHI) 2025 primarily owing to effective revenue mobilisation and debt management. Odisha Finance Department's Budget insights from 2022–2023 state that revenue receipts grew by 35.45% in Financial Year (FY) 2021–2022, driven mostly by a sharp rise in non-tax revenues. Odisha has also drawn on off-budget resources like the DMF to support development in its mineral-rich districts. As an extra-budgetary fund, the DMF is intended to complement government schemes and bridge the funding gap in areas such as drinking water supply, healthcare, education, irrigation, and infrastructure (Finance Department, Government of Odisha [GoO], 2023). In essence, there are finances available for the state to focus on health and education.

Second, Odisha has had continuity in political leadership—from 2000 to 2024, the Naveen Patnaik-led Biju Janata Dal (BJD) retained power in Odisha, making him the second-longest serving CM of any Indian state. Few political regimes in India's history, or for that matter, in the contexts of the electoral democracies the world over, have ever had such a consecutive long-standing reign as that in Odisha (Panda & Sahu, 2024). Additionally, with stable tenures and political support (with tenures lasting a decade in certain cases), senior bureaucracy was allowed space to select problems, design interventions, and address issues. This makes Odisha a unique state in which to study how leadership continuity and stability affect social welfare policymaking in health and education.

Third, given that it is a natural disaster-prone state, Odisha has prioritised disaster management and achieved the status of zero disaster deaths. CSOs have historically aided the government in efforts to achieve this and have been active in the area of disaster response in the state. This demonstrates the capacity to address complex, unpredictable social survival challenges, which can be transferred to other areas of social welfare as well.

Odisha's improvements in select health and education indicators, alongside financial stability, suggest fertile ground for new policy experimentation. Financial stability means that the state can fund social welfare, and political continuity and bureaucratic continuity make Odisha well-positioned to tackle systemic and structural challenges.

This report is divided into four sections. In Section 2, we outline the questions this study addresses and argue for a focus on primary health and elementary education in urban areas. Section 3 details the key methods used in this study, the study sites, and the analytical framework. In Section 4, we present the main findings of this study in four subsections. In the final section, we synthesise the arguments and discuss their implications for policymaking in health and education in Odisha, offering policy recommendations.

2. The Questions

Within the broad health and education sectors, this study is restricted to four areas:

- Primary health and elementary education;
- Government-run schools and UPHCs;
- Urban areas;
- State-level initiatives.

We have chosen to restrict our study to these four areas due to the following reasons:

First, the focus on primary health and elementary education comes from an understanding that, taken together, these are considered the building blocks of human development. Without a strong primary health system, preventive and promotive care are sidelined, and tertiary care becomes overburdened, leading to a cycle of challenges plaguing overall health systems.

Similarly, without strong education at the elementary level, learners find themselves at a disadvantage in later years of schooling, in turn increasing the likelihood of dropouts (Kaffenberger et al., 2021). India has recently pushed for skilling initiatives through vocational training. However, many initiatives rest on a poor foundational learning base and weak linkages with school education, resulting in subpar vocational quality. Odisha has seen a spurt of initiatives in the last decade, including the Nutana Unnata Abhilasha (2023), which offers training in emerging trades and new-age technologies (AI and Robotics) (Skill Development and Technical Education Department, GoO, 2023); the Sudakshya scheme (2018), aimed at enhancing female enrolment in Industrial Training Institutes (ITIs); and the establishment of a 'World Skill Centre' (2021) in Bhubaneswar. While skilling has received dedicated attention in the state, a siloed approach and lack of recognition of the continuum between school education and subsequent pathways are likely to produce a weak skilling ecosystem as well.

Critically, it is in health and education where government provisioning is most needed and has been found wanting. There is an assumption that the government is the sole provider of health and education in rural areas, while urban areas have a higher number of private providers. In Odisha, however, healthcare provision has been more public sector-focused mainly due to the limited presence of private facilities across the state, except for a few urban pockets (Chandrasekhar & Naidu, 2021). The percentage of households that use public health sector facilities when household members get sick are 87.6% (urban—75.7%; rural—90%), a significantly higher proportion than the Indian average of 50.1% (urban—46.9%; rural—51.7%) as per NFHS-5.

In education, while reliance on government-provisioned education is high in rural areas in Odisha, with 89.4% students enrolled in rural government schools

as opposed to the Indian average of 66% in rural areas, the percentage of students enrolled in government schools in Odisha in urban areas is higher than the Indian average (Odisha—47.9%; India—30.1%) (Centre for Media Studies [CMS] Education Survey, NSS 80th round, 2025). Therefore, our focus on government-run schools and UPHCs aims to spotlight how the state has focused on health and education, and to what degree the presence of private providers in urban areas has influenced policymaking in these two fields.

We find that the reliance on public provisioning in health and education manifests differently in urban and rural areas, bringing us to our third focus area on urban locations in a predominantly rural state. In Odisha, urbanisation rates are projected to increase in the coming decade (NIUA, 2022). Between 2021 and 2036, the NIUA 2022 report projects an increase of 15.8% in Odisha's urban population and a drop of 1.5% in the state's rural population during the same period. Many of these increasing numbers in urban areas will be internal migrant workers in search of better economic opportunities (Vathanan & Dasgupta, 2025) and at heightened risk of precarity in the absence of adequate government provisioning of health and education, and institutional support (Kapilashrami & John, 2023). The COVID-19 pandemic demonstrated key fault lines in urban cities and a lack of basic facilities for migrants who make up the cities' workforce, resulting in an unprecedented reverse migration (Naik, 2025). A distinct urban lens is required to address urban-specific issues—for instance, the heightened difficulty to mobilise urban populations due to heterogeneity of the population on lines of tribal lineage, burden and nature of work, and lack of a distinct urban identity. Rural governance structures are better established and have existed longer—for example, the National Rural Health Mission (NRHM) predates the NUHM. Urban governance, by contrast, remains fractured, particularly in health and education (Gupta & Singh, 2025). Achieving improvements in these sectors often requires significant inter-ministerial coordination and convergence between departments (importantly at the ground level), which is more difficult in urban areas. Investigating a state's focus on urban areas thus illustrates its commitment to health and education, given the limited historical policy precedent.

Lastly, our focus on state-level initiatives stems from an understanding that India's constitution bestows responsibility on the states in health, while education remains on the concurrent list (i.e., shared between the centre and the state). In practice, however, these distinctions are blurred by changing fiscal architecture, fractured centre-state dynamics around financing, and delayed disbursement under central schemes (Bose et al., 2022; Choudhury & Mohanty, 2019). These dynamics necessitate a closer look at how states articulate their voice through their own initiatives, what they choose to focus on, and the circumstances that led to their initiation. In Odisha, given the continuity of the political regime and unparalleled stability of tenure within bureaucracy, this question becomes even more pertinent to understand how the state made use of this space to initiate reforms in health and education.

We have focused on the following broad research questions and five sub-questions in this study:

Key Research Question

Why and when did Odisha undertake new initiatives for primary care and elementary education for urban areas during 2014–2024?

Sub-Research Questions

- What are the key initiatives in primary health and elementary education undertaken by the state during this decade? What are their key focus areas and the intention behind developing these initiatives?
- Do they focus on urban areas? In what ways?
- What kinds of challenges do these initiatives focus on, and what are the solutions proposed?
- What are the key challenges related to health and education, particularly in urban areas? Do the initiatives address challenges on the ground? Do they cover critical challenges? Do they cover most challenges?
- What has driven the state-level initiatives, in terms of the context, stakeholders, and incentives during this period?

3. The Methods

The existing literature on health and education in Odisha has focused on disparities in health and education outcomes along lines of social group (in particular, the state's large tribal population), geography (with a prominent focus on rural areas and Kalahandi–Bolangir–Koraput plus [KBK+] districts), and gender. Studies additionally examine the implementation of particular initiatives such as Integrated Child Development Services (ICDS), National Health Mission (NHM) (central), and state initiatives such as BSKY and Multilingual Education (MLE). Few studies have examined why the state introduced these initiatives, what led to their initiation, and the actors involved. Our study aims to address this gap by examining health and education in Odisha's urban areas.

There are several ways to understand the state's focus on education and health. Venkateswaran et al. (2021) argue that it is insufficient to identify technical solutions to healthcare challenges; rather, "the drivers of priority setting in policymaking, and the interaction and incentives of different actors, political and others, are as critical to strengthening health policy." Campos (2020) further argues that an analysis of the "position, power and interest" alongside the dynamics of stakeholders is critical to understand their role in steering reforms in health. In the context of educational reform in India, Kingdon et al. (2014) make a similar case for situating the "paths and outcomes of educational policies [since these] are overwhelmingly impacted by political processes and practices."

In the health sector, several scholars have discussed aspects primarily related to barriers to quality care, inequities within Odisha's health system, and an analysis of select state initiatives. The comprehensive study of Odisha's health system by Yip et al. (2022) highlights many of the state's challenges in terms of poor quality of care, affordability and high OOPE, limitations of the state's insurance scheme, as well as the increasing uptake of private providers for the purchase of drugs. Mor (2025) discusses how geography informs differential health outcomes in the state, with "Health System A" (coastal, more urbanised) being better equipped than "Health System B" (tribal-dominated districts). The study makes an important contribution to recommendations for health systems reforms in both these contexts. There have been several studies that analyse utilisation patterns and implications of state initiatives such as BSKY (Chandrasekhar & Naidu, 2021; Sahoo et al., 2023). These studies estimate changes in OOPE, arguing that despite the scheme, high OOPE persists (Sahoo et al., 2023). Historicising health policy in Odisha, Campos (2020) traces many of Odisha's initiatives from 2000 to 2019 and highlights little documentation on state-level initiatives in steering health innovations, a gap this paper aims to address. While the literature on health in Odisha has arguably enriched the discussion around the barriers and recommendations of improving quality and affordability, this paper unpacks the drivers of these myriad initiatives.

In education, the focus has been on analysing equity implications and tribal inclusion through the state's MLE initiative (Dash, 2013). Odisha has been credited with focusing on mother-tongue-based instruction (from 2006–2007) before the more recent push through the National Education Policy (NEP) 2020. Nayak and Palita's study (2021) is one of the few that examines the primary education ecosystem in Odisha as a whole. They analyse determinants of the quality of primary education and find that parental background, teacher capacity, and increasing privatisation have led to poor quality of learning. Yet, these implementation-focused studies do not shed much light on the drivers of primary education initiatives, or on how these shifts in educational preference are informed by stakeholder dynamics.

Study Methods

This qualitative study employs the following methods:

- Review of government policy documents such as the Economic Survey (2014–2024), Project Approval Board (PAB) minutes (2014–2024), Record of Proceedings (ROP) reports (2014–2024), Comptroller and Auditor General of India (CAG) reports on Public Health Infrastructure and Management of Health Services in the State (Report No. 7 of 2024), Report No. 5 of 2021—CAG's Audit Report (General and Social Sector) for the year March 2020—Odisha, Report of the CAG on School Education in the State (Odisha)—Report No. 5 of 2025, Departmental Annual Reports.

- Secondary data analysis from official datasets— RHS 2017–2021, National Sample Survey Office (NSSO) 75th round, Survey on Household Consumption Expenditure (HCES) 2023–2024, National Sample Survey Office (NSSO) Report No. 596: Household Social Consumption: Health; U-DISE 2012–2013, U-DISE 2022–2023, U-DISE 2023–2024, NAS reports—2017 and 2021, NFHS-3, NFHS-4, NFHS-5, NFHS-6, SRS Special Bulletin on Maternal Mortality in India 2015–2023, and National Health Accounts (NHA) 2021–2022.
- Review of reports produced by autonomous government bodies—NIUA, NITI Aayog, etc.
- Review of civil society reports, including Policy Research Studies (PRS) Legislative Research, Annual Status of Education Report (ASER), and similar reports.
- KIIs with state, district, and facility-level bureaucracy in health, education, finance, urban development, CSO leaders (community-based and international bodies), journalists, school teachers, and Urban Primary Health Centre Medical Officers (UPHC-MOs). Categories of respondents can be found in Table 6 below.[8]
- Focus group discussions with users of services (UPHCs and government schools) and visits to UPHCs.

Table 6: Categorisation of Key Informants According to Their Role in State-Level Initiatives

Type of informant	Category	Rationale
Secretary	State-level bureaucracy decision-makers	They determine which policy to implement, offer technical input on the design and implementation structure, budgets, locations, and timelines, and manage the education and health systems on a day-to-day basis.
Former senior members of bureaucracy: finance, planning, health, education, and urban development	State-level bureaucracy decision-makers	Lead decision-making and liaising between ministries, planning and financing for departments, and high-level decision-making in types of initiatives prioritised by the state.
District-level officers in health, education, local governance, and the collector	District-level implementers	Implement the programme at the district level, raise budget requests, and provide technical inputs on areas of policy gaps and strengths.

[8] To preserve anonymity and respect confidentiality of respondents, all personal identifiers have been omitted in this study, along with exact numbers within each category of respondents.

Type of informant	Category	Rationale
School principals, teachers, representatives of teacher associations, MO of PHCs	Frontline-level bureaucracy	Implement the programme at the facility level, as they are closest to the hard realities of running PHCs and schools, and have the best understanding of the programme's functioning.
NGO leaders	Civil society partners	Works with the state government and district level, providing ideas, technical inputs, and occasionally funding for schools and PHCs.
Technical agencies, national-level donor-funded NGOs, philanthropy bodies, donors, and multilateral bodies	Civil society partners	Works primarily with the state government, providing ideas, technical inputs, and funding support to the state's initiatives.
Researchers and university professors	Academic experts	Members of state-appointed government commissions provide technical insights on health and education and shape popular perceptions through public writings.
Journalists: health, education, and politics	Policy influencers	Influence policy by tracking and observing the implementation of health and education initiatives.
Local journalists	Engaged citizens	May not be working on health and education, but knows the locality enough to have a sharp understanding of the functioning of local schools and PHCs.
Users of schools and PHCs	Ordinary residents	They have no role in policymaking or implementation, but both should be oriented towards these processes.

Source: Authors' analysis.

Note: MO = medical officer; PHC = primary health centre; NGO = non-governmental organisation.

Thus, our methods utilised a range of primary and secondary methods to ensure a cross-section of views in our KIIs to triangulate key information.

Why a Study on Drivers and Dynamics of Policymaking?

Rather than focusing on the implementation of schemes or budgetary allocations as indicators of prioritisation, our choice to focus on drivers of state-level initiatives helps in the following ways.

First, this approach involves examining stakeholders involved in policymaking processes, channels for policy ideas to fruition, and understanding problem–solution alignment, allowing us to trace whether the initiatives are aligned with ground-level demands and challenges. Second, it enables a mapping of policy pathways and looks at the mechanisms through which demands have been articulated. The implication of this approach is that we are suited to identify which channels were more effective, and how these can be mobilised for future policy decision-making. Similarly, ineffectiveness of particular channels or dilution of earlier pathways reveals the changing nature of policymaking in the state. Third, stakeholder dynamics are crucial to understand what the state chooses to focus on. With the right technical advice, policy can be divorced from politics. Yet, prior analyses of health and education initiatives at the state level reveal that visible and electorally viable initiatives are often prioritised (Singh, 2025). Fourth, the limitations of solely relying on the implementation of particular schemes are that these studies are unable to answer why that particular initiative was introduced in the first place. Similarly, budget analysis remains an important indicator of the state's prioritisation, but the presence of consistently under–utilised budgets reveals a deeper challenge and necessitates additional approaches.

Examining Other Approaches That Have Been Used to Examine a State's Health and Education Priorities

A common way of understanding whether governments focus on health and education is to trace budgets. Several organisations like the Centre for Budget and Governance Accountability, PRS Legislative Services (nationally), and the Centre for Youth and Social Development (Odisha) have undertaken this important analysis, which we have immensely benefited from. In Odisha, there have been increases in the budget for the health and education sectors. Yet, in this study, we have chosen not to undertake a thorough budget analysis. We only see if there are any significant increases. In Appendix 1, we demonstrate what a budget analysis would look like and its limitations. We take an example of the increasing budget allocations to the state health insurance scheme, BSKY. While a budget analysis reveals how allocation to BSKY as a proportion of total health budget has increased between 2019–2020 and 2023–2024, it misses two important implications: a) prioritising health insurance can encourage use of private facilities, but primary care can get sidelined; and b) it can lead to low investment and lack of focus on public facilities. Similarly, for education, we consider the case of the Mo School Abhiyaan, cited as a key education

scheme during the decade. We show how the Mo School Abhiyaan budget increased significantly between 2019 and 2023. The initiative aimed to mobilise school alumni for donations for school development, yet this emphasis has come at the cost of prioritising urgent issues plaguing education, in terms of quality, teacher capacity, and urban governance challenges. Therefore, by examining the initiatives, this study highlights whether they align with ground challenges. Across health and education, this study examines what ideas were driving policy initiatives, who the actors and stakeholders were, and what the dynamics were between them, which led to particular ideas being emphasised over others.

Temporality of the Study

Rather than tracing select initiatives, our study examines state-level initiatives over a period of 10 years. The longer duration of our analysis helps understand evolving thinking, changing dynamics impacting the initiation of new ideas, and whether states are able to effectively identify and tackle key challenges. Unlike other sectors, given that quality changes in education and health take a longer time period to fruition, this extended period allows us to trace policy thinking and the types of challenges prioritised over time. Operationally, an analysis of the preceding decade enabled us to access government documents with ease and ensured higher recall from users of services.

Geographical Scope of the Study

While the study focuses on state-level initiatives, we have included district-level implementers to understand institutional alignment and whether ground-level challenges are attuned to the issues being prioritised at the state level. We also trace the policy pathway from the facility to the state level to understand the bottom-up pathways and how local problems and ideas feed into policy thinking at this level. We triangulated bureaucratic perspectives with those not directly involved in policymaking (journalists, CSOs, researchers) to understand what drove different ideation and to what extent other stakeholders had a role to play (for instance, CSO reports, lobbying efforts). Finally, including perspectives from users of services (government schools and UPHCs) enables us to trace the alignment between the solutions offered and challenges and aspirations at the ground level to understand the channels through which citizens engage with policy ideas to shape or contest them.

Study Sites

We selected three districts which have among the highest shares of urban population in Odisha. Given Odisha's intra-state disparities, we further narrowed this down to a capital, an older urban centre (unplanned as compared with the capital) with a dense population, and a coastal urban area across three districts. These sites were selected with varying resource availability, proximity to the centre of power, and differences in the composition of the population. This enabled us to examine how state initiatives play out in urban areas. It also allows us to explore different kinds

of urban areas and whether these have different policy pathways for making state initiatives. For example, in coastal areas, are CSOs more active in proposing and mobilising for new initiatives because these are prone to natural calamities? Lastly, in urban areas, the functioning of urban municipalities becomes critical to health and education delivery. We therefore selected three sites which are run by three different urban municipal corporations.

Data Gathering and Analysis Parameters

Our study probed further into the following five questions, adapted for different categories of stakeholders (for instance, for users of services, we included more follow-ups around their ground-level experiences and engagement with frontline bureaucracy in health and education).

- What are the most important initiatives in elementary education and primary care initiated by the state government in Odisha between 2014 and 2024? Do these initiatives focus on urban areas, in what ways?
- Why were these initiatives conceptualised, and what specific challenges in education/health did these initiatives aim to solve?
- Who were the key actors involved in spearheading these initiatives?
- What kinds of policy challenges do the initiatives focus on, and how do they relate to the everyday functioning of PHCs and schools?
- What factors led to the development of these initiatives?

A detailed summary of the methods, including sub-research questions, probe areas, data sources, and analysis framework, is available in Appendix 3.

4. The Insights

4.1 Greater Focus on Health

Between health and education, Odisha has focused more on health. This includes budget allocations, the number of initiatives (Appendix 2), and identifying critical challenges around which initiatives have been developed. Elementary education, particularly urban elementary education, has received less attention within the broader agenda.

Budgets

In terms of budgets, there has been an increase in the percentage share of health in the total budget—from 5.33% to 7.55%. The state has allocated a higher share than the all-state average since 2018–2020 (barring 2019–2020). In education, between 2018–2019 and 2023–2024, the percentage share remained nearly constant at 13% of the total budget; during this period, the state allocated a lower share than the all-state average to education (PRS Legislative Briefs) (Table 7).

Table 7: Odisha's Expenditure on Education and Health as a Proportion of its Total Budget Compared to Major States

Year	% of Total Budget Allocated to Education	Average Expenditure Allocated to Education by Other States (%)	% of Total Budget Allocated to Health	Average Expenditure Allocated to Health by Other States (%)	Number of States Based on Which Average Expenditure has been Calculated in a Given Year
2018–2019	14.7	16.1	5.1	4.8	18
2019–2020	14.7	15.9	5.1	5.2	27
2020–2021	14.6	15.9	5.5	5.3	29
2021–2022	14.9	15.8	6.4	5.5	30
2022–2023	13.5	15.2	6.8	6	30
2023–2024	13.2	14.8	7.6	6.3	31

Source: Policy Research Studies Legislative Briefs, 2018–2019 to 2023–2024 (State Budget Analyses).

Initiatives

We identified four initiatives that focus exclusively on urban primary care—Ama Clinic, UPHCs in PPP mode, NCD Camps, and mental health initiatives. The focus of health initiatives has been on secondary and tertiary care and cross-systems issues, such as Human Resources for Health (HRH), with limited adaptation for the urban context. Outcome indicators have improved for many health issues, but many critical challenges remain, and some indicators have also seen the opposite effect (for example, IMR in urban areas and MMR across the state).

In education, we identified one urban-specific initiative—Assistance to Needy Women & Eminent Scholars through Holistic Action (ANWESHA), which focuses on scholarships for SC/ST students in private English-medium schools in urban areas. Most of the other initiatives either focus on the entire school system or exclusively on secondary schools. Recent initiatives such as the 5T High School Transformation programme have focused on infrastructure-related issues in secondary schools, which include both physical and digital infrastructure. Additionally, initiatives during this period have prominently focused on mobilising philanthropic and alumni funding for schools (Mo School), free textbooks and uniforms, and school mergers.

In the following two tables, we identify the key initiatives in health and education in the decade 2014 to 2024, the problems that were prioritised, solutions offered through initiatives, and the policy ideas guiding these initiatives.

