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GOVERNMENT OF MAHARASHTRA

A Study of Health Services In Selected Tribal Areas

by

Tribal Research & Training Institute,
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C O N T E N T S

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PREFACE

The Government of India, Ministry of Home Affairs, had suggested to take up a Quick Sample Study through the Tribal Research Institutes so that a clear profile of the health services in the tribal areas is available at the national level.

Accordingly the Tribal Research & Training Institute, Maharashtra State, Pune, took up a Quick Sample study of the Health Services in the selected tribal areas as per instructions of the Government of India.

I am extremely thankful to Dr. B.D. Sharma, Joint Secretary, Ministry of Home Affairs, Government of India and Shri M.P. Rodrigues, Director (T.D.), Ministry of Home Affairs, Government of India for their able guidance in the study. I am also grateful to Shri K.V. Seshadri, Secretary and Tribal Commissioner, Social Welfare, Cultural Affairs, Sports and Tourism Department, Maharashtra State, who kindly allowed us to make use of the services of the entire staff of the Integrated Area Development Programme Cell for carrying out a Quick Sample Survey of Health Services in the selected tribal areas without which the the work would not have been completed in time.

I have also to thank Dr. Badade, Assistant Director, Health Department, Government of Maharashtra, Deputy Director (Integrated Area Development Programme Cell) and his staff, and my colleagues and the staff of the Tribal Research & Training Institute for their co-operation in completing the study. I am thankful to Shri S.R. Kute, who took lot of pains for typing the Report neatly in a very short time. I am sure that this study will be helpful to the administrators in understanding and planning the Health Services in the tribal areas of Maharashtra State.

G. M. GARE
Director,
Tribal Research & Training Institute,
Maharashtra State, Pune.

CHAPTER I

OBJECTIVE AND SCOPE OF THE STUDY

Introduction

1.1 The tribals suffer from many chronic diseases, the most prevalent of which are water-borne. The drinking water supply in many of the tribal areas is very poor. In the hill regions people have to go far down the hills to get water. Even when water is available, it is often dirty and contaminated. Consequently, the tribals are easily susceptible to intestinal diseases; skin diseases, diarrhoea, dysentry, cholera, guinea-worm, which is intensified by nutritional deficiency so common among the tribals in the hilly and forest areas. The tribals have not yet developed an immunity and when they come in contact with new diseases they fall an easy prey to them. The incidence of T.B. seems to be more for that reason.

1.2 One of the horrid diseases of which the tribal is mortally afraid is Yaws which occures in many tribal areas in the country. Hansen's Disease as leprosy should now be called is common through India and has not spared the tribal people. Scabies, ring-worm, small-pox, anaemia, veneral diseases are also common in tribal people.

1.3 One of the most important problems in connection with health is the addiction of the tribals to ~~partiei~~ spiritious and intoxicating liquor and drinks.

1.4 It is generally believed that the tribals are averse to modern medical treatment and that they take to superstitious cures and Bhagat's magic formula. The situation in this behalf is more alarming in primitive and

more backward areas and backward tribes. In other areas the situation is not more alarming. Given the general health education and facilities they are willing to avail the same.

1.5 In the Sub Plan area medical facilities are made available through Primary Health Centres, Dispensaries, Hospitals, Primary Health Sub Centres and Family Planning Centres. There is one rural hospital, 27 Primary Health Centres, 82 Primary Health Sub Centres, 85 Family Planning Sub Centres in tribal Sub Plan area of Maharashtra State. The population served by each doctor is about 47,000 in tribal sub plan area.

Object of the Study

1.6 The review of the health services in the tribal areas shows that coverage in some of the regions is extremely poor. This fact has been brought out glaringly by the State Sub Plans and the different I.T.D. Projects. In view of this problem, the Planning Commission had agreed to relax their norms for health coverage in the tribal areas, within the overall sectoral ceilings for the health services. In some cases even the special Central assistance has been allowed for utilization to solve specific problems. With all these measures even it is felt that the problem has not claimed the attention which it deserved.

1.7 It also appeared that even our own understandi of the problem, the extent of utilization of services, the precise reasons for non-acceptance of the modern medicine in some areas is not adequate. The tribal family believes in the natural cause of various diseases including

even small pox, cholera etc. If the tribals believe in natural causes there is no reason why modern medicine system should not be acceptable to them.

1.8 In the fifth Five Year Plan all these aspects were considered by the Planning Commission and it was envisaged that the health services in the tribal areas will be planned with reference to the needs of each specific area. The Planning Commission agreed to the relaxation of norms of the institutional infra-structures for these regions. It was also decided that the special problem of each of these areas will be identified and programme will be prepared with reference to those specific issues. A review of the efforts so far shows that these objectives have hardly been realized in the field. Planning continues to be schematic and the more backward communities and the backward areas continue to be without effective health coverage. The medical institutions in the tribal areas are also set up in more advanced centres where the clientele of advance sections - generally migrants, is available. The national policy on Family Planning has made good, nay spectacular progress in some of the tribal areas where effective health coverage, however, remains to be provided. This new situation, therefore, needs to be immediately attended to so that initial success in Family Planning in these areas can be consolidated.

1.9 Thus, in view of the urgency of this matter, it was decided by the Ministry of Home Affairs, Government of India, to take up a quick sample study through the Tribal Research Institutes so that a clear profile of the health services in the tribal areas will be available at the national level. This will help in taking important policy decisions in relation to the health programme in tribal areas.

Scope of the Study

1.10 The primary object of the health facility survey was to find out the health problem in tribal areas viz., whether the health facilities provided by the Government are enough to cater to the needs of the tribal people. There are number of aspects which need to be studied for understanding this situation. The following are some of the important aspects:-

i) Geographical coverage of the tribal areas by curative and para-medical institutions;

ii) Infra-structural built up at these centres including:-
   a) Physical infra-structure,
   b) Technical infra-structure, and
   c) Personnel.

iii) Utilization of the infra-structure
   a) Actual geographical coverage,
   b) Group coverage, and
   c) Disease coverage.

iv) Role of different functionaries in solving and their perception about the health problem of the region including:-
   a) Qualified medical doctors,
   b) Para-medical staff, and
   c) Other contact points, if any.

v) ~~Percentage~~ Perception of and utilization by different sections of the community the medical facilities, and

vi) Cost benefit analysis.

Selection of the Tribal Development Blocks

1.11 In Maharashtra there are two distinct geographical or economic regions viz., Sahyadri region and in Vidharba Gondwan region. It was therefore decided to select two Tribal Development Blocks in each of the geographical regions. One of the Blocks should be in a comparatively developed tribal area and the other in a relatively backward area. The extremes have been avoided in both the cases. However, the extremely backward region in Chandrapur District has been taken up. In pursuance of the instructions from the Ministry of Home Affairs, Government of India, the above 4 Tribal Development Blocks (2 in Sahyadri region and 2 in Vidharbha region) were selected for study of the health survey in the tribal areas of Maharashtra. (Annexure I).

1.12 In each of the sample block the study was conducted from two directions viz., the institution's side and the people's side. The first aspect (institution's side) has covered all the medical institutions in the Tribal Development Blocks. In relation to the other side, a number of sample villages were selected. These sample villages were 3 to 4 clusters viz., (a) Around the Primary Health Centre, (b) Around a Sub Centre, (c) Around other medical institutions like Ayurvedic dispensary and (d) Area not covered by any of these institutions. In each of these clusters 2 to 3 villages have been taken up for study viz., the Head Quarter village of the institution, other village less than 5 miles away and third village more than 5 miles away. In the last cluster 2 to 3 (see Table 1.1) villages have been chosen since there is no medical institution. In this way in each Block the representative villages under different categories i.e.

villages at a small distance from the institution and villages far off from the institution have been covered. The last two villages, where no institution has been established, will represent the general situation in the area.

Collection of the information

1.13 So far as geographical coverage of the tribal areas by medical facilities is concerned, information have been collected at the state level for the entire sub plan area of Maharashtra. Similarly, information in relation to the infra-structural built up was also collected at State level. The information on the remaining 4 items was collected through field survey in selected Tribal Development Blocks of Maharashtra State. The information was collected on the following important points:-

i) Health coverage of the tribal households,
ii) Information regarding Primary Health Centres and other health institutions,
iii) Area and group coverage,
iv) Contact points.
v) Expenditure on the medical services etc.

1.14 To study these problems various schedules were framed by the Government of India. The field work of the survey was carried out by the Tribal Research Institute, Pune, in the month of February and March, 1977.

1.15 The question in the household schedule were simple. The heads of households were asked if they had suffered from any diaseses during the last year. The

diseases were classified under three categories:- 1) chronic 2) seasonal and 3) other diseases. The schedule contained immunisation measures taken by the health staff. It also contained the details regarding maternity cases in the family and other details of the treatment taken in Primary Health Centre or Primary Health Sub Centre.

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Table 1.1

Selection of sample villages

Tribal Development Block	Criteria of clusters*	Village of the Institution or Head Quarter	Village less than five miles from the Head Quarter	Village more than five miles away from the Head Quarters	Villages where there is no medical institution or services
1	2	3	4	5	6
Kasa	(a)	Kasa	Vaghadi	Sonati	
	(b)	Tawe	Kalhan	Peth	
	(c)	Saiwan	Chalami	Gangurdi	
	(d)				1.Dhyale 2.Pimpalshet
Ambegaon	(a)**				
	(b)	Ambegaon	Panchale Bk.	Kalambai	
	(c)	Taleghar	Kondhawal	Kushire Bk.	1.Don 2)Adivare 3)Tirpad
Bhamragad	(a)				
	(b)	Bhamragad	Koyanguda	Hemalkasa	
	(c)				
	(d)				1)Valeli 2)Dodepalli
Dharni	(a)	Dharni	Utawati	Padidam	
	(b)	Harisal	Nanduri	Dabka	
	(c)				
	(d)				1)Savalikheda 2)Nagzira

* (a) Around the Primary Health Centre (b) Around a Sub Centre (c) Around other medical Institutions like Ayurvedic Dispensary (d) Area not covered by any of these institutions.

** There is no Public Health Centre in the Tribal Development Blocks.

PART II

GEOGRAPHICAL COVERAGE BY CURATIVE AND PARA-MEDICAL INSTITUTIONS AND INFRA-STRUCTURAL BUILT UP AT THE CENTRES

2.1 Health information may be broadly classified into three categories.

i) Health statistics which provide morbidity, mortality and natality data.

ii) Health establishments which furnish information on hospital, dispensaries, health centres and other health institutions and beds.

iii) Health manpower which give data on qualified medical practitioners and para-medical staff.

2.2 The first category is indispensable to the health administration as it helps to know the pattern of diseases facility etc., prevailing in the community so that health programmes are objectively formulated and evaluated. It is also necessary for measuring the health of the people, epidemiological investigations and research work.

The remaining two categories are needed not only to know the health services provided to the people, but also for assessing their adequacy, and to attempt improvement wherever necessary.

2.3 This part is divided into three sections. Section I mainly deals with the geographical coverage of the tribal areas by curative and para-medical institutions - like number of hospitals, Primary Health Centres, dispensaries and other health

institutions and number of beds available in these institutions Section II concentrates on infra-structural built-up of these centres including (a) physical infra-structure; (b) technical infra-structure; and (c) personnel; and Section III highlights the proposed health activities under the tribal Sub-Plan in Maharashtra State.

Section I

Geographical Coverage of the Tribal Areas by Curative and Para-Medical Institutions

2.4 Prior to independence the situation with regard to the availability of hospital facilities and medical personnel was extremely deplorable. In 1947, the total number of hospitals in India was 6669, 4617 of them were in rural areas and 2052 were in urban areas. In view of the fact that about 80 per cent of t people live in rural areas, one can see the poor facilities, which were available to a great majority of our countrymen.

2.5 There were 8600 hospitals and dispensaries and 1,13,000 beds at the commencement of the First Five Year Plan in 1951. By 1965-66 their number went upto 14,600 and 2,40,100 respectively. While there has been considerable advance through the provision of additional beds in urban areas and through Primary Health Centres in the rural areas, medical facilities in the rural areas were still poor. The bed population ratio in 1966-67 was about 1:12,000.

2.6 Table 1 gives the abstract of the medical institutions

in the tribal Sub Plan area of Maharashtra State for each tribal development block. From the table it appears that as a curative centres there are 27 Primary Health Centres and only one hospital which covers a population of about 28.15 lakhs in the tribal Sub Plan area of the State. Besides the abovementioned curative centres, there are 82 Sub Centres and 85 Family Planning Sub Centres in the tribal Sub Plan area. This reveals that the number of medical institutions at present available is utterly inadequate to serve even minimum needs of the tribal people. The average number of population served by a Primary Health Centre in the tribal areas varies between 41,000 in Peint tahsil (Nashik district) and 1,47,000 in Gadchiroli tahsil (Chandrapur district) and the average is over 1,04,000 for the whole of tribal Sub Plan area. Some new P.H.Cs. have been opened in the tribal areas during the last year but the number is insignificant as compared to the need. As per the model plan each block with a population varying from 60,000 to 66,000 will have to be provided with one Primary Health Centre with three sub centres and three Family Planning Sub Centres. According to this norm additional 20 Primary Health Centres with 60 Sub Centres and 60 Family Planning Sub Centres will have to be opened in the tribal Sub Plan area.

2.7 It appears from Table 1 that there is not even a single curative institution of Ayurvedic medicine in the tribal Sub Plan area. In view of the small number of allopathic doctors available there is enough scope to set up increased number of Ayurvedic Primary Health Centres and dispensaries to meet the need for treatment of diseases on scientific lines. The tribals are already used to herbal remedies.

2.8 As stated above there are 27 Primary Health Centres with the facilities of 150 indoor beds. There are wide differences in the bed populations ratio among the Tribal Development Blocks and the tahsils in the tribal Sub Plan area of the State. The population served by one bed various between 7,000 in Murbad tahsil (District Thane) and 25,000 in Gadchiroli tahsil (Distric Chandrapur) and the average population served by one bed is 18,0 for the whole of tribal Sub Plan area. The recommended standard is one bed per thousand population.

2.9 Public health and medicine cannot easily be assessed in terms of money. The coverage in India for one medical institute is about 100 sq.miles, but a medical institutions in the tribal area, one can unhesitatingly say, serves twice or thrice this area.

Section II

Infra-Structure Built Up at the Public Health Centre

2.10 Table 2 aims at eliciting information about facilities available in the various medical institutions about medical personnel, building, electricity, water etc. Table 3 gives information of the Public Health Sub Centres, Family Planning Sub Centres and the position of para-medical staff.

2.11 From Table 2 it appears that all the curative institutio (27 PHCS) have their own buildings and residential accommodation for the medical and para-medical staff. The electricity and wat is also available to the institutions except one or two institu-tions.

2.12 As far the medical and para-medical personnel the posts sanctioned for the purpose are filled in all the curative institutions and sub-centres. Apart from bed population ratio, another indicator of the extent of medical and public health facilities is the number of doctors and other medical personnel (para-medical staff) available per 1000 of population. The consensus of opinion by the Health Administration is that there should be at least on medical officer for every 20,000 to 25,000 population, one Lady Health Visitor for every 5000 population and one sanitary inspector for every 10,000 population and one midwife for every 100 births. Here again we find wide variation from block to block in the tribal area. The situation becomes more terrifying when we see the doctor population ratio for the interior and peripheral areas separately. The tribal Sub Plan area as a whole, the ratio stands at 1: . This shows that the tribal population of Maharashtra is still unable to get medical facilities adequately. In certain blocks the situation is much worse. Blocks or tahsil like Shahapur (Thane), Kalwan (Nashik), Nawapur and Shahada (Dhule), have a ratio 1:60000 or more.

2.13 As regards ancillary health personnel such as nurses, midwives, health visitors, sanitary inspectors, dais etc. the situation had improved considerably, though still the ancillary health personnel/population ratio is unfavourable.

2.14 The bulk of medical relief in tribal area is at present given by the unqualified practitioners and cultists. As a mere

guess, it may be said that only 5 to 10 per cent of the sick needing medical care, attend the dispensaries. About 15 to 20 per cent are attended to by unqualified practitioners of secular indigenous medicine, Ayurvedic etc. The rest about 70 to 75 of the total sick either go to the cultists or religious healers like Bhagat or go without any treatment. Of course the number of people who undertake self-treatment is larger than those in the rural areas. It is therefore evident that the proportion of the tribal people who attend the dispensaries and the Primary Health Centres is very small.

2.15 The average daily attendance in the out-patient departments varies 5 (in Sakharshet, Mokhad tahsil, district Thane) and 44 (in Kasa, tahsil Dahanu, district Thane). This may be taken as the average figure.

