CHAPTER - V

Tribal Development, Healthcare System and Human Rights

After the Independence of India, many strategies have been undertaken to develop the tribal communities and their areas. Similarly, health of the tribal communities was given due attention, as claimed. In the rural areas of Primary Health Centres in and around the tribal dominated areas were established to cater the needs of healthcare of the surrounding population.

As has already been discussed earlier that good health not only caters to the overall physical and mental development of an individual, but there exists an intricate relationship of health as human rights which have been recognized in the international and national framework. Healthy living conditions and access to good quality healthcare for all citizens are not only basic human rights but also essential accompaniments of social and economic development and policies and programmes need to be implemented in the framework of quality healthcare for all and access to basic determinants of health as a basic right. The tribals are not an exception to this. Backwardness that binds the tribals in the path of progress is partly because of their health situations which are reflected in their overall developmental situation and aspirations.

So, in this chapter we will deal with the constitutional provisions and the programmes undertaken by the Central and State Governments for tribal development and how far those have been beneficial for the overall development and how the prevailing health system contributes in the development process. The discussions in this chapter will also reveal the institutions, services and programmes under implementation in the studied blocks for tribal development and ensuring the health rights of the tribals especially the women and the children.
The present chapter has been divided into two sections. Section – I deals with the issue of tribal development – programmes, policies and their implementation. Opinions of the officials alongside the response of the villagers have also been discussed to assess the impact of the developmental schemes on the tribals. Section – II focuses on elaborate discussion on health issues, consistent upon the primary focus of the study. In this section, a detailed description about modern health infrastructure for example sub-centres, PHCs and Rural Hospitals are given along with their health infrastructure, facilities, manpower resources and coverage in the studied areas have been discussed to have a better understanding as to what extent the health rights of the tribal communities are ensured or denied. Opinions and suggestions of doctors and medical personnals practicing western treatment pattern have also been taken to highlight the actual health related issues and problems faced in the health service delivery system at the grass root level.

SECTION - I

V.1 The Issue of Tribal Development

The United Nations Declaration on the Right to Development, 1986 mention in unequivocal words that right to development is an inalienable human right by virtue of which every human person and all peoples are entitled to participate in, contribute to, and enjoy economic, social, cultural and political development (Article 1). Article 2 further states that the human person is the central subject of development and should be the active participant and beneficiary of the right to development. In Article 2(3) and Article 3 the Declaration also imposes some responsibilities on the state which includes that states have the right and the duty to formulate appropriate national development policies that aim at the constant improvement of the well-being of the entire population and of all individuals and a fair distribution of the resulting benefits of development and the primary responsibility of the state should be creation of national and international conditions favourable for the realization of the right to development.

Following the provisions of the international instruments adopted by the United Nations, the government of India adopted several policies and programmes for tribal
development from time to time but the achievements from those have raised questions for researchers (Vidyarthi; 1981).

There are innumerable constraints responsible for lower pace of tribal development process than desired (Rath; 2006). Some of the major constraints are:

(i) **Destruction of forests:** The forests are not only the source of livelihood for tribals but there exists an intricate relationship between tribals and forests in forest Eco-systems. The depleting forest resources are threatening imminent food security for a large portion of the tribal population.

(ii) **Lack of awareness:** There exists lack of awareness among tribal population about various developmental programmes launched by Government of India and States, resulting in their exploitation.

(iii) **Protection of Tribal Rights and Concessions:** The tribals have been given numerous rights and concessions under various statutes of Central as well as State Governments but they remain deprived of the benefits arising out of such statutory provisions due to their ignorance and apathy of enforcing agencies.

Recognizing the special needs of the tribals, the Constitution of India made certain special safeguards to protect these communities from all possible exploitation and thus ensure social justice. These impediments also hinder the healthcare development among the tribals. Absence of health facilities in the rural area may lead to adoption of traditional healthcare system which prevails within their periphery.

V.1 (a) **Rights of the tribals under the Constitution of India**

Article 14 confers equal rights and opportunities to all, Article 15 prohibits discrimination against any citizen on the grounds of sex, religion, race, caste etc; Article 15(4) enjoins upon the State to make special provisions for the advancement of any socially and educationally backward classes; Article 16(4) empowers the State to make provisions for reservation in appointments or posts in favour of any backward class of citizens, if the state is of opinion that the backward classes are not adequately represented in the services of the State. Article 46 enjoins upon the State to promote with special care the educational and economic interests of the weaker sections of the people and in particular, the Scheduled Tribes and promises to protect them from social
injustice and all forms of exploitation (Thomas; 2005). Further, while Article 275(1) promises grant-in-aid for promoting the welfare of Scheduled Tribes and for raising the level of administration of the Scheduled Areas. Articles 330, 332 and 335 stipulate reservation of seats for Scheduled Tribes in the Lok Sabha and in the State Legislative Assemblies and in services. Finally, the Constitution also empowers the State to appoint a Commission to investigate the conditions of the socially and educationally backward classes (Article 340) and to specify those Tribes or Tribal Communities deemed to be as Scheduled Tribes (Article 342).

The Fifth Schedule to the Constitution lays down certain prescriptions about the Scheduled Areas as well as the Scheduled Tribes in states other than Assam, Meghalaya, Tripura and Mizoram by ensuring submission of Annual Reports by the Governors to the President of India regarding the Administration of the Scheduled Areas and setting up of Tribal Advisory Councils to advise on matters pertaining to the welfare and advancement of the Scheduled Tribes (Article 244(1)). Likewise, the Sixth Schedule to the Constitution also refers to the administration of Tribal Areas in the states of Assam, Meghalaya, Tripura and Mizoram by designating certain tribal areas as Autonomous Districts and Autonomous Regions and also by constituting District Councils and Regional Councils (Article 244(2)). To ensure effective participation of the tribals in the process of planning and decision-making, the 73rd and 74th Amendments of the Constitution are being extended to the Scheduled Areas through the Panchayats (Extension to the Scheduled Areas) Act, 1996.

Besides these, several laws have been enacted by the Central Government like the Protection of Civil Rights Act, 1955; the Scheduled Castes and Scheduled Tribes (Prevention of Atrocities) Act, 1989; the Panchayats (Extension to Scheduled Areas) Act, 1996; the Scheduled Tribes and Other Traditional Forest Dwellers (Recognition of Forest Rights) Act, 2006 as well as by the State Governments (relating to the prevention of alienation and restoration of tribal land, money-lending, reservations, and so on) (Dixit; 2006). Further, a National Tribal Policy is on the Central anvil.

The Constitutional commitments prompted the policy makers and the planners to accord high priority to the welfare and development of Scheduled Tribes right from the beginning of the country's developmental planning launched in 1951.
V.1 (b) Provisions of Tribal Development in the Five – Year Plans

Accordingly the First Five Year Plan (1951-56) clearly laid down the principle that `the general development programmes should be so designed to cater adequately to the Backward Classes and special provisions should be used for securing additional and more intensified development for the Scheduled Tribes.

The Second Five Year Plan (1956-61) envisaged that the benefits of economic development should accrue more and more to the relatively less privileged classes of society in order to reduce inequalities. As for the Scheduled Tribes, `Welfare Programmes were planned for based on respect and understanding of their culture and traditions and an appreciation of the social, psychological and economic problems which they face.

The Third Plan (1961- 66) continued with the very same principle of advocating reduction in inequalities through various policies and programmes to provide equality of opportunity to Scheduled Tribes and to bring about reduction in disparities in income and wealth and a more even distribution of economic power.

The Fourth Plan (1969-74) proclaimed that the basic goal was to realize a rapid increase in the standard of living of the people through measures which promote equality and social justice. An important step in this direction was setting up of six pilot projects in Andhra Pradesh, Bihar, Madhya Pradesh and Orissa in 1971-72 as Central Sector Scheme with a separate Tribal Development Agency for each project with the primary objective of combating political unrest and Left Wing extremism in the tribal dominated belts.

The Fifth Five Year Plan (1974-78) marked a shift in the approach as reflected in the launching of Tribal Sub- Plan (TSP) for the direct benefit of the development of tribals. The Tribal Sub-Plan stipulated that funds of the State and Centre should be quantified on the population proportion basis, with budgetary mechanisms to ensure accountability, non-divertability and utilization for the welfare and development of tribals. With this thrust the concept of Tribal Sub-Plan came into action during the Fifth Plan. There has been a substantial increase in the flow of funds for the development of STs under this arrangement, resulting in the expansion of infrastructure facilities and enlargement of coverage of the target groups in the beneficiary oriented programmes.
The Sixth Five Year Plan (1980-85) sought to ensure a higher degree of devolution of funds so that at least 50 per cent of tribal families could be provided assistance to cross the poverty line. Emphasis was on family-oriented economic activities rather than infrastructure development schemes. A "Modified Area Development Approach" (MADA) was devised for pockets of tribal concentration with population of 10,000 at least half of them being scheduled tribes and 245 MADA pockets were delineated. Also, 20 more tribal communities were identified as "primitive", raising the total to 72.

In the Seventh Five Year Plan (1985-90) there was substantial increase in the flow of funds for the development of Scheduled Tribes, resulting in the expansion of infrastructural facilities and enlargement of coverage. Emphasis was laid on the educational development of the Scheduled Tribals. For their economic development two national level institutions were set up viz., (i) Tribal Cooperative Marketing Development Federation (TRIFED) in 1987 as an apex body for State Tribal Development Cooperative Corporations and (ii) National Scheduled Castes and Scheduled Tribes Finance and Development Corporation (NSFDC) in 1989. The former was envisaged to provide remunerative prices for the forest and agriculture produce of tribals while the latter was intended to provide credit support for employment generation.

In the Eighth Five Year Plan (1992-97) efforts were intensified to bridge the gap between the levels of development of the STs and those of other sections of the society so that by the turn of the century, these disadvantaged sections of the population could be brought on par with the rest of the society. The Plan not only emphasized elimination of exploitation but also paid attention to the special problems of suppression of rights, land alienation, non-payment of minimum wages and restrictions on right to collect minor forest produce etc. Moreover, attention on priority basis continued to be paid for the socio-economic upliftment of Scheduled Tribes. A review of tribal development in early Nineties revealed that although the Tribal Sub-Plan strategy yielded results yet were not in a position to commensurate with the efforts put in and investments made. However, the allocation for development of scheduled tribes was increased during this plan period also.

The Ninth Plan (1997-2002) aimed to empower Scheduled Tribes by creating an enabling environment conducive for them to exercise their rights freely enjoy their privileges and lead a life of self-confidence and dignity at par with the rest of society.
This process essentially encompassed scheduled tribes as agents of socio-economic change and included three vital components, viz. i) Social Empowerment; ii) Economic Empowerment; and iii) Social Justice.

The Tenth Plan (2002-2007) continued with the schemes and programmes directed at the socio-economic development of the tribal population through an area based approach. Initiatives to arrest the incidence of land alienation through legislative mechanisms were also explored during the Tenth Plan.

The Eleventh Plan (2007-2012) envisaged a paradigm shift in the development approach to ensure inclusive growth. It aimed at a tribal-centric, tribal-participative and tribal-managed development process rather than the previous system of large under-effective official delivery system and overall empowerment of the tribal people. It promised to accelerate reduction in incidence of poverty, unemployment, reduction in income inequalities, human resource development by providing economic and health services, development of confidence among people through intensive educational efforts, development and strengthening of infrastructure base for further economic exploitation of the resources in tribal areas and provisions of physical and financial security against all types of exploitation.

V.1 (c) Programmes and Policies of the Central Government for Tribal Welfare in India:

The Ministry of Tribal Affairs continues to implement various Schemes and Programmes aimed at the welfare and development of Scheduled Tribes. Some such activities of the Ministry are as follows:

(i) **Special Central Assistance to Central Sub-Plan: (SCA TO TSP)**

The Ministry of Tribal Affairs extends special central assistance to the Tribal Sub-Plan States and Union Territories in the North Eastern States of Assam, Manipur and Tripura as an additional grant to these states. These grants are basically meant for family oriented income generating scheme in various to meet the gaps which have not otherwise been taken care of by the State Plan.
The Ministry provides Grant-in-Aid to tribal majority States under Article 275 (1) of the constitution to supplement their efforts for tribal development through Tribal Sub-Plan. This assistance is basically meant for family-oriented income-generating schemes in the sectors of agriculture, horticulture, minor irrigation, soil conservation, animal husbandry, forests, education, cooperatives, fisheries, village and small scale industries and for minimum needs programme.

