Chapter 1

Introduction
Indian tribes constitute roughly 8 percent of the nation's total population, nearly 68 million people according to the 1991 census. One concentration lives in a belt along the Himalayas stretching through Jammu and Kashmir, Himachal Pradesh, and Uttar Pradesh in the west, to Assam, Meghalaya, Tripura, Arunachal Pradesh, Mizoram, Manipur, and Nagaland in the northeast. Another concentration lives in the hilly areas of central India (Madhya Pradesh, Orissa, and, to a lesser extent, Andhra Pradesh); in this belt, which is bounded by the Narmada River to the north and the Godavari River to the southeast, tribal peoples occupy the slopes of the region's mountains. Other tribals, the Santals, live in Bihar and West Bengal. There are smaller numbers of tribal people in Karnataka, Tamil Nadu, and Kerala, in western India in Gujarat and Rajasthan, and in the union territories of Lakshadweep and the Andaman and Nicobar Islands.

The extent to which a state's population is tribal varies considerably. In the northeastern states of Arunachal Pradesh, Meghalaya, Mizoram, and Nagaland, upward of 90 percent of the population is tribal. However, in the remaining northeast states of Assam, Manipur, Sikkim, and Tripura, tribal peoples form between 20 and 30 percent of the population. The largest tribes are found in central India, although the tribal population there accounts for only around 10 percent of the region's total population. Major concentrations of tribal people live in Maharashtra,
Orissa, and West Bengal. In the south, about 1 percent of the populations of Kerala and Tamil Nadu are tribal, whereas about 6 percent in Andhra Pradesh and Kamataka are members of tribes.

There are some 573 communities recognized by the Government as Scheduled Tribes and therefore eligible to receive special benefits and to compete for reserved seats in legislatures and schools. They range in size from the Gonds (roughly 7.4 million) and the Santals (approximately 4.2 million) to only eighteen Chaimals in the Andaman Islands. Central Indian states have the country's largest tribes, and, taken as a whole, roughly 75 percent of the total tribal population live there.

Apart from the use of strictly legal criteria, however, the problem of determining which groups and individuals are tribal is both subtle and complex. Because it concerns economic interests and the size and location of voting blocs, the question of who are members of Scheduled Tribes rather than Backward Classes or Scheduled Castes is often controversial. The apparently wide fluctuation in estimates of South Asia's tribal population through the twentieth century gives a sense of how unclear the distinction between tribal and nontribal can be. India's 1931 census enumerated 22 million tribal people, in 1941 only 10 million were counted, but by 1961 some 30 million and in 1991 nearly 68 million tribal members were included. The differences among the figures reflect changing census criteria and the economic incentives individuals have to maintain or reject classification as a tribal member.

These census data serve to underline the complex relationship between caste and tribe. Although, in theory, these terms represent different ways of life and ideal types, in reality they stand for a continuum of social groups. In areas of substantial contact between tribes
and castes, social and cultural pressures have often tended to move tribes in the direction of becoming castes over a period of years. Tribal peoples with ambitions for social advancement in Indian society at large have tried to gain the classification of caste for their tribes; such efforts conform to the ancient Indian traditions of caste mobility. Where tribal leaders prospered, they could hire Brahman priests to construct credible pedigrees and thereby join reasonably high-status castes. On occasion, an entire tribe or part of a tribe joined a Hindu sect and thus entered the caste system en masse. If a specific tribe engaged in practices that Hindus deemed polluting, the tribe's status when it was assimilated into the caste hierarchy would be affected.

Since independence, however, the special benefits available to Scheduled Tribes have convinced many groups, even Hindus and Muslims, that they will enjoy greater advantages if so designated. The schedule gives tribal people incentives to maintain their identity. By the same token, the schedule also includes a number of groups whose "tribal" status, in cultural terms, is dubious at best; in various districts, the list includes Muslims and a congeries of Hindu castes whose main claim seems to be their ability to deliver votes to the party that arranges their listing among the Scheduled Tribes.

A number of traits have customarily been seen as establishing tribal rather than caste identity. These include language, social organization, religious affiliation, economic patterns, geographic location, and self-identification. Recognized tribes typically live in hilly regions somewhat remote from caste settlements; they generally speak a language recognized as tribal.
Unlike castes, which are part of a complex and interrelated local economic exchange system, tribes tend to form self-sufficient economic units. Often they practice swidden-farming clearing a field by slash-and-burn methods, planting it for a number of seasons, and then abandoning it for a lengthy fallow period-rather than the intensive farming typical of most of rural India. For most tribal people, land-use rights traditionally derive simply from tribal membership. Tribal society tends to be egalitarian, its leadership being based on ties of kinship and personality rather than on hereditary status. Tribes typically consist of segmentary lineages whose extended families provide the basis for social organization and control. Unlike caste religion, which recognizes the hegemony of Brahman priests, tribal religion recognizes no authority outside the tribe.

Any of these criteria can be called into question in specific instances. Language is not always an accurate indicator of tribal or caste status. Especially in regions of mixed population, many tribal groups have lost their mother tongues and simply speak local or regional languages. Linguistic assimilation is an ongoing process of considerable complexity. In the highlands of Orissa, for example, the Bondos, Munda tribes use their own tongue among themselves. Oriya, however, serves as a lingua franca in dealings with Hindu neighbors. Oriya as a prestige language (in the Bondo view), however, has also supplanted the native tongue as the language of ritual. In parts of Assam, historically divided into warring tribes and villages, increased contact among villagers began during the colonial period and has accelerated since independence. A pidgin Assamese developed while educated tribal members learned Hindi and, in the late twentieth century, English.
Self-identification and group loyalty are not unfailing markers of tribal identity either. In the case of stratified tribes, the loyalties of clan, kin, and family may well predominate over those of tribe. In addition, tribes cannot always be viewed as people living apart; the degree of isolation of various tribes has varied tremendously. The Gonds, Santals, and Bhils traditionally have dominated the regions in which they have lived. Moreover, tribal society is not always more egalitarian than the rest of the rural populace; some of the larger tribes, such as the Gonds, are highly stratified.

**ECONOMIC AND POLITICAL CONDITIONS**

Most Indian tribes are concentrated in heavily forested areas that combine inaccessibility with limited political or economic significance. Historically, the economy of most tribes was subsistence agriculture or hunting and gathering. Tribal members traded with outsiders for the few necessities they lacked, such as salt and iron. A few local Hindu craftsmen might provide such items as cooking utensils. The twentieth century, however, has seen far-reaching changes in the relationship between tribals in India and the larger society and, by extension, traditional tribal economies. Improved transportation and communications have brought ever deeper intrusions into tribal lands; merchants and a variety of Government policies have involved tribal peoples more thoroughly in the cash economy, although by no means on the most favorable of terms. Large areas fell into the hands of nontribals around 1900, when many regions were opened by the Government to homestead-style settlement. Immigrants received free land in return for cultivating it. Tribal people, too, could apply for land titles, although even title to the portion of land they happened to be planting that season
could not guarantee their ability to continue swidden cultivation. More important, the notion of permanent, individual ownership of land was foreign to most tribals. Land, if seen in terms of ownership at all, was viewed as a communal resource, free to whoever needed it. By the time tribals accepted the necessity of obtaining formal land titles, they had lost the opportunity to lay claim to lands that might rightfully have been considered theirs. Generally, tribals were severely disadvantaged in dealing with Government officials who granted land titles. Albeit belatedly, the colonial regime, realized the necessity of protecting tribals of India from the predations of outsiders and prohibited the sale of tribal lands. Although an important loophole in the form of land leases was left open, tribes made some gains in the mid twentieth century. Despite considerable obstruction by local police and land officials, who were slow to delineate tribal holdings and slower still to offer police protection, some land was returned to tribal peoples.

In the 1970s, the gains tribal peoples had made in earlier decades were eroded in many regions, especially in central India. Migration into tribal lands increased dramatically, and the deadly combination of constabulary and revenue officers uninterested in tribal welfare and sophisticated nontribals willing and able to bribe local officials was sufficient to deprive many tribals of their landholdings. The means of subverting protective legislation were legion: local officials could be persuaded to ignore land acquisition by nontribal people, alter land registry records, lease plots of land for short periods and then simply refuse to relinquish them, or induce tribal members to become indebted and attach their lands. Whatever the means, the result was that many tribal members became landless laborers in the 1960s and 1970s, and
regions that a few years earlier had been the exclusive domain of tribes had an increasingly heterogeneous population. Unlike previous eras in which tribal people were shunted into more remote forests, by the 1960s relatively little unoccupied land was available. Government efforts to evict nontribal members from illegal occupation have proceeded slowly; when evictions occur at all, those ejected are usually members of poor, lower castes. In a 1985 publication, anthropologist Christoph von Furer-Haimendorf describes this process in Andhra Pradesh: on average only 25 to 33 percent of the tribal families in such villages had managed to keep even a portion of their holdings. Outsiders had paid about 5 percent of the market value of the lands they took.

Improved communications, roads with motorized traffic, and more frequent Government intervention figured in the increased contact that tribal peoples had with outsiders. Tribes fared best where there was little to induce nontribals to settle; cash crops and commercial highways frequently signaled the dismemberment of the tribes. Merchants have long been a link to the outside world, but in the past they were generally petty traders, and the contact they had with tribal people was transient. By the 1960s and 1970s, the resident nontribal shopkeeper was a permanent feature of many villages. Shopkeepers often sold liquor on credit, enticing tribal members into debt and into mortgaging their land. In the past, tribes made up shortages before harvest by foraging from the surrounding forest. More recently shopkeepers have offered ready credit—with the proviso that loans be repaid in kind with 50 to 100 percent interest after harvest. Repaying one bag of millet with two bags has set up a cycle of indebtedness from which many have been unable to break loose.
The possibility of cultivators growing a profitable cash crop, such as cotton or castor-oil plants, continues to draw merchants into tribal areas. Nontribal traders frequently establish an extensive network of relatives and associates as shopkeepers to serve as agents in a number of villages. Cultivators who grow a cash crop often sell to the same merchants, who provide consumption credit throughout the year. The credit carries a high-interest price tag, whereas the tribal peoples' crops are bought at a fraction of the market rate. Cash crops offer a further disadvantage in that they decrease the supply of available foodstuffs and increase tribal dependence on economic forces beyond their control. This transformation has meant a decline in both the tribes' security and their standard of living.

In previous generations, families might have purchased silver jewelry as a form of security; contemporary tribal people are more likely to buy minor consumer goods. Whereas jewelry could serve as collateral in critical emergencies, current purchases simply increase indebtedness. In areas where gathering forest products are remunerative, merchants exchange their products for tribal labor. Indebtedness is so extensive that although such transactions are illegal, traders sometimes "sell" their debtors to other merchants, much like indentured servants.