Table 8: Health Initiatives in Odisha 2014–2024 and Associated Key Ideas and Solutions

S. No.	Problem	Policy Idea/ Objective	Initiative	Key Ideas and Solutions in the Initiatives	Status
1	High OOPE in healthcare	Reducing OOPE	Niramaya (2015)	Free drugs and medicines scheme across all health facilities. It started with 150 drugs on the list, which has been updated to 570. These are distributed through the Drug Distribution Centres.	Ongoing (Launched in 2015, extended in 2024)
			Nidaan (2018)	Free Diagnostic Services at identified Public Health Facilities both through their own system and the PPP mode implemented. All types of essential diagnostic services are provided free of cost to all categories of patients in all public health facilities.	Ongoing (Launched in 2018, extended for 5 years in 2024)
			Biju Swasthya Kalyan Yojana (2018)	Health Assurance scheme launched on August 15, 2018. The scheme has two components: 1. Universal Free Healthcare (OPD + IPD) for all: ● In all Public Health Institutions up to Medical College and Hospital level and in Government Blood Banks. ● No Documentation is required for accessing healthcare services. 2. Free healthcare for 70 lakh families that are economically vulnerable.	Discontinued in 2024; Succeeded by GJAY, now merged with Ayushman Bharat
			Sahay (2017)	Free dialysis services to all patients at 29 District Head Quarter Hospitals through PPP mode.	Ongoing
2	Improving uptake of UPHCs in urban areas due to the preference of urban residents for treatment from specialist doctors	Providing specialists from different medical branches who visit UPHCs on a weekly basis	Ama Clinic (2017)	To cater to the demand for specialists in urban areas, Ama Clinic provides a range of specialists who visit UPHCs on a weekly basis during OPD hours to provide services (including gynaecologists, skin specialists, ENT, etc.).	Ongoing
3	HRH challenges in urban PHCs	Ensuring the availability of manpower in UPHCs through the PPP mode	UPHC—PPP mode (2021)	To address the unavailability of doctors in UPHCs, MoHFW recommends PPPs as a tool to deliver various services under NUHM. In Odisha, this has been implemented in UPHC management and doctor recruitment in partnership with NGOs (such as the Red Cross).	Ongoing

S. No.	Problem	Policy Idea/ Objective	Initiative	Key Ideas and Solutions in the Initiatives	Status
4	Urban-specific challenges	Enhancing capacity and outreach for addressing urban-specific challenges	NCD Camps and Mental Health Initiatives	NCD Camps: Urban NCD camps in Odisha focused on outreach to urban populations for awareness and early screening around cancer, diabetes, and respiratory diseases. In addition to the activities under the NP-NCD, Odisha has conducted several NCD camps, with a focus on urban demographics. Mental health: In addition to activities under the DMHP under NHM, Odisha's State Disaster Management Authority launched a psycho-social care programme for disaster-affected communities in six coastal districts—Balasore, Bhadrak, Kendrapara, Jagatsinghpur, Puri, and Ganjam. With technical support from NIMHANS Bangalore, the initiative aims to build community-level capacity (local volunteers and community workers) to provide psychological first aid and counselling.	Ongoing
5	Poor uptake of UPHCs	Strengthening the last-mile delivery of health in urban areas	Extension clinics—UPHCs*	Extension clinics to UPHCs aim to improve accessibility and decentralise primary healthcare. It is aimed to strengthen the last-mile delivery of health services for urban demographics who find it harder to access facility-based care.	Ongoing

Source: Authors' own work.

*Note: *These include initiatives that were shared with us by facility-level staff at the district level. Documentation around the initiatives is not publicly available; however, we corroborated these initiatives with internal programme circulars shared by facility staff.*

OOPE = out-of-pocket expenditure; OPD = out-patient department; IPD = in-patient department; GJAY = Gopabandhu Jan Arogya Yojana; UPHC = urban primary health centre; HRH = human resources for health; PHC = primary health centre; MoHFW = Ministry of Health and Family Welfare; PPP = public-private partnership; NUHM = National Urban Health Mission; NGO = non-governmental organisation; NCD = non-communicable disease; NP-NCD = National Programme for Prevention and Control of Non-Communicable Diseases; DMHP = District Mental Health Programme; NHM = National Health Mission; ENT = ear, nose, and throat; NIMHANS = National Institute of Mental Health and Neurosciences.

Table 9: Education Initiatives in Odisha 2014–2024 and Associated Key Ideas and Solutions

S. No.	Problem	Policy Idea/ Objective	Initiative	Key Ideas and Solutions in the Initiatives	Status
1	Poor access to learning for SC/ ST children in urban areas	Reducing OOPE through scholarships and opportunities for tribal students	ANWESHA Scholarship	Implemented across 17 tribal-dominated districts to provide quality urban education to ST and SC children from BPL families from Class 1. It partners with private schools in urban centres and district headquarters, covering all educational and residential costs.	2015–2025. Launched in 2015–2016. Extended in 2020 for five years.
2	Low enrolment in schools	Rationalising the number of schools through mergers	School merger	Schools with poor student strength closed and merged.	Began in 2020.
3	Poor finances for government schools, due to which basic school needs, such as infrastructure, were weak in some cases	Raising finances from school alumni	Mo School	It was rolled out with the aim of collecting funds from the alumni for the development of schools and colleges in the state. It provided a platform to donate funds, materials, and services to schools.	2017–2024. Launched in 2017. Succeeded by Panchasakha Sikhya Setu in 2024.
4	Poor infrastructure in schools	Improve school infrastructure, primarily in high schools	5T High School Transformation	5T High School Programme (technology, teamwork, transparency, time, and transformation) aimed to modernise 8,679 high schools (categorised as up to Class 10) across the state, including provision of smart classrooms and infrastructural upgrades.	2021–2024.
5	Poor access to learning	Providing quality education in English instruction through a residential model school in every district	Odisha Adarsh Vidyalaya Sangathan	OAVS is a model school program which aims to provide quality education in English medium to the rural children of Odisha, practically at no cost or at low cost. One OAVS is planned in each block of Odisha in a phased manner. All OAVS are affiliated with CBSE. The entry level is Class 6.	Ongoing. Launched in 2016. Carried forward as Godabarish Mishra Adarsha Prathamik Vidyalaya in 2024–2025 for model primary schools.

S. No.	Problem	Policy Idea/ Objective	Initiative	Key Ideas and Solutions in the Initiatives	Status
6	High OOPE in education	Providing free textbooks and uniforms in government schools to encourage uptake and retention	Free textbooks and uniforms	Implemented in several states as a provision under the RTE 2009. The idea was to encourage the uptake of government schools by reducing OOPE in schooling for families. In 2019, the Odisha government announced an extension of free uniforms to all elementary school students in the state.	Ongoing. Introduced in 2010.

Source: Authors' work.

Note: OOPE = out-of-pocket expenditure; OAVS = Odisha Adarsha Vidyalaya Sangathan; RTE = Right to Education; BPL = below poverty line; SC = Scheduled Caste; ST = Scheduled Tribe; CBSE = Central Board of Secondary Education.

There are critical challenges that plague both health and education in urban areas that have so far not been adequately prioritised in these initiatives. Within our identification of initiatives, several key aspects stand out.

While there has been an overall increase in budgets for health and education, these did not match the most critical challenges on the ground. While budgets towards the state's health insurance scheme increased, primary care remained sidelined. Similarly, in education, the Mo School Abhiyaan, cited as a key education scheme during the decade, saw increasing budgets during our study period. Yet, the emphasis on mobilising alumni for school development through the initiative did not address many of the challenges plaguing poor quality and availability of education (refer to Appendix 1 for an analysis of what the budgetary trend shows and the dominant allocations within the health and education budget).

Within the health and education initiative, urban challenges have not been addressed separately. However, there has been a range of initiatives undertaken by the Odisha Government for urban development as a whole (through the Housing and Urban Development Department [H&UDD]) in Odisha. Across these urban development initiatives, health and education are not part of the interventions. For example, an important programme has been the Jaga mission, which aims to provide land titles to the poor living in slums and to create "Adarsh colonies" in slums where the titles have been notified. These Adarsh colonies are defined as having "liveable habitats" and fulfil nine types of basic services, such as roads, drainage, etc. Neither primary health nor elementary education is part of the nine requirements to upgrade a slum to an Adarsh colony. Other schemes by H&UDD in this decade have an explicit focus on dignity for the urban poor—for instance, the Garima Scheme aimed at improving working conditions for sanitation workers. This indicates that while the state has a policy awareness of equity within urban areas as a distinct space for policymaking, government-provided education and health do not feature within this understanding of urban development.

4.2 Alignment Between Initiatives and On-Ground Challenges

Odisha's health and education policy landscape is misaligned with the ground realities of UPHCs and urban elementary schools, particularly regarding uptake. We found two kinds of misalignments: a) problem–prioritisation in which critical problems affecting uptake have received limited attention, and b) problem–solution linkages, in which the solutions proposed by existing initiatives are not fully able to meet either the initiatives' stated objectives or the broader goal of improving uptake. These manifest somewhat differently in health and education, but the broader trends are similar in both sectors.

Problem–Prioritisation Misalignment

There are a wide range of challenges impacting urban elementary education and primary health, and the initiatives, budgets, and expenditure have focused on a limited set—ones that are not necessarily critical. Our findings that state-level initiatives have not focused on the most critical challenges are reinforced by CAG reports, policy documents, think tank reports, and academic papers. For instance, the CAG report on Public Health Infrastructure in Odisha (2024) pointed out stark differences between policy ideas and on-ground needs, including challenges around healthcare facilities in terms of shortages of sub-centres, PHCs, CHCs; HRH challenges, notably state-wide doctor shortages; shortage and sub-par quality of drugs supplied; issue of 'low spending efficiency' impacting scheme delivery and under-accounting of additional finances through DMF (CAG, 2024).[9]

An independent study by Yip et al. (2022) finds that despite the immense focus on the state's insurance scheme, only 14% of households reported having any insurance coverage, further reiterating that the initiatives focused upon (in this case, insurance) have not effectively protected people from financial risk in the state. In the case of education, a CAG audit of school education was released in 2025 (CAG, 2025*), and* we found no third-party audit of elementary education during the study period in Odisha. Media reports have frequently demonstrated challenges in Odisha's teacher hiring policy and filling vacancies over the years. Pradhan (2024) reported that the government planned to hire teachers in response to more than 17,000 teaching posts lying vacant across the state's primary and upper primary schools. A KPMG study commissioned by the Confederation of Indian Industry independently evaluated the impact of the RTE across states. For Odisha, the report concluded that many of the RTE provisions were not met. For instance, in 2015, 92% of the schools did not meet the prescribed standards. Around 6 million children were out of school,

[9] Specifically, the report notes the following: 1. Discrepancy between budget allocation and utilisation. Execution of 456 works, approved during FYs 2016–2017 and 2019–2020, by the NHM, Odisha, had not been completed, even after two to five years of approval, though ₹165.95 crore had been incurred on these works. 2. The doctor to population ratio in Odisha is 1:1,622, against the World Health Organization norm of 1:1,000. For staff nurses, the ratio was 1:3,829, against the norm of 1:300. 3. Shortage and sub-par quality of drugs supplied. There was a short supply of 53% of the indented quantity of essential drugs and medical consumables to public health facilities, during FYs 2016–2017 to 2021–2022. It was noticed that 6.07 crore units of essential drugs, valued ₹11.68 crore, had expired during FYs 2016–2017 and 2021–2022 (CAG report, 2024).

and a majority of these out-of-school children (OOSC) belonged to minority groups (KPMG, 2016). Across health and education, these reports and studies reinforce our subsequent arguments that the state has not prioritised ideas to address these persistent challenges.

Elementary Education

Infrastructure, teacher, and support staff availability in elementary school is not the focus of policy initiatives: In elementary education, this mismatch is particularly acute. Among the initiatives for urban schools, only OOPE for books and uniforms and education costs for tribal children studying in urban private schools have been focused on. Initiatives which focus on all the schooling years and both in rural and urban areas have focused on school mergers, making select schools model schools, and alumni mobilisation to enhance school funding (Mo school). However, critical challenges in infrastructure, human resources, and governance remain unresolved across the bulk of the elementary school level.

These challenges were well illustrated by the school headmaster of a successful, high-enrolment government school (500+ children in the school). He highlighted that his well-performing school faced long-standing challenges, which other smaller schools also face, but to a much worse degree. He stated that despite improvements, school infrastructure in urban areas is poor, particularly lacking functional toilets for girls. Even when toilets are available, the maintenance funds are not sufficient to cover regular cleaning. Even the maintenance for the new infrastructure created as part of the flagship 5T programme is poor because these funds are not sufficient to cover it. His remarks were particularly important because his school had a) high enrolment and b) secondary classes. Due to this, his school qualified for all the top initiatives of the state (5T included) as well as a higher amount of funds as part of school grants. For other schools with low enrolments or only elementary classes, both funding and policy attention are much lower. His insights were echoed in the arguments made by civil society leaders who stated that within school education, the focus of initiatives has been on improving infrastructure in secondary schools.

A retired senior bureaucrat, while emphatically arguing that funds are not a challenge in Odisha, stated that, "Under 5T, high schools were beautified while the primary school collapsed."[10] He also echoed what several others—including those in the state bureaucracy—mentioned that Odisha needs implementable ideas, particularly in the education sector, which has not seen as much attention and improvement over the last several years. Notably, with regard to the 5T programme as well, state initiatives have focused on the relatively less critical issue of infrastructure and not on the more complex challenge of the maintenance of the infrastructure or onboarding relevant and adequate human resources, such as headmasters, teachers, and support staff, such as computer operators, peons, and cleaners.

[10] Authors' translation.

In one instance, one headmaster told us that the cleaning staff from the local municipal corporation is not working in the school because the corporation has not been actively involved in the education system. He used private cleaning service providers, but due to the limited budget, this could only be done once a week. This, of course, has implications for the schooling experience when compared with private schools and the uptake of government schools. In the case of the school merger programme, the stated rationale was addressing low enrolment and a lack of adequate teachers in many schools. The state then decided to 'merge' many of these schools. However, the effect it has had, as reiterated in an important study by Bag and Swetashree (2022), is a spike in dropout rates due to the increasing distance of many habitations from the nearest school, an issue compounded in Odisha's remote settlements. There is a stark mismatch between the solution and challenge, given that the policy has not addressed the fundamental reasons for low enrolment, which include competition from private providers and migration; rather, it has increased inequities in access to schooling for children (Bag & Swetashree, 2022).

Lack of human resources weakens other initiatives in achieving their goals, such as free books, uniforms, mid-day meals, and even the 5T programme. Staff are not sufficient to implement these at the school level, and this invariably means that teachers do these additional tasks during teaching time.

Governance systems at the facility, block, and district level are not a focus: Governance of the school system at the district and block level is a deeper, structural challenge which has been largely ignored. These challenges manifest themselves in several ways. Unlike rural schools, urban schools are not under the local elected bodies, which means that there is weak political accountability of the facilities and services at the local level. In rural schools, the panchayats, the local political leaders, while not formally responsible for school functioning, are actively engaged because the identity of a local school is that it belongs to the village. There is no parallel, political, or social unit to which an urban school belongs. The education governance system has also not been restructured and standardised with changes in the urban population. For example, in one of the study sites, the urban area was put under a municipal corporation in line with changes in the population norms, but the school district continued to remain under the rural block. Urban schools in this city are being run as part of the rural school governance structure. The post of the district education officer responsible for these schools at the district level was vacant for several years. Due to this, school headmasters were not able to petition the state authorities. In the words of a school headmaster and head of the local chapter of the teacher association:

"We need...urban education officer here if we want to change education here. There was a government notification that five cities in Odisha have a separate education officer. Bhubaneshwar, Cuttack, Rourkela, Sambalpur, and Berhampur. This post had scope for the education office to take up the office. Thirteen years later, the post is not there."[11]

[11] Authors' translation.

Teachers stated that monitoring systems for teachers are weak, and the immense paperwork tracking attendance and event organisation does not improve performance. Multiple rounds of data collection in paper and digital formats have created a situation where a mountain of data exists on every activity in the school, but this does not result in improvement in school functioning or higher uptake of government schools by students.

There were no initiatives to improve infrastructure at the urban primary levels, addressing HRH challenges, governance, and accountability-related issues.

Primary Healthcare

The infrastructure of urban primary care centres in non-capital urban areas is not a focus: In health, primary care infrastructure in terms of upgrading buildings, with adequate rooms for various health services, cleanliness, and accessibility, has taken place but it appears to be focused on the capital city, as several civil society leaders working in the area of health and urban governance shared with us.

"In Bhubaneswar, there has been heavy investment in health. The story in the rest of Odisha is different. Even between urban areas, there is a major discrepancy."[12]

The study by Bhakta et al. (2025) substantiates our argument on the notable disparity in performance between UPHCs. Their study draws on one district of Odisha—Berhampur—and assessed the compliance of UPHCs with the National Quality Assurance Standards across its eight domains—service provision, outcome, quality management, patient relations, inputs, support services, clinical services, and infection control. They found that specific UPHCs in the district performed significantly better than others, denoting that there has been a challenge of varying levels of quality between and within urban areas in Odisha.

In our visits to UPHCs, we observed a wide variation in the infrastructure, human resources, and implementation of the services. The challenge of land availability in the congested old cities of Odisha was an important limitation. However, it appears that other aspects of improving UPHCs, which are not dependent on the physical structure, have also not received adequate focus. Primary among them was human resources. The focus of funding and initiatives for infrastructure has been on the tertiary care level. Initiatives to improve human resource availability, including those undertaken before the period of this study, such as place-based incentives, transparent transfer and recruitment policy, and increasing the age of retirement for doctors, do not adequately focus on the challenges of urban primary care.

High competition from private medical options is a prominent challenge, which includes licensed as well as unlicensed practitioners. For UPHCs to emerge as a preferred option, they need regular attendance of doctors, availability of medicines and tests, and more time to care. Most importantly, the linkage of the UPHCs to the local community through the doctors and the field staff is most important. UPHCs

[12] Authors' translation.

outside the capital city face challenges on all these counts. Odisha allows private practice for government doctors and UPHC doctors to run private clinics, which comes at the cost of building connections between the UPHC and its catchment population. In many places, there has been high turnover of MOs, regular stockouts of medicines, and the outsourcing of diagnostics to an external private player.[13]

Current urban primary care initiatives in Odisha—extension clinics, free medicines and tests, Ama Clinic, and NCD camps—address a limited range of policy problems, and they do not solve the most critical challenges to reducing UPHC uptake.

State-level governance challenges: Poor state-level governance, which is an important element of third-party monitoring of welfare programmes, is not a focus. A retired senior bureaucrat told us that he led the creation of a programme monitoring unit at the state level. The idea behind the unit was that it could be used by the various social welfare departments (health, education, women and child development, etc.) to ensure that programmes are being effectively monitored and continuously improved. He stated that despite allocating budgets to this unit, there was limited uptake by the relevant state departments. This leaves CAG audits as the only mechanism to assess the situation, but these audits are infrequent and cumbersome.

Health and education are missing from the urban development agenda: Odisha has rightly focused on a range of urban development-related issues, but government provision of primary health and elementary education in urban areas is not included in this development agenda. Over one-fifth of Odisha's urban residents live in slums and are poor (NUHM Odisha, 2023), and several critical problems facing urban Odisha have been addressed with notable solutions, such as wastewater management and land rights for the poor. Linking the urban poor with social welfare benefits and ensuring that they are aware of programmes and schemes, such as pensions, scholarships, and free health check-ups, is the only aspect of health and education that is included in urban initiatives.

To illustrate further, important CBOs have been created as part of the Jaga mission[14] and other programmes have been implemented in urban areas such as Mission Shakti. These CBOs include slum development committees, ward-level committees, and SHGs. These groups are important players in mobilising women (the key segment of the population with regard to UPHCs and elementary schools), local leaders, and frontline functionaries of the bureaucracy, but they have no role in UPHCs and schools in their catchment area. This is a policy blind spot as long as these groups

[13] The PPP model of diagnostics has been recommended under National guidelines for organising UPHCs—"PPPs can be used as a tool to deliver various services under NUHM—clinical services at UPHCs, specialist outreach services, community outreach services, diagnostic services, mobile health units, etc.," (NHSRC, 2021). In Odisha, PPP model is used in many of these areas including diagnostics, through which Krsnaa Diagnostics (since 2023) won the tender to set up laboratories and diagnostic services including imaging, ultrasounds, and pathology across the state.

[14] Jaga mission comprises nine elements, which need to be completed for the urban slum to be upgraded to an 'Adarsh colony'. Outside of the state capital, the implementation was patchy with Jaga mission staff in smaller urban centres explaining, "While in the capital, 90% have received land rights, there are land issues, and hardly 10% have received the entitlement here—mainly the challenge is that there are many private properties. To relocate people, the government first needs to find space to build houses."

have not been oriented towards engaging with health and education facilities in their catchment area by local government functionaries. But equally puzzling is the fact that these groups have also not organically—and of their own initiative—sought to engage with improving health and education services.

There are several areas in which, without a formal role, these organisations can influence the ways schools and UPHCs function. These are mobilising other members of the community to uptake services, sharing community concerns with the facility leaders, and facility concerns with local leaders and sub-district level bureaucrats. But the role of CBOs so far has been restricted. A former health secretary shared with us that SHGs are involved in the preparation of mid-day meals and nutrition supplements primarily in rural areas. She further highlighted that CBOs created as part of urban development programmes do not engage formally or informally with schools and UPHCs, a point that was corroborated by members of these CBOs themselves and various grassroots government functionaries, such as frontline members of the programme teams of Jaga mission, members of the state-level leadership team of Jaga mission, and civil society leaders.

Misalignment Between Solutions Proposed in Existing Initiatives and Ground Challenges

The limited range of problem prioritisation in both health and education is further constricted by the disconnect between the solutions proposed in existing initiatives and the on-ground needs of schools and UPHCs. Again, this is more pronounced in education than in health.

Elementary Education

Existing education initiatives have not solved the crippling teacher and 'teaching deficit': For urban schools, the critical challenge is addressing the state of the teacher cadre, in terms of recruitment, training, transfers, job allocations, monitoring, and governance. The solutions proposed in the existing initiatives, such as school consolidation and hiring contract teachers, have not improved the availability of teachers or improved the quantity or the quality of teaching time because these solutions do not consider the specific realities of elementary schools, particularly in urban areas.

In the merged 'model schools', adequate teachers are unavailable—particularly specialists for English, Sanskrit, and Hindi—because the foundational problem of teacher availability has not been addressed. To fulfil the requirements, subject specialists are brought in from nearby schools. This not only compromises the legitimacy of the merged school as a 'model' one but also destabilises other neighbouring schools. Schools' mergers have caused other challenges to the teacher cadre. School teachers and civil society leaders told us that merging elementary classes with secondary schools creates friction between the cadres, as secondary teachers are in a higher position than primary teachers. More importantly, secondary teachers are not skilled to understand the needs of primary class students, and

when elementary class teachers are not in decision-making positions in the school hierarchy, it impacts student learning and school uptake.

On-contract hiring, while temporarily addressing teacher shortages, keeps teachers working in precarity. Contract teachers make low pay and are in search of either full-time positions or other jobs. This significantly impacts motivation and teaching commitment, which in turn impacts 'teaching time'.

The impact of these two initiatives is further compounded by existing challenges in the school system, one of which is diversity in the 'types' of teachers in the elementary school system, with different service benefits. This is tied to multiple categories of schools, which were started at different times by the state authorities. Some are called after the year they were started, others after the classes that they include. Teacher union representatives shared with us that, "there are different types of schools, even with aided and unaided, various types exist—2004, 2009 type. It is very confusing. Maybe the reason was revenue." Each category of school has its own cadre of teachers and their own service rules and benefits, and these have not been rationalised. Summarising the implications of these challenges, teacher representatives shared with us:

"We have issues with promotions, and vacancies are high, with some schools not even having a headmaster. Teacher filling vacancies is done at random intervals. Different types of qualifications are required for each position—for example, Bachelor of Education (B.Ed) and Certified teachers—and the benefits are different for different categories. We get a lot of other work as well—for free uniforms, we need to take measurements, during holidays, we need to produce data on dry rations, even pre-election, we need to ensure photos are taken. There is no additional staff to do all this. Basically, the teacher's attention is spread. Private teachers only have 1 responsibility: teaching, so accountability is on them."[15]

These insights from the teachers themselves significantly problematise the assumptions that a) teacher availability in urban schools is not a problem; and b) Pupil Teacher Ratio (PTR) in urban schools meets the RTE standards. In urban schools, both are lopsided. More than the availability of teachers, it is the non-teaching duties that teachers must fulfil and the additional teaching responsibilities they have to take on for subjects they are not trained to teach.

