CHAPTER IV
MODERN HEALTH PROGRAMMES IN NILAGIRI

The health of a society depends on a number of factors - social, psychological, cultural, economic, political and physical etc. Because of this, the programmes for health must encompass broader issues like education and income, housing, environment and personal hygiene, sanitation and water supply, stress and strain, life-style and thinking process, socio-cultural practices, religious beliefs and behaviour and, over and above on health services or medicare.

Health is a state subject in India though it has been brought under the national programmes because of human and political priority, national and international obligations, and institutional and constitutional commitments. For meeting the objectives of the National Health Policy (1983) and achieving "Health for All" (1978) and other post-independence aims of good health, a huge infrastructure has been established all over the country. These infrastructures are in terms of a bureaucratic machinery, educational institutions, and health care centres like hospitals, Primary Health Centres (PHCs), Community Health Centres (CHCs), dispensaries, sub-centres, Mobile Health Units etc. (Sahu, 1991). These, with the employed manpower, have been implementing numerous schemes and programmes under the Minimum Needs Programmes (1974). These programmes, evolved and implemented to fight the major public health problems, include primary health care, control of
communicable diseases, immunisation, mother and child care (MCH), family welfare (FW), nutrition, sanitation, environment and hygiene, health education, safe drinking water, medical relief, etc. (Bhave, Deodhar and Bhave, 1991).

With the advent of the Community Development Blocks (CD) in 1952, a marked increase in the overall development of the people has taken place. Health, being an integral part of the overall development of the people, has been put under the priority list of the CD Blocks. The health care system in these blocks has been an integrated one as there has been a combination of both preventive and curative aspects of health, though a lot of importance has been put on the former through the aforesaid programmes. (Bhave, Deodhar and Bhave, 1991).

This chapter deals with the modern health care system in the Nilagiri CD Block in terms of the health organisations like the hospital, primary health centre (PHC), new PHC (NPHC), subsidiary health centres and their workers, community health workers like the traditional birth attendants (TBAs), Village Health Guides (VHG) and their roles and functions towards the health programmes for the people of the locality. It also focuses on the modern programmes of health and family welfare that have been implemented in the Block. In this context the chapter concentrates on the nature and implementation of such programmes by the organisations staff. However, the
performance of these personnel, the results of the above programmes, and the responses of the tribals towards them are analysed in the ensuing two chapters.

**INFRASTRUCTURE AND MANPOWER AT NILAGIRI:**

To implement the programmes and provide the primary health services to the tribal dominated population in the Nilagiri Integrated Tribal Development Block (ITDB), a PHC is located at Berhampur. Under the PHC, there are a additional or New PHCs (NHPCs), two subsidiary Health Centres or dispensaries (SHCs) and thirty sub-centres. In addition to those there are also two homeopathic dispensaries and one ayurvedic dispensary. Besides such government health institutional infrastructure four private homeopathic dispensaries are also found in the ITDB. The people of Nilagiri are also advantaged by the Community Health Centre (CHC) at Udala of the Mayurbhanja district which is only five kilometers away from the western boundary of the Block. The Balasore district hospital is only twenty kms. away from the eastern boundary of Nilagiri. They are benefited by their sub-divisional hospital established at Raj-Nilagiri.

**HOSPITAL**

The sub-divisional hospital is the referral hospital of all the primary health care centres of the Nilagiri ITDB. The hospital, being in close proximity to Nilagiri Block
headquarter, Integrated Tribal Development Agency and other
development offices at Raj-Nilagari (the place itself having
political, commercial, cultural, educational, economic and
social significance) attracts the patients. The hospital is
22 kms. away from Betakata, 18 Kms. from Madhupuria, 12
Kms. from Garadi, 18 Kms. from Hatimunda and only 6 kms.
away from Sajangarh. Thus, location of the hospital is
important in terms of attracting patients from the near and
far-off villages though the numbers of patients from the
nearby villages may be more. As a referral system, the
hospital provides vital support and guidance to the primary
health care centres. But being secondary health
institution, it concentrates on curative care. The
facilities and functions of this hospital revolve around two
broad division: Outer Patient Department (OPD) and Indoor
Patient Department (IPD). To treat the patients and provide
medical relief in this 60 bed - hospital, there are four
departments of surgery, medicine, gynaecology and
pediatrics. The department of ophthalmology is suppose to
come up soon. Besides the intra-hospital activities, the
doctors are also deputed to check the health of the students
20 of different educational institutions of the sub-division
under the school health check-up programme.