In some instances, tribes have managed to hold their own in contacts with outsiders. Some Chenchus, a hunting and gathering tribe of the central hill regions of Andhra Pradesh, have continued to specialize in collecting forest products for sale. Caste Hindus living among them rent land from the Chenchus and pay a portion of the harvest. The Chenchus themselves have responded unenthusiastically to Government efforts to induce them to take up farming. Their relationship to nontribal people has
been one of symbiosis, although there were indications in the early 1980s that other groups were beginning to compete with the Chenchus in gathering forest products. A large paper mill was cutting bamboo in their territory in a manner that did not allow regeneration, and two groups had begun to collect for sale the same products the Chenchus sell. Dalits settled among them with the help of the Chenchus and learned agriculture from them. The nomadic Banjara herders who graze their cattle in the forest also have been allotted land there. The Chenchus have a certain advantage in dealing with caste Hindus; because of their long association with Hindu hermits and their refusal to eat beef, they are considered an unpolluted caste. Other tribes, particularly in South India, have cultural practices that are offensive to Hindus and, when they are assimilated, are often considered Dalits.

The final blow for some tribes has come when nontribals, through political jockeying, have managed to gain legal tribal status, that is, to be listed as a Scheduled Tribe. The Gonds of Andhra Pradesh effectively lost their only advantage in trying to protect their lands when the Banjaras, a group that had been settling in Gond territory, were classified as a Scheduled Tribe in 1977. Their newly acquired tribal status made the Banjaras eligible to acquire Gond land "legally" and to compete with Gonds for reserved political seats, places in education institutions, and other benefits. Because the Banjaras are not scheduled in neighboring Maharashtra, there has been an influx of Banjara emigrants from that state into Andhra Pradesh in search of better opportunities.

Tribes in the Himalayan foothills have not been as hard-pressed by the intrusions of nontribals. Historically, their political status was always distinct from the rest of India. Until the British colonial period, there was
little effective control by any of the empires centered in peninsular India; the region was populated by autonomous feuding tribes. The British, in efforts to protect the sensitive northeast frontier, followed a policy dubbed the "Inner Line"; nontribal people were allowed into the areas only with special permission. Post independence Governments have continued the policy, protecting the Himalayan tribes as part of the strategy to secure the border with China.

This policy has generally saved the northern tribes from the kind of exploitation that those elsewhere in South Asia have suffered. In Arunachal Pradesh (formerly part of the North-East Frontier Agency), for example, tribal members control commerce and most lower-level administrative posts. Government construction projects in the region have provided tribes with a significant source of cash—both for setting up businesses and for providing paying customers. Some tribes have made rapid progress through the education system. Instruction was begun in Assamese but was eventually changed to Hindi; by the early 1980s, English was taught at most levels. Both education and the increase in ready cash from Government spending have permitted tribal people a significant measure of social mobility. The role of early missionaries in providing education was also crucial in Assam.

Government policies on forest reserves have affected tribal peoples profoundly. Wherever the state has chosen to exploit forests, it has seriously undermined the tribes' way of life. Government efforts to reserve forests have precipitated armed (if futile) resistance on the part of the tribal peoples involved. Intensive exploitation of forests has often meant allowing outsiders to cut large areas of trees (while the original tribal inhabitants were restricted from cutting), and ultimately replacing
mixed forests capable of sustaining tribal life with single-product plantations. Where forests are reserved, nontribals have proved far more sophisticated than their forest counterparts at bribing the necessary local officials to secure effective (if extralegal) use of forestlands. The system of bribing local officials charged with enforcing the reserves is so well established that the rates of bribery are reasonably fixed (by the number of plows a farmer uses or the amount of grain harvested). Tribal people often end up doing unpaid work for Hindus simply because a caste Hindu, who has paid the requisite bribe, can at least ensure a tribal member that he or she will not be evicted from forestlands. The final irony, notes von Fiirer-Haimendorf, is that the swidden cultivation many tribes practiced had maintained South Asia's forests, whereas the intensive cultivating and commercial interests that replaced the tribal way of life have destroyed the forests.

Extending the system of primary education into tribal areas and reserving places for tribal children in middle and high schools and higher education institutions are central to Government policy, but efforts to improve a tribe's educational status have had mixed results. Recruitment of qualified teachers and determination of the appropriate language of instruction also remain troublesome. Commission after commission on the "language question" has called for instruction, at least at the primary level, in the students' native tongue. In some regions, tribal children entering school must begin by learning the official regional language, often one completely unrelated to their tribal tongue. The experiences of the Gonds of Andhra Pradesh provide an example. Primary schooling began there in the 1940s and 1950s. The Government selected a group of Gonds who had managed to become semiliterate in Telugu and taught
them the basics of written script. These individuals became teachers who taught in Gondi, and their efforts enjoyed a measure of success until the 1970s, when state policy demanded instruction in Telugu. The switch in the language of instruction both made the Gond teachers superfluous because they could not teach in Telugu and also presented the Government with the problem of finding reasonably qualified teachers willing to teach in outlying tribal schools.

The commitment of tribes to acquiring a formal education for their children varies considerably. Tribes differ in the extent to which they view education positively. Gonds and Pardhans two groups in the central hill region are a case in point. The Gonds are cultivators, and they frequently are reluctant to send their children to school, needing them, they say, to work in the fields. The Pardhans were traditionally bards and ritual specialists, and they have taken to education with enthusiasm. The effectiveness of educational policy likewise varies by region. In those parts of the northeast where tribes have generally been spared the wholesale onslaught of outsiders, schooling has helped tribal people to secure political and economic benefits. The education system there has provided a corps of highly trained tribal members in the professions and high-ranking administrative posts.

Many tribal schools are plagued by high dropout rates. Children attend for the first three to four years of primary school and gain a smattering of knowledge, only to lapse into illiteracy later. Few who enter continue up to the tenth grade; of those who do, few manage to finish high school. Therefore, very few are eligible to attend institutions of higher education, where the high rate of attrition continues.
A PRIMITIVE TRIBE

Almost allover India, 623 tribal groups (including sub-groups) preferably inhabit the remote hilly and plain forest regions (Sachchidananda and Prasad, 1996). According to the Census, 1991 the total tribes comprise 8.08 percent out of total population. Among these tribal groups, 74 tribes have been categorized as primitive tribes for their small size of community, pre-agricultural stage of economy, high extent of isolation, low level of literacy, etc. (in Fifth Five Year Plan). Saharia is one among seven primitive tribal groups in Madhya Pradesh. In central India, Saharia primitive tribal groups are acquainted as the very widespread 'Kolarian' tribe (Thakur and Thakur, 1994). The early history of origination of Saharia is not exactly clear till now. Etymological point of view expresses that ‘Saharia’ is the combination of two independent words like 'Sa' (companion) and Haria (tiger) which mean companion of tiger (Tiwari, 1984). Legends describe that once upon a time, 'Lord Shiva' blessed them to have access to the jungle as like as 'Sher' meaning tiger or lion and from there, they were named as ‘Saharia’. A lot of evidences in regarding Saharia are available in ‘Vedic’ literatures, ‘Puranas’, ‘Aranyakanda’ in Ramayana and ‘Shantipurva’ in Mahabgarat. Anthropological literatures support that Saharia are the ‘Kolarian’ tribe and they are totally depressed by successive wave of Hindu migrations. Later on in census report of 1981, these tribal groups have been identified as ‘Aboriginal’ and then categorized as primitive tribe in India.

Hamlet or ‘Phalaya’ is regarded as the first ecological unit in every dispersed Saharia village. To maintain their cultural homogeneity and save from extreme current of water especially in rainy season, they generally construct their rectangular type of huts on middle-top ground of
the hill. Most of the Saharia are depended on ecology which plays an important role in forming their economic structure (Mandai, 1998). The post economic history of these tribal groups implies that they traditionally practice shifting cultivation, hunting, gathering, pastroalism and adopt nomadic life (Prabhu, 1983). But now-a-days, most of them have become daily wage earner, instead of cultivation (Singh, 1994). Bread is considered as the staple food of Saharia. But sometimes, due to unavailability of wheat, they consume roots, tubers, leaves, etc. which are collected from their nearest forest. They are very much addicted to drink local wine. Still now, the aged persons use ‘Languta’ (small piece of cloth) as their traditional dress. Women wear ‘sharee’ (ladies Dhoti), Ghagra (Peticoat), Ordi (blouse), etc. Women are also very much interested to put on various ornaments. Plough, axe, spade, yoke, scythe, ladder, etc. are used as the implement for cultivation. Most of the Saharia inhabit in nuclear families; Saharia are strictly clan exogamous and tribal endogamous and also this study present the existence of 21 clans. Saharia generally practice negotiation, early age at marriage and monogamy form of marriage. Junior Sorrorate marriage is allowed whereas divorce and remarriage are rarely practiced among them. Traditionally, they conduct the child birth in a new hut and observe birth pollution during six days. After death, they cremate the dead body whereas in some cases, the dead bodies of old persons are buried. ‘Behram,’ Thakur, Bhumij, Nahar Singh, Ghaloiya, Sitla Devi, Sardamai, etc. Gods and Goddesses are worshiped by them for various purposes. ‘Saharia’ traditional political head and his subordinates not only maintain their cultural homogeneity but also punish the offenders in their society. Their modern political organization only conducts the development activities in the area.
Literacy rate of Saharia is very low (23.2 percent) whereas 28.2 percent and 17.7 percent are for male and female respectively (Biswas and Kapoor, 2003).

HEALTH BEHAVIOUR

Modern medical science is often accused for its pre-occupation with the study of disease, and neglect of the study of health. It has encouraged people to rely on drugs and tonics for the maintenance of health than teach them the rational ways of health. Our hospitals are indeed flooded with the sick, but there are no institutions which show people how to prevent disease and promote health. In fact, our ignorance about health continues to be profounded. There is no agreed definition of health; there are no yardsticks for measuring health.

Health is often taken for granted, and its value is not fully appreciated until it is lost. In the scale of values held by an individual, it cannot be said that health occupies an important place, it is usually subjugated to there needs defined as more important, "Health was forgotten" when the covenant of the League of Nations was drafted after the First World War. Only at the last moment, was world health brought in. health was again "forgotten" when the charter of the United Nations was drafted at the end of Second World War. The matter of health again had to be introduced adhoc at the United Nations Conference at San Francisco in 1945. During the past few decades there has been a reawakening that health is not merely a precious possession; but also a "resource" in which the whole community has a stake and which is desirable by maintain and promote. Truly, there is no agreed definition of human health, in fact, there have been many definitions the lay man,
"Health implies a sound mind in a sound body, in a sound family in a sound environment". The widely accepted definition of health is that given by the World Health Organization (1948) which state, "Health is a state of complete physical, mental and social well-being and not merely an absence of disease of infirmity".

