Original Article

Impediments to Optimal Health-care Utilization of a Particularly Vulnerable Tribal Group in Wayanad: A Qualitative Study

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Abstract

Introduction: The pathways and mechanisms through which constraints that impede optimal utilization of the government health-care service provisions translate into health inequities among Particularly Vulnerable Tribal Groups seem to be an area that warrants research. **Objective:** The objective is to explore and understand the mechanisms/pathways through which various factors result in health care inequity among the Kattunayakan tribe in Wayanad. **Materials and Methods:** Designed as a qualitative case study, using observations and interviews with mothers, community members, and frontline health-care personnel, the study was conducted in a Kattunayakan hamlet in Wayanad. The data, in the form of digital audio recordings and field notes, were transcribed, coded, and analyzed using a thematic approach. **Results and Discussion:** Axes of inquiry like access to health-care institutions, acceptability of the services provided, hurdles faced by the tribes, the health-care personnel, and how the system responded to these issues were explored. Disregard for the identity and culture of the tribes, geographical barriers for utilization and providing health services, proactive efforts from government systems, collaborations with private and professional bodies are important factors that possibly influence health inequities among tribes. **Conclusion:** Acknowledgment of the sociocultural identity of the tribes, gaining their trust, proactive efforts from the government machinery, innovative context-specific programs, strategic partnerships and a departure from the "blame the victim" philosophy are key in the effort to provide services that meet the health-care needs of the tribes.

Keywords: Accessibility, equity, health-care utilization, Kerala, Particularly Vulnerable Tribal Group, qualitative, tribes, Wayanad

Introduction

Many policy interventions have been successful in targeting vulnerable sections of the population, like those of women and children, but large sections are still far from the benefits of these health-care policies. This is evident from findings from studies that suggest there is a great deal of variation between states in India, between urban and rural areas and between scheduled tribes and the scheduled caste population, compared to other groups.[1]

Within the tribes, 75 groups were identified in 17 states and 1 Union Territory, who initially were called Primitive Tribal Groups, and later renamed as Particularly Vulnerable Tribal Groups (PVTGs). Of the 36 scheduled tribe communities in Kerala, of which five (Cholanaikkan, Kadar, Kattunayakan, Kurumba, and Koraga) are PVTGs.

Evidence seem to suggest a widening health inequity gap between tribal and nontribal population.[2] Studies among tribal populations suggest that it is important to determine the extent of the impact of culture, attitude, historical oppression, and socioeconomic factors such as household income, access to safe drinking water and sanitation, family size, rate of literacy, social isolation, transportation difficulties/geographical mobility on the prevailing health gap between the tribal and the nontribal population.[2-6]

With a broad overarching objective to explore the health-care utilization among tribal and nontribal population of Kerala, this study was a subsidiary qualitative component of a larger mixed-method study[7,8] titled "Exploring health inequity by

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assessing the nature of health-care utilization and its correlates among the tribal population of Kerala." Conducted by Health Action by People (HAP), a not-for-profit organization based in Thiruvananthapuram, Kerala, India, this component of the study ventured to explore and understand the pathways through which various factors result in health-care inequity among the Kattunayakan tribe in Wayanad.

Materials and Methods

Designed as an exploratory qualitative case study,[7,8] using a narrative approach, the study was conducted within a tribal colony in Wayanad district. The colony visited had a population of about 100 people, all belonging to Kattunayakan community. The name Kattunayakan is derived from two words, "*kattu*" (meaning forest) and "*naikan*" (meaning lord). Historically, and even now, they are mostly forest dwellers and their livelihood is closely related to these forests.

The research team visited the colony, in June 2017, along with the tribal health mobile unit and a made detailed account of the observations. Three mothers, two community members, the Moopan (village head) and the tribal JPHN appointed by the Tribal Welfare department were interviewed. The team had also visited the primary health center (PHC), under which the colony was listed and interacted with the health-care personnel. The team was able to hold a small informal group discussion with the PHC staff. The nearest taluk hospital, the first referral unit, was also visited, and discussions were held with various functionaries.

The data, in the form of digital audio recordings and field notes, were transcribed, coded (open, followed by axial and selective coding), and analyzed using a thematic approach. The standards for reporting qualitative research checklist[9] was used as a guide to aid in writing up the study.

Ethics clearance was obtained for the entire study from the Institutional Ethics Committee at HAP, Trivandrum, Kerala, India. All interactions were conducted only after obtaining verbal informed consents. Confidentiality of the participants was protected in all conceivable ways.

Results

A little over 100 people were living in that colony, of whom around 55% were females. The inhabitants ranged from people who did not go to school at all, right up to a few who were pursuing degree education. For their livelihood, the members of the colony mainly resorted to cattle rearing and gathering resources and produce the forest had to offer, like the fungus that grows on teak bark (which reportedly was in high demand due to its medicinal properties) and honey. Being a quite closely-knit community, rarely did they marry and mingle with the nontribe and other tribal communities. Their livelihood, heritage, and culture being considerably intermingled with the forest, they strongly resisted the efforts (both from the government and otherwise) to relocate from their settlements.

