HEALTH STATUS AND DISEASES IN TRIBAL DOMINATED VILLAGES OF CENTRAL INDIA

Manish Mishra*

ABSTRACT

Health is one of the important indicators of social development. Health of indigenous or tribal people is the perception and conception in their own cultural system with less awareness of the modern health care and health sources. The article analyzes on as to how Gond tribes of Madhya Pradesh react to both indigenous and exogenous health management practices? What are the facilitating and inhibiting factors in their health management? How their health and diseases shall be managed in a sustainable manner? The study was conducted in a tribal dominated panchayat of Schedule V area. Interview schedule, case study, observation, group interview and documentary sources were the tools used for data collection. Historically, tribals have followed traditional healing practices. But today, not only the number of those who were not attending to any healing method have decreased significantly but also their dependence on modern health practices have increased. Villager’s dependence on state initiated health management mechanisms like PHC and CHC have significantly increased. There is a need to capacitate the traditional healers by linking them with modern health institutions. If properly linked and managed, they can be an integrating force between tribal masses and the modern health practices. Also, the health centres need to be fully equipped round-the-clock with doctors and medicines.

BACKGROUND

The World Health Organization (WHO) defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity.” It is well recognized that health is not the exclusive domain of medical science because every culture, irrespective of its simplicity and complexity, has its own beliefs and practices concerning diseases. No culture works with a meaningless approach in its treatment of diseases. Every culture evolves its own

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system of medicine in order to treat diseases in its own way. Thus, treatment of
disease may vary from group to group. To understand health and health related
problems in a proper perspective, it is very important to consider the socio-
cultural issues, economic dimensions and environmental aspects. This is more
relevant in the context of tribal people, particularly living in the rural areas.

Although the National Health Policy, 1983 accords high priority to extending
organized services to those residing in the tribal, hilly and backward areas as
well as to the detection and treatment of endemic diseases affecting tribals,
yet they continue to be one of the fragile population, mainly due to their poor
health and disease management. Tribal health is one of the important areas for
action in the health sector. The major contributors to the increased disease risk
amongst tribal communities include- (i) poverty and consequent under nutrition;
(ii) poor environmental sanitation, poor hygiene and lack of safe drinking water
leading to increased morbidity from water and vector-borne infections; (iii) lack of
access to health care facilities resulting in the increased severity and duration of
illnesses; (iv) social barriers and taboos preventing utilization of available health
care services; (v) vulnerability to specific diseases like G-6 PD deficiency, yaws
and other endemic diseases like malaria etc. Also, the tribal population, being
heterogeneous, there are wide variations in their health status, access to and
utilization of health services.

The different tribal communities in India, represents a heterogeneous group.
There is considerable variation in the context of socio-economic life, custom and
tradition and behaviour and practices. Similarly, variations are also there in the
context of demographic features. There is one factor common among all tribal
communities except North-east tribals, it is low literacy rate and poor health
status and indigenous method of disease management. The tribal illiteracy has a
close link between health and disease management.

Health and disease management reflect the social solidarity of a community.
In a tribal community, for example, illness and the consequent management of
disease is not always an individual or familial affair, but sometimes the decision
about the nature of treatment is taken at the community level. In the tribal
areas, in case of some specific diseases, not only the diseased person or his/her
family, but the total village community is affected. All the other families in the
village are expected to observe certain taboos or norms and food habits. The
non-observance of such practices often calls for action by the Village Council/
Caste Panchayat. One cannot deny the impact of this psychological support in the
context of treatment and disease management.
The common beliefs, customs, traditions, values and practices connected with their health and disease have been closely associated with the treatment of diseases. In most of the tribal communities, there are number of folklories related to health. Knowledge of folklore of different socio-cultural systems of tribals may have positive impact, which could provide the model for appropriate health and sanitary practices in a given eco-system. Tribal health system and medical knowledge over ages known as ‘Traditional Health Care System’ or ‘Indigenous Health Practices’ depend both on the herbal and the psychosomatic lines of treatment. While plants, flowers, seeds, animals and other naturally available substances formed the major basis of treatment, this practice always had a touch of mysticism, supernatural and magic, often resulting in specific magico-religious rites. Faith healing has always been a part of the traditional treatment in the Tribal Health Care System, which can be equated with rapport or confidence building in the modern treatment procedure. Certain practices are suggested to avoid illness or diseases, while some are prescribed to have better health. These should not be ignored as mere folk-beliefs, but need careful attention. There are different folklories to avoid illness, during illness, regarding food and so on.

