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Research Paper

An Assessment of the Rural Healthcare System with Special Reference to the Kuda (Mirdha) Tribe of Rural Western Odisha

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ABSTRACT: *Health is a significant concern worldwide, particularly for developing countries with large populations and limited healthcare resources. Most of the population is neglected by policymakers and livesin a state of insecurity regarding their health. The rural massesin India are still ignorant regarding the basic structure of health care and living conditions. There is a much wider gap concerning health care between urban and rural areas. It would also push the country as a whole into a worse imbalance. The present study focuses on the health care system prevalent in the rural tribal area of Western Odisha and its functioning. Data has been gathered using different qualitative methods like Focus Group Discussions, In-depth Interviews, and Case Studies, Observation has also been used to cross-check the earlier gathered information. Different sets of sample respondents have been used for collecting quantitative data.*

KEYWORDS*: Health Care System, SCs, PHCs, CHCs, Anganwadi Workers (AWWs), ASHA, Auxiliary Nurse Midwife (ANM)*

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I. INTRODUCTION

Health Care System in Odisha

The Health Care System in India is primarily administered by the State. The Constitution of India has assigned each state to provide health care services to its people. The Government of India launched the National Rural Health Mission (NRHM) in 2005 to address the lack of medical coverage in rural areas that have weak health services. The Mission has the hope of improving health care in India's poorest and most remote regions. In addition to this, the Ministry assists each State in preventing and controlling the spread of seasonal diseases and epidemics through technical assistance (MoH&FW, 2012-13). Further, the areas of public health, sanitation, and so on come under the purview of the State. However, family welfare and population control, medical education, prevention of food adulteration, and quality control in the manufacture of drugs are governed and maintained jointly by the Union and the State Governments.

The poor quality of public health care provided to the rural areas arises from the reluctance of experienced healthcare providers to visit the rural areas. As a result,the majority of the public healthcare system catering to rural and remote areas relies on inexperienced and unmotivated interns who are mandated to spend time in public healthcare clinics. Some of the other major reasons why people do not seek services from these sources of healthcare are distance, long wait time, and inconvenient hours of operation (IIPS and MI, 2007: 436-440). Hence, it leads to a situation where only 2% of doctors are in rural areas, where 68% of the population live (Britnell, 2015: 59; Wikipedia 'Healthcare in India').

It is also a big challenge for every State Government as there is an increasing reluctance in qualified and experienced healthcare professionals to provide services in rural areas with under-equipped facilities, a lack of availability of diagnostic facilities, and financially less lucrative payment structures. This is a kind of situation where there is only one way left for the rural as well as the tribal folk to rely on their system of health care. They further seek the help of private healthcare providers from their area or the nearby areas. The practitioners of private health care services provide modern allopathic medicine without having any formal training. They are regarded as *Rural Medical Practitioners* (RMPs). While doing research in some districts of West Bengal, like Malda, Bankura, and the like, *Mondal* and his teammates observed that the rural residents

highly seek after rural medical practitioners as they are financially affordable and geographically accessible than the medical practitioners working in the formal public health care sector (Mondal *et al*., 2007: 1-8). However, some practitioners find it too risky to provide service in such rural and tribal areas. There are also some incidents where practitioners or even doctors were attacked and even killed in rural India (Madhiwalla and Roy, 2006: 51-54).

Moreover, to provide accessible, affordable, accountable, and effective primary healthcare facilities to the rural poor, the Indian Government carried out a plan forthe National Rural Health Mission (NRHM) in 2005 (NRHM, 2005-12). The Ministry of Health and Family Welfare was established by the Indian Government and intended to maintain the healthcare system to provide basic healthcare services. In the early 80s in the 20th century, the Government established a special '*three-tier system'* in India as a Rural Healthcare System (RHS). For the rural healthcare services structure, there are three levels: Sub-Centres (SCs), Primary Health Centres (PHCs), and Community Health Services (CHCs). The CHC is the uppermost tier of the network of rural health care institutions, which takes charge of larger populations.

