CHAPTER VI

NATURE AND TREND OF HEALTH CARE DEVELOPMENT AMONG TRIBALS

In this chapter we attempt a synthesis of the findings discussed in previous sections. The factors that determine the accessibility to and availability of health care are discussed first; followed by a discussion of these aspects in the context of Wynad. The chapter concludes with the emerging trends in health care development among tribals.

The foregoing discussions on the health care system and its interaction with tribal communities in solving their health problems and needs can now be analysed in a framework to understand the nature and trend of health care development for tribals. The discussion on the social production of illness, or what makes people ill and also how much of it is avoidable, outlines the linkage between the organisation of societies, the working and living conditions of tribals and their health problems. The social production of illness along with the forces that control the production of health care, decides the nature and pattern of health care development. The interaction of these during the post Independence period generated several contradictions and
evolved a health care organisation in accordance with the interest of the dominant classes. The system, at the beginning of Independence, was committed to the task of eliminating poverty, ignorance and ill health and to provide adequate nutrition and public health facilities to all within the framework of equality and justice. It assigned a privileged status to tribals and their health problems based on their backwardness and historical isolation. But the health care system that evolved during the last forty years, as evident from the discussions, was unsuccessful in internalising this spirit envisaged in the constitution. Instead it developed a pattern and a structure that is subservient to the interest of those who control the production of medical care.

This imbalance in the user-provider relationship where the interest of those who control the production of health care takes an upper hand is engendered with contradictions as it comes in conflict with the extent and pattern of utilisation of health care facilities. These contradictions are glaring at the micro level where the two interests manifest and interact when programmes are implemented. The process of this interaction and the forms it assumes, particularly at the microlevel, can be explained in terms of two sets of factors - the availability and accessibility - which together determine, at the primary
level, the nature and extent of utilisation of health care facilities and then, the contradictions it develops with various interests that control production. Each of these aspects represent a system or a set of factors that are internally coherent but interact between them and shape the directions of health care development. This section focuses on these two aspects and the way it explains and determines the dynamics of change.

Availability and Accessibility: the conceptual framework

The aspect of availability manifest itself in the provision of health care institutions and services. Two sets of factors or considerations operate in this context that decide the nature and size of provision: the market considerations which evaluate the individual's or investor's benefits and costs in terms of profit, and the social considerations which evaluate the social benefits and social costs. Health care development in the private sector subscribe to the spirit of the former and locates institutions in regions, and for groups of population, where profit can be maximised. The concentration of such facilities in metropolitan centres explains this logic. They will have a well-defined constituency of clients that can sustain the requirements of investment and operates on the principles of supply and demand. The pursuit of profit, the
motive behind the growth of health care in this setup, however, leads to a series of conflicts or market imperfections that manifest themselves in the form of inflation of medical care, uneven geographical distribution of facilities between centre and peripheries and disparities in the consumption of medical care between different income groups. These imperfections often assume grave proportions affecting large sections of population who do not have the required level of purchasing power. This in turn, can generate conflicts between groups that may even threaten the system.

The development of health care in the public sector subscribes to the latter logic which compares social benefits with social costs in deciding its nature and size. The evolution, relevance and justification of public health care, however, varies between societies depending on their social and economic organisation and their social philosophies. In certain developed capitalist societies, market imperfections and the conflicts it generates between groups of populations justify state interventions either in the form a parallel public health system or in the form of subsidies and other concessions that enable the poorer sections to avail themselves of medical care. In some other developed capitalist societies, it evolved out of organised struggle by the working class that extracted this concession
from the ruling classes which over the years has developed into mammoth systems, such as the National Health Service of Britain, having new orientations, contradictions and logic. In fact, the accumulation of capital in medical care production also requires such changes and expansion of health care net-work as it opens up new market irrespective of the nature of control of these net-works. In India, and in several other developing countries with a colonial background, the public health care system grew out of a different logic. The national liberation movement, though initiated and controlled by the privileged classes, necessitated the mobilisation of vast majority of underprivileged sections, and to ensure their participation the leadership had to promise a better social order and improvement in living standards which included, necessarily the provision of basic health care. The democratic system that evolved after Independence continued with this commitment and embarked on attempts to develop a public health care system. The considerations were the social benefits and the principles of equality and justice. The problems of the poor and the under privileged in this scheme of development assumed special significance and emphasis.

