CHAPTER-XII

Health

Preservation of health is a fundamental social problem. Future development of a country is conditioned by how its people live and work. Realising the importance of health, the framers of the First Five Year Plan made an axiomatic statement regarding the importance of health. In terms of resources for economic development, nothing can be considered of higher importance than the health of the people. Health is a positive state of well being in which the harmonious development of physical and mental capacities of the individual lead to the enjoyment of a rich and a full life. It is not a negative state of mere absence of a disease.1

Broadly speaking, there are three main influences on the health of the individual, i.e. (a) though a lot of improvement has taken place because of the advancement of science, yet for all practical purposes the effect of climate and other geographical conditions has not been fully controlled, (b) environmental conditions which

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include proper handling of water supply and sewage disposal etc. and the task of proper housing facilities, and (c) The movement from the old and traditional methods to modern conditions of life require a mental adjustment to the rapid change in the way of life and physical adaptation to changes.  

As can be seen from the foregoing, the concept of public health has grown under the impact of all these influences. It has been broadened to the extent that, at least in advanced countries, it includes the intelligent study of all influences which have a bearing on the preservation of health, happiness and well being of individuals, communities, special groups and nations. Fraser Brockington identifies five stages in the preservation of health. The most ideal is the promotion of health by positive vital forces, i.e. by teaching physiological principle of healthy living or by providing good diet. Second stage seeks to prevent illness, chiefly by application of medical knowledge in relation to specific diseases by inoculation, etc. The third seeks to detect early departures from normal health with the object of bringing about a remedy in advance of established disease. These three stages precede the normal

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consultation of the doctor. The fourth stage constitutes after care of sickness or injury in which remedies are sought for social factors and the last stage deals with the management of incurable sickness and it seeks for a worthwhile amelioration of it.³

Health of an individual is important no doubt, but when the collective health of a group as a whole, as distinct from the individual is taken into consideration, discussion centres round what is called 'Public Health'. The Expert Committee of World Health Organisation has called it as the science and art of preventing diseases, prolonging life and promoting mental and physical health and efficiency through organised community efforts for the sanitation of the environment, the control of communicable infections, the education of the individual personal hygiene, the organisation of medical and nursing services for early diagnosis and preventive treatment of disease, the development of social machinery to ensure to every individual a standard of living, adequate for the maintenance of health and so organising these benefits as to enable every citizen to realise his birthright of health and longevity.⁴ The


major objectives of public health are to: (a) increase the average length of human life, (b) decrease the mortality rate from preventive disease, (c) decrease morbidity rate, (d) increase physical well being of individual, and (e) increase the rapidity of adjustment of the individual to his environment.

The economic aspect of health programs cannot be over emphasized. Mushkin identified the following economic effects of health programs: (a) improved motivation for economic changes, incentives towards enterprise by demonstration of modern health techniques, longer life expectancies and lengthening the time perspective for returns on investment projects; (b) labor product gains by reductions in: (i) death (loss of workers), (ii) disability (loss of working time), (iii) debility (loss of productive capacity while at work); (c) non-labor product gains through: (i) opening up of new land areas, (ii) opening up of new mineral resources, (iii) saving in animal life by reducing the sickness; (d) additional consumption and physical capital, i.e. (i) increased capital and (ii) increased number of dependents; and (e) impact of labor market imperfections.5

Health being fundamental to national progress and development, it has to be looked after in a very serious way as most of the policies of the government are not likely to succeed if people with healthy minds in healthy bodies become scarce. A sound public health policy must be well planned and take into account the maintenance of a proper relation between the population and the available supply of the necessities of life. Thus the basic principles of health policy can be enumerated as follows: (i) health opportunities, particularly preventive, should not be related to purchasing capacity of the individuals; (ii) while the public health programmes benefit the community as a whole, specialised medical facilities must remain within a poor man's reach; (iii) investment on health both on preventive and curative schemes is a sound one; (iv) doctors should act as social physicians protecting the people and guide them to healthier and happier life; (v) health is not an isolated phenomenon, it is related to housing, sanitary conditions, drainage, recreation facilities, etc; and (vi) health consciousness should be stimulated by providing health education on a wide basis as well as providing opportunities for the individual participation in local health programmes.6

The scope of the public health can be divided into following four categories: (a) those fields in which activity must be on a community basis, e.g. supervision of food, water and control of pollution etc; (b) those fields which deal with preventible illness, disability or premature death, i.e. communicable diseases, accidents, risks of cancer, metabolic diseases, etc; (c) those fields of medicine which need organised official leadership like facilities of pre-graduate and post graduate education; and (d) research and scientific investigation and evaluation.

Before independence, the general death rate in this country was 27.4 per thousand, infant mortality rate was 183 per thousand live births, and expectation of life at birth varying between 31 to 32.5 years. About half the number of deaths were among children below 10 years and half of them occurred within the first year of life. In rural areas, 6.1 per cent to 11.3 per cent of people were not well at anytime and out of which 1.9 per cent to 6.5 per cent were actually ill and 2 per cent to 8 per cent were chronically ill.7 Medical institutions and facilities were very much

limited and mostly located in urban areas and health services were concerned mainly with medical relief and control of epidemics. organised attempt to meet the community health requirements was conspicuous by its absence.