The hospital consists of the sub-divisional medical
officer (SDMO), who is the chief of the hospital. Besides,
there are 2 gynaecologists, 1 medicine specialist, 1
assistant surgeon, 1 lady assistant surgeon and 1 leave
reserve and training Medical Officer (LTRMO). The posts for
1 paediatrician and 1 surgery specialist are still lying vacant. The SDMO of the hospital admits that lack of adequate manpower and medicines has hampered its proper functioning.

Though the doctors of the hospital are satisfied with their capabilities and expertise because of long years of specialised training and experiences, they are unhappy with the inadequate supply of medicine and equipments to the hospital. As a result, they have to regularly write prescriptions to the patients instead of providing medicines to them. The patients who come to the hospital for free and better medicine are dissatisfied as well. This dissatisfaction of both the doctors and patients implies that the hospital is not functioning the way it should have.

Despite such hindrance the tribals come to the hospital because of their growing belief in the modern medicine although they have still retained their faith in the faith-healers and supernaturalism. The dichotomy between the tribals' belief in supernaturalism, such as offering 'bongas' and doctors' strong bias against such values has discouraged the tribals from visiting the hospital frequently. Though these doctors are aware of the psychological nature of some of the problems faced by the tribals, they appear to be unmindful of the fact that from these religious practices and behaviour, the people derive some psychological satisfaction that helps in healing many ills as is claimed by modern science. Neglecting this
aspect, many doctors feel that they can provide the elixir of all ills. They openly criticize and rebuke the patient if they come to know that the latter has offered sacrifices to the 'bongas' and has gone to the Ojha. However, there are a few doctors in the hospital who are not against people who harbour such beliefs. Rather, they are sympathetic and culturally relative as they respect the customs and traditions of the Santals. They politely try to convince the tribal patient to come to the health centres as and when they face any problem. They ask the tribals to accept modern medicine while simultaneously encouraging them to worship their 'bongas'. It is because of these doctors that the hospital has been attracting the tribals who realise that they have some people in the hospital to feel for them.

PHC:

A broad-based infrastructure has been established in India after independence for reaching out the primary health care services, especially to the rural, tribal people within their physical and economic reach. Under the National Health Policy (NHP), the relaxed population coverage norms for the tribals living in the forests, hills and remote rural villages are 20,000 persons for a PHC and 3000 persons for a sub-centre against 30,000 persons for a PHC and 5,000 persons for sub-centre in the general rural areas (Annual Report 1995-96). According to 1991 census, there is only one PHC in the Integrated Tribal Development Block of Nilagiri consisting of 93,618 persons with more than 53.9
percent tribals (50,463). Though there are two additional or New PHCs (NPHCs) established late in the Block, these are functioning under the main PHC as these have not reached to its level in staffing pattern, stock of medicines and equipments. Though as a rule there should be more than 4 PHCs in the Block the government has failed to conform to the norms relaxed for the area. This has serious implications for the tribals' health as the implementation of the programmes by these NPHCs are not as intensive as that of the PHC.

It is obvious that the health services have not reached the tribals wherever and whenever they have needed. But the Block Extension Educator (BEE) of the PHC feels that as the tribals have just started accepting the modern medicine, the health organisation and services are adequate to meet their requirements. He strongly believes that the services of these institutions are under-utilised as the health personnel are sitting idle because of the poor attendance of the patients. When reminded that the presence of 4 full-fledged PHCs and their intensive implementation of the programmes would have brought better health situation, he puts the blame on the ITDA and its shortage of fund in establishing more PHCs. However, he adds that there are 2 NPHCs, 3 SHCs and 30 Sub-Centres spread all over the Block operating under the directives of the PHC to compensate the inadequacies.
As mentioned above, the main PHC of the Nilagiri Block is situated at Berhampur and is 15 Kms. away, on a motorable road, from Raj-Nilagiri, the sub-divisional town and Block Head Quarter of Nilagiri. According to the Multi-purpose Health Scheme (MPHS) implemented since 1981 in Nilagiri to achieve "Health-for All", the PHC is known as the Medical Head Quarter of the Block (MHQB), and the doctors and medical-in-charge are designated as the Block Medical Officers (BMO) and Block Chief Medical Officer respectively. But these terms have not been popular even with the medical personnel. Also, changes in their designation have neither brought any qualitative improvement in their treatment nor any change in the perception of the patients about their treatment and relations. The core of medical manpower resources in the PHC is constituted by three medical officers, the chief medical officer (CMO) coming from the Department of Health, besides a Block Extension Educator (BEE), one Laboratory Technician (LT), a Pharmacist, an Ophthalmic Assistant and the Clerical and the Nursing Staff. Under the CMO, there are two additional doctors one each coming from the Department of Family Welfare and of the Integrated Child Development Services (ICDS) to help achieve the target of the PHC.