II. OBJECTIVES OF THE STUDY

Against this backdrop, the study has the following objectives;

- Critically examine the health care system prevalent among the Mirdhas
- Highlight how it is functioning in the sample area

III. METHODOLOGY

3.1 Research Setting

Using the purposive sampling method, the Ghenupali Gram Panchayat of Jujomura Block was selected to carry out the study covering seven villages, namely;Sansahir, Ghenupali, Pabpali, Jhankarpali, Khajuripali, Badsahir and Sanatanpali with multi-caste and multi-tribal communities comprising fourteen hamlets. It is predominantly inhabited by five tribal communities, namely, Mirdha (Kuda), Gond, Kandha, Sahara, and Khadia. Among them, Mirdha (Kuda) is the numerically dominant tribe in the sample area. Hence, they have been taken as the sample population. 429 Mirdha households were taken for procuring relevant information on these aspects.

3.2 Research Methods

Both primary and secondary data are used for the study. The primary data were collected with the help of unstructured interviews, group discussions, and case studies. The observation method was used to cross-check the earlier generated data. Secondary materials were also collected from various journals, books, newspapers, reports, census data, and records from Government officials. The data required for this study were gathered by combining both quantitative and qualitative research techniques. Quantitative data have been collected through household surveys using interview schedules. In addition to all these, the attitude of the respondents towards health institutions and healthcare providers was also a part of the schedule, which consisted of both open-ended and closed-ended questions.Community health care providers such as ANM, AWWs, ASHA, and MukhyaSahayika (Anganwadi Supervisor) have also been interviewed regarding different diseases and illnesses experienced by the respondents, treatment-seeking behaviour concerning these illnesses, and associated factors like socio-demographic variables. For this purpose, the respondents were the head of the household (male) or elderly members of the family, as they play a key role in the process of decision-making and seeking appropriate sources of medical care.

IV. RESULTS AND DISCUSSION

4.1 Health Delivery System in the Sample Area

(a)Sources of Health Care in Ghenupali Gram Panchayat

The sample Mirdha community of Ghenupali GP possesses a medical system that includes traditional healers, and formal as well as non-formal healthcare institutions. The source of treatment usually depends upon the type of illness and its symptoms. Among the Mirdha of the study panchayat, the sources of treatment run by the Government are health care institutions (Sub-centre/PHC/CHC), including community-based mother and child care centres (AWCs), Homoeopathic Institutions. It is mentioned here that the Mirdhas go for pluralistic treatment and approach different sources of care depending upon the type, cause, and perceived severity of the illness.

(b)Local Health Centres and their Functioning

- ***Sub-Centre (SC)***

The Sub-Centre is the most peripheral outpost and first contact point between the primary health care system and the community. Each sub-centre is required to be managed by at least one Auxiliary Nurse Midwife (ANM),

who is the female health worker, one male Multi-Purpose Worker (MPW), and there is also a provision for one Lady Health Visitor (LHV), who is entrusted with the task of supervision of six sub-centres. They are assigned tasks relating to interpersonal communication to bring about behavioural change. The Sub-Centres of the Ghenupali usually provide services about family welfare, family planning and counselling maternal and child health, prevention of malnutrition, immunisation, diarrhoea control, control of communicable diseases, etc. They also provide medicines for minor ailments like cough, cold, fever, worm infection, etc.

- ***Primary Health Centre (PHC)***

Primary Health Centre (PHC) is the first port of call of the public health sector in rural areas. It is regarded as the cornerstone of rural health services. The concept of a Primary Health Centre was given by the *Bhore Committee* in 1946, considering it as the basic health unit to provide as close to the people as possible, integrated curative and preventive health care to the rural population. Its main emphasis is on preventive and promotive aspects of health care (IPHS, 2012).

The sample villages do not have modern medical facilities. The block Jujomura has two primary health centres, but all these lack modern medical equipment and proper medicines. The people of the study villages, particularly the tribal people, prefer the service of these health care institutions to some extent. The dependence upon these facilities is much less; this is because of their system of medicine, which persists to a great extent in their community. The lack of diagnostic facilities in the Government health institutions acts as a major hurdle in seeking services from these sources. Further communication barriers and apathetic attitudes of the staff of health centres are factors that encourage the Mirdha to rely on other sources of health care service. The nearby PHC from the study villages is situated at a distance of 13 km, so people do not want to seek treatment in case of minor ailments.

