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# HEALTH CARE ACCESS AND ITS CHALLENGES: A SOCIOLOGICAL STUDY BASED ON ALIKKAMPAI VILLAGE, SRI LANKA

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**ABSTRACT**

The tribal community struggle with high level of poverty and unemployment, and limited access to public services like health care. Thus, this study aims to explore how the people access the health care system in Alikkampai village and their challenges. It is completely a qualitative study. Purposive sampling method was administrated to select the samples. Semi-structured interviews were conducted with 32 persons above 18 years old from the tribal community. 06 key informant interviews were employed. Finally, this study found that the availability of health care services in the study area are very limited. Health seeking behavior of most of the people in Alikampai area changed to Western medicine from their indigenous health seeking patterns. Lack of self-awareness and inadequate knowledge were also found among the people to protect themselves from communicable diseases. Once accessing the facilities given by the public healthcare services of the government, the people who live in this area has been suffering from insufficient to cure these people's long-time health troubles. Finally, the study identified numerous challenges: (a) limited public transportation services, (b) long distance to travel, (c) high expenses for getting private health care services, (d) language issues in communicating with health care service providers and (e) social exclusion.

**KEYWORDS:** Health, Health seeking behavior, Health care services, Social exclusion, Tribal community

## 1. INTRODUCTION

Sri Lanka is a multi-ethnic society (Fernando, 2000), predominantly Sinhalese (74.9%), the majority of whom are Buddhists. Sri Lankan Tamils constitute 15.3 percent of the total population and Sri Lankan Moors 9.3%. The ratio of each of the other ethnicities (Burgher, Malay, Sri Lanka Chetti, Bharatha, and others) is 0.2% or less. Hindus form 12.6% of the population, 9.7% are Catholics and 6.2% belong to other Christian denominations (Department of Census and Statistics, 2015a, as cited in Rajapaksa et al., 2021). The country is home to 21.7 million people of whom 52% are females. The majority of the people (81.5%) live in rural areas (Department of Census and Statistics, 2015 as cited in Rajapaksa et al., 2021). Sri Lanka holds a unique position in South Asia as one of the first of the less developed nations to provide free health and education, strong gender equality, and better opportunity for social mobility (Samarage, 2006). Life expectancy at birth in Sri Lanka 75.3 years.

Healthcare Access and Quality Index (HAQI), calculated using 37 of the 50 Sustainable Development Goals (SDGs), is a proxy measure of the overall effectiveness of the healthcare system. Sri Lanka's score of 73 out of a hundred is the highest score among the comparison countries (Department of Census and Statistics, 2017a, as cited in Rajapaksa et al., 2021). Among the comparison countries, Sri Lanka is placed fourth in service coverage, although having worldwide coverage for signs such as bed accessibility, vaccination, and pregnancy care.

Sri Lanka has been able to reach a relatively great level of health while still being a low-middle-income country. The country has been able to eradicate malaria, filariasis, leprosy, polio, and neonatal tetanus and succeed near elimination of most other vaccine-preventable diseases (VPDs) targeted by the EPI. Hospital data show decreasing trends in admissions for gastrointestinal infections and parasitic diseases.

On the other hand, emerging new infections such as dengue, epidemic influenza, and leptospirosis, and the reemergence of old infections such as tuberculosis pose challenges to health (World Health Organization, 2018a as cited in Rajapaksa et al., 2021).

The health system of Sri Lanka comprises modern allopathic and further indigenous systems, with the former serving the majority of the population (Fernando, 2000). The public sector offers nearly 95% of inpatient care and about 50% of outpatient care. While the private sector is becoming a developing attendance, its services are available to only a fraction of the population due to the high expenses involved (Rajapaksa et al., 2021). The MOH offers overall stewardship and observing of government health services throughout the country (Fernando, 2000).

Sri Lanka does not have a social health insurance scheme. A semblance of such a scheme, the Agrahara insurance scheme, exists only for government sector employees (14% of employees are in the government and semi-government sectors) and their immediate family members. Limited insurance schemes are also available for some large-scale private sector companies. However, the informal sector of the country accounts for 60% of employees in the country (Labour Force Survey Annual Report, 2017 as cited in Rajapaksa et al., 2021). Another health insurance available in the country is Suraksha. This is a free health insurance policy covering school children between the ages of 5 and 19 years. The health insurance policy eases the financial burden when students are faced with illnesses, accidents, and disabilities in and out of school.