(ii) Scheme of Development of Primitive Tribal Groups

Based on pre-agricultural level of technology, low level of literacy, declining or stagnant populations, 75 tribal communities in 17 States and 1 Union Territory of Andaman & Nicobar Island have been identified and categorized as Primitive Tribal Groups (PTGs). Considering the vulnerability of these groups, a Central Sector Scheme was introduced in the year 1998-99 for the all round development of Primitive Tribal Groups. The scheme is very flexible and covers housing, infrastructure development, education, health, land distribution/development, agriculture development, cattle development, social security, insurance, etc.

(iii) Tribal Research Institutes

Fourteen Tribal Research Institutes (TRIs) have been set up in Andhra Pradesh, Assam, Bihar, Gujarat, Kerala, Madhya Pradesh, Maharashtra, Orissa, Rajasthan, Tamil Nadu, West Bengal, Uttar Pradesh, Manipur and Tripura. These Institutes are engaged in providing planning inputs to the State Governments, conducting research and evaluation studies, collection of data, codification of customary law and conduct training, seminars and workshops. Some of these Institutes are also having museums exhibiting tribal artifacts.

(iv) Hostel for Tribal Boys and Girls

Girls’ hostels scheme was started in Third Five-Year Plan with the aim of providing residential facilities to tribal girls in pursuit of education. Central assistance of 50 per
cent cost of construction to the States, cent percent to the Union Territories is provided under the scheme. Boys hostels scheme was started in 1989-90 and under the same pattern as the Girls’ Hostels.

(v) Vocational Training Centres in Tribal Areas

The scheme aims at upgrading the skills of the tribal youths in various traditional and modern vocation depending upon their educational qualification, present economic trends and the market potential which would enable them to gain suitable employment or enable them to become self employed. The scheme provides 100% grant and is implemented through State Governments, Union Territory Administration and NGOs. The scheme prescribes fixed financial norms. No construction cost is provided.

(vi) Ashram Schools in Tribal Sub-Plan Area

The scheme of Ashram Schools was launched in 1990-91 with the objective to extend facilities like establishment of residential schools for the tribals in an environment conducive to learning to increase the literacy rates among the tribal students and to bring them at par with other population of the country. The funding for the scheme to the State is done on matching (50:50) basis, while cent percent assistance is given to Union Territories.

(vii) Strengthening Education among Tribal Girls in Low Literacy District

This gender scheme aims to bridge the gap in literacy levels between the general female population and tribal women, through facilitating 100% enrolment of tribal girls in the identified Districts or Blocks, more particularly in Naxalite affected areas and in areas inhabited by Primitive Tribal Groups (PTGs) and reducing drop-outs at the elementary level by creating the required ambience for education. The scheme recognizes the fact that improvement of the literacy rate of tribal girls is essential to enable them to participate effectively in and benefit from socio-economic development.
The scheme covers 54 identified districts in 12 States and 1 Union Territory where the tribal population is 25% or more, and tribal female literacy rate is below 35% or its fractions, as per 2001 census. In addition, any other tribal block in a district, other than aforesaid 54 identified districts, which has scheduled tribal populations 25% or above, and tribal female literacy rate below 35% or its fractions, as per 2001 census, are also covered. The scheme also covers Primitive Tribal Group areas and gives priority to areas affected by Naxalism. The scheme is implemented by non-governmental organizations (NGOs) and autonomous societies of the State Governments and Union Territories.

The scheme primarily envisages the running and maintenance of hostels linked with schools running under Sarva Shiksha Abhiyan or other schemes of Education Department. Where such schooling facilities are not available, the scheme has provision for establishing a complete educational complex with residential and schooling facility. The scheme has provision for tuitions, incentives and periodical awards to encourage the tribal girls. The scheme does not provide and construction cost. The scheme prescribes fixed financial norms. The scheme also envisages the establishment of District Education Support Agency (DESA) which would be a non-government organization or a federation of non-governmental organizations, for varied functions like ensuring 100% enrolment, reducing drops outs, arrangement of preventive health education, monitoring the performance of NGOs etc.

(viii) **Tribal Cooperative Marketing Development Federation of India Limited**

The Tribal Cooperative Marketing Development Federation of India Limited (TRIFED) was set up by the Government of India in 1987 with the prime objective of providing marketing assistance and remunerative prices to tribal communities for their minor forest produce and surplus agricultural produce and to save them from the hands of exploitative private traders and middlemen.

The Central Government also provides grants-in-aid to its corporation, TRIFED to set off losses on account of fluctuations in prices of minor forest products being marketed by it for ensuring remunerative prices to tribals engaged in collection of minor forest
products either directly or through State Tribal Development Cooperative Corporations and other such Cooperative Societies.

Grants-in-Aid to State Tribal Development Cooperatives, Corporations and others. This is a Central Sector Scheme with 100% grant available to the State Tribal Development Cooperative Corporation (STDCCs) and other similar corporations of State engaged in collection and trading of minor forest produce through tribals grants under the scheme are provided to strengthen the share capital of corporations, construction of warehouses, establishment of processing industries of minor forest products etc. to ensure high profitability of the corporation so as to enable them to pay remunerative prices for minor forest products to the tribals.

Village Grain Bank Scheme provides grants for establishment of Village Grain Banks to prevent deaths of tribals specially children in remote and backward tribal villages facing or likely to face starvation and also to improve nutritional standards. The scheme provides funds for building storage facility, procurement of and purchase of initial stock of one quintal of food grain of local variety for each family.

(ix) **Coaching for Tribal Students**

The scheduled tribe candidates coming from deprived families and disadvantaged environment find it difficult to compete with those coming from a socially and economically advantageous background. To promote and provide tribal candidates a better chance to succeed in competitive examinations, the Ministry of Tribal Affairs supports a scheme for coaching for disadvantaged tribal candidates in quality coaching institutions to enable them to successfully compete in examinations for jobs and admission to professional courses.

(x) **Grant-in-Aid to Voluntary Organizations Working for the Welfare of Tribals**

The prime objective of the scheme is to enhance the reach of welfare schemes of Government and fill the gaps in service deficient tribal areas, in the sectors such as
education, health, drinking water, agro-horticultural productivity, social security net etc. through the efforts of voluntary organizations (VOs) and non-governmental organizations (NGOs) and to provide an environment for socio-economic upliftment and overall development of the tribals. Any other innovative activity having direct impact on the socio-economic development or livelihood generation of the tribals are also considered through voluntary efforts.

Under this scheme 90% grant is provided by the ministry and 10% cost is required to be borne by the non-governmental organizations from their own resources, except in Scheduled Areas where the Government bears 100% cost. The scheme provides a list of categories of projects viz. residential school, non-residential schools, 10 or more bedded hospitals, mobile dispensaries, computer training centers, etc., which could be covered under the scheme, and also prescribes fixed financial norms. The scheme does not provide any construction cost.

(xiii) Scholarships and Financial Assisting for Tribal Students

(a) Post Matriculation Scholarship

Under this scheme is financial assistance is provided to students belonging to Scheduled Tribes pursuing Post-Matriculation recognized courses in recognized institutions. The scheme covers professional, technical as well as non-professional and non-technical courses at various levels and the scheme also includes correspondence courses including distance and continuing education. The scheme is implemented by the State Government and Union Territory Administrations, which receive 100% Central Assistance over and above the committed liability which is required to be borne by them from their own budgetary provisions.

(b) Upgradation of merit

The objective of the scheme is to upgrade the merit of tribal students by providing them remedial and special coaching in classes IX to XII. While remedial coaching aims at removing deficiencies in various subjects, special coaching is provided with a view to
prepare the students for competitive examinations for seeking entry into professional courses like Engineering and Medical disciplines. The scheme provides for 100% central assistance to the States and Union Territories. Besides this, students with disabilities are also eligible for some special benefits also.

(c) Rajiv Gandhi National Fellowship Scheme

This Scheme was introduced in the year 2005-06. Under the Scheme, fellowship is provided to tribal students for pursuing higher studies such as M.Phil. and Ph. D. The maximum duration of a fellowship is 5 years. Every year 667 fellowships provided to tribal students. The scheme is being implemented by University Grant Commission (UGC) on behalf of the Ministry of Tribal Affairs. Any ST student who has passed post-graduation from a UGC recognized University can apply under the scheme.

(d) Scheme of Top Class Education for Tribal Students

Ministry of Tribal Affairs has introduced a new Central Sector Scholarship Scheme of Top Class Education for ST Students from the academic year 2007-08 with the objective of encouraging meritorious ST students for pursuing studies at degree and post degree level in any of the identified institutes. There are 127 institutes identified under the scheme in both the Government and private sectors covering the field of management, medicine, engineering, law and commercial courses. Each institute has been allocated five awards, with a ceiling of total 635 scholarships per year. The family income of the ST students from all the sources shall not exceed Rs. 2.00 lakh per annum.

(e) National Overseas Scholarship for Tribal Students

This scheme provides financial assistance to meritorious students belonging to Scheduled Tribes for pursuing higher studies abroad in specified fields of Master level courses, Ph.D. and Post-Doctoral research programmes, in the field of Engineering, Technology and Science. The selected candidates are given cost of tuition and other
educational fees charged by the foreign university etc., maintenance and other grants along with travel expenses. In addition passage grants are also available to candidates who are in receipt of merit scholarship for postgraduate studies, research or training abroad (excluding attending seminars, workshops, conferences) from a foreign government or organization or under any other scheme where cost of passage is not provided. 15 awards are sanctioned to tribal students per year. (Annual Report 2004-05 & 2008-09, Ministry of Tribal Affairs, Govt. of India)

V.1 (d) Programmes and Policies of the West Bengal Government for Tribal Welfare

Following the lines of the Central Government, the Backward Classes Welfare Department under the Government of West Bengal also implements the programmes for tribal welfare at the state level. In addition to that the state government also has some programmes of providing book grants, maintenance and examination fees for needy tribal students, bicycles for tribal girls for going to school in selected tribal areas, old age and widow pension for the needy tribal population. Apart from this, several schemes are sanctioned from time to time for the economic empowerment of the tribals and development of the tribal areas.

V.2 Implementation of Tribal Development schemes in the study areas

The tribal developmental schemes operational in the studied blocks have been gathered with information from the Block Development Officers of the studied blocks. The views and suggestions of the Block Development Officers have also been collected to find the loopholes behind the implementation of the tribal development in practical sense.

The BDO of Bamongola block, Mr. Ayan Dutta Gupta informed that in this block there are at present 665 tribal beneficiaries of the pension scheme which includes old age pension, disability pension, krishi pension and widow pension. The amount of pension under this scheme is Rs. 750/- monthly and plans are there to increase it to Rs.
1000/- from the next financial year. The number of tribal students receiving the benefits of Pre-Matriculation maintenance grant for the 2011 – 2012 financial year was 1767. There is no quota of students for the Pre-Matriculation maintenance grant. The number of students receiving this grant will be more than 2000 in the ongoing financial year i.e. 2012 – 2013. The amount of this maintenance grant is Rs. 480/- annually. The Post-Matriculation scholarship is given on the recommendation of the concerned schools and colleges and processed in the Block Development Office and the grant is given through bank accounts from the Office of the Project cum District Welfare Officer. The amount of grant depends on the type of course that the student is pursuing. For students pursuing technical courses and science disciplines admission, laboratory and examination fees are given and for students pursuing humanities stream only the admission and examination fees are given. As part of women empowerment and income generation schemes, the activities of the Self-Help Groups (SHG) are noteworthy. The total number of SHG currently in the block is 718 as against 418 last year. Tribal women are also engaged with the activities of the SHG. The women of the SHG perform activities like basketry, tailoring, making spices like turmeric, bori, pickles, incense sticks, mats, jute items and handicrafts. For the sale of the products of the SHG an annual fair named Sabalamban is also organized. Apart from this, the women of these groups are also engaged in cooking mid-day meals in different schools. This serves as their extra income. In schools where there are large number of students more than one group is engaged in cooking and serving the food. Plans are also there to house the SHG in clusters Gram Panchayat wise and building plans have already been made but the funds have not yet been sanctioned. Besides these, Sabla scheme for adolescent girls are also operational in the block and tribal girls are also benefitted from it. Mainly nourishment supplements are given to the adolescent girls in association with the anganwadi centres under this project. Under the provisions of Tribal Sub-Plan loans are given to tribal families individually or group-wise as a support for carrying out small business, cattle rearing, poultry, piggery etc. Developmental programmes are also carried out in the tribal dominated mouzas under the Integrated Tribal Development Project (ITDP) which includes construction of culverts and roads and providing drinking water facilities. Under the National Rural Employment Guarantee Scheme (NREGA) ponds and dug wells are being dug in the block and tribals are also engaged under the scheme. Women work participation under this scheme is especially encouraged and tribal women are participating in a big way. Last year the women work
participation under this project was 43% and this year target has been set to raise it to 50%. In the last financial year i.e. 2011-2012, Bamongola block ranked second in the utilization of the funds of NREGA. It crossed the target of Rs. 6 crores for the six Gram Panchayats under this block and ended utilizing Rs. 8.78 crores, an all time record. The BDO also informed that the tribal families lack knowledge of the schemes meant for their welfare. To sensitize them instructions have been given to the Gram Panchayat members who actually interact with them at the grass root level and for that seminars, workshops and awareness camps are also in the agenda.