At the national and State level, in a democratic society such as ours, decisions on the availability of facilities, its nature, magnitude and its distribution to
regions and groups, are a function of political will. In other words, it depends upon the equations of various class interests and the bargaining strength of different groups. Development considerations such as the constitutional commitments to protect the interests of weaker sections like the tribals and considerations of social justice which cannot be ignored as they form a powerful vote bank as well as the resource considerations play an important role in accommodating the various interests. The process repeats at the micro level where the bargaining strength of different groups decides primarily, the location of health care facilities. Those who are powerful and articulate, which depends on a number of factors like their economic strength, level of awareness, quality of leadership and numerical strength, prevail over those who are weak and inarticulate. However, at this level the bargaining has to take place within the broad framework of development which sets norms and other criteria for protecting the interest of underprivileged sections. A schematic representation of the factors that influence the availability of health care facilities is explained in chart 1.

The aspect of accessibility belongs to the realm of consumers of service. It manifest itself in two forms - the spatial and the social - and ensures the utilisation of facilities and therefore, in conjunction with availability,
Chart I
Schematic representation of factors influencing the size and distribution of health care facilities

Macrolevel decisions concerning the size of health care facilities

* Pattern of interaction between different classes
* Dominant class interest

Macrolevel decisions concerning the distribution of health care facilities between regions and groups

Relative bargaining strength of Regions/State

* Economic strength
* Political proximity with centre in terms of identity of interest and size of representation
* Quality of representation, articulation, leadership

Microlevel decisions concerning the distribution of facilities to locations and groups

Bargaining strength of different groups

* Social and Economic position of groups
* Size of representation
* Level of awareness
* Leadership, articulation
* Proximity with larger political interest
* Linkages with higher level decision making
* Linkages with the administrative machinery
* System of governance - centralised/decentralised

Political will

Development considerations and commitments

Resource availability

Norms and criteria

Other development considerations to overcome backwardness

Resource availability
decides the health status of populations. The spatial dimension of access to health care pertains to the location of facilities which, as we explained above, is decided by a set of relationships that are social economic and political. And, the availability of facilities within approachable distance is a prerequisite and influences directly the decisions concerning their utilisation. The social dimension of accessibility is more complex and precipitates in different forms but originates out of the unequal character of society and its hierarchial categorisation of populations on the basis of income, caste, customs and practices. The income, as the basic factor that generates and sustain the inequalities, acts upon populations which discriminate the poor income groups and limits their access to health care. It accentuates their, difficulties in availing the facilities that are distantly located or that which extort a price for the services even if it is minimal. Income is the expression of ability to avail a service. The social and economic differences in a hierarchial society also discriminates populations in such a way to perpetuate the dominance - dependence relationship between privileged and the underprivileged on the basis of wealth, education and other attributes of power. The method of domination of the privileged over others may either be direct and brutal like physically restricting the poor from using a facility or
indirect and subtle such as denying information, evoking traditional beliefs and practices and providing indifferent and unsympathetic services. In fact, the latter category of subtle mechanism are more successful in creating a social distance between poorer sections and the facilities. In the case of illiterate and backward tribal communities the traditional beliefs, customs and practices paly a crucial role in availing facilities that are different from their traditional framework.

Awareness about facilities, their location, the type of services offered, the advantages and disadvantages of these services, forms a distinct set that influences the accessibility aspect. As a prerequisite, like availability, it ensures the utilisation of a facility and is determined by the level of literacy, the information activities on health care and the physical presence of institutions. The level of literacy is the basic ingredient and prepares people for receiving and synthesising information. It comes along with development and in hierarchial societies it varies from group to group depending on their level of development and their social and economic position.