Like the hospital, the PHC also has two broad divisions: the OPD and IPD. But unlike the hospital with 60 beds for the IPD, the PHC has only 6 beds whose condition are far below basic hygienic levels. However, the PHC provides medical relief to both in-patients and out-
patients. But in case of emergency, it refers them to the hospital. The most important function of the PHC, according to the CMO, is not the treatment and cure but the prevention of infections and ailments, and the eradication of the dreaded diseases. It also works for the dissemination of medical knowledge and skill for improvement in the quality of life. To vigorously promote the essential elements of the primary health care and prevent the rural and tribal people from being burdened by the physical problems, the PHC has introduced some low-cost, with high-impact interventions in maternal and child health, family welfare, prevention and control of locally endemic diseases, and immunization etc. besides making people aware of water supply and environmental sanitation, and providing essential drugs and medical relief.

To meet its goals, the PHC depends on the dispensaries working under it. Besides, the PHC personnel also directly participate in the implementation of its programmes of cure and prevention of diseases. Its doctors visit the villages and impart education on various aspects of health by way of informal talks. They educate the tribals about the tenets of mother and child care as well as family planning. While treating the patients in the PHC doctors explain to the patients about its prevention and need for an early treatment of the diseases.

However it seems the doctors have not handled the delicate issues of the tribal tradition properly as they
have appeared to have directly discouraged the tribals from worshiping the 'bongas' and taking Ojha's herbs. This has the potential to discourage the tribal patients from coming to the PHC.

The Chief Medical Officer (CMO) of the PHC admits that the PHC is under-staffed and needs to be supplied with more medicine and equipments. Though the tribals are dissatisfied with PHC because of its mal-functioning, ill-maintenance and scant services, the CMO feels that the patients still visit it because the traditional practices of the institution of Ojhaism is on the decline.

**NEW PHC (NPHC)**

Under the main PHC, there are two additional PHCs called APHC or NPHC set up at the villages of Ayodhya and Betakata. The Betakata NPHC is manned with a doctor, pharmacist, male and female attendants, and an Auxiliary Nurse Midwife (ANM). The main function of the NPHC is to treat the minor ailments including some minor operations. In the eventuality of serious cases the patients are referred to the bigger health institutions like the PHC or the hospital. The ANM, who is in-charge of a sub-centre is attached with the NPHC and helps the pharmacist and the doctor. The NPHC also works towards implementing the multi-purpose health schemes and other programmes of the PHC. Sometimes the doctor visits the villages and encourages the people to accept family planning, immunisation etc.
The main handicap of the NPHC is that it is still neglected and not yet fully developed. It does not have a campus, hence, unprotected from the wild animals especially the bears who come to eat Mahul flower at night. As a result, the personnel do not stay in the quarters near the health centre and are not available for regular consultation. The centre is deprived even of minimum civil amenities like electricity, and toilet etc. Over all this, as the doctor complains, the NPHC is not supplied with adequate equipments and medicines even for the minor ailments, the life-saving drugs are also not in the stock. As a rule, there should be one bed in the NPHC for observing the patients for a day in the IPD before taking the next course of treatment. But the NPHC is not yet provided with the bed. Despite the pathetic plight of this health centre the health personnel promise to implement the prescribed health programmes for the tribals in the areas.

SUBSIDIARY HEALTH CENTRE (SHC)

There are two subsidiary Health Centres in the ITDB, one in the village Kansa and the other in the Kalkad, village located on the Seragarh-Udala bus road. Besides, there is one more dispensary at the Panabandha hamlet of the village Sajangarh. But this dispensary is not yet sanctioned because of some political reasons and has been functioning since 1982 without the government's recognition.
Manned with a pharmacist to provide drugs for the minor ailments, the dispensary has been functioning directly under the Chief District Medical Officer of Balasore.