The BDO of Habibpur Block, Mr. Avijit Ghosh informed that the total beneficiaries of the ST Pension scheme in the block currently are 1137. 3331 new names have been sent for new inclusion in the pension scheme. This includes the pension schemes for the aged tribal citizens, widows and the physically challenged persons among the tribal families. Under the provisions of Tribal Sub-Plan loans are given to tribal families individually or group wise as a support for carrying out small business, cattle rearing, poultry, piggery etc. The amount of loan for individuals has been Rs. 20,000 and group wise Rs. 10,000. Further, under provisions of Article 275(1) of the Indian Constitution funds are allocated by the Backward Class Welfare Department of the Government of West Bengal to promote tribal welfare. For this, ashram schools have been established; additional class rooms have been constructed for the benefit of the tribal students. Hostel fees and free accommodation are provided to needy tribal students. Maintenance grants of the amount of Rs 480/- annually are given to tribal students upto 10th standard. For Post Matriculation tribal students only the admission charges in schools and colleges are given. There are 4000 student beneficiaries in the block currently. Tube wells, dug wells and submersible pumps have been installed in the tribal villages.

Under the Total Sanitation Campaign, sanitation facilities have also been provided in the tribal villages. The major activities under the National Rural Employment Guarantee Scheme (NREGA) include dug wells and small ponds in the villages. The tribal population is involved in this work in considerable numbers and is benefitted from this scheme. As part of the Individual Benefit Scheme, loans are given to individual tribal families and tillers to arrange their water facilities by way of digging wells and small ponds. With the financial assistance of the Central Government under the Integrated Tribal Development Project (ITDP) in mouzas having more than 50% tribal population roads, drinking water facilities, anganwadi centres and sales counter
for Self-Help Groups (SHG) have been installed for the benefit of the tribal families. A fair named Sabala Mela is arranged every year for the sale of handicrafts items of the Self-Help Groups. Under the Sabala scheme of the Central Government for adolescent girls nourishment supplements are also given to them.

The BDO of Habibpur pointed out that the tribals are not sensitized about the schemes of tribals welfare. Even the students and their families are not aware of the maintenance grant scheme. The tribal families also show little interest in taking loans for starting small business. They get confused while procuring loans and the bank procedure due to ignorance. The officials of the Block Development Office have also helped them in this regard but in vain. The money of all the pension schemes is now given through bank accounts. Due to large scale migrated labour in the block the money cannot be disbursed timely to the tribal families on time and it remains unclaimed and then the funds return unutilized.

The Joint BDO of Old Malda, Mr. Pranay Majumdar informed on the state of the implementation of the developmental schemes for tribals in the block. The below poverty line cultivator tribal families in this block receive Krishi pension worth Rs. 750/- monthly. The widow, disability and old age pension for the tribals amount Rs. 1000/- monthly. The Pre-Matric and Post-Matric scholarship is Rs. 480/- annually for tribal students. There is no quota for this. Those applying for it will receive the scholarship. Presently, there are 1611 tribal student beneficiaries in the Pre-Matriculation scholarship scheme and 132 students in the Post-Matriculation scholarship scheme in the block. With financial assistance from the Backward Class Welfare Department, Govt. of West Bengal roads have been built in the tribal villages. Under the Integrated Tribal Development Project (ITDP) loans have been given to the Self-Help Groups in the tribal villages, rooms have been constructed for the anganwadi centres, roads have been built and drinking water facilities have installed. The progress of the sanitation project is slow because of the socio-cultural attitude of the tribals towards sanitation. Under the sanitation project the tribals have to earlier deposit Rs. 300/- and the government provides assistance of Rs. 3200/- for building domestic toilets. But it is found that the tribals are not interested in the project and the toilets provided under the government sanitation scheme are lying unused. Under the Individual Benefit Scheme (IBS) the tribal families are getting assistance for digging wells for individual as well as community benefit. As a part of the Backward Region
Grant Fund (BRGF), funds are allocated for repairing existing roads, construction of new roads, rural health and education, infrastructure development, safe drinking water and women empowerment. These projects are undertaken on identifying the backward regions which may include the tribal villages after passing the resolution by the Panchayat Samity. The BDO only performs an executive role in this case. There are at present nearly 1000 SHG groups in the block. There are also 150 such groups among tribal women. They are engaged in cultivation activities, cattle rearing, pickle, jam, mat and jute item manufacturing. They do not have any handicrafts items. Besides this, the tribal women from the SHG also cook and serve mid-day meals in schools. Caste certificates issuance is more or less regular among the tribals of this block. There are no first generation caste certificate claimants among the tribals in this block. Under Bangla Swanirvar Karmasansthan Prakalpa (BSKP) there are two twin projects, Atmasamman and Atmamaryada. In case of the first loans are given to individual tribals upto a maximum of Rs. 10,00,000 for doing small business or after providing training through self-employment generation schemes like making jam, jelly, sauce, pickle, tailoring, handicrafts etc. while for the second one loans upto a maximum of Rs. 25,00,000 are given to groups for engagement in various livelihoods. Coming to the NREGA, the participation of the scheduled tribes is figuring low in this block because most of the tribal men are migrant workers and they go to Delhi, Mumbai, Hyderabad, Kerala etc. to work in construction sites where they earn more. The wages under NREGA currently in this block is Rs. 136/- daily while if a wage earner works under a mason he/she earns Rs. 200/- daily. So the tribal wage earners are not much interested in the work under NREGA. Moreover, such a project has failed to create interest among tribal men and women because the wage is not given on daily basis. The poor tribal families need daily payment of wages to run their households. They do not understand savings or onetime payment. Under Indira Abas Yojana houses were made for houseless families of the block which included tribal households also. Financial assistances upto Rs. 35, 000/- in two installments were also given to poor tribal families living in dilapidated houses. A health oriented programme under the flagship of the Rural Development Department named Community Health for Community’s Management Initiative (CHCMI) is also under implementation and the BDO takes regular feedback and monitors the programme.
The **BDO of Gazole Mr. Ajmal Hussain** said that the number of tribal beneficiaries of the old age pension scheme is 1197 for the ongoing financial year (2012-13) and the amount of pension is Rs. 750 per month which is likely to increase to the tune of Rs. 1000 per month from the next financial year. There are approximately 3000 tribal student beneficiaries of the Pre-Matriculation scholarship scheme. The amount of scholarship remains Rs. 480 annually. Besides, this book grant of Rs 280 annually is given to the tribal students at Pre-Matriculation level. Some grants are also given to them for buying school uniforms. There are nearly 450 tribal widow pension holders who get Rs. 750 monthly. The amount of *krishi* pension is also Rs. 750 monthly. There are 4400 tribal student beneficiaries at the Post-Matriculation level who get scholarships of the amount of Rs. 2700 annually. Besides these, there are other pension schemes of the State Social Welfare Dept. for disability, old age and widowhood which are given on the basis of quota. There are no pending cases of caste certificates issuance in the block currently. Bharat Literacy Mission or National Rural Health Mission (NRHM) in running successfully in Bengali in this block. Under the *Rashtriya Swastha Yojana* expectant mothers can get Rs. 30,000 annually by which tribal women also get benefitted. The main activity under the NREGA scheme in which the tribal participation is maximum in the block is social forestry. Tribal men and women from the SHG are mainly engaged in this activity. The tribals get engaged in this activity mainly during the lean season i.e. February-March and April and thus get benefitted. Besides there are some schemes in which the tribal women are given preference in free tailoring training and later on, after completion of training are given knitting machines on loans. At present there are nearly 300 self-help groups in the block but they do not have any ongoing projects. Under the Individual Benefit Scheme (IBS) the tribal families are get assistance for digging wells for individual as well as community benefit. As a part of the Backward Region Grant Fund (BRGF), funds are allocated for repairing existing roads, construction of new roads, rural health and education, infrastructure development, land leveling, safe drinking water and women empowerment. These projects are undertaken on identifying the backward regions which may include the tribal villages.
V.3 Response of the villagers on the Implementation of Tribal Development schemes

For the purpose of the present research, the present researcher interviewed the villagers of the studied villages about the nature of facilities they have been receiving under various government schemes. Some such case studies have been stated below:

**Case study: 1**

Haradhan Munda, (Male, Age 65 years, Community – Munda, Village – Arotpur, Block – Old Malda) is unable to move about and work due to old age sickness and infirmity. He does not have any earning family members and stays all alone. He does not receive old age pension or benefit from any health schemes.

**Case Study: 2**

Phulo Tudu, (Female, Age 61 years, Community – Santal, Village – Lakhripir, Block – Gazole) a widow have no means to support herself. She was facing severe hardship to maintain herself because she was not physically fit to work and she was not even receiving the widow pension.

**Case study: 3**

Khagen Murmu (Male, Age 35 years, Community – Santal, Village - Nariali, Block – Old Malda) had been a worker at a local flour mill. He had an accident during his work in which he received severe injuries in his hand and his hand had to be amputated later. Having lost his right hand in the accident he is now handicapped by one hand. Since then he has not received any suitable compensation from the owner or any other agency. He regrets not to have received a suitable work or any benefit from welfare schemes either and this has led him to face severe hardships in maintaining his family.

**Case study: 4**

Shyamal Soren (Male, Age 20 years, Community – Santal, Village – Habinagar, Block – Gazole) completed his Madhyamik (Secondary) Examination successfully with a Second Division but is an unemployed youth. He regretted on his unemployment and the limited scope of employment opportunities in the rural areas for youths like him. He
also complained about non-benefits from rural employment schemes in such remote tribal villages.

**Case study: 5**

Dukhilal Koramudi, (Male, Age 42 years, Community – Kora, Village – Tolabhangi, Block – Old Malda) an agricultural labour opined that the distance from the Block Development Office is another factor that influences the sharing of equitable benefits of the tribal development schemes. Villages nearer to the block office get better facilities and benefits than the remote and far off tribal villages. Moreover, those villagers and the elected panchayat members who share better genial relationships with the officials of the block office are at an advantageous position which helps them get their purpose easily done or loans promptly granted. Political issues, colours, beliefs and influence also count in matters of individual benefit sharing and accessibility to social infrastructures and schemes, he regretted. Those having political connections get benefitted hugely and the general tribal families face negligence in all fields.

**Case study: 6**

Sunil Hansda, (Male, Age 35 years, Community – Santal, Village – Nimdanga, Block – Bamongola) a daily labour said that the workers of the villagers do not get the stipulated number of working days under the NREGA scheme regularly and the wages are not paid instantly. Since his family is dependent on daily wage earning, delay in payment of wages creates problem in running the household. To meet the needs of the family he has to go to other states like Kerela or Delhi to work as a migrant worker there at various construction sites as the wages are higher there and work is also available there.

**Case study: 7**

Nilima Soren, (Female, Age 30 years, Community – Santal, Village – Aktoil, Block-Habibpur) a young penniless widow is shelterless with her children after the sudden death of her husband. The living condition of her mud house is dilapidated. She went to the Block Development Office and approached the concerned officials for reconstructing the house under the *Indira Abas Yojana scheme* and conformed to the formalities as instructed by them but she has not yet received any benefit till now.
After interviewing the tribal villages it appeared that the developmental schemes that have been especially formulated for the tribal communities have very few beneficiaries. These schemes exist more in papers and the tribals do not enjoy the actual benefits. The benefits of the programmes that are run by the central and state governments do not percolate evenly to the grass root levels. Even many tribals families do not know about all the programmes and some of them do not know the process of procurement due to ignorance. There was a persistent and growing discontent among the tribal families about the PDS (Public Distribution System). They expressed discontent in the matter of BPL (Below Poverty Line) list. They could not identify the reason as to why their names have been transferred from BPL list to APL (Above Poverty Line) list. They identify the hands of corrupt Panchayat members behind this. Many villagers complained that some influential and well-to-do families in the locality have enrolled in the BPL (Below Poverty Line) list. Those families who have influence, money and political interests get greater benefits from such schemes. Even during the field survey most of them complained that they receive almost nothing from the government schemes and whatever is there, that too is irregular. Many tribal families expressed discontent over the pension schemes and the payment of wages through the NREGA as they belong to low socio-economic status group they depend on daily or monthly earnings and in that case the irregularity of grants and wages makes their living more uncertain. For this reason some tribal men and women have lost interest to work in NREGA schemes. Besides this, the amount of wages in the NREGA schemes is much lower than existing market rates. Some tribal parents also said that the scholarship amount for tribal children in not enough for continuing education and they have to face hardships for this reason many children drop out and help their parents to keep the pot boiling.