2.16 The present method of indenting for medical supplies in the remoter areas is very frustrating. When forms are filled up and reach the head-quarters, scrutiny is made on the basis of the normal requirements of the plain area. It is all mathematically done on the basis of the Primary Health Centre returns. It is forgotten that the medical personnel in tribal areas have not only to treat the patients but also brave the rigours of climate and on many occasions to meet the urgent requirement which require the maintenance of stock of special remedies at hand.

2.17 The above discussion and the data supporting show that the existing medical facilities in the tribal Sub Plan area are far less than those needed to satisfy even minimum requirements.

Fresh facilities have of course been added since April 1976 but the population and the capacity of the people seeking medical aid have also correspondingly increased. Difficulties in the way of augmenting the facilities are well known, but unless there is a perspective plan for medical services, these will always remain unresolved.

2.18 The real problem that the tribal Sub Plan area faces on the medical front is that of provision of facilities in the tribal areas. Doctors are reluctant to serve in the tribal villages. Unless some incentives are given to the medical personnel to serve in the tribal villages, the problem will continue to be serious. The problem is big. Its solution requires bigger effects.

Section III

Proposed Health Facilities under the Tribal Sub Plan

2.19 Tables 4 and 5 highlight the proposed health facilities under the tribal Sub Plan. It appears from the tables that the Directorate of Public Health Services, Maharashtra State, proposes to establish 38 New Primary Health Centres in the Sub Plan area. In 38 tahsils notified under tribal Sub Plan, 30 Primary Health Centres are already located. With a view to cover the entire population of the tribal area in the tahsils, it is proposed to open 38 additional Primary Health Centres in these tahsils. The population which will not be covered by the Primary Health Centre, will be covered by the Primary Health Units proposed to be established. Each P.H.C. will have 3 to 4

sub-centres. Thus the entire tribal population in area will be covered by the Primary Health Centres.

2.20 The Government had also taken a policy decision in the year 1966 to establish Primary Health Units in the area which is not covered by the P.H.C. located in the area. The scheme envisages the conversion of the Zilla Parishad Dispensaries into Primary Health Units with a view to provide better health facilities to the people. Under this scheme it is now proposed to convert 35 Zilla Parishad Dispensaries located in the notified tribal Sub Plan area into Primary Health Units. The Zilla Parishad Dispensary buildings are already available for locating Primary Health Units in most of the places. The staff quarters will have to be constructed and modern facilities like electricity and water supply will have to be provided.

Table 1: Health Facilities in Tribal Sub Plan Area (1976)

Name of I.T.D.P. District	Name of I.T.D.P. Tahsil	No.of T.D. Blocks	No.of villages included in Sub Plan area	Population (in lakhs)		No. of curative centres		
				Total	Tribal	Hospital	PHCs	Ayurvedic
1	2	3	4	5	6	7	8	9
1. Thane	1. Dahanu	3	127	1.70	1.19	-	2	-
	2. Talasari	1	27	0.53	0.47	-	1	-
	3. Mokhada	1	69	0.54	0.50	-	1	-
	4. Jawhar	2	113	0.90	0.84	-	1	-
	5. Wada	-	165	0.76	0.39	-	1	-
	6. Shahapur	-	202	1.35	0.45	-	2	-
	7. Palghar	2	140	1.13	0.61	-	1	-
	8. Bassein	-	45	0.42	0.21	-	-	-
	9. Bhivandi	-	61	0.28	0.14	-	-	-
	10. Murbad	-	77	0.42	0.15	-	1	-
2. Nashik	11. Surgana	2	156	0.70	0.67	-	1	-
	12. Kalwan	1	154	1.24	0.60	-	1	-
	13. Baglan	-	57	0.41	0.29	-	-	-

Contd...

Table 1: (Continued)

Name of I.T.D.P. District	Name of I.T.D.P. Tahsil	Average population per PHCs(in lakhs)	Indoor beds	Population per bed (in '000)	Sub centre	Average population per sub centre (in '000)	F.P. sub centre	Average population per F.P.sub centre (in '000)
1	2	10	11	12	13	14	15	16
1. Thane	1. Dahanu	0.85	12	14	6	28	6	28
	2. Talasari	0.53	6	9	4	13	4	13
	3. Mokhada	0.54	6	9	3	18	4	14
	4. Jawhar	0.90	6	15	3	30	3	30
	5. Wada	0.76	6	13	3	25	3	25
	6. Shahapur	0.68	6	23	4	34	3	45
	7. Palghar	1.13	12	9	5	23	6	19
	8. Bassein	-	-	-	-	-	-	-
	9. Bhivandi	-	-	-	-	-	-	-
	10. Murbad	0.42	6	7	4	11	3	14
2. Nashik	11. Surgana	0.70	6	12	3	23	3	23
	12. Kalwan	1.24	6	21	3	41	3	41
	13. Baglan	-	-	-	-	-	-	-

1	2	3	4	5	6	7	8	9
	14. Peint	2	143	0.82	0.78	-	2	-
	15. Dindori	1	103	1.05	0.59	-	1	-
	16. Igatpuri	1	85	0.70	0.43	-	-	-
	17. Nashik	1	63	0.46	0.28	-	1	-
3. Dhule	18. Taloda	1	83	0.53	0.40	-	1	-
	19. Akkalkuwa	2	172	0.79	0.67	-	2	-
	20. Akrani	1	156	0.46	0.43	-	-	-
	21. Nawapur	3	93	1.16	1.10	-	1	-
	22. Sakri	2	77	1.18	0.78	-	-	-
	23. Nandurbar	2	75	0.76	0.52	-	1	-
	24. Shahada	2	140	1.22	0.68	-	1	-
	25. Shirpur	-	61	0.49	0.28	-	-	-
4. Jalgaon	26. Chopda*	-	17	0.06	0.05	-	-	-
	27. Yawal*	-	5	0.01	0.01	-	-	-
	28. Raver*	-	9	0.02	0.02	-	-	-

Contd...

Table 1: (Continued)

1	2	10	11	12	13	14	15	16
	14. Peint	0.41	12	7	6	14	6	14
	15. Dindori	1.05	6	18	4	26	4	26
	16. Igatpuri	-	-	-	-	-	-	-
	17. Nashik	0.46	6	8	4	12	4	12
3. Dhule	18. Taloda	0.53	6	9	3	18	3	18
	19. Akkalkuwa	0.40	12	7	7	11	7	11
	20. Akrani	-	-	-	-	-	-	-
	21. Nawapur	1.16	6	19	3	39	6	19
	22. Sakri	-	-	-	-	-	-	-
	23. Nandurbar	0.76	6	13	4	19	3	25
	24. Shahada	1.22	6	20	3	41	3	41
	25. Shirpur	-	-	-	-	-	-	-
4. Jalgaon	26. Chopda*	-	-	-	-	-	-	-
	27. Yawal*	-	-	-	-	-	-	-
	28. Raver*	-	-	-	-	-	-	-

Contd...

Table 1: (Continued)

1	2	3	4	5	6	7	8	9
5. Ahmednagar	29. Akola	2	93	0.73	0.57	-	1	-
6. Pune	30. Ambegaon*	1	56	0.35	0.25	-	-	-
	31. Junnar*	1	63	0.39	0.37	-	-	-
7. Amravati	32. Melghat	2	335	1.05	0.79	-	2	-
8. Yavatmal	33. Wani	1	129	0.39	0.24	-	-	-
	34. Kelapur	-	156	0.79	0.42	-	-	-
9. Chandrapur	35. Sironcha	3	650	1.41	0.74	1	-	-
	36. Gadchiroli	2	579	1.47	0.90	-	1	-
	37. Rajura	1	174	0.66	0.26	-	-	-
10. Nanded	38. Kinwat	-	118	0.82	0.27	-	1	-
Sub Plan Area Total		43	5028	28.15	18.23	1	27	-

* Not applicable as PHC is not located in the tribal area of the tahsil.

Table 1: (Continued)

1	2	10	11	12	13	14	15	16
5. Ahmednagar	29. Akola	0.73	6	12	4	18	3	24
6. Pune	30. Ambegaon*	-	-	-	-	-	-	-
	31. Junnar*	-	-	-	-	-	-	-
7. Amravati	32. Melghat	0.53	12	9	7	-	6	-
8. Yavatmal	33. Wani	-	-	-	-	-	-	-
	34. Kelapur	-	-	-	-	-	-	-
9. Chandrapur	35. Sironcha	-	-	-	-	-	-	-
	36. Gadchiroli	1.47	6	25	3	49	7	21
	37. Rajura	-	-	-	-	-	-	-
10. Nanded	38. Kinwat	0.82	6	14	3	27	3	27
Sub Plan Area Total		1.04	150	18	82	34	85	

Table 2: Facilities Available in Medical Institutions (Hospitals) in the Tribal Sub Plan Area

Name of I.T.D.P. District	Name of I.T.D.P. Tahsil	No. of villages included in Sub Plan Area	Population (in lakhs)		Place of institution	Building	
			Total	Tribal		Institution	Residence
1	2	3	4	5	6	7	8
1. Thane	1. Dahanu	127	1.70	1.19	1)Vangaon 2)Kasa	Yes	Yes
	2. Talasari	27	0.53	0.47	Talasari	"	"
	3. Mokhada	69	0.54	0.50	Sakharshet	"	"
	4. Jowhar	113	0.90	0.84	Vikramgad	"	"
	5. Wada	165	0.76	0.39	Gorhe	"	"
	6. Shahapur	202	1.35	0.45	Kasara	"	"
	7. Palghar	140	1.13	0.61	1)Maswan 2)Safala	"	"
	8. Bassein	45	0.42	0.21	-	-	-
	9. Bhivandi	61	0.28	0.14	-	-	-
	10. Murbad	77	0.42	0.15	Dhasai	Yes	Yes
2. Nashik	11. Surgana	156	0.70	0.67	Surgana	"	"
	12. Kalwan	154	1.24	0.60	Abhohe	"	"

Name of I.T.D.P. District	Name of I.T.D.P. Tahsil	Indoor beds	Electricity	Water	Personal doctors		Average population per doctor (in '00
					Sanctioned	Position	
1	2	9	10	11	12	13	14
1. Thane	1. Dahanu	12	Yes	Yes	4	4	43
	2. Talasari	6	"	"	2	2	26
	3. Mokhada	6	"	"	2	2	27
	4. Jowhar	6	"	"	2	2	49
	5. Wada	6	"	"	2	2	38
	6. Shahapur	6	"	"	2	2	68
	7. Palghar	12	"	"	4	4	28
	8. Bassein	-	-	-	-	-	-
	9. Bhivandi	-	-	-	-	-	-
	10. Murbad	6	Yes	Yes	2	2	21
2. Nashik	11. Surgana	6	"	"	2	2	35
	12. Kalwan	6	"	"	2	2	62

Contd...

Table 2: (Continued)

Name of I.T.D.P. District	Name of I.T.D.P. Tahsil	Para-medical personnel		Average daily attendance 1975-76 (outdoor)	Total indoor patients treated	Average patients attendance per 10000 population
		Sanctioned	Position			
1	2	15	16	17	18	19
1. Thane	1. Dahanu	8	8	45	190	11
	2. Talasari	4	4	38	111	21
	3. Mokhada	4	4	14	63	12
	4. Jowhar	4	4	5	27	3
	5. Wada	4	4	18	105	14
	6. Shahapur	4	4	31	75	6
	7. Palghar	8	8	30	452	40
	8. Bassein	-	-	-	-	-
	9. Bhivandi	-	-	-	-	-
	10. Murbad	4	4	31	217	52
2. Nashik	11. Surgana	4	4	-	-	-
	12. Kalwan	4	4	24	117	9

Contd...

Table 2: (Continued)

1	2	3	4	5	6	7	8
	13. Baglan	57	0.41	0.29	-	-	-
	14. Peint	143	0.82	0.78	1)Peint 2)Harsul	Yes	Yes
	15. Dindori	103	1.05	0.59	Wani	"	"
	16. Igatpuri	85	0.70	0.43	-	-	-
	17. Nashik	63	0.46	0.28	Trimbak	Yes	Yes
3. Dhule	18. Taloda	83	0.53	0.40	Pratappur	"	"
	19. Akkalkuwa	172	0.79	0.67	1)Molgi 2)Khaper	"	"
	20. Akrani	156	0.46	0.43	Dhadgaon	"	"
	21. Nawapur	93	1.16	1.10	Khandbara	"	"
	22. Sakri	77	1.18	0.78	-	-	-
	23. Nandurbar	75	0.76	0.52	Ranala	Yes	Yes
	24. Shahada	140	1.22	0.68	Wadala	"	"
	25. Shirpur	61	0.49	0.28	-	-	-
4. Jalgaon	26. Chopda	17	0.06	0.05	-	-	-
	27. Yawal	5	0.01	0.01	-	-	-

Contd...

Table 2: (Continued)

1	2	9	10	11	12	13	14
	13. Baglan	-	-	-	-	-	-
	14. Peint	12	Yes	Yes	4	4	21
	15. Dindori	6	"	"	2	2	53
	16. Igatpuri	-	-	-	-	-	-
	17. Nashik	6	Yes	Yes	2	2	23
3. Dhule	18. Taloda	6	"	"	2	2	26
	19. Akkalkuwa	12	"	"	4	4	20
	20. Akrani	6	No	"	2	2	23
	21. Nawapur	6	Yes	"	2	2	58
	22. Sakri	-	-	-	-	-	-
	23. Nandurbar	6	Yes	Yes	2	2	38
	24. Shahada	6	"	"	2	2	61
	25. Shirpur	-	-	-	-	-	-
4. Jalgaon	26. Chopda	-	-	-	-	-	-
	27. Yawal	-	-	-	-	-	-

Contd...

Table 2: (Continued)

1	2	15	16	17	18	19
	13. Baglan	-	-	-	-	-
	14. Peint	8	8	42	126	15
	15. Dindori	4	4	36	670	64
	16. Igatpuri	-	-	-	-	-
	17. Nashik	4	4	-	-	-
3. Dhule	18. Taloda	4	4	-	-	-
	19. Akkalkuwa	8	8	-	-	-
	20. Akrani	4	4	-	-	-
	21. Nawapur	4	4	-	-	-
	22. Sakri	-	-	-	-	-
	23. Nandurbar	4	4	-	-	-
	24. Shahada	4	4	-	-	-
	25. Shirpur	-	-	-	-	-
4. Jalgaon	26. Chopda	-	-	-	-	-
	27. Yawal	-	-	-	-	-

Contd...

Annex 2: (Continued)

1	2	3	4	5	6	7	8
	28. Raver	9	0.02	0.02	-	-	-
5. Ahmednagar	29. Akola	93	0.73	0.57	Rajur	Yes	Yes
6. Pune	30. Ambegaon	56	0.35	0.25	-	-	-
	31. Junnar	63	0.39	0.37	-	-	-
7. Amravati	32. Melghat	335	1.05	0.79	1)Dharni 2)Chikhaldara	Yes	Yes
8. Yavatmal	33. Wani	129	0.39	0.24	-	-	-
	34. Kelapur	156	0.79	0.42	-	-	-
9. Chandrapur	35. Sironcha	650	1.41	0.74	-	-	-
	36. Gadchiroli	579	1.47	0.90	-	-	-
	37. Rajura	174	0.66	0.26	Chandrapur	Yes	Yes
10. Nanded	38. Kinwat	118	0.82	0.27	Wai	No	No
	Grand Total	5028	28.15	18.23	-	-	-

Table 2: (Continued)

1	2	9	10	11	12	13	14
	28. Raver	-	-	-	-	-	-
5. Ahmednagar	29. Akola	6	Yes	Yes	2	2	37
6. Pune	30. Ambegaon	-	-	-	-	-	-
	31. Junnar	-	-	-	-	-	-
7. Amravati	32. Melghat	12	Yes	Yes	4	4	26
8. Yavatmal	33. Wani	-	-	-	-	-	-
	34. Kelapur	-	-	-	-	-	-
9. Chandrapur	35. Sironcha	-	-	-	-	-	-
	36. Gadchiroli	-	-	-	-	-	-
	37. Rajura	6	No	No	2	2	-
10. Nanded	38. Kinwat	6	-	-	2	2	41
	Grand Total	168	-	-	56	56	50

Table 2: (Continued)

1	2	15	16	17	18	19
	28. Raver	-	-	-	-	-
5. Ahmednagar	29. Akola	4	4	-	-	-
6. Pune	30. Ambegaon	-	-	-	-	-
	31. Junnar	-	-	-	-	-
7. Amravati	32. Melghat	8	8	23	107	10
8. Yavatmal	33. Wani	-	-	-	-	-
	34. Kelapur	-	-	-	-	-
9. Chandrapur	35. Sironcha	-	-	-	-	-
	36. Gadchiroli	-	-	-	-	-
	37. Rajura	4	4	1	31	5
10. Nanded	38. Kinwat	4	4	44	53	6
	Grand Total	112	112	-	2344	8

Table 3:

Name of I.T.D.P. District	Name of I.T.D.P. Tahsil	No.of villages included in Sub Plan Area	Population (in lakhs)		Sub-Centres		Average population per P.H.C. Sub Centre (in '000)
			Total	Tribal	P.H.C. Centre Nos.	R.F. PWC Nos.	
1	2	3	4	5	6	7	8
1. Thane	1. Dahanu	127	1.70	1.19	6	6	28
	2. Talasari	27	0.53	0.47	4	4	13
	3. Mokhada	69	0.54	0.50	3	4	18
	4. Jawhar	113	0.90	0.84	3	3	30
	5. Wada	165	0.76	0.39	3	3	25
	6. Shahapur	202	1.35	0.45	4	4	34
	7. Palghar	140	1.13	0.61	5	6	23
	8. Bassein*	45	0.42	0.21	-	-	-
	9. Bhivandi*	61	0.28	0.14	-	-	-
	10. Murbad	77	0.42	0.15	4	3	11
2. Nashik	1. Surgana	156	0.70	0.67	3	3	23
	2. Kalwan	154	1.24	0.60	3	3	41

Contd...

