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Utilisation of Primary Health Care by the Tribal Women: A Critical Anthropological Study of Parojas in Odisha

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Abstract: ***Background: The coverage utilization of primary health care service and the problems among paroja tribal women two villages of koraput district of Odisha. Primary health care is a new philosophy as well as a policy to take health care to the people; it promotes the diagnosing and improvement of health status for whole communities quite than for single patients. Aim: The study was done to determine the existing health problems, health status, role of doctors and health workers in the study area. Setting and Design: This was a sampling survey was conducted in two villages of Koraput district namely, Kakirguma and Tunpar in Odisha. Materials and Methods: Among all women of study area one come across data collected to understand the primary health care system. This data of special survey is undertaken as a research method for better understanding of the field situation. The sample surveys used in health serves to understand the utilization of PHC. Statistical Analysis: Multivariate analysis statistical techniques and methods will be implemented for data analysis to describe the inferences. Gathered quantitative data will be analyzed using SPSS/STATA data analysis computer packages to describe result and discussion. Result: The resolution of utilization in the tribal women was general awareness, affordability, accessibility and quality of services along with motivation by health workers. In that village's respondents prefer the PHC, 30 percent people prefer PHC in emergency situation and 4.5 percent respondents prefer in normal problems but 65.5 percent respondents prefer in both of the situation. Conclusion: Besides the health services, emphasis may be given on the development of infrastructural facilities, transport and communication, economy, education and other sectors of development. An integrated development of the Paroja's of study area will be the true development of their health status.***

Keywords: primary health care (PHC), Tribal women, utilization

1. Introduction

Primary care refers to first - contact care that deals with the popular of health problems. Primary health care is commonly viewed as a first level of care or as the entry point to the health care system for any kind of countryman. It is the root level of medical system for rural people and their first consideration to the PHC as a health resource. The minority would disagree with that health systems need to take action better and faster to the challenges of a changing world. But only PHC can do that. There is today a recognition that the population is left behind and a sense of misplaced opportunities that are reminiscent of what gave rise, thirty years ago, to Alma - Ata's model shift in thinking about health. The Alma - Ata Conference mobilized a "Primary Health Care movement" of professionals and institutions, governments and civil society organizations, researchers and grassroots organizations that undertook to attempt the politically, socially and economically unacceptable" health inequalities in all countries. The Declaration of Alma - Ata was clear about the values pursued by social justice and the right to better health for all, participation and solidarity. There was a sense that progress toward these values required fundamental changes in the way health - care systems operated and harnessed the possibility of other sectors. This was for universal health conceptual.

PHC has remained the benchmark for most countries' discourse on health precisely because the PHC movement tried to provide rational, evidence - based and anticipatory responses to health needs and to these social expectations. Achieving this requires trade - offs that must start by taking into account citizens' expectations about health and health care and ensuring that voice and choice determinedly influence the way in which health services are designed and operate. A recent PHC review echoes this perspective as the right to the highest possible level of health, "maximizing equity and solidarity" while being guided by responsiveness to people's needs. Moving towards health for all requires that health systems respond to the challenges of a changing world and growing opportunity for better performance. This involves substantial reorientation and reformation of the ways health systems operate in society today, those reforms constitute the schedule of the renewal of PHC. It's called as "New PHC". Primary health care, often shortened as "PHC", has been defined as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made for universally accessible to individuals and families in the community through their full contribution and at a cost that the community and the country can afford to maintain at every stage of their development in the courage of self - reliance and self - determination". In other words, PHC is an approach to fitness beyond the traditional health care system that focuses on health equity - producing social policy. This ideal model of health care was adopted in the declaration of the International Conference on Primary Health Care held in Alma Ata in 1978 (known as the "Alma Ata Declaration"), and became a core concept of the World Health Organization's aim of 'Health for all'. The Alma - Ata Conference generate a "Primary Health Care movement" of professionals and institutions, governments and civil society organizations, researchers and grassroots organizations that undertook to tackle the "politically, socially and economically unacceptable" health inequalities in all countries.

Primary health center and NGOs in Odisha:
The Government of Odisha has opened doors for Non - Government Organizations (NGOs) to take over the operations of non - functional Primary Health Centers (PHCs), subject to normal conditions laid down by the Government of India. The objective of this policy is to operationalise non - functional PHCs in order to get together the aim of universal access to healthcare.