In the first phase of the field survey during June 2008 – December 2009 it was reported by the villagers that they were not receiving any benefits from the schemes meant for tribal development. Developmental activities halted during that point of time. The above data has been represented on the basis of the information collected during that time. But field visits during June – July 2012 and interactions with the tribal families revealed a somewhat changed situation in respect of the benefits of the pension schemes, maintenance grant for students and NREGA. As reported, the backlog of the widow, old age and disability pension are now being disbursed. Developmental
schemes are being implemented but beneficiaries’ point of view of receiving benefits differs from the officials’ claim. Officials generally try to impress that a lot of benefits are being given to the tribals but the tribals’ perception varies to a great extent. It is true that there are many schemes for development of the tribals including health but tribals reported that actually they are not receiving the due benefits. The reason behind this non availability of benefits may include factors such as lack of education, indifference, lack of communication and lack of overall knowledge about the scheme. When the fieldwork was initially started in 2008, it was the regime of the Left Front Government in West Bengal. Field visits and interviews with villagers during that time revealed that the benefits from different schemes for the tribals did not percolate to them but with the change of the political scenario in 2011, the situation has changed in favour of the common people including tribals. Some government officials also added that they can now work with more freedom than before as the game of politics have lowered to expand the outreach developmental benefits at all levels.

Health situation should not be dealt in isolation rather it should be linked with economic development. Infrastructural development is intricately linked economic development which ultimately leads to health development. If there is no infrastructure linked with the treatment centre there will not be easy access to healthcare facilities.

In this context, it is interesting to note here that the developmental schemes undertaken by the Ministry of Tribal Affairs, Government of India and the programmes undertaken by the Backward Classes Welfare Department, Government of West Bengal under the Special Central Assistance to Tribal Sub-Plan includes sectors like Income Generation Schemes, Infrastructure Development Schemes and Job Oriented Training but are devoid of health specific programmes in holistic sense. Health programmes are mostly targeted for family planning and immunization. There are health and family welfare schemes under the flagship of both the central and the state government which focuses more on family planning and universal immunization programmes under the NRHM and some nutrition supplementation programmes for women and children under ICDS rather than on improvement of overall health. The main implementing agency of the above mentioned two schemes are the Department of Health and Family Welfare, Government of West Best Bengal and the Department of Women and Child Development and Social Welfare, Govt. of West Bengal.
It is evident from the field visits that there have been wide gaps between official reports and the actual requirements and benefits from health services. In all the health institutions of the tribal dominated blocks that were visited during fieldwork lack of health infrastructure and were common. It was observed that in the urban areas some improvements have been noticed in terms of introduction of modern equipments, diagnostic and treatment facilities in health but no significant changes were reported in the health scenario of the villages. Moreover, the choices in treatment facilities are comparatively concentrated in the urban areas than in the rural areas. Sprawling private nursing homes and diagnostic clinics are a common picture.

In human rights discourse development implies all round development including health. So improvement in the health services and infrastructure will be boon to the common people including tribals. It should also be noted here that the existing health infrastructure needs to be judiciously and sustainably utilized so as to enjoy lasting benefits.

SECTION - II

V.4 Health scenario and its challenges in India

Improvement in the health status of the population has been one of the major thrust areas for the social development programmes of the country. India was one of the pioneers in Health Service Planning with special emphasis on primary healthcare. In 1946, the Health Survey and Development Committee, headed by Sir Joseph Bhope recommended establishment of well structured and comprehensive health service with a sound primary healthcare infrastructure. This report not only provided a historical landmark in the development of public health system but also laid the blue print of subsequent health planning and development in independent India.

At the time of Independence, the country’s healthcare infrastructure was mainly urban and clinical based. Hospitals and clinics were only equipped to provide curative care to patients. Outreach of health services in rural areas was very limited. From the First Five Year Plan itself, the Central and State Governments made efforts to build primary,
secondary and tertiary health institutions and link them through appropriate referral systems. (Ministry of Health & Family Welfare, Annual Report 2010).

As a comprehensive step towards building health infrastructure in the country, the National Health Policy, 1983 was adopted which reaffirmed India’s commitment to ‘Health for All’ in the context of social justice and democratization. The main objective of the policy was the universal access to comprehensive primary healthcare services by the people of the nation at affordable rates (Ministry of Health & Family Welfare; 2005). For the achievement of this goal, the Policy envisaged an integrated package of service which included –

(i) Reorganization of the health scenario infrastructure.
(ii) Major modifications in the existing system of medical education and paramedical training.
(iii) Integration of health related and socio-economic sectors into health plans.

Since India is the second most populous country in the world, so it has a changing socio-political-demographic and morbidity pattern that is of interest to the whole world. Despite several growth oriented policies adopted by the government, the widening economic, regional and gender disparities are posing challenges for the health sector. In India attention towards health has always been at the bottom of the agenda.

Let us now look at some grueling facts of health situations in India:

**Table V.4.1 showing public health spending in select countries**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Population with income of less than 1$ per day</th>
<th>Mortality Rate / 1000 live births</th>
<th>Health Expenditure to GDP</th>
<th>Public Expenditure on Health to Total Health Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>44.2</td>
<td>70</td>
<td>5.2</td>
<td>17.3</td>
</tr>
<tr>
<td>China</td>
<td>18.5</td>
<td>31</td>
<td>2.7</td>
<td>24.9</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>6.6</td>
<td>16</td>
<td>3</td>
<td>45.4</td>
</tr>
<tr>
<td>UK</td>
<td>-</td>
<td>6</td>
<td>5.8</td>
<td>96.9</td>
</tr>
<tr>
<td>USA</td>
<td>-</td>
<td>7</td>
<td>13.7</td>
<td>44.1</td>
</tr>
</tbody>
</table>

Source: NHP - 2002
The main task and responsibility of building health infrastructure rests with the State Government supplemented with funds from the Central Government and external assistance. Major disease control programmes and Family Welfare Programmes are funded by the Central Government with some assistance from external agencies and implemented through the state government. The food supplementation programmes for mother and child are implemented by the State Government through the ICDS funded by the Central Government. Safe drinking water and sanitation programmes which are essential pre-requisites of health were initially funded by the Department of Health and Family Welfare but subsequently these programmes happened to be implemented by the Department of Urban and Rural Development and Department of Environment with funds from both the State and the Centre.

The main reason behind the failure of universal access to healthcare facilities is that about 75% of health infrastructure, medical man power and other health resources are concentrated in urban areas where only 27% of the population lives. The health status in India especially that of the rural population is a cause of grave concern. To improve the prevailing situation, the problem of rural health has to be addressed both at macro (national and state) and micro (district and regional) levels. The problem needs to be dealt holistically and with genuine effort to include the poorest population to the centre of the fiscal policies. Although the National Health Policy (NHP) 2002 set out some targets that used to address the then prevailing health situation of the country, yet many of the targets have remained unachieved in these ten years. So, a revised National Health Policy addressing the prevailing inequalities and deficiencies in the rural health sector as well as a socio-cultural conducive model of health in the rural setting is the urgent need of the hour.

V.5 Healthcare System in India

Health and socio-economic development are so interrelated issues that it is impossible to achieve one without the other. While the economic development of India is gaining momentum of the past few decades, accordingly the Indian health system is at crossroads today. Ironically, India’s healthcare infrastructure has not kept pace with the economy’s growth. The physical infrastructure is inadequate to meet today’s healthcare demands. The number of public health facilities is also inadequate.
It is important to mention here that the healthcare facilities are divided under State List and Concurrent List of India. While some items such as public health and hospitals fall in the State List, others such as population control and family welfare, medical education and quality control of drugs are included in the Concurrent List. The principal responsibility of public health funding lies with the State Government which provides about 80% of public funding and the Central Government contributes another 15% for national health programmes (Bhandari and Dutta; 2007).

Structurally, India’s healthcare system comprises of the Public Health Sector, Private Health Sector and Indigenous Systems of Medicines (AYUSH). Let us look at each of the categories and its sub-categories:

1. **Public Health Sector**
   (a) Primary Healthcare
      - Primary Health Centres
      - Sub-centres
   (b) Hospitals/Health Centres
      - Community Health Centres
      - Rural Hospitals
      - District Hospitals/Health Centres
      - Specialty Hospitals
      - Teaching Hospitals

2. **Private Sector**
   (a) Private Hospitals, Polyclinics, Nursing Homes and Dispensaries.
   (b) General Practitioners and Clinics.

3. **Indigenous Systems of Medicine (AYUSH)**
   (a) Ayurveda, Yoga and Siddha
   (b) Unani and Tibbi
   (c) Homeopathy
   (d) Unregistered Practitioners

4. **Voluntary Health Agencies**

5. **National Health Programmes**
For the purpose of the present study we will consider healthcare system in the rural setting in greater detail. The rural healthcare infrastructure has been developed as a three-tier system and is based on the following population norms:

<table>
<thead>
<tr>
<th>Centre</th>
<th>Plain Area</th>
<th>Hilly/Tribal/Difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-centre</td>
<td>5000</td>
<td>3000</td>
</tr>
<tr>
<td>PHC</td>
<td>30,000</td>
<td>20,000</td>
</tr>
<tr>
<td>CHC</td>
<td>1,20,000</td>
<td>80,000</td>
</tr>
</tbody>
</table>

Source: MHFW (2005), Population Norms (Census 2001), [http://www.mohfw.nic.in](http://www.mohfw.nic.in)

The sub-centre is the most peripheral institution and the first contact point between the PHC and the community. Sub-centres are run on 100% Central Government assistance. It caters for maternal and child health, family welfare, nutrition, immunization, diarrhea control, control of communicable diseases and provides basic drugs for minor ailments and health needs of men, women and children.

There are 1,45,894 sub-centres (as on March 2009) in India. Each sub-centre is manned by one Auxiliary Nurse Midwife (ANM) and one male Multi-purpose Worker [MPW (M)]. A Lady Health Worker (LHW) is in charge of six sub-centres each.

The Primary Health Centre (PHC) is the first contact point between village community and the Medical Officer. It acts as a referral unit for 6 sub-centres with 4-6 beds for inpatients. A medical officer is in charge of the PHC supported by fourteen paramedical and other staff. There are 23,391 Primary Health Centres in India (as on March 2009). Its activities involve curative and preventive healthcare and family welfare services to the rural population with emphasis on preventive and promotive aspects of healthcare. Promotive activities include promotion of better health and hygiene practices, tetanus inoculation of pregnant women, intake of IFA tablets and institutional deliveries. The PHCs are established and maintained by the State Government under the Minimum Needs Programme (MNP).

Community Health Centres (CHC) forming the uppermost tier are established and maintained by the State Government under the Minimum Needs Programme (MNP) and caters to 80,00 - 1,20,000 population. There are 4,510 Community Health Centres
District Hospitals provide tertiary healthcare which includes all specialty care including AYUSH facilities. AYUSH facilities have been collocated with district hospitals, CHCs and PHCs in the country. (Ministry of Health & Family Welfare, 2005).

In terms of healthcare facilities and quality in the delivery system, there is a huge divide in urban and rural sector. Mostly the urbanite Indians have access to western medicine i.e. allopathic medicine which is mainly practiced in urban areas and two-thirds of India’s hospitals and health centres are located there. Many rural poor have to depend on alternative forms of traditional treatment and ethno-medicine due to inadequacy and inaccessibility in healthcare facilities.

To improve rural healthcare, the Central Government launched National Rural Health Mission (NHRM) 2005-2012 in April 2005. The aim of the Mission is to provide effective healthcare to India’s rural population throughout the country with a focus on 18 states that have low public health indicators or inadequate infrastructure (Husain; 2011). These states are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Nagaland, Tripura, Sikkim, Madhya Pradesh, Uttar Pradesh, Orissa, Rajasthan and Uttarakhand.