Table 3: (Continued)

Name of I.T.D.P. District	Name of I.T.D.P. Tahsil	Average population per R.F. PWC (in '000)	Buildings		Staff Para-Medical	
			Institution	Residence	Sanctioned (PHC sub-centre only)	Position
1	2	9	10	11	12	13
1. Thane	1. Dahanu	28	-	-	6	6
	2. Talasari	13	NA	NA	4	4
	3. Mokhada	14	NA	NA	3	3
	4. Jawhar	30	NA	NA	3	3
	5. Wada	25	NA	NA	3	3
	6. Shahapur	34	NA	NA	4	4
	7. Palghar	19	NA	NA	5	5
	8. Bassein	-	-	-	-	-
	9. Bhivandi	-	-	-	-	-
	10. Murbad	14	NA	NA	4	4
2. Nashik	1. Surgana	23	NA	NA	3	3
	2 Kalwan	41	NA	NA	3	3

Contd...

Table 3: (Continued)

1	2	3	4	5	6	7	8
	3. Baglan*	57	0.41	0.29	-	-	-
	4. Peint	143	0.82	0.78	6	6	14
	5. Dindori	103	1.05	0.59	4	4	26
	6. Igatpuri*	85	0.70	0.43	-	-	-
	7. Nashik	63	0.46	0.28	4	4	12
3. Dhule	1. Taloda*	83	0.53	0.40	-	-	-
	2. Akkalkuwa	172	0.79	0.67	7	7	11
	3. Akrani*	156	0.46	0.43	-	-	-
	4. Nawapur	93	1.16	1.10	3	6	39
	5. Sakri*	77	1.18	0.78	-	-	-
	6. Nandurbar	75	0.76	0.52	4	3	19
	7. Shahada	140	1.22	0.68	3	3	41
	8. Shirpur*	61	0.49	0.28	-	-	-
4. Jalgaon	1. Chopda*	17	0.06	0.05	-	-	-
	2. Yawal*	5	0.01	0.01	-	-	-
	3. Raver*	9	0.02	0.02	-	-	-

Contd...

Table 3: (Continued)

1	2	9	10	11	12	13
	3. Baglan	-	-	-	-	-
	4. Peint	14	NA	NA	6	6
	5. Dindori	26	NA	NA	4	4
	6. Igatpuri	-	-	-	-	-
	7. Nashik	12	NA	NA	4	4
3. Dhule	1. Taloda	-	-	-	-	-
	2. Akkalkuwa	11	NA	NA	7	7
	3. Akrani	-	-	-	-	-
	4. Nawapur	19	NA	NA	3	3
	5. Sakri	-	-	-	-	-
	6. Nandurbar	25	NA	NA	4	4
	7. Shahada	41	NA	NA	3	3
	8. Shirpur	-	-	-	-	-
4. Jalgaon	1. Chopda	-	-	-	-	-
	2. Yawal	-	-	-	-	-
	3. Raver	-	-	-	-	-

Contd...

Table 3: (Continued)

1	2	3	4	5	6	7	8
5. Ahmednagar	1. Akola	93	0.73	0.57	4	3	18
6. Pune	1. Ambegaon*	56	0.35	0.25	-	-	-
	2. Junnar*	63	0.39	0.26	-	-	-
7. Amravati	1. Melghat	335	1.05	0.79	7	6	-
8. Yavatmal	1. Wani*	129	0.39	0.24	-	-	-
	2. Kelapur*	156	0.79	0.42	-	-	-
9. Chandrapur	1. Sironcha*	650	1.41	0.74	-	-	-
	2. Gadchiroli*	579	1.47	0.90	-	-	-
	3. Rajura	174	0.66	0.26	3	7	22
10. Nanded	1. Kinwat	118	0.82	0.27	3	3	27
Tribal Sub Plan Area		5028	28.15	18.23	79	85	36

NA = Not applicable

* Information not available

Table 3: (Continued)

1	2	9	10	11	12	13
5. Ahmednagar	1. Akola	24	NA	NA	4	4
6. Pune	1. Ambegaon	-	-	-	-	-
	2. Junnar	-	-	-	-	-
7. Amravati	1. Melghat	-	NA	NA	7	7
8. Yavatmal	1. Wani	-	-	-	-	-
	2. Kelapur	-	-	-	-	-
9. Chandrapur	1. Sironcha	-	-	-	-	-
	2. Gadchiroli	-	-	-	-	-
	3. Rajura	09	NA	NA	3	3
10. Nanded	1. Kinwat	27	NA	NA	3	3
Tribal Sub Plan Area		33	-	-	79	79

Table 4: Proposed Health Facilities Under the Tribal Sub Plan

District	Name of Tahsil	No.of villages	Mid year population	No.of existing PHCs	No.of new PHCs proposed to be established	No.of Z.P. dispensary to be consented
1	2	3	4	5	6	7
1. Thane	1. Dahanu	127	1.86	2	2	2
	2. Talasari	27	0.60	1	-	-
	3. Mokhada	69	0.59	1	-	2
	4. Jawhar	113	0.97	1	2	1
	5. Shahapur	202	1.74	1	2	2
	6. Palghar	140	2.55	2	2	2
	7. Wada	165	0.83	1	1	1
	8. Bassein	45	0.92	-	1	1
	9. Bhivandi	61	0.31	-	1	-
	10. Murbad	77	0.47	1	1	-
	Total	1026	9.84	10	12	11
2. Nashik	11. Peint	143	0.91	2	-	-
	12. Surgana	156	0.77	1	2	-
	13. Kalwan	154	1.41	1	-	1
	14. Dindori	103	1.16	1	1	1
	15. Igatpuri	85	0.88	-	1	-

Contd...

Table 4: (Continued)

1	2	3	4	5	6	7
	16. Nashik	63	0.84	1	1	-
	17. Baglan	57	0.84	-	1	1
	Total	761	6.81	6	6	3
3. Dhule	18. Nawapur	93	1.43	1	2	1
	19. Taloda	83	0.56	1	1	1
	20. Akkalkuwa	172	0.94	2	-	1
	21. Akrani	156	0.53	1	1	-
	22. Sakri	77	1.38	-	2	2
	23. Nandurbar	75	0.84	1	1	-
	24. Shahada	140	1.34	1	-	-
	25. Sirpur	61	0.83	-	1	2
	Total	857	7.85	7	8	7
4. Jalgaon	26. Chopda	17	0.20	-	-	1
	27. Yawal	5	0.08	-	-	1
	28. Raver	9	0.13	-	-	1
	Total	31	0.41	-	-	3
5. Ahmednagar	29. Akola	93	1.19	1	1	-
	Total	93	1.19	1	1	-

Contd...

Table 4: (Continued)

1	2	3	4	5	6	7
6. Pune	30. Ambegaon	56	0.84	-	-	2
	31. Junnar	63	0.94	-	2	-
	Total	119	1.78	-	2	2
7. Nanded	32. Kinwat	118	1.18	1	1	-
	Total	118	1.18	1	1	-
8. Amravati	33. Melghat	335	1.31	2	2	2
	Total	335	1.31	2	2	2
9. Yavatmal	34. Wani	129	0.81	-	1	-
	35. Kelapur	156	1.09	-	1	2
	Total	285	1.90	-	2	2
10. Chandrapur	36. Sironcha	650	1.62	-	1	2
	37. Gadchiroli	579	3.72	-	3	2
	38. Rajura	174	1.11	1	-	1
	Total	1403	6.45	1	4	5
Grand Total		5028	38.72	30	38	35

Source: 1) Tribal Sub Plan of Maharashtra, Directorate of Health Services, 1976.
2) Tribal Area Sub Plan (Draft), 1976-79, Social Welfare, Cultural Affairs, Sports and Tourism Department, Maharashtra State.

Table 5: Health Activities Under the Tribal Sub Plan

District	Taluka	Mid-year est. pop. (in lacs)	Existing facilities			Facilities available in taluka but not including in T.D.Areas		
			PHCs	Rural hospitals	Dispensaries	PHCs	Rural hospitals	Dispensaries
1	2	3	4	5	6	7	8	9
1. Thane	1. Dahanu	1.86	Wamgaon Kasa	-	Chinchani Gholwad Datchari	- - -	- - -	- - -
	2. Talasari	0.60	Talasari	-	-	-	-	-
	3. Palghar	1.56	Maswan Saphala	-	Kalwa Satpanli Daudi Bhoisar Mahim	Palghar - - - -	- - - - -	- - - - -
	4. Mokhada	0.59	Sakharshet	-	Mokhada Khodala	- -	- -	- -
	5. Jawhar	0.97	Vikramgad	-	Bhaudhan	-	-	-
	6. Shahapur	1.71	Kasara	-	Shahapur Kinholi Washind	- - -	- - -	- - -
	7. Wada	0.88	Gorhe	-	Wada Kasus Khanivali	- - -	- - -	- - -

Contd...

Table 5: (Continued)

1	2	3	4	5	6	7	8	9
	8. Bassein	0.92	-	-	Mandvi Sopare	Navghar -	Virar -	- -
	9. Bhavandi	0.31	-	-	Vaire-shwari	Padgha	-	-
	10. Murbad	0.47	Dhasai	-	Khamabala Murbad Sirosi Vaisha-khare	Kharbav - - -	- - - -	- - - -
2. Nashik	1. Peint	0.91	Peint Harsul	Peint -	Thanpada -	- -	- -	- -
	2. Surgana	0.77	Surgana	-	Borgaon	-	-	-
	3. Kalwan	1.41	Abhona	Kalwan	Dalwat	-	-	-
	4. Dindori	1.16	Wani	-	Dindori Khejgaon Mohadi Manashi	- - - -	- - - -	- - - -
	5. Igatpuri	0.88	-	-	-	Ghoti	-	-
	6. Nashik	0.84	Trimbak	-	-	-	-	-
	7. Baglan	0.84	-	-	Nampur	Satana	-	-

Contd...

Table 5: (Continued)

1	2	3	4	5	6	7	8	9
5. Ahmednagar	1. Akola	1.19	Rajur	-	Bhandar-dara	-	-	-
					Akola	-	-	-
6. Pune	1. Ambegaon	0.84	-	-	Peth	Ghodegaon	-	-
					Ambegaon	Dhamni	-	-
					Taleghar	-	-	-
					Khalungep	-	-	-
	2. Junnar	0.94	-	Junnar	Amrapur	Otur	-	-
					Madh	-	-	-
					Umbraj	-	-	-
7. Nanded	1. Kinwat	1.18	Wai	-	-	Islapur	-	-
8. Yavatmal	1. Wani	0.81	-	-	Mukuthem	Sirpur	-	-
	2. Kelapur	1.09	-	-	Ralegaon	-	-	-
					Khohiri	-	-	-
					Datanbori	-	-	-
9. Chandrapur	1. Rajura	1.11	Chanaur	-	Kadhali	-	-	-
	2. Gadchiroli	3.72	-	-	Belgaon	-	Gadchiroli	-
					Kadhali			
					Porala			
					Wadsa			
	3. Sironcha	1.62	-	-	Dhasali-patta	Sironcha	-	-
					Tekada	-	-	-
					Ankisa	-	-	-
10. Amravati	1. Melghat	1.31	Dharni	-	Semadoha	-	-	-
			Chikhaldara	-	Taranwada	-	-	-

Source: Tribal Sub Plan of Maharashtra State, Directorate of Health Services, 1976.

Table 5: (Continued)

1	2	3	4	5	6	7	8	9
3. Dhule	1. Taloda	0.56	Pratapur	Taloda	Rajvihir	-	-	-
	2. Akkalkuwa	0.94	Molgi	-	Borad	-	-	-
			Khapar	-	Akkalkuwa	-	-	-
	3. Akrani	0.53	Dhadgaon	-	Dhadgaon	-	-	-
	4. Nawapur	1.43	Khandbara	-	Navapur	-	-	-
					Khadki	-	-	-
	5. Sakri	1.38	-	-	Sakri	Nijampur	-	-
					Pimpalner	Dahivel	-	-
					Choupala	-	-	-
	6. Nandurbar	0.84	Ranale	-	Kondan-wadi	-	-	-
	7. Shahada	1.34	Wadali	-	Saranc-kheda	-	-	-
	8. Sirpur	0.83	-	Sirpur	Mobthane	Thalpe	-	-
					Boradi	-	-	-
4. Jalgaon	1. Chopda	0.20	-	-	Gorgawale	Fated	-	-
	2. Yawal	0.00	-	-	Nhavi	Bhalod	-	-
					Savar-kheda	Mangaon	-	-
	3. Raver	0.13	-	-	Phor-gavhan	Chinchvel	-	-
						Ainpur	-	-

Contd...

C H A P T E R III

Survey of the Health Services in the selected Tribal Development Blocks.

CHAPTER III

Survey of the Health Services in the selected Tribal Development Blocks.

(1) The Bhamragad Tribal Development Block (District Chandrapur)

I

General Background of the Block

Location of the Block

3.1 The Panchayat Samiti, Etapalli has two Tribal Development Blocks viz., Etapalli and Bhamragad under its jurisdiction with its Head Quarters at Etapalli. The staff of the Panchayat Samiti looks after the activities of both these Blocks.

3.2 The total area of the Block is 211 square metres with a population of 21849. This includes the tribal population of 18989. There are 178 villages in Block. The Bhamragad Tribal Development Block lies in Godawari Basin. There are hills of the eastern Ghat Range covered with thick forest. Three big rivers, P Nibra and Kothari run through the Bhamragad Block. Indravati, a big river and tributory of Godawari form the south east side boundary of the Block.

3.3 The entire Block is hilly and covered wi thick forest. There is some cultivable land at the f of the hills where rice is produced. The crops such a Kodo, Kutki and Maize are produced on the slopes. Te and other timber are the main forest produce in the B Bamboo is also available in abundance. The Block is populated by the Gonds, the Madia Gonds and a few Mal The eastern hilly part of Bhamragad area is populated the Madia Gonds.

3.4 The daily food of the tribals consists or rice, kodo, kutki and maize, supplemented by roots and fruits collected from the forest. Even the cheapest commodity like salt is not available sufficiently. Sugar, oil and such other things are luxaries for them. The tribals therefore, are undernourished. The children in an infant stage have to depend upon feeding by their mothers who are also undernourished. Delivery cases are dealt with most rudimentary methods. The infantile death rate, therefore, is higher in the area.

II

Health Survey in the Block

Selection of the villages

3.5 As discussed in Chapter I, 5 villages were selected for the health facilities survey in the Bhamragad Tribal Development Block. The villages selected are as follows:-

Group	Villages
A)	Nil
B)	1). Bhamragad 2) Koyanguda and 3) Hemalkasa
C)	1) Vateli and 2) Dodepalli

The second group consists of the Sub Centre village, village less than 5 miles away and village more than 5 miles away from the Sub Centre. The fourth group consists of 2 villages which are far off from the Primary Health Centre and the Sub Centre in the Bhamragad Block.