Sri Lanka is one of the prominent countries in South Asia in providing better health care services to the general public. Its specialty is providing free health care services to all without any discrimination or exclusion. However, people living in some parts of the country are still facing many difficulties in accessing healthcare services. In particular, the rural and isolated areas inhabited by the tribal people can be mentioned. Accordingly, the study acknowledged that the focus was on the Tribals living in the Alikampai Grama Niladhari Division under the Alayadiwembu Divisional Secretariat in the Ampara District, especially the opportunities and challenges for the access of health care services for women, children, and the elders.

## 2. ORIGIN OF THE STUDY COMMUNITY

Studies show that the origin of the *Kuravar* living in Sri Lanka is India. Among them two divisions can be identified as *Vanakuravar* and *Sasthirem Sollum kuravar*. The two groups have different clan customs. Among those who live in small groups widely in Sri Lanka, those who call themselves Vanakuravar live in the eastern, north central, and uva provinces of the country. Some of the Sri Lankan people call the Vanakuravar in the term of Narikuravar (Guhaballan, 2000; Rameez et al., 2017). Archaeologists say that both the Vanakuravar and the Narikuravar may have lived in southern India from the 6$^{th}$ to the 7$^{th}$ century. Because the language pattern practicing by the Vanakuravar presently is not related to the language pattern practiced in the Indo-Aryan culture. On the other hand, as Telugu speakers, South India is their homeland (Thananjayarajasingham, 1973 as cited in Widyalankara, 2015; Dissanayaka, 2017). However, there are no authentic records of a gypsy migration from India to Sri Lanka.

It is not possible to say definitively when and how they came to Sri Lanka. In the records of British, Portuguese and the Dutch were not mention about the Vanakuravar. There is no evidence of their arrival before the arrival of the Europeans. There has been periodic political unrest not only in South India but throughout India. They may have fled the country to protect themselves in those days. Therefore, in summing up all this, that the arrival of the Vanakuravar must have been within a few hundred years (Guhaballan, 2000). Likewise, Okely (1983) assumed that gypsies found both in Europe and in Asia are descendants of migrants from India around 1000 A.D.

The nomadic Vanakuravar has been living by trekking from the Point Pedro in the north to Dondra Head in the south and from Sangaman Kanda, Ampara District in the east to Colombo in the west. Despite the expulsion of settlers from the arid areas since the 1950s, some of the minorities have relocated to the

forests of the Eastern Province, namely the Batticaloa and Ampara districts (Widyalankara, 2015). Guhaballan (2000) stated that, after 1950s, a group of the Vanakuravar migrated to the forests of Polonnaruwa, Trincomalee, and Batticaloa. They pursued their livelihood by setting up temporary settlements, especially in the forest areas of the Ampara district. In particular, they have been living in the forests of *Puliyadipitiya, Mottayandaveli, Mullikkulam, Ambalattaru, Odiyaveli, Velvenda, Panayaruppakkeni,* and *Hingurana* from time to time. Following this, they settled in *Periya Vihara, Sinne Vihara, Sangamithakulam, Mikkeni, Kandamveli, Mudirichelai,* and some other places.

The Vanakuravar who lived as nomads when no one cared to change their lives. Rev. Fr. Godfrey Kook wanted to make a change in their lives. He founded St. Xavier's Church in Alikampai, Akkaraipattu in 1961 and baptized the Vanakuravar those who wished to convert to Catholicism. As well as huts built to help get rid of nomadic life. However, despite the establishment of permanent residences, they did not abandon their traditional way of life (Guhaballan, 2000; Rameez et al., 2017; Ilma et al., 2020). Initially, they led a nomadic life. However, due to the distribution of agricultural lands in the areas belonging to the Alikampai, some people were interested in agriculture. However, they have also been involved in begging, palm reading, soothsaying, snake charming, and hunting (Widyalankara, 2015; Dissanayaka, 2017).

## 3. PROBLEM STATEMENT

People in Alikampai village face challenges while trying to access health care services. They are understudied population, and so far, no formal study has been done about their health status and health access, apart from the present one. Generally, they having low level of socio-economic condition, high level of poverty and unemployment. In this situation, they face institutional marginalization also in access of public services like health care. Thus, this study aims to explore how the tribal community access the health care system and its challenges in Alikkampai village?