It has also been noted that among the tribals there is high incidence of communicable diseases, like: Tuberculosis, Hepatitis, Sexually Transmitted Diseases (STDs), Malaria, Filariasis, Diarrhoea and Dysentery, Jaundice, Parasitic infestation, Viral and Fungal infections, Conjunctivitis, Yaws, Scabies, Measles, Leprosy, Cough and Cold, HIV/AIDS, etc due to lack of sanitation and unhygienic living (Baldir 2005). Though the tribal communities constitute nearly 8 per cent of the total population of India, they contribute 25 per cent of the total malaria cases and 15 per cent of the total Pf cases, leading to 30-50 per cent malaria deaths in India. A high transmission of Pf is in the forest regions because malaria control in such settlements is unattainable due to technical and operational problems. In tribal areas, the diarrhoeal/dysentery diseases including cholera occur throughout the year attaining peak during the rainy season (from June to October). The acute diarrhoeal problems were basically due to poor environmental hygiene, lack of safe drinking water, improper disposal of human excreta, aggravated by low literacy, socio-economic status coupled with blind cultural belief, lack of access to medical facilities leading to serious public health problems.

With the coming of the state in the tribal areas during pre and post-independence number of changes are taking place in both material and non-material culture of tribal masses. Change in health and disease management is one among them. How tribes at large perceive health and disease today? What are the common diseases among them? Do the traditional and indigenous methods and the modern and exogenous interventions go hand in hand or there is conflict between both of
them? How they perceive and react to the new intervention which is by and large institutional? What is the state of functioning of traditional health management practices? Is there relevance and possibility of integration between the traditional and the modern treatment methods? How functioning of state induced modern health and disease management mechanisms may be made inclusive and tribal friendly in a sustainable manner? In order to address these issues this paper has written.

Study Area

The study was conducted in Pathai Panchayat of Sahpur Development Block of Betul district in Madhya Pradesh. Logic behind selecting Sahpur Block was numerical predominance of tribal population (64 per cent and included in Schedule V area). In Pathai panchayat more than 99 per cent population is tribal and is either Gond or Korku. The entire area of Sahpur is dominated by Gond population and Korku tribe exists only in a few villages. Pathai is located at a distance of about 4 kms, Nishana is 6 kms and Bhagtadhan is 8 kms from Sahpur Development Block office as well as Betul-Itarsi National Highways (NH 69). There are 386 households i.e. Pathai (200), Nishana (124) and Bhagtadhan (62) in Pathai Panchayat and all of them participated in the study. Details are as under:

**TABLE 1**

DEMOGRAPHIC PROFILE OF PATHAI PANCHAYAT

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Profile</th>
<th>Pathai</th>
<th>Nishana</th>
<th>Bhagtadhanha</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Household^</td>
<td>201</td>
<td>124</td>
<td>62</td>
</tr>
<tr>
<td>2</td>
<td>Population^</td>
<td>1174</td>
<td>672</td>
<td>338</td>
</tr>
<tr>
<td>3</td>
<td>Tribal Population^</td>
<td>1078 (91.8%)</td>
<td>618 (92.1%)</td>
<td>337 (99.7%)</td>
</tr>
<tr>
<td>4</td>
<td>Farmer *</td>
<td>85</td>
<td>100</td>
<td>52</td>
</tr>
<tr>
<td>5</td>
<td>Labourer*</td>
<td>410</td>
<td>56</td>
<td>45</td>
</tr>
<tr>
<td>6</td>
<td>Engaged in other work*</td>
<td>36</td>
<td>87</td>
<td>9</td>
</tr>
<tr>
<td>7</td>
<td>Literacy rate*</td>
<td>37.7</td>
<td>26.5</td>
<td>27</td>
</tr>
<tr>
<td>8</td>
<td>Name of tribe^</td>
<td>Gond</td>
<td>Gond</td>
<td>Gond &amp; Korku</td>
</tr>
<tr>
<td>9</td>
<td>Geographical Area#</td>
<td>598.290 Hec.</td>
<td>363.804 Hec.</td>
<td>120.608 Hec.</td>
</tr>
<tr>
<td>10</td>
<td>Sex Ratio*</td>
<td>1030</td>
<td>1030</td>
<td>971</td>
</tr>
</tbody>
</table>

Note: * Data obtained from Census 2001. # Data obtained from Patwari (Revenue Official). ^ Data obtained from field work.
Pathai Panchayat is numerically dominated by illiterates, poor and non-workers. 56 per cent households do not have land and villagers depend on wage work, farm work or both for their livelihood. The villages are near to forest. Historically tribes have been dependent on this forest for their social and economic requirements. Even today significant numbers of tribal women collect firewood from this forest in order to meet their daily needs. But in the broader sense the forest is now no more an important source of livelihood for the inhabitants of Pathai Panchayat villages.