The goals of the National Rural Health Mission (NHRM) include:

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR).
- Universal access to comprehensive and integrated public health services.
- Promoting healthy lifestyles.
- Maintaining gender and demographic balance and population stabilization.
- Improving child health, hygiene and sanitation.
V.6 Family Welfare Programmes in India

At the time of Independence, the health care services in India was mainly hospital based, curative and restricted mainly in the urban areas. General practitioners were well versed in maternal and child health and pediatricians and obstetricians provided health care to women and children who came for treatment. Majority of the population living in rural areas and belonging to poorer segments did not have access to health care. As a result, the morbidity and mortality rates among them were quite high. Thus during the fifties good quality integrated, maternal, child health care and institutional deliveries were available to the urbanite educated who could afford the services of the physicians. Efforts to improve coverage of health services to the rural areas as apart of block development programme began to gather momentum from this time but the progress was slow due to lack of resources and manpower.

India launched the National Family Welfare Programme in 1951 with the objective of reducing the birth rate to the extent necessary to stabilize the population at a level consistent with the requirement of the national economy. Since then, India’s National Family Welfare programmes have focused to address the needs of families, notably women and children and to control population growth. The thrust of the programmes, as is well known to us, has been disproportionately focused on achieving demographic targets by increasing contraceptive prevalence and female sterilization. So in the real sense, the programme has not lived up to its title of ‘family welfare’.

The basic premises of the Family Welfare Programmes included Maternal Child Health (MCH), Reproductive Child Health (RCH), Family Planning services and Disease Control Programmes – Communicable and Non-Communicable. These programmes have been recognized as a priority area and are being implemented on a 100% central sponsorship basis.
The Reproductive and Child Health (RCH) Programme was launched throughout the country on 15th October, 1997. This programme aimed at achieving a status in which women would be able to regulate their fertility and go through their pregnancy and child birth safely resulting in healthy survival of mother and child. Different services to mother, child and eligible couples are provided under RCH programme which have been mentioned hereunder. The package of services for the mothers includes Tetanus, Toxoid immunization, prevention and treatment of anaemia, antenatal care and early identification of maternal complications, deliveries by trained personnel, promotion of institutional deliveries, management of obstetric emergencies and birth spacing. The package of services for children includes essential newborn care, exclusive breast feeding, immunization, appropriate management of diarrhoea and treatment of anaemia. For eligible couples the programme includes prevention of pregnancy, safe abortion and prevention and treatment of reproductive tract infection and sexually transmitted related services. Apart from these, the programme includes health counseling services to women of reproductive age group on the importance of the care of girl child, optimal timing and spacing of birth, small family norms, use and choice of contraceptives, prevention of reproductive tract infection and sexually transmitted diseases, information on availability of medical termination of pregnancy services, intra uterine devices and sterilization services and family planning services which includes distribution of condoms, oral contraceptives and intra uterine devices.

To encourage institutional deliveries and reduce infant and maternal mortality rates Janani Suraksha Yojana (JSY), a centrally sponsored scheme was launched in the year 2003 under the umbrella of National Rural Health Mission (NHRM) for pregnant women above 19 years of age upto two live births belonging to below poverty line families. Under Janani Sishu Suraksha Karyakram (JSSK), approved in May 2011 provisions have been made to provide free and cashless health care services to pregnant women including normal deliveries and caesarean operations and treatment of sick newborn babies upto thirty days after birth in government health institutions in both rural and urban areas.

Disease Control Programmes for communicable diseases include National Vector Borne Disease Control Programme for diseases like malaria, *kala azar*, filaria, japanese encephalitis, dengue and chikungunya, Revised National TB Control Programme (RNTCP), National Leprosy Eradication Programme, National AIDS Control
Programme. Disease Control Programmes for non-communicable diseases include National Iodine Deficiency Disorder Control Programme, National Programme for Control of Blindness, National Programme of Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke, National Mental Health Programme, Programme for Prevention of Burn Injuries and National Programme for the Health Care of the Elderly initiated in June 2010 for providing preventive, curative and rehabilitative services to the elderly persons at various levels of health care delivery system in the country. (Central Bureau of Health Intelligence, 2010)

Apart from these, there are two other projects namely, Kishori Shakti Yojana (KSY) and Rajiv Gandhi Scheme for Empowerment of Adolescent Girls – SABLA, the purpose of which is improvement of health status of adolescent girls, health education for promoting awareness of health, hygiene, nutrition, family care, counseling/guidance on family welfare, training on adolescent reproduction and sexual health, child care practices, home management, life skills education, accessing public services and providing better understanding of their social environment so that they can become productive members of the society. (Planning Commission, 2011)

V.7 (a) Health situation in Malda district

Health is one of the most important factors in the path of development and universal achievement of human rights. Human development is impossible without improvement of health especially of the women and children.

To improve maternal and child health, reduce maternal and child mortality and encourage institutional delivery as a part of Janani Suraksha Yojana (YSY) has recorded poor response in Malda District and among the tribals the response has been poorer. The table given below reflects the status of institutional deliveries under Ayushmati Scheme in chosen districts of West Bengal. Under the present Ayushmati scheme private sector has also been engaged for providing quality essential and emergency obstetric care to pregnant women belonging to BPL and SC/ST families. The cost is reimbursed by the government which intends to generate demand and improve access to services while providing choice.
Table V.7.1 showing the status of institutional delivery at public and private facilities in chosen districts of West Bengal

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Districts</th>
<th>% of Institutional Delivery (RCH Survey 2003)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Govt.</td>
<td>Private</td>
</tr>
<tr>
<td>1.</td>
<td>Uttar Dinajpur</td>
<td>15.8</td>
<td>4.8</td>
</tr>
<tr>
<td>2.</td>
<td>Malda</td>
<td>20.9</td>
<td>6.6</td>
</tr>
<tr>
<td>3.</td>
<td>Murshidabad</td>
<td>29.8</td>
<td>3.4</td>
</tr>
<tr>
<td>4.</td>
<td>Coochbehar</td>
<td>27.7</td>
<td>9.1</td>
</tr>
<tr>
<td>5.</td>
<td>Paschim Medinipur</td>
<td>29.2</td>
<td>14.4</td>
</tr>
<tr>
<td>6.</td>
<td>Dakshin Dinajpur</td>
<td>40.1</td>
<td>4.8</td>
</tr>
<tr>
<td>7.</td>
<td>Birbhum</td>
<td>40.1</td>
<td>8.0</td>
</tr>
<tr>
<td>8.</td>
<td>Purulia</td>
<td>40.7</td>
<td>8.2</td>
</tr>
<tr>
<td>9.</td>
<td>Bankura</td>
<td>52.9</td>
<td>9.5</td>
</tr>
<tr>
<td>10.</td>
<td>Nadia</td>
<td>58.1</td>
<td>7.0</td>
</tr>
</tbody>
</table>

Source: Health & Family Welfare Dept., Govt. of West Bengal, NHRM (2005-2012)

From the above table it is seen that the percentage of institutional deliveries at government institutions (20.9%) in Malda district is second lowest while institutional deliveries at private hospitals remain (6.6%) among the ten selected districts of West Bengal.

The maternal and child health issues in the district depict a dismal state. It has been mentioned in the DHDR 2007 that the ANMs attached to the sub-centres do not stay within their service area and hence are not available during emergency of the expectant mothers of the villages. Neighbourhood Dais’ and quack practitioners attend during such non-institutional births. Although some government initiatives are taken from time to time to train up traditional birth attendants through hands on training programmes, often the persons who have received training are not the persons who attend births.

Pregnant women in the far flung areas face grave problems in quick access to healthcare facilities during sudden labour pains. The reach out of health facilities having arrangements to handle critical cases in case of any complication arising during delivery is also very poor.
Immunization of mothers and children needs special attention as there exists wide anomalies between reported coverage and evaluated coverage of pregnant women and children with immunization services.

Malnutrition among mothers and children are common and the number of low birth weight babies is also very high.

**V.7 (b) Health Infrastructure in the blocks under study**

In any modern civilization the capacity to live long and fulfilling healthy lives depend on the demographic terms to the life expectancy of the population which is also an important parameter for estimation of the Human Development Index or the HDI. The life expectancy also depends on a number of proximate factors which include general health status of the population, status of public health and hygiene, the status of maternal and child health, the extent of coverage of public healthcare services available to the population, the incidence of morbidity and disease, the regional endemicity of diseases if any and so on. Before assessing the health situation in the study areas, we must have an overview of the existing healthcare system of the district from secondary sources.

The table given below highlights the institutional structure of the healthcare system in the studied blocks:

**Table V.7.2 showing the institutional structure of the healthcare system in the studied blocks**

<table>
<thead>
<tr>
<th>Blocks</th>
<th>Hospitals</th>
<th>PHCs</th>
<th>Government Clinics</th>
<th>Government Dispensaries</th>
<th>Total Health Institutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Old Malda</td>
<td>-</td>
<td>2</td>
<td>22</td>
<td>-</td>
<td>24</td>
</tr>
<tr>
<td>Gazole</td>
<td>1</td>
<td>4</td>
<td>50</td>
<td>1</td>
<td>56</td>
</tr>
<tr>
<td>Habibpur</td>
<td>1</td>
<td>2</td>
<td>42</td>
<td>2</td>
<td>47</td>
</tr>
<tr>
<td>Bamongola</td>
<td>1</td>
<td>2</td>
<td>23</td>
<td>1</td>
<td>27</td>
</tr>
</tbody>
</table>

Source: District Human Development Report, 2007

It is learnt from the District Human Development Report, Malda (2007) that in Gazole there are 56 health institutions in total which includes 1 hospital, 4 Primary Health
Centres (PHCs), 50 government clinics and 1 government dispensary. In Bamongola block there is a total of 27 health institutions which includes 1 hospital, 2 PHCs, 23 government clinics and 1 government dispensary. In Habibpur there is a total of 47 health institutions out of which 1 is hospital, 2 PHCs, 42 government clinics and 2 government dispensaries. In Old Malda there are only 24 health institutions in total in which 2 are PHCs and 22 government clinics. There are no hospitals and government dispensaries present in Old Malda. The referral healthcare chain in the studied blocks runs from the government clinics and dispensaries which offer only out-patient services to the Primary Health Centres which provide basic in-patient facilities and finally the government hospitals situated at block, sub-division and district headquarters level which provide both in-patient and out-patient services. It has already been admitted in the District Human Development Report 2007 that the public healthcare system in the district has not kept pace with the rapid population growth which falls largely inadequate and carries an exceptionally heavy load. On account of such inadequacies and heavy load on the healthcare system, the population of the studied blocks is deprived in terms of the existing capacity of healthcare service delivery. The healthcare infrastructure and the health manpower resources in the studied blocks is certainly inadequate when compared with the requirements of the regional population. The table below represents the health infrastructure, health manpower resources and the health coverage in the blocks under study:

Table V.7.3 showing the healthcare infrastructure, health manpower resources and the health coverage in the studied blocks

<table>
<thead>
<tr>
<th>Blocks</th>
<th>Population</th>
<th>RH/ BPHC</th>
<th>PHC</th>
<th>S-C</th>
<th>Pharmacist &amp; Lab. Asst</th>
<th>Total Beds</th>
<th>Medical Officers</th>
<th>Nurses</th>
<th>Female Health Assistants</th>
<th>Total Villages</th>
<th>Villages &gt; 1.5 km S.C.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bamongola</td>
<td>1,27,252</td>
<td>1</td>
<td>3</td>
<td>23</td>
<td>5</td>
<td>39</td>
<td>4</td>
<td>9</td>
<td>22</td>
<td>274</td>
<td>14</td>
</tr>
<tr>
<td>Habibpur</td>
<td>1,87,650</td>
<td>1</td>
<td>2</td>
<td>42</td>
<td>5</td>
<td>39</td>
<td>2</td>
<td>9</td>
<td>41</td>
<td>379</td>
<td>23</td>
</tr>
<tr>
<td>Gazole</td>
<td>294,715</td>
<td>2</td>
<td>3</td>
<td>50</td>
<td>8</td>
<td>65</td>
<td>4</td>
<td>20</td>
<td>49</td>
<td>813</td>
<td>50</td>
</tr>
<tr>
<td>Old Malda</td>
<td>1,31,255</td>
<td>1</td>
<td>2</td>
<td>22</td>
<td>4</td>
<td>18</td>
<td>4</td>
<td>6</td>
<td>25</td>
<td>231</td>
<td>40</td>
</tr>
</tbody>
</table>

V.7 (c) Existing health infrastructures in the studied areas

Information from the concerned Block Development Office and Block Medical Officer of Health’s Office on existing health infrastructure were collected during field visits. For this, the sub-centres, Primary Health Centres (PHC) and Rural Hospitals in all the studied blocks were visited to have an overview of the functioning of the healthcare system and to understand as to whether the service provided sufficient for the population under study. Along with this, health officials vis-à-vis the villagers were interviewed to get the real picture of healthcare facilities in the studied villages.

