CHAPTER ELEVEN

# HEALTH SERVICES

The organisation of health care in the tribal areas is bound to be much the same as for other rural districts throughout the country. In view of the special circumstances of the tribal areas, however, the method of execution will naturally vary, in relation to the local cultural pattern, customs, habits and environment. For example, the tribals often live in small and widely dispersed communities, and it is thus necessary to have mobile services, so that medical services can be carried to their very doors.

It is essential to have a survey of the area to ascertain the health problems and thus give priorities for effective development of the programme. Past experience has shown that certain specific diseases are specially common in the tribal areas and naturally high priority should be given to them.

*Primary Health Centres*

The Primary Health Centre is a unit whence integrated health care has to radiate into the homes of the tribal people. Its location should be decided by the Block Development Committee after taking into consideration the following criteria.

(1) Service to the maximum number of people ;
(2) Health problems of the area as revealed by a survey ;
(3) People's participation; and
(4) Easy accessibility for referral services.

*Construction of Buildings*

The buildings of the Primary Health Centre should be simple and inexpensive. They should be constructed as far as possible with locally available material (but there must be a really *pucca* Operating Theatre) and the design should conform to the local environment. The main criterion should be its utility and capacity to offer service. The establishment of sub-centres should also be of a similar pattern.

*Basic Services*

These consist of :

(1) Medical relief;
(2) Maternal and child health care including family planning and training of Dais;
(3) School health ;
(4) Health education;
(5) Control of communicable diseases, with priority for malaria and small-pox ;
(6) Environmental sanitation—with high priority for safe drinking water; and
(7) Collection of vital statistics.

*Medical Relief*

Medical coverage in almost all the Tribal Blocks is extremely inadequate and even when there is money and sometimes even when buildings

for hospitals and dispensaries have been erected, doctors, nurses, compounders and midwives are unwilling to come and serve in such remote places.

It is true that in Andhra Pradesh, Bihar, Orissa and Rajasthan there are medical officers in all the Multipurpose Blocks, and it is only in Nawhatta (Bihar) that the first appointment was made as late as July 1959. But in other States the position is serious and disappointing.

In Assam although in Lungleh, Saipung-Darrang and Mairang the posts were filled in good time, by the middle of 1957, three of the seven Blocks are still without their own doctors and no doctor was appointed to Dambuk-Aga until 1959.

In Bombay, the situation is even worse, although the Multipurpose Blocks here are in the main conveniently located and have made good progress in other ways. The following facts are significant.

Aheri : No doctor appointed until September 1959.
Akrani Mahal : No doctor appointed until August 1959.
Dharampur : The post has been occupied for only two months (October-December 1959) during the whole progress of the Block.
Khedbrahma : A doctor has been appointed.
Mokada-Talasari : A doctor was first positioned in November 1958, but left after two months. A second doctor worked from January 1959 until the middle of April of that year, but since then the Block has been without its own doctor.
Peint : No doctor has yet been appointed.
Sukhsar : No doctor was appointed until April 1959, but did not join his post. Another doctor was appointed in December 1959, but he too did not take up his duties.

In Madhya Pradesh there are ten Multipurpose Blocks, and doctors have been appointed to only three of them, and even then very late : Bhimpur did not get its doctor until January 1959, Pushparajgarh until September 1958, and Dantewara until March 1960. The remaining seven Blocks have never had a doctor on their staff at all.

In the Tamenglong Block no appointment was made until the 28th October 1959, but the doctor concerned had not taken up his duties even by the end of March 1960. In the Amarpur Block of Tripura a doctor was appointed in November 1958, but resigned in June of the following year. By March 1960, the Block was still without a medical officer, though an appointment letter has now been issued.

This does not mean, of course, that the Block areas have been entirely without medical coverage. Doctors of the State Health Departments, missionaries and voluntary organisations have sometimes filled the gap. But it is disconcerting to find that where there are so many posts provided in the Block budgets, so large a proportion has been left unfilled.