**METHODODOLOGY**

Interview schedule and interview guide were the two specific techniques used to collect data. Those who participated in the study were head of the household (usually male), anganwadi worker working at PHC, traditional medicine men (Bhagat), private practitioners working at Sahpur and health functionaries working at Community Health Centre (CHC) Sahpur. Information was also collected from secondary source especially from records provided by PHC, CHC and Mobile Health facility working under Deen Dayal Antyodaya Upchar Yojna. Fieldwork was carried out during 2007-09 and the findings of the study are as under:

**DISCUSSIONS**

**Villagers Perception about Health and Disease**

Perception of villagers, doctors and other health workers working in Pathai Panchayat and Sahpur was mapped to get comprehensive and comparative picture of different aspects of health and disease. So far as tribes are concerned, they have their own perception about health and healthy person. To them, healthy person is one who eats properly (5.5%), looks pleasant (18.4%), has slim body (2.3%), move around here and there easily (8.8%), looks neat and clean (5.4%), is active in day to day life (2.7%), performs hard physical work (7.9%), avoid alcohol (2.4%) and carry a glow on their face (6.9%). Happy life (8.3%), consumption of vegetarian food (3.4%) and straight posture of body (3.7%) are also indices of good health.

The interpretation about root cause of diseases in Pathai Panchayat villages are based on objective consideration. Fatalistic or metaphysical interpretation is today largely absent from the scene. Patel (1991) studied traditional health management practices among Baiga primitive tribe of Madhya Pradesh. He documented number of religious beliefs, supernatural power, unhygienic food habit, faith in the concept of sin and virtue, birth and re-birth belief, violation
of taboos etc. which were held responsible by Baigas for various diseases. He also found number of traditional treatment like worship, black magic, herbs and medicinal plants etc; being used by them for treatment. There was no role of modern medicine used for the treatment of about 44 diseases among them.

Among the tribes of Pathai Panchayat villages, the situation is totally different today. They have by and large objective interpretation of both health and disease management. For instance, most of the diseases – both simple and complex, are perceived (30%) as due to lack of cleanliness. Here cleanliness refers to cleanliness of one’s body, clothes, houses, use of pure and safe drinking water, cooking utensils and so on. 27 Per cent villagers said that people become ill because their food habit and meal time is not properly managed. Remaining respondents perceived use of chemical fertilizer in agriculture contributing to increase diseases. Carelessness, consumption of unclean water and rotten food, use of meat and regular consumption of Mahua liquor, which is very common in Pathai, Nishana and Bhagtanandhana village, and lack of proper and in time medical check-ups on a regular basis also contribute to the rise of diseases. Role of black magic or religion was hardly rated by any respondent as a key of health and disease management. Hence, all the villagers expressed objective views about indices and roots of both health and disease. Khera (1990) also observed the same thing while conducting study on Baiga tribe of Madhya Pradesh. According to him “The Baiga are fully acquainted with the mosquitoes, the deadly cerebral malaria that infests the region as well as other poisonous insects and have developed special protective measures for it as well as for snake bite, bear bite, dog bite etc. It is their knowledge about medicinal plants and herbs that has made them famous. Indeed a Baiga is sought after as the healer of the area”. Similar studies carried out by NIHFW among the Gond (Muria and Madia), Bhatra, Halba tribal groups of Bastar district of Chhatisgarh showed following trends (Basu et al. 1989):

(a) The average protein calorie intake was found to be much less in the Gond children as compared to Bhatra and Halba children.
(b) Higher frequencies of Biot’s spot, Angular stomatitis and mottling of teeth were found among Gond children as compared to Bhatra and Halba children.
(c) Muscular wasting was noticed to be higher in Gond children as compared to Bhatra children.

**Doctors Perception about Disease**

To them some of the common diseases and health problem found in Sahpur area in general and Pathai Panchayat villages in particular (as narrated by 2 MBBS doctors who are practicing at Sahpur) are fever, vomiting and dysentery,
malaria, joint-ache, cough and cold, body-ache, swelling in leg, swelling in lever, tuberculosis, chicken-pox and small-pox, throat infection, piles, skin disease, sexually transmitted disease, jaundice, abortion, anaemia, habit of eating soil, snake bite, delivery, fracture, tooth pain, wound, cut, itching, and so on.

According to them, such diseases occur primarily because of malnourishment, lack of vitamins in food, poverty, lack of awareness about health and disease management, lack of sufficient treatment facility at Sahpur hospital, lack of de-worming treatment, etc. They observed that tribes not only make delay in approaching doctor/proper health service provider, but also there is total lack of follow-up on the part of patients. Chaudhary and Singh (2006) observed a similar narrative made by the local medicine man which inhibit patient to approach modern health institution at the earliest. The healer narrated: “If somebody is bitten by scorpion, crushed kapur is applied on the bitten part to remove poison. If it fails, which usually does not, then jhar-phuk technique is used. If bitten by snake like Kobra, Kaili, Padmani and Patalhari, both jhar-phuk technique and very small tablet made out of poisonous kalahari kund is taken with water. If it fails then only patient is brought to hospital at Tamia”.