In 2005, a communication of Understanding was signed with the NGO National Youth Service Action and Social Development Research Institute (NYSASDRI), for organization of two PHCs in Jeypore and Dhenkanal districts. Similar agreements were signed with ***Karuna*** Trust and the Human Development Foundation for operating five more PHCs in Ganjam District. At present, there are 22 such PHCs in service through PPP (public private partnership) method. Although there are around 2200 PHCs in Odisha, many are not prepared due to lack of infrastructure, equipment and manpower. Though a few PHCs have been made prepared by presence to the infrastructure issues, the human resource issue posed a much better challenge to the government. Given that a few NGOs which were previously active in the region were interested within pooling resources to develop their operations, the government felt that constricting with these agencies could help turnaround the operations of non - functional PHCs in the area. In the study area Kakirguma and Tunpar, both villages have NGO called '**Sobha'** which works with the collaboration of PHC. They work with - in MHU (mobile health unit); they provided some equipments and manpower or ideas for awareness of the local people. The MHU goes village to village and provides good health services. Some non - tribal are working with them and they helps NGO people more awareness programmers' in that area.

Paroja tribes:
All over the states of India, Odisha has the largest number of tribes, as many as 62. In terms of percentage they constitute an impressive 24 percent of the total population of the state. These tribes mainly inhabit the Eastern Ghats hill range, which runs in the north - south direction or southern Odisha. More than half of their population is disturbed in three districts of Koraput (undivided), Sundergarh and Mayurbhanj. The word paroja is a local Odia word sometimes pronounced as Paraja, parja or poroja. The word paroja also has another meaning in Odia language denoting the tenant (peasant) or the *Royat* (**S. C. Mohanty**). Tribal economy is life oriented. It is based on food gathering, hunting and fishing and thus revolves around the forests. Even the other large tribes like the Santal, Munda, Oram and Gond, who are settled agriculturists, often, add to their economy with hunting and gathering. While farming they make use of a very simple technology and a simple division of labour, often limited to the immediate family. They are unable to find out because their holdings are small and unproductive, lacking irrigation capability since the terrain is hilly and rolling.

The Paroja are one of the well known major tribes of Odisha. This tribe divided into two sections such as Bada Paroja and Sana Paroja. The Bada paroja's are basically following the Hindu tradition that does not eat beef or buffalo meat and observe complex purification rituals even when a cow or buffalo dies in their households while the Sana paroja's eat the flesh of both these animals. And also according to their economic status the Paroja are divided into two categories the "Bada Paroja and Sana Paroja". The former class of people is more prosperous and progressive than the latter. Though they lack education and are steeped in superstition, the Paroja are simple, hard working, tolerant and hospitable.

Compared with other tribal communities they show some differences in admiration of their pattern of settlement, manners and customs and cultural pattern. The dress and ornaments of the Paroja and the ornaments used by their women are of special types. The regular ornament use by women's called bangles, armlets, bracelets, silver, aluminum, brass and sometimes gold. A number of brass ear rings dangle as of each ear and the nose and a married woman must wear these rings last she may be subjected to severe social criticism and ridicule. Silver rings called *shamka* frequently studded with coin are also worn around fingers. Metallic chains and bead necklaces adorn silver ring is used as a necklace while a thinner type name *khadu* adorn the fore arm and upper arm.

These ornaments were used a long time ago but these days the young generation does not follow the tradition, they adopted the modernity. A 53 year women of my study area told me about these things. Her name is Padama Muduli. She is illiterate and lives in hut, but she has knowledge about their culture and traditions. She told me some women have these ornaments but not much little bit. She told me they practice of tattoo. They are common among poraja women and girls who are above five years of age they are found with the tattoo marks in their face and hands.

They like to remain isolated from the people of the communities and feel shy of them. Free mixing and honest conversation with outsiders are not their custom. The Paroja houses are of one type for all, irrespective of economic or social differences among them. The houses of different families are built in isolations from one another and there is only one entrance to each dwelling house. No exit is provided at the back of the house. Thus the front door of the house serves both as entrance and exit. There are hearth, granary, abode of the family deity, and place for sleeping are all inside the house. All the members of a family irrespective of age sleep on floor inside the house. Their traditional economical organization, marriage and kinship system, political set up, magical religious life, as well as flock culture views still continues to function effectively.

2. Review of Literature

Knowing about PHC we should know about the primary care first. Then primary care is about the first medical care. Canadian Medical Association, (1994) concerning that "Primary medical care consists of first - contact appraisal of a patient and the provision of continuing care for a wide range of health concerns. The scope of primary care includes the diagnosis, treatment and management of health problems, prevention and health promotion, and ongoing

support, with family and community intervention where desirable. "

Barbara Starfield, (1998) regarding that Primary Care is the "level of a health service system that provides entry into the system for all new needs and problems, provides person - focused (not disease - oriented) care over time provides care for all but very uncommon or unusual situation, and co - ordinates or integrates care provided somewhere else by others. "

Then the Primary health care means the grass root level care in rural people. Ontario Health Services Restructuring Commission, Primary Health Care Strategy, (1999) the first level of care and generally the first point of contact that people have with the health care system. PHC supports individuals and families to make the best decisions for their health. It includes advice on health encouragement and disease prevention, health assessments, diagnosis and treatment of periodic and chronic conditions and supportive and rehabilitative care.

