

Public and Private Healthcare Services in the Tribal Areas of Eturnagaram

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Abstract

India being the nation of villages requires an intensive access to rural health care. Rural health is one of the important subject matter to rural life. It's the right of every individual but lack of quality infrastructure, dearth to medical facility and shortage of primary health care components thwarts its reach to 70% of the population in India and that is why rural health care is one of the biggest challenges faced by the Health Ministry of India. India being the nation of villages requires an intensive access to rural health care. Rural health is one of the important subject matter to rural life. It's the right of every individual but lack of quality infrastructure, dearth to medical facility and shortage of primary health care components thwarts its reach to 70% of the population in India and that is why rural health care is one of the biggest challenges faced by the Health Ministry of India. India being the nation of villages requires an intensive access to rural health care. Rural health is one of the important subject matter to rural life. It's the right of every individual but lack of quality infrastructure, dearth to medical facility and shortage of primary health care components thwarts its reach to 70% of the population in India and that is why rural health care is one of the biggest challenges faced by the Health Ministry of India.

Since independence India has achieved significant progress in improving health standards in rural areas. The Government of Andhra Pradesh launched several innovative health service programs including private-public partnership (PPP) to provide health care services in an effective manner, the most popular among them being Rajiv Arogyasri, 108 and 104 services. Apart from the above health services the state has a vast public health infrastructure like sub-centers, primary health centers, community health centers and other alternative health care services like AYUSH, RMP, RNTCP and ICTC to provide health services to rural and tribal areas.

Although the public health infrastructure and private-public partnership health care looks impressive, their functional status needs to be studied in terms of ensuring quality services. With this background the present work aims to study the functioning and assessment of Rajiv Arogyasri, 108 and 104 services AYUSH, RNTCP and ICTC facilities. Since the registered medical practice was bound to remain in place as an institution for a long time to come, the study made an attempt to understand the implications of its sustenance.

This paper also dealt with the issues related to necessary coordination required between different stakeholders who played a significant role in preventive and curative health care. A cross-sectional, observational study was done in the above health care services, selected from the Eturnagaram Integrated Tribal Development Agency (ITDA) area of Warangal district. Data was collected through open-ended questionnaires using interviews and focus group discussions. Further, this study has suggested improving the shortfall in the above health care services from both structural and functional point of view.

Keywords: Tribal areas, primary health centre, private public partnerships, rajivarogyasri, ayush, Warangal district, Telangana region.

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I. INTRODUCTION

Since independence India has achieved significant progress in improving health standards in rural areas. Health sector reforms gained focus in the mid- eighties and took momentum in the early nineties, alongside economic reforms initiated by the Government of India. Health sector reforms in the state of Andhra Pradesh have brought about innovative approaches including large-scale private sector involvement, from which new technologies, use of IT, service delivery and financial mechanisms for health care, have evolved. International organizations such as the World Bank, European Commission and the Department for International

Development (DFID) have a history of being involved with the health sector in Andhra Pradesh, initiated back in 1995.

In Andhra Pradesh the private-public partnership (PPP) models are also being used to improve the delivery of health and welfare services (Ravi Mallipeddi, Hanna Pernefeldt, and Sofi Bergkvist, 2009). In health sector the PPP model is playing a crucial role in improving health status in Andhra Pradesh, the most popular among them being Rajiv Arogyasri, 108 and 104 services. Given the overwhelming presence of the private sector in health, various state governments in India have been exploring the option of involving the private sector and creating partnerships with it in order to meet the growing health-care needs of the population.

The 10th Five-year plan (2002-2007) welcomed hi-tech tertiary sector market as a part of health reform and advocated public-private partnerships (Sunita Reddy and Immaculate Mary, 2013). The present inefficiencies and inequities in the public health system in India have pushed forward the need for creative thinking and innovative solutions to strengthen the same. Crippling health problems have provided apparent calls for change in the existing structure of health service provision and risk pooling, involving both public and private sector.

To provide health services to rural and tribal areas, Andhra Pradesh has a vast public health infrastructure such as sub-centers, primary health centers and community health centers and other alternative health care services such as AYUSH, RNTCP and ICTC. Although the public health infrastructure and private-public partnership health care looks impressive, their functional status needs to be studied in terms of ensuring quality services. With this background the present work aims to study the functioning and assessment of Rajiv Arogyasri, 108 and 104 services AYUSH, RNTCP and ICTC facilities. Since the registered medical practice was bound to remain in place as an institution for a long time to come, the study made an attempt to understand the implications of its sustenance. This paper also dealt with the issues related to necessary coordination required between the different stakeholders who played a significant role in the preventive and curative health care.