Respondents hesitate to revisit doctors when they are asked to visit twice or thrice. As a result, the treatments remain incomplete which in many case results in re-appearance of some of the diseases especially malaria in a more complicated form (typhoid), after few weeks or months. It was reported that in many cases most of the patients suffering from common ailments do not complete the total course of treatment as prescribed by doctors. Needless to mention that cataract, itching, ulcer and malaria are the very common diseases in the entire district, since long (Gazetteer of India, 1907, reprint 1999: 228).

On the basis of these two sets of interpretation; especially of health and disease, it may be said that both experts and villagers have more or less similar perception about types of diseases as well as factors and conditions which originates and contributes to these diseases. Tribal perception about health and diseases in an objective manner clearly refers to the fact that now gone are the days of magico-religious explanation of disease and illness. This development has taken place because of numerous exogenous factors, especially due to the state initiated health management institutions at the village and at the district level.

**Disease Preventive Measures at Village level**

At the family level many of the villagers take regular bath, use soap for bathing, follow modern teeth cleaning methods, take food in time, consume so-called clean
water, wash hand after toilet and most of the villagers also do physical labour. At the village level, some efforts are made by Anganwadi Workers to make villagers aware about importance of environmental cleanliness and names and reasons of air and water born disease, villagers are also advised to take precaution in their day to day life in order to keep away the diseases. In the recent past several efforts have been initiated at the village level in order to improve health and disease management of villagers. Important among these are:

**Total Sanitation Campaign**

Total Sanitation Campaign (TSC) is an intervention for environmental up-gradation. This project is directed to provide toilet facility in all the households where this facility is not available. Besides household, this facility is provided to all the schools and Anganwadi Kendras. It is also directed to encourage cleanliness in the village and teach lesson to keep hygienic atmosphere of cooking place and space clean in and around house and the place where drinking water is kept.

So far as Pathai Panchayat villages are concerned, here during 2007-08 in more than 50 per cent household toilet facility was provided. It was promised that this facility will be extended to other households in the due course. It was assumed that villagers will use this technique and help each other in the environmental up-gradation, which will subsequently keep them healthy.

But the picture was altogether different in 2009. We observed that most of the toilets are not in a working condition. Length and breadth of toilet is small and villagers hesitate to use it because of its narrow size. In certain cases it is used only by children. There are other inhibiting factors. The village is surrounded by forest and there is no paucity of open space. Therefore, by habit, villagers prefer to defecate in the open space and the so-called awareness programme initiated by PHC and Gram Panchayat has turned out to be a failure to change the mindset of the people. Also, villagers prefer open space because it requires less amount of water in comparison to their home based recently constructed toilets. In some of the households, however, people use their toilet in the rainy season. It is needless to mention that in large number of houses *mahua* liquor is prepared for their own consumption as well as for market. We observed that some of the toilets, which is totally unused, villagers use it as a store room for *mahua* liquor equipments.

We have observed that villagers at large neither know the negative implications of huge consumption of *mahua* liquor on their health nor they know the positive impact of use of family based toilet on their health and environment.
Safe Drinking Water

There are 22 Hand Pumps in Pathai Panchayat i.e. Pathai (11), Nishana (8) and Bhagtanahana (3) villages. However, during 2006-09, 28 wells were constructed under MNREGS of which 23 are well used even today. These wells satisfy domestic as well as agriculture requirement of water in a successful manner. In the past, villagers at large used to face drinking water problem. Today not only this problem is resolved but also this scheme has ensured supply of safe drinking water.

Public Distribution System (PDS)

In order to address the problem of food insecurity and mal-nutrition there is a special provision for the poor. Blue and yellow ration cards have been issued to obtain food grain at the cheaper rate from the local PDS shop for BPL family. For instance, while APL (Above Poverty Line) card holders receive wheat at the rate of Rs. 7/- per Kg., BPL (Below Poverty Line) and most poor (Antyodaya Anna Yojana) Card holders (Yellow Card) receives at the rate of only Rs. 3/- and Rs. 2/- per Kg. respectively. Other food grains have also been provided to them at the cheaper rate. But Kerosene Oil has not been given in subsidized rate to BPL or AAY card holders.