In the first two Five Year Plans, in the health programmes the emphasis was on the control of communicable diseases, improvement of environmental sanitation, rural and urban water supply, provision of services for maternal and child health care, health education and nutrition. The broad objectives of the Third Plan were to expand the health services to bring about progressive improvement in the health of the people and to create conditions conducive to efficiency and production. Fourth Plan mainly addressed itself to creation of an effective base for health services in the rural areas by strengthening the Primary Health Centres, integration of the maintenance phases of control of communicable diseases with those services, strengthening of Sub-divisional and District hospitals to serve as a referral hospital for the P.H.C.s. and for family planning programmes. 8 Steps were taken to

expand medical education and training of many categories of health personnel for meeting the manpower requirements and for creating self-sufficiency in drugs and equipments.

In the Fifth Plan, these objectives included the provision to increase accessibility of health care services in rural areas, further development of referral services, integration of health, family planning and nutrition, augmentation of training programmes of multipurpose workers, qualitative improvement in the education and training of health personnel, correction of regional imbalances in health care and development of special services to provide medical specialists in the upgraded health centres. 9

Medical and public health services, which include services, such as improvement of environmental sanitation, control of communicable diseases, health education and nutrition, maternal and child health care, etc. occupy a significant place in Himachal Pradesh. The National Policy aims at controlling and even reducing the present high rate of population growth which up till now has been eating into the vitals of the economy and thus putting the economic growth at a naught. In order to render timely medical

treatment to the patients, the working efficiency of the medical institutions were toned up. The total number of outdoor and indoor patients treated in the various medical institutions in Himachal Pradesh was 37.54 lakhs and 4.39 lakhs respectively during the period from January to November, 1976.10 Besides, 21,074 major and 47,996 minor operations were also performed during this period in the various medical institutions.11

**Tribals and Health Administration:** In ancient times, the population was overwhelmingly dependent upon the deities whose intervention they sought even in matters of health, individual as well as public. As a byproduct of this mass practice of faith healing, there was quite a number of individuals who commended adherence by their claim to cure through magic or through the invocation of some spirits of deities. Physicians practising either the 'ayurvedic' system or any mumbo-jumbo under the garb of medicine, probably existed in the tribal areas from very early times. Their

11. Ibid,
number gradually went on increasing and these charlatans, quacks and some genuine physicians, offered the only alternative to the spirits and deities and in the course of time, grew in vogue and developed into the adoption of regular medical means for health.

In primitive societies, the practice of medicine was associated with religion, magic and astrology. The basis of modern medicine is provided by the biological services.

In recent years the scientific content of medicine has increased enormously. Although medicine developed in its scientific content, it had lagged behind as an 'art'.

Today, there is an increasing recognition that successful application of medicine to individual and community does involve an understanding of behaviour of the individual and community who live together and share certain values of life.

Among the tribal communities, it is difficult to study the problem of health isolated from other aspects of their culture. Public health is an integrated part of the social system and cultural pattern. Health is the expression of harmony with the universe. In tribal society, man is continuous with his environment. A person in tribal society

is not healthy unless his environment is healthy and that, which causes disease and illness, may also cause failure of crops, ill-luck in hunting, mishap in family and misfortune to village. In these societies a man's body, mind, activities, emotions and social relations are all one, and his discontinuity with land and society may result in misfortune in any of these aspects. Physical illness is only one of such misfortunes.

The tribals in Bhamour and Pangi Sub-divisions, as elsewhere in the world, are very much attached to their native place, which is continuous with them. To break connection between body and the land may be hazardous not only to a particular person but also to the society to which he belongs. Such a conception of continuity of body with land, environment, society and other objects of the universe and unity of functions of each of them underlines the way in which medical treatment and hygienic measures are accepted and worked out.13

The low level of nutrition in the tribal areas of Chamba District is one of the major problems of great concern. With the increase in population the man-land ratio has been

distorted. The result of the imbalance between the carrying capacity of land under the present land use pattern and the pressure of population on land has been out-migration, low intake of food, physical suffering and indebtedness. Repeated clearing and over cultivation of the hill slopes has led to deforestation and soil erosion resulting in diminishing returns, deficient in essential nutrients.14 Conception concerning cleanliness and uncleanliness, dirty habits and hygienic habits vary from community to community particularly among the tribal communities. Except certain sections of tribal communities all others are most untidy and keep their houses and surroundings unclean.

Medicine connotes medical care. This care gives relief from suffering and tells people what they should do to avoid illness and suffering. This aspect deals with types of diseases and nature of suffering, causation of diseases and their prevention and cure. The concept of health, as already indicated, is a part of man's total view of universe and his place within it. As long as his relationship with the universe is harmonious, he is healthy

and hearty. No sooner than this harmony is disrupted by some means or the other than the man falls ill and meets his misfortune. In other words, the loss of harmony is itself a disease.  