Population of the selected villages

3.6 Table 3.4 gives village wise households, their total and tribal population and the percentage of tribal population.

Table 3.1

Population of the selected villages

Village	No. of house holds	Total population			Tribal Population			Percentage of S.T. population
		M	F	T	M	F	T	
1	2	3	4	5	6	7	8	9
1. Bhamragad	91	199	185	384	104	116	220	57.29
2. Koyanguda	14	43	52	95	43	52	95	100.00
3. Hemalkasa	49	150	154	304	145	151	296	97.37
Sub total	154	392	391	783	292	319	611	78.03
4. Vateli	32	90	91	181	90	91	181	100.00
5. Dodopalli	43	99	116	215	95	113	208	96.74
Sub total	75	189	207	396	185	204	389	98.23

The Table shows that the Scheduled Tribe population in the selected five villages was about 85% of the total population and thus the villages selected are predominant tribal villages.

Coverage of the households

3.7 Table 3.2 gives the number of households and the percentage of households covered under the health facilities survey.

Table 3.2

Village	Total No.of households (1971)	No.of households covered in survey	Percentage of households covered to total households
1	2	3	4
1. Bhamragad	91	45	*49
2. Koyanguda	14	22	100
3. Kenalkasa	49	43	88
Total	154	110	71
4. Vateli	32	32	100
5. Dodepalli	43	41	95
Total	75	73	97
Grand Total	229	183	80

*Only tribal households were surveyed.

Table 3.2 shows that more than 88% of the households were covered in the surveyed villages except Bhamragad where only tribal households were chosen for the survey.

Group coverage in the surveyed villages

3.8 Table 3.3 gives sub groups or tribewise details of the households surveyed in the selected villages.

Table 3.3

Sub groups or tribewise distribution of the surveyed households

Village	Sub groups or tribes				Total No.of households surveyed
	Madia Gond	Gond	Parâhan	Others	
1	2	3	4	5	6
1. Bhamragad	12	31	2	-	45
2. Koyanguda	22	-	-	-	22
3. Hemalkasa	10	32	1	-	43
Total	44	63	3	-	110
4. Vateli	32	-	-	-	32
5. Dodopalli	40	-	-	1	41
Total	72	-	-	1	73
Grand total	116	63	3	1	183

(183) households were surveyed in five villages. Out of these 116 (63.4%) were the Madia Gonds and 63 (34.4%) households were the Gonds. It shows that the Madia Gond was the predominant tribal group constituting about two thirds of the total tribal households in the survey.

Health coverage in the surveyed villages

3.9 As regards preventive measures taken by the Health Department of Chandrapur District, it was revealed that about 57% of the persons were innoculated for Cholera/ Small Pox/ B.C.G. etc. Its detailed analysis shows that 944 cases were immunised against epidemics, of which 493 pertained to Cholera and 438 to Small Pox.

Table 3.4 gives distribution of the cases innoculated in 5 selected villages.

Table 3.4

Distribution of immunisation cases

Village	Total No. of house holds surveyed	Total No. of members of the households surveyed	Health coverage			
			Cholera	B.C.G	Small Pox	Any other
1	2	3	4	5	6	7
1. Bhamragad	45	228	169	4	70	-
2. Koyanguda	22	118	1	-	32	3
3. Hemalkasa	43	262	-	-	2	2
Total	110	608	170	4	104	5
4. Vateli	32	195	171	-	173	-
5. Dodepalli	41	208	152	-	161	4
Total	73	403	323	-	334	4
Grand total	183	1011	493	4	438	9

3.10 Table 3.4 shows that as much as 49% and 43% of the population was immunised in xxxx 5 villages for Cholera and Small Pox. It reveals that effective measures were taken against the spread of epidemics except Koyanguda and Hemalkasa village. In the case of [illegible] measures were not taken in any of these villages.

Disease coverage

3.11 The survey was conducted to find out the major diseases which are prevailing in the population of the selected villages. Accordingly the diseases which were reported are classified into three categories. The number of persons suffering from one disease or other in the surveyed families is given in Table 3.5.

Table 3.5

Diseasewise classification of the persons in the households surveyed*

Village	Chronic Disease				Seasonal/accidential disease				Other than seasonal disease				Total	Percentage of population suffering from diseases
	T.B.	Leprosy	Other	Total	Male	Female	Children	Total	Male	Female	Children	Total		
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. Bhamragad	-	1	6	7	-	-	-	-	7	6	9	22	29	13
2. Koyanguda	-	-	-	-	1	-	-	1	3	2	6	11	12	10
3. Hemalkasa	6	1	-	7	-	-	-	-	7	4	8	19	26	10
Sub total	6	2	6	14	1	-	-	1	17	12	23	52	67	11.5
4. Vateli	-	-	2	2	-	-	-	-	10	3	8	21	23	12
5. Dodepalli	-	-	-	-	-	-	-	-	8	3	12	23	23	11
Sub total	-	-	2	2	-	-	-	-	18	6	20	44	46	11.4
Grand total	6	2	8	16	1	-	-	1	35	18	43	96	113	11.2

*The classification of persons suffering from diseases based on the reports of the respondents.

3.12 From Table 3.5 it appears that 11% of the tribal population in the households surveyed was suffering from various diseases at the time of survey.

The quarterly report submitted by the District Health Officer revealed that the diseases of respiratary system were very large in the tribal area when compared to the total cases in Chandrapur District. It shows the inoidence of respiratary diseases like T.B.etc. is more in the tribal areas. It may be largely due to the poor quality of food which the people eat. Similarly the percentage of people suffering from Anaemia is also considerably large in the tribal areas when compared to the cases in the district.

Family Planning

3.13 As regards family planning programme information was collected from the surveyed households. In 183 surveyed households, 62 persons were operated and all of them were males. The villagewise details of the persons operated is given in Table 3.6.

Table 3.6

Family Planning Programme in the ~~x~~ selected villages

Village	Total No.of household surveyed	Family Planning Cases		
		Male	Female	Total
1	2	3	4	5
1. Bhamragad	45	12	-	12
2. Koyanguda	23	7	-	7
3. Hemalkasa	~~xx~~ 63	23	-	23
Sub total	~~xx~~ 110	~~x~~ 42	-	~~x~~ 42
4. Vateli	32	7	-	7
5. Dodepalli	41	13	-	13
Sub total	73	20	-	20
Grand total	183	62	-	62

Maternity cases

3.14 Villagewise distribution of the maternity cases reported during the year under report is given below:-

Table 3.7

Maternity cases in the surveyed households

Village	Maternity cases
1. Bhamragad	12
2. Koyanguda	1
3. Hemalkasa	7
Sub total	20
4. Vateli	8
5. Dodepalli	13
Sub total	21
Grand total	41

It was generally observed that the maternity cases in the selected villages were attended by the local dais.

III

Health Services in the Tribal Development Blocks

Health Centres and Health Facilities

3.15 There are no adequate means of communication in the Block. Recently a road from Etapalli to Bhamraga has been constructed. However, this road is closed durin the rainy season. At present there is only one Primary Health Centre for the two Blocks- Etapalli and Bhamragad. No separate Primary Health Centre is established for the Bhamragad Tribal Development Block. Taking into consideration the area and the number of villages this arrangem is not sufficient to serve the health needs of the peopl

3.16 The Primary Health Centre is established at Etapalli in the year 1964, with its centres at Kasans Jarawandi, Laheri and Gatta. There are three Family Planning Sub Centres also at Halewara, Burgi and Ghotsur. Out of these seven centres, only Laheri and Gatta Sub Centres of the Primary Health Centre and Burgi Family Planning Sub Centre are situated in Bhamragad Tribal Development Block. Etapalli, the Primary Health Centre' Head Quarters is situated in the south-west corner of th Etapalli Block. The longest distance of the villages is eighty miles from this centre.

3.17 There are four Sub Centres attached to this Primary Health Centre. They are situated at 1)Kasansur 2) Jarawandi 3) Gatta and 4) Laheri. They are 22,36,22 and 40 miles away from the Primary Health Centre.

3.18 The Leprosy Centre is also attached to the Primary Health Centre. The Head quarters of the Leprosy worker is at Aheri who visits the Centre periodically.

3.19 There is no maleria unit in the Block. Only one maleria servilence worker is posted in the Block who is not the control of medical officer of the Primary Health Centre. The blood slides are taken at the Primary Health Centre and are sent to Chandrapur for further action. The dusting of D.D.T. is undertaken but maleria has not yet been completely wiped out in the Block.

Position of staff and medical services

3.20 The sanctioned strength and the present position of staff for the sub centres at Bhamragad and Ghotsur is as follows:-

Sub Centre	Personnel (Doctor)		Para-medical staff	
	Sanctioned	Present position	Sanctioned	Present position
1	2	3	4	5
Bhamragad	1	1	4	2
Ghotsur	1 (Vaidya)	1	-	-

3.21 Two posts of para-medical staff are vacant at Bhamragad Sub Centre while at Ghotsur no postsn have been filled uptil now. The Sub Centres have no government buildings and the medical staff have also no residential quarters at Bhamragad and Ghotsur.

3.22 Besides the above medical staff, 3 posts of para-medical staff are sanctioned for Bhamragad Family Planning Sub Centre, out of these one is vacant.

3.23 The injections necessary for the diseases which are common in the area are supplied to the sub centres. The patients who visit the sub centres are treated free of charge. The medical officer visits the sub centres as well as the officers-in-charge of the sub centres also visit the villages nearby and treat the patients.

3.24 At the time of epidemics, preventive measures are adopted in the Block. All the staff available at the Primary Health Centre and the Sub Centres are provided with necessary medicines and equipment to combat the epidemic. Additional help is also rendered from all other quarters.

3.25 There is no separate record from which the number of tribal patients could be ascertained. In the daily out patient register no caste or tribe is mentioned. It is therefore not possible to give figures for the tribal and the non-tribal patients treated in the health sub centre. The average daily attendence at Bhamragad Sub Centre is 23 in the year 1975-76.

3.26 From the out patients register maintained by the Primary Health Centre at Etapalli, it is observed that during the second fortnight of February, 1977, 269 patients from 26 villages visited the Public Health Centre for treatment. Details in this respect are given below:

Sr. No.	Village	No. of patients treated	Sr. No.	Village	No. of patients treated
1.	Etapalli	151	14.	Arkapalli	3
2.	Aheri	4	15.	Parsal Goar Masakat	2
3.	Todka	9	16.	Allapalli	1
4.	Jivangatta	25	17.	Udera	3
5.	Dodi	3	18.	Recha	4
6.	Alenga	2	19.	Chandanweli	3
7.	Kurnavelti	1	20.	Tatigudam	1
8.	Geda	11	21.	Gurpalli Masakat	2
9.	Krushar	8	22.	Barsewala	7
10.	Dumme	7	23.	Bidri	1
11.	Wasawoudi	4	24.	Tambda	8
12.	Kasansur		25.	Pandeweli	2
13.	Dolanda	2	26.	Aldandi	3
				Total	269

contd.

Medical and Para-medical staff of the Etapalli Primary Health Centre

3.27

I) Medical staff

Sr. No.	Designation	No. in position	Length of service in years-months of each person mentioned in Col.3					
			in Tribal Area		In non tribal area		Total	
			Yrs	Months	Yrs	Months	Years	Months
1	2	3	4	5	6	7	8	9
1.	Medical Officer	1	1	3	-	-	3	-
2.	-"-	2	1	-	9	-	-	9
3.	-"-	3	1	3	-	-	3	-
4.	-"-	4	1	-	7	-	-	7

II. Para-medical staff

1. Sanitary Inspector	3	* Not available -
2. Nurse Midwife	1	
3. Auxilliary Nurse Midwife	8	
4. Compounder	2	
5. Vaccinator	2	

The above information reveals that the medical staff posted at the Etapalli Primary Health Centre have no experience of working in the tribal areas.

Linkage with higher and lower level

3.28 Information given below will highlight the linkage of the medical and para-medical staff with higher and lower level institutions.

Linkage with higher level

Designation	No.of visits	Reason
1. District Health Officer	1	Inspection of the P.H.C. and inspection of records.
2. Dy.Director of Health Services, Nagpur	1	
3. C.A. and F.O. Zilla Parishad	1	Inspection of accounts
4. Chief Executive Officer, Zilla Parishad.	2	Inspection of P.H.C.

Linkage with lower level

Designation	No.of visits	Reasons
1.Medical Officer	37	Attending M.C.H.Clinic Work
2.H.L.S.(PHC)	18	Inspection of records
3.Sanitary Inspector (Etapalli)	2	Family Planning Works
4.Sanitary Inspector (Bhamragad)		Maleria work Epidemic duty
5. Health Visitor	Weekly visit	For planning MHC work etc.

Information given above indicates that the linkage with higher level institutions is rather unsatisfactory.

Budget Provision

3.29 During the year 1975-65, the expenditure incurred by the Primary Health Centre at Etapalli was about Rs. 88,00 as against the budget provision of about Rs.95,000. In addition to this, each Primary Health Centre gets about Rs. 25,000/- towards purchase of medicines.

IV

Health conditions of tribals and common diseases in the Bhamragad Tribal Development Block (Chandrapur)

3.30 The present economic condition does not permit the tribals to have nutritious and sufficient diet and in the circumstances they have to often live half-starved. Moreover, inadequate facility of clean drinking water can be added to it.

3.31 The important diseases therefore commonly prevalent among the tribals are:-

1. Leprosy
2. T.B.
3. Skin disease
4. Small Pox

The facilities which are provided at present are too inadequate to meet the situation. There is certain a great need to start and maintain health centres fully equipped in remote areas.

3.32 The important diseases can be classified as under:-

Tuberculosis is found in the tribals. Semi-starvation condition or inferior diet and with unhygienic conditions do result in contacting Tuberculosis. The tribals have both these factors in great percentage and therefore the incidence of T.B. is more among the tribals. The T.B. patients in tribals do not avoid close contacts of their family members and as such others are also affected by this disease.

3.33 The incidence of small pox is still a major problem in the remote areas. The tribals even do not get their children vaccinated periodically.

3.34 Skin diseases are found prevalent on a larger scale and more particularly among the small children and aged persons.

Health, Hygiene, Food supply and Nutritional needs in Dhamragad Area

In Dhamragad area the following important points with some of the health problems are emerged:-

3.35 Child mortality rate is high since notwithstanding married Adivasi women undergoing 10-12 deliveries, children who eventually grow to adulthood were only 3-4 per family. Obviously there is no awareness of family planning in these regions.

3.36 It is virtually impossible for the Adivasis to afford modern medical care. It is therefore important that one should consider extending medical care with the help of cheap Ayurvedic medicines which could be prepared from the local flora. It would also be useful to extend health care through training the village headman, medicinemam and the senior woman from each village who normally conducts delivery of babies. The concept of 'Bare-foot Doctor' could be extended to the forest villages by motivating/training the village headman himself to serve as a bare-foot doctor. A small honorarium/fee may be paid for such service. Administration of household remedies for most common diseases could be taught to these headmen, Common diseases arising mostly through exposure, bad hygiene, unsatisfactory housing, under-nourishment, malnutrition, insufficient and unhygiene water supply (availability) etc. will have to be treated.

Public Health, Hygiene and Housing

3.37 Most of the Madia village huts are mud huts. Hardly any light percolates through these huts and they are therefore exceedingly dark. There is scope for providing better houses through the Maharashtra Government's programme for rural housing. There is tremendous water scarcity also. Lack of availability of water would one of the causes for poor hygiene and health.

3.38 There are some villages where leprosy is rampant. For example, the village across the river near the forest rest house at Bhamragad has a population of only lepers. Due to remoteness this village is left completely without any medical care and people there have to lead a life of great agony and neglect.

Food supply and needs

3.39 The major source of food for the Adivasis is Paddy (Dhan). Apart from growing paddy, Adivasis have small plots of land around their houses where they usually grow a small kitchen garden, consisting usually of beans, tubers and white guard (Dhudi).

3.40 In most weekly bazars dried fish seems to attract a large number of buyers. Fish appears to be the major source for protein for forest tribes. There is a good potential for fisheries in natural ponds and ponds which may be created by nullah bunding in forest regions. As in West Bengal such ponds could serve not only as a source of clean water for health and hygiene but also for taking two crops and for fishing. Indeed the fish thus made available from such ponds and lakes could be the major source of protein for Adivasis and through it the health of the forest people is likely to improve.

3.41 As regards cooking oil, there seems to be a great scope for hanna na mesta oil extraction. The Adivasis do use mahua fruits as a supplement to their food and to some extent mahua oil also. However, there is a great scope for cultivation of mesta in forest regions and oil derived from mesta fruit should be an excellent source for vegetable cooking oil. The Adivasis hunt almost anything that moves and eat it. If alternative foods are made available they may not be required to go in for such undesirable and wasteful methods for procuring food.