Health Situation of Tribes in Warangal District

In Warangal district the scheduled tribes constitute 13.65% of the total district population of 32.5 lakhs. Out of the 51 mandals (sub-district administrative units) in the district, 11 mandals, known as the tribal sub-plan area, have a strong presence of tribal population. Out of 11 only one mandal, viz., Mangapeta with overwhelming tribal population, was classified as fully covered scheduled area and the other 10 as partially covered scheduled areas which enjoy a special constitutional status.

Another 16 mandals were classified as MADA mandals, based on the tribes inhabiting the mandals. Koyas, Lambadas, Yerukala, Konda Reddi, and Yanadi are the tribes inhabiting in the district. Though Erukulas, Konda Reddi, and Yanadi inhabit the integrated tribal development agency (ITDA) area, their number is not significant. Notwithstanding the persistent efforts made by the government, the health service delivery system as well as the health-seeking behaviour of the tribes leaves a vast scope for improvement.

The demand for and utilization of public health facilities continue to remain low in the district. Major health problems in ITDA area are malaria, dengue, viral fevers and liver cirrhosis, white discharge, joint pains, TB and health problems arising out of anemia and nutritional deficiency. Though it is an endemic area for vector-borne and water-borne diseases, nature was little munificent this season as out of 229 dengue cases reported from the district only 12 were from ITDA area.

A perusal of the NRHM monthly progress reports suggests that the proportion of tribal population subject to seasonal fevers, diarrhea and other water-borne diseases and TB is higher in the sub-plan area compared with the district average. The number of villages classified as 'high risk' in the TSP area was 128. The NRHM monthly reports suggest the HIV positivity rate among ANCs as 0.5%. Among men and non-ANC women tested, the HIV positivity rate was 4.2% and 4.7% respectively. On the average, 3.4% of those tested during the last three months were reported to be HIV positive. This data suggest that the HIV epidemic is spreading to general population in the district.

The proportion of women and children suffering from anemia is relatively higher in the sub-plan area. The seriousness of anemia and nutritional deficiencies can be gauged based on the demand for IVFs by the patients in the CHCs, PHCs and SCs. About 25% of the patients at these facilities seek IVFs. With the advent of 108 services the rate of institutional deliveries increased substantially in the district.

The MMR, the IMR and the neonatal mortality rate clearly reflect the relatively poor health status of the people inhabiting the district. The condition of tribes that live in far remote and inaccessible areas is worse. Which means, the ITDA area has to go a long way to achieve the RCH-II objectives of reducing IMR to 25, MMR to 0.80 and neonatal mortality to 20 per 1,000 live births. Despite the phenomenal expansion in the primary and secondary health care services, the registered and unregistered medical practitioners continue to hold sway over the tribal areas.

Methodology and Approach of the Study

A cross-sectional, observational study was undertaken in a primary health centers, and the alternative healthcare centers, selected from the Eturnagaram Integrated Tribal Development Agency (ITDA) area of Warangal district. This study was undertaken during the year 2014. Both primary and secondary data was collected for the study. The present study refers to the undivided Andhra Pradesh. The state of Andhra Pradesh has bifurcated into Telangana and Andhra Pradesh according to the Andhra Pradesh Reorganisation Act, 2014.

Data was collected by means of survey through open-ended questionnaires using interviews schedules, and focus group discussion. Patients, attendants, medical and para-medical staffs were interviewed with pre-designed schedules and questionnaires. For collecting relevant data and information the study was conducted in the integrated tribal development agency area. The study covered both private-public partnership health care services and alternative health care services.

To study the alternative systems of medicine, the dispensaries of Ayurveda, Homeopathy and Unani were visited by the researcher. Study of these dispensaries was done in the non-scheduled mandals as the medical officers and the paramedical staffs were not available in the dispensaries of the scheduled mandal (Mangapet). To understand the role of the RMPs and the URMPs in providing the health services to the tribal and the other population of the ITDA area, one RMP and one URMP were chosen for study. The study covered the services rendered by the Rajiv Arogyasri, 108 and 104 services.