The social dimensions of accessibility goes even deeper discriminating individuals on the basis of gender and restricts access to health care for them. Though it varies from society to society, the accessibility to health care
for women depends on their status in the society including the society's response to the health needs of women, their income level and the availability of health institution within approachable distance. These factors operate in terms of 'need', 'permission', 'ability' and 'availability'. Need denotes the extent of ill health among women, perceived and otherwise, but indicating the extent of health care required by them whereas permission refers to the familial, communal and societal norms that allows women to seek health services. Ability reflects on the economic status decided by her employment status, income, control over income and her household responsibilities. Availability pertains to the supply of health care services which is an extraneous factor compared to the other three. The interaction between availability and other factors decides the extent and use of health care which in the case of women generally falls short of their needs or requirement. This relationships are explained in Chart 2.

The various factors that determine the availability of and accessibility to health care form an interactive whole and decide the pattern of utilisation of health care facilities. In ideal situations this necessarily reflects the health needs of people. But in unequal societies, in spite of the interventions by the state to protect the interest of those with near-nil purchasing
Chart 2

Schematic representation of relationship between factors affecting the accessibility to health care facilities

Accessibility

Spatial Dimension → Location/Distance to service → Bargaining strength of different groups, articulate leadership, norms and other development considerations

Social Dimension

Social status/position in the social hierarchy → Economic status/ability to avail

Custom, Norms and Practices

Nature of dominance dependence relationship

Direct/Physical Restrictions

Indirect/Denying knowledge education etc.
ability through the provision of free services or subsidies, the pattern of consumption is always one-sided or skewed in favour of the richer sections. This results in a pattern of growth of health care system that caters to the richer sections ignoring the health problems and requirements of the poor that stems, basically, from their living and working environment. The interest which controls the production of medical care too requires such a trend for furthering their position. The manifestation of this is reflected in the concentration of medical institutions in locations advantageous to the better off sections, development of curative health services that neglect the promotive, preventive and rehabilitative aspects of health care, the uneven emphasis on programmes that do not consider the health needs of people, the provision of services through personnel who are ill equipped and ill informed of the local culture and needs and in the discouraging attitude of medical system as such to the health problems of people. If no structural changes take place the present pattern shall only continue further reinforcing the inequalities.

Availability and Accessibility: the context of Wynad

The availability of facilities in terms of medical institutions and manpower had always been deficient in Wynad. The formation of the district as a separate
administrative unit itself was an attempt to overcome this backwardness. The number of medical institutions in Wynad during 1980-81, immediately after the formation of the district, was only 29 or about 2.9 per cent of the total institutions in the State. This number over a period of 10 years has gone up to 38 constituting about 3.3 per cent of the State's total. In 1980-81 a medical institution in Wynad therefore, was catering to population in an area 73.5 sq.kms. while the corresponding area for the State as a whole was only 39.9 sq.kms. The situation improved remarkably by 1990 to 56.1 sq.kms. in Wynad and to 33.6 sq.kms. in Kerala. The eighties also witnessed a comparatively impressive rate of growth in both the number of institutions and of beds available. In the case of the former the annual rate of growth was about 3.1 and 1.8 per cent respectively for Wynad and Kerala; in the case of availability of beds, the rates were still more impressive, 5.3 and 1.13 per cent for Wynad and Kerala respectively during the period between 1980 and 1990. The number of beds available per thousand population in Wynad was 0.69 in 1980-81 and it has gone up to 0.91 in 1990-91 while for the State as a whole it was 1.2 in 1980-81 and it remained unchanged during the decade. Notwithstanding the improvement in medical care facilities during the eighties, especially after 1985, Wynad still lags behind other districts in the
State. The 80's, however, was a turning point for the district because of the introduction of India Population Project which concentrated on improving the infrastructure in medical care. This is evident from the pattern of growth of institutions and availability of beds before and after 1985.

Table 1 Rate of growth of medical institutions (allopathic) and number of beds available in Wynad and Kerala —1980-85 and 1985-90.

<table>
<thead>
<tr>
<th>Institutions/Beds</th>
<th>Average annual growth during the period (Percentages)</th>
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<tbody>
<tr>
<td></td>
<td>VI Plan(1980-85)</td>
</tr>
<tr>
<td></td>
<td>Wynad</td>
</tr>
<tr>
<td>1. PHCs— Beds in PHCs</td>
<td>13.31</td>
</tr>
<tr>
<td>2. Hospitals— Beds in hospitals</td>
<td>00.00</td>
</tr>
<tr>
<td>3. Dispensaries— Beds in Dispensaries</td>
<td>2.60</td>
</tr>
<tr>
<td>4. Total Medical Institutions</td>
<td>0.69</td>
</tr>
<tr>
<td>Total beds available</td>
<td>7.43</td>
</tr>
</tbody>
</table>

Source: Computed from data provided by the Directorate of Health Services, Trivandrum.