The WHO definition projects three dimensions of health physical, mental and social - all closely related. Some more dimensions have also been suggested namely - spiritual, emotional vocational, educational, nutritional, philosophical, economical, cultural, preventive and curative. These symbolize a huge range of factors, which will people to lead a socio-economically productive life.

Health, a fundamental human right, is still not availed by backwards and scheduled caste communities throughout the country, often because their lower social and economic status increases their specific biological vulnerabilities. Such factor combine to affect scheduled caste families are in disadvantageous position in term of receiving education, improving their economy because of illiteracy and poverty. The reproductive role of women in scheduled cast families also imposes particular stresses and risks on women for much of their lives. Half-a-million women die each year. 90% of them in developing countries, from causes related to pregnancy and childbirth. Nearly all of these maternal deaths are preventable. If we want to give equitable specific health needs, we must integrate reproductive health services in to primary health care and make them easily available locally.

As scheduled caste families are on front line that should be provided care within the family and this is the key of human development and well-being. Their health, in its turn, has a strong impact
on the country production because families' health is the surest means of improving their health in general and economy in particular.

Any sustainable improvement in scheduled caste well-being is inseparable from improvements in their social and economic status. This will be achieved by giving scheduled caste more power over their lives, educating them and providing opportunity for them to earn more income. Scheduled caste families must be recognized as equal partners of society.

Education is crucial. Scheduled caste families who have access to education are better able to enhance not only their health but also the community health. The families of scheduled caste community are better informed on nutritional needs.

**SOCILOGY OF HEALTH**

As a result of new out look, concept of sociology is increasing being used in the study of disease processes. The social scientists who until recently, were pre-occupied with study of human society, structure and functions are now stepping into the field of health and health behaviour of people, which offer them a rich field for investigation. To sum-up, the courtship of medicines and social sciences have begun with honorable intention on both sides.

Medicines and social sciences are concerned in their own special way with human behaviour. Specialists in community health, clinical medicine, and epidemiology are all seeking the co-operation and help of social scientists in understanding problems such as the social components of health and diseases, illness behaviour of people, efficient use of medical care and the close study of medical institutes.
All people, whether rural or urban have their own beliefs and practices concerning to health and disease. It is now widely recognized that cultural factor are deeply involved in all the affairs of man, including health and sickness. Not all customs and beliefs are bad; some are based on culture of trial and error and have positive values, while others may be useless or positively harmful. Some of this way of implementing health programme. Where a change of behaviour was involved, the resistance of the people was maximum in accepting new programmes. Information about these factors, which is customs, cultural mores, habits, beliefs and superstitions are still wooing fully lacking. A brief account of cultural factors relating to health and sickness is given below.

Sociology of health includes a complex interplay of factor and conditions - cultural values, custom, habits, beliefs, attitudes, morals, religion, education, occupation, standard of living, community life, availability of health services, social and political organizations. Man is exposed to the social environment through various means such as songs and stores of literature, arts, press, radio and television.

Indeed it's very largely a product of his social and cultural environment which he shapes and is shaped by it. In addition to his broad aspect of social environment man is in constant interaction with that part of social group and number of family, of a caste, of a community and a nation. Between the individual and other members of the group, there can be harmony or disharmony, interest and point of view that are shaped or that are in conflict. The behaviour of one individual can affect other more or less directly, conflict and tension between the individual and the group as a whole or between individual.
Many medico-social research workers point out that prevention of major chronic, degenerative diseases depend more upon changing man's way of life, e.g. his psycho-social environment. In fact, man today is viewed as the 'agent' of his own disease, his state of health determined more by what he does to himself. For example, the medical cause of lung cancer may be chemical substance in cigarettes, but the psychological cause in a behaviour - smoking. Similarly, medical illness and a whole host of psychosomatic ailments can be attributed to man's attitudes and behaviour.

From the psycho-social point of view, disease may be viewed as a result of failure to perceive and interpret a health danger combined with failure to react appropriately and effectively. Disease viewed as "Maladjustment of human organism to his physical or social environment represents a mal adjustment resulting from misconception, misinterpretations and misbehavior".

It is obvious that social environment plays a very important role in the causation of health and disease. "A harmonious adjustment to the social environment enables man to enjoy and happiness, whereas maladjustment may not cause illness but may also deprive him to taking adequate action against".

There is an increasing recognition that successful application of medicine to individuals and groups does involve 'more than scientific or biological knowledge, it involves an understanding of the behaviour of individual and groups who live together and also share certain values of life. Man is no longer viewed as merely biological animal but also a social animal. The patient is no longer considered as one who is under strict laboratory control, but an individual with personal idiosyncrasies,
erratic habits, customs and beliefs reaching upon his body and mind. Even a person with a broken leg may present complex social and personal factors which may influence his recovery.

Thus there has been a shift from the earlier concept of visualizing disease in terms of specific germ or disease in a certain organ of the human body, to the involvement of "multi-factor" in the occurrence of disease.

A brief sketch of current interest of these disciplines of social sciences is given below. Community health workers are often faced with the people of why people, who need a particular service, are least likely to use it or fail to secure the total benefit, which is expected. A case in point is vaccination against six killer diseases of child for the last 20 year; yet vaccination against tuberculosis, tetanus, diphtheria, pertussis, polio and measles has been joined universal acceptance. The family planning in India is a recent example of the health services of which people are not making use of the extent desired. Similarly, Health programmes relating to mother and child health, immunization, improvement of water supply, installation of sanitary latrines, improvement of dietary patterns and infant rearing practices have all proved abortive or only partially successful.

The resistance of the people is felt not only in the field of community health, but in fast even in the fields designed to improve their general standard of living. The central question in community health has become: why people behave as they do? This is basic problem which the social scientists are studying in India and are asked to explain this failure of health measures. In Western countries, social scientists are working on problem of mental health, hospital organization, and social class
differences in disease rehabilitation and professional role and relationship. In industries, the social scientists are invited to look into the relationship between members of the team who are concerned with doing a job in order to improve the overall performance of the work team. In short, the social scientists are stepping in increasing numbers in to the field of community health. The theme common to community health and social sciences is human behaviour. Many community problems in essence are social problems and vice-versa.

It has become apparent that control of these diseases involves not merely medical care but basic changes in the behaviour and the habit of the patient which is a field of specialization of social scientists. The social scientists are asked to investigate the life situations of the patients with a view to discover linkage between specific life situations and specific type and cases of illness.

The clinicians have also show interest in what is know as illness behaviour of patients i.e. why different people react in different ways to the some disease process or regimen of treatment. It is not known why some people (whether by reason of education, religion, social class difference or occupational status) make light of symptoms and some respond in an exaggerated manner, to the slightest pain or discomfort. This is an important area of medical sociology. The doctor patient relationship, patient care, management, hospital organization, collusion of medical treatment and cultural practices are all current interest of medical sociology.

Criticism is often varied that the present medical sciences (e.g. anatomy, physiology, microbiology, pathology) are insufficient to train the physicians to cope with the socio-cultural aspects of medicine. It is
recognized that the physician needs two kind of knowledge, so that he could more effectively serve the patient and the community. Hence the current interest of medical men in social sciences is well based.

Epidemiologists have also forced to have close attention with social scientists in studying the distribution of health and disease in human population, and of factors that cause the distribution. Disease is studied in relationship of such factors a social status, income, occupation, housing, over-crowding, social custom, habit and behaviour.

DETERMINANTS OF HEALTH

Health is multifactor. The factors which influence health lie both within the individual and externally in the society in which he or she lives. It is a truism to say that what man is and to what diseases he may fall victim depends on a combination of two sets of factors - his genetic factors and the environmental factors to which he is exposed. These factors interact and these interactions may be health-promoting or deleterious. Thus, conceptionally, the health of individuals and whole communities may be considered to be the result of many interactions. Only a brief indication of the more important determinants or variables can be given here; they are:

1. Heredity

The physical and mental traits of every human being are to some extent determined by the nature of his genes at the moment of conception. The genetic make-up is unique in that it cannot be altered after conception. A number of diseases are now known to be of genetic origin, e.g., chromosomal anomalies, errors of metabolism, mental retardation, some types of diabetes, etc. The state of health therefore depends partly on the genetic constitution of man.
Thus, from the genetic stand-point, health may be defined as that "state of the individual which is based upon the absence from the genetic constitution of such genes as correspond to characters that take the form of serious defect and derangement and to the absence of any aberration in respect of the total amount of chromosome material in the karyotype or stated in positive terms, from the presence in the genetic constitution of the genes that correspond to the normal characterization and to the presence of a normal karyotype".

The "positive health" advocated by WHO implies that a person should be able to express as completely as possible the potentialities of his genetic heritage. This is possible only when the person is allowed to live in healthy relationship with his environment - an environment that transforms genetic potentialities into phenotypic realities.

2. Environment

It was Hippocrates who first related disease to environment, e.g., climate, water, air, etc. Centuries later, Pettenkofer in Germany revived the concept of disease-environment association.

Environment is classified as "internal" and "external". The internal environment of man pertains to "each and every component part, every tissue, organ and organ-system and their harmonious functioning within the system". Internal environment is the domain of internal medicine. The external or macro-environment consists of those things to which man is exposed after conception. It is defined as "all that which is external to the individual human host". (30). It can be divided into physical, biological and psychosocial components,
any or all of which can affect the health of man and his susceptibility to illness. Some epidemiologists have used the term "microenvironment" (or domestic environment) to personal environment which includes the individual's way of living and lifestyle, e.g., eating habits, other personal habits (e.g., smoking or drinking), use of drugs, etc. It is also customary to speak about occupational environment, socioeconomic environment and moral environment.

It is an established fact that environment has a direct impact on the physical, mental and social well-being of those living in it. The environmental factors range from housing, water supply, psychosocial stress and family structure through social and economic support. Systems, to the organization of health and social welfare services in the community.

The environmental components (physical, biological and psychological) are not water-tight compartments. They are so inextricably linked with one another that it is realistic and fruitful to view the human environment in to when we consider the influence of environment on the health status of the population. If the environment is favourable to the individual, he can make full use of his physical and mental capabilities. Protection and promotion of family and environmental health is one of the major issues in the world today.