Disharmony with the universe may result if a man does not have good thoughts, if quarrelsome and aggressive, if violates social regulations and cultural values and does not act in conformity with the belief system and social order. As a result, his psychosomatic health is impaired. Among many tribal communities, disease is the punishment for breach of socio-cultural norms. Other sources of disease are the machinations of witch-craft, spirits, black magic and displeasure of malevolent deities and spirits of hills and forests. The belief which is common to the tribal communities is that propitiation of these unseen forces cures illness and restores harmony between the ailing persons and the universe. The witch diviner cum medicine man is called for at the time of illness to find out the cause of disease, and then the village priest is requisitioned to propitiate the offended deities and remove the illness.

16. Ibid.
17. Ibid.
Illness is also caused by the evil power set in motion by some malevolent magician or witch. The tribal life, is shadowed by the menace of witchcraft and dread of black magic. Of course, the malicious actions of supernatural powers and magicians are not the only sources which cause disease and unpleasant events, but they are there as possible causes of illness, annoyance and disaster. White magic counteracts the effects of black magic. In every tribal communities there are specialists in white magic or shamanism. A shaman acts as a doctor and psychiatrist, faith-healer and prophet. By various types of charms, spells and divination, the shaman tries to bring good effects in what would usually be regarded as hopeless cases.

Health administration in Chamba District: The climate of the Chamba District, as a whole, is salubrious. Malaria fever has practically disappeared. Goitre is noticeable in the Tundah area of Bharmour Sub-division, Sech area of Pangi Sub-division and some other parts of Chamba District. The incidence of venereal disease (syphilis) is comparatively less in Bharmour and Pangi Sub-divisions as compared to other

19. Ibid.
parts of the District. Leprosy is found in various parts of the District. Tundah area of Bharmour Sub-division is also affected by this disease. The leprosy asylum at Sarol near Chamba is said to be one of the oldest institutions of its kind in India. It was organised by the Church of Scotland Mission in the middle of the last century. It was taken over by the Chamba State in 1936.

The staple diet of the people in Bharmour and Pangi Sub-divisions is maize. Indigestion and bowel complaints are common and many patients suffer from appendicular abscess as well. Symptoms of malnutrition, especially pellagra and night blindness are not uncommon seen in the patient dealt with by the out patient departments as well as those admitted in the wards. The incidence of pellagra is due to the deficiency of vitamins B (PP Factor) in the diet whereas the night blindness is due to the shortage of vitamin A.20

The incidence of tuberculosis in Bharmour and Pangi Sub-divisions is quite high. Other chest diseases, such as pneumonia, bronchitis and asthma are also fairly common.

Incidence of hydatid-cyst in lung and liver is also rather high, because the people are mostly owners of sheep and goats, who invariably keep dogs to guard their flock and this disease is caused by *Taenia echinococcus*, a worm found in the dogs. Stone in bladder and kidney is quite common. Usually multiple stones are found in the kidney and in many cases they are bilateral. Rheumatic affection involving both joints and heart is also fairly common. No seasonal relation has so far been established.

Diseases of eye, such as trachoma, conjunctivitis and senile cataract are not uncommon. The incidence of diseases of the alimentary system, such as gastric ulcer, gastritis, diarrhoea and dysentery, *enteric fever*, anaemia with or without hook worm and that of injuries, including fractures are also fairly high. Cholera and plague are uncommon in these areas.

Organisation: The organisational set up for health administration in Himachal Pradesh has been shown in Chapter No. 12.1.

References:
22. *Ibid*.
CHART NO. 12.1

Organisation set up of Health Department

Minister
Secretary

Director

Deputy Director(3)

Assistant Director(7)

Chief Medical Officer(12)

Ayurvedic dispensaries

Primary Health Centres

Medical Officer (I/C)

Medical Officer (Health)

Hospital
The department is headed by the Director of Health Services. There are three Deputy Directors and Seven Assistant Directors below him. Out of the seven Assistant Directors, one is in charge of malaria and the other of smallpox. At the District level there are Chief Medical Officers. There are 12 Chief Medical Officers in Himachal Pradesh, each having two senior doctors under him. One is in charge of Public Health and the other is in charge of the District hospital. There are other doctors both general duty officers and specialists in the hospitals. In each block there are Primary Health Centres (P.H.C.). There is one P.H.C in Bhamour Sub-division at Bhamour and the other in Pangi Sub-division at Kilar. There are twelve beds in P.H.C. at Bhamour and eight beds in P.H.C. at Kilar. The three sub-centres functioning under the Primary Health Centre Bhamour are at Khanni, Ulansa and Holi. The sub-centres under P.H.C. Kilar are at Sach, Dharwas and Karyas.