To understand the community perceptions about the health services delivery, questionnaires were canvassed among the patients, attendants of the patients, and the community members. Interviews were conducted to collect information from one RMP and one URMP. Visits to the interior villages in the sample mandals indicate that several remote villages continue to remain under-served and exposed to the risks associated with the untrained, unqualified and ill-equipped private medical practitioners. The researcher also visited sub-centers, PHCs, CHC, medical college hospital and clinics of one registered medical practitioner and one unregistered medical practitioner.

Health Emergency Services Through Public-Private Partnership (PPP) Mode

Andhra Pradesh is the first state in India that has envisaged the role of private sector in its Vision 2020 in assisting the state efforts to achieve the health objectives (Rao, 2003). Collaborations between the private sector and the government in the delivery of health services are of recent origin in Andhra Pradesh. A project for health care services in urban slums was a first innovative effort to contract private providers, non-profit organizations, to provide primary health care. The Government of Andhra Pradesh has thereafter undertaken major initiatives with the private sector for health care delivery. The main initiatives for contract arrangements with private health care providers to improve the access to health care were initiated in 2006. Three major contract arrangements for improved access to quality health care services are

- Rajiv Arogyasri Community Health Insurance Scheme for the population Below Poverty Line for which the government has stepped in to cover the premium for the insurance.
- Emergency Management and Research Institute (EMRI) is a non-profit organization originally providing ambulance services in Hyderabad. In 2006 it was asked by the government to scale the services to cover rural areas.
- Health Management and Research Institute (HMRI) provides primary health care services through mobile vans in rural areas and a toll-free health helpline providing standardized medical information, advice and counseling.

To improve health status in Andhra Pradesh, especially in rural and tribal areas, public-private partnership services are contributing very well but still there are gaps between service provision and the utilization of the services (Ravi Mallipeddi, Hanna Pernefeldt, and Sofi Bergkvist, 2009).

Rajiv Arogyasri Community Health Insurance

The Andhra Pradesh government recognized that public hospitals could not attract the needed medical specialists and did also not have adequate equipment to improve access to quality care for the poorest. Chief Minister Dr. Rajshekar Reddy Garu saw an opportunity in harnessing the vast private sector in health care delivery to benefit the poor. With a view to bring in high cost specialist services within the reach of poorer communities, Rajiv Arogyasri scheme was implemented in Andhra Pradesh.

The Arogyasri scheme provides financial protection to families holding a White Card for treatment requiring hospitalization up to approximately USD 4,500 in a year. To encourage the use of these services, 60 arogyamitra mandal camp coordinators (AMCCOs) were positioned in 69 PHCs of the Warangal district. With regard to the integrated tribal development agency area, 10 AMCCOs were positioned in the 13 PHCs. Primary responsibilities of the AMCCOs were:

- mobilizing the patients to attend the Arogya Mitra Medical Camps conducted by the Network Hospitals (NWHs),
- mobilizing the patients to undergo medication and
- monitoring the post-medication condition of the patients.

The success of the scheme depended on the effective campaign for mobilizing the patients to the camps, proper diagnosis of the health problems, mobilizing the patients to use the medication properly and completely and providing the post-medication care (Ravi Mallipeddi, Hanna Pernefeldt, and Sofi Bergkvist, 2009).

B. Ramakka, a 50-years old tribal women from Monraigudem hamlet, attended a NWH camp under the guidance of MPHA (F) seeking treatment for uterus problem. She was advised to go to NWH and undergo hysterectomy. She went to the NWH after four days and got operated. She was provided food during her stay in the NWH. She hasn't paid money, not even to the paramedical staff. Later two more women from the hamlet underwent hysterectomy.

It is estimated that in the state about 80% of the population has white card below poverty line ration cards and are considered eligible to utilize the benefits provided by Rajiv Arogyasri scheme. This scheme currently covers nearly 8 crore people who live BPL in 23 districts of AP. Nearly 350 hospitals from government and private sector across the state have been involved in implementing the health insurance scheme (Statistical figures mentioned in the Aarogyasri website). The state government is the sole funding agency for this health insurance scheme. The government takes care of the entire premium on behalf of the beneficiary. In the first financial year 2008-2009, the budget allocation was only Rs. 3,474,000 which rose to Rs. 925 crore in 2010-2011 and recently asked for 30% hike, estimated to be Rs. 1,300 crore (Sunita Reddy and Immaculate Mary, 2013).

Almost all the cases benefitting under Rajiv Arogyasri were found to be surgical cases. The beneficiaries under the scheme were reaching the facilities and utilizing the services in three different ways:

- through screening camps conducted by the NWHs
- through the PHC and the CHC referrals
- by directly approaching the NWHs.