Canadian Health Services Research Foundation, (2003) apprehensive about Primary Health Care is defined as a set of universally accessible first - level services that promote health, prevent disease, and provide diagnostic, curative, rehabilitative, supportive and palliative services.

The WHO Alma Ata Declaration, (1978) concern about that Primary health care is essential health care based on practical, scientifically sound and socially satisfactory methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

The European Definition of Primary Care, (2002) WONCA stands for the World Organization of National Colleges, Academies and Academic Associations of General Practitioners and Family Physicians. It lists a number of defining standards, such as point of first medical contact within the health system manages illness at an early stage in its development establishes a relationship with the patient over time promotes health and well - being both by appropriate and efficient anticipation deals with health problems in their physical, psychological, social, cultural and existential dimensions.

The concept of illness was viewed as apathetic deviance, remediable by the application of impartial knowledge owned by a special class of persons (**parsons**, 1951). In delineating the sick role concept, the sufferer is not to be held responsible for his deviance, he is exempted to seek capable help and co - operate with the treatment in order to become normal performer in the social system within this functional point of view, **Cockerham** consider "medical sociology" dealing with social facets of health and illness. Besides at the Alma Ata Conference (September 1978) on primary health care, it was recognized that in view of a large majority of population in the developing countries, residing in rural areas, where health resources are incomplete, it is necessary to provide them with low cost available and applicable heath care through their involvement and participation (WHO 1980).

Mehta (1984) on the basis of analysis of country case studies on his teamwork in primary health care has raised a fundamental question, "can the delivery system of primary health care (PHC) through team work be successful devoid of a change in the bureaucratic and socio - political structure of developing nation."

Despite the development made in public health through improved hygiene and sanitary living condition. Development of **Germ**, theory of diseases through bacterial research for combating disease and restoring normally, they believe in some magic or religious power involving force beyond human comprehension. Such belief is still being held by a large population especially in the developing world (Mehta 1992). The concept of parson sick role views sickness as a disorder in the human being both biologically and socially (Parsons, 1951). The hypothesize being sick is not just expectation and reinforced by the norm of society corresponding to these expectations (P - 46). Primary Health Centers, no scientific efforts have been made to evaluate the impact of these health centers in improving the health of the people. It may be important to study the health needs expectation and services to the changing situations.

For the surroundings up of primary health center, brought new health functionaries such as the auxiliary nurse midwife (ANM) lady health visitor health workers, sanitary inspection, and so on, in contact with the members of the village community. A request to bring the indigenous medicine practitioners in the villages into the mainstream of the health services for their effective utilization has been given by **Mehta** (1975, society and health). Primary health centers, sub - centers, dispensaries, indigenous medicine practitioners and folk medicine men in the rural areas. As such there are larger needs to explore the community response to health is unclear. They are not sure that a healthy person is more productive. They consider an individual healthy if he is free from any physical ailments. There is need to assess the health nation, beliefs, scientific knowledge needs and expectations of people in regard to health and disease in different socio cultural environment of the community and in various geographical and cultural regions of the country for building up an anthropological concept of health and disease. The role of social institutional structures like family, kinship and religious in affecting the utilization of health and medical services also needs to be researched for better understanding of the stresses and Straus in the health behaviors of people. The Food habits and beliefs are also for important areas of anthropological point of view.

Primary health care and anthropology:

Primary health care and anthropology both are related to each other. Anthropology is the study of human being day to day life socially and physically. Health is a necessary part of human life. The basic needs are of a human being are food, shelter, clothes and good health care. So, primary health care

is first step of government to serve public health. In the applied anthropology include business studies which include in its economic, marketing, anthropology and organization theory. Primary health care illustrated on it. In cultural anthropology especially the study of the ways of life and belief system, works in accordance with the communities and societies. In primary health care it studies the culture, value and identities. It includes organizational culture, professional culture and so on as well as the ideas and practice of different ethnic groups.

Primary discipline studies include social science like, sociology, anthropology and psychology. For this reason, it may clear that primary discipline are a particularly difficult subject to study. That for it cleared the study of primary care is best accomplished through open and pluralist discussion in learning groups. So then it is called both multi - disciplinary and multi - professional. Because it comprises individual who studied different theoretical disciplines and multi professional include of roles in their working lives and hence different perspectives on primary care problems. Socio - cultural anthropology deals with many aspects of human society, culture, behavior, beliefs, and ways of life and so on. Traditionally, it focused on the study of primitive or unusual societies or groups, but increasingly these days it studies more developed societies and familiar groups within those societies (as the professional bodies or organizations). In the past, cultural anthropology suffered from intellectual imperialism (benchmarking 'their' beliefs against 'our' knowledge). These days, the research tools of the anthropologist (mostly in depth qualitative methods) can be applied to the study of one's own culture through self - awareness and distancing techniques designed to make the familiar strange. Because the study of humans is so relevant to many academic disciplines, cultural anthropology cross - cuts a number of other disciplines traditionally taught in universities – for example, foreign languages, economics, psychology, sociology, political science, ecology, women's studies, history and of course the health sciences.