Shortages of support staff: Shortages of teachers and 'teaching time' are accompanied and compounded by shortages of support staff such as computer operators and administrative staff. These also stifle the solutions proposed by the initiatives. For example, the free books and uniform scheme has to be managed at the school level in addition to the Mid-Day Meal Scheme (MDMS), which significantly adds to the responsibilities of the fragmented teacher workforce. Provision of computer labs and smart classes (though this has only happened at the secondary level) remains

[15] Authors' translation.

ineffective because many schools either do not have the equipment operators or the existing staff have not received training in using these.

Teachers, civil society leaders, local journalists, and government functionaries across sectors have noted this misalignment. The focus on physical and digital infrastructure has preceded efforts to identify relevant human resources or assess what is critical for government school uptake. The misalignment has been highlighted in the context of the 5T schools, which have been the government's flagship initiative. The initiative focused on rural areas where there are prominent infrastructure gaps in schools. Infrastructure upgrades under 5T produced these well-painted schools with good buildings, and this created a lasting impression among people. However, rural 5T schools also suffered from a lack of relevant human resources, particularly for digital devices like smart classes and computer labs. This severely diminished the relevance of the programme.

A senior civil society leader mentioned, "In education, only infrastructure was focused upon. Smart classrooms are there, but teachers are not oriented on how to use these facilities. 5T was mostly rural." A senior journalist explained that the focus on infrastructure over systemic issues stemmed from electoral priorities, and not necessarily from the need to improve the school system—"In the last decade, the government appears to have focused more on infrastructure, which is visible for votes. The focus was not on key issues that make the infrastructure operational." Ironically, while 5T focused on classroom upgradation through smart classrooms, headmasters of schools in non-capital urban cities shared that they did not even have enough space for one playground for students. The relevance of prioritising smart classes for elementary grades, where a play area is important, was widely questioned.

Teacher training is another key challenge: Training topics are misaligned with the skills and knowledge needed by the teachers. At times, teachers on the verge of retirement are sent for training programmes. CSOs do run a range of smaller initiatives on teacher training, and these do aid the classroom interactions, but these are few and need more personnel support in the classroom to really sustain over a period of time.

Signalling that the state is not responsible for providing elementary education: A key initiative which impacts urban schools is the Mo school programme. The solution proposed in this programme is that of engaging alumni of the schools and requesting them to contribute funds to their alma mater. While the idea is an important one, as it builds connections between the school and the local community, it now questions the legitimacy of the government school system. A retired senior bureaucrat in the government shared that he was approached to raise funds for repairing the building of his school, which was on the verge of collapse. He raised the issue with the state education bureaucracy and was told that since it was an urban school, the municipality would not have the money to support the repairs. The Mo school programme was recommended to him. Under this programme, he mobilised local business owners to contribute a third of the cost of the construction, and the government contributed

the remaining two-thirds, and the school building was repaired. However, he noted that there are few schools which would have alumni of his stature who can mobilise resources in this manner. He also noted that this programme signals to the people that the government is relinquishing its responsibility to invest in basic education and creates serious inequities in the social system. Similar arguments were stated by school authorities that the programme is not connected with the realities on the ground. Affluent alumni are few, and there are limits to the number of times they can be approached to improve school infrastructure. With local MLAs and political leaders, it is also a related challenge. Funding under MLA Local Area Development (MLAD) and Member of Parliament Local Area Development Scheme (MPLAD) cannot be used to repeatedly support basic infrastructural aspects of an urban school.

Primary Healthcare

In health, the solutions proposed in the initiatives are UPHC-MO training on mental health challenges, extension clinics to UPHCs, outsourcing HRH to NGOs, UPHCs in PPP mode, weekly specialist visits (Ama Clinic), screening for NCDs, and free medicines and tests (Niramaya and Nidaan scheme). At a cursory glance, these seem to be addressing important challenges, but the ground realities of UPHCs make them ineffective, most prominent of which are UPHC deficits and shortfalls in the staffing, specifically of health workers (female), pharmacists, and laboratory technicians in urban PHCs (Table 3).

Solutions do not focus on addressing the health workforce in urban areas: Odisha has made notable improvements in health workforce hiring (doctors and nursing staff are in surplus in UPHCs as per Table 3), but prominent deficits still continue across categories of UPHC personnel.[16] Without health workers such as pharmacists and lab technicians, none of the important schemes, such as Niramaya and Nidaan (mental health trainings), can function well. Civil society leaders, local journalists, and research scholars working on health issues highlighted that the lack of human resources makes most of these initiatives effectively non-existent on the ground. Yet, for urban primary care, this has not been the focus of existing policy solutions. Even the overall policy imagination has focused on creating secondary and tertiary health facilities such as medical colleges and district hospitals. More worryingly and indicative of the lack of solutions to improve HRH challenges is that even in these newly created institutions, chronic staffing challenges remain. A senior doctor at one of the leading hospitals in Odisha stated that in his medical college, there were 60% vacancies for medical professors. Given that his medical college was one of the oldest and most established, and in an urban area close to the capital, it only further suggests how much more challenging the state of district hospitals in rural areas would be.

Admission points for Doctor of Medicine (MD) programmes do not sufficiently incentivise UPHC-MOs. Urban doctor availability faces distinct challenges that

[16] While RHS data show surplus of doctors in UPHCs, they do not differentiate between those on-contract and permanent positions. Our qualitative findings point to a dominance of the former category, particularly due to the PPP arrangement between private entities/NGOs and the government to fill these positions.

existing HRH cadre management initiatives—such as transparent transfers and extended retirement ages—do not address. Medical graduates with Bachelor of Medicine, Bachelor of Surgery (MBBS) degrees seek to attain specialisation degrees because they are socially more prestigious as well as financially lucrative. Thus, many doctors who join as UPHC-MOs use the position strategically and prepare for MD entrance exams and quit the MO position as soon as opportunities are available. The government offers more points for MD programme aspirants who would serve in difficult areas, but this does not apply to urban doctors. Even for rural areas, the point system is not enough of an incentive, and the supervision and accountability of doctors who join government appointments is poor. This has resulted in extreme cases. One such case was shared with us by a senior CSO leader active in health. They explained, "They advertise for doctor vacancies—then after two years they find out, those doctors are not on duty. Even now, the government doesn't know where the doctors went. The system doesn't have proper monitoring."

Allowing private practice to disincentivise the focus on strengthening UPHC uptake: *Doctors* take up appointments in UPHCs because urban areas provide other benefits to the doctors, but the turnover is high and has not reduced even when doctors are provided the incentive to continue private medical practice. In fact, allowing the option for private practices may have created an environment where some UPHC-MOs do not focus on them fully. A local journalist shared with us: "UPHCs have vacancies here. One of them did not have a doctor for 1.5 years. Many of these doctors have their own private practice. In private, they charge ₹400–500 per person; money in government is not comparable." Building community connections with the catchment, which is critical for high uptake of a UPHC, gets impacted, and initiatives like mental health training programmes to UPHC-MOs of Niramaya or Nidaan scheme cannot deliver their goals if the doctors are not available.

Several recent studies reinforce our findings. For example, Yip et al. (2022) find that the consequence of this persistent poor quality of care is low citizen satisfaction, which has implications for trust in the health system. Haakenstad et al. (2022), in their study, reaffirm that encouraging private providers has had significant implications for citizens' experience of the health system and their financial risk protection. In particular, the authors argue that "use of the private sector, including the private market for drugs, is an important determinant of poor financial risk protection in Odisha."

Lack of specialist doctors, particularly those with specialities relevant to district-level health challenges: Initiatives such as the Ama Clinic for UPHCs, which appears to be Odisha's own innovation, have been scaled up in other states in India. On the other hand, a valuable solution also becomes restricted in its impact. Members of the state health department and CSO leaders shared that urban residents prefer accessible doctors with postgraduate specialisations rather than those with MBBS degrees. The Ama Clinic initiatives respond to this need. Under this initiative, specialists in fields such as gynaecology, dermatology, and radiology visit UPHCs weekly. The initiative reduces their OOPE of visiting hospitals and eases the burden

on hospitals. However, since there is a shortage of specialists (Table 3), the efficacy of the initiative is severely impacted. There is also a misalignment between the available specialists and the specific medical conditions that are prominent in the catchments or urban areas. A senior civil society leader who runs a well-regarded medical clinic for children with extreme illness told us that in his city, skin problems are prominent, but there is a severe lack of skin specialists in the district.

Need for doctors with age and experience to manage the complexity of a UPHC: Increasing the age of retirement and making UPHCs available in a PPP mode so that NGOs can hire doctors by passing the government's age-related norms has not entirely solved the problem. This was one of the solutions proposed to address the HRH challenge in urban areas, as explained by a senior former bureaucrat: "There was an increase in retirement age of doctors from 58 to 60. This was done to reduce vacancies." The energy and outreach skills needed for a UPHC-MO are limited in post-retirement for doctors, and it also reduces the trust of the community in the quality of services that they receive in UPHCs.

Need for reliable supply chains for medical countermeasures: Programmes like free medicines and tests are met with the significant challenge of stock-outs at the UPHC level. Diagnostics have been outsourced to an external agency called Krsnaa Diagnostics since 2023, covering several government health institutions. Medical staff have limited control over the timing and quality of the tests undertaken at these external facilities. The range of tests also does not fully align with what ordinary residents need. One of the UPHC-MOs shared that X-ray machines should be available at the UPHC level, along with the technician. He asserted that external testing delays the diagnosis. In one of the urban slum visits, a young woman explained that the scanning facilities have not been functional, so even though there is a public health facility in the vicinity, pregnant women need to travel much longer for ultrasounds in a functional centre. Supply chain problems are further apparent in the delayed disbursement of drugs by Odisha's State Medical Corporation (OSMC), as a study by Yip et al. (2022) finds. This significantly affects the citizens' perception of the availability and quality of drugs available in the public health facilities.

Strengthening governance and oversight systems: Governance challenges of the overall health system, particularly primary health, weaken the initiatives. Primary among them is poor data collection and monitoring. While senior bureaucrats regularly make new initiatives based on evidence and the national-level rankings in which Odisha frequently underperforms, at the frontline level, health researchers, health journalists, and civil society leaders highlighted that data accuracy is weak and monitoring and course correction of programmes on a routine basis based on new data has been rarely undertaken. A striking example of this systemic breakdown is the outbreak of malaria and diphtheria in parts of Odisha, which indicates that core functions of the public health system, such as vector-borne disease prevention and immunisation, are not taking place. As per NFHS-5, while 90.5% of children aged 12–23 months have received all basic vaccinations across the state, there are

stark intra-state disparities—from 79% in Jajpur district to 100% in Debagarh. A public health researcher in Odisha discussed how "recently, there was a diphtheria outbreak, which means immunisation is flawed. What is missing is a regular third-party evaluation to sustain initial improvements." Similarly, for malaria, Odisha focused immensely in 2015–2016 on tackling the high burden through the Daman Malaria Eradication programme. This resulted in a significant reduction in cases with focused attention and priority. Yet, more recently, malaria surges and charges of under-reporting the burden of malaria (Rout, 2024) have cast a shadow on the capacity to sustain improvements due to a lack of third-party monitoring.

4.3 Drivers of Initiatives

The initiative-making process for urban primary care and elementary education in Odisha has been driven by a combination of four factors: a) central government policy push; b) engaged role of the state bureaucracy; c) the role of the chief minister's office (CMO); and d) the political culture of the state in which political opposition has been less prominent. Other stakeholders and driving factors have been less important during 2014–2024. These include internal bureaucratic processes, civil society advocacy, social movements, demands for services from community-based organisations, and users of UPHCs and schools. Important enabling conditions, which Odisha has and could have pushed it towards a more proactive focus on grassroots-linked initiatives for urban areas, such as stability in political and bureaucratic regimes as well as the availability of finances, have not had the desired effect. Odisha has yet to develop: a) coherent agenda built on the diversity of health and schooling needs of users, particularly in urban areas; b) regular and collaborative engagement with key stakeholders engaged in health and education, particularly community based CSOs; and c) a responsive initiative-making loop through which initiatives once implemented are located in an accurate and timely data system which provides insights into relevance and areas of weakness. Based on this, the system improves.

Central Government Policy Push

Several of the key initiatives, both in elementary education and primary health, have emerged because of a policy push received from the central government, either in the form of funding (UPHC extension clinics), programmes (SATH-E programme for school consolidation by NITI Aayog), or policy ideas (free books and uniforms under Samagra Shiksha Abhiyaan [SSA]).

Engaged Role of the Bureaucracy

The state bureaucracy across health, education, and finance, particularly the chief secretary, has been critical in driving new initiatives. Three aspects of their position impact new initiatives.

First, the political leadership empowered bureaucrats to lead the initiative-making agenda without constraining them to a specific political vision or competing

political ideas. Continuity of political leadership and the lack of political opposition appear to have enabled the bureaucracy to lead, prioritising problems and proposing solutions. This includes engaging external partners and selecting solutions proposed by multiple partners. Heads of education, health, and finance departments at the state level have also had long tenures, which is not the norm in state bureaucracy in other Indian states. This helped in building trust between the political leadership and the bureaucracy. As a retired senior bureaucrat told us, in Odisha, if you are doing well, you are not moved out of your department. Unlike other states,[17] getting better promotions is not the primary motivating factor for Odisha's bureaucrats, given their continuity of tenure.

Second, senior bureaucrats interacted more closely with their peers within and outside Odisha and had to respond to the poor light in which Odisha was discussed in national policy circles. Odisha was facing severe challenges in malnutrition, poverty, and a high burden of maternal and child deaths. This became a trigger for the senior bureaucracy itself to address challenges to improve Odisha's standing within the national bureaucracy. A retired senior bureaucrat shared with us the following:

> "For a long time, Odisha was considered a basket case. Even though formally not in BIMARU [Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh], we had the worst IMR and very poor MMR. Nutrition parameters were also bad. What shamed Odisha was the periodic stories of starvation in the 80s and 90s. This captured the imagination of what Odisha was. The 1999 super cyclone moment was the final nail in the coffin—we couldn't manage anymore. In 2000, a new government came in, and we were able to begin initiating reforms. The narrative of Odisha started changing. First, it was the fiscal story. Then it was the disaster story (recognised by the UN). Then the declines in NFHS story; then 2011–2012 poverty indicators came out—where we had the largest reduction."

Similarly, a current member of bureaucracy shared the persistence of the push to maintain a high standing of Odisha in national indices: "What drove bureaucracy to take on these issues was the political visioning and influence of national surveys. We used to have meetings on how to improve our position in these. It was left to the bureaucracy to figure out how to improve the situation, and we didn't face many difficulties in getting approvals."

Indeed, Odisha's bureaucracy was described as progressive and social welfare-oriented. Senior bureaucrats stated that they took the lead in addressing health and education challenges, with the political leadership actively embracing new ideas. Due to this specific context, Odisha's bureaucrats were actively picking up relevant solutions and models from other states also. For example, the free medicines and tests

[17] Singh (2025) is the second report in this project and examines drivers of urban primary care and elementary education initiatives in Rajasthan. The report highlights that promotions and lucrative postings are a major motivator for health and education bureaucracy.

initiative was taken from Rajasthan. Civil society engagement led by the local chapter of Jan Swasthya Abhiyan (JSA) was important in pushing for this initiative. But the fact that it translated into an initiative was shaped by the availability of a successful bureaucratic model. Teams from the health department were sent to both Rajasthan and Tamil Nadu to understand the programme. A senior bureaucrat shared the career incentives behind proposing new initiatives: "Bureaucrats compete with one another at the national stage. Other state secretaries have made visits here to look at our models, and many states also took our examples and implemented them."

The bureaucracy had the support of the political leadership and had to link the problems they wished to solve and the solutions that they were providing with defined political outcomes. It is important to note that the problems that Odisha has solved are still critical ones, and the solutions were addressing specific health/education needs. However, the presence of the problem itself was not enough to drive initiatives. The initiative had to have an express political purpose. For instance, a former senior bureaucrat shared with us how enhancing highway connectivity was utilised for electoral gains at the Panchayat level: "We gave them the idea that if you need to build the road, do the road construction inauguration before the panchayat elections, so that you get some brownie points and then let the construction continue."

Third, with the dominant role that they were allowed to play by the political leadership, bureaucrats had to pick initiatives which created a visible output at the ground level and directly addressed a defined need. They also had to demonstrate constant activity through new initiatives in a wide variety of areas within health and education. Senior leaders of the state bureaucracy told us that they were able to get proposals for health and education passed if they were able to present the ideas in a manner which appealed to the senior political leadership. There was not much involvement in the granular details of the ideas and solutions that they proposed. The relatively loose relationship between the political leadership and the bureaucracy on social welfare issues also meant that the senior-most members in the bureaucracy were the main contact point with the chief minister. They played the role of a liaison and positioned new ideas in a manner that would be acceptable. The bureaucratic stakeholders involved in social welfare agenda-making acquired a hierarchy within them, with the CM and the senior-most bureaucrats (mainly the chief secretary) being the top-most level.

The dominance of the bureaucracy in the initiative-making process created certain distinctive patterns. First, given how poor several health and education indicators were, the focus became on improving Odisha's image. Solutions were targeted at solving specific problems. Deeper structural changes and institution-building became less important in policy focus. For example, the conditional cash transfer scheme improved institutional delivery, but the systems needed to ensure that all aspects of maternal care improved were not focused on. This includes easy access to primary care, referral linkages with medical doctors, etc. Both in turn mean that shortages of primary care facilities or of doctors, medicines, and specialists must

be addressed. The more recent steep reversal in earlier MMR gains suggests that the gains from a targeted initiative, such as a conditional cash transfer, were short-lived. This appears to be the result of narrowly focusing on improving specific data points in the absence of undertaking systemic reform, which is necessary to sustain improvement. Reducing high MMR required attention to the proximity of delivery-equipped healthcare facilities and the quality of care, including skilled birth attendants and adequate postnatal care.

Second, pathways through which new problems receive policy focus are limited. The space to course-correct existing initiatives is also constrained. This is because other stakeholders (for example, CSOs, community leaders, local political leaders) who can bring in new policy problems or highlight shortcomings in existing initiatives are less dominant in the policy space. Local political leaders have a limited role in taking the initiative. Dominance of the bureaucracy in the making of state-level initiatives has led to further strengthening of initiatives which have a bureaucratic lens. A bureaucratic approach frames problems in terms of indicators which need to be improved through data collection and monitoring. By this, we mean fluid, complex education and health realities are designed as 'problems' which are bundled into defined indicators (like MMR and learning outcomes) which are then tracked through data and addressed through technical, 'solution' based policy initiatives.

Often, a predominantly bureaucratic approach puts the indicators before the social reality they are seeking to improve. For example, improving vaccination can be done via a bureaucratic approach of cash transfers, but a more systematic, sustainable approach, which links with the complexity of the social reality, is providing an adequate number of frontline health workers who know the community and the challenges that prevent mothers from getting their children vaccinated. The latter solution requires local leaders who understand the community and the reasons for low uptake of health facilities. The two approaches are different in terms of their policy focus. The first one can be delivered within the existing constraints of the health system; the second one requires a focus on the frontline health services. It is other, non-bureaucratic stakeholders, such as CSOs and political leaders, who bring to light the non-technical policy problems and solutions. In the words of a senior civil society leader, "policy influence can only happen through political leaders, not bureaucrats." In a similar line, a retired senior bureaucrat told us that when politicians provide ideas for policy solutions, they are qualitatively different from the ones identified by bureaucrats because political leaders have an acute sense of the needs and challenges of their constituencies. This would be difficult for a bureaucrat, as they do not engage directly with people.

Third, because a very small set of leaders in the bureaucracy and political leadership oversaw the social welfare agenda, the policy loop from the top to the frontline level was not strong, responsive, and agile to pick and relay the diversity of challenges in implementing initiatives. For example, a civil society leader with over two decades of experience working in Odisha told us that senior bureaucrats often relied on their

inputs, which are given informally, because in the formal bureaucratic process, there was limited room for reflection on existing initiatives.

"It took some time to establish trust with state-level bureaucrats. There was space and avenues for CSOs to raise their voice—there was a person in CMO whom you could call. We also had access earlier and could unofficially go through channels. When there is a senior bureaucrat, they have limitations—they have distance from the field reality and rely on our inputs. But you need to package the solution in a way that the bureaucracy is amenable to. This means proposing solutions that are measurable and benefit communities. Our MoUs [Memorandums of Understanding] need to be specific and measurable."

The foremost implication is that despite long tenures for bureaucrats and political leaders, chronic structural and governance problems in health and education—particularly in education—could not be addressed. Systemic challenges in hiring, monitoring, and training remain. Social welfare, via the bureaucracy, became the way through which the stability of the political regime was ensured. For bureaucrats, more than pushing for professional advancement and preferred postings, the pressures of creating a legacy were important career incentives.

Chief Minister's Office (CMO)

The CMO is the prominent and, in some ways, the only actor among the political stakeholders who is involved in taking the initiative. Its role includes recommending and approving policy ideas, but at times also monitoring them. Several civil society leaders shared with us that an important way to know if an initiative is a priority in the state is to know if it is being monitored directly by the CMO. For example, the 5T programme in the contemporary period, but also the Mamata scheme and Mission Shakti from the period before the one we focus on in this study. Other political leaders from the governing party in Odisha, both in elected offices as well as outside of them, have had a limited role in driving state-level initiatives. Consultations with MLAs are infrequent, and in the absence of political opposition, there is limited contestation of ideas on strengthening health and education or on the implementation challenges. Due to this, social welfare programmes are designed to augment the image of senior political leaders, not to generate the identity of the party as a whole or even to solve social welfare challenges as such. Whichever social welfare challenge does get solved, it does so when they align with creating a certain political image for the governing regime. Political continuity and, through that, bureaucratic continuity have not been sufficient to push for structural, complex, systematic challenges in both health and education. For example, several health and education-related problems specific to urban areas exist, but these have not been the reason why initiatives have been made. Mental health issues, non-communicable diseases, and nutrition are critical problems in urban areas because of poor social support and readily available high-quality food. In education, given the poverty levels in Odisha, private education is very costly for low-income households, and the gap between learning outcomes in

private and public schools is high.[18] Yet, initiatives for urban health and education have been few and far between.

The dynamics of social welfare (health and education included) provision in Odisha are not those where social welfare has become a way through which constituents are mobilised. The provision of welfare services has provided the political leaders with support in elections, but it is less clear whether there is an on-ground culture of welfare in which competing models of welfare are articulated, or whether existing welfare provision is put through scrutiny by different stakeholders. Electoral value of a particular initiative is important even in recent initiatives such as the Jaga mission, which were shaped by the central government push and CSO involvement. The Jaga mission appears to have been driven by addressing the requirements of the urban slum constituency because they have a large share in urban Odisha. State politics revolves around a powerful political leader and the extent to which social welfare can support the leader's political identity and leadership. Whichever important initiatives have been developed, and whatever social protection policies have emerged, have been within this broad contour.

Other pathways for initiative-making

The role of CSO in driving state-level initiatives: The role of CSOs in promoting state-level initiatives is a complex one and determined by a) the state of the political regime; b) the nature of CSOs; and c) the sector (whether it is health, education, or other ancillary sectors such as urban development or disaster relief). Given that Odisha is a poor society, frequently ravaged by natural disasters, and until recently, one with a weak reach of the state to the marginalised for service provision, one would assume that there would be robust civil society movements and organisations bridging the last mile gap, particularly in the context of urban health and education. This conclusion must be drawn tentatively.