A respondent stated that:

"our own medicine (traditional medicine) is very effective; we do not rely on the Government sources"

"we do not feel comfortable interacting with the physician"

During a group discussion, some female respondents narrated:

"we are unable to narrate all the symptoms to an outsider; we don't feel comfortable"

"it is not a part of our culture to reveal all the things regarding the symptoms of illness in front of outside male members"

Some adolescent girls have the view that:

"the allopathic medicine smells very odd, due to this, we don't prefer to go to the primary health centre"

"due to the odd smell, vomiting starts"

"the Anganwadi Didi has provided Iron tablets, which we take from her, but we never consume them due to foul smell"

Some elderly male respondents in a group discussion stated:

"they are not our community members,nor do they belong to our village, so they cannot be trusted"

"the physician does not know us; he never knows what we need, how can he treat us?"

"he does not listen to what we want to tell, how he will treat our illness and how we can get well with his treatment?"

"in some cases, he takes an interest in treating the general caste people, we are like unwanted for him"

"Sometimes they prescribe the medicine without asking anything, only to minimise the overcrowding atmosphere"

"how can an outsider cure for us?"

"the PHC provides common medicine for all kinds of illness, so we do not rely on its service"

The father of an ill child narrated:

"I went to the PHC as referred by the ASHA didi when my son fell sick. The doctor did not ask anything about the symptoms. He just entered my child's name in the register and told me to take medicine from the PHC itself. Then I was given some medicines (six tablets from a strip), which were also given to a malaria patient whose husband (JaithuKhadia) was standing just before me in the queue. I just stood there after taking medicine and observed that the next patient (BalaramMirdha) was also given medicine from the same strip (four tablets from the remaining six tablets which were given to me earlier) by the health worker. Balaram had hadan earache forthe past three days, as he told me when he was asked. "Similar tablets for any illness… what is it ???...they are not trustworthy"

Another respondent stated that:

"sometimes it cures illness, but not all the time we are being provided with good medicines..."

The Mirdhas seek the service of the Government hospital for the treatment of serious and acute illnesses like malaria and diarrhoea. However, their dependence on PHC is not satisfactory. In the case of malaria, only 19.34% and for diarrhoea 14.45% of people rely on the service. Quantitative data reveal that the majority of the

households (60.83%) among the Mirdha never visited the Primary Health Centre. There are also several reasons why the Mirdha do not usually go to Government hospitals.

- ***Community Health Centre (CHC)***

The Community Health Centre is the uppermost tier of the network of rural healthcare institutions. As per norms, the required number of Community Health Centres has not yet been established. The scarcity of resources (unavailability of doctors or specialists) is a major factor inthe malfunctioning of CHC, including infrastructural facilities and the coverage of the large geographical areas. Since the utilisation services of the Centre are influenced by all these factors.

In view of the majority of people in the sample community, the referral centre lacks healthcare facilities. As access to health care services is determined by the availability of public health institutions, it should be at a satisfactory level. According to a study, 70% of the CHCs are running either with one specialist or sometimes without any specialist. As the sub-centres, which are the most peripheral and first contact point between the primary health care system and the community, their progress is a prerequisite for the overall progress of the entire system.

(c) Anganwadi Centre and its Functioning

To combat the situation of child hunger and malnutrition, the Government of India initiated the Integrated Child Development Programme in 1985. It operates at the State level to address the health issues of small children. Under the *Integrated Child Development Scheme,* trained persons are allotted (one trained person to a population of about 1000 people) to bridge the gap between the person and organised healthcare. Their main focus is on the health and educational needs of children aged 0-6 years. They are called Anganwadi workers. It provides basic health care in Indian villages, as it is a part of the Indian Public Health System.