The SHC at Kalakad is manned with a doctor, one pharmacist and an attendant besides the multi-purpose male and female health workers. There is no bed or IPD and the main function of the SHC is the OPD where the patients are treated for their minor ailments. In absence of the equipments and medicines for radical treatment (RT) in the IPD, the SHC concentrates on the Minor ailment treatment (MAT) and sends the serious patients to the PHC or the hospital for the RT, which according to the doctor serving in the SHC, is an urgent and intensive care given to the serious or emergency patients.

Apart from the curative care, the SHC also works on the preventive aspects of health care to make the programmes of the PHC a success. The SHC at Kalakad collects the blood slides to detect malaria and takes the necessary preventive steps. The staff also make the people conscious about the problems and solutions related to pregnancy, leprosy, tuberculosis, etc. However, the medical officer is of the view that the SHC is not provided with the necessary drugs and equipments. This has encouraged him to indulge in private practice. He feels that other doctors in the ITDB also do the same. He justifies such practice by saying that it not only compensates the inadequate supply of drugs by
the government but also protects the poor people from being exploited by the local quacks.

Besides the institutional inadequacies, the personal problems faced by the medical personnel acts as a hindrance to properly carry out the health programmes. The doctor of the SHC feels that the condition of his quarters, water supply and electricity are not satisfactory. The educational facility for his children is also poor. When the doctors are not satisfied, it is difficult to take care of the patients and implement the programmes for better health.

THE AUXILIARY NURSE MIDWIFE (ANM) SUBCENTRES

For proper implementation of the health programmes, the whole ITDB has been divided into five sectors of Berhampur I and Berhampur II, Kalakad, Ayodhya and Mitrapur. Under each sector there are 5 to 7 sections which are better known as ANM sub-centres or even sub-centres. In the whole of the ITDB, there are 30 sub-centres working under the supervision of these five sectors. Though the sub-centres have been set up for every 5,000 persons in rural areas in general in the norms have been relaxed for the tribal area. For instance, one sub-centre has been set up at Nilagiri to cover only 3000 tribals.

The health personnel of these sectors and sections have been given comprehensive training under the multi-purpose
health scheme (MPHS). Each sector is headed by one male and
one female health assistant. They are also known as Multi
Purpose Health Supervisors or Supervisors. The Female
Supervisor is more popularly known as Lady Health Visitor
(LHV). These Health Assistants supervise the operations of
the sub-centres and provide technical guidance to the health
workers and ANMs of the sub-centres. Working under the
directives of the PHC, they visit the villages with the
Health Workers and impart health education to the people.

Each sub-centre is supposed to be manned by one Multi-
purpose Health Worker (Male) or (MPHW(M)) and one MPHW
(Female), though both of them simply known as Health Workers
(Male or Female). The Female Health Worker is better known
as ANM. In the 30 sub-centres of the ITDB, there are 30
ANMs but only 17 posts for the MPHWs (M) are sanctioned, out
of which one post is lying vacant for long. As a result
each Health Worker (M) has to cover two sub-centres or works
for 15 days at a time in one sub-centre and then is shifted
to the other. This implies that as the male health workers
are over-burdened, and as a result the quality of their duty
suffers. But the ultimate suffers are the people who do not
find these workers readily available to attend to their
health problems.

The health workers and supervisors trained earlier in
particular aspects of health services are now given training
and exposer to many aspects of health care though the
problem of leprosy has not yet been integrated in the
overall health scheme but is dealt with separately by a separate organ under the Leprosy Eradication Programme. A Health Worker attending patients of a particular patient disease is required now to attend the problems of malaria, diarrhoea, fever and common cold. He or she is also to care for the maternal and child health, and family welfare, etc. except leprosy. The Health workers of these sub-centres are in close contact with the tribals visiting villages to look for their health problems and provide treatment to minor ailments. In case of major ailments they refer the patients to the sector supervisor or even to the PHC. They also try to implement the programmes of maternal and child health, immunisation and family welfare in close coordination with the Traditional Birth Attendants (TBAs), Village Health Guides (VHGs) and the Anganwadi Workers.