Medical anthropology is the branch of cultural anthropology that studies the cultural influences, which promote, maintain or contribute to disease or illness, and the strategies and practices that different human communities have developed in order to respond to disease and illness. Exchanges between anthropology and medicine date as back as the end of the nineteenth century, with the pioneering works of Rudolph Virchow, the distinguished nineteenth century pathologist whom doctors may know as the author of the famous 'Virchow's triad' (the three classical signs of thrombosis) but who also emphasized the need to consider the patient's illness in the particular cultural context of his or her society. Cultural differences between physicians and their diverse clients make cross cultural misunderstanding expected. Culture also affects behaviors that expose to the disease. Because the reasons are prompting to seek care, how the patients describe the systems and observance with treatments. Patients and provider need knowledge of relationships of culture to health. Because culture is the foundation of everyone's health concern and practices. In improving health care requires attention to cultural influences on health concerns, conditions, beliefs and practices.

3. Materials and Methods

This was an anthropological study of primary health center with its aim of basic health care utilization by women in the study area of PHC. A study of primary health system includes planning, programmes and health status of that area. Therefore, a holistic approach is required to study the various health factors ensuring that knowledge therefore gained might become helpful in micro level planning and execution of the health system welfare programmes. Infrequently does one come across data collected to understand the primary health care system? On the contrary, most of the data is produced for, as a consequence of administrative exercise for exercises carried out by, or under the control of government or non - government agencies for running the welfare programs efficiently. This data of special survey is undertaken as a research method for better understanding of the field situation. The sample surveys used in health serves to understand the utilization of PHC. The advantages of sample surveys, apart from being cost efficient is that they can be organized and executed relatively quickly and that they can gather much more details then a health center include attitudinal information. Presently this sample survey was conducted in two villages of Koraput district namely, Kakirguma and Tunpar.

Objectives:

- To determine the existing health problems and health related practices in selected villages of Kakirguma and Tunpar.
- To determine changes in health status and health related practices in those villages with health programmes in Kakirguma and Tunpar.
- To study the role of doctors and health workers like ASHA in PHC of the sample villages.

Area of study:

The highest numbers of tribal groups are found in Odisha followed by 62 tribal groups including 13 primitive tribes. The state tribal population constitutes 22.8 percent to total state's general population as per 2011 census, 49.62% of the total population is tribal. In the state both southern western regions are known to be tribal dominated regions and the southern region having more than 50 percent of tribal population compared to other region. Among the various tribal group Paroja population is higher as compared to other tribal group population in the Koraput district. Therefore this district is considered for the present study as Paroja tribal population is higher among all tribal groups and this group taken into account for study purpose however majority Paroja population is found in the Koraput district. Health services are provided through number of institutions like District Headquarter Hospital (DHH) - 1, Sub Divisional Hospital **(**SDH) - 1, Community Health Centers **(**CHC) - 16, and PHC (N) - 47, Sub - centers (SC) - 307.

Study Design: The study is explorative and instructive within the environment. It looks into various aspects of social prohibiting and women health with respect to tribal health progress and their health problems. Separately from that this study examines the government responsibility and effort particularly in the progress and consumption of tribal people health. Consequently, this study tries to explore

various problems and factors touching tribal health issues in that area.

Sampling frame and sampling design: Both primary and secondary data have been used for this present study. For the primary study both quantitative and qualitative survey was carried out. The simple random sampling methods have been used to determine the sample size for data collection. Multi - stage sampling method is adopted to select the respondent from top district to bottom household. Desired number of sample size from total universe or total population has been determined analytically.

Basically the block will be selected on the basis of maximum number of Paroja people living in the block. In the block two are selected because of their population of tribe is almost half of the villages. In both villages the "*bodo Paroja*" and the "*sano Paroja*" are living there. The village is selected on the basis of geographical settings. The first village selected where the PHC is situated and another village is 10km remote from the PHC. From the selected villages 100 households from each village will be in consideration for the study. Total 200 from the villages and each selected on the basis of systematic random sampling method. For selecting households on the basis of women from the age group 18 to 55 years. Since the study is mainly to explore the utilization by the Paroja tribal women. Consequently, primarily the households listing task will be carried out to track on the households with women or the age group 18 to 55 years.