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(2) The Kasa Tribal Development Block (District Thane)

I

General information of the T.D.Block

Location of the Block

3.1 The Primary Health Centre, Kasa falls in the Kasa Block in Dahanu Taluka of Thane District. This Block lies at the south-east of Dahanu Taluka. It is surrounded by the Saiwan Block at the north, the Ashagad and Dahanu Block at the west, Jawhar Taluka at the east and Palghar Taluka towards the south. It is a carved out Tribal Development Block of the Panchayat Samiti, Dahanu. It started functioning from 1st April 1964. Village Kasa which is the Head Quarters of the Block is situated on Dahanu-Jawhar Road at a distance of 25 kilometres from Dahanu, the Head Quarters of the Taluka and of the Panchayat Samiti and it is connected with a pucca road on which S.T.buses run regularly. Nearest railway station to the Block is Dahanu.

3.2 The area of the Block is 98.3 sq.miles. It includes 40 villages having a total population of 33600, out of which 88% belong to the Scheduled Tribes. The Varlis, Malhar Kolis, Koknas and the Katkaris constitute the important tribal group in the Block. The Block is underdeveloped and the tribals living there are backward in many respects. The chief economic activities of the people living in the Block are agriculture, agricultural labour and forest labour.

3.3 The medical facilities are available in the Block at a few places only. There is only one dispensary in the Block. It is located at village Charoti which is at a distance of a mile from Kasa. It is run by Christian Missionaries.

II

Health Survey in the Block

Selection of the villages:

3.4 In the Kasa Tribal Development Block eleven villages were selected for the survey of health facilities in the tribal area. The selected villages are as follows:-

A)	1) Kasa	2) Sonali	3) Vaghadi
B)	1) Tawe	2) Kalhan	3) Reth
C)	1) Saiwan	2) Chalani	3) Gangurdi
D)	1) Dhyale	2) Pimpalshet	

3.5 The first group consists of Primary Health Centre Head quarters and one village within 5 miles and the other group consists of villages more than 5 miles. The second and the third group pertains to the sub centre and two villages under each sub centre falling within 5 miles and more than 5 miles. The last group of 2 villages was such that these were situated far off from ~~kk~~ both the Primary Health Centre and the sub centres.

Population of the selected villages

3.6 Table 3.1 gives number of households, total population, tribal population and the percentage of tribal population to total population in the selected villages.

Table 3.1

Population of the selected villages

Sr. No.	Village	No. of House holds	Total population			Tribal population			Percentage of Scheduled Tribe population
			M	F	T	M	F	T	
1	2	3	4	5	6	7	8	9	10
A.	1. Kasa	305	673	613	1286	424	373	797	61.98
	2. Sonali	92	177	189	366	177	189	366	100.00
	3. Vaghadi	143	436	382	818	424	381	805	98.41
	Total A	540	1286	1184	2470	1025	943	1908	79.68
B.	4. Tave	134	403	378	781	369	343	712	90.74
	5. Kalhan	50	146	147	293	..	..	-	-
	6. Peth	50	160	193	353	23	19	42	11.90
	Total B	234	700	718	1427	392	362	754	52.84
C.	7. Saiwan	264	746	739	1485	735	730	1465	98.65
	8. Chalani	181	561	545	1106	543	528	1071	96.84
	9. Gangurdi	97	285	272	557	285	272	557	100.00
	Total C	542	1592	1556	3148	1563	1530	3093	95.00
D.	10. Dhyale	118	362	367	729	342	367	729	100.00
	11. Pimpalshet	64	207	197	404	207	197	404	100.00
	Total D	182	569	564	1133	569	564	1133	100.00
Total A+B+C+D		1496	4156	4022	8172	3549	3399	6948	85.02

From the table it appears that except Kalhan and Peth all other villages are predominant tribal villages.

Coverage of the households

3.7 Table 3.2 gives the number of households covered under the survey and the percentage of the surveyed household to the total households.

Table 3.2

Coverage of the households in the survey

Sr. No.	Village	Total No. of households (1971)	Households covered in survey	Percentage of household covered in survey to total households
1	2	3	4	5
A. 1.	Kasa	305	95	31*
2.	Sonali	92	32	35
3.	Vaghadi	143	92	64
	Total A	540	219	41
B. 4.	Tawe	134	134	100
5.	Kalhan	50	41	82
6.	Peth	50	38	76
	Total B	234	213	91
C. 7.	Saiwan	264	149	56
8.	Chalani	181	92	51
9.	Gangurdi	-	-	-
	Total C	445	241	54
D. 10.	Dhyale	118	31	26
11.	Pimpalshet	64	59	92
	Total D	182	90	49
TOTAL A+B+C+D		1401	763	54

(*Only tribal household were covered.

2.8 The Table reveals that 54% of the households were covered in the surveyed villages in the Kasa Tribal Development Block. The coverage of the households in Sonali and Dhyale village was 26 and 35% respectively. The villagers of Gangardi refused to give information as the people were afraid of the family planning programme.

Group coverage in the surveyed villages

3.9 The distribution of the households surveyed, sub group or tribe or castewise is given in Table 3.3.

Table 3.3
Tribewise distribution of the households surveyed

Sr. No.	Village	Malhar Koli	Katkari	Mangela	Koknna	Varli	Thakar	Others i.e. Maratha etc.	Total No. of households surveyed
1	2	3	4	5	6	7	8	9	10
A.1.	Kasa(PHC)	80	5	1	3	-	-	6	95
2.	Sonali	26	-	-	-	6	-	-	32
3.	Vaghadi	92	-	-	-	-	-	-	92
	Total A	2198	5	1	3	6	-	6	219
B.4.	Tawe(SC)	39	24	4	1	60	-	6	134
5.	Kalhan	39	-	-	-	2	-	-	41
6.	Peth	15	-	-	-	9	-	14	38
	Total B	93	24	4	1	71	-	20	213
C.7.	Salwan(SC)	1	3	-	98	34	-	13	149
8.	Chalani	1	-	-	21	68	-	2	92
	Total C	2	3	-	119	102	-	15	241
D.9.	Dhyale	15	-	-	-	16	-	-	31
10.	Pimpalshet	-	-	-	-	57	2	-	59
	Total D	15	-	-	-	73	2	-	90
Total A+B+C+D		308	32	5	123	252	2	41	763

It appears from Table 3.3 that 763 households were surveyed, out of these 308 (40.4%) were the Malhar Kolis, 252 (33%) the Varlis, 123 (16.1%) the Kokanas, 32(4.2%) the Katkaris and 41(5.4%) were the non-tribals. It shows that the Malhar Kolis were the largest group followed by the Varlis in the surveyed villages.

Health coverage in the surveyed villages

3.10 It was revealed in the survey that about 68% of the persons were innoculated for Cholera/Small Pox/B.C.G. etc. A detailed analysis shows that about 5,552 cases were immunised against epidemics. Out of these cases, 2459 pertained to Cholera, 2029 Small Pox, 785 B.C.G. and 279 pertained to other diseases.

Table 3.4 gives information regarding immunisation casees in 10 selected villages.

Table 3.4
Distribution of immunisation cases

Sr.No.	Group of villages	Total members in the households surveyed	Immunisation cases under: Cholera	B.C.G.	Small Pox	Any other
1	2	3	4	5	6	7
1	A	1236	1064 (86)	63 (6)	961 (78)	138 (11)
2.	B	934	154 (16)	233 (25)	174 (19)	59 (6)
3.	C	1259	1017 (81)	249 (20)	693 (55)	67 (5)
4	D	807	224 (28)	234 (29)	201 (25)	15 (2)
	Total	4236	2459 (53)	785 (19)	2029 (48)	279 (11)

(Figures in bracket indicate percentage of the total member)

3.11 It reveals that as much as 58 and 48% of the population was immunised in 10 selected villages for cholera and small pox respectively. If the groupwise villages are seen the picture is different. It shows that the percentage of the populations immunised in the villages far off from the Primary Health Centre and the villages where there is no medical institutions is very low for Cholera, Small Pox and B.C.G. Thus, it can be concluded that effective measures were not taken by the Primary Health Centre against the spread of epidemics in the far off villages.

Disease coverage in the surveyed households

3.12 The survey was conducted to ascertain the major diseases in the selected villages. Accordingly the diseases reported were classified into three categories are given in Table 3.5.

It seems from the Table that 5% of tribal population was suffering from the various diseases at the time of survey in the selected villages. From the observation made by the investigators after discussion with the Health Officer at Primary Health Centre, Kasa it become evident that the following six types of diseases were predominantly found in the areas:-

1) Scabbies
2) Roundworms
3) Branchopneumonia
4) Gastroenteritis
5) Malnutrition
6) Discharge from the ear

Table 3.5

Diseasewise classification of the persons in the surveyed households*

Sr. No.	Name of Village	Chronic diseases				Seasonal/accidental				Other than seasonal				Total
		T.B.	Leprosy	Other	Total	Male	Female	Children	Total	Male	Female	Children	Total	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
A.	1. Kasa	1	2	4	7	–	–	–	–	10	3	8	21	28
	2. Vaghadi	–	–	5	5	–	–	1	1	6	6	6	18	23
	3. Sonali	–	–	1	1	–	–	–	–	4	5	10	19	20
	Total A	1	2	10	13	–	–	1	1	20	14	24	58	71
B.	4. Tawe	1	5	3	9	1	2	2	5	9	6	20	35	49
	5. Kalhan	–	–	2	2	–	–	–	–	3	4	7	14	16
	6. Peth	–	–	3	3	1	–	1	2	11	12	13	36	38
	Total B	1	5	8	14	2	2	3	7	23	22	40	85	106
C.	[illegible]awan	2	–	8	10	2	–	–	2	8	1	7	16	28
	[illegible]lani	–	–	1	1	–	–	–	–	7	–	5	12	13
	[illegible] C	2	–	9	11	2	–	–	2	15	1	12	28	41
D.	[illegible]e	–	–	–	–	–	–	–	–	–	–	1	1	1
10	[illegible]shet	1	–	1	1	1	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	6	9
	Total D	–	1	–	1	1	1	–	2	4	–	3	7	10
	Grand Total A+B+C+D	4	7	27	39	5	3	4	12	62	37	79	180	228

*The classification of the persons suffering from diseases is loose and based on the reports of the respondents.

Family Planning Programmes

3.12 As regards family planning programme, details were collected by asking the households as to the number of persons operated in their family under family planning programme. In 10 villages selected for the survey 419 persons were operated. Out of these 380 were males and 39 were females. The following table gives villagewise breakup of the people operated in the Family Planning programme.

Table 3.6

Family Planning Programme in the surveyed households

Sr. No.	Village	Family Planning		
		Male	Female	Total
A	1. Kasa	41	8	49
	2. Sonali	16	1	17
	3. Vaghadi	39	-	39
	Total A	96	9	105
B.	4. Tawe	83	5	88
	5. Kalhan	15	1	16
	6. Poth	13	9	22
	Total B	111	15	126
C.	7. Saiwan	64	14	78
	8. Chalani	57	1	58
	Total C	121	15	136
D.	9. Dhoyale	16	-	16
	10. Pimpalshet	36	-	36
	Total D	52	-	52
Total A + B + C + D		380	39	419

The table reveals that out of the total male population (above 16 years) in the surveyed villages, 30% were operated in the Family Planning Programme. Further analysis is needed in this respect according to age, marital status and number of children. As no information was collected on these points it is difficult to ascertain the percentage of the operation in the eligible male population of the surveyed villages.

The above table also reveals that vasectomy operations for outnumbered tubectomy operations in the surveyed households.

Maternity cases

3.14 As regards maternity cases in the selected villages it was generally observed that they were attended mostly by the local Dais. The total number of cases villagewise are given below:-

Table 3.7

Maternity cases in the surveyed households

Sr.No.	Village	No.of maternity cases
1.	Kasa	36
2.	Sonali	14
3.	Vaghadi	39
4.	Tawe	15
5.	Kalhan	6
6.	Dhayale	3
7.	Peth	7
8.	Pimpalshet	9
9.	Saiwan	52
10.	Chalani	11
	Total	192

III

Health Services in the Block

Public Health Centre and Health facilities

3.15 The jurisdiction of the Primary Health Centre, Kasa is spread over 70 villages, out of which 32 fall in the Kasa Tribal Development Block and 38 in the Saiawan Tribal Development Block. The remaining 8 villages of the Kasa Tribal Development Block are attached to the Primary Health Centre Wangaon which is located in the Dahanu Community Development Block. The Centre thus covers the entire Saiawan Block and more than 3/4 portion of the Kasa Tribal Development Block. The Head quarters of the Primary Health Centre, Kasa, is located in the heart of the Block. The longest distance of villages from the Primary Health Centre is 9 to 10 miles in the Kasa Tribal Development Block and 15 to 17 miles in the Saiawan Tribal Development Block. The Kasa Health Centre has three Sub Centres located at Tawa (5 miles), Saiawan (10 miles) and Dhundalwadi (10 miles). Of these, Tawa is in the Kasa Block and Saiawan and Dhundalwadi fall in the Saiawan Block. One Family Planning Unit is also working at this Centre. This unit has three sub centres located at Dharampur (4 miles), Kalamdevi (15 miles) and Dapohari (12 miles). The Dharampur Sub Centre is situated in the Kasa Tribal Development Block and the Kalamdevi and Dapchan Sub Centre are in the Saiawan Tribal Development Block. Besides the above medical institutions, there is one mobile dispensary at Kasa also. However, it has no such centres. The

mobile dispensary has only 22 villages under its jurisdiction, out of which 2 are from the Palghar Tribal Development Block. The unit visits four to five villages on working days in a week for giving treatment to the patients.

Medical and para-medical staff and medical services

3.16 The staff working at the Kasa Primary Health Centre includes the following staff:-

Medical staff	No.
Medical Officer (P.H.C.)	1
Medical Officer (FP)	1
Sanitary Inspector	1
Para-medical staff	
Co-ordinator	1
Compounder	1
Nurse Midwife	1
Auxilliary Nurse Midwife	1
Family Planning Worker	4

The medical and para-medical staff working at the Kasa Tribal Development Block have acquired technical qualification for discharging their duties satisfactorily.

3.17 The following table gives the expenditure of the medical and para-medical staff in tribal area.

Table

Length of services in tribal areas

Designation	Total length of service (in years)		
	Tribal Area	Non Tribal Area	Total
Medical Officer (P.H.C.)	1	19	20
Medical Officer (F.P.)	2	-	2
Sanitary Inspector	10	-	10
Co-ordinator	10	-	10
Compounder	10	-	10
Nurse Midwife	10	-	10
Auxilliary Nurse Midwife*	-	-	-
F.P. Worker*	-	-	-

*The last two categories of the workers have experience only in tribal areas.

3.18 In addition to the above staff, one Auxilliary Nurse Midwife and one Vaccinator is provided at each of the three sub centres. One female field worker is also attached to the Family Planning Unit at each sub Centre. The Family Planning Unit is provided with a vehicle and a driver. The staff working in the mobile dispensary includes one medical officer, one compounder, one driver and one attendant-cum-cleaner. One mobile van is also provided to this dispensary.

3.19 The Health Centre provides a maternity home for attending to maternity cases. It has also a leprosy centre and a maleria unit. The midwife is in charge of the maternity home and the other existing staff of centre looks after the leprosy patients and the maleria eradication work. The centre has no separate arrangement to transfer serious patients to the district hospital. In emergency cases family planning vehicle and mobile van is utilized for this purpose. Disinfections of wells, small pox vaccinations and cholera inaculations are the important programmes which the centre undertakes to prevent epidemics in the region. The Centre provides free treatment to the tribals.

3.20 The staff working at Kasa Primary Health Centre are provided with staff quarters except the attendants. Those working at the sub centres have, however, no staff quarters except the auxilliary nurse and midwife of Tawa. The sub centres have no separate building for office purpose. As regards the mobile dispensary unit, the quarters are provided to all the staff members except the compounder. There is however no separate building for the mobile dispensary unit at Kasa.

Linkage with high level and low level institutions

3.21 The information given below will highlight the higher level and lower level linkage of the Primary Health Centre and the sub-centres.

P.H.C. visited by

Designation	No. of visits	Purpose
1. Deputy Director of Health Services.	5	Inspection of the P.H.C.
2. District Health Officer, Bombay/Thane	15	Inspection of records.
3. Collector, Thane	3	Family Planning work.
4. Chief Executive Officer	2	Epidemic work.

The information about the visits paid by the medical officer and other para-medical staff to the sub centres was not readily available at the time of field survey.

Attendence of the patients

3.21 The extract of the out patients register shows that 291 patients had attended Primary Health Centre for treatment. These patients were from 46 different villages. Out of these 46 villages, 27 villages were from Dahanu Taluka and remaining 19 from outside the taluka. The position of the villages has been shown in a map No.2.