In order to meet this very serious shortage of medical staff we suggest that, as in Andhra Pradesh, there should be a certain period of service in a tribal area for all doctors as a condition of promotion, crossing the efficiency bar or for being sent for higher studies in India or abroad. Those doctors who serve well should receive special commendation in their Character Rolls and be considered for accelerated promotion.

Mobile Units should be placed as a matter of routine in centres at some distance, where practicable, from the main Health Centre and the Block

headquarters. The value of these Mobile Units has been questioned, but we feel that in many Blocks they have done useful work and that provided the doctor or compounder attends regularly at specified places, specially if this is done on bazaar days, a lot of good can be done.

We, feel, however, that it is unrealistic to provide these Mobile Centres in the tribal areas with ambulances or large vans which often cannot get along the rough roads or tracks even in the fine weather. An ordinary jeep is quite sufficient to take a doctor with his staff and medicines to a number of outlying villages. Serious cases can easily, by a little ingenuity, be accommodated in a jeep and brought back to hospital. It might even be considered whether an improved type of bullock-cart could not be sometimes used by the Mobile Units; in NEFA these Units have to move about in the most difficult country on foot, and doctors there have performed successful operations under the most impossible circumstances in village camps without any assistance from motor transport. Special financial provision will, of course, have to be made for this type of touring, as we have suggested elsewhere.

*Medicine Chests*

Medicine chests should be provided at the rate of at least one for each V.L.W. circle. These chests can be kept under the charge of the V.L.W. or school-teacher. The most important thing is that arrangements should be made to refill these chests and maintain them properly.

*Maternal and Child Health Care*

These are the essential services and deserve highest priority. In view of the difficulty in getting women to go to these areas, short training courses should be started for tribal women who are carrying out domicilary midwifery at present. This training should preferably be carried out on the spot and will require a mobile team of a health visitor and a trained midwife. It is essential for the staff to be fully conversant with the existing practices and beliefs in relation to maternal and child-health care, so that service training can be integrated with them. This scheme must always include health education for the improvement of nutrition, environmental sanitation, control of communicable diseases and improvement of other personal health services. For its effective development it may be necessary to enlist the active help and participation of the local Mahila Samithis and Health Committees.

*School Health*

Children of school-going age form a large section of the population and it is necessary to inculcate healthy habits and hygienic practices among them. A comprehensive programme for the medical examination of school children with adequate arrangements for the correction of defects, immunisation, improvement of environmental sanitation, supply of drinking water and provision of mid-day meals, should be developed. Kitchen gardens and orchards (as in Orissa) should be developed in every school.

*Control of Communicable Diseases*

The National Malaria Eradication programme is already in operation in those areas where it is a problem. In addition, steps should be taken for

the eradication of certain other diseases like leprosy, yaws, goitre, small-pox, V. D. and so on wherever they have a high incidence.

*Drinking-water*

The provision of drinking-water wells is a subject which is beyond controversy, one which can do nothing but good, and which is of incalculable benefit to the tribal people. While it would be an exaggeration to say that most of the people have to walk three or four miles to get their water, there is no doubt that they do have difficulty in getting a supply of really clean drinking-water and we urge that this programme should be given very high priority. In some places the people are not used to wells and prefer to draw water from running streams. Here cisterns, such as have been built in Orissa, can be a valuable substitute.

We feel that the cause of health and sanitation will be better served by concentrating on wells at present and since it is the general policy to simplify the programme, the erection of latrines and bathrooms which in any case are rarely used, can be postponed for the time being, as we have suggested in Chapter Sixteen.

*Health Education*

This is one of the most important items of every basic health service.

To accomplish his goal the health educator should be familiar with the nature of the culture and the way of life of the people, their values, beliefs traditions, customs and taboos about health and illness. He should understand the objectives for which the people are willing to strive, and conversely, the aspects of life that mean very little to them or they are as yet unable to understand. He should know what the people can understand and what they will reject. Having once learned these facts he can work with the people in planning and using educational measures which will harmonize with their life and character.