- ***Role of Anganwadi Workers***

The Anganwadi workers and the helpers are the basic functionaries of the ICDS scheme who run the Anganwadi Centres. The AWWs have a better insight into the health status of the concerned region as they belong to the same area, hence better equipped than a physician to reach out to the rural population. Some of the AWWs belong to the Mirdha community itself; they are trusted and as they have better social skills and make it easier to interact with people, they are in a better position to understand and identify the real malady of healthcare issues. Ghenupali Gram Panchayat comprises seven villages and fourteen hamlets. Thereis one Anganwadi Centre and a Sub-Centre in each village. These centres provide supplementary nutrition to children below 6 years of age, immunisation to all children less than 6 years of age, health check-ups and referral services, health education, and non-formal preschool education to children between the ages of 3 and 5 years.

The provision of healthcare services, healthy food, hygiene, and a healthy learning environment for infants, toddlers, and children should be the biggest assets of every centre. Children between the ages of 7 months and 3 years are provided with 2 packets of '*Chhatua'*. Each packet contains 2 kgs, hence the children have been provided with 4 kgs of Chhatua in a month, and each Wednesday and Saturday, they are provided with boiled eggs (twice a week, hence eight boiled eggs in a month). The Chhatuaconsists of Rice-Wheat-Mandia *(Ragi)*-Sugar powder. Similarly, children between the ages of 3 and 5 years also get Chhatua from the centre. They get boiled eggs for three days a week, i.e. on Wednesday, Friday, and Saturday. The malnourished children get one more packet in comparison to others, and in addition to this, one packet of peanuts (containing 50 grams) is also provided.

Fornewborn babies, BCG, DPT, and Polio Vaccines are given when the child reaches 1 and a half months. 3 doses are given, each at an interval of one month. Iron tablets are given to the adolescent girls. They are provided with one tablet a week, i.e. on Saturday (four tablets in a month). The pregnant women are provided with Iron tablets. Two pkts of Chhatua, each containing 2 and a half kg (hence a total of 5 kg) are provided. Eight eggs (2 eggs per week) are provided within a month. All these records are maintained by the AWWs, which could be verified by the CDPO on his visit.

In the present study, the AWCs lacked toilets. There is no toilet facility even in a single AWC. The children and the workers were using open toilets. While the study of Thakare*et al.* (2011: 253-258) found that 56% of AWCs lacked toilet facilities. There are no child-friendly toilets in any of the AWCs. Lack of proper *toilet facilities* has also been reported by other studies done in various states in India *(Forum for Creche and Child Care Services, 2005, 'Rajasthan').* According to the study, out of the total number of AWCs (70849) in Odisha,only 32824 AWCs (46.33%) have toilet facilities *(Indian Institute of Development, 2001;Pandey, 2008)*.

The effect of the lack of proper *infrastructure* was reflected by the *poor attendance* of children aged 3-6 years at the AWCs. The previous study conducted in Delhi reported that only 43% of beneficiaries utilised the services of preschool education. Another study in Delhi found that only 3% of the beneficiaries took food at the AWCs *(FCCCS).* Also, a study done in Madhya Pradesh reported that attendance was very short in the AWCs.

For preschool activities, there were always fewer children than at the time of supplementary nutrition (Khosla and Kaul, 1997). Construction of AWC has been notified as a permissible activity under the Mahatma Gandhi National Rural Employment Guarantee Act *(MGNREGA).* The construction of AWC buildings can be taken up in convergence with MGNREGA (Ministry of Women and Child Development, GOI).As per the norms, every AWC should have various required tools, but in the current study, it is found that nearly 30% of the AWCs do not have weighing scales, growth scales, growth charts, drug kits, and tools for pre-school education.