There are several reasons that contributed to this low level of availability of health facilities in Wynad. Some of the reasons are historical and pertains to the
geographical seclusion of the region from the mainland and its specificities in the composition of its population. The geographical seclusion insulated the region from the developments that were taking place elsewhere in the State during and after Independence. The absence of large scale participation of the region in the social and political movements restricted social leadership in the hands of few enlightened groups and communities. They controlled the society, both politically and economically, and therefore, were able to divert what ever development that took place during the post Independence period to their advantage.

The composition of the population in which the tribals constitute a significant percentage facilitated this process as the tribals were undemanding and voluntarily excluded themselves from the mainstream. They are largely untouched by development initiatives such as education and remain in the background without a leadership or a perspective. However, in spite of their desire to be excluded from the mainstream culture, they were drawn more into it because of the developing economic relationships which controls property and production. The large scale migration from the mainland and their conquest of land and other resources once enjoyed by the tribals resulted in new relationships in which the tribals now depend heavily on these sections for their survival. Differentiation in
Society has become sharp with plantation owners, irrespective of the size of land, on the one hand and the pauperised tribals who are now unskilled plantation labourers on the other. The position of the tribals in terms of ownership of land, income and employment as analysed in Chapter III testifies this. Their income is appallingly low as 85 per cent of the families earn an average annual income of Rs.5000 or less; the land they owned are inadequate with 75 per cent of them owning 1 acre or less. This also reflects in their employment pattern where 78 per cent are unskilled agricultural labourers. The resultant economic exclusion along with the social and cultural exclusion of tribals due to the lack of education and their beliefs in traditional customs and practices is still continuing almost uninterruptedly in the absence of an effective leadership from among them who can bargain and bring in development initiatives such as health care facilities to tribals. This was explicit from the sample which shows a complete vacuum in terms of leadership or political participation. There is not a single individual in the sample households who holds, or held, a position in the party or in local bodies like the Panchayat or a Co-operative. The outcome was the continuous neglect of the region as well as its tribal population. The process has also resulted in uneven development in the availability facilities within the region which
discriminates the tribal populations. The privileged classes through their economic dominance and political proximity were able to wrestle out health facilities in developed centres and townships that are advantageous to them. To supplement this private investment in health care was also encouraged which further resulted in the neglect of interior regions in Wynad where the tribals are concentrated.

The number of institutions under private sector in Wynad during the mid eighties according to the Survey of private medical institutions was 219 compared to 59 institutions in the government sector for the year 1988. Most of these institutions are located in three township of Kalpatta, Sultan Battery and Mananthody.

However, the process of extreme exclusion of tribal communities from the benefits of health care began to weaken in the eighties because of some unintended consequences of migration. The migrants who had completed their conquest by this time started consolidating their base by demanding several infrastructural developments such as education and health care facilities to the interior regions of the district where they displaced the tribals. During the Seventies and Eighties they were functioning as efficient pressure groups and were successful in bringing about improvement in the availability of health care services. The tribals too were benefited out of these developments as the
facilities, for the first time, became accessible to them. Another outcome of migration and the resultant interaction with the nontribal settlers was the change in their outlook towards modern institutions such as education and health care system and the developing acceptance of their advantages. In fact, education is gradually making in roads among them and the position has changed considerably during the eighties. This has helped in the emergence of a leadership which, though nascent and ineffective in the present context, nevertheless, is aware of the reasons of their backwardness and the importance of political actions and bargaining. The unprecedent rate of increase in health care institutions in Wynad during the 80's is largely due to these developments, but there are also important extraneous factors like the change in emphasis, and therefore norms about provision, at the national level due to initiatives such as the Alma Ata Conference and the National Health Policy, as well as the introduction of special programmes to rectify the imbalances and to ease tensions and contradictions. The India Population Project funded by the World Bank was one such programme which changed, dramatically, the backward status of the district in terms of the availability of health care institutions.