"We (Kattunaikans) live in the forests…. That's how our ancestors also lived…. We don't like to move to areas close to the town which the government is offering us…. Our meansof living and our culture is closely related to the forest…." – Tribal respondent.

The members of the colony were living in Pucca houses constructed for the settlers by the Tribal welfare department. All the houses had toilets, which were located just outside the house. Most people used toilets except the older generation, who prefer open defecation. They resorted to a nearby natural spring for their water needs. They called this "*jeevanulla vellam,*" which loosely translated meant "water with life."

"The wild animals only choose what is good and pure…. So whatever is good for them, it's good for us too…" – Tribal Inhabitant.

The hamlet was connected to the outside world by a forest trail, more than 10 km from the nearest asphalted road. Although it was not a pucca road, it was a motorable with four-wheel drive vehicles. Two of the families residing in the colony had two such jeeps, which frequented trips to the nearest town. These were also used by the other members of the colony, whenever they needed to go outside the forest.

The members of the colony used different systems and practices when fall sick, which included modern medicine, Ayurveda, and their own traditional methods of healing. It was evident from the interaction with these people that they had traditional herbal remedies for many ailments. It was interesting to note how they attributed the causes of diseases to be associated with spells and curses. They were of the belief that any such disease was a consequence of one's actions and curses on them, either in this life or the earlier ones. They also relied on magic-religious means to cure diseases and conditions. However, most people sought health care in modern medicine institutions when fell sick. They also selectively used private and government facilities for different types of care. Home deliveries were prevalent in the past. However, now, women access services in the hospital.

An issue that came up during the study was the nonavailability of the Accredited Social Health Activist (ASHA) in the colony. There was an ASHA who was assigned earlier, but due to geographical access issues, she had rarely visited the place. When the team visited the hamlet, the position of the ASHA for the hamlet was vacant, and the tribal JPHN informed that a person was yet to be selected.

"If an ASHA is selected for a hamlet from another community or even another tribe, there are difficulties in communication and acceptability of such a person. If they come from the same community, they will be more understanding of the problems and issues the members of the hamlet face…" – Tribal Health JPHN.

It was interesting to note how many of the members of the colony had a high opinion of the senior doctor couple who were running a private health-care institution in the nearby township. Although resorting to the services rendered by this hospital did entail a considerable out of pocket expenditure for the tribes, they held these doctors in high esteem and had a great trust in them.

"They (the senior doctors mentioned above) were initially working in government hospitals. They then started a hospital of their own around 20 years back. They are very nice doctors…. We have to pay for the services there but they are very kind to us (tribes) when we go to them for help…." – Tribal Inhabitant.

When asked about why they did not prefer to go to the Government hospital, they did cite many reasons such as they did not feel they were given enough care, or that they would be often referred to a higher center such as Calicut Medical College, or the difficulties in availing the services there due to the rush and paperwork involved.

There were three under-five children present in the colony, and all of them were delivered in institutions. Antenatal care (ANC) visits were regularly made by the tribal health JPHN, though she did mention her difficulty in realizing their services for this and other colonies under her supervision. One of the mothers residing in the colony had nine ANC visits to the nearest taluk hospital. However, interestingly, she had to undergo a cesarean section operation to deliver her child in a private hospital in Wayanad. It was during a time when there was a dearth of specialists in the district, and there was a tie-up with a recently opened private medical college in Wayanad to help cater to the needs of the tribes residing in the district.

The team did also come to know of an unfortunate incident which led to the death of an adolescent girl 2 years back in the colony. The deceased girl was staying in a tribal hostel within the district and had an infected wound in one of her legs. She was taken to a private health care institution around 20 km away from the colony, from where she was referred to the District hospital Mananthavady. The family had decided not to go there, and the girl died the next day, possibly due to sepsis. It was only after her death that the health system was informed of such an incident. Consequent to her death, her family members left the colony and relocated to another colony in the district where they had relatives. It seemed that when such unfortunate deaths occurred, the tribes considered it as a bad omen and they often chose not to live in the dwellings they inhabited during the time of the incident.

The interactions with the functionaries of the PHC that catered to the area in which the colony was situated was also quite interesting. Providing both outpatient and in patient care facilities, the concerned PHC, in addition to the auxiliary and field personnel, the doctors would take turns to conduct camps in the colonies under the aegis of the Tribal Mobile Medical Unit (TMMU).

Apart from this routine work, there were initiatives formulated by the PHC, along with the panchayath, like "*Gothrasparsham,*" which was an endeavor to mobilize tribal antenatal mothers to attend ANC clinics. Under this initiative, vehicles were arranged to transport antenatal women to the PHC and subcentres for check-ups. In addition to the transport, the expectant mothers were given tea, snacks, lunch, and health education classes.

"Gothrasparsham is a pretty successful program we have implemented for the tribal mothers. Not only do we arrange for transport and snacks and lunch for them, we try to make it an enjoyable experience for them on the whole. We also get an opportunity to educate them about the things they need to take care of during and after pregnancy…. Its like a small "tour" for them…" – Medical Officer.