The response was poor to Rajiv Arogyasri camps mainly due to the casual way of conducting such camps by the NWHs: the NWHs were sending non-specialists like BAMS graduates and newly recruited MOs to the screening camps, who were not capable of screening the patients. In this regard the NWHs need to be told to send specialist doctors alone to the camps. Removing NWHs that were not following these guidelines from the list of NWHs needs to be considered.

Two main problems were observed by the Rajiv Arogyasri beneficiaries:

- patients directly approaching the NWHs were told that the relevant disease was not covered under the Rajiv Arogyasri
- the post-operative care that was given to them was not to their satisfaction.

In the opinion of the AMMCOs, they were not given feedback on the treated patients for follow up and Rs.500 FTA paid to the AMMCOs was not enough to undertake multiple field trips to the assigned villages. This situation indicated the need for utilizing available electronic and print media for canvassing about the Rajiv Arogyasri rather than simply depending on the AMMCOs for effective implementation of the scheme.

Emergency Management and Research Institute (EMRI)

Over 200,000 people need medical emergency a day in India. Over 86,000 people die in accidents and another 453,000 people suffer from serious injuries in accidents in a year in India. In India, Andhra Pradesh has the highest number of road accidents; during 2005, four accidents per hour and 1.3 deaths per hour occurred in the state. The ambulance services were highly fragmented and unorganized.

This scenario prompted Mr. Ramalinga Raju to create the Emergency Management and Research Institute in Andhra Pradesh. The Emergency Management and Research Institute (EMRI) was funded by the Raju brothers, of Satyam Computers Services, with the vision of an emergency response service of global standards applying innovative technology to respond to 30 million emergencies and save one million lives per year.

The toll- free number 108 enables people to call from landlines and mobiles to access medical, police and fire department support. The ambulances are equipped to provide quality care during the transportation to the hospital within the golden hour. The government recognized the impact and encouraged EMRI to provide services outside of Hyderabad to cover the entire state including rural areas. The government stepped in to cover more than 95 percent of the operational costs through funding from the National Rural Health Mission. The funding structure enabled the system to scale up and there are now 652 ambulances covering the state. EMRI receives about 57,000 calls per day. They have tied up with 3,331 private hospitals in Andhra Pradesh, apart

from the government hospitals that can handle emergencies (Ravi Mallipeddi, Hanna Pernefeldt, and Sofi Bergkvist, 2009).

To attend to health emergencies, the Government of Andhra Pradesh launched 108 services. In Warangal district 40 vehicles were providing the services and of them, 11 were providing services in the integrated tribal development agency (ITDA) area. Better performance of these services implied non-dependence of people on uncertain public transport for reaching the public health facilities from their remote habitations in the ITDA. No validation of call was required in the ITDA for attending the 108 calls as was required in the non-ITDA areas. Due to the poor road connectivity and conditions the response time between the 'wheel to scene' was 25 minutes in the ITDA area compared to 21 minutes in the non-ITDA areas. Delivery related emergencies were among the important cases transported by the 108 services. Interaction with the staff of the 108 services revealed the necessity for undertaking the labour room responsibilities within the vehicle in case of emergency. To overcome the problem the Government Maternity Hospital, Warangal provided 15 days of in-service training in labour room to the 108 staff.

Services rendered by the 108 vehicles were less than optimal in the ITDA area as the operational jurisdiction of the vehicles was only 30 km though no referral hospitals were located within this distance. Whenever patients were brought by the 108 service to the CHCs or the PHCs, and if they were to be taken to the MGM Hospital, district hospital or the Government Maternity Hospital in Warangal, the transport arrangements were made by the ITDA or the patients themselves, losing critical time and money; and in a few cases leading to serious consequences to the patients.

An assessment of the share of services provided in the ITDA area compared to the district revealed that though the population of the ITDA area represented 11% of the total district population, a higher percentage of calls were attended by the 108 services, which indicated the dependency of the population of the ITDA area on the transport facilities provided by the 108 services.

On 23 October 2009, during their routine recess 25 school children (11 girls and 14 boys) of Kanthapalli primary school ate *adaviamudam* seeds. All of them started vomiting within an hour. The school headmistress called 108. Crossing 35km of fair-weather road, 108 reached school and took children to CHC, Eturnagaram. The headmistress and the parents spent a sleepless night anxiously waiting around the CHC of Eturnagaram. The parents felt that but for the 108 services, their children would not have survived. The below (Table 1) show the details about emergency health services provided by 108 average per month.