V.7 (c) (i) Sub – Centres

As the sub-centres are the first contact point of the villagers, information regarding the nature of services and activities of the sub-centres will reflect the nature of diseases and health services in the studied areas. For this, information were gathered from the Public Health Nurse (PHN) who supervises the sub-centres of the concerned blocks. Their information on the tribal diseases are very helpful for this study to cross-check information gathered during the survey as they also work at grass root levels.

The activities of the sub-centres are almost the same in the studied villages. The sub-centres in the studied villages primarily perform activities under Reproductive Child Health (RCH), Maternal Child Health (MCH) and Family Planning programmes. As part of this programme, they carry out antenatal care for expectant mothers, giving pregnant mothers vaccines and Iron and Folic Acid (IFA) tablets, immunization and initial treatment of children. Apart from this, under Village Health and Nutrition Day (VHND) programme, health counseling, immunization and nutrition through Integrated Child Development Scheme (ICDS) is provided to the villagers. For any kind of disease the tribal people visit the sub-centres for initial treatment. Basic medicines for any disease like diarrhea, leprosy, tuberculosis, kala azar and filaria is given from the sub-centres. Besides, the sub-centres perform family planning programmes. Oral Contraceptive Pills (OCP), Intra Uterine Devices (IUD) and Condoms are given to them. Tubectomy operations are also done in the sub-centres. There has been 100% coverage of sterilization programmes in the tribal dominated blocks. The sterilization programmes have also gained wide acceptance among the tribal families.
The Supervisor of the sub-centres in all the studied blocks reported that the common diseases among the tribals are tuberculosis, kala azar, leprosy, filaria. Filaria is very common among the tribal families because they live in damp conditions and wet mud houses. The supervisor of Habibpur block reported that the occurrences of tuberculosis is most common among tribals of this block but due to negligence and ignorance they neither go for early detection nor do they follow up the treatment process regularly or the direction of the attending health personnels at the sub-centre. After taking the initial medication they give up treatment in many cases and when they turn up second time the disease aggravates.

The supervisors of the sub-centres pointed shortage of man power as the main obstacle in the fullest realization of the programmes and quality in services. Safe drinking water, sanitation and non-electrification are the common problem of the health workers of most of the sub-centres. They complain that in most of the sub-centres the infrastructural capacity is under developed and the atmosphere for work is not conducive. Most of the sub-centres are run in rented houses or buildings without proper infrastructure and the rents are not paid regularly by the government. So there is uncertainty in maintaining the location of the sub-centres. Communication is another problem of the health staffs working in the sub-centres located in remote villages. It is pathetic especially during the rainy season.

Besides these, sometimes there are irregular and short supplies in medicines, vaccines and family planning tools and equipments.

V.7 (c) (ii) Primary Health Centres (PHCs)

(a) Moulpur Primary Health Centre at Old Malda

This primary health centre serves the tribal families in all the studied villages of Old Malda block. Although there were very limited services of this primary health centre but after the renovation of the old building and the new building, health services have been recently extended. This BPHC caters to the needs of 1,60,000 rural population and 90,000 urban population.
Services/ Facilities

- Out Patient Department (OPD) services only with General Medicine, Homoeopathy and Ophthalmology (only vision correction done by paramedical staff) departments.
- Services and facilities under Janani Suraksha Yojana (JSY) and Janani Sishu Suraksha Karyakram (JSSK).
- For in-patients there are 15 sanctioned free beds but only 6-7 beds can be used.
- Some essential medicines for minor treatment and diseases are available.
- Minor sterilization operations are done.
- 24 hours emergency services.
- Blood and cough test is done for detection of tuberculosis, blood test for detection of malaria and kala azar
- 1 Matrjan ambulance available under Public Private Partnership (PPP) model.
- Newly built Sick New Born Stabilization Unit (SNSU) and Nutritional Rehabilitation Centre (NHC) present but service not yet opened.
- 2 large oxygen cylinders required for sterilization camps and indoor patients.

Staff Strength

<table>
<thead>
<tr>
<th>Post</th>
<th>Sanctioned</th>
<th>Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medical Officer (Allopathy)</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>2. Medical Officer (Homoeopathy)</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>3. Medical Officer (Ayurvedic)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4. Ophthalmic Asst.</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>5. Pharmacist</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>6. General Duty Asst.</td>
<td>13</td>
<td>4</td>
</tr>
<tr>
<td>7. Sweeper</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>8. Block Sanitary Inspector</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>9. Auxillary Nurse Mid-wife (ANM)</td>
<td>25</td>
<td>14</td>
</tr>
<tr>
<td>10. Lady Counsellor for Anwesha Clinic</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>11. Clerk cum Accounts Manager</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>12. Nutritionist</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

(Source: Field data as on 14.7.2012)

The above staff strength includes both regular and contractual staffs.
The Moulpur BPHC in Old Malda block does not have any specialist doctors and surgeons. Surgeries and caesarean operation cannot be done due to unavailability of anesthetist and specialist obstetrician. The BPHC also do not have X-ray and ECG facilities. The supply of hospital medicines get irregular at times and then medicines are bought from the funds of patients’ welfare (Rogi Kalyan). Some of the studied villages in Old Malda block under the jurisdiction of Moulpur BPHC are equidistant from the District Medical College and Hospital located at Malda Town. Therefore, they avail the services of the district hospital directly as the communication system with this primary health centre is not properly developed. It was also reported from here that the outbreak of diarrhoea is most common among the tribal families in this block. Also the incidence of kala azar is maximum among the tribals. Between January – June 2012 there were reports of sixteen patients suffering from kala azar in this, all of which were tribals.

V.7 (c) (iii) Rural Hospitals (RHs)

(a) Bamongola Rural Hospital

This rural hospital is very vital for the studied tribal families of Bamongola and villagers from Manikpur, Baganpara, Mirzapur, Gurullya, Kumarpur and Bamongola are dependent on this hospital for treatment.

Services/ Facilities

- Services and facilities under Janani Suraksha Yojana (JSY)
- Blood test is done for detection of tuberculosis, malaria and kala azar
- X-Ray, ECG, Labour Room and Operation Theatre facilities present.
- Newly built Sick New Born Stabilization Unit (SNSU) present
- Out Patient Department (OPD) is open regularly in the morning between 9.30 am -1.30 pm.
- For in-patients there are 30 short term sanctioned free beds.
- Essential drugs except for rare and critical care medicines are given.
Staff Strength

<table>
<thead>
<tr>
<th>Post</th>
<th>Sanctioned</th>
<th>Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Doctors</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>2. Nurses</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>3. General Duty Asst.</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>4. Sweeper</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

(Source: Field Data as on 9.6.12)

The Block Medical Officer of Health (BMOH) himself performs the duties of a General Physician, Gynaecologist and other administrative functions. There is one Surgeon available in the rural hospital. The posts of Gynaecologist & Obstetrician, Pediatrician and Anesthetist are lying vacant for a long time. Surgeries and caesarean operation cannot be done due to unavailability of Anesthetist despite the availability of a Surgeon and an acting Gynaecologist (the BMOH himself).

The BMOH, Dr. Gouranga Biswas pointed erratic electricity, irregular supply of medicines and lack of posted specialized doctors, trained nurses and staffs as the major problems in running the hospital smoothly. As a result, the patient to doctor ratio remains below the standardized norms. The number of sanctioned beds for in-patients being 30 but the hospital wards have to accommodate 100 or even more patients during emergency when patients are given admission seats on the floor of the wards or the verandah. Although there is a Sick New Born Stabilization Unit yet its condition is poor due to lack of specialized doctors and limitation of beds. There is also a deficit in demand and supply in hospital equipments and medicines. If any diagnostic machine fails to function or is out of order for some reason it cannot be repaired timely due to unavailability of mechanic. So there is heavy work load on the doctors and the nurses.

Moreover, the staff quarters are not well maintained, paucity in safe drinking water, there are no provisions for rest rooms, toilet and drinking water facilities for the relatives of the patients and there is also security problems for the patients, their relatives and the doctors and staffs’ quarters as there is no gate and boundary wall.
(b) Habibpur Rural Hospital

This rural hospital is the most important place of treatment for the tribal families in the studied villages. Villagers from the villages of Anail, Dholakandar, Aktoil, Nityanandapur, Chachaichandi and Raghabbati solely depend on this rural hospital for treatment purpose. Information regarding the services and facilities provided in this Rural Hospital were provided by the BMOH, Dr. A.N Mondal.

Services/ Facilities

- OPD and 24 hour Emergency facilities
- 30 free sanctioned beds for in-patients alongwith oxygen facilities
- Facilities and the provisions of reimbursement for institutional deliveries under *Janani Suraksha Yojana* (JSY)
- Sick New Born Stabilization Unit (SNSU)
- Mini Laboratory for carrying out family planning programmes
- Dental Chair, Ophthalmological equipments, X-Ray, ECG, Labour Room present
- Homoeopathy treatment facility
- Blood test for malaria, *kala azar* and cough test for tuberculosis.
- 1 private ambulance and 2 NGO ambulances in PPP model acting as mobile unit.
- Essential medicines except rare types.

**Staff Strength**

<table>
<thead>
<tr>
<th>Post</th>
<th>Sanctioned</th>
<th>Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Nurses</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>General Duty Asst.</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>Sweeper</td>
<td>5</td>
<td>3</td>
</tr>
</tbody>
</table>

(Source: Field Data as on 12.6.12)

Besides these, Multi Drug Treatment (MDT) is provided to leprosy patients. One Medical Officer and a Supervisor are there to attend the leprosy patients. The Revised National Tuberculosis Programme (RNTP), Institutional deliveries under *Janani*
Suraksha Yojana (JSY) and Sterilization programmes are running successfully in the hospital. There were 1856 institutional deliveries in the hospital during January – December 2011 and the hospital won prize for it. 836 persons covering the entire block was sterilized during March - April 2011-2012 Financial Year. As part of the filaria control programme the hospital provides medicine in the first day to the patients and they are called for follow up for another two days. To control occurrences of diarrohea during the summer the health staffs are engaged in disinfecting the village wells. The common diseases in the block are tuberculosis, filaria, kala azar, diarrohea etc. Incidents about occurrences of malaria have been reported to be comparatively few in this block.

Regarding the adequacy and quality of healthcare services in the hospital the BMOH said that although they intend to provide better services that what exists presently in the hospital to the rural people yet that cannot be made possible due to the lack of Doctors, Nurses and General Duty Assistants. There are 3 General Physician (1 lady and 2 males) and 2 Gynaecologist. The BMOH himself also acts as a General Physician and looks after the administrative activities of the hospital. The post of Paediatrician is vacant in the hospital. The functional Sick New Born Stabilization Unit can accommodate two sick new born babies at a time and the stabilization corner in the labour room can accommodate only one new born baby. Due to lack of Anesthetist and Surgeon no operation can be done including Caesarean operation. Although there is a dental chair in the hospital, it is non-functional due to absence of a posted Dentist. Same is the case with the Ophthalmology section which is defunct due non-availability of Eye Specialist and Ophthalmic Assistant. The supply of hospital medicines and electricity supply is irregular and this hampers the smooth running of the hospital. Cleanliness and hygienic conditions cannot be maintained due lack of sweepers, general duty staffs and irregular funds for Rogi Kalyan Samity (RKS) or Patients’ Welfare Association.

(c) Gazole Rural Hospital

The Medical Officer In-Charge, Dr. Shyam Sundar Haldar at Gazole Rural Hospital shared some information on the facilities, existing infrastructure, problems and the importance of this rural hospital in the region. Apart from the tribal families of the studied villages this rural hospital is vital for the patients of the adjoining districts of
North and South Dinajpur. This rural hospital acts as a First Referral Unit and provides curative healthcare facilities. Among the studied villages, the tribal families from the villages of Shankarpur, Dahil-Mahil and Updel depend on this rural hospital for treatment.