## 4. LITERATURE REVIEW

Zafiu (2017) assesses the intersection of gender, education, socio-economic status, and nomadism, and its influence on health behaviors and health care access of the "Gypsy" seminomadic Narikuravar community in Tamil Nadu, India. Finally, this study revealed that the low education level of women and their semi-nomadism negatively affect their access to information about accessing health services and the study community faces stigma and discrimination while accessing health care. Likewise, Lau & Ridge (2013) found that the members of the Gypsy and Traveller community suffer significant inequalities in all health and social spheres in the UK. Widyalankara (2015) highlighted that the Sri Lankan gypsies are identified as a marginalized micro-community. But the state has adopted measures to assimilate them into the macro society. The gypsy people in Vakarai were provided with national identity cards, birth certificates, and marriage certificates. Their children are enrolled in schools. They have access to medical care.

Cleemput (2010) presents the health impact of Gypsies and travelers due to social exclusion in the UK. Although Gypsies and travelers remain extremely marginalized in wider UK society. There is a clear commitment at the national health policy level to work in partnership with Gypsy and Traveller communities to reduce their health inequalities and to improve their access to health care. Travelers have 'possibly the highest maternal death rate among all ethnic groups' (Lewis & Drife, 2001).

However, Cemlyn et al. (2009) found that the health status of Gypsies and Travellers is much poorer than the general population. This review study covers Romany Gypsies, Irish Travellers, Welsh Travellers, Scottish Gypsy / Travellers, New Travellers, and Occupational Travellers (including Showpeople). Results of the quantitative survey of Parry et al. (2004) show that Gypsy and Travellers have significantly more self-reported symptoms of ill-health than other minorities in the UK. According to many studies, there is often a poor take-up of preventative healthcare by Gypsy and Traveller women, especially well-

women care and immunization programs (Scottish Executive, 2001; Jenkins, 2004 as cited in Cemlyn et al., 2009).

Moreover, Research on health outcomes indicates that Gypsies and Travellers have the worst physical health outcomes of any ethnic group in the UK (Parry et al., 2007). Common factors are poor maternal health, premature death of offspring, and ten years lower life expectancy (Leeds Census Study, 2005 as cited in Lau & Ridge, 2013). Rameez et al. (2017) found that the impact of communicable diseases is high in Alikampai. Contaminated water and poor hygiene habits are also major causes of infection in these Vanakuravar. Likewise, genetically-transmitted diseases are also very high like these poor health status communities; for example, Sony (2016) discusses his work with the Narikuravar community in Tamil Nadu, showing a high incidence of Alkaptonuria, or "black urine".

Jayasinghe et al. (2021) emphasized how water scarcity affects the socio-economic, cultural, health, and hygienic aspects of Vanakuravar life in Aligambai. In this backdrop, this study aimed to underline that several CKDu cases have been reported from the area, and it may be due to poor quality water consumption from the wells. Further, the women in the village are suffering a great deal due to an inadequate supply of safe water for daily needs, and it has created tension and imbalance in their household chores. Cleemput (2007) explores the barriers to accessing primary care health service provision for Gypsies and Travellers in England. This study emphasized that the health staff response to Gypsies and Travellers at two levels; in the context of the wider social and political climate and the context of specific influences a local health care setting in terms of policy, ethos, and local demography.

The report of the European Monitoring Centre on Racism and Xenophobia (2003) aims to contribute analysis and policy options to eliminate discrimination in and improve access to health care for Roma, Gypsy, and Traveller women and their communities. Finally, this study found that inadequate attention has been paid to Romani women and access to health care at either national or international levels. Roma may experience various kinds of direct and indirect discrimination in accessing health care. These include refusal of assistance by general practitioners or health care institutions; segregation in health care facilities; inferior and degrading treatment; and difficulties in accessing emergency care imposed as a result of their ethnicity.

## 5. METHODOLOGY

The data for this study have been obtained from both primary as well as secondary sources. The research articles, reports of governments and international organizations, news websites, statistical data of Alayadivembu Divisional Secretariat, and other electronic and printed sources were used to collect the secondary data. It is completely a qualitative study. Purposive sampling method was administrated to select the samples. Semi-structured interviews were conducted with 32 persons above 18 years old from the tribal community. 06 key informant interviews were employed in the study area.

The interview was included the following parts. (a) General information of respondents, (b) Health care access of people, and (c) Challenges confronted by them. Collected data have been analyzed and presented in an interpretative way in this study.