The health workers attend the monthly meetings at the PHC besides the weekly meetings on every Saturdays at the Sector head-quarters. These meetings are held for assessing the achievements and sharing the experiences. The feedbacks and guidances are supposed to help the workers in properly tackling the problems and successfully implementing the programmes.

Each sub-centre observes a clinic day on every Wednesday. On this day the people and the patients come to the clinic or the sub-centre for treatment and consultation. On other days the Health Workers visits the villages for health check-up and treatment, and also for educating,
informing and explaining the people about health, sanitation, causes of diseases, and their cure and prevention. Thus, the Health Workers play a very important role in implementing the programmes discussed later in the section on implementation of Modern Health Programmes.

THE TRADITIONAL BIRTH ATTENDANTS/VILLAGE HEALTH GUIDES

Besides Male Health Workers and the ANMs working at the lowest rung of the hierarchy of the government health personnel, there are two types of non-governmental or community health workers who work in close coordination with the former. These community health workers are called Traditional Birth Attendants (TBAs) or Dais who are always female, and the Village Health Guides (VHGs) who can be either males or females. The community health workers especially the TBAs are actually the traditional health personnel at least in regard to their services and who have now been added in the modern health scheme to serve the people in better and specialised manner.

In every village there is at least one TBA or a Dai who has been traditionally attending the female in her delivery. She either volunteers or is chosen by the village community to undergo a short-term training on delivery and disinfection to improve her skill and ascertain antiseptic and safe deliveries in order to reduce infant and maternal mortality. Besides the pre and post natal care, the TBAs are also trained on prevention of common diseases. After
completion of the training they are given a delivery kit with which they not only help women in safe delivery but also train the untrained dais of the village for the purpose. The traditional dais who have proved to be better media for fostering modern methods also motivate their community people to accept contraceptives and permanent methods of family welfare. They work with the ANMs and Anganwadi Workers and provide even minor treatments in common ailments. However, the Anganwadi workers have their own centres and are trained to take care of the pre-school children, adolescent girls, pregnant women nursing mothers in respect of their health, nutrition and family welfare. They work under the Integrated child Development Scheme (ICDS).

According to the Village Health Guide Scheme, a village community selects a volunteer as the VHG for every 1,000 persons or for the village as a whole. She/He is then trained to provide services to the people in the matter of family welfare, mother & child health and primary health care. After completion of the training at the PHC level during which she/he is given a medicine and treatment kit, the VHG acts as a link between the community and the modern health programmes. The VHG raises awareness of the people on family welfare and mother and child health services by imparting health education to them. She/He also keeps track of the locally endemic diseases, takes care of minor ailments and provides first aid to the patients.
Though the TBAs and VHGs are not government servants as stated above, they are attached with the government and are paid monthly honorarium of Rs.50/-. Besides, the TBA is given a free delivery kit and the VHG some free medicines worth of Rs.50/-. Since they get some benefits, they are threatened and cautioned by the government health workers of the PHC against neglecting their duties. This makes them work for implementing the programmes of the PHC.

IMPLEMENTATION OF THE MODERN HEALTH PROGRAMME

The above mentioned health infrastructure and employed human resources have been utilised in the ITDA through implementing various health programmes including health and family welfare with the broad objectives of health and human development. More specifically, these programmes include promotive, preventive and curative health include medical relief, mother and child health, family welfare, immunisation, control of both communicable and non-communicable diseases, supply of drinking water, environmental sanitation, personal hygiene and school health etc. We shall mention below details of these programmes implemented in the study villages.

(a) MEDICAL RELIEF

Though most of the programmes have emphasised on the preventive aspect of health and illness, curative care has been integral aspect of basic health services in the PHC,
dispensaries and sub-centres in Nilagiri. The medical officers and other health personnel provide medical relief and cure to the patient not only in the health centres but they also visit the patients' places for the purpose. For minor ailments, they treat the patients in the OPD whereas in case of the major ailments the patients are provided with the IPD facilities at the bigger health centres. The treatment of both indoor and outdoor patients is not only an end but also a means to prevent further illness. This is because the treatment always goes with health education about the reasons of diseases. For this, the health personnel need to treat the patients with greater degree of sympathy and empathy. Instead of being ethno-centric, they need to be culturally relative and respect the behaviour and beliefs of the tribals who are to be attracted to modern medicine with a display of love and care, emotion and compassion by the doctors.