**Services/ Facilities**

- General OPD and 24 hour Emergency facilities
- 30 free sanctioned beds for in-patients alongwith oxygen facilities and separate wards for males, females, children, labour and isolation wards.
- A temporary New Born Care Corner with two warmers.
- Facilities and the provisions of reimbursement for cashless institutional deliveries under *Janani Suraksha Yojana* (JSY)
- Medicinal cost for mother and child under *Janani Sishu Suraksha Karyakram* (JSSK).
- Homoeopathy and Dental OPD treatment facility.
- Blood, cough and sputum test for tuberculosis detection, free treatment and medication facility.
- Pathological laboratory facility for malaria parasite test and kala azar.
- *Anwesha* clinic for adolescent health counseling and ICTC clinic for HIV/AIDS counseling and testing.
- ECG test on every alternate day, daily X – Ray test facilities and bi-weekly USG facilities under Public Private Enterprise (PPP) model.
- Mini Laboratory for carrying out family planning programmes
- Labour room with facilities of caesarean section operation.
- Separate waiting shed for the attendants of patients during day and night.
- Ambulance facilities available (2 ambulances have been donated by local MP, MLA and 1 *Matrijan* ambulance run by government collaboration with NGO under PPP model).
### Staff Strength

<table>
<thead>
<tr>
<th>Post</th>
<th>Sanctioned</th>
<th>Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medical Officer</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>2. Nurses</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>3. General Duty Attendant</td>
<td>15</td>
<td>7</td>
</tr>
<tr>
<td>4. Lab. Technician</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>For T.B &amp; AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Lab. Technician for</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>X-Ray &amp; ECG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Pharmacist</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>7. Lady counselor/ Nurse for Anwesha Clinic</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>8. Homoeopathy MO</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>9. Dental MO</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>10. Storekeeper</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>11. Sweeper</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

(Source: Field Data as on 12.7.12)

It was known from the Medical Officer In-Charge that the main problem of this rural hospital is with its building which has not been repaired for over two decades and as a result the walls and floors are very damp and water percolates from roof tops during rainy season. This creates immense problem in the wards where patients are admitted and the operation theatre. The electricity connection also remains unchecked for over two decades and the doctors, nurses and patients are living with the fear of fire break out from short circuit at any moment. The condition of the staff quarters are also like hospital building and remain insufficient and the quarters of the Group – D staffs are dilapidated. The hospital does not have a office or an Upper Division Clerk to maintain official affairs. The Medical Officer In-Charge has to do it for himself. The staffs have to travel to Hatimari Rural Hospital to the office of the BMOH located 7-8 kms far for official purposes relating to leave. Further, they have to travel to BMOH office to bring regular contingency materials. The medicine supply of the hospital comes from District Reserve Store (DRS) and being a First Referral Unit (FRU) medicine is also supplied directly from the State Government but the supply sometimes become irregular. Apart
from this, owing to the patient load from the block and adjoining districts, there remains huge deficit in beds all round the year and sometimes 6-7 patients are accommodated on a single bed. Besides this, a considerable number of patients also lie on the floor of the wards, verandah and corridor. Previously there used to be specialized doctors in Paediatrics, Gynaecology and Anesthesia but they have been shifted to District Medical College and Hospital at Malda Town and no replacement has yet been made. These departments are now being run on a make shift basis after providing short term training to the existing doctors. Even caesarean operation is done by a doctor who has been given a short term training of three months.

(d) **Hatimari Rural Hospital (Gazole)**

This rural hospital is the oldest among all health centres in the block and dates back to colonial period. The tribal families from the studied village of Lakhripir mainly depend on this rural hospital for their treatment. Information regarding the services and facilities provided in this Rural Hospital were provided by the BMOH, Dr. S.K Adhikari.

**Services/ Facilities**

- OPD and 24 hour Emergency facilities
- 30 free sanctioned beds for in-patients alongwith oxygen facilities and separate wards for males and females and isolation wards.
- Facilities and the provisions of reimbursement for cashless institutional deliveries under *Janani Suraksha Yojana* (JSY)
- Homoeopathy OPD treatment facility
- Diagnosis, free treatment and free medication for leprosy, tuberculosis, malaria and kala azar.
- Mini Laboratory for carrying out family planning programmes
- Labour room and mini operation theatre for minor surgeries.
- Mini pathological laboratory for malaria parasite test, *kala azar*, tuberculosis and cough test.
- New born care corner with glass room and warmer placed in it.
- Eye screening
- *Anwesha* clinic for adolescent health counseling.
- Essential medicines except rare types.
Regarding the adequacy and quality of healthcare services in the hospital the BMOH pointed out that they are trying their best to provide better services from the available resources that exists in the hospital to the rural people yet he admitted that the outreach of modern healthcare facilities have remained limited due to the lack of Doctors, Nurses, General Duty Attendants and laboratory technicians and limited resources in this rural hospital. The hospital does not provide ECG facilities which had been demanded for a long time. Only normal institutional deliveries are performed on a round the clock basis. There are no provisions for caesarean deliveries due to lack of anaesthetist. Although there is a mini operation theatre in the hospital but only minor surgeries can be performed because of absence of specialized surgeon and anesthetist. There are no ambulance services in the hospital for which the villagers have to face problems for emergency admission in the hospital. The official car and the driver of the BMOH is sometimes temporarily used for this purpose. The cleanliness of the hospital cannot be maintained properly due to lack of sweepers and awareness among the patients. The personal care of the patients also suffers due to lack of availability of nurses and general duty assistants. Due to the insufficient beds for indoor patients, the hospital has to accommodate the surplus patients even on bare floors. The pathological
unit also faces problem in running due to limited laboratory technicians. The major diseases reported in this block are leishmaniasis or kala azar, diarrhoea, tuberculosis, malaria, filaria and typhoid. Tribal families in this block mainly suffer from these diseases. As Gazole block is prone to kala azar which has also been demarcated by the Health and Family Welfare Department of West Bengal Government. So there are large numbers of patients who suffer from kala azar in this block. As a result there is enormous pressure in the pathological unit of the hospital which is quite difficult to manage with such limited staffs.

V.7 (c) (iv) Malda Medical College and Hospital at English Bazar (Malda Town/ Dist. Head Quarter)

The previously District Hospital at Malda had been uplifted to Medical College & Hospital in 2011. For all the tribal families in the four blocks under study, this medical institution forms the apex body of the entire system. Critical patients and such patients who have limited or no scope for treatment in the local health institutions are referred here for better care and treatment. Information regarding the services and facilities provided in this hospital were collected from the Asst. Superintendent, Dr. Samaun Mondal and Dr. Uchchal Kumar Bhadra, Principal, Malda Medical College & Hospital.

Services/ Facilities

- OPD services (Monday – Saturday between 9 am – 2 pm) in Gynaecology & Obstetrics, Medicine, Paediatrics, Surgery, Orthopaedics, Psychiatry, Dermatology, Dental, ENT and Ophthalmology
- 24 hour Emergency facilities
- 600 free sanctioned beds for in-patients with separate wards for males, females, children and isolation wards
- Oxygen cylinders – 60 (large) and 260 (small)
- Sick New Born Stabilization Unit (SNSU) 23 beds with radiant warmer
- Newly opened (on 10.3.13) Fair Price Medicine Shop
• 24 hour Blood Bank service acting as the nodal supplier for the entire district’s rural hospitals and block primary health centres

• ICTC clinic for HIV/AIDS counseling and testing

• Two operation theatres.

• One labour room with six tables.

• Diagnostic testing includes pathological laboratory, USG, X-ray and CT scan done by PPP model.

• Water supply in the hospital is maintained in the campus by Public Health & Engineering Dept.

• Generator service available for OT and other emergency services.

• A post-natal unit for immunization of the new born children of the English Bazar who are born in this hospital.

• Facilities and the provisions of reimbursement for cashless institutional deliveries under Janani Suraksha Yojana (JSY)

• The smartcard holders from BPL families receive all the services under Rastriya Swastha Bima Yojana (RSBY).

• Five Matrijan ambulance run by government collaboration with NGO under PPP model for the to and fro movement of the expectant mothers to the district hospital from all blocks.

### Staff Strength

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<thead>
<tr>
<th>Post</th>
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<th>Available</th>
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<tr>
<td>(Doctors)</td>
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<tr>
<td>1. Medicine</td>
<td>6</td>
<td>3</td>
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<tr>
<td>2. Surgery</td>
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</tr>
<tr>
<td>3. Gynaecology &amp; Obstetrics</td>
<td>6</td>
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<td>4. Paediatric</td>
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<td>5. Orthopaedic</td>
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The Asst. Superintendent, Dr. Samaun Mondal at Malda Medical College & Hospital commented regarding the deficiencies in adequacy and quality of healthcare services in the hospital. The foremost being the deficiency in manpower in each and every department.

He also admitted about the fact that broker racket is active in the hospital and untrained Group D staffs perform surgical activities during operation. The patients are given injection by these untrained staffs. Some of the nurses remain very casual with their responsibilities and keep themselves involved only to keeping patient records in register. He pointed out that although the inpatient bed capacity has been increased

(Source: Office of the Asst. Superintendent, Malda Medical College & Hospital on 11.3.2013)
from 600 to 750 but due to lack of building the service cannot be extended to the patients. Although the foundation stone has been laid for a separate building for Maternal and Child Health but the construction work has not yet started. As of now there is no facility of MRI, dialysis and digital x-ray. There is also no ambulance facility for patient service. There is only one van which is used for call book service of the doctors. There is also one Patient Assistance Booth which has been non-functional for a long time.

There is also one positive aspect that he admitted is that the SNSU cost lower than nursing homes.

**V.8 Response of the tribal villagers on the health services provided**

Here are a few case studies that revealed some anomaly of the healthcare system and the health situation in the studied villages as was evident from the interview of the villagers.

**Case Study: 8**

Baha Tudu, (Male, Age 45 years, Community - Santal, Village - Maligram, Block - Old Malda) was having severe pain in the stomach for quite some time. He initially was under treatment of a village quack. But he got no relief. Thereafter he went to the local health centre and the district hospital where he was told of having tumor in the stomach and was suggested surgery. The surgery was a failure; he was wrongly treated and died due to untimely intervention and medical negligence.

**Case Study: 9**

Samir Murmu, (Male, Age 8 years, Community - Santal, Village - Habinagar, Block - Gazole) a child fell off from a wall. He was rushed in to the sub-centre which remained closed then and the child could not even receive a first aid. The villagers complained that the sub-centre remains closed for most of the time and opens for once a week only for a short time and there are no trained nurses or doctors or equipments. Due to the delay in treatment, the child expired on the way he was being taken to the district hospital.
**Case study: 10**

Madan Mal, (Male, Age 50 years, Community - Malpahari, Village - Katabari, Block - Old Malda) was an alcoholic. He was having liver and lungs problems due to prolonged liquor consumption. The poor wage earning family was on the brink of ruin because whatever he earned was spent on liquor and there were frequent family quarrels over the issue. His wife tried to de-addict him with some traditional herbal medicine from the village medicine man but the results were no better. Somebody suggested her for modern medical treatment and go to the district hospital instead. The wife made arrangements for the same but returned disheartened as there was no scope of psychiatric counseling for drug de-addiction there.

**Case study: 11**

Minu Hembram, (Female, Age 14, Community – Santal, Village – Aktoil, Block – Habibpur) a VIIIth standard student took iron tablets from her school as part of the State government’s health programme. But after having it she felt uneasy and started vomiting. Some of her classmates also felt the same. It was due to the expiry of date of the tablets that were being served to the girls.

**Case study: 12**

Munni Tudu, (Female, Age 1 year, Community – Santal, Village – Gurullya, Block – Bamongola) child had been suffering from cough respiratory problem during winter season. The child was referred to the district hospital. The condition of the child worsened on the way and on being admitted it further deteriorated and due to heavy patient pressure in the district hospital the child could not get proper care and treatment and ultimately the child died.

**Case study: 13**

Sonu Tudu, (Male, Age 2 years, Community – Santal, Village – Jamdanga, Block – Gazole) was suffering from diarrhoea. There were no doctors and nurses present in the emergency department of the rural health centre at that time. The family members in the hope of better treatment and care wanted to admit the child in a private nursing home. The nursing home refused to admit such a critical child.
Case study: 14

Marang Hansda, (Male, Age 45 years, Community – Santal, Village – Kumarpur, Block – Bamongola) old man was suffering from non-remitting fever. He was diagnosed for kala azar and was prescribed antibiotics and costly medicines from the health centre. He could not bear the cost of such medicines. The government hospitals and primary health centres have no provision of free medicines and medical aids. Finally he died for the lack of money to carry out treatment.

Case study: 15

Somai Murmu, (Male, Age 5 years, Community – Santal, Village – Chachaichandi, Block – Habibpur) old child attended an anganwadi centre. One day he fell ill after having the food in the school. The quality of cooked food in anganwadi centre was of such a low quality and the food was cooked in such unhygienic conditions that the child started vomiting due to food poisoning.