Table 1
Emergency Health Services provided by 108 (average per month)

Type of Emergency	Total calls per month		% of calls from ITDA area as compared to district
	ITDA	District	
Medical emergency calls	1827	6173	29.6
Road traffic accidents	121	752	16.1
Pregnancy related cases	197	689	28.6
Suicide/Poison cases	124	440	28.2
Abdomen-related cases	288	954	30.2
Respiratory-related cases	28	142	19.7
Cardiac-related cases	42	210	20.0

Source: Compiled from the data provided by the District Coordinator, 108 services, Warangal

Health Management and Research Institute (HMRI)

The Health Management and Research Institute (HMRI) provides a primary healthcare delivery model, with a rural reach, which integrates innovative technological solutions and process-oriented operations in the provision of healthcare services, while supporting the public health system. The model addresses barriers to health care such as accessibility and quality of care and is focused on augmenting the public health delivery system by harnessing Information and Communication Technologies as well as modern management practices. Through a public-private partnership with the state government of Andhra Pradesh, HMRI has a unique platform to pilot large scale health interventions and thus holds potential of high impact. The model includes components such as the following:

- a round-the-clock helpline for medical advice,
- rural outreach health services,
- a disease surveillance program,
- a blood bank application and
- telemedicine pilot projects.

HMRI's 104- Mobile service provides healthcare services to people in under-served rural communities, through well- equipped mobile vans that visit the villages on a fixed- day basis. The vans bring medical equipment and the para-medical team (Ravi Mallipeddi, Hanna Pernefeldt, and Sofi Bergkvist, 2009).

In the Warangal district to take the health care facilities to the doorstep of the communities, Fixed Day Healthcare Services were provided through 104 services. These facilities were available to such communities which were not having PHC facilities within a radius of three km. Twenty 104 the vehicles were in operation in the district. The community members were of the opinion that the services provided at the vehicles was poor; and that the staff nurse was not the right person to diagnose and prescribe the medicines. Regarding equipment, absence of microscope was seen as an important drawback.

The community members expressed the view that if the medical officers were posted in 104 vehicles, their services would be of great help to the communities. It was also understood that there was no coordination between the PHCs and the 104 services. The MOs of the sample PHCs indicated that they were not informed of the visits of 104 services to the villages under their jurisdiction. There appears to be a need to build proper coordination between the 104 services and the PHCs as both of them seek to address the health issues of the tribal communities.

AYUSH Health Care Facilities

India has a rich, centuries-old heritage of medical and health knowledge. Under the Ayurveda, Yoga, Unani, Siddha & Homoeopathy (AYUSH) various traditional systems of health care have been in use and even today all over the country these are being used. AYUSH focuses on non-allopathic care to the people of the state by providing medical relief through traditional Indian systems of medicine and homeopathy. The aim is to ensure proper development and evaluation of the ancient systems of medicine such as Ayurveda and Unani and also Homeopathy.

Ayurveda, Yoga, Unani, Sidda and Homeopathy were being promoted both as independent dispensaries and also as adjuncts to the PHCs. The communities considered these systems as solutions for their chronic health problems. Successful provision of these services depended on the following:

- the location of the facilities,
- availability of the medical officers,
- availability of the paramedical staff and
- availability the drugs in the dispensaries (availability of drugs being important as no private drug stores were available in the Integrated Tribal Development Agency area)

To understand the working of these systems, one each of Ayurveda and Homeopathy dispensaries and two Unani dispensaries were visited by the review team. The Ayurveda dispensary at Venkatapur and the Homeopathy dispensary at Kothaguda were located within the PHC premises. The Unani dispensary at Chunchupalliwas located in the panchayat building whereas the Unani dispensary at Tadvai was located in a community building constructed by the Forest Department.

The dispensaries of AYUSH required very limited equipment as could be seen from the table below. The currently available young batch of medical officers may be requiring the other equipment once they gain confidence in undertaking independent diagnosis and medication. The medical officers at Ayurveda and Homeopathy dispensaries expressed the view that they required examination tables immediately.