TABLE 2
FOOD GRAINS PROVIDED BY PDS AT PATHAI PANCHAYAT VILLAGES

<table>
<thead>
<tr>
<th>Category of Family</th>
<th>Item</th>
<th>Quantity (in Kg/Liter)</th>
<th>Price (per Kg./Liter)</th>
</tr>
</thead>
<tbody>
<tr>
<td>APL (White Card)</td>
<td>Wheat</td>
<td>10Kg.</td>
<td>7/-</td>
</tr>
<tr>
<td></td>
<td>Kerosene Oil</td>
<td>4 Lt.</td>
<td>10/-</td>
</tr>
<tr>
<td>BPL (Blue Card)</td>
<td>Wheat</td>
<td>20Kg.</td>
<td>3/-</td>
</tr>
<tr>
<td></td>
<td>Rice</td>
<td>4 Kg.</td>
<td>6.50/-</td>
</tr>
<tr>
<td></td>
<td>Sugar</td>
<td>2Kg.</td>
<td>13.50/-</td>
</tr>
<tr>
<td></td>
<td>Kerosene Oil</td>
<td>5 Lt.</td>
<td>10/-</td>
</tr>
<tr>
<td>Antyodaya Anna Yojana (AA Yu) (Yellow Card)</td>
<td>Wheat</td>
<td>31Kg.</td>
<td>2/-</td>
</tr>
<tr>
<td></td>
<td>Rice</td>
<td>4Kg.</td>
<td>3/-</td>
</tr>
<tr>
<td></td>
<td>Sugar</td>
<td>2Kg.</td>
<td>13.50/-</td>
</tr>
<tr>
<td></td>
<td>Kerosene Oil</td>
<td>5 Lt.</td>
<td>10/-</td>
</tr>
</tbody>
</table>

Social Forestry

During 2007-08 efforts were made by Panchayat to undertake plantation work in Pathai and Nishana village. In Pathai 27.5 acres of government land were undertaken for this purpose. Similarly in Nishana village 32 acres of land came under social forestry project. Altogether Rs. 1.30 lacs was spent during 2007 and 1.50 lacs in 2008 for plantation purpose. By doing this Panchayat created 7875 man-days employment under MNREGS. Towards the end of 2007 it was found that about 40 per cent of the seedlings had dried. To fill up the gap new seedlings were planted in 2008. Since this is a social forestry project therefore, in the due course, besides environmental up-gradation this project is also supposed to meet needs of fuel, fodder and non-timber forest produce to villagers.

Health and Disease Management

Number of institutional and non-institutional agencies/bodies are working both at the village and at the Block level to provide modern health and disease management to villagers. Most of these arrangements have been made by the government. Important among these are:

Primary Health Centre (PHC)

PHC is working in Pathai since the middle of 2008. It covers four villages namely Nishana, Pathai, Bhagthandhana and Palaspani. Centre has one trained health worker (ANM). Besides serving at the Centre the worker also moves in each of the villages for awareness generation as well as for extending treatment facility to the needy. Some of the important assignments performed by the PHC are: distribution of medicine free of charge, complicated cases are referred to Sahpur Community Health Centre (CHC), assist villagers to understand procedure to take medicine as prescribed by CHC, awareness generation relating to preventive measures etc. Some of the diseases commonly treated at PHC are fever, cough, dehydration, stomach pain, knee pain, vomiting, eye ailment, cough and cold, headache, breast pain, teeth pain, pneumonia, wound, ear ailment, itching and so on. In the case of failure or partial issues the case is referred to the Sahpur CHC or District Hospital.

During last one year (October 2008 to September 2009) PHC treated altogether 1013 patients belonging to Pathai, Nishana, Bhagtandhana and Palsapani villages. Most of the patients were between the age group of 6 to 35 years. July and August were the peak months during maximum number of patients received treatment.
<table>
<thead>
<tr>
<th>Months</th>
<th>Age (in Years)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-1</td>
<td>2-5</td>
</tr>
<tr>
<td>Oct. 08</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Nov. 08</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>Dec. 08</td>
<td>05</td>
<td>13</td>
</tr>
<tr>
<td>Jan. 09</td>
<td>-</td>
<td>13</td>
</tr>
<tr>
<td>Feb. 09</td>
<td>03</td>
<td>19</td>
</tr>
<tr>
<td>March 09</td>
<td>06</td>
<td>33</td>
</tr>
<tr>
<td>April 09</td>
<td>01</td>
<td>09</td>
</tr>
<tr>
<td>May 09</td>
<td>02</td>
<td>11</td>
</tr>
<tr>
<td>June 09</td>
<td>03</td>
<td>12</td>
</tr>
<tr>
<td>July 09</td>
<td>01</td>
<td>16</td>
</tr>
<tr>
<td>Aug. 09</td>
<td>04</td>
<td>38</td>
</tr>
<tr>
<td>Sep. 09</td>
<td>06</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>49</td>
<td>203</td>
</tr>
</tbody>
</table>

Source: Taken on 20/11/2009 from Register available at PHC Pathai village.

In spite of the fact that on an average 84 patients were treated in each month during 2008 and 2009, PHC and the ANM (Auxiliary Nurse Mid-wife) is facing some of the fundamental challenges in its day to day functioning. These challenges are of two type viz. challenges at the place of work and challenges relating to procedural mechanisms. While the former includes resistance by husbands or other male family members in the case of permanent sterilization of women, confusion among women that sterilization will contribute to number of ailments in the due course such as weakness, illness and fatness, problem of interaction between ANM worker who knows Marathi language and villagers who do not know this language and so on. The latter category includes shortage of essential medicines which PHC receives from CHC, lack of essential treatment facility and lack of instruments like delivery related package, pathological test facility and lack of helping hand. Today the coverage area is big and PHC worker has also to attend weekly meeting on Saturday at CHC, as a result of which she is not available at PHC on that particular day.
Anganwadi Kendra

Anganwadi Kendra (AK) is working in Pathai, Nishana and Bhagtandhana since 1996. There is one Anganwadi worker and one helper posted at every Centre. Anganwadi Worker is responsible to motivate villagers to follow institutional delivery, family planning devices, immunization and other modern health management practices. In order to strengthen health status of women, Iron Folic Acid (IFC) tablet is frequently distributed among them. From 2007 to 2009, 199 women were provided this tablet.

Because of increasing health awareness among villagers as well as spread of state led health and disease management facilities number of children suffering from mal-nutrition is lower in comparison to the normal children. Indicators of mal-nourishment is both gender and age specific as per the indicators and guideline prepared by the WHO. Such as female infant of less than 6.5 kg and male infant of less than 7 kg are called severely mal-nourished. Similarly, female infant between 7 kg to 8.75 kg and male infant between 7.75 kg and 9.5 kg are termed as normal infant respectively. For instance, of 218 children up to 5 years in Pathai Panchayat villages during 2009, 67 per cent were normal, 24 per cent were mal-nourished and remaining 9 per cent were severely mal-nourished. However, the problem of mal-nourishment is more serious among girls in comparison to boys.

Immunization programme carried out by the Anaganwdi Kendra is popular in the village. All the alive children of the specific age group are provided this facility. During 2007, 2008 and 2009, 31, 36 and 30 children were covered under immunization scheme respectively. Because of immunization project number of infant’s death have significantly decreased. During 2007, 2008 and 2009 there was death of 3, 4 and 2 infants respectively. But in spite of this facility the rate of infant death is higher in comparison to death among other age groups. For instance, between 2006 to 2009 total 30 death occurred in Pathai panchhayat villages of which maximum death (16) was of infant i.e. 10 male infant and 6 female infant. Also, in all the age groups rate of death is higher among men (19) than women (11). There was no case of any maternal mortality during this period.

Community Health Centre (CHC)

Community Health Centre located at Sahpur is headed by Block Medical Officer (BMO). Besides running a 30 bedded hospital the centre is also managing Janani Suraksha Yojna (JSY) and Deen Dayal Mobile Hospital (DDMH). At Sahpur CHC hospital most of the time beds are engaged. For registration, Above Poverty Line (APL) patients have to pay Rs. 2/- but for Below Poverty Line (BPL) patients
registration is free. There are 3 Doctors working at this centre. Some of the common diseases for the treatment of which patients at large visit CHC are: fever, cough, cold and headache. Delivery facility as well as family planning operation is also performed at this Centre.

During 2008, total 32,665 patients visited Sahpur CHC for treatment. In Pathai Panchayat there are about 2201 population of which 1926 patient visited this hospital. If we see month-wise variation it is evident that during the months of July, August and September maximum number (994) of patients visited to this hospital for treatment. During these three months number of patients from the CHC catchment area was also highest (12501). This shows that during these three months number of patient’s increases not only in Pathai Panchayat villages but also in the entire catchment area.

**TABLE 4**

**NUMBER OF TOTAL PATIENT REGISTERED AT SAHPUR CHC DURING JAN-DEC. 08.**

<table>
<thead>
<tr>
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| Total    | 32665  | 896    | 616     | 414          |

Source: Data obtained from OPD Register of CHC, Sahpur Block in Dec. 08.

**Janani Suraksha Yojana (JSY)**

This scheme was introduced to provide an opportunity of safe and institutional delivery to women from below poverty line (BPL). Under this scheme economic
assistance is provided to expected mother at the time of delivery. Earlier Rs. 700/- was paid to the concerned woman but today its amount have been increased to Rs. 1400/-. From 2005 to 2007, 175 women from Pathai Panchayat villages have received the support of Rs. 240750/- under this scheme.

Success of JSY may be realized from the fact that between 2006-09 altogether 142 births took place in Pathai Panchayats villages of which 96 took place at hospital and remaining 46 at home. While in the case of former service of nurse was received in the case of latter Dai (both trained and untrained) played crucial role. This data clearly reflect increasing trend in favour of institutional delivery.

Deen Dayal Mobile Hospital

Deen Dayal Mobile Hospital (DDMH) is directed to work in the Development Blocks which are numerically dominated by ST population. Most of them are poor with having poor access to modern health facility. This facility is extended to them free of cost. In Madhya Pradesh, this scheme was introduced on May 26, 2006 in a phased manner. Today this facility is in operation in 86 Tribal Development Blocks, with having 92 Mobile Units. If we see the statistics, it is obvious that from its inception (May 26, 2006) to February 2009, 43,75,414 patients have received treatment. During 2008-09 alone at the state level a sum of Rs. 11.78 crores have been spent on this head. A large number of NGOs have been involved in this task.

Some of the health management activities done by DDMH are as under:

1. Medical advice to patients, first aid and free distribution of medicine,
2. Health Checkup before and after delivery and free distribution of medicine,
3. Collection of blood and spittoon sample relating to malaria and TB disease,
4. Identification of serious patients in villages and refer the case to CHC and other hospitals, Immunization, and
5. Awareness programme relating to various family planning devices, welfare schemes and education.

Mode of Functioning

So far as Sahpur Development Block (SDB) is concerned here a Delhi based NGO named Jagran Solution (An Unit of Jagran Prakshan Private Limited) is running this project since October 2007. There is MOU between this NGO and Health Department of Government of Madhya Pradesh for 3 years which may be extended for another 2 years after review.
Under this scheme a properly equipped vehicle moves in the villages, attends all weekly markets and other common places. It has to follow a rout chart prepared and provided by the Block Medical Officer (BMO). The vehicle moves between 10 am to 6 pm to provide treatment, free medicine and free advice. The mobile hospital examines 100 patients each day and 300 pregnant women in each month. This target is pre-fixed. Besides the facility of GPS, Table for diagnosis, BP test instrument, instrument relating to treatment of pregnant women, IUD kit, contraceptive pills and other material, oxygen mask, blood counter, first aid kit, the vehicle is also loaded with instruments relating to popularization of population education such as TV, DVD, White Board, Chart, Loud Speaker and so on. The mobile van receives medicine from CHC free of cost and it also distributes the same without any charge.

Besides these facilities in each mobile hospital there is a facility of pathological lab, one oxygen cylinder and stature, one MBBS doctor, one pharmacist, one trained ANM, one supervisor and one driver. The mobile hospital moves for 6 days in a week and on an average 26 days in a month. In the beginning of the month rout chart prepared by BMOs in consultation with field staff, is provided to the mobile hospital in-charge. In most of the cases this chart is followed. Sector Medical Officer (SMO), BMO, DMO, CMHO, Janpad Panchayat are the important institutions which have been entrusted to examine the functioning of mobile hospital.

In short, roughly about 1950 patients are examined and treated in each month in the villages of Sahpur. Making comments on the achievement, dresser of this mobile hospital R.K. Pandegra said:

“In spite of lack of ECG machine and spittoon slide in the mobile hospital, this project has reduced the cases of disease among poor dalits and tribal in a significant manner. People at large know about mobile hospital and they eagerly wait for it. Its intervention has provided them health facility at their door step”.

Private Doctors at Sahpur

There are 06 chemist shops and private practitioners at Sahpur. The chemist shops provide advice to the patients on demand and accordingly they also prescribe medicine for various ailments even on credit. In different Kirana shops also medicines for minor ailments are prescribed and sold. Similarly there are 06 Allopathic doctors and 02 Homeopathy Doctors as a private practitioners at
Sahpur. Villagers of Pathai Panchayat also frequently visit to them for treatment purpose.

CONCLUSION AND SUGGESTIONS

Above observation clearly denotes that today tribes at large, especially those who are exposed to outside world, are no more dependent on their traditional healing practices in the case of most of the diseases. Only for snake bite, which is rare, they are still dependent on traditional system. Villager’s dependence on state initiated health management mechanisms like PHC and CHC have significantly increased. Efforts and initiatives taken by CHC are very popular among them. More or less similar situation is PHC. The ever increasing number of patients registered for treatment at both the centres is a testimony to this observation. Also, number of schemes managed by CHC is very popular in tribal villages. Villagers do not hesitate to consult these formal institutions in need.

But this is one side of the coin. The other side needs introspection and overhauling of the total health and disease management mechanism especially in the light of the scattered and poorly connected geographical space where tribes are located and their limited psychological and economic carrying capacity. In spite of the presence of traditional medicine men in many tribal villages, tribes prefer to go to institutional arrangements. But the question is to what extent these institutions, especially PHC is well equipped? Neither the ANM is properly trained to diagnose the disease nor the centre has sufficient medicine and other essential facility to address all patients in a proper manner. Catchment area of ANM is vast. Most of the time ANM is in the field and during this time at the PHC, the visitors are unattended. Besides providing treatment the ANM worker has also to do number of official assignments. In case the ANM is an outsider and also from different cultural background and mindset, they do not associate themselves closely with villagers.

So far as CHC and its different activities are concerned, of course it has become popular over the time, but neither these interventions are well equipped nor easily available to poor tribal in need. Even in the critical situation safe delivery is not possible at the CHC hospital. Patients are referred to Betul based government district hospital. Mobile hospital is neither well equipped nor very frequent in all the villages. There is no proper and frequent monitoring of its functioning. Medicines prescribed by chemist shop is one of the testimonies to this state of affair.
It is true that tribal dependence on modern health and disease management institutions have increased over the time but still there is traditional healers. For the treatment of some of the diseases villagers still go to them. But in spite of that there is no effort to modernize these traditional healers. Traditional knowledge possessed by these healers will disappear with their death because traditionally neither they share this knowledge with new generation nor the new generation is interested to learn this knowledge. But relevance of such knowledge especially from the point of view of poor tribal cannot be completely ignored.

In the light of these findings it can be said that modern health and disease management initiatives have become very popular in tribal villages. Gradually it has made them dependant prone. It has directly or indirectly created environment and mindset against the traditional healing methods. Under the given situation if there is reluctance and apathy on the part of state and its initiatives pertaining to effective functioning of health management schemes, nobody is there to take care of health related needs and requirements of poor tribal. This calls for formulation of action agenda in such a manner that it can ensure inclusive health management for tribal masses.

Some of the steps needs to be undertaken in this direction may be as under:

1. tribal economy, by and large revolves around their basic need and if their health status deteriorates even for few days their basic need of food etc; will be negatively affected, therefore, their health condition has to be improved and retained. For this purpose there is need to ensure proper and fruitful functioning of all the preventive measures initiated at the community level, such as supply of safe and sufficient drinking water, proper functioning of scheme like Public Distribution System (PDS), Immunization programme, Total Sanitation Campaign (TSC), Social Forestry scheme and so on. These interventions, if properly managed, will directly or indirectly create enabling factors and conditions which will not only improve health status but also it may improve other aspects of their life in a proper perspective.

2. However, functioning of all these ongoing initiatives can only be ensured provided beneficiaries at large are made aware about these schemes on constant basis. And for awareness generation, besides PHC and CHC initiatives, services of other institutions such as primary schools, gram panchayats, self help groups, NGOs etc. may be taken. In tribal areas, ‘HAATS’ (weekly market centres) are the focal point of activity. Each ‘HAAT’ should be brought under a Primary Health Centre (PHC).

3. It is true that over the time tribal’s dependence on traditional healing methods have deteriorated and it is further likely to deteriorate but on this
basis alone its contribution in the past cannot be undermined. Nobody can undermine cultural legitimacy and ecological foundation of this practice. Hence, instead of discarding it, there is a need to document this knowledge in different local languages and dialects to make properties of each of the available herbs and medicinal plants popular among the masses for its wider use. There is a need to capacitate the traditional healers by linking them with modern health institutions. If properly linked and managed, they can be an integrating force between tribal masses and the modern health practices. We have to remember that modern medicine and treatment is a new entrant in the tribal world. There is also a need to organize and capacitate Jhola-chap doctors who are found in large number in villages. They are easily available, culturally accepted and many of them extend services even on credit. They have face to face relationship with poor clients. Hence, this institution needs to be capacitated and modernized in the light of current scenario.

4. There is a need to activise and strengthen PHC and CHC. Such institutions exists at their door step. Tribal’s dependence on these institutions have increased over the time. This trust has to be popularized and strengthened. PHC is neither properly equipped nor the ANM is able and capable enough to create needful environment. ANM number needs to be increased at all the PHCs. Also, an organized, structured and well-equipped training and orientation package needs to be formulated and implemented for them.

These are few suggestions from within. If handled with care, definitely it can bring some meaningful improvement in the health status and disease management of tribal masses.

REFERENCES

Reserve and Their Indigenous Knowledge, Bhopal: Indira Gandhi Rashtriya Manav Sangrahalaya.