Aligambai GN Division is divided into two sub-villages as Thevakiramam and Santhipuram. It is situated in the Alayadivembu D.S Division at a distance of 15km in the South – West direction from the Akkaraipattu town. It is bounded by *Neeththayaru* in the North, by *Thalipooddaru* in the South, by *Vachikuda*, *Sagama Road* in the East, and by Thamana DS Division in the west. Aligambai, a rural remote village with a population of 1171 people of which males are 573 and females are 598 out of 353 families, is one of the 22 G.N. Divisions of Alayadivembu Divisional Secretariat Division in the Ampara District of the Eastern Province of Sri Lanka. The extent of this village is 33.61Sq.Km.

## 6. RESULTS AND DISCUSSION

This part of the study covers three main areas. The first part is an analysis of the age, education level, occupation, and income level of the respondents, the second part is an analysis of the information, awareness, usage, and availability of health services related to the health care practices of the respondents, and the third part is an analysis of the challenges faced in obtaining health care services by the respondents. To find out this the analysis has been carried out on the background of the data obtained through interviews, observation, and secondary data. Also, the real names of the respondents are not used here at the discretion of the respondents considering the ethics of the study. The following table details the general information of the respondents.

### *6.1 General information of the respondents*

**Table 02: General information of the respondents**

| **Age** | | **Education** | | **Occupation** | | **Income** | |
|---|---|---|---|---|---|---|---|
| **Age group** | **No. of respondents** | **Educational level** | **No. of respondents** | **Occupation category** | **No. of respondents** | **Income Level** | **No. of respondents** |
| 19-24 | 7 | Non-schooling | 13 | Unemployment | 21 | Below 5000rs | 22 |
| 25-44 | 10 | Up to grade 05 | 11 | Retail shop | 01 | 5000-10,000rs | 08 |
| 45-60 | 10 | Up to grade 10 | 07 | Begging | 01 | 10,000-15,000 | 01 |
| 61-80 | 05 | Higher education | 01 | Fishing, cultivation and others | 10 | Above 15,000 | 01 |
| **Total** | **32** | | **32** | | **32** | | **32** |

Source: Prepared by researchers

### *6.2 Access to health care and services*

#### 6.2.1 Availability of health care services

The availability of health care services in the study area is found to be very limited. Because there is no separate hospital or health center. There is a divisional hospital *(Panankadu Divisional Hospital)* within the A layadiwembu Divisional Secretariat. However, people have to go to Akkaraipattu Base Hospital, 22 km away, to get better health services. However, 2 days a week the health service staff from Panankadu hospital will visit the primary medical care unit in the Alikampai area. One of the respondents mentioned:*"A lady doctor comes here on Mondays and Wednesdays. She gives us medicine for common ailments like fever, cough, and joint pain. Yet there are no medicines here for the serious diseases that afflict us. For that, we have to go to Akkaraipattu Base Hospital"* (Interview-10).

When asked the doctor about the above statement of the respondent, she replied as follows, *"At least 60 patients visit here a day. Most of them are found to be suffering from respiratory ailments and injuries. There is no equipment to store some of the drugs other than the ones we can bring here for the initial testing and medicines for them. So, the patients are sent to the Akkaraipattu hospital. These people need a health care center that can provide services all day of the week with at least one ETU facility"* (Key informant interview-03). Another respondent said: *"MOH and midwife visit on Mondays and Thursdays. They often provide services for pregnant women and children. In particular, services such as height, weight monitoring, vaccination, and triboza (nourishment flour) delivery will be provided" (Interview - 01).*

Services such as scans are not provided here except for the early-stage tests for pregnant mothers. They are being called to Akkaraipattu Base Hospital for further tests. When a pregnant woman mentions during the study, *"I am now the seventh month. This is my second child. I have to go to the hospital for further testing. It will take at least an hour to get there by bus"* (Interview-23). Although most women in the study area are

interested in accessing their health care services, but they are less likely to receive such services due to long distance to travel.

### 6.2.2 Health care-seeking behavior:

When looking at the health-seeking behavior of the people of Alikampai area, most of them seek western medicine. However, self-medication and home remedies were also found to be intermittent. A housewife quoted: *"If anyone in my house has a fever, cough or sneeze, first put lemon leaves and tea powder in boiling water and breathing in it. We will only go to the hospital if the disease does not cure"* (Interview-9, 11 & 30). Remedies like these can be found in many parts of the study area. This is because the area is mostly surrounded by forests, hills, and paddy fields which make it easy to get naturally growing herbals. Frequent infectious diseases in the study area include fever, cough, abdominal pain, toothache, and animal bites. According to the principal, *"Last week, a student was bitten by a snake while holding it in his hand on the school premises. Actually, that was a large cobra. We immediately admitted him to Akkaraipattu Base Hospital"* (Key informant interview-02).

The general public who are attacked by venomous creatures like snakes seek western medicine today. However, the study found that in the early days indigenous medicine was used in such emergencies. As well as those who engage in such practices are highly valued in society. A younger man stated: *"My grandfather had a 'visekkal' (poison sucking stone). If the snake bites, he will cure it. But he is not currently alive. Unfortunately, me and my family members did not learn his traditional medical practices"* (Interview-16).

There are no private clinics in the study area. Thus, the people get their services from the public health service centers. They go to public health service centers like hospitals and MOHs for weekly and monthly series of health care services and other medical services. Examples include diabetes, blood pressure, and cardiovascular diseases. An unmarried woman said: *"My father is an old man. He has diabetes. He should go to the Ezhuvattuvan hospital for a monthly check-up. He has poor eyesight also. So, I need to go with him for help. But now we are unable to go there due to the current covid-19 pandemic. He has been doing home medicine"* (Interview-30).

### 6.2.3 Awareness of health:

The health awareness of the respondents was concerned by focusing on their health-seeking behavior. It includes the diseases that afflict the people and their severity, efforts taken by the people to cure it, vaccination, gestational health practices for women and access the free ambulance service. The study found that women were more likely to be vaccinated and to have pregnancy test. The main reason for this that the awareness provided by Midwife and MOH. It is also worth mentioning that everyone is aware of the free ambulance service in the study area. An old man said: "*We call ambulance at night or during the day for sudden chest pains, such as heart attacks. Neighbors, relatives or Rev. Fr. will help those who do not have telephone facilities"* (Interview – 08,10,13,15 & 20).

The awareness of dengue, diarrhea, malaria, and other major diseases is low among these people, there is a lack of self-awareness to protect themselves from it. Thus, many casualties have been reported here. Rameez et al. (2017 p. 8) pointed out in their study as follows. *Public health medical reports indicate that 105 dengue patients were detected in Alayadiwembu DS area during the period from 2006 to 2016 (RDHS, Kalmunai, 2016). Among such victims, some are from the Alikampai Vanakuravar.*

Although awareness of the coronavirus is found among the Vanakuravar community. However, it was also possible to observe some misunderstandings regarding its spread. The woman responded to a question asked in the study regarding the spread of the coronavirus and compliance with health guidelines, *"When the coronavirus spread in the country, we bathed with detergent more times than ever before"* (Interview-29). Awareness on covid-19 was provided to the study area by the church. That is, the Rev. Fr. led team there was informed of the impact of the covid-19 and urged to follow health guidelines. Also, those who went outsides for work were banned during this period. A woman respondent mentioned: *"I have four children. My husband goes to every area and does the wage work available there. My whole family lived on the income from it. But he did not go for the wage work during the lockdown. My family and I are in a lot of trouble now"*

(Interview-05). However, it was observed that the use of face masks was less common among these people.

### 6.2.4 Knowledge of health care services

When looking at the knowledge related on health care services and existing health practices, it is rarely seen. Proper knowledge related to early marriage, early pregnancy, miscarriage, maternity, and family planning is very low specially among women in the study area. A newly married woman stated with great sadness: *"I am currently 19. I got married last year. I had an unbearable cough while the baby was in my womb. The cough reached an acute stage at 8 months. The baby died in the womb. The baby was taken out after a cesarean. It was the male child"* (Interview-01). Thus, various incidents have been reported in the study area.

The women those who underwent family planning do not have a complete understanding of it. That is the above woman who did the family planning as the doctors advised her that is needed three years to conceive again after the previous incident. Even she noted: *"The doctor advised me not to conceive for another 3 years and that doing so would endanger my life. So right now, I put the rods in my arm (one of the family planning method)"* (Interview-01).

The above-mentioned family planning method is called by the name of 'Jadelle'. This implant is made up of two small rods that the size of a matchstick. The rods are put under the skin inside of a women's arm. They slowly release a hormone called progestogen. They work for up to five years. Women can have them taken out whenever they want. The above respondent is also doing it without knowing the real name of the method and any of its pros and cons.