There is no civil dispensary in Bhamour Sub-division. However, in Pangi Sub-division there is one civil dispensary at Purthi and one Maternity and Child Welfare Centre at Ohra in Bhamour Sub-division. In Pangi Sub-division there is no Maternity and Child Welfare Centre. In both of these sub-divisions, V.D. units are attached with the Primary Health Centres. One T.B. sub-clinic has been attached with
Leprosy units have been attached with Primary Health Centres in both the Sub-divisions. There are seven ayurvedic dispensaries in Bharmour Sub-division, and three ayurvedic dispensaries in Pangi Sub-division. The medical institutions, both allopathic and ayurvedic in these two Sub-divisions have been shown in Chart no.12.2.

**Programmes:** The main development programmes in this direction in these two Sub-divisions are: (a) upgrading of existing health facilities, (b) opening of new health institutions, (c) prevention of diseases and their cure, (d) family planning programmes, etc. These are being done by Doctors posted in the Primary Health Centres and Vaidys in the ayurvedic dispensaries. The C.D. Block agency also assists the medical officers whenever necessary.

The details of patients treated in the Primary Health Centre at Bharmour (both outdoor and indoor) during the years 1975, 1976 and 1977 are given in Table no.12.3.
CHART NO.12.1
Organisational set up of Health Development in Chamba District (Tribal Areas)

Chief Medical Officer

Bharmour Sub-division

Ayurvedic

Dispersanries(7)

(1) Holi
(2) Tundah
(3) Durgethi
(4) Ramkothi
(5) Ulansa
(6) Kugati
(7) Chanhota

Allopathic

P.H.C. (Bharmour)

Fangi Sub-division

Ayurvedic

(1) Dharwas
(2) Sach
(3) Saichu

Civil Dispensary(Purthi)
P.H.C. (Kilar)

Allopathic

Sub-Centre

(1) Khani
(2) Holi M.C.H.
(3) Ulansa (Ohra)

V.D.Unit

Leprosy Unit

Sub-Centre

(1) Dharwas
(2) Sach V.D.
(3) Karyas Unit

T.B. Centre

Leprosy Unit.
### TABLE NO. 12.2

**Patients Treated in P.H.C. Bharmour**

<table>
<thead>
<tr>
<th>Year</th>
<th>Department</th>
<th>New</th>
<th>Old</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975</td>
<td>OPD</td>
<td>5372</td>
<td>5601</td>
<td>11173</td>
</tr>
<tr>
<td></td>
<td>INDOOR</td>
<td>79</td>
<td>672</td>
<td>751</td>
</tr>
<tr>
<td>1976</td>
<td>OPD</td>
<td>6147</td>
<td>6560</td>
<td>12707</td>
</tr>
<tr>
<td></td>
<td>INDOOR</td>
<td>85</td>
<td>608</td>
<td>693</td>
</tr>
<tr>
<td>1977</td>
<td>OPD</td>
<td>7210</td>
<td>6525</td>
<td>13735</td>
</tr>
<tr>
<td></td>
<td>INDOOR</td>
<td>82</td>
<td>573</td>
<td>655</td>
</tr>
</tbody>
</table>

Besides the Primary Health Centre at Bharmour, there are ayurvedic dispensaries at Kugti, Luna, Tundah, Chanbauta, Holi and Ramukothi in Bharmour Sub-division. The number of patients treated in these ayurvedic dispensaries are as follows:

24. Figures collected from Primary Health Centre, Bharmour.
### TABLE NO. 12.4

**Patients Treated in Ayurvedic Dispensaries in Bharmour Sub-division**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Kugti</td>
<td>247</td>
<td>228</td>
<td>475</td>
<td>420</td>
<td>305</td>
<td>725</td>
<td>499</td>
<td>309</td>
<td>808</td>
</tr>
<tr>
<td>2.</td>
<td>Ulansa</td>
<td>726</td>
<td>1279</td>
<td>2005</td>
<td>1206</td>
<td>1328</td>
<td>2534</td>
<td>1120</td>
<td>925</td>
<td>2045</td>
</tr>
<tr>
<td>3.</td>
<td>Tundah</td>
<td>263</td>
<td>397</td>
<td>660</td>
<td>221</td>
<td>300</td>
<td>521</td>
<td>1221</td>
<td>927</td>
<td>2148</td>
</tr>
<tr>
<td>4.</td>
<td>Chenhota</td>
<td>263</td>
<td>821</td>
<td>1084</td>
<td>712</td>
<td>425</td>
<td>1137</td>
<td>824</td>
<td>619</td>
<td>1443</td>
</tr>
<tr>
<td>5.</td>
<td>Holi</td>
<td>1366</td>
<td>810</td>
<td>2176</td>
<td>1419</td>
<td>784</td>
<td>2203</td>
<td>1497</td>
<td>802</td>
<td>2299</td>
</tr>
<tr>
<td>6.</td>
<td>Ranukothi</td>
<td>427</td>
<td>863</td>
<td>1290</td>
<td>614</td>
<td>514</td>
<td>1128</td>
<td>630</td>
<td>635</td>
<td>1265</td>
</tr>
</tbody>
</table>

The number of patients treated in Primary Health Centre and Civil dispensary in Pangi Sub-division are as follows:

25. Figures collected from Chief Medical Officer, Chamba.
### TABLE NO. 12.5

Patients Treated in Primary Health Centre at Kilar and Civil Dispensary at Purthi in Pangi Sub-division

<table>
<thead>
<tr>
<th>Medical Institution</th>
<th>Department</th>
<th>Year</th>
<th>New</th>
<th>Old</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kilar</td>
<td>OPD</td>
<td>1975</td>
<td>2126</td>
<td>2105</td>
<td>4231</td>
</tr>
<tr>
<td></td>
<td>INDOOR</td>
<td>1975</td>
<td>3</td>
<td>21</td>
<td>24</td>
</tr>
<tr>
<td>Purthi</td>
<td></td>
<td>1975</td>
<td>800</td>
<td>1009</td>
<td>1809</td>
</tr>
<tr>
<td>Kilar</td>
<td>OPD</td>
<td>1976</td>
<td>3093</td>
<td>3041</td>
<td>6134</td>
</tr>
<tr>
<td></td>
<td>INDOOR</td>
<td>1976</td>
<td>2</td>
<td>12</td>
<td>14</td>
</tr>
<tr>
<td>Purthi</td>
<td></td>
<td>1976</td>
<td>898</td>
<td>968</td>
<td>1866</td>
</tr>
<tr>
<td>Kilar</td>
<td>OPD</td>
<td>1977</td>
<td>4924</td>
<td>5772</td>
<td>10696</td>
</tr>
<tr>
<td></td>
<td>INDOOR</td>
<td>1977</td>
<td>21</td>
<td>188</td>
<td>209</td>
</tr>
<tr>
<td>Purthi</td>
<td></td>
<td>1977</td>
<td>967</td>
<td>980</td>
<td>1947</td>
</tr>
</tbody>
</table>

26. Figures collected from Primary Health Centre, Kilar and Chief Medical Officer, Chamba.
The details of patients treated in the ayurvedic dispensaries in Pangi Sub-division are as follows:

**TABLE NO. 12.6**

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Location</th>
<th>New</th>
<th>Old</th>
<th>Total</th>
<th>New</th>
<th>Old</th>
<th>Total</th>
<th>New</th>
<th>Old</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sach</td>
<td>461</td>
<td>706</td>
<td>1167</td>
<td>556</td>
<td>693</td>
<td>1249</td>
<td>518</td>
<td>414</td>
<td>932</td>
</tr>
<tr>
<td>2</td>
<td>Dharwas</td>
<td>453</td>
<td>1245</td>
<td>1698</td>
<td>779</td>
<td>1177</td>
<td>1956</td>
<td>925</td>
<td>418</td>
<td>1343</td>
</tr>
<tr>
<td>3</td>
<td>Saichu</td>
<td>334</td>
<td>1137</td>
<td>1471</td>
<td>585</td>
<td>820</td>
<td>1405</td>
<td>821</td>
<td>640</td>
<td>1461</td>
</tr>
</tbody>
</table>

Tuberculosis cases are quite common in these two Sub-divisions. Details of T.B. cases treated during the year 1975, 1976 and 1977 are as under:

**TABLE NO. 12.7**

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Sub-division</th>
<th>1975</th>
<th>1976</th>
<th>1977</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bharmaur</td>
<td>404</td>
<td>424</td>
<td>507</td>
</tr>
<tr>
<td>2</td>
<td>Pangi</td>
<td>131</td>
<td>151</td>
<td>314</td>
</tr>
</tbody>
</table>

27. Figures collected from Chief Medical Officer, Chamba.
28. Figures collected from Chief Medical Officer, Chamba.
Eye disease cases are also quite common in both of these Sub-divisions. These are mostly due to unhygienic conditions of living and ignorance of the health programmes.

The eye disease cases treated in Bharmour and Pangi Sub-divisions during the years 1975, 1976 and 1977 are as follows:

**TABLE NO. 12-8**

Eye disease cases treated in Bharmour and Pangi Sub-divisions.

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Sub-Division</th>
<th>1975</th>
<th>1976</th>
<th>1977</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Bharmour</td>
<td>471</td>
<td>685</td>
<td>481</td>
</tr>
<tr>
<td>(a) P.H.C. Bharmour</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Pangi</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) P.H.C. Kilar</td>
<td>39</td>
<td>87</td>
<td>273</td>
<td></td>
</tr>
<tr>
<td>(b) Civil Dispensary, Purthi.</td>
<td>38</td>
<td>16</td>
<td>16</td>
<td></td>
</tr>
</tbody>
</table>

29. Figures collected from Chief Medical Officer, Chamba.
In addition to these, other works done in Sharmour and Pangi Sub-divisions include construction of rural latrines, construction of village lanes, installation of smokeless chullah, construction and renovation of drinking water supply schemes and disinfection thereof etc. The work done in this regard has been indicated in Table No.12.9. These works are mostly done through the Community Development Block. To further widen the base of health care delivery pyramid "Mural Health Scheme" has been launched since October 2, 1977 whereby a Community Health Worker per 1000 population will serve the primary health needs of the community. Similarly, one Dai (traditional birth attendants) per 1000 population will also be available to rural women for maternity and child health services and they are being suitably trained. Both these workers, i.e. the Community Health Worker and the Dais belong to the community. 30

Performance: The norms laid down by the Planning Commission as well as the State Government as guidelines for the determining of the requirements of various health

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facilities are as follows: (a) one Primary Health Centre for every Block (upto 80,000 population); (b) one sub-centre for every 10,000 population; (c) one upgraded 30 bedded Health Centre for four Primary Health Centres; (d) one urban Dispensary/Civil Hospital for every 20,000 population; (e) one rural Dispensary for every 20,000 population; (f) one bed for 1,000 population; and (g) one Doctor for 3500 population etc.