3.22 During the second fortnight of January 1977, 175 patients were treated in the Primary Health Centre at Kasa, the villagewise distribution of which is given below:-

Sr. No.	Name of the village	No. of patients treated	Sr. No.	Name of village	No. of patients treated
1	2	3	1	2	3
1.	Chari T. Pawan	1	17.	Nikawali	1
2.	Dabchari	1	18.	Kasa Kh.	72
3.	Dabhachi	1	19.	Vaghadi	14
4.	Saiwan	2	20.	Mhasad	1
5.	Niarbapur	1	21.	Aurbiwali	1
6.	Bandhghar	2	22.	Urse	2
7.	Bapgaon	5	23.	Dhaurtane	3
8.	Vadhavan	1	24.	Ghol	2
9.	Dedale	3	25.	Varati	7
10.	Osarwira	1	26.	Veti	14
11.	Khavir	2	27.	Kolhan	1
~~12.~~	~~Charxxxx~~	~~1~~	28.	Tawe	4
~~13.~~	~~xxxCharixTxxGanjadxx~~	~~1~~	29.	Murwad	4
12.	Pawan	1	30.	Pimpalshet Bk.	5
13.	Sonale	6	31.	Dahane	1
14.	Sarai	1		Total	175
15.	Charoti	15			
16.	Chari T Ganjad	1			

Budget and expenditure

3.23 The total budget provision and the expenditure incurred during 1975-76 by the Primary Health Centre at Kasa was Rs. 1,15,455/- and Rs. 1,34,746/- respectively. The break up is given below:-

Budget provision and expenditure incurred during 1975-76

Sr.No.	Item	Budget provision (Rs.)	Expenditure (Rs.)
1.	Salaries	97,975	1,09,479
2.	Office expenses	3,980	2,457
3.	Travelling Allowance	13,500	22,810
	Total	1,15,455	1,34,746

In addition to this, each Primary Health Centre gets about Rs. 25,000/- towards purchase of medicines.

IV

Health condition in the tribal areas of the Kasa Block in Thane District

3.24 The Warlis, Kokanas, Katkaris and Thakurs are the main tribes in the block. The majoriry of them live in small thatched huts which do not provide windows. An apparent defect seen in a normal tribal house or hut is the lack of ventilation. The floors of the huts often get wet, especially during rainy days which are used for rest and sleep. The surroundings of their houses are also dirty. Moreover, the tribals do not take bath daily and wash the clothes regularly. They also do not get clean water to drink and nutritious food to eat. Sometimes they live on wild roots, fruits and leaves of edible plants. Drinking liquor is a common habit of the tribals. Their wage earning is hardly of any worth to give them regular and sufficient food.

3.25 The tribals particularly in hilly area still believe that illness can be cured by treatment of a Bhagat. They often seek his advise and treatment also. On many occasions medical aid is not sought for till the illness is much advanced and moreover the treatment is discontinued as soon as a patient feels a little better. The widespread poverty among the tribals generally leads them to malnutrition which in turn forms the background for many disorders and poor health standard.

3.26 The main diseases of the area which are found common among the tribals are as follows:-

1) Cough
2) Fever
3) Skin disease
4) Parasitic infection
5) Worm
6) Vitamin deficiency
7) Malnutrition
8) Night blindness, and
9) General debility.

In addition to these diseases Malaria, Anaemia, Dysentery, Flue and T.B. are also found in the area.

3.27 There is a serious problem of veneral diseases amongst the tribals. The basic problem in this regard is about the basic survey for want of which an adequate preventive and curative measures are not possible.

Health survey of the Katkaris in Thane District

3.28 The growth rate of Katkari children in early stages is retarded. Regarding nutritional content in the diet of the Katkaris the report points out deficiency of fat and absence of vitamins.

3.29 The reproductive age of Katkari women is given between 16 to 40 years. They do not have any traditional methods of family planning. Vasactomy operations have been done over 80% eligible Katkari males.

3.30 No special health survey was conducted in the past to understand the health problems of the Katkaris. The Katkaris were covered in routine campeigns for eradication of mass killers like Malaria, Cholera, Small Pox etc. There are no specific regular health services started for the Katkaris.

3.31 The Katkari habitat being approachable there are no natural barriers for the utilization of health services.

Genetic findings on the Katkaris

3.32 The Genetic Division of the Department of Medicine of the B.J.Medical College, Pune, was requested to conduct a study on the genetic condition of the Katkaris and make available their expert opinion for being incorporated in the monograph on the Katkaris commissioned by the Tribal Research & Training Institute.

3.33 The team studied the frequency of the following genetic marks.

1. Hemoglobin blood groups
2. Red Cell enzymes
3. Serum protein groups
4. Dermatoglyphies P.T.C.
5. Testing colour blindness

3.34 The Katkaris groups showed 1) High incidence of red cell enzyme 2) Deficiency of glucose 6 phosphate dehydrogenes 3) Abnormal hemoglobin known as sickle cell hemoglobin.

3.35 Approximately 10% of this population carried these abnormal genes in them. The abnormality of these two genes gives rise to haemolytic anaemia with all its known complications. The team also recorded high rate of infant mortality and congenital malformation like poly and syndactyly.

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(3) The Ambegaon Tribal Development Block (District Pune)

General background of the Block

Location of the Block

3.1 The western part of Ambegaon tahsil is largely a hilly tract, formed out of the numerous spurs of the Sahyadri ranges. Out of the total 100 villages in the tahsil 56 villages in the western portion are covered by the Ambegaon Tribal Development Block covering an area of 426 sq.kms. The total population of the Block is 34,963, of which 65% is Scheduled Tribes.

3.2 The Headquarters of the Ambegaon Block is located at Ghodegaon which is 38 kms. away from the heart of the Tribal Block. The Tribal Block begins at 4 kms. away from Ghodegaon, headquarters of the Panchayat Samiti. The Head quarters of the Block is situated at Ambegaon where office building and staff quarters have been constructed.

3.3 The major tribal communities in the Block are the Mahadeo Kolis, the Thakurs and the Katkaris. The tribal communities live in hilly and forest areas. The condition of the soil is very poor and irrigation facilities are also negligible in the Block. The main occupation of the tribal people is agriculture. Besides agriculture, the major occupation is agricultural labour.

Only a small number of persons are employed in other occupations. Agriculture and agricultural labour alone do not seem to provide with sufficient means of livelihood throughout the year and hence the tribal people have to supplement it with cattle breeding, dairy, poultry keeping and collection of forest produce like hirda fruits. Many of them also work as casual labour in road construction and forest plantation.

3.4 The poor economic condition of the people does not permit them to have nutritious and sufficient diet throughout the year and particularly in rainy season. Hence very often they have to live half-starved. This eventually reflects on their health. Moreover, inadequate facility of clean drinking water adds woe to misery.

3.5 The prominent diseases therefore commonly prevalent among the tribals in the Ambegaon Tribal Development Block are as follows:-

i) Fever, particularly cold (Malaria)
ii) Small Pox
iii) T.B.
iv) Skin diseases viz. Round-worms, thread-worms etc.
v) Nutritional disorders viz. protein and vitamin deficiencies and amaemia.
vi) Leprosy.

II

Health Survey in the Block

The Block under survey had started functioning in 1963. Two Primary Health Sub Centres viz., Ambegaon and Taleghar which are situated in the Block were established in the year 1965. These centres were then placed under the fulfledged Primary Health Centre, Ghodegaon.

Selection of the villages

3.6 As pointed in the first chapter, 9 villages were chosen for the study of health facilities in the Ambegaon Tribal Development Block. The villages chosen areg given below:-

Group	Villages
A*	Not applicable.
B	1) Ambegaon 2) Panchale Bk. 3) Kalambai
C	1) Taleghar 2) Kondhavai 3) Kushire Bk.
D	1) Tirpad 2) Don 3) Adivare

*Primary Health Centre is situated outside the Tribal Development Block.

Population of the selected villages

3.7 Table 3.1 gives villagewise total population, tribal population, number of households and the percentage of tribal population to total population.

Table 3.1

Population of the selected villages

Sr. No.	Selected village	No. of households	Population			Tribal population			% of S.T. population
			Male	Female	Total	Male	Female	Total	
1	2	3	4	5	6	7	8	9	10
A. 1.	Ambegaon	192	590	453	1043	184	96	280	26.85
	2. Panchale Bk.	47	142	151	294	118	126	244	82.99
	3. Kalambai	54	131	153	284	115	136	251	88.38
Total A		293	864	757	1621	417	358	775	47.81
B. 4.	Taleghar	109	275	229	504	258	212	470	93.25
	5. Kondhawal	86	242	219	461	233	213	446	96.75
	6. Kushire Bk.	~~118~~ 46	~~107~~ 113	~~220~~ 107	~~225~~ 220	~~97~~ 194	~~201~~ 97	201	91.36
Total B		241	630	555	1185	595	522	1117	94.26
C. 7.	Tirpad	44	129	110	239	109	93	202	94.52
	8. Don	52	146	113	279	139	126	265	94.98
	9. Adiware	58	142	156	298	124	140	264	88.59
Total C		154	417	399	816	372	359	731	89.58
Total A+B+C		888	1911	1711	3622	1384	1239	2623	72.42

Table 3.1 shows that except Ambegaon all other villages selected for the study are predominantly tribal villages having more than 80% of the tribal population. There is only 27% tribal population in Ambegaon village. As stated earlier Ambegaon is the main centre for weekly market, post office, Tribal Development Block office, high school and also for trading.

Coverage of households in the survey

3.8 Table 3.2 gives the number of households covered under the survey and percentage thereof.

Table 3.2

Coverage of households in the survey*

Sr. No.	Village	Total No. of households (1971)	No. of households covered in survey	Percentage of households covered in survey to total households
1	2	3	4	5
B. 1.	Ambegaon	192	36	19
2.	Panchale Bk.	47	27	57
3.	Kalambai	54	18	33
	Total B	293	81	28
C. 4.	Taleghar	109	65	60
5.	Kondhwal	86	34	40
6.	Kushire Bk.	46	13	28
	Total C	241	112	46
D. 7.	Tirpad	44	26	59
8.	Don	52	24	46
9.	Adiware	58	32	55
	Total D	154	82	53
	Grand Total	688	275	40

*Only tribal households were surveyed.

Group coverage in the surveyed villages

3.9 Table 3.3 gives group/tribe or castewise distribution of the households surveyed.

Table 3.3

Sub group or tribewise distribution of the households

Sr. No.	Village	Total No. of households surveyed	Mahadev Koli	Others (non-tribal)
B	1. Ambegaon	36	16	20
	2. Panchale Bk.	27	22	5
	3. Kalambai	18	17	1
	Total B	81	55	26
C	4. Taleghar	65	55	10
	5. Kondhawal	34	34	-
	6. Kushire Bk.	13	13	-
	Total C	112	102	10
D	7. Tirpad	26	14	2
	8. Don	24	24	-
	9. Adiware	32	31	1
	Total D	82	79	3
Grand Total		275	236	39

Table 3.3 shows that 275 households were surveyed, out of which 236 pertain to the Mahadev Koli tribe and 39 were others. It means among the households surveyed, the Mahadev Kolis form about 86% of the total households.

Health coverage in the surveyed households

3.10 While analysing the schedules it was observed that 796 innoculations were given under immunisation programme in the 9 selected villages. Out of this, 707 were for Cholera, 66 for B.C.G. and 16 were for Small Pox.

Data regarding immunisation in the selected villages is given alongwith the population of the respective villages in Table 3.4.

Table 3.4

Distribution of immunisation cases

Sr. No.	Village	Total No. of house holds surveyed	No. of members of households				Health coverage				
			M	F	C	T	Cholera	BCG	Small pox	Any other	Total
1	2	3	4	5	6	7	8	9	10	11	12
B	1. Ambegaon	36	75	65	85	225	157	14	3	2	176
	2. Panchale Bk.	27	54	57	70	181	112	9	2	-	123
	3. Kalambai	18	38	40	44	122	74	6	1	-	81
	Total B	81	167	162	199	528	343	29	6	-	380
C	4. Taleghar	65	117	108	161	386	239	19	3	-	261
	5. Kondhawal	34	68	60	78	206	3	3	2	-	8
	6. Kushire Bk.	13	24	27	40	91	2	5	1	4	12
	Total C	112	209	195	279	683	244	27	6	4	281
D	7. Tirpad	26	40	36	69	145	-	-	2	1	3
	8. Don	24	39	45	72	156	-	-	-	-	-
	9. Adiware	32	56	55	86	197	120	10	2	-	132
	Total D	82	135	136	227	498	120	10	4	1	132
Grand Total		275	511	493	705	1709	707	66	16	7	796

From the Table it appears that 41% of the total population was covered under Cholera innoculation in the year under report. As far as B.C.G. and Small Pox immunisation is concerned the coverage of population was only 4 and 1 percent respectively. It is also revealed from the Table that no measures were taken against spread of epidemics in the interior villages.

Disease coverage in the surveyed families

3.11 The following diseasewise classification was obtained in the surveyed households in the villages surveyed in the Ambegaon Block.

Table 3.5

Diseasewise classification of the persons suffering from various diseases

Sr. No.	Village	Chronic diseases: TB	Leprosy	Any other	Total	Seasonal/ accidental: Total	Other than seasonal: Total
1	2	3	4	5	6	7	8	9
A.	1. Ambegaon	1	-	-	1	5	-	6
	2. Panchale Bk.	-	-	-	-	-	-	-
	3. Kalambai	-	-	-	-	-	-	-
	Total A	1	-	-	1	5	-	6
B.	4. Taleghar	-	2	-	2	12	-	14
	5. Kondhawal	-	1	4	5	-	3	8
	6. Kushire Bk.	-	1	-	1	-	3	4
	Total B	-	4	4	8	12	6	26
C.	7. Tirpad	-	-	1	1	3	5	9
	8. Don	-	1	1	2	1	-	3
	9. Adiware	1	2	-	3	1	-	4
	Total C	1	3	2	6	5	5	16
Grand Total		2	7	6	15	22	11	48

From the above table it is seen that the number of persons with chronic diseases was insignificant. It is also observed that persons ailing from seasonal/ accidental as well as other than seasonal diseases were also few.

Family Planning Programme

3.12 As regards Family Planning Programme details were collected by interrogating the households as to the number of persons operated in their family under family planning programme. In the villages selected 124 persons were operated; out of these 93 were males and 31 were females.

Table 3.6 gives villagewise breakup of the family planning operations in the surveyed households.

Table 3.6

Family Planning operations

Sr. No.	Village	Family planning operations		
		Male	Female	Total
B	1. Ambegaon	9	8	17
	2. Panchale Bk.	8	3	11
	3. Kalambai	7	4	11
	Total B	24	15	39
C	4. Talegaar	24	6	30
	5. Kondhawal	10	1	11
	6. Kushire Bk.	3	4	7
	Total C	37	11	48
D	7. Tirpad	7	1	8
	8. Don	14	1	15
	9. Adiware	11	3	14
	Total D	32	5	37
	Grand Total	93	31	124

124 cases of Family Planning operations reveal a ratio of one operation in two households in the surveyed households.

Maternity cases in the surveyed households

3.13 The information about the maternity cases which took place in the surveyed families during the year under report was collected. The villagewise breakup of the maternity cases is given below:-

Table 3.7

Maternity Cases

Sr. No.	Village	Maternity cases
B.	1. Ambegaon	3
	2. Panchale Bk.	1
	3. Kalambai	2
	Total D	6
C	4. Taleghar	3
	5. Kondhawal	4
	6. Kushire Bk.	-
	Total B & C	7
D.	7. Tirpad	1
	8. Don	1
	9. Adiware	3
	Total D	5
	Grand Total	18

As regards the maternity cases it was generally observed that they were attended to mostly by local dais.

Attendance of the patients at the Sub Centre, Ambegaon

3.14 The Primary Health Unit at Ambegaon, where there is a subsidised medical practioner covers 32 villages having a population of 14,977.

In this tribal area scabbies and ring-worm are the commonly found diseases. Lack of cleanliness xx is the main cause for these ailments. The out-patient register revealed that during the first fortnight of January, 1977, 86 patients from 23 villages attended the Primary Health Unit at Ambegaon for treatment. The details are given below:-

Sr. No.	Name of the village	No. of patients treated	Sr. No.	Name of the village	No. of patients treated
1	2	3	1	2	3
1.	Borghar	10	15.	Amade	1
2.	Panchale Kh.	3	16.	Asane	4
3.	Panchale Bk.	2	17.	Nhaved	2
4.	Tirpad	1	18.	Megholi	1
5.	Vachape	6	19.	Jambhori	1
6.	Malin	6	20.	Kushire Bk.	1
7.	Adiware	9	21.	Kashire Kh.	1
8.	Kolthavade	7	22.	Patan	3
9.	Ambegaon	12	23.	Sarvarli	1
10.	Don	1			
11.	Kalambai	2		Total	85
12.	Dimbhe Kh.	6			
13.	Phusavade				

III

Health services in the Block

3.15 Two Primary Health Units viz., Ambegaon and Taleghar which are situated in the Block were established in the year 1965. These centres were then placed under the fulfledged Primary Health Centre established at Ghodegaon. Besides these two units, the following family planning sub centres are working under the Primary Health Centre, Ghodegaon.