Table 2
Availability of Infrastructure and Equipment at AYUSH Dispensaries

	Infrastructure Required	Equipment	
		Available	Required
Ayurveda	<ul style="list-style-type: none"> • Accommodation • Furniture • Cupboards to store medicines 	<ul style="list-style-type: none"> • BP Apparatus (2) • Stethoscopes (2) • Knee Hammer (2) • Weighing Machine (1) 	<ul style="list-style-type: none"> • Examination Table
Homeopathy	<ul style="list-style-type: none"> • Accommodation • Furniture • Cupboards to store medicines 	<ul style="list-style-type: none"> • BP Apparatus (2) • Stethoscopes (2) • Knee Hammer (2) • Weighing Machine (1) 	<ul style="list-style-type: none"> • Examination Table • Vaginal Speculums
Unani	No idea	No idea	No idea

Note: The subordinate staff at Unani facilities could not give details regarding the infrastructure. Source: Ayurveda, Homeopathy and Unani dispensaries

With regard to the sample facilities the vacancy position indicated that, there were no MOs in both the Unani dispensaries and there was shortage of paramedical staff in both Unani and Homeopathy facilities.

Table 3
Availability of Medical Officers and Paramedical Staff at AYUSH Dispensaries: Sample

System	Medical Officers		Paramedical Staff	
	Sanctioned	Vacancies	Sanctioned	Vacancies
Ayurveda	1	-	2	-
Homeopathy	1	-	2	1
Unani	2	2	2	1

Source: Ayurveda, Homeopathy and Unani dispensaries

The medical officers of both Ayurveda and Homeopathy dispensaries did not visit the dispensary on the day of this teams' visit. The medical officers were found using uncertified leaves and not regularly attending the dispensaries. The distances between the place of the residence and the place of AYUSH dispensary of the MOs of the Ayurveda and Homeopathy dispensaries were found to be 60 km and 110 km respectively; the former commuted from Warangal to Venkatapur and latter from Jangoan to Kothaguda.

The major health problems at the AYUSH facilities were arthritis, cold, cough, asthma, digestive disorders and gynaecological problems. Most of the patients visiting these facilities were suffering from chronic problems. The number of patients utilizing these services per day in each dispensary ranged between 5 and 24; and the numbers of patients were declining slowly. Absence of the medical officers and the non-availability of important drugs were found to be the main reasons for the decline in the number of patients utilizing the AYUSH facilities.

Table 4
Major Health Problems Reported at the AYUSH Dispensaries: Sample

System	Number of patients using the service per day	Major health problems
Ayurveda	15	Gynaec problems, fever, urinary tract infections, digestive disorders, body pains and arthritis
Homeopathy	5	Arthritis, cold, cough and asthma
Unani	24	Knee/joint pains

Note: 1) The MOs did not visit the dispensaries on the day of the teams' visit took place at Warangal.

2) No patient visited the Unani facility at Chunchupalli as it had neither an MO nor a compounder.

Source: Ayurveda, Homeopathy and Unani dispensaries

With regard to medicines, the Ayurveda and the Homeopathy dispensaries had only supplementary medicines but not the main medicines: in the Ayurveda dispensary only churnams were available; and in the Homeopathy dispensary only biochemical tissue salts, oils and ointments were available and the main drugs like dilutions and mother tinctures were not available.

The available medicines did not cure the patients fully and gave only temporary relief. Both the Ayurveda and the Homeopathy dispensaries were given Rs.24,000 each as Contingency Fund. However, guidelines were not available regarding its usage with the facilities. The medical officers were also not aware of any guidelines on spending the amount. About 45.5% of the amount was spent on stationery, equipment window curtains and tablecloth, etc. These purchases were made at the medical officer's discretion. The utilization of Contingency Fund may be brought into the fold of Hospital Development Fund and its utilization within the purview of Hospital Development Committee.

Registered Medical Practitioners

Generally, the registered or rural medical practitioners are unqualified nurses or assistants to doctors, who after gaining substantial experience act as the first contact for health care in villages. This cadre of health workers is widespread in the state and they are the most accessible and affordable sources of treatment for the poor, thus many turn to them for even serious diseases of children and adults. Thus their wide presence and coverage, there is no real evidence on the quality of care they provide. Some of the anecdotal evidence points to harmful practices reported in the state, indicating that there is an extensive use of unnecessary or inappropriate drugs in the care the Rural Medical Practitioners provide. This cadre furthermore plays an important role in the referring system, as links to private hospitals for recruiting patients for surgeries and tertiary care (Center for Good Governance, 2006).