The PHC authorities had also forged a tie-up with a local private hospital to facilitate antenatal ultrasound screening for the tribal mothers, the expenses of which were reimbursed through schemes such as the Janani Suraksha Yojana. The local branch of the Federation of Obstetric and Gynecological Societies of India (FOGSI) had also come forth with providing the services of an obstetrician once a month. A non-governmental organization working in the field of providing mental health care, also tied up with the TMMU to provide mental health-care services once a week.

It was apparent that the team in the PHC functioned like a well-oiled machine, with personnel at all levels stepping out of the confines of their respective designated duties and responsibilities. The enthusiasm exhibited by the medical officer in charge seemed to be contagious and was quite evident from his approach to tribal health.

"These people (tribes) are different… We (health care personnel) have to respect their uniqueness and act accordingly. For example, you can't scold a tribal patient for coming to the OP with her/his *mouth red from chewing betel leaves….. That patient might not come next time to that doctor. Instead, we can make a provision and ask them to clean their mouths before they come to the OP…. The main problem that the health system needs to address is the attitude of ours towards these tribes…."* – Medical Officer.

The team also had an opportunity to closely interact with the tribal health JPHN who was in charge of looking after the reproductive and child health needs of the inhabitants of the colony. Having a service history of more than a decade among tribes, she was initially a part of the government health-care system, but later got deputed to the scheduled tribe department to be re-designated as tribal health JPHN.

The team later visited the nearest Taluk Headquarters Hospital and interacted with various functionaries of the institution. The team met with a tribal promoter, who had been working in the hospital for around 2 years. Working under the tribal welfare department, he had explained how the tribal promoters were posted in such referral hospitals, with a view to help out the tribes that may need to use the services of the respective hospitals. Apart from helping out with registration, admission, and investigations, these promoters are also entrusted to ensure quick and comfortable referrals to higher institutions if need be.

The tribal promoter opined that the biggest issue they faced was the lack of awareness among tribes about the need to resort to urgent medical care when required. He expressed that often, after an initial consultation with a doctor and getting medicines, it was difficult to get the tribal patients to come for a review. He felt that a strong initiative was necessary on the part of the tribal department and the health-care system to effectively educate the tribes on the importance of seeking medical care and compliance.

"If the field staff and ASHAs and others in the field inform us beforehand, we might be able to bring the patients to the hospitals earlier and may be able to save their lives…. We need an elaborate system where information about critical patients are shared between us."

This delay in the patient care was also reflected in the interactions with another functionary of the hospital, who dealt with tuberculosis (TB) patients. He said that there were a number of TB patients among the tribes who were in the advanced stages. He felt that a lack of educational interventions on the part of the system, the inadequacy in number of the field staff, and geographical access issues were the major impediments.

One interesting finding from both these interactions was the expressed need for a cohesive team in hospitals such as this and for such a team to work optimally, a responsible stewardship was necessary. When such a team was in place, it eventually translated into better acceptance of the services rendered by the hospital as well.

"The personnel have to be motivated to take that extra step for the benefit of these tribes… but it is also important that for them to work in such a way, a strong leadership is needed. And trainings are required to be given to staff to be more tribe friendly…. the need to give a service with a smile…."

Discussion

From the above findings, there seem to be a plethora of factors that, if addressed, may help to bridge the health inequity gap among the tribes and nontribe populations. Acknowledging that the tribes value their own traditional habitats, livelihoods, cultures, and beliefs appear to be key to bringing forth tribe-friendly changes in health care. Although geographical access barriers probably play an important role in the existence of health inequities, both to utilize and provide health-care services, it is interesting to find that people are ready to overcome such physical barriers and go to private health care institutions if their trust is gained, as evidenced by their high opinion about the couple-run private hospital. The opinions of the health-care personnel, pointing toward the need for the health system functionaries to acknowledge and respect the identity, culture, and beliefs of the tribes, are hints on how the public health system can also be privy to such levels of trust.

The rolling out of innovative programs such as "*gothrasparsham*" is an example of how the system functionaries should think out of the box and conceive context-specific solutions to address issues of inaccessibility and trust, and in turn, inequity. Inclusion of the private sector and forging of partnerships with professional bodies, as done with a private medical college for deliveries and the collaboration with FOGSI respectively are examples of how the public health-care system can try to close the inequity gaps. Coupled with a realization on the part of the functionaries within the health system that the lack of awareness about their health-care needs is not a deficiency of the tribes but is actually a failure of the system to address the same, it is possible that these measures could address the health inequities among tribes and nontribes to a considerable extent.

Conclusion

Axes of enquiry like access to health-care institutions, acceptability of the services provided, hurdles faced by the tribes, the health-care personnel, and how the system responded to these issues were explored. It is concluded that acknowledgment of the sociocultural identity of the tribes, gaining their trust, proactive efforts from the government machinery, innovative context-specific programs, strategic partnerships and a departure from the "blame the victim" philosophy are key aspects to be considered in the effort to provide the services that adequately meet the health-care needs of the tribes.

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Conflicts of interest

There are no conflicts of interest.

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