(d) Function of NRHM and the Role of ASHA

The National Rural Health Mission, launched in 2005, seeks to provide effective health care to rural folk throughout the country. Its main focus is on the 18 states that have weak public health indicators and weak infrastructure *(Choudhury and Umesh, 2005: 783-788).* The State of Odisha is one among them. The mission is an articulation of the commitment of the Government to increase public spending on health from 0.9% of GDP to 2-3% GDP *(Rural Health Statistics, 2014-15).*

One of the key components of the NRHM is to provide a trained female community health activist (ASHA) in every village in the country, who must be a female resident of the village, preferably in the age group of 25 to 45 years, and should be literate up to class eighth. In the study villages, ASHA is the first port of call for any health-related demands, especially for women and children who find it difficult to access health services. Each ASHA is meant to cover a population of 1000. She actively participates in providing information to the community on determinants of health, such as basic sanitation and hygiene practices, nutrition, healthy living and working conditions, etc. They also provide information on existing health services and the need for the timely utilisation of health and family welfare services. ASHA has been the vital link between the community and the health care in our sample population.

According to the Sarpanch of the Gram Panchayat:

"ASHA creates awareness on health"

"shemobilises the community towards health-related services available at the Anganwadi Centres, Sub-centres, and Primary Health Centres"

The ANM has the view that:

"though people, especially the tribal, are not that much aware of health care practices, in that situation, ASHAs have been playing a very crucial role in mobilising the community to upgrade appropriate health-seeking behaviour"

One lady, a primary school teacher, stated that:

"in such a remote area among the tribal people where health care is very neglected, as it is bound by their culture, here ASHA plays the pivotal role to promote the right kind of health practices".

She is an honorary volunteer who receives performance and service-based compensation for promoting universal immunisation, referral, and escort services for institutional deliveries, ensuring family planning, construction of household toilets, and other health care delivery programmes (Bhatt, 2014: 18-24). Promoting institutional delivery under the national scheme, Janani Suraksha Yojana (JSY), is the most common ASHA task, which comes with an incentive. JSY is a demand-side financing programme incentivising institutional delivery.

During a focus group discussion, ASHAs highlighted that:

"our main aim is to teach the people about nutrition, sanitation, and personal hygiene"

They also narrated

"as the doctor cannot visit all the places, we all act as a bridge between the community people and the hospital"

"as the villages have poor records and communication, it is very difficult to reach the hospital when they need it, especially the pregnant women"

"from our records, the health personnel can identify sick people, pregnant women, and ill children"

(e) Auxiliary Nurse Midwife (ANM)

Today, public health nursing in the village is still limited to services rendered by the Auxiliary Nurse Midwife (ANM) in India (Malik, 2009: 88-90). The Auxiliary Nurse Midwives render services in different aspects as they are assigned avariety of work. So, they are also designated as Multipurpose Health Worker (female) [MPHW(F)]. They are regarded as the first contact person between the rural folk and the organisation. Hence, the first contact is between needs and services and also between the consumer and the provider. They are further considered as the key workers at the interface of health services and the community or people. Through the ANMs, the planners at the upper level gain insights into the health problems and needs of the rural people. To achieve health-related targets, they are assigned a heavy responsibility as their services are considered essential to provide safe and effective care as a vital resource (NRHM, 2005-2012).

The block under our study has *fourteen* Sub-Centres, primary health centres are *two* in number, and the community health centre is situated in the headquarters of the Jujomura block, which is also known as the headquarters hospital. Among the two PHCs, one is situated in Hatibari and theother is in Padiabahal, which are termed as Hatibari PHC (New) and Padiabahal PHC (New). *Six* Sub-Centres come under Padiabahal PHC, *four* SCs are under Hatibari PHC, and the other *four* SCs come under Jujomura CHC. The Padiabahal PHC is functioning as a referral centre. However, the Hatibari PHC lacks adequate staff; no staff nurse is present. Hence, it does not function as a service delivery point.

But there is no such provision in the panchayat taken for our study. Even in every Panchayat of the Jujomura block, only one ANM is posted. Here also, only one regular ANM is posted in Ghenupali Sub-Centre. She has to cover areas like **Badsahir** 1, Badsahir 2, **Khajuripali**, Buromal (hamlet), Semeltikra (hamlet), **Sanatanpali**, Talbeda (hamlet), **Sansahir,**Panupali (hamlet), Dudhiamal (hamlet), **Ghenupali**, Thakurmal (hamlet). The average rural population covered by a Sub-Centre is 3000-5000 and the average number of villages covered by a Sub-Centre is *four* in number (Census, 2011) whereas, in the study panchayat, the ANM has to cover approximately 8000 population (as reported by the ANM of the GP) and the number of villages covered by her is more than the average coverage. As we can see from the above-mentioned names of the villages, she has to cover *five* villages and some hamlets of other villages that belong to the panchayats.