The sample RMPs expressed that about 70% of the patients that went to the RMPs were from scheduled tribes. The RMPs took steps to enhance their clientele. The RMPs undertook community visits between 7.30 am

and 10.30 am or when the patient could not be moved. On an average, a RMP treated about 15 OPs a day. They charged between Rs.10 and Rs.30 per patient but they didn't charge the repeat patients. The RMPs provided services on loan basis also. Reasons for the sustenance of Registered Medical Practice, as explained by the community were that:

1. There were only a few qualified doctors doing private practice in the ITDA area.
2. Uncertified absence of the MOs in the PHCs and the CHCs,
3. Drugs of similar colour, make and size (okerakaminagolilu) were given in the PHCs since many years, whereas RMPs gave capsules, tablets, injections, and especially IVFs.
4. The RMPs advised diet restrictions such as taking only bread, milk and kanji while undergoing treatment whereas the MOs of the public health facilities did not insist on such restrictions.
5. The patients could knock the door of the RMPs even during midnight.
6. The patients visited the RMPs when visits to the sub-centers did not yield any results.
7. The RMPs gave drugs of high dosage so that patients got immediate relief whereas drugs given at the PHCs were of low dose.

The RMPs would not sustain if the services provided by the sub-centers improved. The case of Otai bore testimony to this, where in a span of 1 year and 6 months, five RMPs dropped out of practice in the sub-center village.

The institution of Registered Medical Practice was bound to sustain in the years to come as public health facilities might not be able to provide health care effectively to break the dependence of poor people on the RMPs. Under these circumstances, the RMPs need to be trained in testing skills for identifying malaria, sugar, jaundice and giving first aid to the cases of snake bite, scorpion bite and poison consumption cases. A large section of the RMPs were also willing to join if positions were offered in 104 services at a marginal payment of Rs.2,000 per month.

ICTC and RNTCP Health Care Service

The Andhra Pradesh Health Sector Reform Programme (APHSRP) actively seeks to strengthen linkages between National AIDS Control Programme (NACP), Revised National Tuberculosis Control Programme (RNTCP) and other health services. According to National Aids Control Organisation HIV counselling and testing services were started in India in 1997. As on 31st August 2016 in India, there are 20,756 Integrated Counselling and Testing Centers (ICTC), mainly located in government hospitals. An ICTC is a place where a person is counselled and tested for HIV, of his own free will or as advised by a medical provider.

Ideally, a health facility should have one Integrated Counselling and Testing centre for all groups of people. However, an ICTC is located in facilities that serve specific categories such as high risk group, pregnant women, STI cases, TB Patients, HIV/ AIDS symptomatic patients. Accordingly, an ICTC is located in the General OPD or Obstetrics and Gynaecology Department of a medical college or a district hospital or in a maternity home where the majority of clients can access counselling and testing services. There were 18 Integrated Counselling and Testing Centers (ICTCs) in the district and five in the ITDA area. The ICTC in Eturnagaram was located in the CHC. Outreach workers namely the ASHAs, the AWWs and the ICDS staff mobilized the ANCs for HIV testing. On an average, 135 ANCs were tested for HIV at the ICTC facility at the CHC of Eturnagaram, of whom 1% tested positive. Some of the important problems faced by the infected included:

- The ICTC was located at a distance of 3 km from the bus stop in Eturnagaram.
- The infected were not visiting to have CD4 count testing or ART Centre as these facilities were located at Warangal.
- Travel cost for going to these centers was beyond their means
- The nutritional support was not given to them.

The largescale implementation of the Indian government's Revised National Tuberculosis Control Program (RNTCP) (sometimes known as RNTCP 1) was started in 1997. The RNTCP was then expanded across India until the entire nation was covered by the RNTCP in March 2006. In rural and tribal areas of Andhra Pradesh heavy consumption of gudumba (local alcohol), chewing of tobacco (thambaku) and gutka and smoking of chutta are among the important reasons for the spread of TB in Integrated Tribal Development Agency area.

In the PHC area of Venkatapur 29 TB cases were reported. The efforts of field staff in controlling the TB has hardly brought the positive results, with 15 cases of relapse. Patients are taking the CAT-I treatment and then relapsing. Use of medicines caused giddiness and vomit and increased hunger; indicating the reasons for relapse and the need for nutritional support and regular counseling to the patients. The discussion with TB patients, their household members and the MPHA (F) working in Govindaraopet area revealed that the TB

patients were discontinuing medication mainly because of gastritis, giddiness, weakness and jaundice caused by the usage of TB drugs. This suggested the need for proper counseling with regard to strict compliance to the drug regime and supplementary nutrition. Given the preponderance of cash crops in the district, the tribal households faced different degrees of food insecurity. It is essential

- to augment the nutrition support,
- to undertake nutrition education programs to follow healthy food habits and
- to scale up the nutrition rehabilitation centers provided under the ICDS in selected centers for ANCs and PNCs.