The perceptible increase in the availability of institutions, especially during the last decade, does not
explain the extent to which they were beneficial to the tribals in fulfilling their health needs. The data available in this regard is extremely inadequate if not non-existent, as there is no system, so far, to monitor the progress in the health status of tribals. The pattern of utilisation of health care facilities by the tribals in the sample, their perception about the factors that influence the choice of a facility, the responses of these institutions such as the services they provide and the attitude of health personnels together reveal how these facilities have been unfolding to them. These dimensions also explain the factors that determine the access to health care in the case of tribals. A direct indication of these factors and its implications on accessibility in Wynad reflects on the perceptions expressed by the tribals about the reasons that influenced their decisions to avail a facility. The tribal households in this regard are guided by considerations such as distance, cost and attitude and behaviour of health personnels. The distance, or the availability within approachable distance, ranks high in their reasoning and about 54 per cent of them considered this as the chief reason which prompted them to use an institution. Cost consideration is also important and about one-fourth of them regard this as the main reason. These perceptions and the weightage they attached to each of these reasons evolves from the social realities which
ultimately decides the nature and extent of accessibility of health care institutions in the district.

A crucial element of accessibility in the case of tribals in Wynad is their historical backwardness and cultural seclusion from the mainstream. Historically they constitute a distinct group isolated from the mainstream and maintaining discrete contacts with the rest. This has resulted in an outlook and value system that was consistent to their living environment and survival. The process of integration of tribals that began with the exploitation of forest resources and land for plantation purposes, largely by migrants, and with government interventions to improve their standard of living resulted in certain positive changes that improved their level of awareness. But unlike other categories, tribals carry a stigma of their aboriginal background which, inspite of their preparedness to adopt the mainstream culture, subjected them to an attitude of ridicule and neglect from other communities. This was evident from our interactions with a cross-section of nontribal populations in Wynad who included health personnel and development bureaucracy and they consider tribals as a 'social burden' and a group of population who take away the benefits which otherwise could have been used for the 'general welfare' of the community and not for any 'particular sections'. The attitude expresses itself in the
style of their interaction with tribals who in the course of time develop a total mistrust of nontribals among whom they survive.

The traditional customs and practices of tribals are another set of factors that influence their decisions in availing the services of health care institutions. In the case of Wynad the influence of these practices is pervasive and it encompasses all aspects of life. Disease is one such occasion which induces them to observe these practices and, as seen from the sample, a sizable percentage, 51 per cent, of them do resort to these practices which are partly rational and partly irrational and superstitious. The dividing line between the two is extremely thin and they are often branded as irrational superstitious practices. As seen from our earlier discussions the immediate response of tribals in the context of disease is to take the patient to the medicine man who is accessible and affordable. The medicine man combines tribal medicines with customary ceremonies and if proved ineffective advises the tribals to seek the help of modern medicine. The practice, therefore, enables them to overcome to a certain extent, the other difficulties like distance, cost and the unfavourable response from health personnels. The attitude of tribals towards modern medicine, as we have seen from the responses, opinion and the pattern of
utilisation of health care facilities, proves this point that the tribals accept modern medicine and utilise the health care institutions if they are located within their reach. However, few among them, like Kattunaickans and Paniyans, are sceptical about unfamiliar practices and rely heavily on their traditional system. But even among them there are no norms or taboos that prevent individuals from using modern health care facilities. The belief in the efficacy of these practices however, is on the decline and many of them are unwilling to accept openly that they practice traditional customs.