As per these norms, there should be one P.H.C. each in Bharmour and Pangi Sub-divisions. There should be three sub-centres in Bharmour Sub-division and one in Pangi Sub-division. As against this, there are three sub-centres in Bharmour and three in Pangi Sub-division. There should be one Civil Dispensary for every 20,000 population. Though there is one Civil Dispensary in Pangi Sub-division, there is none in Bharmour Sub-division. As per norms laid down by the Planning Commission, there should be 27 beds in Bharmour Sub-division and 10 in Pangi Sub-division. Against the requirement of 27 beds in Bharmour Sub-division, at present there are only twelve beds and against the requirement of 10 in Pangi Sub-division there are eight at the moment.
### Table No. 12.9

**Health and Rural Sanitation in Bharmour**

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Item</th>
<th>1st Plan</th>
<th>2nd Plan</th>
<th>3rd Plan</th>
<th>4th Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Har-Pan Har-Pan Har-Pan Har-Pan Har-Pangri</td>
<td>Har-Pan Har-Pan Har-Pan Har-Pan Har-Pangri</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>mour gi mour gi mour gi mour gi mour gi</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Primary Health Centre Started</td>
<td>- - 1 - - - - 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Rural Latrines constructed</td>
<td>- - 8 35 30 112 40 12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Smokeless Chilla installed</td>
<td>- - - - - 14 30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Pucca Drains constructed</td>
<td>- - - - - - -</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Soakage pits constructed</td>
<td>- - 56 52 107 167 755 51</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Drinking water wells/baslis constructed</td>
<td>- - 7 15 18 32 -</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Drinking water wells/baslis renovated</td>
<td>- - 22 7 24 - -</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Drinking water baslis disinfected</td>
<td>NA N.A. 476 33 - -</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

31. Figures collected from District Statistical Officer, Chamba.
Again there should be one Doctor for 3500 population. This would justify presence of about 8 Doctors in Bhansour Sub-division and 3 in Pangi Sub-division. During 1975-76 there were only one Doctor and three Vaidas in Bhansour Sub-division and one Doctor and one vaid in Pangi Sub-division.

Other indicators of development in this direction are (a) number of medical institutions per 1000 population; (b) number of beds per thousand population (g) number of institutions per 100 sq.km. of the area.

Table No.12.10 gives total number of institutions in Bhansour and Pangi Sub-divisions as per above indicators.

**TABLE NO.12.10**

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Sub-Division</th>
<th>Population (P.H. C.)</th>
<th>Inst. per 1000</th>
<th>Inst. per 100</th>
<th>Beds per 100</th>
<th>Area (Sq.km)</th>
<th>P.H.C.</th>
<th>Population (Sq.km)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bhansour</td>
<td>27067</td>
<td>8</td>
<td>1818</td>
<td>12</td>
<td>8</td>
<td>0.29</td>
<td>0.344</td>
</tr>
<tr>
<td>2</td>
<td>Pangi</td>
<td>9794</td>
<td>5</td>
<td>1654</td>
<td>8</td>
<td>3</td>
<td>0.51</td>
<td>0.81</td>
</tr>
</tbody>
</table>
Thus the number of medical institutions per thousand population in Bharmour Sub-division (0.29) is more than those in both the hilly Districts of Meghalaya, Tuensang District of Nagaland, South Tripura, Darjeeling District of West Bengal, all the hilly Districts of Uttar Pradesh, all the Districts of Arunachal Pradesh except Lohit, Mizo hills District of Assam and all the hilly Districts in Jammu and Kashmir except Ladakh (as on 1969). The institutions per thousand population in Pangl Sub-division (0.51) is more than all the hilly Districts of India except Mikir and North Cachar hills (1969).

A comparison with similar figures of various Districts of Himachal Pradesh reveals that the number of such institutions per thousand population in Bharmour and Pangl Sub-divisions is more than that all the non-tribal Districts. The institutions per thousand population is however, highest in Kinnaur District (0.74) followed by Lahul-Spiti District (0.59), Pangl Sub-division (0.51) and Bharmour Sub-division (0.29). The number of institutions per thousand population in Bharmour and Pangl Sub-divisions is higher than the State average as well which is 0.19.