District – Block (1) - - - GP (2) - - - Villages (2) - - - Households (100 each villages) - - - Respondent (200 both villages).

Data collection tools and techniques: The first part of the interview schedule is related to information on proper identification and household composition. The second part of the interview schedule probes in to the reproductive profile of women and health facilities available in their villages. The third part probes in to the marital status of the respondents as per topic of study. Finally the last part deals with the utilization of PHC by the respondents. The information was elicited from 200 respondents of two villages of Kakirguma and Tunpar. Keeping in mind the present study, it was decided to use a schedule as a fieldwork tool, which would supplement the interview process for data collection. A same structured schedule was designed which contained both, a series of closed and open ended question. Factual question, eliciting data regarding age, marital status, educational status, occupation, economic status, family structure, number of children were placed in the beginning of the schedule. These initial queries served as an effective prelude, be friendly with the respondents to 'open out' to the more probing questing that followed regarding their reproductive history, knowledge and practice of birth control methods and health status. Observation study will be carried out to collect the qualitative information regarding various cultural aspects of tribes. The quantitative survey will be based on household and individual information collected through interview survey. For in detail qualitative interview and participant observation technique will be adopted to obtain the all information regarding cultural setting of tribes.

Data analysis methods: Multivariate analysis statistical techniques and methods will be implemented for data analysis to describe the inferences. Gathered quantitative data will be analyzed using SPSS/STATA data analysis computer packages to describe result and discussion and describe the study conclusion. To the analysis data set of variables both independent and dependent variables.

4. Result and Discussion

Utilization of Primary Health Care by Paraja Women: The tribal women's utilization of primary health care (PHC) and health services introduced under different programmes of health sector. It attempts to highlight the Paroja concepts of health and illness as well as their traditional provisions of health care. The arrival of modern medicine and its success the centre of the Paroja medicine has lost its hold to a great extent. Slowly but certainly, the tribal's have started moving towards the modern doctors and health centers though they still retain some of their traditions of health care. However, when the diseases attack them and the pain is unbearable, they find ways for the relief. This shows that they are still in a stage of "cure is better than prevention". In other words, their health behaviour is more concentrated on cure rather than prevention of diseases. For cure of diseases, the Paroja are heavily dependent on their deities because of their religious beliefs and traditional practices as mentioned earlier. When they stick to the traditions for the reasons other than religiosity, they being social conformists are happy to accept and respect the long practiced social habits or customs. Those who are really religious by heart believe that '*dishari'* then they go for the black magic. They believe that the gods can cure all the diseases caused by them or by other reasons - natural and human, malevolent and manipulative. Contrary to this, 6.5% respondents feel that the diseases are caused by other sources like the individuals themselves apart from hard work, unemployment, dirty and stale food, contaminating water, irregular and unhygienic living, alcohol and tobacco, unhealthy housing and environment, dogs, rats, flies, mosquitoes and germs.

Out of 200 respondents were drawn from the two villages (Kakirguma and Tunpar village) of the Laxmipur block. Basically the block was chosen on the basis of maximum number of Paroja living in the block. The village is chosen because of their population in the community. In the Kakirguma village the 'primary health centre' is situated. The Tunpar village is 10k. m. far from the health centre. The age group where I worked was of 18 - 55 years, focusing mainly on most women utilizing the facilities provided by PHC. It helps them on health concentration of their day - to - day life and work. The statistical information relates to the age - wise classification of women in the study area. Out of the 200 respondents, in Kakirguma and Tunpar villages 22% & 18% respondents belong to above 46 years age group, 35% & 24% respondents belongs to 36 - 45 age group, followed by 22% & 37% respondents in 26 - 35 age group, 21% & 21% respondents are below 25 age group respectively.

Treatment of Choices: The medical treatment is the basic need of a person to seek aide when he/she goes for cure. Some of their first step is to go for the traditional methods or the home made indigenous medicines. But many people go for first aid prevention in health centres. Diseases have always been sources of sorrows and sufferings. These have not only been the hazards to health but also created obstructions to work and achievement, to stability and mobility – spatial and social. Though in serious diseases, the tribal people go to the health centres; in minor ailments they prefer the chemist shops, as it is time effective. Further, for treatment of the minor ailments, the respondents need to spend only small amount which they can easily afford. As the result shows that out of the total respondents 93 percent of the respondents are prepared for medical treatment and depend upon PHC and only 7 percent respondents are prepared for traditional medical practices. They also believe that many medicines for one ailment are more effective. The study clearly shows that the PHC nearest to the reach of people have now developed more faith in the medical treatment. Like 96% women from Kakirguma village trust the medical aid provided by PHC. This varies as 90% of the women in Tunpar village. But those 4% and 10% women are forced to opt for the traditional treatment in these villages because the PHC centre is far away from their reach. Obviously a sick person would not like to travel a long distance every time in their illness.