(b) CONTROL OF COMMUNICABLE DISEASES

The communicable diseases like diarrhoea, malaria, filaria, tuberculosis, leprosy, enteric fevers, tetanus, trachoma, diphtheria, etc. have been the major cause of morbidity and mortality especially in the Third World countries (WHO Report, 1996). To check and manage these maladies, several programmes have been introduced and implemented in Nilagiri. For reduction in morbidity and mortality through control and containment of the epidemics the PHC personnel including the grassroots level multi-

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purpose health workers, the ICDS workers, TBAs and VHGs have been actively involved. As Nilagiri is a malaria endemic area, anti-malarial measures have long since been adopted in the area. For prevention of other diseases like diarrhoea, the anticipatory and anti-diarrhoal inoculations and immunisation are administered. The health personnel also work for early detection and immediate information of the patients suffering from such diseases. Besides, the people are explained about the importance and utility of their early reporting of the epidemics, to the doctors, of environmental safety and sanitation, disinfection of water supplies and contaminating materials, and immunisation against the preventable diseases.

(c) NATIONAL FAMILY WELFARE PROGRAMME

A child's health and safety is of utmost importance. As a child's life starts from its embryonic stage in the mother's womb, care is to be taken from pre-natal or antenatal period. As the mental and physical health of the mother is crucial for her as well as child's well-being, her care also cannot be neglected. For the proper care of mothers and children, maternal and child health has occupied a paramount place in the primary health care services. Realising the important role played by family planning in caring for the health of mothers and children, both the programmes of family planning and mother and child health have been integrated into one package called 'Family Welfare' services offered through the primary health care
services in rural areas (Tiwari, 1992). This remains an integral part of the health services scheme in the study villages.

(d) CHILD SURVIVAL AND SAFE MOTHERHOOD (CSSM)

For an overall strategy of reducing maternal, infant and child morbidity and mortality, and of bringing better health to mother and child, universal immunisation programmes (UIP), Oral Rehydration Therapy (ORT), Prophylaxis Schemes, and Dai Training Programmes were introduced in Nilagiri under the Maternal and Child Health (MCH) services. However according to the Chief Medical Officer (CMO) of the PHC, these and some other MCH services have been integrated into one project called Child Survival and Safe Motherhood (CSSM) that has been launched in the ITDA since the year 1992-93.

The new programme (CSSM) plays an important role in family welfare. It ensures effective ante-natal care, safe delivery and post-natal services by the health personnel from the PHC and sub-centres. The problems of pregnant women are detected early and treated properly. The Health Workers and ANMs of Nilagiri visit its villages and houses and advise the people on balanced and nutritious diet, environmental sanitation, disinfection and diseases. The CSSM not only emphasises on control of diseases like diarrhoea and acute respiratory infections (ARI) or pneumonia but also on immunisation against illnesses.
The PHC chief reports that the Universal Immunisation Programme (UIP) has been implemented in Nilagiri since 1985 to protect all infants against six vaccine preventable diseases. Diptheria, Pertusis (whooping cough), Neo-Natal tetanus, Poliomyelities, Tuberculosis (childhood) and Measles, and all expectant women and their infants against tetanus. Every year all infants (below one year of age) are to be vaccinated with three doses of Polio Vaccine (orally administered), three doses of DPT vaccine (Diptheria, Pertusis and Tetanus), and one dose each of BCG and measles vaccines. All expectant mothers are to be administered two doses of tetanus toxide (TT) injections to protect them and their expected children against tetanus.

Nutritional anemia has been one of the major reasons of the problem of maternal health of Nilagiri. It has also been a deteriorating factor in Sepsi, hemorrhage and toxemia. To protect the mothers and children upto 5 years of age against bloodlessness (anemia) the prophylaxis schemes are being implemented. Under the present schemes, the pregnant women are provided with Iron and Folic Acid (IFA) for 100 days from the registration of pregnancy or the date of detection of anemia. The CSSM project also provides for prophylaxis scheme for prevention and control of vitamin A deficiency among children under 5 years of age. To virtually eliminate vitamin A deficiency which totally blinds or impairs the eyesight, the sub-centre workers administer five doses of vitamin A solution to all children
under 3 years of age. The first dose (100,000 international unit or i.u.) is administered alongwith Measles vaccine when the child is 9 months of age. The second dose (200,000 i.u.) is given alongwith DPT/OPV booster dose. The next three doses (200,000 i.u.each) are given at six months interval. As a part of Vitamin A prophylaxis and health education, the parents are advised to provide their children with ghee, butter, milk, yellow of eggs, fish oil, tomatoes, yellow fruits and all green, leafy vegetables.