3. Lifestyle

The term "lifestyle" is rather a diffuse concept often used to denote "the way people live", reflecting a whole range of social values, attitudes and activities. It is composed of cultural and
behavioural patterns and lifelong personal habits (e.g., smoking, alcoholism) that have developed through processes of socialization. Lifestyles are learnt through social interaction with parents, peer groups, friends and siblings and through school and mass media.

Health requires the promotion of healthy lifestyle. In the last 20 years, a considerable body of evidence has accumulated which indicates that there is an association between health and lifestyle of individuals. Many current-day health problems especially in the developed countries (e.g., coronary heart disease, obesity, lung cancer, drug addiction) are associated with lifestyle changes. In developing countries such as India where traditional lifestyles still persist, risks of illness and death are connected with lack of sanitation, poor nutrition, personal hygiene, elementary human habits, customs and cultural patterns.

It may be noted that not all lifestyle factors are harmful. There are any that can actually promote health. Examples include adequate nutrition, enough sleep, sufficient physical activity, etc. In short, the achievement of optimum health demands adoption of healthy lifestyles. Health is both a consequence of an individual's lifestyle and actor in determining it.

4. Socio-economic conditions

Socioeconomic conditions have long been known to influence man health. For the majority of the world's people, health status is ermined primarily by their level of socioeconomic development, per capita GNP, education, nutrition, employment, housing, the cat system of the country, etc. Those of major importance are:
(i) **Economic status:** The per capita GNP is the most widely accepted measure of general economic performance. There can be doubt that in many developing countries, it is the economic progress that has been the major factor in reducing morbidity, easing life expectancy and improving the quality of life. Economic status determines the purchasing power, standard of living quality of life, family size and the pattern of disease and deviant behaviour in the community. It is also an important factor in seeking care. Ironically, affluence may also be a contributory cause of s as exemplified by the high rates of coronary heart disease, diabetes and obesity in the upper socioeconomic groups.

(ii) **Education:** A second major factor influencing health status is an especially female education). The world map of illiteracy closely coincides with the maps of poverty, malnutrition, ill health, high infant and child mortality rates. Studies indicate that education, to some extent, compensates the effects of poverty on health, irrespective of the availability of health facilities. The small state of Kerala in India is a striking example. Kerala has an estimated infant mortality rate of 17 compared to 80 for all-India in 1990. A major factor in the low infant mortality of Kerala is its highest female literacy rate of 86.93 per cent compared to 39.42 per cent for all-India.

(iii) **Occupation:** The very state of being employed in productive work promotes health, because the unemployed usually show a higher incidence of ill health and death. For many, loss of work may mean loss of income, and status. It can cause psychological and social damage.
(iv) Political system: Health is also related to the country's political system. Often the main obstacles to the implementation of health technologies are not technical, but rather political. Decisions concerning resource allocation, manpower policy, choice of technology and the degree to which health services are made available and accessible to different segments of the society are examples of the manner in which the political system can shape community health services (35). The percentage of GNP spent on health is a quantitative indicator of political commitment. Available information shows that India spends about 3 per cent of its GNP on health and family welfare (36). To achieve the goal of health for all, WHO has set the target of at least 5 per cent expenditure on each country's GNP on health care? What is needed is political commitment and leadership which is oriented towards social development, and not merely economic development. If poor health patterns are to be changed, then changes must be made in the entire sociopolitical system in any given community. Social, economic and political actions are required to eliminate health hazards in people's working and living environments.

5. Health Services

The term health and family welfare services cover a wide spectrum of personal and community services for treatment of disease, prevention of illness and promotion of health. The purpose of health services is to improve the health status of population. For example, immunization of children can influence the incidence/prevalence of particular diseases. Provision of safe water
can prevent mortality and morbidity from water-borne diseases. The care of pregnant women and children would contribute to the reduction of maternal and child morbidity and mortality. To be effective, the health services must reach the social periphery, equitably distributed, accessible at a cost the country and community can afford and socially acceptable. All these are ingredients of what is now termed "primary health care", which is seen as the way to better health.

Health services can also be seen as essential for social and economic development. It is well to remind ourselves that "health care does not produce good health". Whereas, there is a strong correlation between GNP and expectation of life at birth, there is no significant correlation between medical density and expectation of life at birth. The most we can expect from an effective health service is good care. The epidemiological perspective emphasizes that health services, no matter how technically elegant or cost-effective, are ultimately pertinent only if they improve health.

6. Other factors

Other contributions to the health of populations derive from systems outside the formal health care system, i.e., health related systems (e.g., food and agriculture, education, industry, social welfare, rural development) as well as adoption of policies in the economic and social fields that would assist in raising the standards of living. This would include employment opportunities, increased wages, prepaid medical programmes and family support systems.
In short, medicine is not the sole contributor to the health and wellbeing of populations. The potential of intersectoral contributions to the health of communities is increasingly recognized.

**NATIONAL HEALTH POLICY-2002**

Policies are general statements based on human aspirations, set of values, commitments, assessment of current situation and an image of a desired future situation (55). A national health policy is an expression of goals for improving the health situation, the priorities among these goals, and the main directions for attaining them (84). Health policy is often defined at the national level.

Each country will have to develop a health policy of its own aimed at defined goals, for improving the people's health, in the light of its own problems, particular circumstances, social and economic structures, and political and administrative mechanisms. Among the crucial factors affecting realization of these goals are: a political commitment; financial implications; administrative reforms; community participation' and basic legislation.

A recent landmark in the development of health policy was' the world-wide adoption of the goal of HFA by 2000 AD. A further landmark was the Alma-Ata Declaration (1978) calling on all Governments to develop and implement primary health care strategies to attain the target of HFA by 2000 AD. The Ministry of Health and Family Welfare, Govt. of India, evolved a National Health Policy in 1983 keeping in view the national commitment to attain the goal of Health for All by the year 2000. Since then there has been significant changes in the determinant factors relating to the health sector, necessitating revision of the policy, and a new National Health Policy-2002 was evolved.
The main objective of this policy is to achieve an acceptable standard of good health amongst the general population of the country. The approach would be to increase access to decentralized public health system by establishing new infrastructure in the existing institutions. Over-riding importance would be given to ensure a more equitable access to health services across the social and geographical expanse of the country. Primacy will be given to preventive and first line curative initiatives at the primary health level. The policy is focused on those diseases, which are principally contributing to disease burden such as tuberculosis, malaria, blindness and HIV/AIDS. Emphasis will be laid on rational use of drugs within the allopathic system. To translate the above objectives into reality, the Health Policy has laid down specific goals to be achieved by year 2005, 2007, 2010 and 2015.

Health services research

Health research has several ramifications. It may include (a) Biomedical research, to elucidate outstanding health problems and develop new or better ways of dealing with them; (b) Intersectoral research, for which relationships would have to be established with the institutions concerned with the other sectors, and (c) Health services research or health practice research (now called "health systems research")

The concept of health services research (HSR) was developed during 1981-1982. It has been defined as "the systematic study of the means by which biomedical and other relevant knowledge is brought to bear on the health of individuals and communities under a given set of conditions. HSR is wide in scope. It deals with all aspects of management" of health services, viz. prioritization of health problems, planning,
management, logistics and delivery of health care services. It deals with such topics as manpower, organization, the utilization of facilities, the quality of health care, cost-benefit and cost-effectiveness:

Thousands of people suffer morbidity, mortality and disability not because of deficiencies in biomedical knowledge but as a result of the failure to apply this knowledge effectively. Health services research arms to correct this failure.

The concept of HSR is holistic and multidisciplinary. The prime purpose of HSR is to improve the health of the people through improvement not only of conventional health services but also of other services that have a bearing on health. HSR is essential for the continuous evolution and refinement of health services

**HEALTH PLANNING IN INDIA**

Health planning in India is an integral part of national Socio-economic planning (2, 13). The guidelines for national health planning were provided by a number of committees dating back to the Bshore committee in 1946. These committees were appointed by the Government of India from time to time to review the existing health situation and recommend measures for further action. A brief review of the recommendations of these committees, which are important landmarks in the history of public health in India, is given below. The Alma Ata Declaration on primary health care and the National Health Policy of the Government gave a new direction to health planning in India, making primary health care the central function and main focus of its national health system. The goal of national health planning in India was to attain Health for All by the year 2000.
1. Bhore Committee, 1946:

The Government of India in 1943 appointed the Health Survey and Development Committee with Sir Joseph Bhore as Chairman, to survey the then existing position regarding the health conditions and health organization in the country, and to make recommendations for the future development. The Committee which had among its members some of the pioneers of public health, met regularly for 2 years and submitted in 1946 its famous report which runs into 4 volumes. The Committee put forward, for the first time, comprehensive proposals for the development of a national programme of health services for the country. The Committee observed: "if the nation's health is to be built, the health programme should be developed on a foundation of preventive health work and that such activities should proceed side by side with those concerned with the treatment of patients". Some of the important recommendations of the Bhore Committee were:

- Integration of preventive and curative services at all administrative levels;

- The Committee visualised the development of primary health centers in 2 stages: (a) as a short-term measure, it was proposed that each primary health centre in the rural areas should cater to a population of 40,000 with a secondary health centre to serve as a supervisory, coordinating and referral institution. For each PHC, two medical officers, 4 public health nurses, one nurse, 4 midwives, 4 trained dais, 2 sanitary inspectors, 2 health assistants, one pharmacist, and 15 other class IV employees were recommended (b) a long-term programme (also called the 3
million plan) of setting up primary health units with 75-bedded hospitals for each 10,000 to 20,000 population and secondary units with 650-bedded hospitals, again regionalized around district hospitals with 2,500 beds; and

- Major changes in medical education which includes 3 months training in preventive and social medicine to prepare "social physicians".

Although the Bshore Committee's recommendations did not form part of a comprehensive plan for national socio-economic development, the Committee's Report continues to be a major national document, and has provided guidelines for national health planning in India.

2. Mudaliar committee, 1962:

By the close of the Second Five Year Plan (1956-61), a fresh look at the health needs and resources was called for to provide guidelines for national health planning in the context of the Five year Plans. In 1959, the Government of India appointed another Committee known as "Health Survey and Planning Committee", popularly known as the Mudaliar Committee (after the name of its Chairman, Dr. A.L. Mudaliar) to survey the progress made in the field of health since submission of the Shore Committee's Report and to make recommendations for future development and expansion of health services.

The Mudaliar Committee found the quality of services provided by the primary health centres inadequate, and advised strengthening of the existing primary health centres before new centres were established. It also advised strengthening of sub divisional and district hospitals so that they may effectively function as referral centres.
The main recommendations of the Mudaliar Committee were:

1. Consolidation of advances made in the first two five year plans;
2. Strengthening of the district hospital with specialist services to serve as central base of regional services;
3. Regional organizations in each state between the headquarters organization and the district in charge of a Regional Deputy or Assistant Directors - each to supervise 2 or 3 district medical and health officers;
4. Each primary health centre not to serve more than 40,000 population;
5. To improve the quality of health care provided by the primary health centres;
6. Integration of medical and health services as recommended by the Bhore Committee; and
7. Constitution of an All India Health Service on the pattern of Indian Administrative Service.

3. Chadah committee, 1963:

In 1963, a Committee was appointed by the Government of India, under the Chairmanship of Dr. M.S. Chadah, the then Director General of health Services to study the arrangements necessary for the maintenance phase of the National Malaria Eradication Programme.

The Committee recommended that the "vigilance" operations in respect of the National Malaria Eradication Programme should be the responsibility of the general health services, i.e., primary health centers at the block level. The Committee also recommended that the vigilance operations through monthly home visits should be implemented through basic health workers. One basic health worker per 10,000 populations was recommended. These workers were envisaged as "multipurpose" workers to look after additional duties of collection of vital statistics and family planning, in addition to malaria vigilance. The Family Planning Health Assistants were to supervise 3 or 4 of these basic health workers.
At the district level, the general health services were to take the responsibility for the maintenance phase.

4. Mukherji committee, 1965:

Within a couple of years of implementation of the Chadah Committee's recommendations by some states) it was realized that the basic health workers could not function effectively as multipurpose workers. As a result the malaria vigilance operations had suffered and also the work of the family planning programme could not be carried out satisfactorily. This subject came up for discussion at a meeting of the Central Health Council in 1965. A committee known as "Mukerji Committee) 1965" under the Chairmanship of Shri Mukerji, the then Secretary of Health to the Government of India) was appointed to review the strategy for the family planning programme. The Committee recommended separate staff for the family planning programme. The family planning assistants were to undertake family planning duties only. The basic health workers were to be utilized for purposes other than family planning. The Committee also recommended to delink the malaria activities from family planning so that the latter would receive undivided attention of its staff. The recommendations were accepted by the Government of India.

5. Mukherji committee, 1966:

As the states were finding it difficult to take over the whole burden of the maintenance phase of malaria and other mass programmes like family planning, smallpox, leprosy, trachoma, etc. due to paucity of funds, the matter came up for discussion at a meeting of the Central Council of Health held in Bangalore in 1966. The Council recommended
that these and related questions may be examined by a committee of Health Secretaries, under the Chairmanship of the Union Health Secretary, Shri Mukherji. The Committee worked out the details of the BASIC HEALTH SERVICE which should be provided at the block level, and some consequential strengthening required at higher level of administration.

6. Jungalwalla committee, 1967:

The Central Council of Health at its meeting held in Srinagar in 1964, taking note of the importance and urgency of integration of health services, and elimination of private practice by Government doctors, appointed a Committee known as the "Committee on Integration of Health Services" under the Chairmanship of Dr. N. Jungalwalla, Director, National Institute of Health Administration and Education, New Delhi to examine the various problems including those of service conditions and submit a report to the Central Government in the light of these considerations. The report was submitted in 1967.

The Committee defined "integrated health services" as: (i) a service with a unified approach for all problems instead of a segmented approach for different problems; and (ii) medical care of the sick and conventional public health programmes functioning under a single administrator and operating in unified manner at all levels of hierarchy with due priority for each programme obtaining at a point of time.

The Committee recommended integration from the highest to the lowest level in the services, organization and personnel. The main steps recommended towards integration were: (a) unified cadre (b) common seniority (c) recognition of extra qualifications (d) equal pay for equal
work (e) special pay for specialized work (f) no private practice, and good service conditions. The Committee while giving sufficient indication for action to be taken was careful neither to spell out steps and programmes nor to indicate an uniform integrated setup but left the matter to the States to work out the set-up based on the experience of West Bengal, Punjab and Defense Forces. The Committee stated that "integration should be a process of logical evolution rather than revolution".

7. Kartar Singh committee 1973:

The Government of India constituted a Committee in 1972 known as "The Committee on Multipurpose Workers under Health and Family Planning" under the Chairmanship of Kartar Singh, (Additional Secretary, Ministry of Health and Family Planning, Government of India). The terms of reference of the Committee were to study and make recommendation on: (a) the structure for integrated services at the peripheral and supervisory levels; (b) the feasibility of having multipurpose, bipurpose workers in the field: (c) the training requirements for such workers; and (d) the utilization of mobile service units set up under family planning programme for integrated medical, public health and family planning services operating in the field.

The Committee submitted its report in September 1973. Its main recommendations were: (a) That the present Auxiliary Nurse Midwives to be replaced by the newly designated "Female Health Workers", and the present-day Basic Health Workers, Malaria Surveillance Workers, Vaccinators, Health Education Assistants (Trachoma) and the Family Planning Health Assistants to be replaced by "Male Health Workers". (b) The Programme for having multipurpose workers to be first introduced in
areas where malaria is in maintenance phase and smallpox has been controlled, and later to other areas as malaria passes into maintenance phase or smallpox controlled. (c) For proper coverage, there should be one primary health centre for a population of 50,090; (d) Each primary health centre should be divided into 16 sub-centers each having a population of about 3,000 to 3,500 depending upon topography and means of communications; (e) Each sub-centre to be staffed by a team of one male and one female health worker. There should be a male health supervisor to supervise the work of 3 to 4 male health workers; and a female health supervisor to supervise the work of 4 female health workers (g) The present-day lady. The Govt. of India (1973): Report of the committee on multipurpose workers under health and F.P. programme Dept. of F.P., Ministry of Health & F. P. New Delhi. Health visitors to be designated as female health supervisors and (h) the doctor in charge of a primary health centre should have the overall charge of all the supervisors and health workers in his area. The recommendations of the Kartar Singh Committee were accepted by the Government of India to be implemented in a phased manner during the Fifth Five year Plan.

8. Shrivastav committee, 1975:

The Government of India in the Ministry of Health and Family Planning had in November 1974 set up a 'Group on Medical Education and Support Manpower' popularly known as the Shrivastav Committee: (1) to devise a suitable curriculum for training a cadre of health assistants so that they can serve as a link between the qualified medical practitioners and the multipurpose workers, thus forming an effective team to deliver health care, family welfare and nutritional services to the people; (2) to suggest steps for improving the existing
medical educational processes as to provide due emphasis on the problems particularly relevant to national requirements, and (3) to make any other suggestions to realize the above objectives and matters incidental thereto.

The Group submitted its report in April 1975. It recommended immediate action for: (1) creation of bands of para-professional and semi-professional health workers from within the community itself (e.g., school teachers, postmasters, gram sevaks) to provide simple, promotive, preventive and curative health services needed by the community; (2) establishment of 2 cadres of health workers, namely - multipurpose health workers and health assistants between the community level workers and doctors at the PHC; (3) development of a 'Referral Services Complex' by establishing proper linkages between the PHC and higher level referral and service centers, VIZ taluka /Tehsil, district, regional and medical college hospitals, and (4) establishment of a Medical and Health Education Commission for planning and implementing the reforms needed in health and medical education on the lines of the University Grants Commission.

The committee felt that by the end of the sixth Plan, one male and one female health worker should be available for every 5,000 population. Also, there should be one male and female health assistant for 2 male and 2 female health workers respectively.

9. Rural Health Scheme, 1977:

The most important recommendation of the Shrivastava Committee was that primary health care should be provided within the community itself through specially trained workers so that the health of
the people is placed in the hands of the people themselves.

The basic recommendations of the Committee were accepted by the Government in 1977, which led to the launching of the Rural Health Scheme. The programme of training of community health workers was initiated during 1977-78. Steps were also initiated (a) for involvement of medical colleges in the total health care of selected PHCs with the objective of reorienting medical education to the needs of rural people; and (b) reorientation training of multipurpose workers engaged in the control of various communicable disease programmes into unipurpose workers. This "Plan of Action" was adopted by the Joint Meeting of the Central Council of Health and Central Family Planning Council held in New Delhi in April 1976.


A working group on Health was constituted by the Planning Commission in 1980 with the Secretary, Ministry of Health and Family Welfare, as its Chairman, to identify, in programme terms, the goal for Health for All by 2000 AD and to outline with that perspective, the specific programmes for the sixth Five Year Plan.

The Working Group, besides identifying and setting out the broad approach to health planning during the sixth Five Year Plan, had also evolved fairly specific indices and targets to be achieved in the country by 2000 AD.

7. HEALTH SECTOR PLANNING

The Government of India set up a Planning Commission in 1950 to make an assessment of the material, capital and human resources of
the country, and to draft developmental plans for the most effective utilization of these resources. In 1957, the Planning Commission was provided with a Perspective Planning Division which makes projections into the future over a period of 20 to 25 years. The Planning Commission consists of a Chairman, Deputy Chairman and 5 members. The Planning Commission works through 3 major divisions - Programme Advisers, General Secretariat and Technical Divisions which are responsible for scrutinizing and analyzing various schemes and projects to be incorporated in the Five Year Plans. Over the years, the Planning Commission has been formulating successive Five Year Plans. By its terms of reference, the Planning Commission also reviews from time to time the progress made in various directions and to make recommendations to Government on problems and policies relevant to the pursuit of rapid and balanced economic development. The planning process was decentralized towards Decentralized District Planning by the year 2000.

Since "Health" is an important contributory factor in the utilization of manpower, the Planning Commission gave considerable importance to health programmes in the Five Year Plans. For purposes of planning, the health sector has been divided into the following sub-sectors. (1) Water supply and sanitation (2) Control of communicable diseases (3) Medical education, training and research (4) Medical care including hospitals, dispensaries and primary health centers (5) Public health services (6) Family planning; and (7) Indigenous systems of medicine.

All the above sub-sectors have received due consideration in the Five Year Plans. However, the emphasis has changed from Plan to Plan depending upon the felt-needs of the people and technical considerations.
To give effect to a better coordination between the Centre and State Governments, a Bureau of Planning was constituted in 1965 in the Ministry of Health, Gout, of India. The main function of this Bureau is compilation of National Health Five Year Plans. The Health Plan is implemented at various levels, e.g., Centre, State, District, Block and Village.

**BUDGET FOR HEALTH IN FIVE YEAR PLANS**

Shrivastav, J.B. (1972-99): "Since health is an important contributory factor in the utilisation of manpower, the planning commission gave considerable importance to health programmes in five year plans. For purpose of planning, the health sector has been divided into the sub sector". (1) water supply and sanitation, (2) control of communicable diseases, (3) Medical education, training and research, (4) medical care including hospital, dispensaries and primary health centre, (5) public health services, (6) family planning and (7) indigenous system of medicine.

The entire above sector have received consideration in five year plan. However emphasis has changed from plan depending upon the feel needs of people and technical considerations. To give effect the better coordination between the central and state Governments, a bureau of planning was constituted in 1965 in the ministry of health Government of India. The main function of this bureau is compilation of National Health Five Plans. The health plan is implemented at various levels, e.g. Centre, State, District, Block and Village.

Dhir, S.L. (1972-186) and Government of India (1987): the five year plans were conceived to rebuild rural India, to lay the foundation of
industrial programmes and to secure the balance development of all parts of the country. Recognizing health an uplifting of the economic condition of the country, the planning commission gave considerable importance to health programmes in the five year plans.

**First five year plans (1951-56):**

The first five year plan relates to the period 1951-56, the public sector outlay was Rs.2,356 crores to which Rs. 140 crores (5.9%) expenditure, however amounted to Rs. 1960 crores and Rs.1 0 1 crores respectively.

**Second five year plan (1956-61):**

The second five year plan was continuation of development efforts commenced in the first plan. The public sector outlay was Rs. 4800 crores of which Rs. 255 crores were allotted for health programmes. The actual expenditure, however, amounted to Rs. 4672 crores and 216 crores respectively.

**Third Five Year Plan (1961-66):**

The public sector outlay was Rs. 7500 crores of which Rs. 341.80 crores were allotted for health programmes. The actual expenditure, however, amounted to Rs. 8,577 crores and Rs. 357 crores respectively. While continuing the programmes initiated during first two plans, greater emphasis was placed on preventive public health services and on the eradication and control of communicable disease.

**Fourth five year plan (1969-74):**

The revised estimate of public sector outlay was Rs. 16,774 crores of which Rs. 1156 crores (7.2%) were allotted for health. During the
fourth plan, efforts were made to strengthen the primary health centre. Besides, high priority was given to the control of malaria, tuberculosis, leprosy, trachoma, eradication of small pox and family planning.

**Fifth year plan (1974-79):**

The fifth plan was launched on April, 1974 with an outlay of Rs. 37,500 crores in the public sector. The primary objective during the fifth plan is to provide minimum public health services integrated with family planning; nutrition and immunization of children as "package programme" under the minimum need programme.

**Sixth five year plan (1980-85):**

Six five year plan was launched with an outlay Rs. 97,500 crores, of which Rs. 1821.05 crores were for health, Rs. 1010 crores for family planning and Rs. 3022.02 crores for water supply and sanitation.

**Seventh five year plan (1985-90):**

Seventh five year plan was started with an outlay of Rs.180,000 crores in which Rs. 3,392 crores for health, Rs. 3,256 crores for family welfare and Rs. 6,522.47 crores for water supply and sanitation. The objective of the seventh plan have been formulated as part of the longer term strategy which seek by the year 2000 to virtually eliminate poverty and illiteracy, achieve near full employment, secure satisfaction of the basic needs of food, clothing and shelter and provide health for all.

Against the above background, the current objective of the state and National Health Plans is to continue the organization of the health services infrastructure already begun in the sixth five year plan (1980-85) and strive towards the goal of health for all by the year 2000 through the provision of universal primary health care to all section of society.
By the end of the seventh five year plan, it is (as lay down in health policy) that the infrastructure for primary health care as required on present population norms would be fully operated with regards to Village Health Guide (V.H.G.), Primary Health Centre (P.H.C.) and Sub centre (S.C.) and multipurpose health worker (M.P.H.W.). Programme for the control of communicable diseases of health services research and the health education will be strengthened, the plan universal immunization of expectant mother and all eligible children by the year 1990. The family welfare programme will be implemented with greater so as to achieve couple protection rate of 42% by the end of the 7th plan period with increased emphasis on female education and M.C.H. services.

Eight- five year plan (1992-97):

The objectives of eight five year plan have been formulated as part of the long term strategy, which seeks by the 2000, to virtually eliminate poverty and illiteracy, achieve near full employment, secure satisfaction of the basic needs of food, clothing and shelter, and provide health for all.

Against the above back ground, the current objective of the state and National Health Plans is to continue the reorganization of the health services infrastructure, already begun in the 9th plan and strive towards the goal of health for all by 2000 A.D. through pro of universal primary health care to all section of society.

By the end of plan, it is envisaged as lay down in health policy that the infrastructure for primary health care as require on present population norms in keeping with the objectives of international drinking
adequate drinking water facilities for the inter population both in urban and rural areas, and sanitation facilities for 80% of the urban population and 25% of the rural areas.

The total public sector plan outlay of Rs. 79,8000 crores represents a public investment. Out of this national cake, nearly Rs. 7575.92 crores are earmarked for health, Rs. 6500 crores for family welfare programme the target to be achieved are laid down in the National health policy.

**Ninth Five Year Plan (1997-2002):**

The Ninth Five Year Plan is unique in a way that although the plan commenced from 1st April 1997, the formal 9th plan document finally received all the necessary clearance and was adopted only on 19th February 1999.

Today India has a vast network of Governmental, voluntary and private health infrastructure manned by large number of medical and paramedical persons. During the Ninth Plan, efforts will be further intensified to improve the health status of the population by optimizing coverage and quality of care by identifying and rectifying the critical gaps in infrastructure, manpower, equipment, essential diagnostic, reagents and drugs.

The approach during the Ninth Plan will be to improve access to, and enhance the quality of primary health care in urban and rural areas by providing an optimally functioning primary health care system as a part of Basic Minimum Services and to improve the efficiency of existing health care infrastructure at primary, secondary and tertiary care
The new initiatives in the Ninth Plan are as follows

a. Horizontal integration of vertical programmes;

b. Develop disease surveillance and response mechanism with focus on rapid recognition report and response at district level

c. Develop and implement integrated non-communicable disease control programme;

d. Health impact assessment as a part of environmental impact assessment in developmental projects;

e. Implement appropriate management systems for emergency, disaster, accident;

f. Screening for common nutritional deficiencies especially in vulnerable groups and initiate appropriate remedial measures;

g. Reduction in the population growth rate has been recognized as one of the priority objectives. It will be achieved by meeting all felt- needs for contraceptives and by reducing the infant and maternal morbidity and mortality so that there is reduction in the desired level of fertility; and

h. Implementation of reproductive and child health programme by effective maternal and child health care; increased access to contraceptive care; safe management of unwanted pregnancies; nutritional services to vulnerable groups; prevention and treatment of RTI/STD; reproductive health services for adolescents; prevention and treatment of gynecological
Tenth Five Year Plan (2002-2007):

Today India has a vast network of Governmental, voluntary and private health infrastructure manned by large number of medical and paramedical persons. During the Tenth Plan, efforts will be further intensified to improve the health status of the population by optimizing coverage and quality of care by identifying and rectifying the critical gaps in infrastructure, manpower, equipment, essential diagnostic reagents and drugs.

The approach during the Tenth Plan will be to improve access to, and enhance the quality of primary health care in urban and rural areas by providing an optimally functioning primary health care system as a part of Basic Minimum Services and to improve the efficiency of existing health care infrastructure at primary, secondary and tertiary care settings through appropriate institutional strengthening, and improvement of referral linkages.

The monitorable targets for the Tenth Five Year Plan and beyond are as follows:

1. Reduction of poverty ratio by 5 per cent points by 2007, and by 15 per cent points by 2012;

2. All children in school by 2003; all children to complete 5 years of schooling by 2007;

3. Reduction in gender gaps in literacy and wage rates by at least 50 per cent by 2007;
4. Reduction in the decadal rate of population growth between 2001 and 2011 to 16.2 per cent;

5. Increase in literacy rate to 75 per cent within the plan period;

6. Reduction of infant mortality rate to 45 per 1000 live births by 2007 and to 28 by 2012;

7. Reduction of maternal mortality ratio to 2 per 1000 live births by 2007 and to 1 by 2012; and

8. All villages to have sustained access to potable drinking water within the Plan period.

These targets reflect the concern that economic growth alone may not lead to the attainment of long-term sustainability and of adequate improvement in social justice. Earlier plans have had many of these issues as objectives, but in no case specific targets were set. As a result, these were viewed in terms of being desirable but not essential. However, in the 10th plan, these targets are considered to be as central to the planning frame work as the growth objective.

Technological improvements and increased access to health care have resulted in a steep fall in mortality, but the disease burden due to communicable diseases and non-communicable diseases, environmental pollution and nutritional problems continue to be high. In spite of the fact that norms for creation of infrastructure and manpower are similar throughout the country, there remains substantial variation between states and districts within the states, in availability and utilization of health care services and health indices of the population. During Tenth Plan there is continued commitment to provide essential primary care, emergency life saving services, services under national disease control
programme free of cost to individuals, based on their needs, and not on their ability to pay.

Government has set targets in the Tenth Five Year Plan to control certain diseases like HIV / AIDS, tuberculosis, leprosy, malaria, and blindness etc.

HEALTH SYSTEM IN INDIA

India is a Union of 28 States and 7 Union territories. Under the Constitution of India, the States are largely independent in matters relating to the delivery of health care to the people. Each State, therefore, has developed its own system of health care delivery, independent of the Central Government. The Central responsibility consists mainly of policy making, planning, guiding, assisting, evaluating, and coordinating the work of the - State Health Ministries, so that health services cover every part of the country, and no State lags behind for want of these services. The health system in India has 3 main links, i.e., Central, State and Local or Peripheral.

I. AT THE CENTRE

The official "organs" of the health system at the national level consist of: (A) Union Ministry of Health and Family Welfare; (B) The Directorate General of Health Services; and (C) The Central Council of Health and Family Welfare.

(A) Union Ministry of Health and Family Welfare

(1) Organization

The Union Ministry of Health and Family Welfare is headed by a Cabinet Minister, a Minister of State and a Deputy Health Minister.
These are political appointments. Currently, the Union Health Ministry has the following departments: (1) Department of Health and (2) Department of Family Welfare. The Health Department is headed by a Secretary to the Government of India as its executive head, assisted by joint secretaries, deputy secretaries and a large administrative staff. The Department of Family Welfare was created in 1966 within the Ministry of Health and Family Welfare. The Secretary to the Govt. of India in the Ministry of Health and Family Welfare is in overall charge of the Department of Family Welfare. He is assisted by an Additional Secretary & Commissioner (Family Welfare), and one Joint Secretary.

(2) Functions

The functions of the Union Health Ministry are set out in the seventh schedule of Article 246 of the Constitution of India under (a) the Union list and (b) the Concurrent list.

(a) Union list: The functions given in the Union list are: (1) International health relations and administration of port quarantine (2) Administration of central institutes such as the All India Institute of Hygiene and Public Health, Kolkata; Hygiene and Public Health, Calcutta; National Institute for the Control of Communicable Diseases, Delhi, etc. (3) Promotion of research through research centres and other bodies (4) Regulation and development of medical, pharmaceutical, dental and nursing professions (5) Establishment and maintenance of drug standards (6) Census, and collection and publication of other statistical data (7) Immigration and emigration (8) Regulation of labour in the working of mines and oil fields and (9) Coordination with States and with other ministries for promotion of health.
(b) Concurrent List: The functions listed under the concurrent list are the responsibility of both the Union and State Governments. The Centre and the States have simultaneous powers of legislation; the powers of the latter are restricted to the framework of such legislation as may be undertaken by the Centre. The concurrent list includes: (1) Prevention of extension of communicable diseases from one unit to another (2) Prevention of adulteration of foodstuffs (3) Control of drugs and poisons (4) Vital statistics (5) Labour welfare (6) Ports other than major (7) Economic and social planning, and (8) Population control and Family Planning.

(B) Directorate General of Health Services

(a) Organization:

The Director General of Health Services is the principal adviser to the Union Government in both medical and public health matters. He is assisted by an additional Director General of Health Services, a team of deputies and a large administrative staff. The Directorate comprises of three main units, e.g., medical care and hospitals, public health and general administration.

(b) Functions:

The GENERAL functions are surveys, planning, coordination, programming and appraisal of all health matters in the country. The SPECIFIC functions are (1) International health relations and quarantine: All the major ports in the country (Calcutta, Visakhapatnam, Madras, Cochin, Bombay, Kandta) and international air ports (Bombay - Santa Cruz, Calcutta- Dum - Dum, Madras Meenambakkam, Tiruchirapalli, Delhi - Palam) are directly controlled by the Directorate General of
Health Services. All matters relating to the obtaining of assistance from International agencies and the coordination of their activities in the country are undertaken by the Directorate General of Health Services. (2) Control of drug standards: The Drugs Control Organization is part at the Directorate General of Health Services, and is headed by the Drugs Controller. Its primary function is to lay down and enforce standards and control the manufacture and distribution of drugs through both Central and State Government Officers. The Drugs Act (1940) vests the Central Government with the powers to test the quality of imported drugs.

p) Medical store depots: The Union Government runs medical store depots at Bombay, Madras, Calcutta, Karnal, Gauhati and Hyderabad. These depots supply the civil medical requirements of the Central Government and of the various State Governments. These depots also handle supplies from foreign agencies. The Medical Stores Organization endeavours to ensure the highest quality, cheaper bargain and prompt supplies. (4) Post graduate training: The Directorate General of Health Services is responsible for the administration of national institutes, which also provide post-graduate training to different categories of health personnel. Some of these institutes are:- the All India Institute of Hygiene and Public Health at Calcutta, All India Institute of Mental Health at Bangalore, College of Nursing at Delhi, National Tuberculosis Institute at Bangalore, National Institute of Communicable Diseases at Delhi, Central Research Institute at Kasauni, National institute of Health and Family Welfare at Delhi, etc. (5) Medical education: The Central Directorate is directly in charge of the following medical colleges in India: the Lady Hardinge, the Azad and the medical colleges at Pondicherry, and Goa. Besides these, there are many medical colleges in the country which are guided and supported by the Centre. (6) Medical
Research: Medical Research in the country is organised largely through the Indian Council of Medical Research, founded in 1911 in New Delhi. The Council plays a significant role in aiding, promoting and coordinating scientific research on human diseases, their causation, prevention and cure. The research work is done through the Council's several permanent research institutes, research units, field surveys and a large number of ad-hoc research enquiries financed by the Council. It maintains Cancer Research Centre, Tuberculosis Chemotherapy Centre at Madras, Virus Research Centre at Poona, National Institute of Nutrition at Hyderabad and Blood Group Reference Centre at Bombay. The funds of the Council are wholly derived from the budget of the Union Ministry of Health. (7) Central Govt. Health Scheme: (8) National Health Programmes: The various national health programmes for the eradication of malaria and for the control of tuberculosis, filaria, leprosy, STD and other communicable diseases involve expenditure of crores of rupees. Health programmes of this kind can hardly succeed without the help of the Central Government. The Central Directorate plays a very important part in planning, guiding and coordinating all the national health programmes in the country. (9) Central Health Education Bureau: An outstanding activity of this Bureau is the preparation of education material for creating health awareness among the people. The Bureau offers training courses in health education to different categories of health workers. (10) Health Intelligence: The Central Bureau of Health intelligence was established in 1961 to centralise collection, compilation, analysis, evaluation and dissemination of all information on health statistics for the nation as a whole. It disseminates epidemic intelligence to Stales and international bodies. The Bureau has an Epidemiological Unit, a Health Economics Unit, a National Morbidity Survey Unit and a
Manpower Cell. (11) National Medical Library: The Central Medical Library of the Directorate General Health Services was declared the National Medical Library in 1966. The aim is to help in the advancement of medical, health and related sciences by collection, dissemination and exchange of information.

(C) Central Council of Health and Family Welfare:

A large number of health subjects fall in the Concurrent List which calls for continuous consultation, mutual understanding and cooperation between the Centre and the States. The Central Council of Health was set up by a Presidential Order on 9 August, 1952 tinder Article 263 of the Constitution of India for promoting coordinated and concerted action between the Centre and the States in the implementation of all the programmes and measures pertaining to the health of the nation. The Union Health Minister is the Chairman and the State Health Ministers are the members.

Function:

The functions of the Central Council of Health are: (1) To consider and recommend broad outlines of policy in regard 10 matters concerning health in all its aspects such as the provision of remedial and preventive care, environmental hygiene, nutrition, health education and the promotion of facilities for training and research. (2) To make proposals for legislation in fields of activity relating to medical and public health matters and to lay down the pattern of development for the country as a whole. (3) To make recommendations to the Central Government regarding distribution of available grants in-aid for health purposes to the States and to review periodically the work accomplished
in different areas through the utilisation of these grants-in-aid. (4) To establish any organization or organizations invested with appropriate functions for promoting and maintaining cooperation between the Central and State Health administrations.

II - AT THE STATE LEVEL

Historically, the first milestone in State health administration was the year 1919, when the States (then known as provinces) obtained autonomy, under the Montague - Chelmsford reforms, from the Central Government, in matters of public health. By 1921-22, all the States had created some form of public health organization. The Government of India Act, 1935 gave further autonomy to the States. The health subjects were divided into three groups: federal, concurrent and state. The "state" list which became the responsibility of the State included provision of medical care, preventive health services and pilgrimages within the State. The position has largely remained the same, even after the new Constitution of India came into force in 1950. The State is the ultimate authority responsible for all the health services operating within its jurisdiction.

State Health Administration

At present there are 26 States in India, and as many types of health administration. In all the States, the management sector comprises the State Ministry of Health and a Directorate of Health.

1. State Ministry of Health:

The State Ministry of Health is headed by a Minister of Health and Family Welfare and a Deputy Minister of Health and Family Welfare. In some States, the Health Minister is also in charge of other portfolios. The
Health Secretariat is the official organ of the State Ministry of Health and is headed by a Secretary who is assisted by Deputy Secretaries, Under Secretaries and a large administrative staff. The Secretary is a senior officer of the Indian Administrative Service. The Bhore Committee (1946) recommended that the Director of Health Services should also be Secretary to the State Government to facilitate administration, but this recommendation has not been implemented.

2. State Health Directorate:

For a long time, two separate departments, medical and public health, were functioning in the States; the heads of these departments were known as Surgeon General and Inspector General of Civil Hospitals and Director of Public Health respectively. The Bhore Committee (1946) recommended that the medical and public health organizations should be integrated at all levels and therefore, should have a single administrative officer for the curative and preventive departments of health. West Bengal led the process of integrating health services at the State level by creating a post of the Director of Health Services in August 1947; the process was completed by Maharashtra in May 1970.

The Director of Health Services (known in some States as Director of Medical and Health Services) is the chief technical adviser to the State Government on all matters relating to medicine and public health. He is also responsible for the organization and direction of all health activities. With the advent of family planning as an important programme, the designation of Director of Health Services has been changed in some States and is now known as Director of Health and Family Welfare. A recent development in some States is the appointment of a Director of Medical Education in view of the increasing number of medical colleges.
Some experts feel that there is no justification for the removal of medical education from general health services under the Director of Health Services. The health services and training institutions should develop into one logical whole designed to an end - the protection of the health of the people.

The Director of Health and Family Welfare is assisted by a suitable number of deputies and assistants. The Deputy and Assistant Directors of Health may be of two types - regional and functional. The Regional Directors inspect all the branches of public health within their jurisdiction, irrespective of their specialty. The Functional Directors are usually specialists in a particular branch of public health such as mother and child health, family planning, nutrition, tuberculosis, leprosy, health education etc. The Public Health Engineering Organization in most States is part of the Public Works Department of the State Government. It has been recommended by experts in the public health that the public health engineering organization in every State should be part of the State Health Department, and that the Chief Engineer of Public Health should have the status of an Additional Director of Health Services.

**III - AT THE DISTRICT LEVEL**

**The District**

The principal unit of administration in India is the district under a Collector. There are 466 districts in India. There is no "average" district, that is the districts vary widely in area and population within each district again, there are 6 types of administrative areas.

1. Sub-division
2. Tehsils (Taluks)

3. Community Development Blocks

4. Municipalities and Corporations

5. Villages

6. Panchayats

Most districts in India are divided into two or more subdivisions, each in charge of an Assistant Collector or sub-Collector. Each division is again divided into tehsils (taluks), in charge of a Tehsildar. A tehsil usually comprises between 200 - 600 villages. Since the, launching of the Community Development Programme in India in 1952, the rural areas of the district have been organized into Blocks, known as Community development blocks, the area of which mayor may not coincide with a tehsil. The block is a unit of rural planning and development, and comprises approximately 100 villages and about 80,000 to 1,20,000 population, in charge of a Block Development Officer. Finally there are the village panchayats, which are institutions of rural local self-Government.

The urban areas of the district are organized into the following institutions of local self-Government:

1. Town area committees - (in areas with population ranging between 5,000 and 10,000)

2. Municipal Boards - (in areas with population ranging between 10,000 and 2 lakhs)

3. Corporations - (with population above 2 lakhs)
The Town area committees are like panchayats. They provide sanitary services. The Municipal Boards are headed by a Chairman/President, elected usually by the members. The term of a Municipal Board ranges between 3-5 years. The functions of a municipal board are: construction and maintenance of roads, sanitation and drainage, street lighting, water supply, maintenance of hospitals and dispensaries, education, registration of births and deaths, etc. Corporations are headed by Mayors. The councilors are elected from different wards of the city. The executive agency includes the Commissioner, the Secretary, the Engineer and the Health Officer. The activities are similar to those of the municipalities, but on a much wider scale.

Health Organization:

The Bshore Committee (1946) recommended integrated preventive and curative services at all levels and the setting up of a unified health authority in each district. Subsequent expert committees, appointed by the Government of India have also recommended the same. Since "health" is a state subject, there is no uniform "model" of a district health organization in India; each State developed its own pattern to suit its policy and convenience.

Under the Multi-Purpose Workers Scheme, it has been suggested to the States to have an integrated sat-up at the district level by having a Chief Medical Officer with three Deputy CMOs (existing Civil Surgeons, District Health Officers and District Family Welfare Officers) with each of the Dy. CMOs being incharge of onethird of the district for all the Health, Family Welfare and MCH programmes. The recent Working Group on Health for All by 2000 AD, appointed by the Planning
Commission, recommended that the District Hospitals should be converted into District Health Centres, each centre monitoring all preventive, promotive and curative services of one million populations. It has been recommended that the district set-up should be reorganised on the basis of the number of primary health centres it comprises.

**PANCHAYATIRAJ**

The Panchayati Raj is a 3-tier structure of rural local Self-Government in India, linking the village to the District. The three institutions are:

1. Panchayat - at the village level
2. Panchayat Samiti - at the block level
3. Zila Parishad - at the district level

The Panchayati Raj institutions are accepted as agencies of public welfare. All development programmes are channeled through these bodies. The Panchayati Raj institutions strengthen democracy at its root, and ensure more effective and better participation of the people in the Government.

**1. At the Village Level**

The Panchayati Raj at the village level consists of:

1. The Gram Sabha
2. The Gram Panchayat and
3. The Nyay Panchayat

Gram Sabha: It is the assembly of all the adults of the village, which meets at least twice a year. The gram sabha considers proposals
for taxation, discusses the annual programme and elects members of the gram panchayat.

Gram Panchayat: It is the executive organ of the gram sabha, and an agency for planning and development at the village level. Its strength varies from 15 to 30, and the population covered also varies widely from 5,000 to 15,000 or more. The members of the panchayat hold office for a period of 3 to 4 years. Every panchayat has an elected President (Sarpanch or Sabhapati or Mukhiya), a Vice-president and a Panchayat Secretary. The power and functions of the Panchayat Secretary are very wide - they cover the entire field of civic administration, including sanitation and public health; and of social and economic development of the village.

2. At the Block Level

The block consists of about 100 villages and a population of about 80,000 to 1,20,000. The Panchayati Raj agency at the block level is the Panchayat Samiti Janpada Panchayat. The Panchayat Samiti consists of all Sarpanchas (heads) of the village panchayats in the Block; MLAs, MPs residing in the block area; representatives of women, scheduled castes, scheduled tribes and cooperative societies. The Block Development Officer (BDO) is the ex-officio Secretary of the Panchayat Samiti. The prime function of the Panchayat Samiti is the execution of the community development programme in the block, the funds provided by the Government for Stage I and Stage II development are channeled through the Panchayat Samiti. The Block Development Officer and his staff give technical assistance and guidance to the village Panchayats engaged in development work.
3. At the District Level

The Zila Parishad Zila Panchayat is the agency of rural local self-Government at the district level. The members of the Zila Parishad include all heads of the Panchayat Samitis in the district; MPs, MLAs of the district; representatives of scheduled castes, scheduled tribes and women; and 2 persons of experience in administration, public life or rural development. The Collector of the district is a non-voting member. Thus, the membership of the Zila Parishad is fairly large varying from 40 to 70.

The Zila Parishad is primarily supervisory and coordinating body. Its functions and powers vary from State to State. In some States, the Zila Parishads are vested with administrative functions. In Gujarat, the district Officer and the district family planning and MCH officers are under the control of the Zila Parishad.

NEED OF THE STUDY

Scheduled tribes represent 11 percent in India population. According to Indian constitution 212 groups are included in the list of scheduled tribe. Any social group is classified on the basis of its certain features as class, caste, race and tribe. Here we aim to discuss on such group that is called scheduled tribe. Anthropologist and sociologist gave them so many names. Harish Chandra (1970) referenced the name of scholars such as Rezley, K. Marton and Thaker, Servance (1970) called them Hill Tribe, Dr. Ghurey-Advasi and Schedule tribe. Which are provisional in Article 342 in Indian constitution.

Saharia is also such tribe which is residing in Bundelkhand region of U.P. on which no independent study is carried out in the field of
health. This tribes (Saharia) was first time declared as scheduled tribe by Indian Government in 1956. this tribe is suffering from socio-economic, health and cultural problems which attract attention of social researchers. The subject of research is selected on the basis of sociology of health. Schedule tribes families which represent culturally, are neglected in several aspects. These scheduled tribe family in Bundelkhand region are facing many problems, such as high morbidity, mortality infants and mothers, environment sanitation problems, communicable diseases problems, tuberculosis, filarial, malaria and diarrhea etc. along with malnutrition. Scheduled tribes families are good human resource of country because they contribute a lot in the field of agriculture, construction and industrial production, thus contribute in national income. But their due share is not given to them as they deserve. Though central and state Government are implementing many welfare, developmental and empowerment scheme but owing to their illiteracy, lack of community leadership and will power of Government officers the expected benefit is not ripped by these scheduled tribe families. Any type of investment on these would be profitable investment in favour of national development.

Therefore it is essential to study the health status, problems and cultural health behaviour of these tribe families so that their health could be promoted, protected and restored in future because health is recognized by WHO as an essential component of development.

**IMPORTANCE OF STUDY**

Without utility and importance a single act is not performed by an individual, group and community, while research is most significant work of human being especially in the reference of social change, development
and social welfare. Individual has several needs and there needs are not fulfilled without difficulties. To understand what causes of difficulties are, he has to conduct observations; survey and research to diagnosis the problems so that treatment can be made. Social research whether its design is explanatory, exploratory or experimental, research is always important. There are two type of importance of each research study. They are as follows:

Theoretical importance:

The investigator had very little awareness about health status and problems of scheduled tribes families but had curiosity and interest to know. The process of present research study provided him to identify health status, sociology of health, health behaviour and health problems of scheduled tribes community though scientific procedures. Research also know the knowledge attitudes and practices of schedule tribe family about various health policy, programmes and schemes which were launched by both central as well state Government time to time to promote, safe-guard and maintain the physical, mental and social wellbeing of the tribal community. In present study attempts had been made to understand the influence of social, economic, psycho, environmental, lifestyle, health services and others factors on scheduled tribe families.

Practical importance:

So far as utility of this study is concerned, there are several type of utilities (i) it fulfills our curiosity which are investigator has in his brain or mind. (ii) this study will strengthen knowledge about scheduled tribe families regarding their health and hygiene aspects (iii) this study will
also quench the thrust and provide satisfaction at al. because we came to know those very hidden causes of health problems of scheduled tribe families. This study highlighted the sociology of health of scheduled tribe along with their health behaviour. Such as which condition was understood by them as ill health, in which conditions or when these families seek treatment, all known by this study findings. Onward which systems – Ayurvedic, allopathic, unani or homeopathic, was adopted, from which agencies, private of public were consulted by there scheduled tribes families and why? It is all came to know this research study. What is present awareness of scheduled tribe families about various health schemes so that an adequate modification can be brought by the information – education and communication cell of state, district and block level especially in these communities. This study will also provide data on which proper health planning can be drafted specially this vulnerable group in relation to health services. The valuable findings shall be utilized by non Government organization to submit their health projects about tribal areas. The results of this study will motivate to social workers and students of social work to formulate further hypothesis for research in future. In to this study shall be very utilizing because it first time conducted in Bundelkhand mandal about scheduled tribe families. In last, this study will also beneficial to readers to know how socio-economic and cultural factors influence the health of community.
LIMITATION OF THE STUDY

1. The present work has certain limitations, which must be reckoned with for the purpose of specify and the limited nature of the research undertaken.

2. The present research work, “Study of health status and problems of schedule tribe families” was conducted taking into consideration 300 members of schedule tribe families of Tahseel Talbehat of Lalitpur district. The selection of 300 members was done on the basis of “Random sampling”. Thus the sample of 300 members was comparatively less extensive but the selection was done in such a way that it presented the universe structure of “women self help group and it gave an integrated representation to it.

3. The study sample was some what small in size. Due to this reason, result of the study can be taken to be true for the community study only. However the result can also be taken true in other area, where similar socio-economic background and with respondents resembling on different other aspects.

4. Since the research work was concerned with the members of schedule tribe families and the interview schedule prepared for the purpose was quite extensive which resulted in either respondents becoming bored or becoming emotionally charged and took more than usual time. The researcher patience took interest and appreciated the response of the respondents so as to make interview process interesting and overcome this problem successfully.

5. Another problem faced by researcher was that of collection of information. The process solely depended for data and primary
information on the respondents and to draw inferences from the same. Due to excessive dependence on the respondents, drawing appropriate inference was difficult, as many of the respondents could not provide correct data and concealed personal information. But the researcher secured information and cross checked them from their relatives and friends and appreciated them by saying that the information provided by them was highly valuable of that they have provided highly novel information. The researcher fully assured the respondents that the information provided by them would be kept secret.

6. For the data collection another problem faced by researcher was due to the secondary source because the employees and bank officers concerned refused to divulge details declaring them as secret but the researcher offered them tea and snacks and used his personal relations to secure the required information.

7. The analysis to data presented in different table though every care and precaution was table during information collection and their analysis, however, possibility of interview bias during the conduct of the interviews and of non-sampling errors during data collection as well as in their analysis, can not be ruled out.
OBJECTIVE OF THE STUDY

1. To study the socio, economic and demographic features of schedule tribe families.

2. To discuss about the health status of scheduled tribe families.

3. To assess knowledge, attitude and utilization of various health programme among schedule tribe families.

4. To find out the effect of socio-psychological and cultural factor on schedule tribe families.

5. To identify the various health problems among schedule tribe.

6. To trace out the various issues of information, education and communication about health among scheduled tribe families.

7. To discuss conclusion and suggestions of the study.