The social and economic inequalities in Wynad in the absence of any structural changes apportions the gains of economic development to the benefit of richer sections resulting in the perpetuation of dominance-dependence relationship between various categories of populations in society. The relationship manifests in different forms. In its blatant and direct expression it uses physical force to restrict the poor sections from using public funded facilities like a Public Health Centre or a Sub Health Centre. Wynad is relatively free of such incidents largely because of the high level of political consciousness in the State. The indirect manifestations of this relationship is strong and operates subtly through advantages such as control over education and knowledge and especially the
institutions that provide knowledge. The educational superiority of the upper classes and the advantages they appropriate for themselves is an obvious phenomenon that does not require explanation. But in Wynad this takes a different turn in the form of a campaign which characterises tribals as hopelessly anti-change and unwilling to get educated or utilise the government 'concessions' that are offered to them. It points out that the development efforts are useless and mere 'waste of resources'. This belief about the tribal inferiority, about their indifference to changes, the superstitions, customs and practices is pervasive and is even shared by the bureaucracy who are responsible for implementing development projects. The result is disastrous. Projects are not taken seriously; schools, hospitals and other public institutions are poorly located; inadequately staffed and badly run, offering inadequate services. The failure in achievement targetted for these officials are often justified on the ground that tribals are apathetic, non co-operative and resistant to change. This also helps to siphon off large funds into the hands of privileged sections who have vested interest in perpetuating this image about tribals. Also, it develops barriers, especially at the level of attitudes that discourages tribals from utilising modern health care facilities and to fall back upon traditional health care practices for their immediate needs.
The emerging trend

The post Independence developments in health care among tribals does not follow a linear path. The commitment given in the beginning that they will be treated differently, though it facilitated a favourable flow of resources to them failed to produce the desired results. The remote and hilly regions where the tribals are concentrated were ignored consistently in spite of the emphasis and priorities it received in our Five Year Plans. This realisation about the non achievements periodically resulted in the launching of new programmes and schemes hoping to clear backlogs and making up for failures. But, there had been a qualitative change in the attempts towards health care development during the eighties after the Alma Ata Conference of 1978 which declared a new commitment to provide 'health for all by 2000 AD' and also after the enactment of National Health Policy in 1983. The norms for providing health care facilities in remote, hilly and tribal areas were revised and fixed. The delivery system was also geared up to fulfill this commitment.

These developments that have been taking place since Independence towards improving the health status of tribals were discussed in Chapter III in the context of Wynad. The pre-Alma Ata period, as is the case elsewhere,
neglected this region and its tribal population and thereby widening the gap between the region and the State. The catchment area served by a medical institution as well as the availability of bed per thousand population, the two indicators used to discuss the regional disparities clearly explain this gap. There was a concerted effort after the eighties that grew out of the realisation about the disparities to narrow the gap in terms of provision of facilities. The district received a special boost in the later half of eighties with the introduction of IPP which facilitated an accelerated growth in medical infrastructure.

The study focuses on these developments in a historical and empirical perspective to explain the trends that are emerging in the context of health care development for tribals. The preceding discussions therefore concentrated on various aspects such as the tribal situation or the social, economic and cultural dimensions of their existence and the changes that is occurring over time; the environment and its implications on their health; the nature of interventions initiated by the Government its changing emphasis and priorities; the delivery system that had evolved over time, its organisation and the structure; the orientation of health personnel and especially that of medical officers; the programmes implemented and the importance they receive while implemented; the nature of
interaction between health care institutions and tribals and the messages that are propagated which together explains what and how health care had been operating as an extraneous system in the tribals setup and the perceptions of tribals about their health problems and needs; their nature of response to these problems they face with the new health culture and their strategies of combining tradition with modernity which combine explain, on the other hand, how it had been received by the tribals. The trends that are emerging out of this discussion can be summarised in the following order.

The tribal situation evolving out of the social and economic changes in Wynad can be characterised as one which pushes the tribal communities to the status of pauperised and marginalised groups who constitute the lowest rung in the social hierarchy. The process of pauperisation began with the large scale migration of non tribal communities and the eventual appropriation of their resource base initially, through direct and forceful methods and then, through subtler ways of neo-feudal exploitation or through market, credit, knowledge and other dependency generating methods which were increasingly getting stronger during the later years of Independence. The differentiation between tribals and other sections of population, especially the privileged sections perpetuated a dominance-dependence
relationship that places the tribals in an extremely vulnerable position in relation to their access to health care. This runs basic to their backwardness and therefore to their low health status. Consequently, mere provision of health care facilities without structural transformation of the society and without altering the exploitative relationship, may prove the task of providing primary 'health care to all' an uphill task. The trickle-down effect of more growth and more facilities in an unequal society can only sharpen the differentiation and hence the contradictions. Health care development is impregnated with these contradictions.