Village	Unit of health services
I. Ambegaon	I. Primary Health Unit and subsidised medical practioner centre.
II. Taleghar	II. Primary Health Unit and Family Planning Sub Centre.
III. Dimba	III. Family Planning Sub Centre
IV . Pokhari	IV. Family Planning Sub Centre and Ayurvedic dispensary.
V. Sinoli	V. Family Planning Sub Centre.

3.16 Besides the above institutions some leprosy clinic is also working at Ghodegaon having its sub-units at Ambegaon and Taleghar. One field worker for nearly 12 villages attached to the Primary Health Sub Centre, Taleghar and one Maleria Sanitary Inspector with three assistant workers attached to the Primary Health Sub Centre, Ambegaon attends the maleria medical programme in the Block.

3.17 Further it is also noted that there is no provision of milk distribution to the children through these health centres at present. Maternity and child welfare services are very few in the tribal area. In the case of annormal or difficult labour pains, the patient is usually left to her fate or has to be transported for long distances before any medical aid can be available, and it is not unusual to find a woman in labour pains arriving in extremis in the hospital.

3.18 The Primary Health Centre, Ghodegaon is equipped with medicines and surgical instruments. The sub centre at Ambegaon though fully equipped with medicines is partially supplied with surgical instruments. The sub centre at Taleghar reports inadequate supply of medicines. No surgical instruments are provided to the sub centres. Similarly no injections on dog-bite, snake bite etc.are also supplied to these centres. The injections on snake bite and other diseases are supplied to the centre at Ghodegaon.

3.19 This provision appears to be the ceilings fixed for the expenditure per year per centre. Arrangements to store the medicines in a refrigator is only available at the ~~Ghodegaon~~ Ghodegaon centre. So also no arrangement to transport the patients is available at Taleghar and Ambegaon. UNISEF vehicle is only available at Ghodegaon. This vehicle is used very rarely for transporting the patients to the district hospital in emergency.

3.20 Generally the treatment is given free of cost to all patients but many times the patients are required to pay the cost of medicines or injections given to them by the medical officers, especially at Ambegaon and Taleghar Sub Centres. This is due to non availability of stock of medicines or injections. The medical officers of these centres have to purchase the required medicines or injections privately through the local market since there is no provision to stand excess amount for the purchase of medicines or to get more supply of stock from Government district hospitals.

3.21 During epidemics, preventive measures are undertaken by all these centres such as vaccinations, innoculations, cholera vaccinations etc. Only serious cases are referred to Sassoon Hospital,Pune. As also disinfection of well programme is undertaken regularly by all these centres.

3.22 Out of the centres mentioned above the centres at Ghodegaon and Taleghar are located in the buildings owned by Zilla Parishad whereas the centre at Ambegaon is housed in a rented building. No staff quarters are provided at any of these centres. The staff attached to the centres and their experience of work in tribal areas is ~~xixxx~~ as follows:-

Primary Health Centre, Ghodegaon

Sr. No.	Designation	No. in position	Lenght of service (in years) of each person mentioned in Col.3		
			In tribal area	In non-tribal area	Total
1	2	3	4	5	6
I.	Medical staff				
	1. Medical Officer-I	1	4	1	5
	2. Medical Officer-II	1	1	-	1 (Less than 1 year)
II.	Para-medical staff				
	1. Sanitary Inspector	1	Not available		
	2. Leprosy Technician	1			
	3. Vaccinator	3			
	4. Health Visitor	1			
	5. Nurse Midwife	1			
	6. Auxilliary Nurse Midwife	5			

Primary Health Unit, Ambegaon

I.	Medical staff				
	1. Medical Officer-I	1	-	15	15
II.	Para-medical staff				
	1. Health Visitor	1			
	2. Auxilliary Nurse Miswife	1			
	3. Vaccinator	1			
	4. Male Attendant	2			
	5. Female Attendant	1			

Primary Health Centre's Sub Centre, Taleghar

I. Medical staff- Nil-

II. Para-medical staff

1. Vaccinator	1)	Not available
2. Peon	1)	
3. Lady attendant	1)	

3.23 The Medical Officer visits the Primary Health Units and Sub Centres once a week. The Auxilliary Nurse Midwife of Ambegaon has to visit one village per day around Ambegaon and Taleghar. The Sanitary Inspector and the Vaccinator go round the villages in the tribal areas for preventive treatment.

Budget provision

3.24 In the following table the budget provision and expenditure incurred during 1975-76 by the Primary Health Centre at Ghodegaon is given.

Table 3.8

Budget provision and expenditure (1975-76)

Sr. No.	Item	Budget provision	Expenditure
1.	Salaries	1,02,991	1,38,886
2.	T.A.	10,486	9,846
3.	Other	11,200	11,200
	Total	1,84,677	1,59,932

In addition to this, each primary health centre gets about Rs.25,000/- towards the purchase of medicines.

Health condition of tribals and common diseases in the Ambegaon Tribal Development Block

3.25 In a village all the houses of a particular tribe are in one group and in a separate pada in Ambegaon Tahsil of Pune District. The sites are at higher levels and houses are situated generally near the sources of water. However, for want of clean drinking water the tribals are suffering from skin diseases and diseases like Cholera and Dysentry.

3.26 The notable diseases of the area which are found common among the Adivasis are:-

1. Maleria
2. Small Pox
3. Skin diseases
4. Vitamin deficiencies of anaemia
5. Leprosy

Among these diseases Maleria has been markedly reduced. The control of Small Pox is rather difficult since it depends on the willingness of the population to be vaccinated. Leprosy is generally being controlled as it becomes evident. In Ambegaon Taluka there is one leprosy centre attached to the Primary Health Centre. The Public Health Centre and Sub Centres fall short to give medical help to the tribals from interior. One mobile van at Ambegaon is badly essential to help the tribals from interior areas.

I

The Dharni Tribal Development Block

General information of the Block

Location of the Block

3.1 Dharni is the taluka head quarters of Melghat Tahsil and the Dharni Tribal Development Block, which is 90 miles away from the district Head Quarters, i.e. Amravati. It is connected by an all season traffic road, Amravati-Barhanpur. To the east of Dharni Block is the Chikhaldara Block and to the west the border of Burhanpur Taluka of Nimad District of Madhya Pradesh is at a distance of about ten miles from Dharni. Akot Taluka from Akola district is to the south and to the north is the Bhaisdehi Tahsil of Betul District of Madhya Pradesh.

3.2 As per 1971 census there are 145 villages in the Dharni Block covering an area of 1812 sq.kms. The total population of the Block is 64232 of which 47675 i.e. 74.06% is tribal population. An area of 65 kms.of the Dharni Block is covered by Tapti river. Sipna and Gadga are the other two important rivers in the Block. The land under cultivation in the Block is black and porous and that of the river side suitable for irrigation.

3.3 The forest in the Block falls broadly under the category "Souch tropkical dry deciduous Forest". The teak is a valuable specie found in this forest. Dhawda, Tendu, Achav and Rohan are the other important forest produces. Rusa grass and gum is also found in the inferior land and used by the tribal people in the interior.

3.5 Apart from Dharni, Kalamkhar, Harisal, Dhulghat railway, Baratanda and Susarda are unregulated markets. The major market for satisfying the needs of this Block is Paratwada which is 62 miles from Dharni.

3.6 The Korkus, the Gonds, the Nihals and the Pardhis are the tribal groups of the area. The Korku is the major tribal group of the Block. The main dialect prevalent in the Block is Korku. It is spoken by the Korkus. Marathi is also spoken by the people. The medium of education in the primary stage is in Marathi. The Korku dialect has no script.

3.7 The Primary Health Centre is functioning at Dharni. Harsul, Satrabadi and Chakarda are the sub centres of the Primary Health Centre, Dharni. Harisal is 15 miles away from Dharni and Sadrabadi is 11 miles. Chakarda is at a distance of 8 miles. The Chakanda Sub Centre is inaccessible during rainy season. Three Ayurvedic dispensaries are functioning at Harisal, Bairagad and Susarda.

II

Health Survey in the Block

3.8 As stated earlier the Dharni Tribal Development Block from Melghat Taluka was selected for the Health facilities survey. The Primary Health Centre is situated at Dharni. Jurisdiction of the Primary Health Centre covers a population of 64,232, out of this the tribal population according to 1971 was 47675 i.e. 74%.

Selection of the villages

3.9 According to the norms stated in the first chapter 8 villages were selected from the Dharni Tribal Development Block for the health facilities survey. The villages selected according to the groups are as follows:-

A) 1. Dharni 2. Utawali 3. Padidam

B) 1. Harisal 2. Nanduri 3. Dabka

c) Nil

Population of the selected villages

3.10 Table 3.1 gives villagewise total population, tribal population, number of households and percentage of tribal population to total population.

Table 3.1
Population of the selected villages

Sr. No.	Village	No. of house holds	Total population	Total tribal population	Percentage of S.T. population
1	2	3	4	5	6
A.	1. Dharni	994	5357	1158	21.62
	2. Utawali	61	315	245	77.78
	3. Padidam	25	188	168	89.36
	Total A	1080	5860	1571	26.81
B.	4. Harisal	102	495	250	50.51
	5. Nanduri	80	503	436	86.68
	6. Dabka	94	521	402	77.16
	Total B	276	1519	1088	71.63
C.	7. Savalikheda	226	1276	1018	79.78
	8. Nagzira	75	445	434	97.53
	Total C	301	1721	1452	84.37
Grand Total		1657	9100	4111	45.18

From the table 3.1 it appears that except Dharni (Head Quarters of the Block, Tahsil place and the Primary Health Centre) all other villages selected for study are predominant tribal villages in the Block

Coverage of the household in the survey

3.11 Table 3.2 shows groupwise number of households, the number of households covered under the survey and the percentage of households covered to the total households.

Table 3.2

Coverage of the households in the Survey

Sr. No.	Village	Total No. of households	No. of households covered in the survey	Percentage of households covered to total households
1	2	3	4	5
A.	1. Dharni	994	88	9
	2. Utawali	61	47	77
	3. Padidam	25	16	64
	Total A	1080	151	14
B.	4. Harisal	102	33	32
	5. Nanduri	80	45	56
	6. Dabka	94	67	71
	Total B	276	145	53
D.	7. Sawalikheda	226	195	86
	8. Nagzira	75	39	52
	Total D	301	234	78
Grand Total		1657	530	32

Except Dharni and Harisal, the coverage of the ~~M~~ households in the survey was more than 50%. Further it is observed in ~~that~~ the selected villages that the majority of the households surveyed were from the tribal groups.

From the table it appears that 6% of the total population was covered under Cholera innoculation, 0.06% and 47% was covered under B.C.G. and Small Pox respecti-

Disease coverage in the surveyed households

3.14 In the surveyed villages the following diseasewise classification was obtained.

Table 3.5

Diseasewise classification of persons suffering from various diseases

Sr. No.	Village	Chronic Diseases				Seasonal/ accidental	Other than seasonal	To
		TB	Leprosy	Any other	Total	Total	Total	
1	2	3	4	5	6	7	8	
A	1.Dharni	-	-	2	2	37	-	3
	2.Utawali	-	-	4	4	18	18	4
	3.Padidam	-	-	1	1	6	-	7
	Total A	-	-	7	7	61	18	8
B.	4. Harisal	1	-	6	7	17	4	2
	5. Nanduri	1	-	1	2	14	5	2
	6. Dabka	-	-	1	1	17	6	2
	Total B	2	-	8	10	48	15	7
D.	7. Sawali-khedа.	4	5	3	12	32	30	7
	8. Nagzira	-	1	1	2	2	1	
	Total D	4	6	4	14	34	31	7
Grand total		6	6	19	31	143	64	238

The above data reveals that the number of pers suffering from chronic and other than seasonal diseases rahte small as compared to seasonal/accidential disea

Family Planning Programme

3.15 As regards Family Planning Programme details were collected from the members of the households. 164 operations were performed in the villages, out of which 146 were males and 18 were females.

Table 3.5

Family Planning Cases

Sr. No.	Village	Family Planning cases		
		Male	Female	Total
A	1. Dharni	30	1	31
	2. Utawali	13	3	16
	3. Padidam	3	1	4
	Total A	46	5	51
B	4. Harisal	11	-	11
	5. Nanduri	8	1	9
	6. Dabka	23	7	30
	Total B	42	8	50
	7. Sawalikheda	56	5	61
	8. Nagzira	2	-	2
	Total D	58	5	63
Grand total		146	18	164

Maternity cases in the surveyed families

3.16 The distribution of maternity cases in the surveyed families of 8 villages during the year under report is given below:-

Table 3.6

Maternity Cases

Sr. No.	Village	No. of maternity cases
A	1. Dharni	11
	2. Utawali	14
	3. Padidam	2
	Total A	27
B	4. Harisal	6
	5. Nanduri	9
	6. Dabka	11
	Total B	26
D.	7. Sawalikheda	20
	8. Nagzira	6
Grand Total		79

Except Dharni in other villages the maternity cases were attended by the local dais.

III

The Public Health Services

3.17 The Primary Health Centre is located at Dharni, Harisal, Sadarabadi, Chakarda are the sub centres of the Primary Health Centre, Dharni. New buildings are constructed at each place. Harisal is 15 miles from Dharni and Sadarabadi 11 miles. Chakarda is at a distance of 7 to 8 miles. Only Harisal is connected by pacca road. Chakarda centre, however, has a four mile fair weather ~~xxxx~~ season road and the remaining a pacca road. The Chakarda Sub Centre is inaccessible during rainy season.

3.18 The Primary Health Centre is equipped with all the surgical equipment as are allowed for the Primary Health Centre. Three sub centres are provided with neoessary medicines.

3.19 There is no regular programme of milk distribution to the children from the Primary Health Centre and attached sub centres. The staff of the Maleria unit is working in the Block and one Maleria Health worker is working at Dharni and one at Kalamkhar Centre.

Attendence of the patients at the Primary Health Centre Dharni

3.20 During the first-fortnight of February, 1977 347 patients from 14 villages visited the Primary Health Centre at Dharni for treatment. The details are given below:-

Sr. No.	Name of the village	No. of patients treated
1.	Dharni	320
2.	Tingariya	1
3.	Jamba	2
4.	Bori	1
5.	Susarda	5
6.	Sadrabadi	1
7.	Gharkund	2
8.	Hardoli	2
9.	Jatpani	1
10.	Mandwa	4
11.	Baspani	2
12.	Talai	3
13.	Diya	2
14.	Shirpur	1
	Total	347

It shows that more than 90% of the patients are only from Dharni proper and only few of them are from the surrounding villages.

Medical and para-medical staff

3.21 The following medical and para-medical staff is in position at the Primary Health Centre, Dharni.

Designation	No. in position	Qualification	Length of service in years		
			In tribal area	In non tribal area	Total
1	2	3	4	5	6
I. Medical staff					
Medical Officer	1	M.B.B.S.	1	17	18
	2.	M.B.B.S.	1	5	6
	3.	M.B.B.S.	1	2	3
	4.	B.A.M.S.	1	-	1
II. Para-medical staff					
1. Co-ordinator	1	*			
2. Sanitary Inspector	1				
3. Compounder	1				
4. Computor	1				
5. Vaccinator	5	Not available			
6. Nurse Midwife	1				
7. Auxilliary Nurse Midwife	10				
8. Dresser	1				

(*All the staff possess the required qualification).

It shows that the medical staff at the Dharni Primary Health Centre have only one year's experience of working in the Tribal areas.

Visits

3.22 During January, 1977, 5 visits were paid by the medical officers in connection with the family plan camps and checking up of the records of the sub centres.

Budget and expenditure

3.23 For the year 1975-76 the budget provision for the Primary Health Centre at Dharni was Rs. 208250/-. Against this, the expenditure was incurred Rs.159,124/- In addition to the above a provision of about Rs.25,000/- per year is made for medicines.

IV

Diseases commonly prevalent among the tribals of the Dharni Tribal Development Block

3.24 The Medical Officer, Primary Health Centre, Dharni reported that the following diseases are prevalent among the tribals in the tract. This is also seen from the number of cases treated in the primary health centres in 1975-76.