First, the role of civil society has varied across different terms of the government during the study period of the last 10 years. In the early 2010s, channels for CSOs to approach senior bureaucrats and the CMO were available. This has been less so in the last few years. CSOs working on health and education in urban areas are few, and those with ambitions and resources to influence policy are even fewer. Lack of formal, accessible channels through which CSOs can connect with the state-level bureaucracy shrinks the range of ideas that they emerge into the policy domains and the pressures on CSOs to develop policy-influencing capacities.

[18] The ASER 2024 results show huge disparity between performance of children in government and private schools in mathematics and language over the years. The survey is based on 30 rural districts in Odisha. It finds that the percentage of children in Class 3 who can do subtraction is 63% in private schools, compared to 34.6% in government schools. Further, the percentage of children in Class 5 who can do division is 62.1% in private schools, compared to 29.7% in government schools. Even though ASER surveys include rural samples, they conduct the only independent nationally representative non-government survey of learning outcomes. Moreover, the disparity between government and private school performance is indicative of overall state of extremely disparity in learning outcomes in Odisha.

Second, the nature of the organisation determines the kinds of roles that CSOs play in initiative-making in Odisha. The CSOs we discovered in our research can be categorised into two groups. First are community-based CSOs, for example, JSA or the RTE forum, which directly work with communities on ground-level issues and are largely local within Odisha, and second are technical agencies, which have international presence and mandate, for example, United Nations Children's Fund (UNICEF), United Nations Development Programme (UNDP), or national-level NGOs—such as Azim Premji Foundation (APF) or Janaagraha. Over the last decade, community-based organisations have not been prominent in shaping policy initiatives in Odisha, particularly for urban health and education. They were engaging with the state government during 2000–2010s through state-provided channels, including MoUs to work with government facilities. This began changing at the start of the study period, and in the last tenure of the outgoing government, formal channels for engaging with CSOs became even fewer. In areas such as education, their role has particularly been limited, except for specific sub-fields like Early Childhood Care and Education (ECCE), where some CSOs are involved in training and curriculum development. In nutrition and disaster relief, where most community-based CSOs were engaged in the earlier period, their role has also been reducing in the last term. On the other hand, the role of international agencies and national-level organisations has been prominent in working with the government in designing/implementing their policy priorities. It must be emphasised that even technical agencies and international NGOs have limited scope to shape government thinking on which policy areas to prioritise. They align themselves with existing priorities of the government, i.e., the challenges which senior state bureaucracy and political leaders identify as being important and solutions that they accept as being useful.

Third, the pathways that a CSO follows remain the same, irrespective of the type of CSO. It is through the senior state-level bureaucrats in health, education, and other sectors in which they are working and the alignment of policy ideas and solutions with the political utility prevalent at the time. The state authorities are open to experiment and to new ideas, but the path to getting the ideas into the room is through the senior-most state bureaucracy, and organisations close to the bureaucracy, through an informal network, and end up speaking for the voices of all the marginalised. For example, in an interaction with the head of a national-level funding body which had recently started operations in Odisha, we got to know that it was his personal, informal connection with a former health secretary that gave him the opportunity through which he suggested the inclusion of single women as beneficiaries of social welfare schemes. He highlighted that bureaucracy welcomes insights from community CSOs because bureaucrats themselves do not have a connection with the community, and internal channels within the bureaucracy to communicate ground issues all the way to the state level are weak and ridden with mistrust. But he emphasised that the reason this idea was accepted was that he had a personal connection with the bureaucrat, which many other CSOs and community workers do not have.

The receding role of CSOs, particularly in initiative-making processes, is in part the product of the paradigmatic changes which have happened in governance and the implementation of social welfare programmes. In areas such as health, with more central government funding, contract-based external consultant positions have been developed, and some roles that were previously performed by CSOs are now implemented by consultants. In education, globally recognised consulting firms are more closely involved in driving policy initiatives than CSOs. Furthermore, the nature of policymaking has taken a route where the goal is to improve 'indicators' of narrowly defined health and education problems, such as MMR or IMR. This problem-and-solution-focused approach is often not accompanied by system building or linking community demands and rights with institutional and social welfare provisions in an ongoing and responsive manner. 'Problems', when defined as such, can be 'solved' by solutions which bypass the health or education system, such as cash transfers or technology-based accountability. Resultantly, this at times makes it difficult to sustain gains in health outcomes.

Weak CSO–government ties have two prominent implications for policy initiatives. First, several social change ideas in Odisha have come through CSOs, such as Mission Shakti, which was based on the SHG movement led by CSOs. This idea, which was taken up by the government and transformed into the Mission Shakti programme and later a state department, had a limited formal role for CSOs after it was taken up as a government programme. By not formally engaging with CSOs, even in programmes which were initiated by them, the scope for a continuous feedback loop was limited. This ultimately impacted the programme in the long run, as happened in the case of Mission Shakti, as several CSO leaders shared with us. They highlighted that the actual empowerment of women's groups has been patchy over the last 20 years, and SHGs have not reached their potential. There are on-ground challenges in health and education where CSO engagement is needed, such as in training of field functionaries, developing and managing systems for local accountability for social welfare services, but engaging with CSOs in this manner does not appear to be a policy-focused approach anymore.

The second implication of weak CSO–government links is that they do not sufficiently strengthen internal state capacity. The state government still works with large national and international CSOs. These organisations provide high-level technical support to the state departments in policymaking, service design, and implementation. However, once these CSOs finish their interventions, the state departments often lack the capacity to ideate, design, or implement future initiatives on their own. This problem is particularly acute at the sub-district level. Weak linkages with community-based CSOs effectively reduce an important channel through which government departments can identify social welfare problems and design solutions.

Beyond weak CSO–government linkages, there are two additional limitations. First, government-mobilised community bodies have not emerged as effective

accountability platform. Odisha has a range of government-mobilised community bodies, both from older state-level programmes, such as Mission Shakti, and central government programmes, such as NHM and newer programmes, such as Jaga mission. At the community level in urban areas, there are SHGs, Mahila Arogya Samitis (MAS), Slum Rehabilitation Committee, and Ward Development committees, just to name a few. However, the mobilisation of these community members has not resulted in them playing a role in raising local demands for health and education or holding health and education facilities to account.

Second, social movements around health and education remain relatively weak. Odisha has witnessed several social movements around forest rights and tribal rights. Some protests and weak movements have focused on health via JSA and RTE forums on school education, but none have really translated into full movements in these sectors or have led to important state-level initiatives.

5. The Implications

Three broad conclusions appear from our discussions so far.

First, Odisha's state-level initiatives for health and education during 2014–2024 indicate a weak focus on primary healthcare and elementary-level education, which partly explains the poor state of health and education outcomes. These outcomes are partly impacted by the quality of services provided at this level. It is important to highlight that in health, the link between achievement of health outcomes shaped by primary care services, such as immunisation and the uptake of these services at primary care facilities (PHC/UPHC), is weak. Due to the poor state of primary care facilities, primary care services are taken up at secondary and tertiary facilities (government hospitals, community health centres, etc.) or even in private facilities. For example, immunisation at public facilities does not necessarily have to be at primary care facilities and data on the extent to which improvement in immunisation levels is due to higher uptake at PHCs is not available. Having said that, there are some health indicators, such as Antenatal Care (ANC) visits by a health worker, which refer to frontline health workers at PHCs. Data on the extent to which visits by PHC health workers translate into better outcomes are also not available to the public, but trends in improvement in health outcomes alongside improvements in outreach by PHC-level health workers suggest there is a positive link between the two. For elementary education, we have data on learning outcomes at levels 3, 5, and 8.

Reversals in critical health indicators such as MMR and urban IMR along with low learning outcomes at elementary levels in government schools in urban Odisha, suggest that a poor state of primary care facilities, particularly in elementary schools, is an important contributing factor. Gopal et al. (2025) find that despite key urban-specific initiatives, including UPHCs, the urban healthcare system primarily emphasises secondary and tertiary care, at the cost of primary care. Community outreach, home visits, and follow-ups are limited in urban areas, contributing to poor child health

outcomes in urban areas. As our study highlighted, state-level initiatives are limited in terms of the numbers, the range of problems that they seek to tackle, and the alignment of the problems that they prioritise, and the solutions that they propose with the critical issues impacting the functioning of facilities. Stability of bureaucratic tenures and political leadership, along with availability of funds, does not appear to have improved either the number, nature, and/or alignment of the initiatives.

Second, the pathways, actors, and the incentives for state-level initiatives are restrictive, and this impacts a) the types of ground challenges that are addressed in the initiatives and b) the ideas proposed to address the challenge. Even the number of initiatives—a crude but insightful indicator—reflects limited policy focus. State-level initiatives are anchored by the senior state bureaucracy led by the chief secretary, broadly working within the political contours set by the CM. Their incentives have been to 'solve' a set of 'problems', address electoral needs, and create a legacy. For example, to 'solve' the high OOPE in health, the free tests and medicine scheme was launched. The idea for the scheme was taken from Rajasthan, where it has done well. The mobilisation for the free tests and medicines schemes was a local community-based CSO, and it was taken up by the state bureaucracy. However, there are several ways through which the OOPE challenge can be addressed, and free tests and medicines are not the only or even the predominant one.

In the context of urban areas, providing adequate health facilities (at present Odisha has a 39% deficit of UPHCs), health staff who build connections with the community, shape active health-seeking behaviour, and a trust regarding the quality of medicines, tests, and treatment, etc., available at a PHC is also essential to reduce high OOPE. If the free tests and medicines are only available in far-off health facilities that have long queues, or the quality of tests and medicines is not found to be adequate, or if the medicines available freely are fewer than the ones essentially needed at the ground level, or if the frontline staff is not oriented towards making the free medicines and tests available to the needy, then the health outcomes will not be met, even though the problem of high OOPE has technically been 'solved'. This is not a mere implementation issue, but also one of policy idea prioritisation. The prioritised approach is making a health 'product' available, rather than building responsive systems within which such products function. Product provision is more amenable to 'solutions', while the complexity around the provision of health status requires institutional and systemic approaches. The fact that free tests and medicines as a policy idea/solution was taken up and not the other systemic challenges, highlights that this solution was meant to give primacy to the pressures (creating political visibility, legacy, alignment with political leadership, etc.) and the resources of those proposing the idea rather than working backwards to develop systems for the provision of overall high-quality health services or improving health outcomes. Had the free medicine and tests idea been accompanied by a comprehensive plan to address health outcomes, then the solution would have gone beyond 'product provision' and included questions such as who needs them, why, when, how, and in what circumstances.

Formal inclusion of other actors and pathways for making new initiatives could perhaps have been an important way to induce the much-needed comprehensiveness in the initiative-making process. Through other actors and pathways, another set of incentives may emerge, instead of just those of the senior bureaucracy, which is to create legacy, address the poor image of Odisha in national-level circles of senior bureaucrats, and respond to the electoral pressures facing the CM (particularly in terms of creating his own brand and image, and not necessarily that of the MLAs who receive petitions from their constituents about the state of schools and hospitals). For example, creating spaces for local-level elected representatives to share ground-level health and education challenges that ought to receive policy focus can provide newer ideas for electoral wins/visibility. Improving and strengthening internal bureaucratic feedback from the facility level to the state level can also provide a more accurate account of ground challenges.

The inclusion of community-based CSOs could create an incentive for including provisions for grassroots accountability in state-level initiatives. Although all of these actors, pathways, and incentives are present and do impact policymaking in the present scheme of things, their impact could be further strengthened through inclusion of formal mechanisms. For example, a community-based CSO mobilisation took place for free tests and medicines in Odisha, and the demand was accepted by the bureaucracy and was then turned into an initiative. But there is no formal mechanism through which ground challenges or ideas for new initiatives are recommended to the bureaucracy and political leadership from CSOs or other actors through a process that is easily accessible and not dependent on personal connections with senior leaders. Such a process also needs to be ongoing and transparent. The very presence of such a process would also give the state leadership an opportunity to develop legitimacy and the involvement of all actors in new initiatives, which is weak in the present system. The SHG programme, which was led by CSOs in Odisha and later taken up by the state government and transformed into the Mission Shakti Department, had this limitation. Several CSO leaders shared with us that once the programme was incorporated into the bureaucracy, the engagement with CSOs became weak; ownership of the programme at the ground level and connections with the community also became fragile, which in the end impacted the efficiency of the programme. Channels through which community-based CSOs and other actors, such as technical agencies, are involved with state-level leadership will also ensure a continuous policy feedback loop beyond the initial point of ideation.

For example, the free tests and medicines programme was a product of CSO mobilisation till the point of its introduction to the bureaucracy. The selection of the problem and its translation into an initiative and subsequent initiative-making process largely remained with the bureaucracy. Other elements needed to make the programme useful to achieve health outcomes were not focused upon. Similarly, the school mergers programme was introduced to the state-level leadership by a consulting firm as part of a national-level programme. In the absence of channels through which other actors would have shared the ground challenges of such an

initiative, particularly in urban areas, there was limited, publicly visible debate, discussion, and a feedback loop. Due to the challenges that the initiative had in operationalising, it has been reversed in part recently. A formal system is needed for initiative-making, which involves other actors. By a formal system, we mean a transparent, accessible pathway which is available in an ongoing manner at the state level, in which various actors put forth their understanding of the problems which need policy focus and propose solutions.

Third, the weak alignment of state-level initiatives with the ground challenges indicates that the system for course correction and ground review within the bureaucracy is weak. Indeed, many of our respondents highlighted that programme reviews through high-quality data, independent but within-bureaucracy audits, and oversight are weak across the initiatives. If these were not a challenge, then insights from routine review of initiatives would be shared with the highest levels within the bureaucracy and publicly with other relevant stakeholders as well, which would create pressures to review, reframe, and reprioritise the initiative. In the present scheme of things, any initiative, for example, the 5T programme for schooling, when undertaken, has limited external, independent, and publicly available review of its alignment with whether it has focused on the right problems or is giving the right solution.[19] Those within the school system are aware of the limitations, but only those limitations which pertain to their own access point vis-à-vis the initiative, for example, teachers know of the limited teacher training introduced as part of the programme and their own lack of knowledge to operationalise digital devices. There is a limited comprehensive understanding of the systemic strengths and weaknesses of the initiatives from within the bureaucracy. This further consolidates the disproportionate role of the senior bureaucracy in the initiative-making process. There are a few pathways internal to the bureaucracy which can provide context and diversity to the ideas and solutions proposed by the senior-most bureaucracy.

Fourth, electoral incentives for initiatives are those as understood by the CM and align with his idea of welfare provision. A wider political constituency (among elected political representatives) around the idea of health and education provision has not developed. Electoral benefits of certain health and education provisions as they accrue to the governing regime are the only form in which the governing regimes respond to the 'political' aspect of health and education provision at the ground level. But diversity and variation are needed. Different political aspects of health and education at the ground level, as well as channels other than elections and

[19] There are limited audits or evaluations for school education. One of the key sources currently is the CAG audit but it is not a routine evaluation of the sector. The most recent CAG Performance Audit Report on School Education in the State, points out important gaps. For instance, regarding smart classrooms, the audit finds major variations between U-DISE+ data and availability of physical infrastructure. In the U-DISE+ report, 13 sampled schools had smart classrooms; a stark contrast to the Audit's finding that smart classrooms were not available in any of the sampled schools. Specifically, it notes, "the State had set a target of establishing Information and Communications Technology (ICT) infrastructure in 2,317 Upper Primary schools and smart classrooms in 6,065 and 909 Upper Primary and Secondary schools, respectively. However, due to delayed finalisation of procurement formalities by the OSEPA, the facilities had not been established in any of the targeted schools, as of March 2023" (CAG report, 2025).

electoral priorities of the CM, are needed to widen the ambit of the citizens' needs and demands that translate into initiatives. For example, while creation of infrastructure is a highly 'visible', electorally translatable idea for policy initiative, which mostly has a seamless path from a ground challenge (lack of UPHCs and falling infrastructure of urban schools) to the actions of state-level political leadership to solve it, there are other politically visible solutions whose ambit is smaller and local and can provide electoral dividends to local leaders. For example, providing free NCD checks in a constituency, which can eliminate the high cost of testing, particularly for seniors, can be achieved if steps are taken to ensure that the tests are considered legitimate.

We propose four policy recommendations that can address these implications. The overall idea is to widen the diversity of ideas, actors, and incentives under which initiatives are made. Our recommendations do not focus on programmatic inputs with respect to the ideas and solutions needed to improve health outcomes. They only suggest ways in which better, more aligned initiatives which are owned across the different stakeholders in the system can emerge.

5.1 Create a Stakeholder-Wide Body at the District Level to Identify Urban Issues in Health and Education

To address the limited range of initiatives in urban areas, particularly in urban education, we recommend creating a stakeholder-wide body at the district level to identify urban issues and recommend amendments to existing initiatives that align with urban-specific challenges. We find that alignment between top-down policy prescriptions and the on-ground challenges in urban areas is weak. This is primarily due to the lack of recognition of urban context-specific issues such as land availability, fragmented character of urban communities, social, economic, and cultural diversity in urban classrooms, which includes language diversity among migrant children, and a unique disease profile that is dependent on urban climatic conditions (coastal vs interior/mountainous areas).

Creating a district-level body to publicly identify and suggest implementable solutions can lead to greater ownership, rather than following the prescribed policies, which do not differentiate between rural and urban areas. Moreover, given the increase in Odisha's urban demographic in the coming decades, a dedicated body at the district level that ideates for urban issues is needed to develop an urban agenda for health and education.

In health, the central government's NUHM has attempted to do this, but the district body does not segregate the urban issues from the rural ones. The body that we are recommending is also different from the district health/education societies, which are created under the leadership of the district collector. DHS focuses on district-wide issues and has a prominent administrative role, which includes financial management. Their role rarely includes policy ideation. The district health plans primarily focus on identifying gaps and progress vis-à-vis existing facilities and programmes. District education societies are largely ad hoc bodies at the district level

and have a less formal role in administration and planning than a DHS. The District Institute for Education and Training (DIET) is an education-focused district-level body that has a formal administrative role in oversight and planning. But neither of these bodies is involved in the policy ideation process.

The district-level body being recommended would play the role of prioritising local urban health and education issues, building consensus across various actors, and suggesting policy focus for the state leadership. Their findings would also be publicly available. The body would report to the consultative panel created at the state level. The body we are suggesting should include local CSOs, CBOs, research professionals, activists, select retired members of the district-level health and education bureaucracy (former DHOs and DEOs), and representatives of frontline professional organisations such as teachers' unions and doctors' unions. This body should make publicly available recommendations regarding priority areas for state-level initiatives in urban health and education within the district. Recommendations can be made at the start of every new governing regime at the state level, and/or when new initiatives are being proposed.

5.2 Create Consultative Panels with Both Community-Based and National Civil Society Organisations for Identification of Issues and Focus Areas at the State Level

Community-based CSOs and national-level CSOs, donor bodies, state-level CSOs, pan-India CSOs, technical agencies, and consulting firms which provide technical assistance to state governments in policy design and programme implementation approach the key challenges in health and education from different lenses, which need to be integrated at the state level. Formal channels through which CSOs working in Odisha could approach the state government and propose new initiatives were active during the early 2000s and yielded immense gains in terms of identification of on-ground challenges. CSOs tend to have a deep community connection, which is critical to establishing trust with communities. National-level CSOs (as well as consulting firms), now working closely with the state-level bureaucracy, are more attuned to the technical aspects of health and education challenges and less to the way they impact the community at the everyday level or even the everyday functioning of the health and education facilities. To illustrate, training programmes for teachers when they are developed by national-level NGOs are often not sustainable over the longer period, because they are so niche and need specialists from the NGOs themselves to be implemented systematically.

For example, the alumni mobilisation programme, while an important option for addressing low financial resources available to government schools, faced several operational challenges, particularly the one indicating to the ordinary people that the state is not taking the full responsibility for basic education. A consultative panel in which this idea would have been discussed could have highlighted its limitations in the context of Odisha. This panel, where such ideas are discussed across a variety of

CSOs and where processes are built to develop consensus and understanding, would create a channel through which the strengths of community-based and technical agencies can be harnessed. Local CSOs often find it difficult to get access to top-level bureaucracy to propose new ideas. Similar kinds of programmes end up being made irrespective of the context by a smaller number of nationally recognised actors. This would also reduce the influence of personal connections between senior bureaucrats and civil society leaders regarding the ideation process of new initiatives.

While the role of personal connections across different stakeholders in shaping policy ideas cannot be entirely removed, nor is it necessarily desirable, what is needed are more equitable access points for different kinds of CSOs to engage with the state-level decision-makers. Among the many benefits of such a consultative panel is that changes in political regimes and bureaucratic leadership would not result in the exclusion of the entire set of ideas and priorities supported by CSOs not closely connected with those in power. It will also create some kind of pressure with regard to the policy ideation process. Much of the accountability in the social welfare sector largely focuses on the implementation side of programmes. But accountability and inclusion are also important in the policy ideation process. Making such panels inclusive of different kinds of CSOs and opening their discussions to the public would, at the very least, bring different perspectives on existing initiatives and on newly proposed ones into the public domain.

There are unique incentives for setting up and operationalising such panels for both senior bureaucrats and political leaders. For senior bureaucrats, an important challenge in the present process is the lack of implementable ideas. For political leadership, the challenge is the lack of politically visible ideas. Both are needed for a wider constituency of actors who can engage with the ground challenges in health and education and think through solutions that frontline-level staff may already be undertaking. For example, the headmaster of one of the local schools shared with us that he has been using private agencies for the weekly school cleaning and sanitation activities because the cleaning staff under the municipal corporation was not available. Just addressing the basic sanitation and infrastructure repairs in government schools can make a significant difference in the appeal of these schools in comparison to low-cost private ones. It can perhaps even increase enrolment, all of which would then become electorally beneficial to political leaders who can speak of constituency-wise increase in enrolments as a success of the regimes.

5.3 Reinvigorate Third-Party Audits and Programme Monitoring to Initiate System-Level Checks in Health and Education

Despite the availability of finances and increasing budgets, a recurrent feature in Odisha is the under-utilisation of budgets and the under-accounting of non-budgetary revenue sources towards social welfare projects. Taken together, these point to a persistent problem of lack of monitoring of programmes in the state and insufficient third-party audits to point out the challenges in the two areas. While

CAG is one mechanism through which sporadic audits, particularly in health and higher education, have been conducted, there is a need for consistent monitoring of inputs, including finances and resource allocations, to improve efficiency in programme delivery and sustain gains. Therefore, we recommend reinvigorating the existing state body for third-party audits and programme monitoring, which exists within the state bureaucracy as an independent body from social welfare and other spending departments such as health, education, women and child development, etc. The monitoring body has both funding and personnel attached to it. But social welfare departments have not utilised the audit and monitoring services of this body, and the body itself has been sidelined.

An independent but state bureaucracy-led regular audit of the government programmes and schemes in health and education is critical to highlighting the strengths and limitations. Since this is led by the bureaucracy, but is also independent from the department and done at the request of the health and education secretaries, it will ensure the legitimacy of the findings. An internal audit also means that access to the internal workings of the health and education programmes, data, decision-making processes, and interrelationships with other departments can be included in the review. This is something that social audits, or independent private audits, cannot do. Invigorating the third-party audit body in the department would add another pathway and set of actors through which on-ground challenges that need policy priority are made visible to state-level actors. This would be another lens through which policy challenges are examined, and it will widen both the ambit of policymaking processes and provide external incentive for bureaucrats and senior political actors to take cognisance of a wider set of challenges. The mere availability of financial resources and stability of tenures of health and education secretaries has not been sufficient to ensure that the systemic challenges are addressed or that there is policy creativity to position solutions for governance and systemic challenges in electorally advantageous ways.

5.4 Institute Engagement of Political Leaders in Health and Education Through a Biannual MLA's Conference to Enhance the Legitimacy of Public Provisioning in Both Areas

To address low levels of engagement between elected political representatives and health and education issues, we recommend a biannual conference of MLAs on social welfare, with specific attention to health and education. This body would exist at the state level in Odisha, with the health and education ministers meeting biannually with MLAs. In this study, we found that MLAs do not have a formal role in the everyday running of schools and hospitals, but they are informally involved in a prominent capacity. When new facilities are to be opened or new initiatives are to be implemented, MLAs are consulted by the bureaucracy regarding implementation in their constituencies. MLAs also receive petitions from their constituents where there are infrastructure or HR gaps, or demands for funds from MLA-LAD. MLAs

petition the state bureaucracy when new initiatives or services are announced for their own constituencies. Most importantly, MLAs are attuned to the ground-level challenges constituents face regarding health and education. A former health secretary shared with us that the insights the bureaucracy receives from political leaders are different from those received from CSOs, staff within the bureaucracy, or even leaders of schools and PHCs. Political leaders often have a sharp understanding of which health and education challenges are a top priority for constituents and would make an immediate difference in their lives. She gave the example of a former MLA who highlighted malaria-related illness as the most critical issue for his constituents, which led the bureaucracy to prioritise malaria interventions in that region. The intervention was later scaled up at the state level.

Annual Conference of Education Ministers and the NEP 1986

During the 1970s and 1980s, an annual conference was held nationally with the state education ministers at the conference, and this would result in a publicly available report. One of these reports was published in 1983, "Challenges of Education". This document became an important impetus for the 1986 National Education Policy (Singh, 2025).

Other examples of conferences of political representatives are the National Integration Council, which is called by the prime minister and consists of CMs of all states and other relevant stakeholders on issues of national importance.

A formal platform where MLAs discuss social welfare, particularly health and education, on a regular basis has distinct advantages. First, engagement from MLAs can lead to greater ownership of solutions in the context of the constituency itself. Second, it will provide insights to the senior state leadership on which aspect of health and education provision is finding political resonance. This can also be an incentive for senior political leadership to set up this body, as at present, there are limited platforms for the senior leadership to formally tap into the political perspectives of ground-level elected representatives for health and education. Internal, informal party processes exist, but these are often episodic. Setting up a formal mechanism can also incentivise the constituents and users of health and education facilities to approach MLAs more frequently with their concerns, since they would know that there is a formal, publicly known platform where these ideas are voiced to the senior state leadership.

In essence, our recommendations are focused on widening the set of stakeholders involved in identifying and formulating policy initiatives in education and health to address the current narrow set of issues prioritised. Within this, we emphasise the need for a distinct urban lens to account for the wide contextual differences within districts and the necessity to focus on urban areas in the coming decade. Lastly, our recommendations around monitoring and feedback loops address the persistent lack of quality both in health and education and are intended to foster greater ownership of the urban health and education agenda in Odisha.

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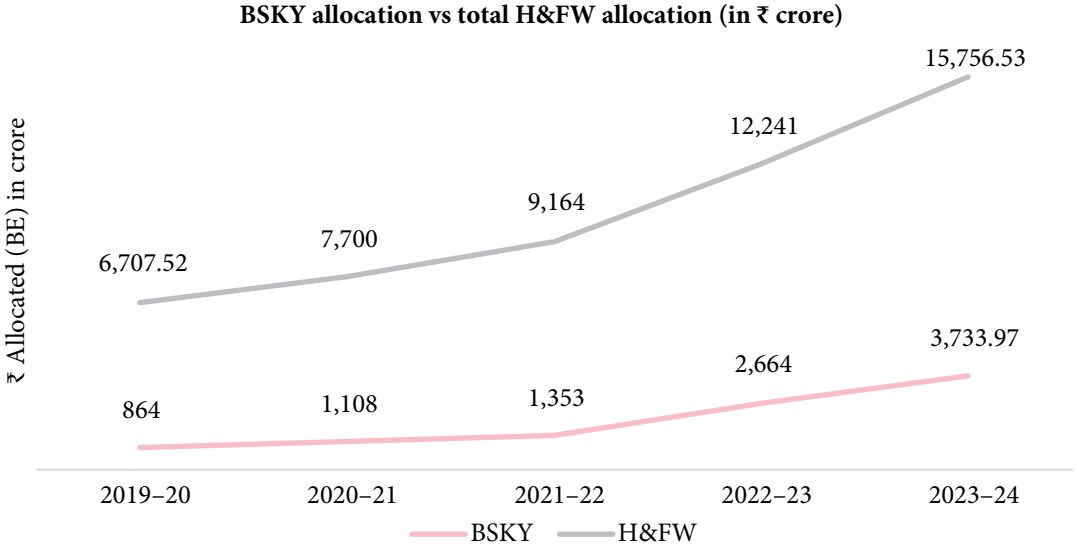
Appendix 1: Budgetary Trends in Health and Education in Odisha

A common way of understanding whether governments focus on health and education is to trace budgets. Several organisations like the Centre for Budget and Governance Accountability, PRS Legislative Services (nationally), and Centre for Youth and Social Development (Odisha) have undertaken this important analysis, which we have immensely benefited from in this study.

We have seen increasing budgets when it comes to health and education. However, an increase in budgetary allocation towards particular health and education initiatives did not necessarily match the most critical challenges on the ground, as discussed subsequently. School and Mass Education (S&ME) departments have consistently had among the top budgetary allocations of all departments, though most of the budget in each year is allocated to the state's share in central schemes such as the SSA and MDMS (see Table A–2 for key allocations within the S&ME Department).

In health, BSKY, GoO's health assurance flagship scheme introduced in 2018, was allocated between 12% and 23% of the total Health and Family Welfare (H&FW) budget from 2019–2024. In the case of BSKY, it was cited as the state's flagship scheme in health during the decade. Given Odisha's adequate fiscal resources, investing in insurance,[20] Universal Health Coverage is particularly revealing of the evolving focus areas in the state. This point is further illustrated through the negligible emphasis on primary care within the budget. In Table A–1, through other dominant allocations, primary care does not feature among the highest allocations.

Figure A–1: Biju Swasthya Kalyan Yojana Allocations Versus Total Health and Family Welfare Department Allocation (in ₹ crore)



Source: Authors' analysis.
Note: BSKY = Biju Swasthya Kalyan Yojana; H&FW = Health and Family Welfare; BE = Budget Estimate.

[20] However, it must be noted that in 2018, the Odisha government argued that its coverage through BSKY was higher than that of Ayushman Bharat and therefore chose to opt out of the scheme.

Table A–1: Biju Swasthya Kalyan Yojana as Share of the Health and Family Welfare Budget

	BSKY	H&FW	% of H&FW	Other Dominant Allocations
2019–2020	864	6,707.52	12.88	
2020–2021	1,108	7,700	14.39	₹1,652 crore—NHM; ₹1,000 crore is proposed to transform SCB Medical College into a state-of-art facility over next two years.
2021–2022	1,353	9,164	14.76	₹1,720.4 crore—NRHM; ₹1572 crore—Mukhya Mantri Swasthya Seva Mission (a basket of schemes which includes infrastructure development of Public Health Institutions (non-residential and residential); Public Health Response fund to address public health emergencies; Odisha State Treatment Fund to provide financial assistance for critical healthcare; and Health Investment Promotion Policy.
2022–2023	2,664	12,241	21.77	*Highest allocation to BSKY in 2022–2023 BE, followed by Mukhya Mantri Swasthya Seva Mission and NRHM.
2023–2024	3,733.97	15,756.53	23.70	*Highest allocation to BSKY in 2023–2024, followed by Mukhya Mantri Swasthya Seva Mission and NHM.

Source: Authors' Compilation based on Budget documents 2014-2024, Odisha and Economic Survey 2022-23.

*Note: *BE taken for each year.*

BSKY = Biju Swasthya Kalyan Yojana; H&FW = Health and Family Welfare; NHM = National Health Mission; SCB = Srirama Chandra Bhanja Medical College and Hospital; NRHM = National Rural Health Mission; BE = Budget Estimate.

Similarly, in education, we consider the case of the Mo School Abhiyaan, cited as a key education scheme during the decade. The Mo School Abhiyaan, under which the 5T high school programme is allocated, started with an allocation of 40 crore in 2019–2020, but increased to 805 crore by 2023–2024 (an increase of 1912.5%) (Table A–2).

Table A–2: Mo School Abhiyaan as Share of the School and Mass Education Budget

Year	Mo School	S&ME	% of S&ME	Other Prominent Allocations
2019–2020	40	16,400.00	0.24	SSA: 2,550 crore; MDM: 844 crore (of this 40% share of the state). State Schemes: OAVS—300 crore; Gangadhar Meher Sikhya Manakbrudhi Yojana (school bags, free textbooks and uniform)—239 crore.
2020–2021	40	17,458.42	0.23	SSA: 3157 crore; MDM: 800 crore (of this 40% share of the state). State schemes: pre- and post-matric scholarships—1407 crore; OAVS—400 crore.
2021–2022	253	18,279.82	1.38	SSA: 3066 crore; MDM: 957 crore (of this 40% share of the state). State schemes: Student scholarships—1002 crore; OAVS—280 crore.
2022–2023	521	20,330.76	2.56	SSA: 3,552 crore (of this 40% share of the state); State scheme: OAVS—420 crore.
2023–2024	805	22,527.95	3.57	Mukhyamantri Medhabi Chatra Protsahan Yojana for disbursement of scholarship to eligible students: 811 crore; Chief Minister's Awards for Education for best performing Districts, Blocks, Schools, Head Teachers, Teachers, Elected PRIs, SMC/SMDCs, CRCCs, BEOs, DEOs, Alumni Committees, and DIETs: ₹139 crore.
2024–2025	521	24,764.28	2.10	OAVS: 880 crore; High School Transformation Programme under 5T: 10 crore.

Source: Authors' Compilation based on Budget documents 2014-2024, Odisha.

*Note: *Figures are BE.*

S&ME = School and Mass Education; SSA = Samagra Shiksha Abhiyaan; MDM = Mid-Day Meal; OAVS = Odisha Adarsha Vidyalaya Sangathan; SMC = School Management Committee; SMDC = School Management and Development Committee; CRCC = Cluster Resource Centre Coordinator; BEO = Block Education Officer; DEO = District Education Officer; DIET = District Institute of Education and Training; PRI = Panchayati Raj Institutions.

Appendix 2: Summary of Health and School Education-Related Initiatives

In this study, we highlight the key health- and education-focused initiatives from 2014–2024 using two approaches. The first table presents a year-by-year listing of initiatives highlighted in the Economic Survey report. This listing includes ongoing and some new initiatives at the state and national levels. Secondly, a listing was developed by the research team through a review of government documents and stakeholder interviews at the state level.

Table A–3: Summary of Key Health- and Education-Related Initiatives in Odisha 2014–2024 as per the Economic Survey Reports

Year	PCI and GSDP at Constant Prices	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
2014–2015	PCI: ₹28,384 GSDP: ₹3.10 lakh crore GSDP Growth Rate: 8.78%	RNTCP aims to detect 70% of infectious sputum TB cases and cure at least 85% of them. Implemented through 31 implementing units, 109 TB units, 549 microscopy centres, and 42,673 DOT centres. Total 462,749 TB cases detected; 349,425 cured by December 2013. Detection rate of 55% and success rate of 87% in 2013. NFCP: To control and eliminate lymphatic filariasis by conducting MDA. Conducted in 20 endemic districts; 15 Filaria control units and clinics. Disease rate reduced from 9.99 to 3.10 from 2009 to 2013. NPCB: Introduced in 1976 as a World Bank-assisted project; currently fully centrally supported. 1,10,342 cataract surgeries were performed in 2013–2014. 4.21 lakh students screened, and 33,000 were identified with refractive error. NLEP: Operational in Odisha since 1982, to eliminate leprosy and reduce disability. Prevalence reduced from 121.4 per 10,000 in 1982 to 1.47 in 2013–2014. During 2013–2014, 102 highly endemic blocks were identified to conduct ICDD through house-to-house visits. In 2013, 17 districts achieved the leprosy elimination goal. NVBDCP: To reduce morbidity and mortality from vector-borne diseases such as malaria. Focus on malaria control with LLIN distribution, monitoring, and treatment strategies. 45 lakh LLINs were distributed in 2013. Malaria positive cases reduced from 12.7 per 1,000 in 2002 to 5.3 in 2013.	Relaxation of Norms for Opening New Primary Schools: The Government relaxed norms to improve access to elementary education and achieve 100% enrolment by facilitating the establishment of new primary schools. Free Textbooks for Elementary Students: Supplied free textbooks to all students at the elementary level during 2013–2014. Recruitment of Sikhya Sahayaks: Recruited 12,875 Sikhya Sahayaks to strengthen the teaching workforce in elementary schools. Provision of Uniforms: Provided two sets of uniforms to 51.46 lakh students to promote regular attendance and reduce financial burdens. Computer-Aided Education Programme: Implemented in 2,645 Upper Primary Schools. Benefiting 3.97 lakh students in 2013–2014. Mother-tongue-based education: Operational in 1,257 schools of 14 tribal districts and 17 Tribal Languages, benefiting 45.63 thousand tribal students. Support for CWSN: Enrolled 118,168 out of 118,295 CWSN, distributed 12,417 aids and appliances, supplied 2,013 Braille books, constructed 18,038 ramps, and built 21,226 CWSN-friendly toilets. MDM Programme: Covered 54.22 lakh students in 63,531 primary and upper primary schools, serving 9014.84 lakh meals to enhance enrolment, retention, and nutrition. Management of the MDM programme at the school level has been entrusted to WSHGs. School Infrastructure Development under SSA: Completed 15,335 primary and upper primary school buildings and 64,358 additional classrooms, with 849 school buildings and 8,746 classrooms in progress. New Primary Schools and Upgradations under SSA: Opened 9,937 new primary schools, upgraded 10,965 primary schools to upper primary, and 12,641 upper primary schools to high schools.

Year	PCI and GSDP at Constant Prices	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
		NACP: To prevent new HIV infections, particularly among high-risk groups. 226 ICTC; nationwide strategic MIS. Total of 35,000 HIV+ cases by 2014, with Ganjam district having the highest number of cases (11,891). 1,410 deaths due to AIDS by 2014. ESI Scheme: Integrated multi-dimensional health insurance and social security scheme; being implemented in the state since 1960. It is one of the most effective and sustainable social security measures available to workmen employed in industrial and commercial establishments of varying nature and sizes. At present, medical care is provided to 3,29,400 insured persons and their dependents through five ESI hospitals and 46 ESI dispensaries in 19 districts. There are 297 beds and 98 doctors engaged to provide medical services to employees. NIDDCP: To prevent IDD by promoting iodised salt. IDD surveys are conducted periodically; the IDD Monitoring Laboratory was established. 16 out of 20 districts were found to be endemic for iodine deficiency by 2009.	SSA Components: a) NPEGEL provides additional support for enhancing girls' education and is implemented in Educationally Backward Blocks. By 2013–2014, 20.11 lakh girls benefited under the scheme. b) KGBV is a residential school programme at the elementary level. During 2013–2014, 182 KGBVs were made operational, out of which 134 buildings benefited 18,180 girls. Teacher Training: 102,732 teachers were trained across subjects. Block Grant to Madrasa Teaching Staff: Block grants are provided to the teaching staff of 138 Madrasas at the primary level to support educational activities. Block Grant to Upper Primary Schools: Provided block grants to 916 eligible Upper Primary Schools to support their operations and infrastructure. Home-based Education and Special Training: Addressed 1,060 OOSC through home-based education, provided special training to 7,556 (residential) and 4,239 (non-residential) OOSC.
2016–2017	PCI: ₹61,678 GSDP: ₹2,91,22,687 lakh GSDP Growth Rate: 7.94%	JSY: Promotes institutional delivery by providing cash assistance to pregnant women. Institutional deliveries rose from 28% (2005) to 69% (2016). JSSK: Provision of free drugs, blood, diagnosis, diet, and referral services to all pregnant women and sick newborns and infants (up to one year). Maternity Waiting Homes (Maa Gruha): Accommodate pregnant women from remote areas 7–10 days before delivery. 49 operational out of the targeted 62. VHNDs: Weekly sessions at Anganwadi Centres for health education and basic services. 4.54 lakh sessions held out of 4.66 lakh planned (97%).	Scholarships for Elementary Students: Merit-based and merit-cum-poverty scholarships to retain and support meritorious students in Class 3 and 5. 10,000 students benefited across four categories of scholarships including the Pathani Samanta Mathematics Talent scholarship for upper primary to +2 level. KGBV: Total numbers of 182 KGBVs in 23 districts were operational benefiting 18,200 girls. MDM Programme: Nutrition support scheme aimed at improving attendance, retention, and nutrition levels. 49.27 lakh students of 62,640 primary and upper primary schools were covered in the scheme. 1.28 lakh cook-cum helpers get honorarium of ₹1,000/- for 10 months in a year. Besides this 29,900 WSHG and two trusts namely Akshya Patra Foundation and Mana Trust are also managing the MDM Programme. To ensure smoke free and eco-friendly environment 12,619 schools have been sanctioned budget from GoO.

Year	PCI and GSDP at Constant Prices	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
		Maternal Death Review: Monitor and investigate maternal deaths to improve healthcare systems. 722 maternal deaths were reported and reviewed in 2015–2016. DAKSHATA Programme: Standardise labour rooms using the MNH toolkit to improve the quality of care. Implemented in 18 districts. 108 and 102 Ambulance Services: 420 (108 Ambulances) and 408 (102 Ambulances) are operational to provide free transport services for all medical treatment. SAB Training: Train AYUSH doctors and paramedics to handle safe deliveries. Provided across districts, number not specified. KMC: Promote skin-to-skin contact and breastfeeding for low-birth-weight infants. 10-bedded units established in five districts. Mobile Health Teams Formed for Screening: 640 Mobile Health Teams are formed under RBSK for screening, treatment, and referral of children identified with defects, deformity, or diseases. More than 60 lakh school children have been covered under the scheme. RKSK: Under RKSK: a) 148 AFHC-designated "SRADHA" clinics have been established to provide services for adolescent girls and boys; b) Peer Education Programme is a community-based component of RKSK. 4700 out of 23,600 planned peer education have been identified till March, 2016; c) Integrated Counselling Centres have been established in the areas of Adolescent Health, ANC, PNC, IYCF, and GBV; d) Four one-stop Crisis Centres have been established at Puri DHH, Sambalpur DHH, Capital Hospital, and MKCG Hospital.	Residential Hostels for Urban Deprived Children: Eight residential hostels with intake capacity of 50 each for urban deprived children, child labour, and street children are being opened. Increases to Sikhya Sahayak under SSA: 9,121 new Sikhya Sahayaks have been appointed during 2015–2016 under SSA. Career Advancement Policy for Teachers: 5,040 newly recruited teachers were trained in 30 days teachers training module with the objective of improving teaching capabilities and assuring reasonable career growth. Free Textbooks and Uniform: Free textbooks have been supplied to all students of all government and aided schools. Uniform provided to all girl students and SC/ST and BPL boys in government schools. Performance Tracking: A comprehensive monitoring mechanism 'Samikshya' has been adopted to track performance of elementary education throughout the state. Urban Education for ST&SC Students (ANWESHA)—Anwesha is a GoO initiative launched in 2015–2016 across 17 tribal dominated districts to provide quality urban education to ST and SC children from BPL families from Class 1. It partners with private schools in urban centres and district headquarters, covering all educational and residential costs, including tuition, books, transport, and hostel stay. Each year, 5,000 students (70% ST and 30% SC) are selected through a lottery, aiming to reach 25,000 children over time. Sponsored students are admitted beyond the 25% seats reserved for disadvantaged students under RTE Act. Students are selected, out of eligible applicants, through a lottery system by the District Level Committee under the Chairmanship of the District Collector. Urban Hostels in Bhubaneswar for ST and SC Students (AKANKSHA)—The state government has sanctioned two urban hostel complexes named AKANKSHA in Bhubaneswar. 80% seats are for ST students and 20% are assigned for SC students. Of the total seats reserved for each category, 30% seats will be reserved for the +2 courses, another 30% for the graduate and post-graduate courses.

Year	PCI and GSDP at Constant Prices	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
		RNTCP: Aimed to detect 70% infectious sputum-positive TB cases and cure at least 85% of them, and provide free and domiciliary treatment. This programme has been implemented through 31 implementing units, 159 TB units, and 584 DMCs. NPCB: During 2015–2016, 78,566 cataract operations were performed, as against the target of 1,57,300 NIDDCP: Periodic iodine deficiency surveys, monitoring laboratory activities underway. NLEP: Prevalence rate of leprosy in the State came down from 121.4 per 10,000 population in 1982–1983 to only one in 2015–2016, and the ANCDR was 210 per 100,000 population during 1982–1983, coming down to 16.55 by the end of January 2015. NVBDCP: Malaria prevention and control initiatives. In Odisha, 66.08 lakh fever cases were screened for malaria during 2015, and 4.37 lakh were found positive. The number of malaria-positive cases per 1,000 population was 9.97 during 2015. To protect the expectant mothers, the state has initiated a scheme 'Mo Mashari'. NACP: HIV testing and prevention programmes. NACP-IV (2013–2017) has been implemented to prevent new infections, particularly among high-risk groups. NRCs: Treat severely malnourished children with medical care and nutrition. 5,056 children admitted; 75% (3,693) discharged with 15% weight gain. Pustikar Diwas: Mass treatment initiative for malnourished children. 8.02 lakh children treated from 2009 to 2016. SNP: Provide daily nutrition to 6-month to 6-year-old children, pregnant, and lactating women for 300 days/year. 45.17 lakh beneficiaries, ₹843.68 crore spent, 71,306 AWCs implementing.	

Year	PCI and GSDP at Constant Prices	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
		NBCC: Provide immediate care at delivery points to prevent newborn mortality. 781 functional NBCCs. SNCU: Facility-based care for critically ill newborns. 30 SNCUs operational; 34,230 children admitted; 71% discharged. NBSU: First-line stabilisation for newborns before referral to higher centres. 49 NBSUs are operational. NHED: Educate women (15–45 years) on health, hygiene, nutrition, family planning, and child care. 9.19 lakh women/month covered. Health Checkups at AWCs: Ante/post-natal care, child health, basic diagnostics, deworming, etc. 21.71 lakh beneficiaries covered, 77% were children. Referral Services through AWWs: Refer sick/malnourished children and mothers to health facilities. 6.33 lakh referred cases.	
2017–2018	PCI: ₹67,522 GSDP: ₹3,23,218 crore GSDP Growth Rate: 7.14%	Free Drugs Services (Niramaya): Operationalised since May 1, 2015, across hospitals at all levels for providing free drugs to the citizens. 570 types of drugs are included in state EDL and facility-wise EDL is in place which includes essential drugs, cancer drugs, drugs under mental health, and consumables. Free Referral Transport Services (108 and 102): To ensure free referral transport services to patients, including pregnant women and sick infant of state, 892 ambulances under "102 ambulance services" and "108 ambulance service" are operational. RSBY: Launched in 2009–2010, BKKY) in the year 2013 for farmers, OSTF was created by the state under OSTF Society under which patients belonging to BPL category or AAY category or having income up to ₹50,000/- in rural areas and ₹60,000/- in urban areas or referred from registered Mental Asylum/Destitute Home/Orphanage or unknown accident victims are entitled to cashless treatment at various hospitals in and outside the state. In 2016–2017, beneficiaries under:	Scholarship for Elementary Students: Primary and upper primary merit scholarship, primary and upper primary merit-cum-poverty scholarship is there for meritorious students of Class 3 and Class 5. During 2016–2017, 10,000 students were getting scholarship for four categories. Pathani Samanta Mathematics Talent Scholarship was introduced by the state government to regular students beginning from upper primary to +2 level. During 2016–2017, 3,771 Class 6 and 2,385 Class 9 students were awarded. SSA: a) KGBVs: During 2016–2017, the total number of 182 KGBVs in 23 districts have been made operational benefiting 18,245 girls. Odisha made self-defence training of girls to develop self confidence among the girls at upper-primary-level. Constructed 176 KGBV building and six KGBV building are under progress.

Year	PCI and GSDP at Constant Prices	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
		RSBY: 9.77 lakh families with a claim amount of ₹333.89 crore. 423 public and 162 private hospitals empanelled under RSBY. BKKY: 2.77 lakh families with a claim amount of ₹147.27 crore. 423 public and 134 private hospitals empanelled under BKKY. OSTF: 28,134 patients and ₹60 crore worth of claim settled under OSTF. The number of households with any usual member covered by a health scheme / insurance has increased from 1.6% in 2005–2006 to 47.7% in 2015–2016. Boat ambulances proposed: 4 out of 6 boat ambulances proposed for tribal districts under State budget. ICDS: a) SNP—Under ICDS, provides nutrition to children (6 months to 6 years), pregnant, and lactating mothers. Revised costs: ₹6, ₹9, and ₹7 per beneficiary/day for normal, severely malnourished, and mothers, respectively. In 2016–2017, 47.90 lakh beneficiaries were covered via 72,587 AWCs with ₹843.68 crore. b) NHED—NHED is a key element of ICDS, comprises information on basic health, nutrition, childcare, and development, infant feeding practices, utilisation of health services, family planning, and environmental sanitation. This is imparted through counselling sessions during home visits on FIDs and in gatherings of women's groups and mothers' meetings in the area. During 2016–2017 (up to March 2017) about 8.98 lakh women per month have been covered under NHED.	b) Building construction: Under SSA, 16,603 buildings for primary and upper primary schools have been completed and 473 buildings are under progress; 72,335 additional classrooms for Government Elementary Schools were completed and 2,322 under progress. Relaxation of Norms for Opening of New Primary Schools: Opened 9,943 new primary schools and 11,008 new upper primary schools during 2001 to 2016–2017. Provided Transport/Escort Facilities in Scattered Habitations: These were given to 4,049 children of sparsely populated and scattered habitation more than 1 km and 3 km in primary and upper primary schools. Ujjawala Programme: Aimed to ensure quality education in all elementary schools in the state. 9,84,062 (57.42%) students achieved the outcome. Educational Kits Distribution: Provided to 19,51,908 students in Classes 1–3, including school bags, teaching-learning materials, and storybooks to encourage enrolment and retention. Single window delivery system of unified training calendar prepared for School and Mass Education. Swachha Vidyalaya Programme: Implemented in all schools. Beti Bachao Beti Padhao implemented in Nayagarh district. Organised Enrolment Drive (Prabesh Utsav), Purna Upasthan Divas and counselling of Mothers programme in all government and government-aided elementary schools. Srujan Calendar (Activity Bank) distributed: Guidelines for conducting different (12) child centred activities were distributed under Srujan to all schools. SMCs: Formed in 61,945 out of 63,158 government and government-aided schools to improve school governance. SCPCR—SCPCR was notified and functionalised. Adopting the Eight Years of Elementary Education (Class 1–8) Policy. Notification for No Board Examination issued.

Year	PCI and GSDP at Constant Prices	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
		Immunisation Programme: Targets six diseases (polio, diphtheria, pertussis, tetanus, tuberculosis, measles). In 2016–2017, 6.74 lakh children immunised for DPT, 6.72 lakh for polio, 6.62 lakh for BCG, 6.80 lakh for measles, and 6.70 lakh pregnant women for TT. RKSK: a) Established 148 Adolescent Friendly Health Centres (AFHC) designated as "SRADHA" clinics for adolescent girls and boys; b) Peer Education Programme is a community-based component of RKSK. 4,700 out of 23,600 planned peer education have been identified till March 2016.; c) Established Integrated Counselling Centres in the areas of Adolescent Health, ANC and PNC, IYCF and GBV. d) Established 4 no. of One Stop Crisis Centres at Puri DHH, Sambalpur DHH, Capital Hospital, and MKCG Hospital. Strengthening Facility-Based Newborn Care by establishing 781 Newborn Care Corners. Operationalisation of FRUs: To provide comprehensive maternal and child health services, 85 FRUs were made functional at high-volume health facilities. Operationalisation of HBNC: 44,023 ASHAs have been trained on HBNC for prompt identification and referral of sick neonates and infants through home visits. Establishment of NRCs: Keeping in view the high incidence of malnourished children, 49 NRCs were set up at DHH, SDH, and high-burden CHCs. KMC: Establishment of 10 Bedded KMC units in five districts.	Textbooks and Uniform declared as child entitlements at the elementary level. Hostels for migrant children: Retention of 7,420 children of migrant families in 208 seasonal hostels functioning from November 2016. Residential hostels for Urban deprived children: Operating 16 residential hostels for urban deprived children, child labour, and street children. Education for SC/ST children: a) Nine more Eklavya Model Residential schools (for Class 6–12) are in progress. Set up of English language labs in all 13 EMRS. Set up of smart classrooms with modern teaching, learning aids, and lectures, multimedia contents in all 13 EMRS; b) State government has established 11 Kalinga Model Residential Schools from Class 6–12 in TSP areas from its own resources; c) A multi-language education training module was developed for the teachers of SC/ST Department in TSP districts. MDM Scheme: During 2016–2017, in Odisha, every day, 47.71 lakh (31.21 Primary + 16.50 Upper Primary) children of 62,784 schools benefited from hot cooked nutritious food. The ration cost was enhanced from 4.31 to 4.58 for primary students and from 6.43 to 6.83 for upper primary students. The government entrusted the management of the MDM programme at the school level to WSHGs and served eggs twice in a week. Urban Education for ST and SC Students (ANWESHA): ANWESHA provides quality education to ST/SC students in 142 best private schools in 17 districts from 2015–2016. 13,440 ST/SC students have been admitted in Classes 1–3, out of which 50% are girls. Construction of 250 hostels under ANWESHA has been initiated during 2016–2017 to meet the accommodation demand for the next five years. Urban Hostel Complex for Post-matric ST and SC Students (AKANKSHA): During 2016–2017, steps were initiated to establish another six new urban hostels at Berhampur, Sambalpur, and Rourkela, one each for boys and girls.

Year	PCI and GSDP at Constant Prices	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
		Universal Screening for children for Four DS: 640 Mobile Health Teams are engaged under RBSK for screening of children at the AWCs and school-level to identify birth defects, diseases, delayed milestones, and deficiencies among children up to 18 years of age. More than 60 lakh school children have been covered under this scheme. Strengthening of Immunisation Programme: In addition to the continuation of BCG, DPT, Polio, TT, Measles, and Hepatitis-B, four new vaccines have been included. JSY: 5.01 crore beneficiaries from 2005–2006 to 2016–2017. Increased the institutional delivery from 28% in 2005 to 69% in February 2016 (HMIS) against expected delivery due to JSY. As per NFHS-4 report, JSY benefits (72.6%) received by mothers is the highest in Odisha, compared to other states. ESI Scheme: Medical care is provided to 6,07,246 insured persons and their dependents through five ESI hospitals, 40 ESI dispensaries, and 14 important centres in 20 districts. Public Health Response Fund under State Budget: To initiate preparedness and management in response to various natural calamities, 5 crore have been allotted in the current financial year under state budget.	
2018–2019	PCI: ₹75,796 GSDP Growth Rate: 8.4%	BSKY: A Health Assurance scheme, was launched on August 15, 2018 with an outlay of ₹1,003 crore for the year 2018–2019. The scheme has two components: 1. Universal Free Healthcare (OPD+IPD) for all (4.5 crore population of Odisha) • In all public health institutions up to medical college and hospital level and in government blood banks. • No documentation is required for accessing healthcare services.	LEP: Ujjwal, Utthan, and Utkarsh: Ujjwal programme focuses on equipping students from Classes 1 to 5 with basic competency in Odia, Mathematics, and English; Utthan is for students of Classes 6 to 8 to enable them acquire grade-level competency in these three subjects. Utkarsh aims to equip students of Classes 9 and 10. For these programmes, teacher trainings were organised. 'SATH-E': NITI Aayog Project envisaged as a programme from 2018–2020 that aims to transform elementary and secondary school education. It aims to achieve a significant improvement in one or more areas of access, equity, learning outcomes, and governance.

Year	PCI and GSDP at Constant Prices	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
		2. Free healthcare for economically vulnerable 70 lakh families (about 3.5 crore population of Odisha) • All families with BKKY Card, BPL card, AAY Card and families with low income certificate (₹50,000 p.a. in rural areas and ₹60,000 p.a. in urban areas) are covered under the second component. However, in case of cancer, kidney, and cardiac patients, the income ceiling is raised to ₹3,00,000 p.a. • Assured Annual Cashless Healthcare coverage of ₹5 lakh per family and ₹7 lakh for women members of the family per annum. • Hospitals empanelled: 196 private empanelled hospitals within and outside the state. All government hospitals and premier health institutes outside the state. • 4,036 treatment packages (including diagnostics) are available under this component of BSKY. SAMMPurNA: Launched in 2015, a special budget of ₹398 crore has been sanctioned to take up special state specific strategies for accelerated decline of IMR and MMR in 15 high focus districts of the state including identification of high-risk pregnancies; issuance of RED card to all high-risk pregnancies; reimbursement of transportation cost to mother at ₹1,000. Free Diagnostic Services ('Nidaan'): All types of essential diagnostic services are provided free of cost to all categories of patients in all public health facilities as per its level from sub-centres to medical colleges and hospitals. The diagnostic services under 'Nidaan' include general pathology service, CT-Scan, and MRI in 10 DHHs, where new Medical College and Hospitals are coming up and in SCB MCH, MKCH, MECH and VIMSAR, and Tele-radiology of X-Rays in all DHHs, SDHs, and selected CHCs through PPP mode. Annually, over 1.50 crore patients requiring diagnostic services at public health facilities are benefited.	Residential schools for SC/ST children: 4,200 residential schools in the state provide primary to senior secondary education to more than 5.70 lakh ST/SC students. About 70% of these residential schools are concentrated in the tribal dominated 12 Scheduled Districts. ANWESHA: Under this scheme, over 19,000 ST and SC students are getting free quality education in the best private schools in 17 districts.

Year	PCI and GSDP at Constant Prices	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
		Free Dialysis Service (Sahay): To reduce the OOPE towards dialysis services, 'Sahay' has been launched. Patients requiring dialysis services recommended by treating physicians are provided free dialysis services at all Medical College Hospitals through the hospital's own system. Steps are being taken to provide free dialysis services in 25 District Head Quarter Hospitals and CHC, Narshingpur, through the PPP mode to ensure easy access to dialysis services. Annually, about 50,000 patients are benefited. Free Drug Services (Niramaya): About 593 types of essential drugs that include surgical items and other consumables are provided free of cost at public health facilities. More than 3 crore patients have benefitted since 2014. Free Blood Services: Under the strengthening of blood services, provision has been made to ensure quality blood to all patients requiring blood at public health facilities. Digital Dispensaries in Health Sector (Swasthya Sahaya): Efforts are being made to establish digital dispensaries in underserved and hard-to-reach areas, strengthening specialist services at major hospitals, and establishing a helpdesk for facilitating better patient care and sustaining the motivation of ASHAs. In the first phase, 30 digital dispensaries have been made operational in Keonjhar and Nabarangpur districts, and 102 additional digital dispensaries are being established in other districts.	

Year	PCI and GSDP at Constant Prices	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
		Strengthening of Ancillary Services at Public Health Facilities (Nirmal): For promotion of Healthy and Hygienic Hospitals, a new scheme 'Nirmal' has been launched for strengthening of ancillary services (sanitation, laundry, security, lift services, etc.) at Public Health Facilities. The main objective is to minimise hospital-acquired infections and improve patients' satisfaction. Specialist Services in Urban PHCs/CHCs (Ama Clinic): To reduce OOPE of the urban population and slum dwellers in particular, GoO has launched 'Ama Clinic' to provide weekly specialist services in the Urban PHCs and Urban CHCs. The specialist services include O&G, paediatric, nutritionist, medicine and geriatric, adolescent services, psychiatric services, ophthalmology services, and physiotherapy services. These services in 'Ama Clinic' are provided depending on the availability of the concerned specialists (government or hired contractual) in the urban area. Place-Based Incentives for Doctor Retention in Remote Areas: To attract and retain doctors in inaccessible and remote areas, place-based incentives are given to doctors and specialists. It is given to the MOs working in different difficult/remote areas in the state as per the vulnerability status of the places, taking into consideration certain key parameters such as difficulty and backwardness of the location, tribal dominance, left-wing extremism, train communication, road and transport facilities, social infrastructure, and distance from the state headquarters, etc. Creation of New Public Health Facilities: To improve easy access to healthcare services through the establishment of 12 new Sub-Divisional Hospitals, 224 CHCs, including the upgradation of PHCs/OHs to CHCs, 11 New PHCs, 95 Urban PHCs (42 new and 53 PHCs converted to UPHCs), seven urban CHCs (four new and three CHCs converted to UCHCs), and 761 Sub-Centres since 2005.	

Year	PCI and GSDP at Constant Prices	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
		Infrastructure Development: Created state-of-the-art healthcare infrastructure through the establishment of nine new 300-bedded District Head Quarter Hospital buildings, 56 new MCH wings, 56 new Operation Theatres, 114 Labour Rooms, 75 new PHC (N) buildings and 2760 Sub-Centres to provide better healthcare services in rural areas and established two UCHCs and 47 UPHCs. IDCF: An intensified diarrhoea control fortnight has been held every year since 2015 during the monsoons, where a prophylactic dose of ORS is distributed to each under-five child to prevent any death due to childhood diarrhoea. JSY: A total of 5,996,494 beneficiaries benefited under JSY (from 2005–2006 till March 2018), and out of this, in the last five years, 2,309,713 got JSY benefits. JSSK: During 2018–2019, 4.89 lakh pregnant women and 1.34 lakh sick children got benefits. Delivery points: The state has a target of 1,190 delivery points, of which 652 institutions are functional, and steps have been taken for functionalising the remaining DPs. First Referral Unit: 86 hospitals are functioning as FRU (L3) institutions out of 95 for providing Comprehensive Emergency Obstetric care, including C-Section. Safe abortion care services: Out of 439 targeted institutions, 295 facilities are in readiness for providing CAC service in the state. During 2017–2018, up to December 2017, 15,442 numbers of MTPs were conducted in public facilities and 911 in private facilities. Village Health Sanitation and Nutrition Day: 5,11,022 VHSND sessions held out of 5,22,772 planned (98%) during 2017–2018 (up to March 2018). VHSND has been named as Mamata Diwas in the state.	

Year	PCI and GSDP at Constant Prices	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
		DAKSHATA programme: 18 districts are given focused attention for improving infrastructure and practice in the labour room. Maternity Waiting Homes (Maa Gruha): So far, 64 MWH are operational out of 73 targeted, and 52,811 pregnant women have benefited. Till 2018–2019, 81 MWhs got operationalised. PMSMA: This programme was started in November 2016, which focused on screening of antenatal cases by a doctor, preferably an O&G specialist, at least once during the 2nd or 3rd trimester. So far 2,51,121 nos. of anti-natal cases have been screened and 17,461 high-risk pregnancies detected. Till March 2019, 4.67 lakh antenatal cases have been screened, and 26,870 high-risk pregnancies have been detected. SNCU and NBSU: Till 2018–2019 (March 2019), 39 SNCUs got operationalised. Six new SNCUs are under process to function, and five NBSUs are being upgraded to SNCUs. Mothers' committees for AWC monitoring: 72,587. Mothers' committees functioning at the AWC-level are involved in planning, management and monitoring of AWCs. Jaanch Committees for community participation in AWC: 58,489 Jaanch Committees functioning at the village level ensure community participation in planning, implementation and monitoring of activities at the AWC level. Members of the committee monitor the quality of food provided at AWCs, hold regular meetings at AWCs to ensure delivery of services and ensure standards of quality and quantity. ONAP: Multi-Sectoral Plan for Nutrition was launched in the state in December 2016. It charts a road map for planning of multi-sectoral interventions to improve the nutritional status of women and children.	

Year	PCI and GSDP at Constant Prices	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
		Crèches in PVTG and hard to reach areas: Crèches for children from 6 months to 3 years set up in PVTG and hard-to-reach areas to prevent undernutrition in five districts. Statewide campaign on Complementary Feeding: A statewide campaign has been launched to improve complementary food and feeding practices of children under two years age in four focused districts: Koraput, Nabarangpur, Rayagada, and Keonjhar. Jiban Sampark: Project 'Jiban Sampark' launched for the welfare of the PVTG. The project aims at improving the uptake of health and nutrition services to which they are entitled. The other stakeholder departments are H&FW, ST and SC Development.	
2019–2020	PCI: ₹1,01,587 GSDP Growth Rate: 6.16%	JSY: Benefitted 5,996,494 individuals (2005–2018), with 2,309,713 in the last five years. In 2018–2019, 4.75 lakh pregnant women received benefits, increasing institutional delivery from 28.8% (2005–2006) to 85% (2015–2016, NFHS-4). JSSK: Launched in November 2011, provides free treatment to pregnant women and sick newborns (up to one year) at public facilities. Since 2013–2014, 25,34,365 women and 4,27,674 children benefited; in 2018–2019, 4.89 lakh women and 1.34 lakh children were helped. FRU: 86 out of 95 targeted hospitals function as FRUs, providing Comprehensive Emergency Obstetric Care, including C-sections. SAB: Trained 7,481 HW(F)/LHV, 4,447 staff nurses, and 1,559 AYUSH doctors by February 2018 to improve delivery of care, with 67 HW(F)/LHV, 205 staff nurses, and two AYUSH doctors trained in 2018.	Odisha Adarsha Vidyalaya: Provides quality education in English to the rural children in every block practically at no cost or at best at low cost. 214 Odisha Adarsh Vidyalaya started functioning in 214 blocks covering 29 districts from 2016–2017 to 2019–2020. 36 more will be more operational from the academic session 2020–2021. 30 OAVS upgraded to senior secondary from 2019–2020 and 30 more will be in 2020–2021. Total 58,712 students enrolled in 214 OAVS. Mo School Abhiyan: For strengthening citizen-government partnership in schools. It has provided a platform to donate funds, materials, and services for overall development of schools in the State. 8,937 Schools in 30 districts received ₹29,70,25,792 as contribution to Mo School during 2018–2019. State-wise Parents Teacher Association Meeting: Odisha has decided to organise statewide PTM four times in an academic year in all government Schools of Odisha in a campaign mode.

Year	PCI and GSDP at Constant Prices	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
		Safe Abortion Care Services: 295 out of 439 facilities offer CAC. In 2017–2018, 15,442 public and 911 private MTPS were conducted: 1,04,419 safe abortions in the last five years. VHSND: Organised on Tuesdays/Fridays at AWCs, with 98% of 5,22,772 planned sessions held in 2017–2018. Over five years, 23,48,694 sessions conducted, with 2.4 crore ANC/PNC check-ups. Standardisation of OT and Labour Room: Implements MNH toolkit and DAKSHATA programme in 18 districts to improve infrastructure and practices in labour rooms and OTs. MWH: 81 out of 73 targeted MWHs operational by 2018–2019, hosting 52,811 women from remote areas near delivery points for safe institutional deliveries. Initiatives for Anaemia Control: Covers approximately 9 lakh pregnant women annually with IFA and calcium supplementation, iron sucrose/blood transfusion services, and one-time deworming in the 2nd trimester. PPMSMA: Started in November 2016, screens women in the 2nd/3rd trimester on the 9th of each month. By March 2019, 4.67 lakh women screened, 26,870 high-risk pregnancies detected. NBCC: 580 NBCCs are functional at labour rooms and OTs across delivery points, with a progressive target of 1,190 to provide essential newborn care and resuscitation. SNCU and NBSU: 39 SNCUs (target: 41) and 46 NBSUs operational by March 2019. SNCUs admitted 2,05,753 newborns by January 2018, with 72% discharged after treatment. KMC: Established in 30 SNCUs to promote skin-to-skin contact and early breastfeeding for preterm, low birth weight, and sick newborns.	Odisha Girls' Incentive Programme: Enrolment of 2.5 lakh girl students. OGIP in an add-on cash incentive programme aimed at facilitating increased participation of ST and SC girl students in the Secondary Education. Education for SC/ST children: a) Establishing 182 KGBV with 18,400 children in 23 districts for ST and SC girls; b) 16 Residential Hostels for urban deprived children with 1,000 capacity in 11 districts; c) 165 seasonal hostels for 7,169 migrant children; d) MLE has been introduced at primary level to address the issue of language barrier faced by the children of tribal communities. It is operational in 1485 schools of 17 tribal dominated districts in 21 Tribal Languages during 2018–2019. 3,369 Shikhya Sahayaks for MLE programme are placed in MLE adopted schools to teacher the children in mother tongue. MDMS: The state performs favourably in terms of provision of mid-day meals, a service prevalent in close to 99% of schools. Odisha ranks fourth among states on this parameter. Talent Promotion Through Scholarships: Three scholarships namely Odia Bhasa Bruti, Mukhya mantra Medha Bruti and Best School Award have been introduced by the state government during 2018–2019 to promote talent in Odia Medium government and Aided Schools of the State. SATH-E: NITI Aayog project from 2018–2020. It includes initiatives for improvement in elementary and secondary education through its 15 points, like School Rationalisation by merger, ensuring access, equality in tribal areas, filling up vacancies, remediation training to in service teachers, MIS at all levels, accountability to access the strength and weakness, provision modern education, etc. Garima Awards: The School Certification Programme (Garima) recognises and rewards schools that are performing in terms of learning Outcomes. Under this programme, schools can nominate themselves to be assessed and certified under three categories: Bronze, Silver, and Gold.

Year	PCI and GSDP at Constant Prices	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
		Training and Capacity Building: Provides training under INAP/IAPPD, Facility-based IMNCI, FBNC, and AYUSH MO orientation for community-based child death review to enhance service efficiency. HBNC: Trains ASHAs to identify newborn danger signs, refer high-risk cases, and counsel caregivers. In 2017–2018, 12% of LBW babies reported, 93% of high-risk newborns were referred. IDCF: Conducted annually since 2015 during monsoons, providing ORS to children under five. In 2017, 84.4% received ORS; in 2018, 5.7% coverage was achieved. Free Dialysis Services (Sahay): Available in all Medical Colleges, expanding to 25 DHHs and one CHC, benefiting approximately 50,000 patients annually. Free Ambulance Services (108/102): Operates 420 emergency (108) and 489 maternal/infant (102) ambulances, with 92 new ambulances and six boat ambulances added, serving over 34 lakh beneficiaries. Free Blood Services: Provides free blood and transfusion services, benefiting 1.5 lakh patients annually. Innovation in Health (Swasthya Sahaya): Operates 30 digital dispensaries, with 102 more planned to enhance healthcare access. Ancillary Services (Nirmal): Enhances sanitation, hygiene, and support services in hospitals to improve patient care. Sanitary Napkins (Khushi): Provides free postpartum napkins and sanitary napkins to 17 lakh schoolgirls to promote menstrual hygiene. SAMMPurNA: Targets maternal and child health, benefiting over 10 lakh individuals annually through high-risk case management and infrastructure support.	ANWESHA in Urban Areas: Under this scheme, over 23,000 ST and SC students are getting free quality education in the best private schools in these districts. Mission SUVIDYA: The ST and SC Development, Minorities and Backward Classes Welfare Department, Odisha has signed a MoU with Akshara Foundation for Mission SUVIDYA in December 2019. It aims to bring qualitative improvement in accommodation provided in 6,500 hostels with 5.7 lakh students.