II. CONCLUSION

Rajiv Arogyasri in Andhra Pradesh has been very popular social insurance scheme with a private-public partnership model to deal with the problems of catastrophic medical expenditures at tertiary level care for the poor households. The following important problems were noticed with regard to the Rajiv Arogyasri from the study:

- The Network Hospitals (NWHs) were sending non-specialists like BAMS graduates and newly recruited medical officers to the screening camps, who were not capable of screening the patients and assessing the specialist services required.
- Patients directly approaching the NWHs were told that the relevant disease was not covered under the Rajiv Arogyasri.
- Post-operative care was not to the satisfaction of the patients.
- The Arogya Mitra Mandal Camp Coordinators (AMMCOs) were not being given the feedback on the treated patients for follow up.
- Hysterectomy was restricted to women of above 40 years though a significant number of women of less than 40 years also sought this facility in the Integrated Tribal Development Agency area.

The NWHs may explore the possibility of sending specialist medical officers to the camps. The NWHs not following the rule need to be deleted from the list of the NWHs.

In the tribal areas the operational jurisdiction of 108 services may be enhanced based on the distance between the farthest villages of the PHC and the referral hospital, including the second referral hospital. The management of 104 may examine the scope for positioning of the medical officer in the 104 service. The service must also have a microscope for testing purposes.

The Ayurveda, Homeopathy and Unani facilities had no accommodation of their own, and mainly functioned either as adjuncts to the PHCs or from the available public buildings, like Panchayat Office (Chunchupalli) and community building constructed by the Forest Department (Tadvai). The functioning of these facilities was affected whenever the premises were used by the concerned departments. The medical officer at Ayurveda facility resided 55kms away whereas the medical officer at the Homeopathy facility resided 110kms away, and both were commuting everyday to the facilities. There were no MOs at both the Unani facilities. The major health problems of patients visiting Ayurveda facility of Venkatapur included gynaec disorders, fevers, urinary tract infections, digestive tract disorders and joint pains.

The average number of patients was 15 per day. The number of patients using these services was reported to be on the decline due to the availability of only supplementary drugs and not the main drugs. Similarly, patients were consulting the Homeopathy facility at Kothaguda to get relief from arthritis, cold, cough and asthma. On an average, five patients visited the facility per day. The medical officer of this facility observed that only supplementary drugs like biochemical tissue salts, oils and ointments were supplied but not the main drugs viz., dilutions and tinctures. Supplementary drugs did not help full recovery of patients. Hence the patients were not satisfied.

In the Unani facility at Tadvai most OPs sought treatment for joint pains, cold, cough and fever. The Compounder was found to be attending the patients. The number of patients per day was 24. Due to the non-availability of the medical officer, the number of patients per day was on the decline. There were no OPs at the Chunchupalli facility as it had neither a medical officer nor a compounder.

Vacancies of MOs and paramedical staff need to be filled in immediately. Supply of drugs needs to be monitored on a monthly basis. Clear guidelines need to be given for the use of contingency fund earmarked for AYUSH dispensaries. Spending of the contingency fund must be brought into the fold of community. Local PHC medical officer needs to be made part of the decision-making regarding the use of contingency fund.

In the tribal areas since the institution of RMPs was bound to continue in the near future, it would be better if skills were given to the RMPs for identifying malaria, sugar, jaundice and giving first aid to cases of snake and scorpion bites rather than exposing the communities to completely untrained RMPs. The ICTC located at the community health centre needs to be relocated at an appropriate place at Eturnagaram as the

current location was about 3 km away from main town. The CD4 testing and ART facilities need be made available at Eturnagaram as currently available facilities were located at Warangal, a faraway place to the ITDA. Majority of the rural and tribal population may require basic primary health-care services and access to proper referral services to reduce their disease burden and financial consequences. The public need to be made aware of the advantages of using the services provided by the public health facilities. A public health campaign in mission mode needs to be taken up every year focusing on the public health facilities, timings of the facilities and services available in such facilities. The available electronic and print media needs to be utilized for this purpose.

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