Table 1: Choices of treatment

Village name	Choices Of Treatment		Total
	Choose PHC	Choose Traditional Treatment	
Kakirguma	96	4	100
	96.0%	4.0%	100.0%
Tunpar	90	10	100
	90.0%	10.0%	100.0%
Total	186	14	200
	93.0%	7.0%	100.0%

Delivery in PHC:

However according to the Chief Medical Officer (CMO) of the PHC, these and some other MCH services have been integrated into one project called Child Survival and Safe Motherhood (CSSM) that has been launched in the ITDA since the year 1992 - 93. These programs are not successful in this region. The new programmer (CSSM) plays an important role in family welfare. It ensures effective ante - natal care, Safe delivery and post - natal services by the health personnel from the PHC and sub centers. The problems of pregnant women are detected early and treated properly. The Health Workers and ANMs visit the villages and houses as well as advice the women and family on balanced and nutritious diet, environmental sanitation, disinfection and diseases. The CSSM not only emphasizes on control of diseases like diarrhea and acute respiratory infections (ARI) or pneumonia but also on immunization against illnesses. The responding 34 percent women do not want to go to PHC for delivery because they are happy with the dais for home delivery.

Others are of study areas, 66 percent of the tribal women deliver their child in PHC. Because of the ASHA, it promotes the pregnant women and her family for PHC. She suggests them about the janani suraksha yojana (JSY) and also about the janani suraksha yojana expresses (JSYE). JSY is for a safe motherhood intervention under the National Rural Health Mission (NRHM). It started from 2005 in India for reducing maternal and neo - natal mortality by promoting institutional delivery among the poor pregnant women. In the UNICEF India Partralekha article written by **Patralekha Chatterjee** 2007, tribal woman for the first time gave birth to her child in PHC. Her name is Sadamani Majhi (a Paroja woman) lives in Tunpar village in Laximpur block. ASHA and a local health work arranged a jeep by themselves to carry her to the PHC. After the 3 year the PHC got a janani express for safe motherhood. They also got the money for delivery in health centre in the scheme of government for STs and SCs pregnant woman. Now at this stage some awareness about the delivery system available and woman are going to health centre for delivery. When I asked about it these women say that, in health centre child and mother both are safe. They also told about the free medicine and extra care.

Table 2: Delivery in PHC

Village name	Delivery In PHC		Total
	Yes	No	
Kakirguma	61	39	100
	61.0%	39.0%	100.0%
Tunpar	71	29	100
	71.0%	29.0%	100.0%
Total	132	68	200
	66.0%	34.0%	100.0%

Utilization of PHC by Women:

Gunj Muduli a villager of Tunpar, she is 24 years married women. There are three members in her family with a one old year girl child, she and her husband both are daily labour. Her monthly income is around Rs.2500 - 2800. Though she does not have any education degree but she can write her name and she lives in a hut. She also has own agricultural land. She is one of the people who have used the PHC in recent days. She is suffering from malaria disease. That is why she used the PHC and she also delivered her child in the centre. She took 30 minute reach PHC and in private transport, she spent every time 50 rupees per round. She also mention that in her pregnancy time JSY express was there that helped her to reach medical care in time. ASHA is very kind to her and she always helps her in pregnancy. ASHA told her if she gave birth to a child in PHC, government would pay her money (1500 for girl child). The health workers of PHC are so kind to her all the time. She use PHC only in emergency situation and in normal situation she follows the traditional methods.

She is comfortable with both doctors male or female to share her problem and also feels free to ask about any information for health problems. She prefers to speak in her own language (*Deshia*) and Odia with doctors, sometimes use her own language which creates some difficulties because there is no interpreter available there. Sometimes she does not feel like going to PHC just because of the distance in the rainy season in roads which turns to very bad condition and local transport is very bad in these days. The villagers use health centre when they are sick. But the Paroja woman starts taking prevention in her home. First they use traditional method then after if it doesn't works they prefer health centre doctor or the medicines. In the study area respondents prefer the PHC, 30 percent people prefer PHC in emergency

situation and 4.5 percent respondents prefer in normal health care but 65.5 percent respondents prefer in both of the situation.

Table 3: Showing Utilization of PHC by Women

S. No.	Utilization Of PHC	Village name		Total
		Kakirguma	Tunpar	
1	Emergency Situation	22	38	60
		22%	38%	30%
2	Normal Problems	4	5	9
		4%	5%	4.5%
3	Both	74	57	131
		74%	57%	65.5%
Total		100	100	200
		100%	100%	100%

PHC capable of handling epidemics:
In epidemic situation everyone thinks about health care first. So, Paroja people also think the same way. When they get sick they think about the cure also. First they go for the traditional methods but now these days, they believe in modern health system and medicines.