Year	PCI and GSDP at Constant Prices	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
		Free Cancer Care: Establishes district chemotherapy units, treating 10,309 patients with 8,132 chemo cycles completed. MHUs (Swasthya Sanjog): 177 MHUs cover 6,251 remote villages to provide healthcare access. Specialist Services (Ama Clinic) in Urban Areas: Offers weekly specialist clinics in urban PHCs/CHCs to improve healthcare access. Place-Based Incentives: Provides ₹40,000–₹80,000 incentives for doctors in remote areas to strengthen healthcare delivery. Corpus Fund: Allocates ₹1 crore per backward district for human resource support in health services. Casualty/Trauma Care: Operates eight trauma centres, with 25 more planned to enhance emergency care. Swasthya Seva Mission: Includes infrastructure development, emergency response, and treatment funding to improve healthcare services. Free Mental Healthcare: Offers district-wise screening, drugs, and awareness programmes to address mental health needs. New Government Medical Colleges: Four colleges are operational, increasing MBBS seats to 1,050 to enhance medical education and healthcare capacity. New Nursing Training Institutes: Establish new ANM, GNM, DMLT centres, and two nursing colleges to strengthen the healthcare workforce training. New Public Health Facilities: Develops new SDHs, CHCs, PHCs, UPHCs, UCHCs, and sub-centres to expand healthcare infrastructure. Cadre Restructuring: Creates 2,508 doctors, 400 dentists, and 5,719 paramedics posts, with a specialist cadre to improve healthcare delivery. Infrastructure Development: Constructs new MCH wings, OTs, labour rooms, PHCs, and sub-centres to enhance healthcare facilities.	

Year	PCI and GSDP at Constant Prices	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
2020–2021	PCI: ₹1,04,566 GSDP: ₹3,76,998.43 crore GSDP growth rate: -4.92%	NHM: a) Operationalisation of First Referral Unit: 94 FRUs at strategic locations across the State for providing C-Section facility along with specialised manpower and infrastructure. b) Delivery points: State has a target of 1190 delivery points of which 530 institutions are functional, and steps have been taken for functionalising the remaining DPs. c) NBCC: 560 NBCCs are established at all functional delivery points. d) NBSU: 45 NBSUs are currently operational in the state. e) KMC Units: Established in all 40 SNCUs adjoining the SNCU. f) CDR: Child death review has been implemented in the state during 2015–2016, under which committees have been formed at the state and district level for detailed review and analysis of each under-five child death and taking necessary corrective actions. EMAS: Started in 2013, 512 ambulances are operational and so far, more than 26 lakh patients have benefited from the service. Referral Transport Ambulance Service (Janani Express/102): 493 out of 500 ambulances are operational, and more than 25 lakh beneficiaries have benefited so far. Boat Ambulance Service: To provide transportation to the sick and injured in riverine areas in the four districts, the government has sanctioned six Ambulances out of the state fund, as a feeder service to both EMAS and Janani Express. JSY: The institutional delivery has increased from 28.8% in 2005–2006 to 85% in 2015–2016 as per NFHS-4.	School mergers: Schools with poor student strength closed and merged, leading to a decrease in the number of schools. Reduced from 36,760 primary schools in 2015–2016 to 33,340 in 2019–2020; at upper primary level, the schools decreased from 22,795 in 2015–2016 to 21,719 in 2019–2020. School syllabus reduced by 30%: In August 2020, the School and Mass Education Department of the GoO reduced the syllabus for the academic year 2020–2021 by 30% in view of the COVID-19 pandemic. The state government's decision is applicable for Classes 1–12. 'Radio Pathsala' and 'Radio Surbhi': With schools closed since March 17, 2020, the School and Mass Education Department, GoO announced that students from classes one to eight of government-run institutes in Odisha will be taught via radio from Monday September 28, 2020. Odisha Shiksha Sanjog: A digital learning programme through WhatsApp groups has been initiated since April 2020 to engage students in teaching learning activities during lockdown. Ashram Schools: Residential schools for tribals (Ashram Schools), particularly for girls in tribal dominated areas. OAV: 214 OAV started functioning in 214 blocks covering 29 districts from 2016–2017 to 2019–2020. 36 more will be more operational from 2020–2021. 30 OAVs upgraded to senior secondary from 2019–2020 and 30 more will be in 2020–2021. Total 58,712 students enrolled in 214 OAVs. Odisha Girls' Incentive Programme: Enrolment of 2.5 lakh girl students. 1.96 lakh students benefitted during 2019–2020 with financial assistance of ₹18.88 crore. Girl students of Class 9 and 10 are provided with a cash incentive of ₹950 per annum. Mo School Abhiyan: Project cost has touched ₹100 crore mark. Since the programme started in June 2018 schools have reported 1,49,536 contributors with total contribution of ₹33,60,01,428 till August 2019. Mo School Abhiyan has sanctioned a total of 1,205 projects from 9,950 schools in 308 blocks with a matching grant of ₹67,09,22,856 (2x). School and Mass Education Department has sanctioned 1,257 projects in 708 schools with a project cost of ₹6,45,30,387.

Year	PCI and GSDP at Constant Prices	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
		JSSK: In the last six years, 105 pregnant women and children availed free referral transport services under the scheme. VHND: Fixed day health and Nutrition Day (VHND) is being organised every Tuesday/Friday at village Anganwadi centres. In 2019–2020, 5,65, 774 sessions were conducted in the state. LaQshya: Under this programme, the LR and MOT are being standardised for providing quality care services. The target is set to standardise all Medical Colleges and FRUs as a prospective target. To date, LR and OTs of 11 facilities have been certified by the state. Maa Gruha: 80 operational out of 106 targeted. Initiatives for Anaemia Control: IFA and Calcium Supplementation—about 7 lakh pregnant women covered during 2019–2020. Hospital Accreditation: One DHH (DHH Kalahandi), one FRU CHC (CHC Ghatagaon, Keonjhar), one Non-FRU CHC (CHC Mandasahi, Jagatsinghputr), and three UPHCs of Berhampur city (UPHC Ambapua, UPHC Askaroad, UPHC Agasahi) are NQAS Certified. Nidaan Scheme: Free Diagnostic Services at identified Public Health Facilities, both through the own system and PPP mode implemented. Sahay Scheme: Free dialysis services provided to all patients at 29 identified Public Health Facilities, both through the own system and PPP mode. ANMOL: ANM Online is an Android-based application, developed to facilitate seamless work of ANMs as well as ensure the collection of good-quality data and its digitisation at its source. It has been implemented in all 30 districts.	Education for SC/ST children: a) 1,746 institutes and 6,898 hostels are being run by ST and SC Development Department. b) KGBV: 18,400 students in 23 districts for ST and SC girls. One KGBV has been opened in Bhadrak district for Muslim minority girls. MLE: Introduced at primary level to address the issue of language barrier faced by the children of tribal communities. It is operational in 1,485 schools of 17 tribal dominated districts in 21 Tribal Languages during 2018–2019. As many as 3,369 Shikhya Sahayaks for MLE programme are placed in MLE adopted schools to teach the children in mother tongue. Residential Hostels for Urban Deprived Children: 16 Residential Hostels with 1,000 capacities in 11 districts are in place. Remedial materials for Primary Classes: Includes remedial materials on UJJWAL for Odia, Mathematics, and English for the children of Class 2 to 5 and UTTHAN materials for Mathematics, Odia, English and science for the children of Class 6 to 8. Ganita Kalita Andolan: A programme being implemented in collaboration with AKSHARA foundation Bangalore in two districts namely Bolangir and Raygada on a pilot basis. Mission SUVIDYA: The ST and SC Development, Minorities and Backward Classes Welfare Department, Odisha has signed a MoU with Akshara Foundation for Mission SUVIDYA in December 2019. SATH-E: A NITI Aayog project, underway in the state from 2018–2020. ANWESHA: Over 23,000 ST and SC students are getting free quality education in the best private schools in 17 districts. ₹8,304.20 lakh was allotted for 21,682 beneficiaries in 2019–2020.

Year	PCI and GSDP at Constant Prices	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
		SAMMPurNA: For accelerated reduction of IMR and MMR in the State, a state-specific scheme —'SAMMPurNA' has been implemented in the state since 2015–2016. Nikshay Poshan Yojana: More than 59,900 TB patients received cash incentives under Nikshay Poshan Yojana through DBT. Ama Clinic: Annually, more than 10 lakh slum populations are getting a range of specialist healthcare services at their doorstep through Ama Clinic—Specialist Services in Urban PHCs/CHCs. Khusi: Scheme for providing free sanitary napkins to school girls from Class 6 to 12 in all the government and government-aided schools in the state. Vatsalya programme to institutionalise care and stimulation for children under three: Launched in November 2020, Vatsalya aims to sensitise parents and facilitators to work towards optimal development of a child through care and stimulation in the early years. Introduction of Millets in SNP in Keonjhar and Sundergarh: Introduction of millets in the morning snacks of preschool children has been introduced since September 2020, with funding from the District Mineral Fund.	
2021–2022	PCI: ₹1,27,383 (Current Price) GSDP: ₹4,27,592.17 crore GSDP Growth Rate: 10.11%	Combining e-governance through 5T and Mamata scheme, MAMATA integrated under Mo Sarkar. MAMATA is a conditional cash transfer maternity benefit scheme launched in 2011, aimed at motivating pregnant and lactating women to seek maternal and child health services and adopt optimal nutrition behaviours and practices. Under 5T, to ensure transparency and make the scheme more citizen-centric, hassle and paper-free, an app-based MIS integrated with a Mobile application is operational in all districts of the state from August 1, 2020. Further, the MAMATA Scheme was integrated under the 'Mo Sarkar' programme in December 2019.	Mo School: Has been rolled out with the aim of collecting funds from the alumni for development of schools and colleges in the state. Gangadhar Meher Sikshya Manakbrudhi Yojana: A state specific scheme for accelerated reduction of IMR and MMR in the state. To provide school bags to all children from class 1 to 5, free textbooks and school uniform including shoes to all children from Class 1 to 8 and free bicycles to all students in Class 9 of Government and fully aided schools including OAVs.

Year	PCI and GSDP at Constant Prices	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
		BSKY: From September 1, 2021, the BSKY benefit in private hospitals extends to 3.5 crore persons of 96.5 lakh NFSA/SFSS cardholder families in Odisha. Cashless medical Services included under BSKY. Nidaan Scheme: More than 1.20 crore tests were done for patients who attended public health facilities from April to September 2021. Sahay Scheme: Free dialysis services to all patients at 29 District Head Quarter Hospitals and CHC, Narshingpur, and SDH Bhanjanagara through PPP mode. Digitalisation through ANMOL: an Android-based application, developed to facilitate seamless work of ANMs. SAMMPurNA Scheme: For accelerated reduction of IMR and MMR in the State. Ama Clinic: To reduce OOPE of the urban population and slum dwellers in particular, Ama Clinic will provide weekly specialist services in the UPHCs and UCHCs. Khushi: Government has introduced social marketing of Khushi sanitary napkins in the rural community, through ASHAs, at the subsidised rate of ₹6 per packet of six napkins. Boat Ambulances: More than 3.62 lakh beneficiaries availed the services under '108' services and more than 2.57 lakh beneficiaries availed the services under '102' services during April to September 2021. BLS and ALS Ambulances introduced: 84 new BLS ambulances and 28 ALS ambulances have been introduced during 2021 to boost the reach and scale of emergency medical ambulance care. Free Referral Transport Service (Janani Express): 5,31,273 beneficiaries have availed the service in 2020–2021, whereas 4,54,860 beneficiaries have availed the service in 2019–2020.	Mobile Schools for PVTG: The initiative called as 'School Sanjog Programme' is a collaboration between Bharat Gyan Vigyan Samiti, Siksha Sandhan in partnership with UNICEF and SC/ ST Development Department, Odisha. It focuses on continued learning among children in PVTG areas, as an alternative to address the disruption in education, among children of Classes 1 to 5, during the phase of school closures due to COVID-19. Hostel Facilities for the ST and SC students: In 2020–2021, around 6,700 hostels are providing accommodation facility for education purposes to more than 4.50 lakh ST and SC students, of which around 2.75 lakh are girls. To cater the needs, some special educational institutions like 27 Eklavaya Model Residential Schools, 62 Higher Secondary Schools, 186 Girls high schools, and 720 Ashram Schools are operating in the state under the SSD department. Mission SUVIDYA for ST and SC students: More than 4.6 lakh ST/ SC students receive education from primary to senior secondary levels in Department run educational institutions. Presently, 6700 hostels are functional providing accommodation facility to more than 5.7 lakh students.

Year	PCI and GSDP at Constant Prices	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
		Family planning in urban areas: Special initiatives have been taken in urban areas with the conduct of capacity building of urban ASHAs and facility-level workshops in UCHCs and UPHCs for young couples and Mahila Arogya Samiti members, which has resulted in increased uptake of Newer Contraceptives in the urban areas. COVID Vaccination: Conducted a successful vaccination drive, with over 95% of the eligible population receiving the first dose and 91% being covered with two doses. NCD Parks in Urban Odisha: Keeping in view the patient Load and availability of space, NCD parks have been operationalised within the campus of 12 urban PHCs in the cities/towns to provide an option for the NCD patients and people nearby to use the facility for a healthy lifestyle. On average, 25–35 people per day visit these facilities.	

Year	PCI and GSDP at Constant Prices	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
2022–2023	PCI: ₹1,50,676 (Current Price) GSDP growth rate: 7.8%	Ayushman Bharat-Health and Wellness Centres: All PHC/UPHC and Sub-Centres are being converted to Health and Wellness Centres for providing comprehensive primary healthcare with 12 expanded packages of services, telemedicine, and wellness activities. Till September 2022, around 5,053 Sub Centres, PHCs, and UPHCs were converted to HWCs. BSKY: 96.5 lakh families covering over 3.3 crore people of Odisha are provided with annual cashless health coverage of ₹5 lakh for the family and an additional ₹5 lakh for the female member after exhaustion of the initial limit. From September 1, 2021, onwards, beneficiaries are availing entitlements under BSKY on production of the New BSKY card or NFSA/SFSS card if the New BSKY Card not provided for some reason. The BSKY benefit extends to 3.3 crore people, including 96.5 lakh NFSA/SFSS cardholder families in Odisha. Specialist Services in Urban PHCs/CHCs (Ama Clinic): Aimed to reduce OOPE for the urban population, especially slum dwellers. The services include O&G, paediatrics, nutrition, geriatrics, psychiatry, ophthalmology and physiotherapy services. Niramaya: Since 2018, more than 19.97 crore patients have benefitted. Nidaan: Over 5.97 lakh patients have received free CT scans, and 1.47 lakh patients have received free MRI Scan services since 2019. Over 2.20 crore tests are done per year. Mukhya Mantri Swasthya Seva Mission: It is a basket of schemes which includes infrastructure development of Public Health Institutions (Non-Residential and Residential); Public Health Response fund to address public health emergencies; OSTF to provide financial assistance for critical healthcare; and Health Investment Promotion Policy.	5T—High School Transformation Programme: Launched under the Mo school Abhiyaan. Under this, the state government mobilises CSR funds from different corporate houses to the tune of ₹796.5 crore against which twice matching grant is provided under Mo School Abhiyan. It is aimed to bring about equity in the education system, thereby increasing investment and improving efficiency and includes ICT based interactive sessions. Mukhya Mantri Sikhya Puraskar: Aimed to encourage healthy competition and recognition of excellence for the transformed schools and other schools of the state. These awards will be presented every year to 50,000 students and 1,500 teachers. OAVS: Total 315 OAVS have been made operational. During the academic session 2022–2023, 1,00,253 students are in OAVs out of which 58,343 are girls and 41,910 are boys. Eighty-five KGBV Type-IV Girls' hostels are functional within the premises of OAVs wherein 6,028 girl students are residing. Hostel Facilities for the ST and SC Students: The state has 1,737 residential schools and about 5500 hostels for ST and SC students which provide primary to senior secondary education to more than 4.50 lakh ST/SC students of which 2.75 lakh are girls. In the last 16 years, the number of hostels increased by more than 250%. OGIP: Under OGIP, 1,32,994 students have been benefitted during 2021–2022 with financial assistance of ₹12.63 crore. ANWESHA: Under this scheme, over 18,887 ST and SC students were given pre- and post-metric scholarships during the year 2021–2022. Nua Arunima curriculum: ECCE curriculum was revised and launched on August 19, 2019. The revised Nua Arunima focused on pre-primary school readiness, corner activities, inclusiveness, and age-specific school readiness activities by involving the parents and community in pre-school education of children aged 3 to 6 years in accordance with NEP 2020. Mo Bikash Patra: Child Assessment Card (Mo Bikash Patra) is being provided to all pre-school children to measure the physical, language, aesthetic, creative, motor, and social development as per their age through observation and a continuous participation process in pre-school activities. A total of 16.37 lakh children between 3 and 6 years of age have received the Mo Bikash Patra.

Year	PCI and GSDP at Constant Prices	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
		Sahay: Around 50,000 patients benefit every year under the scheme. Nirmal: The scheme aims to strengthen ancillary services for cleanliness, hygiene, and sanitation in public health facilities. Due to additional funding from the state budget, around 337 public health facilities in 2019–2020 and 586 in 2020–2021 were covered under the scheme. Air Health Services: Odisha is the only state in India providing Air Health Services to patients in remote locations. Free Blood Services: Over 7.9 lakh units of blood were given free of cost to patients under Free Blood Services. More than 4.4 lakh patients received free blood during 2021 (January to December 2021) and 2.8 lakh till September 2022. Development of PHC and UPHC: Efforts are being made to establish new PHCs/UPHCs and upgrade PHCs to CHCs and CHCs to SDH as per the mandate of IPHS 2022. Anaemia Mukta Lakhya Abhiyan: To accelerate the reduction of anaemia, Odisha has launched the AMLAN. The objective of this initiative is to achieve a 10% reduction in anaemia every year, considering NFHS-5 as the base. The strategy was designed and built on the technical and operational evidence derived from NIPI, WIFS programmes, and AMB. Promotion of quality assurance standards: Includes NQAS and LaQshya certification for labour room and OTs, and promotion of hygienic hospitals by institutionalising the Kayakalp Award to public health facilities.	

Year	PCI and GSDP at Constant Prices	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
2023–2024	PCI: ₹1,61,437 (Current Price) GSDP: ₹8,32,790 crore (Current Price) GSDP Growth rate: 8.5%	New medical colleges: Eight new medical colleges at Balasore, Baripada, Bolangir, Koraput, Puri, Keonjhar, Sundargarh, and Kalahandi and two new Post Graduate Institutes at Acharya Harihar Cancer hospital, Cuttack and Capital Hospital, Bhubaneswar have been established. Odisha University of Health Sciences established: This has been established in the state in 2023, to provide uniform and Medical Education in Undergraduate and Post Graduate Courses of Allopathy, Homoeopathy, Ayurveda, Nursing, Laboratory Technology, and other Paramedical Sciences in the state. Expanding specialist care in the state through PPP: Affordable Healthcare projects for setting up multi-speciality hospitals providing specialist care, in PPP mode, are underway in four locations, i.e., Angul, Barbil, Jharsuguda, and Bhadrak. Odisha Comprehensive Cancer Care Plan: Establishes 11 cancer hospitals in three phases at a cost of over ₹1,000 crore to provide chemotherapy, onco-surgery, radiotherapy, and palliative care. The Government Cancer Hospital in Bargarh was inaugurated in 2023–2024. Health Infrastructure Expansion: Operates 9,757 public healthcare facilities, including 11 MCHs, 32 DHHs, 32 SDHs, 375 CHCs, 7 UCHCs, 55 OHs, 1,236 PHCs, 6,688 sub-centres, and 116 UPHCs. Upgrades PHCs to CHCs and CHCs to SDHs per IPHS 2022 standards, though the average number of beds per hospital (10) is below the national average (20).	Samagra Shiksha: a) School Upgradation: 16 upper primary schools to secondary schools (Class 9 and 10). Establishment of 92 new secondary schools. b) Civil works School buildings: 19,248 P+UP school buildings and 769 SS Additional classrooms: 77,931 in elementary schools and 2,696 in SS. c) FLN Programme: Teachers training through NISHTHA 3.0. d) E-Contents Development for Class 9 and 10: Uploaded on the DIKSHA portal. KGBVs: Operates 304 Type-III and IV KGBVs across 23 districts, accommodating 28,119 and 7,706 girls, respectively, to promote girls' education in disadvantaged areas. OAVS: It provides free quality education in English medium to students at secondary and higher secondary level from Classes 6 to 8 across the semi-urban and rural areas of the state. Currently, 315 OAVs are operational across the state. Rani Laxmi Bai Atma Rakhya Prashikhyana: Provides financial support of up to ₹5,000 per month for three months to schools enrolling girls in Classes 6 to 8, encouraging girls' participation and retention in education. Residential Schools and Hostels for SC/ST: Manages 1,737 residential schools and 5,500 hostels catering to 4.5 lakh SC/ST students, including 2.75 lakh girls, across primary, secondary, and higher secondary levels to improve educational access for marginalised communities.

Source: Authors' compilation, based on Economic Surveys, 2014–2024.