Almost all the health personnel of Nilagiri are of the view that diarrhoea has been the single largest threat to the tribals particularly children under 5 years of age in the block. To reduce diarrhoea diseases and deaths due to dehydration, the CSSM Project has started the Oral Rehydration Therapy (ORT) programme in the block. The Oral Rehydration Salts (ORS) packets have been provided to the Health Workers of the sub-centres to distribute to the people when affected by diarrhoea and advise them as to how to use these rationally. The people are also informed about the home available fluids like salt-sugar solution, butter milk, rice-water, green coconut water, etc. that can prevent dehydration. The health workers also encourage uninterrupted breast feeding, alongwith supplementary nutrition to infants of 4 to 6 months. Since children get exposed to food borne pathogens during weaning, the parents are advised about the preparation of safe weaning food. Besides, they are told to maintain personal and domestic hygiene and to go for better environmental health practices.
particularly the proper use and maintenance of drinking water and sanitation provisions.

In the Dais training scheme under the World Bank and UNICEF assisted Child Survival and Safe Motherhood programme, the untrained Dais or the traditional birth attendants (TBAs) are trained for improving maternal care and achieving safe and antiseptic delivery. To encourage the trained TBAs to attend to more and more deliveries, the reporting fees to the TBAs has also been increased from Rs.3.00 to Rs.10.00 per case. Under the same programme the pregnant woman provided with disposable delivery kits (DDKs) for safer delivery and better mother care.

(e) FAMILY PLANNING

To meet the national objective of reducing the birth rate, stabilize the population growth, and bring improvements in maternal and child health, the family planning programme has been being implemented by the PHC, and its sub-centres in the Block since its inception in 1957. The trained medical and para-medical personnel of these centres seek to promote responsible and planned parenthood through willed and informed choices of the family planning methods. Instead of authoritarianism or coercion, voluntarism or cooperation is taken as the means in this movement. However, as the health workers admit the actual approach to the acceptance of family planning methods has been the economic incentive.
The Multi Purpose Health Workers (MPHWs) especially the ANMs have been entrusted with the greater responsibility of explaining and encouraging the people to accept the small family norm and go for wider spacing between two births. They identify the eligible couples of 16 and 44 years of age and motivate them to utilise the facilities of family planning. To maintain a healthy time-gap between the births of two children, the Health Workers and the Anganwadi Workers of the ICDS scheme provide contraceptives like condoms, oral pills and IUDs to those parents with more than two children. Parents are also advised to accept permanent methods of family planning like vasectomy for males and tubectomy for females. To implement the programmes among the tribals some monetary incentives are given to them. However, the real success of the programme depends on motivation of the grass-root level government personnel like ANMs, Anganwadi Workers of the ICDS scheme and the Community Workers like the TBAs and VHGs.

(f) WATER SUPPLY AND ENVIRONMENTAL SANITATION

The unhealthy environment and unsafe as well as inadequate water supply in Nilagiri have always caused major public health problems especially the water-borne diseases among the tribals. To reduce the full pathological effects of diseases, modern hygienic measures have been introduced in Nilagiri since the inception of the Block. For instance, tube-wells have been bored in the hamlets to supply pure
portable water. In some cases, ring-wells have also been
dug. The health workers visit the villages and put
bleaching powder in the water sources. They also advise the
community people to take care of the surrounding environment
of these sources of water.

Besides water supply, the MPHWs advise the people to
to ensure that their both domestic and village surroundings
are kept clean and the soil and water pollution is
prevented. Emphasis is laid on improvement in domestic
sanitary care and proper disposal of waste water. They also
instil a sense of personal hygiene in the people and make
them aware of the hazards of rats, cats, flies and dogs.
They are convinced to allow the health workers to spray
insecticides (DDT) in and around the houses as a preventive
measure against malaria. In all these programmes, the
health workers attempt to ensure the involvement of the
community members. These health workers, however, feel
that the tribals have still a long way to go in leading a
hygienic way of life. At present they are bound by
illiteracy, ignorance, poverty and unhygienic ways of life,
a legacy of their past.