The villagers from the studied villages and some local political persons were interviewed to which they responded in the following manner. The villagers complained that they do not get regular medicines from the sub-centres and rural hospitals, the OPD and Emergency services are irregular as the doctors remain absent most of the times, the behaviour of the health personnels towards the patients and their relatives are not gentle, the in-patient wards, toilets and the hospital campus is unhealthy, unhygienic and domestic animals like cats and dogs cohabit with the patients in the wards. The villagers complained that due to lack of infrastructure, absence of doctors and nurses in the Emergency section of the hospital and due to the referral tendency of the doctors they have to shift their patients at odd hours of night to the District Medical College

Hospital at Malda Town located very far away from the studied blocks like Gazole, Bamongola and Habibpur, where communication facilities are unavailable. This is totally impossible for the poor villagers and those who have means can only manage. This crisis situation worsely affects the health condition of the ailing patients.

It was learnt from interviewing the villagers that the cost of diagnosis and treatment is another reason that pervades the villagers from accessing western medicines as they do not get free medicines from the hospitals. Hence it is difficult for them to bear the cost
of medicines required for treatment due to their low socio-economic status. Moreover, there are huge amounts of fake medicines in the medicine shops which cost higher than the original medicines. The ignorant villagers often fall easy prey to this unscrupulous practice.

The family welfare services provided to the mothers, children and family planning programmes have failed to reach the anticipated level of success as the staffs in the sub-centre remain absent mostly.

Lack of goodwill and insensitivity on the part of a section of health staffs and doctors alongwith poor and inadequate health service remain as a major barrier in the proper outreach of health rights among the public in general and the studied communities in particular. It was noticed during visits to the rural hospitals that some doctors were busy with their private practice and devoted major time and effort for that rather than attending patients in the hospitals. Some doctors also remained absent in the hospital during duty hours and remained busy attending private patients in staff quarters and charged high fees from the patients which included patients from poor tribal families. During such situation, if the villagers opt for private nursing homes going beyond their capacity, the private nursing homes refuse treatment or admission for critical patients and patients with low socio-economic backgrounds thinking that they would not be able to pay off medical charges. These creates delay in proper treatment at right time for critical patients and have to accept harsh realities in the delivery of health services and the health conditions either worsen or they have to go untreated.

It was also learnt from the patients and the villagers that while getting admission in Malda Medical College and Hospital they have to pay heavy amount to the local agents/brokers. Moreover, beds can be booked by special recommendations and influence of political leaders and the general public have to suffer for this. Reportedly, the behavior of the nurses at duty in the wards, emergency department and outdoor services are inhuman and negligent in their duties and responsibilities. Since the nurses are permanent employees of the State Government, they are not committed in their work and keep themselves busy in gossip while behaving rudely with the families of the patients. They do not even care for any higher instructions and live under the protective umbrella of their employees’ union. The only work they does is that of maintaining official records of the patient while untrained and unrecognized sweepers
and other Group D staffs carry out duties at the operation theatre, stitching, giving injections and other duties. Patients’ parties have to engage special private caretakers for the patients. Even the hospital authorities are well aware about this practice and some of the officials who wanted to keep their name and designation confidential also admitted about the malpractices going around.

Apart from these, the poor civic amenities in the tribal villages are another reason that compels the tribal villagers to live an unhealthy lifestyle and fall prey to a number of diseases. The foremost among these been the lack of safe drinking water sources that makes them susceptible to seasonal and water borne diseases. The poor tribals mainly depend on the tube wells and wells mainly under the supervision and maintenance of the local panchayats and block level offices for their primary source of drinking water and the villagers in some of the studied villages reportedly told that there is a substantial lack in the number of tube wells or wells in their villages and the ratio of tube wells to the number of families remain poor. As a result the pressure is high on the village tube wells. The problem aggravates when the tube wells goes out of order and the mechanics from the concerned maintenance agency does not turn up for weeks or even months for repair. The crisis becomes acute in summer months when the water table goes down. Most of the wells and water bodies get dried up. The women and young tribal girls have to travel long distances to neighboring villages to fetch water. This compels them do depend on unhygienic water sources for daily uses and drinking purposes which affect their health badly.

During interview sessions some of the better learned tribal families were free enough to express their views about the prevailing situation of the tribal health in the region. They reported that the poor state of sanitation among the low socio-economic families has been another reason for poor tribal health. They also indicated about the reluctance of the tribals towards the use of sanitary toilets and the related socio cultural beliefs that makes them vulnerable and prone to certain diseases. They also admitted that poor education coupled with ignorance is responsible for lack of health consciousness and personal hygiene among the tribal families. Reportedly, they blamed that the concerned agencies have shown little or no interest in making the tribals aware about the use of sanitary toilets. Almost nothing has been done to erect community toilets or individual family toilets in most of the villages under study.
V.9 The health and nutrition interventions under ICDS in the studied areas

The ICDS programme which was launched in India on 2\textsuperscript{nd} October 1975 represents one of the largest and most unique programmes of early childhood development. It is a centrally funded scheme. According to the envisaged objectives of the programme, the ICDS personnels in the studied areas carry out the implementation services in the blocks under study. There are three tiers in the delivery system. At the apex are the District Programme Officers (DPOs) followed by Child Development Project Officers (CDPOs), Supervisors, Anganwadi workers and Anganwadi helpers. The population norms as fixed up by the Central Government for setting of Anganwadi centres in the tribal and other difficult areas 1 an anganwadi centre covers 300-800 population size and 1 mini anganwadi centre covers 150-300 population.

On having interviewed the Supervisors of the four blocks under study reflections on the broad activities of the programme were gained which included:

- Supplementary nutrition
- Immunization
- Health check up
- Referral services
- Pre-school non-formal education
- Nutrition and health education
- Generation of social awareness and life skill training.

For every Gram Panchayats in the blocks there are respective supervisors. The foremost activity that of an anganwadi worker is to identify and enlist the pregnant women and children below 6 years in their respective areas. The workers then conduct counseling and refer the pregnant mothers to the centres where they are given IFA tablets and tetanus injections. This service starts from the third month of pregnancy, covers the full pregnancy, lactation period and continues upto the sixth month of post pregnancy. The mothers receive four check-ups during pregnancy period and counseling is also provided to encourage institutional delivery. This has been especially given importance for the tribal families where non-institutional births still continue. The workers also aim in creating awareness against superstitions, especially relating to personal health and hygiene, dowry and witchcraft system in the tribal families. The workers of the ICDS
also regularly observe Village Health Nutrition Day (VHND) and Nutrition Health Day (NHD) and provide counseling for nutrition and dietary benefits from easily available local herbs, plants, herbs and cheap vegetables, fruits.

The pregnant mothers are provided with nutritious diet which includes nine months during pregnancy and six months post pregnancy totaling fifteen months. The diet includes khichudi, sabji and half egg. The ration size for pregnant mothers vary from 70 gm rice, 22 gm lentils/ masoor dal, 1 gm mustard oil, 2 gm salt, 55 paisa vegetables, 10 paisa soyabean and Re. 1.70 paisa egg per head. For children between 6 months to 6 years of age the ration size varies from 50 gm rice, 16 gm dal, vegetables 25 paisa, 1 gm mustard oil, 2 gm salt per child. The anganwadi worker maintains growth chart of the children and newborn babies and particularly identifies malnourished and critical children in need of special care. Due to rapid rise in prices the quota for one full egg has been reduced to half for pregnant women. The quota is also the same for malnourished children because if the malnourished children are served one full egg then the mothers of other children start quarreling among themselves and with the workers.

The workers reported that the tribals in the area commonly suffer from tuberculosis, kala azar and filaria. Most of the tribals especially women and children suffer from anaemia and malnutrition. The workers in Habibpur reported that there are few incidences of HIV in the area also and there could be even more if proper testing is carried out and some NGOs are particularly working on this issue. Besides this the anganwadi helpers carry out family planning and immunization programmes for mothers and children such as providing contraceptive pills, supplying condoms, copper Ts and even tubectomy operations. The workers in Habibpur block reported that although the concern for immunization of children among the tribal families has grown in recent years but the response to family planning programmes has been far below expectations. As part of the education initiatives, the workers now can issue certificates of age proof for children to be admitted in primary schools.

Apart from these services, the workers as part of the ‘Sabella’ project provide readymade packet foods to adolescent girls. Non-school going girls aged between 11 – 14 years and all girls aged between 14 -18 years are the beneficiaries of this project. The workers also generate awareness to restrict the drop-out rates and early marriages
among adolescent girls. The over aged drop-out adolescent girls are helped by the workers to restart education in Sishu Siksha Kendras (SSK) and Madhyamik Siksha Kendras (MSK). As trafficking of young girls and women is a matter that has emerged as an issue of serious concern. To this end the workers are also working in creating awareness among young girls and women. Every Saturday the workers arrange Sabla meetings to generate awareness on personal hygiene. As part of the scheme the workers provide guidance to adolescent girls and their families to promote better healthcare, family welfare, reproductive and sexual health, better childcare practices and improvement of home management skills. The workers also provide life skill education and provides with the support for accessing public services which includes banks, post offices, sub-centres, police stations. Initiatives are also being taken to provide vocational training to the adolescent girls. A ‘sabra group’ is also formed in every centre consisting of minimum seven or more girls out of which three remain in leadership position. One girl becomes ‘sakhi’ and the other two girls ‘sahelis’ who train up the other girls of the group. The girls in leadership are given training by the anganwadi workers and after successful completion of training the girls are awarded with Kishori Card. These girls maintain the growth chart of the other girls and take their height and weight regularly. The adolescent girls are given ration of six days in one day in redymade food packets which is referred as THR or Take Home Ration. When the girls come to collect ration weekly they are given IFA tablets named Memendazol for nutrient supplementation. Thus in the dispensation of health services at grass root levels, the ICDS, the Health Dept. and the Panchayats are such organizations whose work is complimentary to each other and its workers are working in coherence for the same.

V.10 Response of villagers on the benefits from the ICDS programme

The response of the tribal families towards the benefits from the ICDS programme highlighted some important issues. They reportedly told during interviews that the workers and supervisors do not come to the centres regularly and as a result the checkups of the pregnant and lactating mothers remain irregular and they do not get the benefit of the timely checkups and medication at proper time. Moreover, this creates much problem if the mother and child need immediate intervention. The activities of
ICDS in most of villages is carried out in rented houses and they do not have any fixed address and most of the buildings are dilapidated or mud houses which have not been repaired for a long time. The supply of medicines is also irregular. Some of the activities remain in papers and their proper implementation is a far imagination. As claimed by the workers and the programme supervisors that they continuously work among the tribal families for creating awareness against superstitions, witch systems, generating personal hygiene sense or providing life skill trainings, the villagers in some tribal villages reportedly said that these activities are non-existent in their villages on regular basis. The poor state of mother-child health and rampant superstitions and unhealthy life is an indicator to that.

The maximum complaints among the tribal villagers was that regarding mid-day meals. Many responding parents of the tribal children reportedly said that the mid-day meals meant for the primary school children are poor in nutritional quality and insufficient in quantity. In many cases the stipulated diet itineraries are not followed and the taste of the cooked food is so flat that the children do not get taste or interest in eating. Furthermore, in some schools due to the irregularity of the workers and the cooking staffs mid-day meals are not served for days together.

The tribals also reportedly told that during diseases or minor illness they do not receive the help of the workers at their doorsteps and they have to access PHCs or hospitals at their own initiatives which may entail them to cover a long distance for primary treatment. The supply of IFA tablets for adolescent girls and pregnant mothers get irregular, as they are told and are made to believe by the workers, storekeepers and suppliers. They reportedly felt that there can be some hands of other dishonest people behind such frequent irregularities. Moreover, it was reported that the workers are within the grip of the local panchayats and political persons and there are full of irregularities starting from appointments to their activities. They do not often work impartially among the tribal people and follows the instructions and political footsteps of their masters who only remember these poor people at times of elections.

After having discussed the status of the developmental and health schemes under implementation, the corresponding structural infrastructures in detail and the response of both the officials of the implementing agency and the tribal beneficiaries which made it clear that there are loopholes in every stage of the delivery system and a gap
had been observed between the official claims and the response from the actual beneficiaries. The officials of all the agencies involved had the tendency to exaggerate their work and activities just to impress the researcher while the interviews with the tribals reflected the stark contrast in matters of manifestation. We now move on to the discussion of specific health care practices and facilities in the next chapter. This will further help us in the understanding of the extent up to which the health rights of the tribal families have been ensured.