Development in health care during the post Independence period follows an uneven pattern where regions and groups of populations are treated differently in the provision of health care. During the initial three decades, till the 1970's, the disparities between regions were growing at considerable pace, but thereafter it slowed down due to certain concerted actions. The interdistrict disparities in the availability of health care institutions and health manpower are still sharp and it may assume unmanageable proportions again, as it engenders the tendency of further deterioration, if no deliberate steps are taken. The intra-region and intra-district disparities are also growing where facilities are located in developed centres
rather than on places selected on the basis of giving maximum advantage to the underprivileged sections. The development of health care institutions in Wynad substantiate these tendencies which again arise out of the unequal social structure and the weak bargaining position of tribals.

The social and economic backwardness of tribals reflect equally on their living environment and working conditions. Both are mutually reinforcing and explains the health status as well as the pattern of diseases. The diseases of tribals are largely diseases of their living and working conditions and of poverty and malnutrition. The provision of health facilities without touching these basic maladies therefore, proved ineffective or at best, it could provide only a temporary solace. The emphasis and priorities of health care programmes implemented through the vast network of institutions indicate this. The undue emphasis on curative health care and family planning of PHCs is only increasing over the years irrespective of the commitment to provide primary health care to all by 2000 AD. The Minimum Need Programme or the integrated concept of 'primary health care' which is accepted world over after the Alma Ata Conference failed to make any impact at the operational level. The development of this tendency, is deeply entrenched in the organisation of production of health care
and the interest of those who control it. The undue emphasis of family planning also reflects the interest of the privileged classes who feel threatened by the growth of population and its uneasy consequences. In this relationship between the social production of illness, i.e., the complex relationship of living and working environment and health and illness; and the organisation of production of health care which decides the nature of health care development the latter always exerts its dominance in controlling the environment for its benefits. The tendency is strongly visible in Wynad where the PHC, the grass-root level organisation responsible for the overall development of health status of tribals, engage themselves mostly in family planning and clinical services.

The medical officers and other health personnel lack conviction and commitment due to their inadequate understanding about tribal culture and their historical specificities. They consider tribals as irrational and superstitious and therefore, as negative in their attitude to modern health care practices especially family planning activities. This results into routine implementation of health care activities which exclude tribals from the focus. The concept of 'primary health care' itself which promote integrated health care with medical officer as the group leader is unpopular and unacceptable to medical officers.
The field level activities that are intended to generate effective demand for the services and to maintain the interaction between tribal societies and health care system also reflects the same orientation. The activities are unabashedly centred around family planning and of late, on immunisation and other vertical programmes imposed upon them. The attitude of paramedical staff towards tribals is again one of contempt and indifference that results in detachment and mistrust on the part of the tribals.

The responses of tribals as receivers of health services also corroborate the social realities and conflicts expressed above. Their responses against diseases and their pattern of use of health care institutions reveal considerable divergence from the point of view of the providers. Tribals show an indigenous and ingenious sense of rationality in their response towards illness where he combines his traditional medical practices with modern systems at an appropriate time considering his limitations and availability of resources. He believes in the efficacy of modern medical care but poverty, social distance observed by others, nonavailability within accessible limit and the unfavourable attitude of the medical system restrict its use.

The health care system as it is evolved over the years till now lacks a strategy or comprehensive plan in tackling the health problems and improving the health status
of tribals who form a distinct category of population that require preferential attention. This again boils down to the social and economic realities and the inequalities that exist in society. Any concerted effort to improve the health status of tribals, therefore, requires structural changes in society. It should permit people to have access to health care, socially and spatially, and it should involve people in the planning and management of health care. The acceptance of 'primary health care' as a philosophy and strategy is appropriate but its implementation in an unequal and hierarchial social structure where the interest of those who control the health care production dictate the pattern of growth, as well as a health culture, restricts its effectiveness and it is even bound to fail. The pattern of development in the post Independence period and the contradictions that are highlighted indicate this predicament.

References

2. Ibid, p.75.