One of the great difficulties about spreading the use of modern medicine in the tribal areas is the existence of the local priests or medicinemen in whom not only the tribal people but a large number of the Indian peasantry retain considerable faith. Some doctors resent the existence of these tribal practitioners; their work is sometimes held up to ridicule in cultural shows and there is a great deal of propaganda against them. We suggest that a more positive attitude might have better results. In parts of North America, Indo-China and very widely in NEFA a policy has been adopted of looking on the tribal doctor as an ally rather than as a rival. His prayers and incantations do, in actual fact, have a psychological value in freeing a patient from a sense of guilt (which sometimes is the actual cause of an illness) or from anxiety and for promoting the will to live. Doctors in the tribal areas might well enlist the assistance of the tribal medicineman and encourage him to perform his sacrifies and prayers, while he himself gives regular treatment of the modern kind to his patient. This is not so revolutionary as it may seem, for even in the developed civilizations of the West it is a common practice to call the priest as well as the doctor in a serious illness. Moreover, there are many natural remedies, decoctions of forest herbs or healing lotions known to the tribals and, where these are found effective, are by all means to be encouraged.

The new ideas and concepts which health education introduces will give good results only if they can be integrated with the existing values of the people. For the worker in the field of health education, as in any other programme for human development, the importance of good human relations cannot be over-emphasised. The field worker must remember the value of first impressions; the method of his approach should make him acceptable—it should be friendly and human and he should be ready to work with the people; he has to be exceedingly patient and should be able to talk to them in a 'language' they understand.

*Collection of Vital Statistics*

The Health staff should have accurate statistical data based on surveys conducted by the Department of Health or by other departments as its dispostal which will give a fairly accurate picture of the local health problems. On the basis of this, the Medical Officers can plan their programme.

*Progress in the Multipurpose Blocks*

A great deal of good work has undoubtedly been done wherever it has been possible to position an adequate medical staff. The tribal people are beginning to realize the value of modern medicine and although at first they were unwilling to come to hospitals or dispensaries they are now doing so in ever greater numbers.

In so far as figures of expenditure are any guide, most of the Blocks have used from thirty to thirty-five per cent of the allocation of two lakhs of rupees for Health and Rural Sanitation in their schematic budgets. Orissa, for example, has used 63·76 per cent of the total allocation for its four Blocks and Bihar has used 45·71 per cent for its eight Blocks. Some of the individual Blocks have done better than this. Araku has spent nearly 50 per cent; Kundahit, 68·25 per cent; Kushalgarh, 60·38 per cent; Akrani Mahal, 52·88 per cent; Paderu, 54·32 per cent; and Tamenglong, 54·42 per cent of the money available.

On the other hand, the progress of some other Blocks has been very poor. Aheri has only used Rs. 25,349 or 10·35 per cent out of an increased allocation of Rs. 2,45,000. Mokhada-Talasari has spent only 12·07 out of a total budget provision of four lakhs. Peint, which has done very well in other subjects, has used only 22·24 per cent on Health as against 89·40 per cent on Housing. Sukhsar has spent Rs. 29,794 or 15·28 per cent on Health Services but Rs. 46,979 on Social Education and Rs. 51,962 on Arts and Crafts. Utnur has spent 15·35 per cent, Narasampet 23·60 per cent and Pushparajgarh 29·37 per cent.

Amarpur has only spent Rs. 36,063 on Health but has used Rs. 87,421 on Social Education. Adhaura has only spent Rs. 10,765 on Health, but two-and-a-half lakhs on its Project Headquarters.

*Orientation*

In view of the special nature of the work in the Multipurpose Blocks, it is essential that all the members of the health staff, and specially the doctors, should undergo orientation training in the basic philosophy of the general programme as well as in the special health problems of the locality. They must learn the latest developments in extension method and how to work with the tribal people.

*Conclusion*

Tribal India offers a unique challenge and unparalleled opportunities of experience and service to our doctors and nurses. It will not perhaps give them very much money : for some years to come they will have to work under conditions of discomfort and loneliness ; they may have to travel over bad roads in an unkind climate ; they have to break down centuries-old prejudice and suspicion. But for them there is all the thrill and adventure of being pioneers of modern science, the privilege of extending the healing, friendly hand of modern India to her most neglected people in her remotest villages.