The health supervisor (Female) provides supportive supervision and technical guidance to the ANM in the Sub-Centre. She is designatedas a Lady Health Visitor (LHV) by the Health & Family Welfare Department. The ANM has to produce the monthly report of her assignment (monthly report) to the Public Health Education Officer (PHEO) during the review meeting held in Padiabahal PHC onthe last Saturday of every month.

- ***Village Health and Nutrition Day***

Village Health and Nutrition Day is a major initiative under the National Rural Health Mission. The main objective of VHND is to improve access to maternal, newborn, and child health and nutrition services at the village level. The provision is intended to reach all segments of the community, especially disadvantaged groups*(Report on Guidelines for VHND,GOI 2007).* The Village Health and Nutrition Day is also termed *Mamata Diwas*.

Place	Day of every month *(VHND)*
Badsahir	3rd Tuesday
Khajuripali	3rd Thursday
Ghenupali	2nd Friday
Thakurmal	2nd Wednesday

VHND is to be organised once every month, preferably on Wednesdays. It is here in Ghenupali where a large area and a large population are covered. Service is provided from Tuesday to Friday *(four days)* once a monthat different points/centres. For which there is a fixed day for a fixed point. The centres are: Badsahir, Khajuripali, Ghenupali, and Thakurmal. For this, AWC is identified as the hub for providing service. Health services areprovided at the doorsteps of the rural people.

- ***Immunisation Day***

Day of every month	Place
1st Wednesday	Badsahir
2nd Wednesday	Ghenupali
3rd Wednesday	Bairagipali (belongs to another Panchayat- Kabrapali)
4th Wednesday	Sanatanpali

- ***Immunisation for Non-Communicable Diseases***

Day of every month	Place
1st Thursday	Badsahir
2nd Thursday	Khajuripali
3rd Thursday	Ghenupali
4th Thursday	Thakurmal

The ASHAs and the AWWs are responsible for mobilising the community for VHNDs. The ANM provides maternal, newborn, and child health services (antenatal care) and routine immunisations. The quality of VHND needs to be improved. For this reason, the outcomes should be measured and monitored. It requires convergent actions from the Department of Health and Family Welfare, and the Department of Women and Child Development at the state, district, and block levels to plan, implement and monitor the programme *(Report on Guidelines for VHNDs, 2012).*

V. SUMMING UP

India has a vast healthcare system. Still, there remain many differences in quality between rural and urban, as well as public and private health care services. It is widely acknowledged that the Indian Public Health System has very poor performance. The analysts have also attributed this failure to several factors that include various components that make a system functional, like infrastructural facilities, human resources, participation of the community, etc. (Sharma, 2009: 175-182). Further, many studies attribute this failure primarily to low and declining public investment in health care and secondarily to structural and managerial weaknesses in the system.

It is also observed that there isa deficiency in the provision of services at the AWC and village-level health facilities, along with inadequate knowledge among Anganwadi workers and ASHAs regarding revised norms. They need to be trained regularly and their knowledge updated from time to time, followed by timely quality assurance of services. There is also a need to address the problems faced by the workers while delivering their duties. The fact is that the deficiency and inadequacy are not limited to any one project area. There is an urgent need to monitor and evaluate the schemes at all levels through effective supervision at each tier to take corrective actions accordingly.

To provide an optimal level of quality health care, the National Rural Health Mission has provided the opportunity to set Indian Public Health Standards (IPHS) in early 2007 for health centres functioning in rural areas. The standards are a means of describing the levels of quality that the healthcare institutions are expected to meet. Theobjectiveis to provide quality-oriented, comprehensive primary health care, which should be sensitive to the needs of the community through the Primary Health Centres.

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