The table shows that respondents answered my questions about the capability of PHC in handling epidemics situation, 44.5 percent respondents agree to the capabilities of PHC but 55.5 percent says that they are not doing so well. The people are unhappy for the poor performance of PHC because of lack of inadequate amount of so many equipments. When doctor felt wrong about something critical and harmful situation then he refers the patient to CHC or district hospital. Tribal people think they have to spend so much money there, so they are unhappy with that. Most of the Tunpar village people are unhappy compiling to 62%, when any epidemic situation they refer them to Koraput (district medical).

Table 4: Showing PHC capable of handling epidemics

S. No.	PHC Capable of Handling Epidemics	Village name		Total
		Kakirguma	Tunpar	
1	Yes	51	38	89
		51%	38%	44.5%
2	No	49	62	111
		49%	62%	55.5%
Total		100	100	200
		100%	100%	100%

ASHA accompanies patients to PHC: The ASHA is a female volunteer selected by the community, deployed in her own village (one in every 1000 population) after a short training on community health. She is preferred to be between 25 and 45 years old, with a minimum formal education of 8 years and demonstrable leadership qualities. Started in 2006, currently the ASHA program has spread across the country with 820, 000 women trained and deployed. ASHAs are not given salary and they belong to the voluntary cadre of health staffs as they get fixed activity - based incentives. Their responsibilities range from health education to diagnosis of health conditions. Each state oversees the program confined to the guidelines of the National Rural Health Mission (NRHM).

After the study of both villages, it is found that ASHA has a lot of impact on them. It shows interest in local community and acts as effective link to people in the delivery of health services and provides health awareness. She also counsels the women on birth preparedness, importance of safe delivery, breast feeding and complementary feeding, immunization, contraception and prevention of common infections including RTI/STI (reproductive tract infection and sexually transmitted infections) and care of young child. In the study of field area, approximately 66.5% respondents say that ASHA goes with them to the PHC and consult with the doctor. The knowledge was observed regarding giving advice to pregnant women and their families about promoting institutional deliveries and accompanying pregnant women at the time of delivery. Another 33.5% respondents say that ASHA has not been going to PHC with them. When enquired, she says that when she carries the pregnant women then old people of the family also want to come along which gets too difficult to manage.

Table 5: Showing ASHA accompanies patients to PHC

S. No	ASHA Accompany With To PHC	Village name		Total
		Kakirguma	Tunpar	
1	Yes	63	70	133
		63%	70%	66.5%
2	No	37	30	67
		37%	30%	33.5%
Total		100	100	200
		100%	100%	100%

The duty of ASHA (Accredited Social Health Activist) is to reach all disease control programmes to community level, for example Gaon Kalyan Samiti, RNTCP (Revised National Tuberculosis Control Programme), NVBDCP (National Vector Borne Disease Control Programme) etc. from planning to community. ASHA's are provided with a Kit bag in which one Thermometer, Gauze Bandage, Soap, and Some Primary Medicine like paracetmol, Chloroquine, ORS, OP, ECP and IUCD are available. She takes blood serum from people for malaria test, HIV Test and she also reports to nearest medical/PHC about Leprosy in case of finding such symptom in any one. ASHA is responsible for taking pregnant women to ANM and Medical for ANC Check up and Delivery and for PHC check up and also inform people for immunization. ASHA is a convector of GKS.

Problem of supply of safe water and basic sanitation in PHC:
The tribal people suffer from many chronic diseases but most prevalent taking heavy toll of them are water borne. This is mainly due to the very poor drinking water supply. Even when it is available in plenty, it is mostly dirty and contaminated. Consequently, the tribes are easily susceptible to intestinal and skin diseases. Diarrhea, dysentery, cholera, guinea worm, tapeworms, etc. are often the results of this condition. Safe adequate and accessible supplies of water, together with proper sanitation, are therefore foremost among basic health measures. In communities where piped water supplies have not yet been provided, women are the haulers, stores, and distributors of water and the managers of basic sanitation at the family level and often also at the community level. In the Kakirguma village they have the pipeline system but they use the local waterfall water for their bath, washing clothes and the domestics animals are also cleaned there. This pipeline water only they use for drinking and cooking. And another village Tunpar they have

2 bore wells and one common well is there. It is primarily women who have the responsibility for introducing sound personal hygienic practices, promoting the use of latrines and ensuring that clean water is used for drinking and other domestic purposes. But in the PHC, they care about the sanitation. When I reached the Primary health center, I got to know the environment of PHC was totally healthy and in good condition. After talking to the women, the PHC hygiene details are given as follows. This table shows that in the study areas the primary health center (PHC), the respondents say that 82.5 percent PHC is in good hygienic condition and 17.5 percent people say that not so good condition. This table shows the most of respondents are happy with PHC hygienic condition.