1. Deficiency diseases
2. Dysentry or diarohea and/or entrietes
3. Pneumonia
4. Tuberculosis
5. Small pox
6. Skin diseases
7. Leprosy

3.25 The diseases at serial No.1 and 2 are mainly due to inadequacy of nutritious diets and drinking of unclean water. Maleria has been controlled during the past few years but many positive cases have been detected not only in the tribal area but also in the other parts of the district during the last two years. The medical officer also reported further that Maleria has become again a disease worthy of cognizance in the area.

3.26 Pneumonia is yet another cause of death among the people and the tribals in particular of this tract. The tribals are generally exposed to extreme cold because they do not possess pucca houses and even bare clothes and bedings. Obviously, they are affected by cold which turns quickly into pneumonia.

3.27 Tuberculosis is again another disease found in the tribals. Semi-starvation conditions or inferior diet and unhygienic conditions do result in having tuberculosis. The tribals are having both these factors in greater percentage and therefore the incidence of T.B. among the tribals is more. The T.B. patients in the tribals do not avoid contacts of their family members.

3.28 Although the work of vaccination is being done progressively in each year the incidence of small pox is still a major item in the tribal area. The tribals even to-day do not get their children vaccinated after intervals. The go to the Bhumka and take spelled water.

3.29 Skin diseases are found prevalent on a larger scale and more particularly among the small children.

3.30 Leprosy is again a notable disease among the tribals of Melghat and Dharni.

3.31 The snake bite cases do not come under the category of diseases. Due to forest the poisoneous snakes are in greater number and every year many cases are required to be treated in the health centre.

Detailed survey for leprosy

3.32 Gondwadi, Chichghat, Dharni, Duni, Ranitamboli, Hardoli, Diya and Utavai are the villages in Dharni Block where spread of this disease is noticed in a greater number.

There are still other 18 villages from where the patients have approached for receiving the medicines to the leprosy centre. It is therefore necessary to take detailed survey of the patients by physical examination from the Medical Department to know the number of leprosy patients in the area.

3.33 It was noticed that still many children below one year are not vaccinated.

3.34 The supply of clean drinking water is yet required to be made at 20 places where drinking water is available either from the river or the 'zira' in the Nala Beds.

Chapter IV

Observations

4.1 The Primary Health Centres in the surveyed area are not well equipped and adequately fed with necessary drugs for the treatment of various diseases. Equipment necessary for conducting necessary operations is also lacking. Hence the tribals have to travel long distances, incurring considerable expenses to get modern medical treatment at the district Head Quarter hospitals. As most of the tribal patients are still shy to visit new places and to poor to afford any expenses; even those patients who were convinced by the health workers to visit the Primary Health Centre often return disappointed, unable to visit the far off hospitals, foregoing their daily wages. This situation comes in the way of attracting tribal patients who feel that they can not get good attention from the Primary Health Centres. Hence the Primary Health Centres in the tribal areas may be adequately supplied with drugs and equipment for treating various diseases.

4.2 The health programme of the Blocks has not been very successful because of the shortage of staff and also the apathy of the tribals towards disease and its cure. Quite some time the Health Sub Centres at the Block headquarters were without any doctor and para-medical staff. The reason given was that trained doctors in general are unwilling to come to this remote area on a salary which they can easily get in any urban area where there are also opportunities to supplement it through private practice. The same reason is valid for midwives also.

4.3 The tribals are still shy to visit hospitals in far off places. Most of them expressed the view that the staff in the Government hospitals, will not pay any attention towards them. The doctors of the mobile medical units should be made responsible both for the initial diagnosis and follow up treatment. The health visitors may also be made responsible to periodically check whether the patients are taking the drugs regularly. The visits may be utilised for health education also, with a view to change the attitude of the tribals towards modern medicine. When it is necessary for a tribal patient to visit the hospital far away from his home, allowance towards transport and daily expenses may be considered by the Tribal Welfare Department and the Public Health Department.

~~xxx~~

4.4 The problems of health services do not merely relate to expansion of the existing services and creation of new services, but also relate to proper allocation and distribution, keeping in view the diverse needs of the population.

4.5 Apart from the politico-administrative set up, the efficiency of the technical staff is also affected by the service conditions. It has been pointed out that the medical service is many times constrained by the non-availability of adequate equipments, medicines and staff etc. Their performance is also restrained by long drawn procedures which they have to follow in the discharge of their duties. Considering the nature of the emergent situation in which they have

to operate, these rigidly laid down procedures not only slow down their performance but render them ineffective.

4.6 It has also been revealed that the staff engaged in the organisation and management of the health services is not provided with amenities, commensurate with the arduous work they have to put in. This particularly applies to the sanitary and medical staff. The employees in this category had expressed a good deal of dissatisfaction with their work.

4.7 It has been observed that the planning and organisation of health services not only show regional imbalance but they are not based on any rational considerations also. It is partly due to the fact that no systematic information is available about health needs of various areas. No health statistics are available on that basis. It has been found that there are certain areas which show greater incidence of certain types of diseases, yet no systematic information on these lines has been collected. Thus, it is observed that plans and programmes for health services in tribal area are less guided by any rational consideration.

4.8 The tribals still hold fatalistic mentality, great belief in super-natural powers and lack of knowledge of the highly communicable diseases are responsible for their apathy towards isolation. It was also pointed out that the acceptance of the help of the midwife at the time of child-birth among them is accompanied by various taboos and rituals and a midwife so far has not had any place in all these ceremonies. Moreover, a midwife being generally ignorant of these birth ceremonies is liable to make mistakes.

4.9 In the treatment of diseases, the tribals are increasingly recognising the efficacy of modern medicines. This should not however imply that the tribal medicineman with his magic treatment has completel disappeared from the scene. In fact people often take both the treatments and are least bothered to find out which of the two varieties of treatment actually cured them. The most common diseases in this region are maleria, dysentry, skin diseases. Somehow, these people have greater faith in injection rather than in medicines that are taken orally.

4.10 The hold of superstitious and well established unhealthy practices cannot be wiped out over night. However, concerted efforts should be made to minimise the hold of these superstitious and unhealthy practices through persistant propaganda and persuation of the tribal on the advantages of taking moder medicine at the earliest sign of the disease. Health education is the pre-requisite to make the tribals understand the nature, mode of transmission and treatment on various diseases. The health educators, V.L.Ws. and the sanitary inspectors in the tribal areas should arrange film shows and talks to inform the tribals about sanitation and preventive measures. Occasions like fairs and festivals where the tribals congregate in large number should be utilised for the purpose. Informal talks with tribal leaders and house to house camp-aign by the health educators on the need for isolation of leprosy and T.B. patients, use of separate vessels for drinking and spitting, giving nutritious food etc. will be very useful. The tribals should be discouraged

from wasting money on black-magic and quack doctors. This task can be performed by the health education cell. The health education cell can become a focal point of the wide variety of educational programmes to be carried out by the health officer to educate public in usefulness of preventive health information through newspapers, radio and health education camps etc.

4.11 Malnutrition is one of the most important health problems of the tribals. Under-nutrition, the lack of enough food, is the form of malnutrition which is most widespread, it has been estimated that it affects as many as 90% to 95% of the tribal population.

4.12 The causes of under-nutrition among the tribals are many and they are often interrelated. One basic condition which is always present is the inadequate diet. This most frequently results from poverty and the lack of ability to buy enough food. Other factors are the production and use of foods of low nutritive value, the unavailability of nutritious foods such as milk, the lack of understanding about the relation of food to health and beliefs and taboos which deny available food to those who need it. The prevalenceex of diarrheas is known to intensify malnutrition.

4.13 Since most foods contain a number of nutrients, deficiency diseases usually reflect a lack of not one butxf of several dietary essentials. The deficiencies which occur most frequently and affect the largest numbers of people in tribal areas are protein and vitamin A. Vitamin A deficiency is frequently associated with protein-caloric malnutrition and is another result of a generally poor diet. The most serious effect of the lack of Vitamin A is the damage done to the eyes. In

tribal areas the main xxxxx cause of xxxxix avoidable blindness is lack of Vitamin A. Night blindness, the inability to see in dim light, is an early indication of Vitamin A deficiency. Vitamin A is closely associated with growth and with the maintenance of healthy epithelial tissue. Deficiency of Vitamin A may result in lowered resistance to infection. Infectious diseases in turn predispose the child to xorophthalmia. This is especially true of measles, respiratory infections and diarrhea or dysentery which interfere with effective absorption of Vitamin A or carotene.

4.14 The observations bring into lime light certain loop holes in the implementation of family planning programme which are to be plugged for the smooth implementation of the programme without disturbing normal life of the people. It is of paramount importance to see that the material indecement does not take the upper hand in attracting tribals to avoid post-operation hostility towards the programme. Comprehensive, authentic and up-to-date list of "Target couples" should be prepared before conducting mass vasectomy or tubectomy camps. The 'Target couples' register should be periodically checked by random sampling method by a responsible officer to ensure its authenticity and keep it up-to-date. All cases of failure should be thoroughly investigated and the results should be made public to dispel false notions and rumours. Even if it is an established case of failure it should not be hidden from the people in order to avoid casting of aspersions on the professional ethics of the doctor and sincerity of purpose of the programme. Instead of trying to achieve large scale sterilisation it is advistable to suggest the programme

on a moderate scale as the present mass sterilisation programme is giving scope for attributing ulterior motives like extermination of tribes as a whole to kkk the programme. With a view to conteract the malpropagand wide publicity should be given in tribal areas to the achievements of family planning among plains people. Follow up medical aid should be made available for all the acceptors by way of introducing systematic periodical post-surgical checkup. The present family planning slogan "two or three enough" in view of the high incidenc of infant mortality due to inhospitable environment, rampant malnutrition and lack of sufficient medical facilities in tribal areas. There should be provision for meeting out severe punishment to dubious promoters in order to curb their coercive and deceitful tactics in convincing innocent and gullible tribals to undergo vasectomy, though they do not require any family planning. Lastly, there is need for doing spade work before launching mass family planning camp through audio-visual methods in order to keep the tribals fully informed of the aims and advantages of family planning programme and in the process eliminate post-camp mass-hysteria.

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Annexure I

Selection of Tribal Development Blocks in the Sub Plan Area

Geographical region	District	Tahsil	Tribal Development Block	Remarks
1	2	3	4	5
Sahyadri Region				
	Thane	Talasari	1) Talasari	
		Jawhar	2) Vikramgad	
			3) Jawhar	
		Mokhada	4) Mokhada	
		Dahanu	5) Saiwan	
			6) Kasa	Selected
			7) Asave (Ashagad)	
		Palghar	8) Manor	
			9) Warle	
	Nasik	Peint	10) Peint	
			11) N Harsul	
		Surgana	12) Surgana	
			13) Barhe	
		Satana	14) Mulher	
		Kalwan	15) Abhona	
		Dindori	16) Umrale	
		Nasik	17) Trimbak	
		Igatpuri	18) Igatpuri	
	Dhule	Akrani	19) Akrani	
		Akkalkuwa	20) Molgi	
			21) Akkalkuwa	
		Taloda	22) Taloda	
		Nawapur	23) Chinchpada	
			24) Khandbara	
			25) Nawapur	
		Sakri	26) Dahiwel	
			27) Pimpalner	
			28) Dhanora	
			29) Ashte	
		Shahada	30) Mandane	
			31) Mhasavad	
	Ahmednagar	Akola	32) Waki	
			33) Rajur	
	Pune	Ambegaon	34) Ambegaon	Selected
		Junnar	35) Madh	
Gondwan Region or Vidharbha region				
	Amravati	Melghat	36) Dharni	Selected
			37) Chikhalda	
	Yevatmal	Wani	38) Maregaon	
	Chandrapur	Rajura	39) Dewada	
		Sironcha	40) Bhamragad	Selected
			41) Aheri	
			42) Etapalli	
		Gadchiroli	43) Kurkheda	
			44) Dhanora	

Appendex II

Note on health and classification of diseases of the Tribals in Maharashtra.

1. The tribals suffer from many chronic diseases, the most prevalent of which are water-borne. The drinking water supply in many of the tribal areas is very poor. In the hill regions of Maharashtra, especially in Nashik, Pune, Dhule, Thane and Chandrapur people have to go down the hills to get the water. Even when water is available it is often dirty and contaminated. Consequently, the tribals are easily susceptible to intestinal and skin diseases. Incidence of Diarrhoea, Dysentry, Cholera, Guineaworm is not uncommon. Tuberculosis which is intensified by nutritional deficiency so common among the tribals, is found in the hilly and forest areas. The tribals have not yet developed an immunity and when they come in contact with new diseases they fall an easy prey to them. The incidence of respiratory diseases seems to be more for that reason. Scabbues, ring-worm, small-pox, anaemia, veneral diseases are also common in tribal people.

2. It is generally believed that the tribals are averse to modern medical treatment and that they take to superstitious cures and Bhagat's magic formula. The situation in this behalf is more alarming in primitive and more backward tribes like the Madia Gonds of Bhamragad, Warlis of Talasari and Katkaris. The present economic condition also does not permit the tribals to have the nutritious and sufficient diet and in the circumstances they have to live half-starved many times. Moreover, inadequate facility of clean drinking water can be added to it.

The common diseases found in the tribal people are reflected in Tables.

3. It is seen from the tables that respiratory diseases are found very high in the tribals. Semi-starvation condition or inferior diet and with unhygienic conditions do result in contacting these diseases. The tribals having both these factors in greater percentage and therefore the incidence of T.B. among tribals is found more. The T.B. patients in tribals do not avoid the close contacts of their family members and as such others are also affected by this disease.

4. The incidence of skin diseases is also a major item in tribal area and they are found prevalent on a larger-scale and more particularly among the small children and aged persons. The tribals do not get their children vaccinated after intervals; use of adequate water for washing clothes, bathing and other uncleanliness etc. are some of the reasons of sking diseases.

5. The third catagory of major diseases in the tribal area is gastro intestinal diseases, fevers including Maleria, Fileria and influnza etc.

6. Common diseases arising mostly through exposure, bad hygiene, unsatisfactory housing, undernourishment, malnutrition, insufficient and unhygienic water supply (availability) etc. will have to be treated urgently. Lack of availability of water would be one of the causes for poor hygiene and health.

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APPENDIX - TABLE I

Diseasewise distribution of patients treated during the first fortnight of February 77, at Dhanni Primary Health Centre, (District : Amravati).

Sr.No.	Broad classification of diseases.	No. of patients treated				
		Males	Females	Children	Total	Percentage
1	2	3	4	5	6	7
1.	Skin diseases	15	5	16	36	8.8
2.	Gastro intestinal diseases	2	-	11	13	3.2
3.	Respiratory diseases	53	42	43	138	34.0.
4.	Worm infections	-	1	6	7	1.6
5.	Injuries and wounds	-	2	-	2	0.5
6.	Fevers	3	8	5	16	3.9
7.	Others	89	37	69	195	48.0
	Total	162	95	150	407	100.0
	Percentage	39.8	23.3	36.9	100.0	

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TABLE:II

Diseasewise distribution of patients treated during the second fortnight of January 77, at Kasa Primary Health Centre(Dist:Thane)

Sr.No.	Broad classification of diseases	No.of patients treated				
		Males	Females	Children	Total	Percentage
1	2	3	4	5	6	7
1.	Skin Diseases	3	6	13	22	7.5
2.	Gastro intestinal diseases	14	8	23	45	15.5
3.	Respiratory diseases	18	9	15	42	14.4
4.	Worm infections	2	-	9	11	3.8
5.	Injuries and wounds	7	2	4	13	4.5
6.	Fevers	15	4	14	33	11.3
7.	Others	45	42	38	125	43.0
	Total	104	71	116	291	100.0
	Percentage	35.7	24.4	39.9	100.0	

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TABLE III

Diseasewise distribution of patients treated during the second fortnight of February 77, at Primary Health Centre, Ettapalli, (District: Chandrapur)

Sr.No.	Broad classification of diseases	No.of patients treated				
		Males	Females	Children	Total	Percentage
1	2	3	4	5	6	7
1.	Skin diseases	4	-	4	8	2.4
2.	Gastro intestinal diseases	4	4	20	28	8.3
3.	Respiratory diseases	24	18	31	73	21.7
4.	Worm infections	-	-	-	-	-
5.	Injuries and wounds	13	8	6	27	8.0
6.	Fevers including Maleria Fileria, and influenza.	17	9	7	33	9.8
7.	Others	80	55	33	168	49.8
	Total	142	94	101	337	100.0
	Percentage	42.1	27.9	30.0	100.0	

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