Note: PCI = Per Capita Income; GSDP = gross state domestic product; TB = Tuberculosis; RNTCP = Revised National Tuberculosis Control Programme; DOT = Directly Observed Treatment; NFCP = National Filaria Control Programme; MDA = mass drug administration; NPCB = National Programme for Control of Blindness; NLEP = National Leprosy Elimination Programme; ICDD = Intensive Case Detection Drive; NVBDCP = National Vector Borne Disease Control Programme; LLIN = Long-Lasting Insecticidal Net; NACP = National AIDS Control Programme; AIDS = Acquired Immunodeficiency Syndrome; HIV = human immunodeficiency virus; ICT = Information and Communications Technology; ICTC = Integrated Counselling and Testing Centre; MIS = Management Information System; ESI = Employees State Insurance; NIDDCP = National Iodine Deficiency Disorders Control Programme; IDD = Iodine Deficiency Disorders; CWSN = children with special needs; MDM = mid-day meal; SSA = Samagra

Shiksha Abhiyaan; NPEGEL = National Programme for Education of Girls at Elementary Level; KGBV = Kasturba Gandhi Balika Vidyalaya; JSY = Janani Suraksha Yojana; JSSK = Janani Sishu Surakshya Karyakrama; VHND = Village Health and Nutrition Days; SAB = Skilled Birth Attendant; RBSK = Rashtriya Bal Swasthya Karyakram; AFHC = Adolescent Friendly Health Centre; ANC = Antenatal Care; PNC = Postnatal Care; IYCF = Infant and Young Child Feeding; GBV = Gender-Based Violence; DHH = District Headquarter Hospital; MKCG = Maharaja Krishna Chandra Gajapati Medical College and Hospital; DMC = Designated Microscopy Centre; ANCDR = Annual new case detection rate; NRC = Nutrition Rehabilitation Centre; SNP = Supplementary Nutrition Programme; NBCC = Newborn Care Corner; SNCU = Sick Newborn Care Unit; NBSU = Newborn Stabilisation Unit; NHED = Nutrition and health education; AWW = Anganwadi Worker; WSHG = Women Self-Help Group; GoO = Government of Odisha; BPL = Below Poverty Line; EDL = Essential Drug List; RSBY = Rashtriya Swasthya Bima Yojana; BKKY = Biju Krushak Kalyan Yojana; OSTF = Odisha State Treatment Fund; AAY = Antyodaya Anna Yojana; SMC = School Management Committee; MWH = maternity waiting home; FRU = First Referral Unit; HBNC = Home-Based Newborn Care; ASHA = Accredited Social Health Activist; KMC = Kangaroo Mother Care; BCG = Bacillus Calmette-Guérin; DPT = Diphtheria, Pertussis, and Tetanus; TSP = Tribal Sub-Plan; O&G = obstetrics and gynaecology; MO = medical officer; MCH = maternal and child health; UCHC = urban community health centre; UPHC = urban primary health centre; IDCF = Intensified Diarrhoea Control Fortnight; ORS = Oral Rehydration Solution; CAC = Comprehensive Abortion Care; MTP = medical termination of pregnancy; PMSMA = Pradhan Mantri Surakshit Matritva Abhiyan; ONAP = Odisha Nutrition Action Plan; PVTG = Particularly Vulnerable Tribal Group; H&FW = health and family welfare; LEP = learning enhancement programmes; HW(F) = health worker (female); LHV = lady health visitor; INAP = India Newborn Action Plan; IAPPD = Intensified Action Plan for Pneumonia and Diarrhoea; IMNCI = Integrated Management of Neonatal and Childhood Illness; FBNC = Facility-Based Newborn Care; LBW = Low Birth Weight; MHU = medical health unit; GNM = General Nursing and Midwifery; DMLT = Diploma in Medical Laboratory Technology; OOSC = Out-of-School Children; SDH = Sub-Divisional Hospital; PTM = parent-teacher meeting; MLE = Multilingual Education; RKSK = Rashtriya Kishor Swasthya Karyakrama; MoU = memorandum of understanding; NHM = National Health Mission; EMAS = Emergency medical ambulance service; MOT = maternity operation theatre; IFA = Iron and Folic Acid; DBT = Direct Benefit Transfer; OAVS = Odisha Adarsha Vidyalaya Sangathan; NFSA = National Food Security Act; SFSS = State Food Security Scheme; PPP = public-private partnership; IMR = infant mortality rate; MMR = maternal mortality ratio; BLS = basic life services; ALS = advanced life support; UNICEF = United Nations Children's Fund; IPHS = Indian Public Health Standards; AMLAN = Anaemia mukta Lakhya abhiyan; NIPI = national iron plus initiative; FIDs = Fixed Immunisation Days; WIFS = Weekly Iron and Folic Acid Supplementation; AMB = Anaemia Mukt Bharat; NQAS = National Quality Assurance Standards; LTRMO = leave training reserve medical officer; DAMaN = Durgama Anchalare Malaria Nirakaran; TPR = test positivity rate; CSR = corporate social responsibility; OGIP = Odisha Girls Incentives Programme; ECCE = Early Childhood Care and Education; OT = operation theatre; LR = labour room; MNH = Maternal and Neonatal Health; FLN = Foundational Literacy and Numeracy; ANM = auxiliary nurse midwife; AWC = anganwadi centre; AYUSH = Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy; BSKY = Biju Swasthya Kalyan Yojana; CHC = community health centre; CT = computed tomography; HMIS = Health Management Information System; VHSND = Village Health Sanitation and Nutrition Day; ICDS = Integrated Child Development Services; IPD = in-patient department; MBBS = Bachelor of Medicine, Bachelor of Surgery; SCB = Srirama Chandra Bhanja Medical College and Hospital; ANMOL = Auxiliary Nurse Midwife Online; DIKSHA = Digital Infrastructure for Knowledge Sharing; EMRS = Eklavya Model Residential School; NISHTHA = National Initiative for School Heads' and Teachers' Holistic Advancement; OAV = Odisha Adarsha Vidyalaya; SNP = Supplementary Nutrition Programme; SCPCR = State Commission for Protection of Child Rights; NFHS = National Family Health Survey; SAMMPurNA = Sishu Abong Matru Mrutyuhara Purna Nirakarana Abhijana.

Table A–4: Key Health-Focused State-Level Initiatives in Odisha 2014–2024

S.No.	Name	Nature of Initiative	Years Enacted	Aims and Objectives
1	SAMMPurNA	Government Scheme	Launched in 2015 in 15 districts; extended for five years in 2024	Initiates state-specific strategies for accelerated decline of IMR and MMR in 15 high-focus districts of the state, including identification of high-risk pregnancies, issuance of RED card to all high-risk pregnancies, and reimbursement of transportation cost to the mother at ₹1,000.
2	Niramaya	Government Scheme	Launched in 2015; extended in 2024	Operationalised since May 1, 2015, across hospitals at all levels for providing free drugs to the citizens across the state. It started with 150 drugs on the list, while the list has been updated to 570. These are distributed through Drug Distribution Centres.
3	Nidaan	Government Scheme	Launched in 2018; extended for five years in 2024	Free Diagnostic Services at identified Public Health Facilities are being implemented both through the own system and the PPP mode. All types of essential diagnostic services are provided free of cost to all categories of patients in all public health facilities, as per their level, from Sub-Centres to Medical Colleges and Hospitals.
4	BSKY	Government Scheme	Launched in 2018. In 2024, the Gopabandhu Jan Arogya Yojana was launched as a replacement and later merged with Ayushman Bharat in 2025	The Health Assurance scheme was launched on August 15, 2018. The scheme has two components: 1. Universal Free Healthcare (OPD+IPD) for all • In all Public Health Institutions up to Medical College and Hospital level, and in Government Blood Banks. • No documentation is required for accessing healthcare services. 2. Free healthcare for economically vulnerable 70 lakh families (about 3.5 crore population of Odisha). Cashless medical Services were included under BSKY.
5	Ama Clinic	Government Scheme	Launched in 2017	To cater to the needs of the urban population with a focus on the slum population, weekly specialist services during OPD hours were made available through Ama Clinics. The Specialist Clinics have been implemented in all urban health facilities (PHCs and CHCs). Specialist services such as paediatrics, O&G, medicine, psychiatry, ENT, skin and VD, ophthalmology, surgery, orthopaedics, dental, nutrition, and physiotherapy are assigned as per the availability of the Specialists in the locality.
6	Nirmal	Government Scheme	2018–2019	For strengthening ancillary services (sanitation, laundry, security, lift services, etc.) at Public Health Facilities. The main objective is to minimise hospital-acquired infections and improve patient satisfaction.
7	Sahay	Government Scheme	2017	Provides free dialysis services to all patients at 29 District Headquarter Hospitals through the PPP mode.
8	DAMaN	Government Scheme	Launched in 2016 –2017. Extended in 2022 for five years	Reducing the burden of malaria in the endemic pockets in 24 districts. Camps were set up for screening, treatment, and awareness programmes were undertaken.

S.No.	Name	Nature of Initiative	Years Enacted	Aims and Objectives
9	Mukhya Mantri Swasthya Seva Mission	Government Scheme	2017–2018	It is a basket of schemes which includes infrastructure development of Public Health Institutions (Non-Residential and Residential); Public Health Response fund to address public health emergencies; OSTF to provide financial assistance for critical healthcare; and Health Investment Promotion Policy.
10	UPHCs in PPP mode	PPP	2021	To address the unavailability of doctors in UPHCs, MoHFW recommends PPPs as a tool to deliver various services under NUHM, including clinical services, specialist outreach, diagnostics, and UPHC management. In Odisha, this has been implemented in UPHC management and doctor recruitment in partnership with NGOs (for example, Red Cross).
11	U-AAM	Government Scheme	2021	Under the 15th Finance Commission's PM ABHIM, Odisha received finances for Urban HWCs, later renamed as U-AAM. Administrative approvals were granted for setting up 140 U-HWC from FY 2021–2022 to 2024–2025. U-AAMs are intended to deliver comprehensive primary healthcare.
12	Urban NCD Camps*	Outreach—Preventive Health		Urban NCD camps in Odisha focused on outreach to urban populations for awareness and early screening around cancer, diabetes, and respiratory diseases. In addition to the activities under the NP-NCD, Odisha has conducted several NCD camps, with a focus on urban demographics.
13	Mental Health Initiatives—Psychosocial care in coastal districts	Capacity building and training	2024	In addition to activities under the DMHP under NHM, Odisha's State Disaster Management Authority launched a psycho-social care programme for disaster-affected communities in six coastal districts—Balasore, Bhadrak, Kendrapara, Jagatsinghpur, Puri, and Ganjam. With technical support from NIMHANS Bangalore, the initiative aims to build community-level capacity (local volunteers and community workers) to provide psychological first aid and counselling. **In 2025, the Odisha government announced intentions to frame a dedicated state mental health policy.
14	Extension clinics to UPHCs*	Government Scheme		Extension clinics to UPHCs aim to improve accessibility and decentralise primary healthcare. It is aimed to strengthen the last-mile delivery of health services for urban demographics who find it harder to access facility-based care.
15	Home-based Palliative Care	Government Scheme	2021	The Odisha government extended its Palliative Care programme to home-based palliative care, offering free home care services for terminally ill cancer patients. Under the District Palliative Care Programme, launched in 2019, facility-based palliative care was offered with inpatient and outpatient services at Day Care, Cancer, and Chemotherapy Centres in 10 districts.

Source: Collated through web-search of education and health department websites in Odisha; Key informant interviews with members of the bureaucracy, research experts, and annual reports of relevant departments.

*Note: *These include initiatives that were shared with us by facility-level staff at the district level. Documentation around the initiatives is not publicly available; however, we corroborated these initiatives with internal programme circulars shared by facility staff.*

SAMMPurNA = Sishu Abong Matru Mrutyuhara Purna Nirakarana Abhijana; BSKY = Biju Swasthya Kalyan Yojana; DAMaN = Durgama Anchalare Malaria Nirakarana; IMR = infant mortality rate; MMR = maternal mortality ratio; PPP = public-private partnership; OPD = out-patient department; IPD = in-patient department; BSKY = Biju Swasthya Kalyan Yojana; PHC = primary health centre; CHC = community health centre; O&G = obstetrics and gynaecology; ENT = ear, nose, and throat; VD = venereal disease; OSTF = Odisha State Treatment Fund; UPHC = urban primary health centre; MoHFW = Ministry of Health and Family Welfare; NUHM = National Urban Health Mission; NGO = non-governmental organisation; U-AAM = Urban Ayushman Arogya Mandir; PM = Prime Minister; HWC = Health and Wellness Centre; U-HWC = urban health and wellness centre; NCD = non-communicable diseases; NP-NCD = National Programme for Prevention and Control of Non-Communicable Diseases; DMHP = District Mental Health Programme; NHM = National Health Mission; FY = financial year; NIMHANS = National Institute of Mental Health and Neurosciences; KIIs = key informant interviews.

Table A–5: Key Education-Focused State-Level Initiatives in Odisha 2014–2024

S. No.	Name	Nature of Initiative	Years Enacted	Aims and Objectives
1	ANWESHA	Government Scheme	Launched in 2015–2016. Extended in 2020 for five years.	Implemented across 17 tribal dominated districts to provide quality urban education to ST and SC children from BPL families from Class 1. It partners with private schools in urban centres and district headquarters, covering all educational and residential costs, including tuition, books, transport, and hostel stay. Each year, 5,000 students (70% ST and 30% SC) are selected through a lottery, aiming to reach 25,000 children over time. Sponsored students are admitted beyond the 25% seats reserved for disadvantaged students under the RTE Act. Students are selected out of eligible applicants through a lottery system by the District Level Committee under the Chairmanship of the District Collector.
2	Mo School	State–Civil Society Partnership	Launched in 2017. Succeeded by Panchasakha Sikhya Setu in 2024.	It was rolled out with the aim of collecting funds from the alumni for the development of schools and colleges in the state. It provided a platform to donate funds, materials, and services to schools.
3	Rationalisation and Consolidation of Schools under the S&ME Department (School merger)	Policy	Introduced in 2020,	Schools with poor student strength closed and merged, leading to a decrease in the number of schools. Reduced from 36,760 primary schools in 2015–2016 to 33,340 in 2019–2020; at the upper primary level, the schools decreased from 22,795 in 2015–2016 to 21,719 in 2019–2020. Odisha High Court upheld the Rationalisation and Consolidation of School Policy in 2024.
4	5T—High School Transformation Programme	Government Programme	Launched in 2021.	5T High School Programme (technology, teamwork, transparency, time, and transformation) run by the school and mass education department, the Odisha government began an exercise to modernise 8,679 high schools (categorised as those that are up to Class 10) across the state.

S. No.	Name	Nature of Initiative	Years Enacted	Aims and Objectives
5	OAVS	Government Programme	Launched in 2016–2017.	OAVS aims to provide quality education in English medium to the rural children of Odisha, practically at no cost or at best at low cost. One OAV is planned in each block of Odisha in a phased manner. All OAVs are affiliated with CBSE. The entry level is Class 6, and it has been planned to map these institutions' Centres of excellence with provision of education up to Class 12.
6	Gangadhar Meher Sikshya Manakbrudhi Yojana	Government Scheme	2017.	A state-specific scheme for accelerated reduction of IMR and MMR in the state. To provide school bags to all children from Classes 1 to 5, free textbooks, and school uniforms, including shoes, to all children from Classes 1 to 8 and free bicycles to all students in Class 9 of Government and fully aided schools, including OAVs.
7	Free textbooks and uniforms	Government Scheme	2019 (changes to earlier policy).	Under SSA, free textbooks have been supplied to all students of all government and aided schools. Uniform provided to all girl students and SC/ST, BPL boys in government schools. In 2019, the Odisha government announced an extension of free uniforms to all elementary school students in the state.

Source: Collated through web-search of education and health department websites in Odisha; Key Informant Interviews with members of the bureaucracy, research experts, and annual reports of relevant departments.

Note: RTE = Right to Education; S&ME = School and Mass Education; OAV = Odisha Adarsha Vidyalaya; OAVS = Odisha Adarsha Vidyalaya Sangathan; SSA = Samagra Shiksha Abhiyaan; BPL = below poverty line; IMR = infant mortality rate; MMR = maternal mortality ratio; CBSE = Central Board of Secondary Education; SC/ST = Scheduled Castes and Scheduled Tribes; MRI = Magnetic Resonance Imaging; KIIs = key informant interviews.

Appendix 3: Detailed Methods Framework

To understand why and when Odisha undertook new initiatives, data collection and analysis were undertaken using this framework.

Table A–6: Research Questions, Probe Areas, and Data Sources

Question	Probe area	Data source
1) What kind of health and education initiatives were undertaken in the state between 2014 and 2024? 2) Diving deeper, analysing if the initiatives have attempted to address any specific urban primary health/education-related challenge? What were the challenges that the initiative was responding to?	*Mapping the initiatives *Origin of intent underlying the initiatives *Objective of the initiative	*Web search *Review of Economic Survey documents *Review of policy documents on each of the selected initiatives *Department annual reports in which details of initiatives are provided *KIIs
Identifying the origins of the initiative. Which stakeholders led it?	*Mapping of stakeholders involved in the initiative and their role in it	*KIIs *Listing of participants in commissions through review of commission reports
Why was the initiative undertaken?	*Mapping of the process through which the government undertakes new initiatives *Mapping of the process through which the specific initiatives included in this study were undertaken *Role of stakeholders in the initiative *Key factors which led to initiatives such as social movement pressure, instruction from political leadership, routine bureaucratic work, stand-alone bureaucratic interest, civil society/expert committee interest	*Programme and scheme implementation documents *KIIs

Source: Authors' work.

Note: KII = key informant interview.

- The following policy documents were examined as part of the study:
  - Education: ANWESHA programme guidelines, Mo School guidelines, OAVS reports from S&ME Department website, Report of the CAG on School Education in the State (Odisha)—Report No. 5 of 2025.
  - Health: Report of the CAG on Public Health Infrastructure and Management of Health Services in the State (Report No. 7 of 2024), Report No. 5 of 2021—CAG's Audit Report (General and Social Sector) for the year ended March 2020—Odisha, Scheme documents around key schemes such as Niramaya, Nidaan, Biju Swasthya Kalyan Yojana, Ama Clinic from Odisha Health and Family Welfare Department website, NHM Odisha reports on NUHM, and NHSRC documents for Pradhan Mantri Ayushman Bharat-Health Infrastructure Mission (PM-ABHIM) administrative approvals.
- Budget documents, annual economic review documents, and other documents examined as part of the study:
  - Budget documents for 10 years.
  - Annual progress report of the Department of Education and the Department of Health and Family Welfare, OSEPA Annual Report 2024–2025, NHM Programme Implementation Plan Report (PIP), and ROP reports for 10 years.
  - Datasets—RHS 2017–2021, NSSO 75th round, Survey on Household Consumption Expenditure Survey (HCES) 2023–2024, U-DISE 2012–2013, U-DISE 2022–2023, U-DISE 2023–2024, NAS reports—2017 and 2021, NFHS-3, NFHS-4, NFHS-5, SRS Special Bulletin on Maternal Mortality in India 2015–2023, and NHA 2021–2022.

Data collection for this study was undertaken between May 2025 and July 2025. The total number of interviews completed was 65. Interviews were conducted in different phases and included senior and junior bureaucrats in health, education, planning, and statistics departments; district-level health and education officers; headmasters; teachers; and medical officers of six PHCs, along with one urban slum visit each in three districts. Similarly, academics, researchers, journalists, civil society leaders, local activists, and members of teachers' unions also formed part of the KIIs. Key questions across the categories of respondents emerged from the probe areas listed earlier. Some of these questions included a) key initiatives focused on primary healthcare/elementary education in recent years; b) purpose of the initiative; c) where it came from; d) key challenges in primary healthcare/elementary education; measures to strengthen these sectors; and e) the most influential leader (politician, bureaucrat, NGO, etc.) in health and education.

About the authors

Priyadarshini Singh is a Fellow with the Human Development research program at CSEP. She has previously worked with the Centre for Policy Research, New Delhi, Ashoka University and PwC-India. She completed her PhD at the Department of Politics and International Relations at SOAS, University of London as a Felix Scholar. Her research work focuses on political economy of policy making with a focus on education, history of public institutions and grassroots political ideas and politics.

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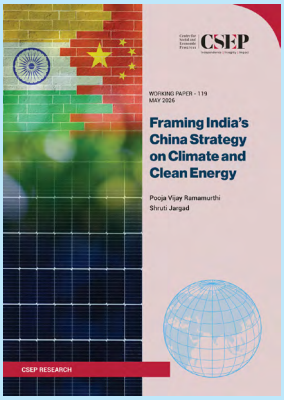
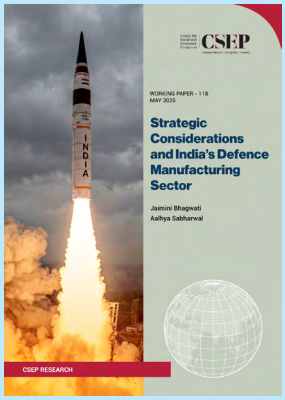
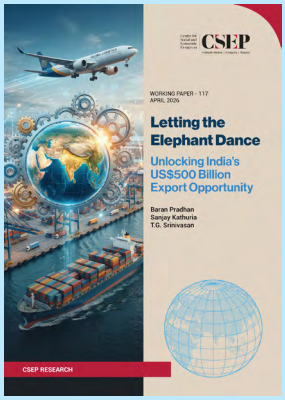
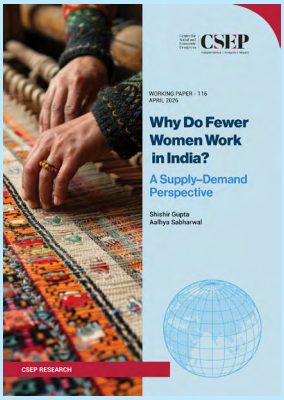
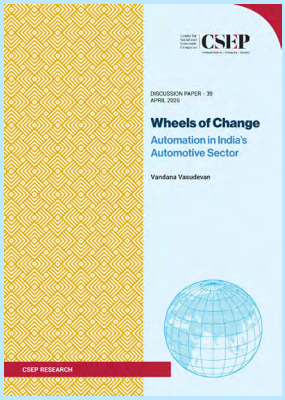
Other publications

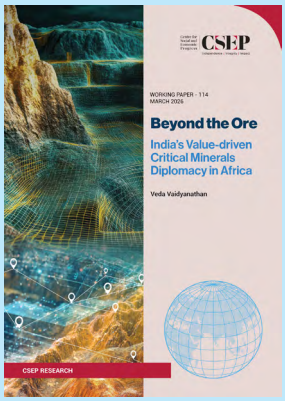


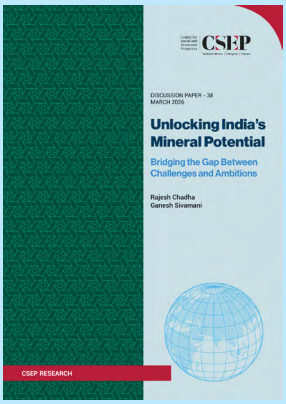


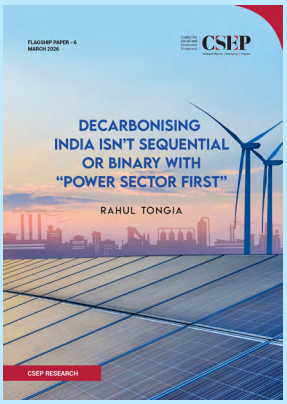


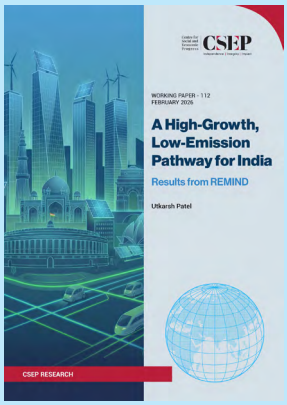


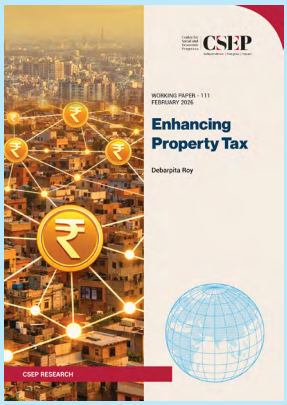


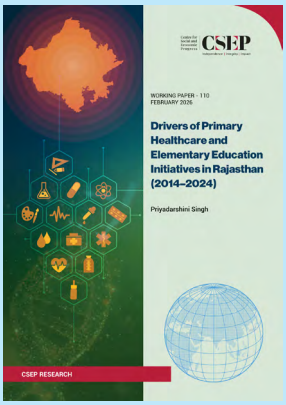


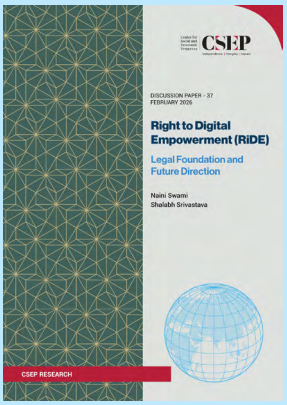












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