The number of beds per thousand population in India was 0.25 before 1952. It had gone up to 0.64 in 1968 and

was 0.58 in 1974. The number of beds per 1000 population in Bharmour Sub-division is 0.44 and in Pangi Sub-division 0.81. Thus, the figures for Bharmour Sub-division are less than the national figures while that for Pangi is higher than the national figures (0.58). The number of beds per thousand population in Bharmour Sub-division (0.44) is higher than similar figures for Hamirpur and Una Districts of Himachal Pradesh, whereas the number of beds per thousand population in Pangi Sub-division (0.81) is higher than similar figures for Hamirpur, Lahaul-Spiti and Una Districts. Among the tribal areas, the number of beds per thousand population is highest in Kinnaur District (1.9) followed by Pangi Sub-division (0.81), Lahaul-Spiti District (0.76) and Bharmour Sub-division (0.44). The number of institutions per 100 sq.km. of the area in Bharmour Sub-division is 0.44 and in Pangi sub-division 0.3. As compared to this, there are 0.3 and 0.11 institutions per 100 sq.km. area in Kinnaur and Lahaul-Spiti Districts respectively. Table No.12.11 indicates the distances of health facilities from the selected villages.

### TABLE NO. 12.11

**Distances of Health facilities from selected villages**

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Name of the Village</th>
<th>Distance of P.H.C. (km)</th>
<th>Distance of nearest health facility (km)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Bharmour</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2.</td>
<td>Tundah</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td>3.</td>
<td>Holi</td>
<td>43</td>
<td>0</td>
</tr>
<tr>
<td>4.</td>
<td>Dharwas</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>5.</td>
<td>Malet</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6.</td>
<td>Saichu</td>
<td>29</td>
<td>0</td>
</tr>
</tbody>
</table>

It is thus clear that all the selected villages have the health facilities within the village. Except for the sub-divisional headquarters, Bharmour and Malet (Kilar) the distances of Primary Health Centres from the other sample villages are quite large.

**Assessment:** As stated earlier, Primary Health Centres (PHCs) and Sub-centres are located in rural areas for providing basic health services comprising curative care, control of environmental sanitation, health education and registration of vital statistics. Their numbers by March, 1976 was 5,325 main centres and 34,088 sub-centres in this...
Originally, a P.H.C. having 4-6 beds was to cover a population of 60-80 thousands persons which has now increased considerably. Initially, three sub-centres were attached to each P.H.C. but now there is one per 20,000 population due to the maternity and child health programme and family welfare programme. Upto March 31, 1975 there were 76 PHCs. in Himachal Pradesh, 69 in rural and 7 in Urban areas. As against this, there are seven ayurvedic dispensaries in Bhamour Sub-division and three in Pangi Sub-division. There are four PHCs. in Kinnaur District, two in Lahaul-Spiti District. There are three allopathic dispensaries in Kinnaur District and seven in Lahaul-Spiti District. Though the population of Bhamour Sub-division is more than Lahaul-Spiti District, there is no allopathic dispensary in this Sub-division.

No malaria and small pox cases were reported in Bhamour and Pangi Sub-divisions during the year 1975, 1976, 1977. It is estimated that there are nearly 9 million active T.B. cases in the country of which nearly 2 million are infectious. As many as 82 percent of sputum

34. H.S. Gandhi, _op.cit_, p.581.
positive cases are scattered in the rural and tribal areas of the country. T.B. mortality is of the order of 80-100 per 10,000 persons per year. A total of 606 T.B. clinics and 298 upgraded District T.B. Centres are now functioning in the country. There is one T.B. clinic at Chamba and one sub-clinic at Kilar in Pangi Sub-division. Though the cases of T.B. are quite common in these two tribal Sub-divisions, people do not come forward for treatment.

The National Leprosy Control Programme now covers 30 states and Union Territories in this country covering almost all the pockets of high and moderate prevalence through a network of 324 leprosy control units, 3101 survey education and treatment units. There are five leprosy hospitals in Himachal Pradesh. Leprosy units have been attached in the PHCs both Sharmour and Pangi Sub-divisions.

The chief factors which have to be taken into consideration for tackling the health problems of an area are its population, the age structure, birth rate, death rate,

35. H.S. Gandhi, op.cit, p.578.
36. Ibid.
infant mortality rate, maternal mortality rate, growth rate, expectancy of life, the number of towns and villages and the population structure therein, the student population at various levels, the national income, food and nutrition of the people, housing, environmental hygiene, water supply and drainage, mortality, health administration, technical manpower, industrial health, vital statistics, etc. Though primary health centres have been opened in these tribal areas, adequate measures have not been taken to provide physical facilities for living as well as working for the personnel posted in these areas. For social services, no amount of allocation of funds is enough. Though due share has been allocated for public health but inspite of all the care, the programme has mostly failed for lack of adequate finance. In addition to this, due to remoteness of these tribal sub-divisions and difficult approach, it becomes difficult to post medical officers and even vaidas in these areas. Moreover, the difficult approach creates a problem of supply of medicines.