Table 5: Showing Hygienic conditions of PHC

Sl. No.	Hygienic Of PHC	Village name		Total
		Kakirguma	Tunpar	
1	Yes	83	82	165
		83%	82%	82.5%
2	No	17	18	35
		17%	18%	17.5%
Total		100	100	200
		100%	100%	100%

In this situation I observed that PHC condition was good but the village people were not aware about the sanitation. Some of them use the water of waterfall for drinking and cooking also. Through that they got diseases like malaria, cholera etc., even in the village they do not maintain proper hygienic conditions. They have drain system but the drains were broken.

Child care and the family planning

For the proper care of mothers and their children, maternal and child health has occupied a paramount place in the primary health care services. Realizing the important role played by family planning in caring for the health of mother and children, both the programs of family planning and mother and child health have been integrated into one package called family Welfare services offered through the primary health care services in rural areas (Tiwari, 1992). This remains an integral part of the health services scheme in the study villages.

The Multi-Purpose Health Workers (MPHWs) especially the ANMs and the ASHAs have been entrusted with the greater responsibility of explaining and encouraging the people to accept the small family norm and go for wider spacing between two births. They identify the eligible couples of 18 and 45 years of age and motivate them to utilize the facilities of family planning. To maintain a healthy time - gap between the births of two children, the Health Workers and the Anganwadi Workers of the ICDS scheme provide contraceptives like condoms, oral pills and IUDs to those parents with more than two children. Parents are also advised to accept permanent methods of family planning like vasectomy for males and tubectomy for females. To implement the programmes among the tribals some monetary incentives are given to them. In studied villages most of the women accept the permanent method of family planning tubectomy but no male persons goes for the vasectomy. Because they do not agree to looses or endanger their masculinity.

In this area of my study, as in those dealt with below, women still play a more or less predominant part. They are the main providers of child care and family planning, since most of the relevant action and decisions take place within the family. Women are aware of the need for preventive measures and the need to inspire healthy behavior. They also take the initiative in such matters as first aid for childhood accidents and they are aware of the nutritional needs of nursing mothers. In the study area some women are aware about the family planning but they were not aware about the child care. The Paroja women in the morning time when she prepares for going to work she totally neglects the child, she basically manages to cook food and let them on with work or she gives responsibility of the child to someone else like some elder people or the elder sister of the child. In this community, so many children are suffering from malnutrition. They only give them rice and ragi food (*mandia jauu*).

The PHC personnel also directly participate in the implementation of its programs of cure and prevention of diseases. Its doctors visit the villages and impart education on various aspects of health by way of informal talks. They educate the tribals (especially woman) about the tenets of mother and child care as well as family planning. Table: show that in the study area, respondents counting 42.5 percent practiced family planning and all generally practice tubectomy.57.5 percent of the respondents did not practice any family planning. Respondents have not practiced family planning because they did not have the awareness of such planning at those times.

Table 6: Showing Practiced family planning

S. No	Practiced Family Planning	Village name		Total
		Kakirguma	Tunpar	
1	Yes	42	43	85
		42%	43%	42.5%
2	No	58	57	115
		58%	57%	57.5%
Total		100	100	200
		100%	100%	100%

5. Conclusion

Above discussion of tribal health problem is a big issue and related with the health problems of Paroja women personal hygienic, drinking water problem, nutrition and malnutrition problem, drinking alcohol, malaria diseases, PHC problems, education, immunization, child and mother health care, family panning etc. the Paroja women still have some faith in traditional medicinal men and she worships to the god for good health of the family. The mother and child health lack nutritional improvement, the government has been facilitating them with many different health related polices but these polices have not being working well in their favorers. These people need safe drinking water as the water supplies to them is heavily contaminated and unhygienic. In the matter of family planning male dominates female, the male members do not generally opt for any family planning method. They do not agree to endanger their masculinity. Paroja woman now even these days, she trusts the modern health service but she is also believes in their traditional black magic and medicines. Tribal men and women like

alcohol and they both enjoy it in the same ways. The alcohol addiction creates disease and unhygienic alcohol makes people ill mentally and physically. Tobacco affects their lives and children also tend to take tobacco as well. The immediate spread of health education among the tribal is very crucial. As most of the tribes are illiterate, various audio visual methods may be adopted to put across to them the basic principles of health and sanitation. Unnecessary to say that for raising the standard of healthy tribal population, cooperative endeavor is necessary among states, the center, the non - official organizations and the medical personnel.

Lastly, health is holistic and depends on a multiplicity of factors. An isolated development of the health sector alone is not enough. Besides the health services, emphasis may be given on the development of infrastructural facilities, transport and communication, economy, education and other sectors of development. An integrated development of the Paroja's of study area will be the true development of their health status.

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