### 6.2.5 Public health care services given by Government in practice:

They also have access to the Suraksha children's insurance policy granted by the Ministry of Education. Principal of KM/TK/ST Xavier's Vidyalaya, Alikampai said: "*Students get Suraksha insurance when they are admitted to the hospital for accidents, surgeries and snakebite. About 15 students have received this insurance during my tenure"* (Key informant interview-02). Midwife stated: *"All pregnant mothers in the Alikampai area who have registered in the government's maternal clinics will get Nutritious food worth Rs. 2,000 per month during the last 6 months of pregnancy and for the first 4 months after the delivery of the child under the Health Maternal Programme of Sri Lanka's government"*. The study area can be able to activate the free ambulance service also.

## *6.3 Challenges faced in obtaining health care services*

### 6.3.1 Time and cost

The biggest challenge facing Vanakuravar living in the Alikampai area in accessing health care services is the time and cost of going to the health care service centers. This means that due to the lack of hospitals in the area, it is necessary to go to the Ezhuvattuvan Divisional Hospital or the Akkaraipattu Base Hospital. It is noteworthy that the above-mentioned hospitals are located at a distance of 12 and 32 km from the Alikampai area respectively. The pharmacy is also located at a distance of about 16 km from the area. And if they want to go to these, they have to go by public bus. The public bus comes here only twice a day. The bus will arrive between 7.00 am to 8.30 am and 1.30 pm to 2.30 pm. If they miss it, they can go on a three-wheeler or a tractor. However, the hire fee for that is very high.

The opinion of one of the respondents in the study was found as follows, *"If I want to go to Akkaraipattu Base Hospital by bus, I will need 150 rupees. At the same time, for the three-wheeler, I will have to pay at least up to 1200 rupees. I would never go to the hospital if I missed the bus. The reason is I do not have enough money to pay for a three-wheeler. There are no own vehicles for my family. There is only one bicycle. It will take more time to get there"* (Interview-06). Thus, people can spend more time and even go to the hospital by bicycle or any other own vehicle,

the number token given to consult the doctor is very far away so there will be wait long time. The study also found that sometimes the time it takes to distribute number tokens can be exhausting.

### 6.3.2 Social exclusion

Social exclusion is seen as another important challenge faced by the study community. They are subjected to the most severe exclusion and discrimination when moving from the Alikampai to other areas to obtain health care services. Sometimes this can be due to their appearance, possessions, and habits. Most of the respondents in interview stated: *"When we go to the hospitals some of the staff there exclude us. They think of us as unclean and treat us like untouchables. Particularly the minor workers there are also treat us with disrespect. Thus, we never want to be called by the word 'Kuravar'. We want to live like a centralized community"* (Interview-02, 17, 25 & 27). Due to the exclusion and some kind of discrimination, some are reluctant to access public health services in the study area.

However, it is a pity that the Alikampai Vanakuravar has not yet been selected as a doctor or nurse from their community. Thus, they firmly believe that only when health workers are selected from within their community, they will be able to change the exclusion from the mainstream community. Children and adults are found to be in the habit of betel consumption. At the same time, they consider it proud. Yet these people are still unaware of the health risks of this habit. One of the key informants said that even this habit sometimes causes them to be ostracized by the health service staff.

### 6.3.3 Language

"Telingu language versions of 'Tulu' is the spoken language of the Alikampai people. Their second language is Tamil. There is not a single adult in the present Sri Lankan Vanakuravar community who is aware of its written version" (Dissanayaka, 2017 p.339). Thus, they may face language problems wherever they go. Most of the areas around Alikampai are mostly Tamil speaking. In this case, it's a little difficult to understand, even when they are talking normally. The study found that many health care workers face various difficulties in understanding their physical and mental health problems when seeking out health care services in such a situation. They also point out that the language problem is exacerbated when they go to urban hospitals for further treatment. The main reason for this is the Sinhala language in use there. Thus, the spoken language of these people is also an issue in getting services from the Sinhala-speaking health workers.

## 7. CONCLUSION

The opportunities for access to health care facilities for the people in the study area are found to be very limited within the territory of the study area. People have to travel about 22km to get improved or 24-hours health care services. Alikampe people can access the public health care services given by Government. Although the study identified some practical barriers to obtaining it. More over indigenous medical practices, which were once found in the study area, are now weakened and they prefer Western medicine today. Physical and mental health, health care-seeking behavior, knowledge, and awareness related to health care services are less among women. The study also identified challenges such as limited public transportation services, long distance to travel, high expenses for getting private health care services, language issues in communicating with health care service providers and social exclusion in accessing health care services.

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