and other life-saving drugs. The norms fixed for opening
dispensaries, sub-centres and other medical institutions
cannot be followed in these areas strictly due to difficult
terrain and extremely low density of population. The
belief in supernaturalism is also one of the strong
causes of illness in the tribal areas. It is no easy
matter to accord appreciation and acceptance by the tribals
of the modern health and hygienic measures which are intro-
duced through various levels of medical and para medical
infrastructure. Mere filling in the functional gaps in
respect of health services might not improve the health
and nutritional status of the tribals. It is, therefore,
 imperative to take stock of the belief system and indi-
genous practices concerning food habits and child care,
hygienic habits and disease treatment, concept of contageion an
pollution, preventive measures and surgery. Then the
patterns of resistance to acceptance of medical innovations
and their bases need to be understood thoroughly. A
medical practitioner who has a good knowledge about the
tribal life and culture, customs and practices will be in
a better position to understand and appreciate tribals' point of view and their mental make up in regard to health
practices than a novice who lacks this knowledge. 38

Therefore, following principles of health policies may be enunciated for Sharmour and Pangi Sub-divisions:

(a) The medical care of the common man is immensely worthwhile. It must be approached with an objective attitude of mind which must be free as far as possible from pre-conceived notions exported from advanced areas. The maximum returns in human welfare must be obtained from the limited money and skill available; (i) in estimating return, means must not be confused with ends; (ii) medical care must be adopted to the needs of an intermediate technology. (b) A medical survey must be organised to provide for steady growth in both quantity and quality of medical care. (c) Patients should be treated as close to their homes as possible in the smallest, cheapest, most humbly staffed and most simply equipped unit that is capable of looking after them adequately. (d) Some form of medical care should be supplied to all the people at all the time. (e) In respect of most of the common conditions there is little relationship between the cost

38. N. Patnaik and S. Bose, op. cit., p. 213.
and size of a medical unit and its therapeutic efficiency. The medical care can be effective without being comprehensive. (f) Medical services should be organized from the bottom up and not from the top down. The health needs of a community must be related to their wants. (g) The role that a doctor has to play in these tribal areas differs in many important respects from that in an advanced area. (h) The role played by auxiliaries is both different and more important in the tribal areas than in the other areas. (i) All medical workers have an educational role which is closely linked to their therapeutic one: (i) Skilled staff members have a duty to teach the less skilled ones. (ii) All medical staff have a teaching vocation in the community they serve. (k) In developing countries, medical care requires the adaptation and development of its own particular methodology. As medical care and local culture are closely linked, it must be carefully adapted to the opportunities and limitations of the local culture. Where possible, medical services should do what they can to improve the non-medical aspects of a culture in the promotion of a 'better life' for the tribal people.
The principles may be kept in view while planning for the health programmes in these two sub-divisions.

In order to determine the exact location of the proposed health facilities in the cluster of villages, it is necessary to keep the following facts in view i.e. (i) inter village distance; (ii) relative accessibility; (iii) the nature of the terrain, etc.

The following formula may be used for determining the intervillage distance in the sub-division.40

\[ d = \frac{A}{n} \]

Where \( d \) = inter-village distance;
\( A \) = area in sq.km., and
\( n \) = number of inhabited settlement in the sub-division.

Information regarding the inter-village distance for both the sub-divisions is required in order to have a comparative view of settlement pattern and distance covered by people for inter-village travel. In addition to this, the clusters are to be grouped and locations of growth centres, service centres, central villages and

40. N. Patnaik and S. Bose, op.cit, p.225.
their hinterlands have to be indentified. While planning a health facility all these things have to be kept in view.

Till it is not possible to increase the number of dispensaries in these Sub-divisions, arrangements for mobile medical teams may be examined so that each village is visited by them at least once in a month. There is urgent need for supply of safe and hygienic drinking water in each and every village. A survey in regard to the availability of this facilities may be conducted and the facility needs to be provided wherever required. Cleanliness drives may be launched jointly by the Medical and Block agency especially by the lady workers in the Medical and Block Department.

At present, to avail of the medical facility, people have to travel a long distance. Moreover, the shortages of medicines especially during winter months causes much hardship to the people. More attention, therefore, requires to be paid to improvement of medical facilities and circumventing other related difficulties presently experienced by the people in obtaining quick and adequate medical aid. Adequate accommodation, equipment, furnitures, medicines and staff should be provided in the medical institutions at Bharmour and Pangi Sub-divisions. More
establishment of dispensaries will not help much in improving the health of the people unless the required quantity of medicines and necessary equipments are provided to the institutions and doctors posted there.

In the existing circumstances of today, where each sector of development is claiming the maximum share of the scarce national resources, it has become necessary to make a convincing case for allocation of more funds for health. This has become particularly necessary in view of the fact that arguments have often been advanced that expenditure on health is not productive. It is, therefore, necessary to demonstrate that investment in health is also financially rewarding apart from its humanitarian aspect. 41

The need for intensifying the health education and family welfare programmes in these two Sub-divisions may be examined. The supervision over the field staff in these remote areas is also equally necessary. The health programme has already made its impact on the people of these tribal areas. It is hoped that in times to come further improvements would be made.

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