(g) SCHOOL HEALTH PROGRAMME

Under this programme the school has been chosen as a
good place for building up healthy habits and developing
right attitudes for better health of school children.
Besides health education, the infrastructures like proper
sitting arrangements, lighting, ventilation, toilets and safe drinking water are provided to make the school an ideal place for ideal health.

Under the same programme the health professionals of the hospital, the PHC and sub-centres visit the schools and check-up the health of children. They take necessary steps whenever they find any sign of diseases. Besides, immunisation programmes are conducted in these schools regularly and whenever there is an epidemic. For the clean and healthy physical environment of the school, the students are encouraged to develop school garden by growing green and leafy vegetables and flower plants. The mid-day meal programme has been implemented recently by the government of Orissa in the primary schools where all students are supplemented with important nutrients like proteins and vitamins to compensate their deficiency in the diet at home.

Health education always goes with the implementation of the above mentioned curative and preventive programmes of health. People are informed and explained about health and diseases by the health personnel of the PHC and sub-centres, the ICDS workers and the trained community representatives. On the whole, they who feel that the health situation in Nilagiri is improving but still a lot needs to be done and achieved.
Besides the above programmes run by the Ministry of Health and Family Welfare, the Ministry of Education and Social Welfare have implemented the ICDS scheme since 1975 with the assistance from the UNICEF, the World Food Programme (WFP) and Cooperative for American Relief Everywhere (CARE). The important objectives of the scheme are to build up the foundations for proper psychological, physical and social development of children to improve their health and nutritional status. These are also intended to reduce the incidence of morbidity, mortality, malnutrition and school dropout rates, and to improve the ability of the mother to take care of the health and nutritional needs of the child. Besides these, the ICDS scheme provides for supplementary nutrition, immunisation, health checkup, referral services, pre-school non-formal education and health and nutritional education for the mothers. The beneficiaries of the scheme consist of children upto 6 years of age, expectant and nursing mothers and women upto 45 years of age. The school drop-out adolescent girls have of late been brought as the beneficiaries under the scheme. They are trained and imparted with the skills for future mothers and social animators, according to the child development project officer (CDPO) of the Nilagiri.

The 'Anganwadies' are the grass-root level ICDS units set up in tribal and rural areas or in urban slums, with a population of 1,000 persons, to fulfill the above
objectives. The Nilagiri ICDS project area is divided into 8 sectors and each sector is headed by a sector supervisor. Under each sector, there are several Anganwadi centres on the basis of the population. In the whole ITDB there are 141 Anganwadi Centres, each being manned by one Anganwadi Worker and one helper who provide the package of services to the beneficiaries.

For ensuring community involvement, the Anganwadi workers are chosen from the local villages. Besides services like pre-school training, immunisation, administration of vitamin A prophylaxis, iron and folic acid (IFA) to counter anemia, management of acute respiratory infection (ARI) in children, and diarrhoea etc., the Anganwadi workers are now expected to look into water supply, personal hygiene, environmental sanitation and economic development of the villages. In addition, they also work to implement the programme of family planning. They work in partnership with the MPHWs especially the FMPWs (Female Multi-Purpose Workers or the ANMs) as is explained by the Child Development Project Officer (CDPO) of Nilagiri.

CONCLUSION

The network of a referral hospital, a PHC, NPHCs and other dispensaries, the sub-centres and Anganwadi centres has been set up all over the Block area to implement the above programmes for cure and prevention of diseases. Besides, there are a number governments ayurvedic and
homeopathic dispensaries working in the area. There are also some untrained private practitioners of allopathic medicine in the ITDB. However, the head-strong Ojhas, modern quacks and traditional beliefs of the tribals are responsible for the slow progress in implementation of the programmes for, they (the Ojhas and quacks) not only give harmful medicines to the patients but discourage them from visiting the health centres. The important obstacles in making these programmes successful, the health personnel opine, are their problems of living in the government or even private quarters, lack of clean drinking water, electricity and lack of educational facilities for their children. Finally, lack of proper buildings for locating the health centres, inadequate medical and para-medical manpower resources, and lack of adequate supply of drugs and equipments are serious problems of the programmes for better health in the area of study.

REFERENCES:


