

CHAPTER – IV

MODERN HEALTH CARE FACILITIES AND PROGRAMMES

4.1 Introduction:

To understand the health behavior of the concerned population, it is essential to study the modern health care facilities and programme provided to them. In this chapter emphasis is given to reveal the functioning the modern medical system in the village of Totopara.

The present chapter is divided into two sections. In the first section a detail discussion is made regarding the health care services of the country (India), for better understanding of the basic health facilities, different health planning executed by Government of India. Special attention is given on the rural and tribal health in the concerned chapter.

The second section will reveal the scenario of modern health care facilities, institutions, services, programmes and their implementation in the studied village of Totopara. It is already stated in the previous chapter that the studied village Totopara is divided into six sectors. Discussion regarding the functioning of modern medical system in each sector is based on modern health facilities in close proximity/ vicinity (i.e. Primary Health Centre). In this chapter detailed descriptions are given about the Primary Health Centre (PHC), Sub-centers, Block Hospital, Sub-divisional hospital and District hospital along with the medical infrastructure and staff strength. Interviews of the modern medical personnel are given in detail for better understanding of the problems. Neonatal and post neonatal child health care and pregnant mother health care are also discussed. A separate sub section is made for detailed discussion and analysis for the vaccination, pulse polio and immunization programmes. As the Totos are the Primitive Tribal Group (PTG), there is a Government restriction for family planning. A sub section is also made for detail discussion, regarding the population control measures. Safe drinking water and sanitation facilities along with health hygiene concept are analyzed in detail to unfold the issues regarding the water borne, vector borne and other communicable diseases. Discussion is also made on the communication infrastructure which is important for achieving good medical help.

Section - A

A.4.1 Health Service Scenario of the Country:

India was one of the first countries to recognize the merits of Primary Health Care Approach (PHC) as the backbone of health service delivery. This approach was first conceptualized in 1946, when Sir Joseph Bhore made recommendations that formed the basis for organizing basic health services in India. Although the National Health Policy (NHP) in India was not framed until 1983, India has build up a vast health infrastructure and initiated several national health programmes over last five decades in Government, voluntary and private sectors under the guidance and direction of various committees (Bhore Committee 1946, Mudaliar Committee 1956-61, Junganwala Committee 1967, Katar Singh Committee 1973, Shrivastava Committee 1975), the Constitution, the Planning Commission, the Central Council of Health and Family Welfare and Consultative Committees attached to the Ministry of Health and Family Welfare.

Since independence improvement in health status of the population has been one of the major thrust areas for the social development programmes of the country. To achieve the goal the country has been formulating various welfare programmes during Five Year Plan Period for better utilization of health, Family Welfare and Nutrition services, giving special emphasis on underserved and under privileged segments of population (viz. Scheduled Caste and tribal population).

The first formulated National Health Policy 1983 (NHP-1983) aimed to achieve the goal of 'Health for all' by 2000 AD, through the provision of comprehensive primary health care services. It stressed the creation of an infrastructure for primary health care; close co ordination of health related services and activities (like nutrition, drinking water supply and sanitation), the active involvement and participation of voluntary organizations, the provision of essential drugs and vaccines; quality improvement of health and family planning services, the provision of adequate training and medical research aimed at the common health problems of the people. After the formulation of first National Health Policy 1983 (NHP-1983), the period after 1983 witnessed several major developments in the policies impacting the health sectors-73rd and 74th Constitutional Amendments in 1992, National Nutrition Policy 1993, National Health Policy 2002 (NHP-2002), National Policy on Indian System of

Medicine and Homeopathy in 2002, Drug Policy 2002, introduction of Universal Health Insurance schemes for the poor in 2003 and inclusion of health in Common Minimum Programme of the Government of India in 2004.

Nearly twenty years after the first health policy, the 2nd National Health Policy 2002 (NHP-2002) was presented. Recognizing the noteworthy successes of previous health policy the NHP 2002 sets out a new policy framework to achieve public health goals within the socio-economic circumstances currently prevailing the country. The approach aims at increasing access to the decentralized public health system by establishing new infrastructure in deficient areas and upgrading the infrastructure of existing institutions. It sets out an increased sectarian share of allocation out of total health spending to primary health care.

More recently (2005), the Government of India has launched the National Rural Health Mission (NRHM) with the goal of improving the availability of and access to quality health care by people, particularly in rural areas. As a result bulk of tribal population gets benefited out of this project. All over the country the food supplementation programmes for mother and child are implemented by the state through ICDS infrastructure funded by the Central Government to serve particularly mal-nutrition. To supply safe drinking water Central Government had launched Rajiv Gandhi Water Mission Project. Both environmental sanitation and safe drinking water projects are guided and funded by Department of Urban and Rural Development, Ministry of Health and Family Welfare, Central Government either directly or through State Government To decentralize the urban and clinical based infrastructure of the country Government has formulated three-tier health care system in different Five Year Plan period by building up primary, secondary and tertiary care institutions and link them through appropriate referral system.

A.4.2 Health Care System in India:

The health care services are divided under State list and Concurrent list in India. While some items such as public health and hospitals fall in the State list, others such as population control and family welfare, medical education, and quality control of drugs are included in the Concurrent list. The Union Ministry of Health and Family Welfare (UMHFW) is the central authority responsible for implementation of various programmes and schemes in areas of family welfare, prevention and control of major diseases.

The health care system in India has been developed as a three- tier structure based on predetermined population norms. The health care system consists of:

- (b) Primary, secondary and tertiary care institutions, manned by medical and paramedical personnel
- (c) Medical college and paraprofessional training institutions to train the needed manpower and give the required academic input
- (d) Programme manager managing ongoing programmes at Central, State and District level
- (e) Health management information system consisting of a two way system of data collection, analysis and response

Table: A.4.2 (a) Primary Health Structure and their Population Norm

Centre	Population Norm	
	Plain area	Hilly area/Tribal/Difficult area
Sub-centres(SCs)	5000	3000
Primary Health Centre (PHCs)	30,000	20,000
Community Health Centre (CHCs)	1,20,000	80,000

Source: Rural Health Statistics, MOHFW, GOI, 2007

A.4.2.1 Sub- Centre (SC):

The Sub-Centre is the most peripheral health units and first contact point between the primary health care system and the community. Each sub-centre has one female health worker/ ANM (Auxiliary Nurse Midwife) and male health worker. One female Health Assistant (Lady Health Visitor; LHV) and one male health assistant supervise six sub-centres. Sub-centres are assigned to perform tasks related to components of primary health care. They are provided with basic drugs (both allopathic and AYUSH) for minor ailments needed for taking care of essential health needs of population. There is 1, 45,272 sub-centres functioning in the country as on March, 2007 (Source: Rural Health Statistics, MOHFW, GOI, 2007).

A.4.2.2 Primary Health Centre (PHC):

Primary Health Centre (PHC) comprises the second tier in rural health care structure. PHC remains the first contact between village community and Medical Officer. They are manned

by a Medical Officer supported by 14 paramedical and other staff. It acts as a referral unit for 6 sub-centres. It has 4-6 beds for patients. There are 22,370 PHCs functioning as on March 2007 in the country (Source: Rural Health Statistics, MOHFW, GOI, 2007).

A.4.2.3 Community Health Centre (CHC):

Community Health Centre (CHC) forming the uppermost tier are established and maintained by the State Government under the minimum need programme/ basic minimum service programme. Four medical specialists including surgeon, physician, gynecologist and pediatrician supported by twenty one paramedical and other staff are supposed to staff each CHC. Norms require a typical CHC to have thirty in door beds with OT, X- ray, labor room and laboratory facilities. A CHC is a referral centre for four PHCs within its jurisdiction, providing facilities for obstetric care and specialist expertise. As on March 2007, there are 4,045 CHCs functioning in the country (Source: Rural Health Statistics, MOHFW, GOI, 2007).

A.4.3 Indian System of Medicine and Homeopathy (ISM&H):

The umbrella term, Indian System of Medicine and Homeopathy (ISM&H) includes Ayurveda, Siddha, Unani, Homeopathy and therapies such as Yoga and Naturopathy. Practitioners of ISM&H catered to all the health care needs of the people before modern medicine came to India in the twentieth century. Currently there are over 680,000 registered (ISM&H) practitioners in the country; most of them work in the private sector.

Table: A.4.3(a) Registered Medical Practitioners in Indian System of Medicine and Homeopathy

1.	Ayurveda	4,27,504	4,53,661
2.	Unani	42,445	46,558
3.	Siddha	16,599	6,381
4.	Naturopathy	429	888
5.	Homeopathy	1,94,147	2,17,850
	Total	6,81,124	7,25,383

Source: Department of ISM&H, 2001 and Department of AYUSH, Status on 1st January 2007

India has a vast network of governmental ISM&H healthcare institutions. There are 3000 hospitals with over 60 beds and over 23,000 dispensaries providing primary health care. Over 16,000 ISM&H practitioners qualify every year from 405 ISM&H colleges. A major strength of ISM&H system is that it is accessible, acceptable and affordable i.e. cost effective.

A.4.3.1 National Policy on Indian System of Medicine and Homeopathy:

As these systems (i.e. Ayurveda, Unani, Siddha, Homeopathy, Yoga and Naturopathy) are indigenous, the first National Health Policy (NHP 1983) visualized an important role for the ISM&H practitioners in the delivery of health services. In order to give focused attention to the development and optimal utilization of this branch of medicine, a separate Department of ISM&H was set up in 1995. The Indian System of Medicine and Homeopathy were given an independent identity by Ministry of Health and Family Welfare by creating a separate Department of Ayurveda, Yoga, and Naturopathy, Unani, Siddha and Homeopathy (AYUSH) in November, 2003. The department is making efforts to ensure that ISM&H practitioners are brought into the mainstream so that they provide a complementary system of care along with practitioners of modern systems of medicine.

Approach during the Tenth Plan:

The approach during the Tenth Plan will be to ensure that the ISM&H system achieves its full potential in providing health care by

Improving the quality of primary, secondary and tertiary care

Mainstreaming ISM&H institutions and practitioners with modern system of medicine so that people have access to complementary systems of care

Strengthening ISM&H educational institutions so that students get adequate training, giving them confidence to practice their system and participate in national programmes

- Investing in continuing medical education

- Ensuring the conservation, preservation, promotion, cultivation, collection and processing of medical plants and herbs required to meet growing domestic demand for ISM&H drugs and the export potential
- Completing pharmacopoeia of all the systems of ISM&H and drawing up a list of essential drugs and ensuring their availability
- Ensuring quality control of drugs and improving their availability at an affordable cost
- Investing in research and development (R and D) for the development of new drugs and formulations and patenting them
- Undertaking clinical trials of promising drugs by appropriately strengthening the Central Research Councils and co-coordinating their research with other research agencies such as *Indian Council of Medical Research (ICMR), Delhi*

A.4.3.2 Role of ISM&H in Primary, Secondary and Tertiary Health Care:

India possesses an unmatched heritage represented by its ancient systems of medicine which are a treasure house of knowledge for both preventive and curative health care. A broad acceptance by the general public, requirement of low technological input, along with cost effectiveness of the Indian System of Medicine compels to take measures to popularize and develop ISM&H in primary, secondary and tertiary health care.

Primary Health Care:

ISM&H practitioners provide primary health care to vulnerable sections of population especially those living in urban slums and remote areas. In the state like West Bengal ISM&H practitioners alone are posted in Primary Health Centre in some rural and tribal areas. The Central Council for Health and Family Welfare in 1999 recommended that at least one physician from Indian System of Medicine and Homeopathy (ISM&H) should be available in every Primary Health Centre and that vacancies caused by non availability of allopathic personnel should be filled by ISM&H physicians. Majority of ISM&H

practitioners in urban and rural areas are private practitioners and provide primary health care with minimum cost.

Secondary Health Care:

A majority of existing ISM&H secondary hospitals functions as separate institutions and do not have linkages with either primary ISM&H health care institutions or with secondary health care institutions in the modern system of medicine. Very often these institutions lack adequate diagnostic facilities, infrastructure and man power. The Central Council for Health and Family Welfare also resolved that specialist ISM&H treatment centres should be introduced in rural hospitals and a wing should be created in existing state and district level Government hospitals.

Tertiary Health Care:

All ISM&H colleges, private as well as public have attached tertiary care hospitals. In addition, there are tertiary care and/ or specialty centres attached to national institutes. Private or voluntary sector institutes also provide tertiary care in ISM&H.

The Tenth Five Year Plan not only emphasizes to improve all the tertiary care institutions but also establish effective referral linkage between primary, secondary and tertiary care institutions so that there is improvement in teaching, training and R&D and patient care, all at the same time.

Approach during the Eleventh Five Year Plan (2007-2012)

The key intervention and strategies in the Eleventh Five Year Plan are enumerated as

- Documenting measurable outputs for annual plan as well as for five year plans that will facilitate designing and implementing systematic ME system
- Training in public health for AYUSH personnel is envisaged an essential part of education and CME.
- Mainstreaming the system of AYUSH in National Health Care Delivery System by co-locating AYUSH facilities in primary health network

- Restructuring public health management to integrate AYUSH practitioners into the national health care system
- Formulating a two-tiered research framework for AYUSH to interface with modern science while giving due cognizance and importance to development and application of theoretical foundations of the traditional knowledge systems and practices
- Promoting scientific validation of AYUSH principles, remedies and therapies
- Revitalizing, documenting and validating local health traditions of AYUSH
- Improving the status of pharmacopoeial standards by setting up pharmacopoeia commission
- Improving the status of quality of clinical services by creating specialty AYUSH secondary and tertiary care centers
- Upgrading AYUSH undergraduate and post graduate educational institutions by better regulation and establishing a system for NET type testing of AYUSH teachers and NAAC type assessment and accreditation of AYUSH undergraduate and post graduate colleges
- Ensuring conservation of medicinal plants gene pools as well as promoting cultivation of species in high trade and establishment of medicinal plants processing zones
- Strengthening regulatory mechanism for ensuring quality control, research and development and processing technology involving accredited laboratories in the Government and non-Government sectors
- Establishing centre of excellence
- Promoting international co-operation in research, education, health services and trade and market development
- Digitizing India's vast corpus of medical manuscripts in collaboration with the National Manuscript Mission
- Promoting public awareness about the strengths and contemporary relevance of AYUSH through IEC

A.4.4 Role of National Rural Health Mission (NRHM) in Health Care System in India:

After formulation of National Health Policy 2002, more recently (in April 2005), the Government of India has launched the National Rural Health Mission (NRHM) for a period of seven years (2005-2012) with the goal of improving the availability of and access to

quality health care by people, particularly in rural areas. The main aim of NRHM is to provide accessible, affordable, accountable, effective and reliable primary health care, especially to the poor and vulnerable section of population.

A.4.4.1 National Rural Health Mission (NRHM) and Sub-Centre:

NRHM has proposed strengthening of sub-centers in the form of provision of untied fund of Rs.10, 000 per annum. This fund has to be utilized for local needs and maintenance of sub-centers. The units will also be provided with essential drugs, both allopathic and AYUSH. The programme will also promote access to improved health care at household level through the village level worker (Accredited Social Health Activist- ASHA). It also makes provision for strengthening sub-centers through better human resource development, clear quality standards, better community standards, better community support.

A.4.4.2 National Rural Health Mission (NRHM) and Primary Health Centre (PHC):

National Rural Health Mission (NRHM) aims at strengthening of PHCs for quality preventive, promotive, curative, supervisory and outreach services through:

1. Adequate and regular supply of essential quality drugs and equipment to PHCs
2. Provision of 24 hrs service in at least 50% PHCs by addressing shortage of doctors (especially in high focus areas) through mainstreaming AYUSH manpower
3. Observance of standard treatment guidelines and protocols
4. Intensification of ongoing communicable disease control programmes, new programmes for control of non-communicable diseases, up gradation of 100% PHCs for 24 hour referral service and provision of second doctor at PHC level (1 male, 1 female) to be undertaken on the basis of felt need.

A.4.4.3 National Rural Health Mission (NRHM) and Community Health Centre (CHC):

National Rural Health Mission aims to strengthen services at CHCs by operationalising 100% CHCs as 24 hours First Referral Units (FRUs), including posting of anesthetists. The other

key strategies of mission are codification of new Indian Public Health Standards setting norms for infrastructure, staff, equipment, management etc for CHCs; promotion of Stakeholder Committees (*Rogi Kalyan Samitee*) for hospital management; developing standards of services and costs in hospital care; in case of additional outlays creation of new Community Health Centers (30-50 beds) to meet the population norms as per Census 2001, and bearing their recurring costs for the Mission period could be considered.

A.4.5 Role of Accredited Social Health Activists (ASHA) in Primary Health Care:

Under the National Rural Health Mission (NRHM) Plan of Action for infrastructure strengthening every village or large habitat will have a female Accredited Social Health Activist (ASHA) chosen by and accountable to the panchayat to act as the interface between the community and the public health system. ASHA would act as a bridge between the ANM and the village and be accountable to the panchayat. She will be an honorary volunteer, receiving performance based compensation for promoting universal immunization, referral and escort services for RCH, construction of household toilets and other health care delivery programmes. She will be trained on pedagogy of public health developed and mentored through a Standing Mentoring Group at National level incorporating best practices and implemented through active involvement of community health resource organizations. Introduction training of ASHA is to be of 23 days in all, spread over 12 months. On the job training would continue throughout the year. ASHA will facilitate preparation and implementation of the village health plan along with Anganwadi worker, ANM, functionaries of other departments and Self-Help Group members under the leadership of the village health committee of the panchayat. She will be given a Drug kit containing generic AYUSH and allopathic formulations for common ailments. The drug kit would be replenished from time to time.

A.4.6 Role of Multipurpose Health Worker in Primary Health Care:

Serious efforts have been made since the inception of health care service delivery in the country, to create appropriate health infrastructure and raised skilled man power at various levels to develop a vibrant health care delivery system. Toward this effort, the year 1974 proved to be a turning point in the history of health care in India, when the Kartar Singh Committee 1974 submitted its report on the Multipurpose Health Workers Scheme. The

committee's recommendations suggesting a new model by creating a cadre of multipurpose workers was a major step towards integration of health and family welfare services. The committee recommended the conversion of uni-purpose workers including ANM into multipurpose male and female workers. It recommended that each pair of such worker should serve a population of 10,000 to 12,000. Hence the multipurpose worker (MPW) scheme was launched with the objective of retaining the existing cadres of vertical programmes were to be fully integrated into the primary health care package for rural areas.

Under this scheme, the health workers who were engaged in delivering basic health services like malaria control, polio eradication programme, family planning and health education etc were inducted into a new cadre of multipurpose workers with the hope that they would provide all types of health services at one go, rather than different categories of workers providing specific services. Both male and female workers were supposed to stay at the sub-centre village and cater to different health and family welfare service needs of a population of 10,000. While the female multipurpose worker was made responsible for antenatal, intra-natal and post natal care services only, the team was assigned to look into programmes like family planning, malaria eradication, immunization, environmental sanitation, nutrition, health education, training of traditional dais, health care, information of notified diseases, collection of vital statistics in their assigned area. The male multipurpose workers were responsible for delivering all the services except the maternal care (refer such cases to female counterpart). The scheme become operational by 1978 and 1983, almost all the states had converted their staff at the sub-centre level into multipurpose worker.

A.4.7 Rural Health Infrastructure:

The entire family welfare programme is being implemented through Primary Health Care System. The primary health care infrastructure has been developed as a three tier system with Sub-centers, Primary Health Centre (PHC), and Community Health Centre (CHC) being the three pillars of primary health care system in rural India. Progress of Sub-centers, which is the most peripheral contact point between the primary health care system and the community, is a prerequisite for the overall progress of the entire system.

Table: A.4.7(a) Health Infrastructure Scenario

Five Year Plan Period	Sub-centres	Primary Health Centre (PHC)	Community Health Centre (CHC)
Sixth Plan (1981-85)	84,376	9,115	761
Seventh Plan (1985-90)	1,30,165	18,671	1,910
Eight Plan (1992-97)	1,36,258	22,149	2,633
Ninth Plan (1997-2002)	1,37,311	22,875	3,054
Tenth Plan (upto March 2007)	1,45,272	22,370	4,045

Source: Ministry of Health and Family Welfare, GOI, 2011

Keeping the view that health is an integral part of the socio-economic development of any country, Government of India has provided the most holistic understanding to health and also is trying to frame work an appropriate primary health care system for common mass in its post independent period. This primary health care is trying to include at least education concerning prevailing health problems and methods of identifying, preventing and controlling them; promotion of food supply and proper nutrition, adequate supply of safe water and basic sanitation; mal nutrition and child health care including family planning; immunization against major infectious diseases; prevention and control of local endemic diseases; appropriate treatment of common diseases and injuries; promotion of maternal health and provision of essential drugs. Although the Government is trying to put effort in building up the basic health care facilities, India's health care infrastructure has not kept pace with the economy's growth. The physical infrastructure is woefully inadequate to meet today's health care demand, much less tomorrows. While India has several centers of excellence in health care delivery, these facilities are limited in their ability to drive health care standards because of the poor condition of the infrastructure in the vast majority of the country. The number of public health facilities is inadequate. For instance, India needs 74,150 community health centers per million populations but has less than half that number. In addition, at least eleven Indian states do not have laboratories for testing drugs, and more than half of existing laboratories are not properly equipped or staffed. The principal responsibility for public health funding lies with the state Governments, which provide about 80% of public funding. The federal Government contributes another 15%, mostly through national health programmes.

The existing manpower is an important prerequisite for the efficient functioning of the rural health infrastructure. Despite significant progress made in terms of creating manpower over the years, there remains a huge gap in terms of human resource at primary care level which is realized by the Government of India and the process is underway to bridge the gap. As a result, the allocation of funds for health and family welfare activities during Eleventh Five Year Plan (2007-2012) is on steep rise (227%) as against financial outlays and expenditure for health and family welfare for the 2002 -2007 Tenth Five Year Plan (Annual Report, MOHFW, GOI, 2007-2008).

Availability of appropriate and adequate trained human resources is an essential concomitant of rural health infrastructure. Across rural health areas, there are considerable short falls plus a large number of vacant positions of doctors, nurses and paramedical personnel. There is also wide variation in number of persons served by a specialist in rural areas. Despite the existing shortages, whatever few formally trained and qualified doctors are available, are mainly through the public health care system. A large proportion of population visits private providers for their health care needs. The challenge is to resolve these problems and provide the poor access to subsidized or free public health services.

During the last few years there has been a great change in the availability of secondary and tertiary health care facilities in the country. Number of Government hospitals increased from 4571 in 2000 to 7663 in 2006, i.e. an increase of 14.4%. Apart from the public sectors, in 2002, the country had 11345 private/ NGO hospitals (allopathic) with a capacity of 2,62,256 beds. These are mostly in the private sector located in cities and towns.

Table: A.4.7(b) Shortfall in Health Infrastructure – All India

As per 2001 population	Required	Existing	Short fall	% of short fall
Sub-centres	158792	144998	20903	13.16
PHCs	26022	22669	4803	18.46
CHCs	6491	3910	2653	40.87

Source: Bulletin of Rural Health Statistics in India, Special Revised Edition, MOHFW, GOI (2006)

A.4.8 Drawbacks of the Public Health System:

The public health system in our country has various drawbacks. The conceptualization and planning of all programmes is centralized instead of decentralized using locally relevant strategies. The approach towards disease control and prevention is fragmented and disease specific rather than comprehensive. This leads to vertical programmes for each and every disease. This vertical programme is technology centric and work in isolation of each other. The provision of infra-structure is based on population norms rather than habitations leading to issues of accessibility, acceptability and utilization. Inadequate resources also lead to lack of client conveniences and non availability of essential consumables and consumables. The gap between requirement and availability of human resources at various levels of health care is wide and where they are available, the patient-provider interactions are beset with many problems, in addition to waiting time (opportunity cost) for consultation/ treatment. The system lacks a real and working process of monitoring, evaluation and feedback. There is no incentive for those who work well and check on those who do not. Quality assurance at all levels is not adhered due to lacunae in implementation. This results in semi used or dysfunctional infrastructure. Despite constrains of human resources, practitioners of Indian System of Medicine (ISM), Registered Medical Practitioners (RMP) and other locally available human resources have not been adequately mobilized and integrated in the system.

Major Drawbacks of Public Health Care System:

- Centralized planning instead of decentralized planning and using locally relevant strategies
- Institutions based on population norms rather than habitations
- Fragmented disease specific approach rather than comprehensive health care
- Inflexible financing and limited scope for innovations
- Semi- used or dysfunctional health infra-structure
- Inadequate provision of human resources
- No prescribed standard of quality
- Inability of system to mobilize action in areas of safe water, sanitation, hygiene and nutrition (key determinants of health in the context of our country)- lack of convergence
- Inability to mobilize AYUSH and RMPs and other locally available human resources

Table: A.4.8(a) Shortfall in Health Personnel- All India

For the existing infrastructure	Required (R)	Sanctioned (S)	In position (P)	Vacant (S-P)	Short fall (R-P)
Multipurpose workers(female)/ANM at Sub-centre and PHC	167657	162772	149695	13126 (8.06%)	18318 (10.93%)
Health workers (Male) /MPWs(M) at Sub- centers	144998	94924	65511	29437 (31.01%)	74721 (51.53%)
Health Assistant (female)/ LHV at PHC	22669	19874	17107	2781 (13.99%)	5941 (26.21%)
Health Assistant (male) at PHCs	22669	24207	18223	5984 (24.72%)	7169 (31.62%)
Doctors at PHCs	22669	27927	22273	5801 (20.77%)	1793 (7.91%)
Total Specialists at CHCs	15640	9071	3979	4681 (51.60%)	9413 (60.19%)
Radiographers at CHCs	3910	2400	1782	620 (25.83%)	1330 (34.02%)
Pharmacists at PHCs and CHCs	26579	22816	18419	4445 (19.48%)	4389 (16.51%)
Lab-technicians at PHCs and CHCs	26579	15143	12351	2792 (18.44%)	9509 (35.78%)

Source: Bulletin of Rural Health Statistics in India, Special Revised Edition, MOHFW, GOI (2006)

Section- B

B.4.1 Treatment by Modern Medical Institutions and Practitioners:

Selected Case Studies:

It is needed to mention here that the studied villagers had to go to various medical institutions and medical practitioners for their treatment. But variations were reported considering the village sector, category, economy, educational status and sex of the villagers from the medical institutions. *Selected case studies and analysis of tables can give a better interpretation in the context of treatment of the disease affected villagers by the various institutions and personnel.*

Case Studies:

According to the analysis of the Preliminary Schedule Form (PSF) the sample of the detailed case study of the patients in the six studied village sectors were chosen. Some important categories were made for sampling the disease affected people (in last five years). The categories are as follows-

- (i) Sex
- (ii) Procedure of treatment (traditional/ modern/ both)
- (iii) Family income (higher/lower)

The relevant cases are given here for better interpretation of different above discussed issues. Abbreviations of categories are as follows-

M: Male;

F: Female;

L: Lower income group;

H: Higher income group;

M: Modern treatment;

B: Both (modern and traditional treatment);

m: Modern procedure at the first step of treatment;

t: Traditional procedure at the first step of treatment

B.4.1.1 Village Sector: Dhumci gaon (Category-1 village sector)

Distant from local Primary Health Centre and market place

No modern health facility in close proximity

Case: 1

Category: MLM

As reported by his wife, Satish Toto 50 years aged man was suffering from high fever and severe weakness. His family members were not sure about the actual cause behind the ailments. He was admitted to Totopara Primary Health Centre (PHC) for three days and blood test diagnosed *Phalciperum* malaria. Patient was given all the medicines for curing the disease at free of cost from the PHC. The patient party had to buy only one vitamin tonic

from outside which was prescribed by the PHC doctor. He was completely cured after completing the course of medicine.

Case: 2

Category: MLM

Bikol Toto an 11 years old boy suffered also from malaria and was taken to Totopara Primary Health Centre where his disease was detected. According to the parents of Bikol Toto, at that time there was scarcity of medicine at PHC. Due to this reason, they had to buy all the medicines from Madarihat and had to spend more than Rs 500/- for that purpose. Finally the boy was completely cured.

Case: 3

Category: MLM

Taking of unhygienic food might be the cause of diarrhea which affected Siba Toto, a six year old boy. Initially he was taken to Totopara Primary Health Centre (PHC) from where he was referred to Birpara State General Hospital. He was admitted in Birpara hospital for four days. Saline and other medicines were prescribed. The patient family had to buy all the medicines from outside. During this course they had to spend Rs. 2500/- which they were able to manage from monthly family income. Finally Siba was cured and returned back to his home after four days.

B.4.1.2 Village Sector: Mitran gaon (Category-1 village sector)

Distant from local Primary Health Centre and market place

No modern health facility in close proximity

Case: 1

Category: FLM

Kanchan Toto (29 years old), wife of Pratap Toto had always been a patient of anemia. But after getting her first issue, her problem took a serious form. Initially she consulted doctor of local PHC and completed all the prescribed medicines. But she did not get good result. Then she consulted a private doctor at Birpara and took all the medicines. Continuous checking and taking of medicines occurred for a period of two years. Patient's family had to spend more than Rs 2000/- for the whole purpose.

Case: 2

Category: MHM

Dhukrú Toto, a 60 years old man had to visit a nursing home at Siliguri with Tetanus. Initially he started treatment in Totopara Primary Health Centre (PHC) and he was referred to Birpara and then to Jalpaiguri District hospital. During this process he already spend more than Rs. 3000/-. But he did not get cure. Finally he went to Siliguri and stayed for 15 days. He had to take injection for 15 days (twice a day) each costing Rs 550/-. Total costing for the said purpose was Rs. 17,000/-. Finally he was cured and returned back to Totopara.

Case: 3

Category: MLM

Abin Toto, a fifteen years was detected with Thalassemia. According to his parents, the disease was detected in a medical camp in his own village which was organized by some external doctors. Neither Abin nor his family members did know anything about the disease. They also informed, at the time of detection the disease did not show any symptom. Finally blood transfusion was required. It was needed for two times and was taken place at Jalpaiguri. During the field survey he was under treatment of a doctor of Birpara State General Hospital.

Case: 4

Category: FLM

Five years old Ayesha Toto, daughter of Bhupen Toto had also gone through a serious skin infection just after one month of her birth. As reported by her father, she had suffered from infection in her palm and foot. She was taken to the homeopathy doctor at Primary Health Centre. She was given some oral medicine and ointment. Treatment continued up to three month. Finally the baby was completely cured and the infection did not come back. The entire treatment procedure was completely free of cost.

B.4.1.3 Village Sector: Puja gaon (Category-1 village sector)

Distant from Primary Health Centre and market place

No modern health facility in close proximity

Case: 1

Category: FLM

Dolki Toto, a 48 years old lady suffered from arthritis for 6-7 years. As reported by his son, initial treatment was started at local PHC, from where she was taken to a private doctor at Madarihat. During this process they had to spend more than Rs.3000/-, but she was not cured. In last winter her disease took a severe form and she was almost paralyzed. Then she was taken to Birpara State General Hospital and stayed there for 10 days. She got some relief after a long treatment. Family members protected her from cold as well as damp weather. Still, she was not able to participate in regular house hold work. A total expenditure of Rs 5000/- was reported and it was managed from the family savings. Although during the field study she was reported to take the medicines.

Case: 2

Category: FLM

Very poor economic condition, mal nutrition and so many children seems to be the prime cause of tuberculosis of Roma Toto (45 years old lady). A continuous cough was the only preliminary symptom. She was not at all attentive to her problem. After few days, she found that blood was coming out with the cough. Then she was taken to Totopara Primary Health Centre where tuberculosis was detected. Although doctor suggested taking admission, she did not take admission. Then she went to Birpara and took all the medicines as prescribed by the doctor of Birpara State General Hospital. Due to economic constrains her family was not able to provide advised food for remedial purpose. After six months, further detection test reported that the intensity of the disease was decreased but it was not completely cured. Then she carried out her treatment at Totopara PHC. Although during the field survey, she was not cured but was on the process of remedy.

Case: 3

Category: MLM

As reported by his father Bimal Toto, Prasanta Toto (sixteen years old), was attacked by both malaria and jaundice (although not simultaneously). He suffered from jaundice last four years

back. But he was suffered from malaria just few months back. In case of jaundice, although the other family members suggested taking medicine from a renowned *jhakri* but Bimal Toto took his son to local PHC. Doctor confirmed the disease as jaundice and advised some medicine. Doctor also gave him a diet chart which should be strictly followed. All the prescribed medicines were purchased from Madarihat. After taking all the medicines and following the diet chart the boy was cured. But the recovery of the patient took a long time as reported by his father.

Few months back the same boy suffered from malaria. The disease was detected in Totopara Primary Health Centre. But they got all the required medicines from PHC at free of cost. After completing the course the boy was completely cured. According to his father, for the treatment of jaundice he had to spent Rs. 1000/-.

B.4.1.4 Village Sector: Mondal gaon (Category-2 village sector)

Nearer to local Primary Health Centre and market place

Modern medical facility in close proximity

Case: 1

Category: MHM

Samir Toto, a 20 years old boy was attacked by tuberculosis and it existed for six months. He or his family was not known to the reasons behind the disease because it was first time in their family. After realizing some bad symptoms he was taken to local Primary Health Centre by his father Sachin Toto. He was given all the prescribed medicine from PHC. He collected the medicine thrice a week as per the rule of PHC and completed the six months course. As his father was a Government employee, his family was able to provide all the advised food for remedial purpose. After six months, further detection test revealed that he was completely cured and need not to carry out further treatment.

Case: 2

Category: MHM

Elder son of Sachin Toto, Sushanta (22 years old) was also attacked by tuberculosis. His initial symptom was cough and blood was also coming out with cough. Apart from that, he was rapidly losing his weight. As his brother was also a T.B patient, he was immediately taken to the Totopara Primary Health Centre by his parents. Along with sputum test, X-ray

was the main diagnostic test for detection of the disease. His family spent Rs. 2000/- for the purpose of detection tests. His parents started his treatment at Totopara PHC. He took all the medicines as recommended by the physician. But further detection test revealed that he was not completely cured and needed a further course of medicine. During the field survey, it was found that he had been collecting the medicine from local PHC and was under the treatment.

B.4.1.5 Village Sector: Panchayat gaon (Category-2 village sector)

Nearer to local Primary Health Centre and the market place

Modern health facility in close proximity

Case: 1

Category: FLM

Subhadra Toto, a 14 years old girl was admitted to Totopara Primary Health Centre for her severe breathing trouble. Her family members were not sure about the actual cause behind the ailment. But she did not respond properly in the treatment and finally referred to Birpara State General Hospital. According to them, she was given artificial oxygen for one day and stayed in the hospital for three days. Due to unavailability of the medicine in the hospital, the patient party had to purchase all the prescribed medicine from outside shops. But somehow they were able to manage the free beds for the patient. At Birpara State General Hospital asthma was detected for the acute breathing trouble. Since then, as suggested by the doctor they always keep an inhaler with them for the emergency purpose. Although Subhadra got some relief but she was not at all completely cured.

Case 2

Category: MLM

As his wife reported, a 27 years aged man Nirol Toto suffered from gastric problem. Poor digestion and occasional but severe stomach ache were the main symptoms of his disease. He visited initially Totopara PHC, then Madarihat Block Hospital and finally at Birpara in a private chamber giving fees of Rs. 100/- in each visit. Doctor prescribed ultrasound for detecting the actual cause of the ailment. Finally gastric ulcer was detected. Prescribed medicines were brought from local medicine shop and the treatment continued up to one year. Patient had to visit the doctor five times during the treatment process. Total cost of the entire treatment was Rs. 4000/-. Although he did not get complete remedy from his ailment

but got some relief. He also reported that irregular diet sometimes causes severe stomach pain.

B. 4.1.6 Village Sector: Subba gaon (Category-2 village sector)

Nearer to local Primary Health Centre and market place

Modern health facility in close proximity

Case: 1

Category: FLM

Rashmi Toto, a 14 years old girl suffered from some serious head ache. Her problem started one year back. The main symptoms were severe head ache along with vomiting and reluctance of taking normal diet. Her family did not take the problem so seriously and did not think about any interference of supernatural agency in this connection. She was initially taken to Totopara Primary Health Centre and then to Birpara. Instead of getting relief, her problem took a serious form. Finally she was taken to Siliguri Mitra Nursing Home. Further she had to go through many of the diagnostic and clinical tests for instance X-ray, blood test, MRI, scan etc. which cost very high considering the poor economic condition of the family. Finally she was detected with some critical brain problem and was admitted under Dr Chang. Treatment continued up to fifteen days and she was completely cured after completing the full course of treatment. Total costing of her treatment was Rs 50,000/-. Her family had to mortgage the agricultural land to arrange the said money as his family income was below Rs. 5000/- per month. They had been giving Rs 500/- installment back to the bank. But the patient party was satisfied because the girl was finally cured.

Case: 2

Category: MHM

Laxmikanta Toto, 50 years old man was found to affect by both tuberculosis and malaria. Four years ago he was affected by malaria. His symptoms were high fever and severe weakness. He went to Totopara Primary Health Centre and blood test detected malaria (PF). He immediately started treatment according to the prescription of local PHC doctor. After completing the course of medicine he was completely cured. He did not need to purchase any medicine from medicine shop but supplied with all the medicines by Totopara PHC.

Last one year back he was also affected by tuberculosis. He himself recognized the disease through counseling doctor of Totopara PHC. For detecting the said disease required test and X-ray occurred at Birpara in a private laboratory. Initially he started treatment at Totopara PHC and collected all the medicines from the same place at free of cost. But he was not fully cured. After reoccurrence of the previous symptoms he consulted with a private doctor (Dr. Biren Roy) at Birpara. He got a very good response after taking the medicines of Dr Biren Roy. He had to spend more than Rs. 3000/- for the total process. During the field survey it was found that, although the doctor was passed away but still he was taking the medicines prescribed by the said doctor.

Case: 3

Category: MLM

Gopal Toto, a forty-nine years old man suffered from external tumour in his neck. He went to a private chamber of a doctor at the first step of his treatment. According to him, he did not feel any pain or irritation in the affected area. But the said doctor advised him to consult a surgeon either at Jalpaiguri or Siliguri. According to the doctor's advice the patient decided to visit a specialist doctor at Siliguri. He had to go through the various tests to diagnose whether the tumour was benign or malignant. The tumour was detected as a benign growth. Finally tumour was operated in a private nursing home at Siliguri and the patient got early recovery. In due course, patient family took loan from Gramin Bank by showing the agricultural land. The patient was completely cured and very much satisfied with the treatment.

Case: 4

Category: MLM

Fifteen year old Suman Toto, son of Gopal Toto also suffered from the same problem as his father. But he suffered from multiple numbers of tumours in his whole body. As his father went through the similar kind of a problem, patient was immediately taken to the same nursing home at Siliguri. But he did not go through any surgery. Only medicines were prescribed. Patient responded very well and need not to carry out further treatment. But the concern doctor advised him regular check up.

B.4.2 Treatment through both Category (Modern and Traditional)

B.4.2.1 Village Sector: Mondal gaon (Category-2 village sector)

Nearer to Totopara Primary Health Centre and market place

Modern health facility in close proximity

Case: 1

Category: MHB (m)

Surit Toto, a five year old boy suffered from a sore in his head just after three months of his birth. According to his father, the infection had spreading nature. The boy was immediately taken to Madarihat, then to Birpara. After getting treatment there was no such improvement. Then he was taken to Coochbeher. But there was no result. Finally they came back to Totopara and consulted the head *paw*, although they were continuing the medicine. After some calculation the head *paw* advised the worship of *luu* by sacrificing a red fowl. As reported by his father, after that worship the boy was cured. For the whole process the patient family had to spend more than Rs. 5000/- (including both traditional and modern treatment).

B.4.2.2 Village Sector: Panchayat gaon (Category-2 village sector)

Nearer to Totopara Primary Health Centre and market place

Modern health facility in close proximity

Case: 2

Category: MLB (m)

Five years old Bihot Toto was attacked by Pneumonia very poorly in last winter. As reported by his mother he was immediately taken to the Totopara Primary Health Centre. Proper diagnosis detected his disease and he treated by prescribed medicine. The patient family had to buy all the medicines from Madarihat and Birpara. According to his mother, since then the boy was very weak. His digestive system was also poorly affected. Then the boy was taken to a traditional medicine man (belongs to Nepali community). The traditional medicine man or *jhakri* detected that the cause of the disease is *najar laga* i.e. the intervention of super natural power. *Jhakri* suggested some penance worship and also gave a *tabij* (auspicious thing) which always should be carried by the boy. Although for the traditional treatment the patient family had to spent Rs 500/- but they were satisfied with the traditional treatment as the boy was cured after the treatment.

B.4.2.3 Village Sector: Subba gaon (Category-2 village sector)

Nearer to market place and local Primary Health Centre

Modern health facility in close proximity

Case 3

Category: MLB (m)

Ganesh Toto (forty seven years old) had always been a patient of hypertension and blood sugar. He started his treatment at Totopara PHC but carried out his treatment in Birpara under the supervision of a private doctor. In a sudden accident (probably stroke) he was partially paralyzed, even he was unable to leave his bed at any circumstances. His family members were so anxious because he was the only earning member of his family. After consultation with the doctor of Totopara PHC he was taken to Birpara State General Hospital where he was admitted for seven days. The patient's family somehow was able to manage free bed but had to purchase all the medicines. The total costing of the treatment was Rs 15000/- . Patient's family had to take dept for bearing the said cost because the family belongs to BPL category. After spending the said money and giving continuous treatment, there was no such remarkable response. So the patient family had stopped the prescribed allopathic medicines. Apart from that financial constrains were also important cause for discontinuing the treatment. Then they decided to go for traditional treatment as because somebody had informed that herbal medicines have the capacity to cure the paralysis patient. He was taken to a *kabiraj* at Ballalguri. A typical liquid medicine was given for daily massage in lieu of Rs 150/- per bottle. Traditional treatment was carried out at the time of field work. As informed by the patient, traditional treatment was much fruitful than that of modern treatment. It was seen by the researcher that the patient was able to walk after getting traditional treatment.

B.4.3 Modern Medical Institutions:

In this section a brief description of modern health care institutions in the studied areas are given for understanding their physical, administrative and instrumental infrastructure. It is needed to apprehend the situations of modern health facilities available in the studied areas.

B.4.3.1 Sub- Centre:

Sub-centres are also known as Sub Primary Health Centres. There was only one sub-centre for serving the whole Totopara village. The sub-centre was situated at Panchayet gaon. Actually the sub-centre did not have any separate building but operated in a single room inside the Totopara Primary Health Centre. The sub-centre was staffed as per the Government rule. There were one ANM i.e. nursing staff and a health assistant (male). The health workers attended the centre trice a week i.e. Monday, Wednesday and Friday from 9 a.m. to 2 p.m. officially. As there was only one sub-centre for serving the whole village, the centre had to attend visitors regularly irrespective of time or day of working. There was an almira for keeping the official records along with some tables and chairs for setting and demonstrating the medicines. The room was noticed cleaned and well decorated with some scientific poster (related to maternal and child care) and calendar. Regarding the equipments, there were two refrigerators for keeping the vaccines. Stock of dettol, savlon, bengine and cotton were noticed. Among the medical instruments, there were thermometer, weight machine (one for babies and one for the adults), pregnancy kit, ceazer, stove, filter and one bed for checkup was also there. Regarding the medicines vitamin oil, paracitamol, metrogil, iron tablets (AFEEL), iron syrup and some medicines for malaria (e.g. chloroquine phosphate tablets) were reported. According to the ANM they always store all those medicines which could cover fever, dysentery, cough and cold, minute eye problem of the babies, protection from septic and skin disease. Huge number of contraceptives i.e. condoms and oral pills were also noticed and that were demonstrated on the table. Copper tubes were also distributed among the women. Regarding the health service, pregnancy tests were regularly done. Immunization (both mother and child) was found to be the major area of concern. ASHA workers submitted their weekly report at sub-centre on Wednesday. Mainly they collected the blood samples and distribute the vaccines in door to door survey. As part of the contact survey process for the treatment of malaria, the ASHA workers were given the duty to distribute malaria medicine to all the inhabitants of 20 meter radius of the concern malaria patient.

Regarding the immunization, TT Buster was given within first three months of pregnancy; second dose was given in four to five month. Iron tablets were given after three months of pregnancy up to nine month. For the delivery of the child, would be mother is referred to Primary Health Centre. Regarding the immunization of the new born baby, first dose of BCG was given 7-15 days; DPT 1 was given in first one and half month; DPT 2 was given in 2.5

month (two and a half month); DPT 3 was given in 3.5 month (three and a half month). Hepatitis A and B vaccines were also given. Measles vaccines were also given in nine to tenth month. When the baby reached one and a half year (1.6 year) DPT Buster was administered and some vitamin oil was also given. The vitamin oil was distributed at a six month interval up to five years of age. Apart from that, in case of large scale polio vaccination, there was only one prefixed immunization date. The health worker along with the Anganwadi workers could distribute a message to the villagers about the day. Medicine supply was reported regular and it was twice in a month from Madarihat.

B.4.3.2 Totopara Primary Health Centre (PHC):

There was only one Primary Health Centre at Totopara for serving the whole village. The health centre was situated at Panchayat gaon. The Totopara Primary Health Centre was established in 1993. Considering the distance, Panchayat gaon, Mondal gaon and Subba gaon can easily access the health facilities provided by PHC in comparison to the rest three sectors i.e. Dhumci gaon, Mitran gaon and Puja gaon. There was a building comprising of two floors. It was a ten bedded PHC. It had eight rooms and two bathrooms. As it was said earlier one sub-centre was also working within the premises of the PHC. The said eight rooms were used for different purposes like (a) observation of patients (b) dressing, stitching and for distribution of medicines (c) store room for keeping the medicines and other necessary materials. There were specific residential place i.e. quarter for doctor and staff. There was one quarter allotted for doctor, one for nursing staff and one for pharmacist. There were total nine staff members in the PHC. A list of them is given below:-

SI No.	Category	Number of Person
1.	Doctor (MBBS)	01
2.	Nurse (GNM)	02
3.	Pharmacist	01
4.	General Duty Assistant	03
5.	Sweeper	01
6.	Driver	01

Source: field survey 2010

As noticed there was only one out door (OPD) for the treatment of the patients and the timing of it were from 9.00 a.m. to 2.00 p.m. for every day except Sunday. The PHC was completely closed on Sundays and National Holidays. Doctor attended the PHC all the six working days

of any week. During his absence the existing nurse and the pharmacist managed the treatment of the patients. Generally, the doctor treated the patient only through clinical observation, but whenever needed, the multipurpose health workers or ASHA collected the blood samples and were sent to Madarihat Block Primary Health Centre or Birpara State General Hospital as per the requirement. Regarding the medical equipments thermometer, weight machine, X-ray machine (but was not in a working condition), autoclave (1), microscope (1), socker machine, oxygen cylinder, nebulizer were noticed. There were instruments viz. needle, forceps, holders, seizers, thermometer, stethoscope and sphygmomanometer for giving the normal treatment to the patients although the presence of dressing tray, bandage, cotton thread for stitching and allied first –aid equipments were noticed during the first visit of the centre. Further it was used during the emergency cases like head injury, cutting of any bodily parts. All the medicines were supplied from District Reserve Store (DRS), District Jalpaiguri to PHC. It was supplied quarterly in a year or in some cases as per the requirement. Three refrigerators were there for preserving the medicines. Regarding clinical examination, diagnosis of malaria and tuberculosis was possible. Detecting malaria, rapid test was followed. Sufficient PF kits were there for detecting malaria. Slide test was also done both for PF and PV malaria. For detection of tuberculosis i.e. AFB test was also provided by PHC.

There was a separate labour room but caesarian facility was available. According to the Medical Officer, regularly 40-50 patient visited Totopara Primary Health Centre for their health need. Fever, cough and cold, dysentery, diarrhea, respiratory tract infection, malaria, tuberculosis and jaundice were treated in PHC. As reported by the medical personnel of PHC, DOT treatment was running very successfully and many T.B. patients were cured after getting treatment in Totopara Primary Health Centre. Paracetamol, Bruphen, Ciprofloxacin, Erythromycin, Ceptran, Vitamin B complex, Agythromycin, Amoxicillin, Artisunate drug etc were noticed in the PHC. As reported, the health personnel stored the medicines under the categories of antibiotic, antiamibic, painkiller, antiscabical, analgesic, paracetamol, paracytological drugs (de-warming drugs). But there was an acute scarcity of anti-venom. In case of snake bite, the patient was referred to Madarihat Block Primary Health Centre or Birpara State General Hospital. Irregular supply of electricity was also a serious problem faced by Totopara Primary Health Centre. Ambulance facility was also available in PHC and to avail that facility the patient party had to pay Rs 150/- to Rs. 350/- depending on the distance to be travelled. Birth controlling medicines and accessories were mainly kept in the adjacent sub-centre and it was distributed from there. In some cases the requisite iron tablets

for the pregnant mother was also distributed from the centre. Although the immunization or regular medical checkup could be done in the PHC but cesarian delivery was not possible there. The infrastructural set up of the Totopara PHC only could permit the normal delivery but there were some instances of forceps deliveries. The serious patients were referred to Madarihat or Birpara or Alipurduar sub-divisional hospital.

Regarding the permanent family planning programme (such as vasectomy or tubectomy operations), the concern PHC did not provide any such facility as per the Government rule. As the studied tribe is Primitive Tribal Group (now known as Particularly Vulnerable Tribal Group) of West Bengal as well as India, Government has restricted their permanent family planning programme. Over all Totopara Primary Health Centre was well equipped and well functioning health centre.

B.4.3.3 Madarihat Block Primary Health Centre: (BPHC upgraded Rural Hospital)

Madarihat Block Primary Health Centre was located at the heart of the block Madarihat, just beside the National Highway 31. Since 1972 to 1980 Madarihat Block Primary Health Centre had been working as Madarihat Primary Health Centre. In the year 1980 Madarihat Primary Health Centre got the status of Madarihat Block Primary Health Centre BPHC. In November 2009, an order was issued by the State Government in which Madarihat BPHC was upgraded to a Rural Hospital, although the order came into force in 2011. During the field survey, it was not found that Madarihat BPHC has been working as a full flagged rural hospital but it was under the process of up gradation. Madarihat BPHC had the bed strength of 30 patients and did not have paying bed facility. There was a male ward and a female ward. Beds were adjusted as per the requirement of the male and female ward. But flour admission was not allowed by the BMOH.

During the field study, five separate buildings were seen and some construction work was going on. One building was allotted for BMOH office, one was for OPD and medicine store, one was for indoor (male and female ward), one building was for 'Anneswa' used for pathological work and counseling section (both the mother and child care, adolescent female problems as well as HIV patients), one building was found to use for various official work. One point should be noted in this regard that, there was a sub-centre with in the premises of

Madarihat BPHC. But the sub-centre had its own separate building. There was no separate labor room as reported the doctors; one section of female ward was used as labour room. A veranda was used for the waiting lounge for the patients. There was no operation theatre (OT).

With the campus of Madarihat BPHC, there were the quarters allotted for doctors, nurses and other health works. As reported, six quarters were allotted for doctors, twelve quarters for nurses (GNMs), six quarters for Group D staff, one for pharmacist and one for PHN (Public Health Nurse).

During the field work, the working strength of the hospital was as follows:-

Sl No.	Category		Number of Persons
1.	Doctor (permanent)	Block Health Officer of Health (BMOH)	01
		Medical Officer (2 nd MO)	03
2.	Doctor	Medical Officer under National Rural Health Mission	01
3.	Homeopathy Doctor		01
4.	Nurse GNM		08
5.	Pharmacist		01
6.	Health Assistant		01
7.	Laboratory Technician (National Rural Health Mission)		02
8.	Health Inspector	Acting Malaria Inspector	01
		Acting Sanitary Inspector	01
9.	Upper Division Clerk		01
10.	Lower Division Clerk		01
11.	Group D Staff		10

Source: field survey 2011

Apart from that one homeopathy doctor was there who was attending the patients all the six working days of a week from 9.00 a.m. to 2.00 p.m. During the field survey one second medical officer was in detainment in Alipurduar Sub-divisional hospital and was not available at Madarihat BPHC. There was an emergency section and 24 hours emergency duty for the doctors and nurses in terms of shifting. OPD was completely free of cost. OPD timings were from 9.00 a.m. to 2.00 p.m. as per the Government rule in each day of week except Sunday. During the field study period two doctors were attending the patients during the OPD hours. As reported, doctors had to check minimum 80-90 patients during the OPD hours in each day.

Regarding the medical instruments, there were five microscopes (all were in working condition), two autoclaves (all were working). Artificial oxygen was readily available as reported by the BMOH. There was an urgent need of X-ray and ultrasound machine. Two categories of pathological diagnosis were possible inside the institution (a) blood test for detection of malaria (b) detection of tuberculosis. The detection of HIV was possible, but patients were referred to Jalpaiguri District Hospital for further treatment. According to BMOH, clinical diagnosis was possible and treatment of leprosy patient was provided under the NLEP programme. Malaria, tuberculosis and leprosy treatments were provided totally free of cost. Separate gynecology section was not available but there was a very urgent need of that section. One point should be important in this regard, there was no infrastructure for any kind of operation, even cesarian deliveries were not possible to perform. Ligation operations were possible. As reported by the doctors of BPHC, they organize medical camps once in a month or once in two month for permanent ligation operations. That prefixed date is announced before 7-10 days of that particular date. Apart from malaria, tuberculosis and leprosy, various other types of diseases were treated in the studied BPHC which includes fever, pneumonia, diarrhea, dysentery, food poisoning, minor respiratory tract infection, minor eye problem, snake bite, jaundice, skin infections etc. In majority of the cases, doctors prescribed the medicines on the basis of clinical diagnosis.

All the medicines, vaccines were supplied from District Reserve Store as per the requirement. There was a steady and a regular supply of medicines as reported by the pharmacist of the centre. But in some emergency cases (particularly at the time of monsoon) scarcity of medicine occurs due to maximum pressure of same kind of patients. Preservation of tetanus vaccine was reported. According to BMOH, supply of anti venom was regular. He also reported, maximum number of snake bite cases occurred during monsoon. Mother and child were referred to adjacent sub-centre for vaccination. Generally vaccines were given by the ANM of the sub-centre. As there was particular date and time (working hours) for the sub-centre for that reason emergency case were tackled by the doctors and nurses of the BPHC.

During the study days, various categories of patients were admitted, but majority of them were suffering from high fever. Some of them were detected with malaria. There were few patients with strong dysentery. Due to scarcity of bed, one patient with high fever was referred to Birpara hospital. Two pregnant women were admitted for the delivery. In general,

they were advised to visit the BPHC just before the delivery date. As the infrastructure could provide only the facility of normal delivery, one patient was referred to Birpara. Burn patients were referred to directly Jalpaiguri District Hospital. All the medicines were supplied from BPHC except few special cases whenever the required medicines were not available at the stock of the BPHC.

Considering the seriousness of the patients, they were referred to either to Birpara State General Hospital or Alipurduar sub-divisional hospital. But few critical cases (such as burn cases) were referred to either district hospital or directly to North Bengal Medical College. There was no Government provided ambulance facility. One private ambulance was present over there for shifting the critical patients in lieu of the payment of Rs 200-500/- depending on the distance to be travelled.

B.4.3.4 Birpara State General Hospital:

Birpara State General Hospital is neither a rural hospital nor Sub-divisional hospital. This hospital was located in Birpara, near about 40 km from Totopara. It was established in 1900 to serve near about two lakh people of Birpara and surrounding area. As the Jalpaiguri District hospital is far away from Birpara or Madarihat block, so there was an urgent need of establishing a multi-specialty hospital for those regions. Although Birpara State General Hospital was not a multi-specialty hospital but some extent fulfilled the demand of common mass. As stated earlier in various case studies, Birpara State General Hospital was always one of the choices from various modern medical institutions by the studied people. This hospital serves nearly two lakhs people of the surrounding area.

Birpara State General Hospital had a two storied building. During the field survey some construction work was going on. Apart from that there were some staff quarters. Bed strength of that hospital was hundred. The building was separated in two segments. All the OPD departments were situated inside one segment along with the medicine distribution chamber. Different indoor wards, operation theatre (OT), general wards, labour room, diagnostic and pathological unit, emergency unit, doctor and nurses rest rooms were located inside the another section. In between the two segments a veranda was there which was sometimes used as the waiting lounge for the patients. In some cases whenever beds were not available, patients were kept in veranda as per the demand of the situation.

During the field work the working strength of the hospital was as follows:-

Sl.No.	Category	Number of Persons
1.	Superintendent	01
2.	General Doctor Medical Officer (GDMO)	08
3.	Gynecologist	01
4.	Radiologist	01
5.	Physician	01
6.	Pediatrician	01
7.	Dentist	01
8.	Deputy Nursing Superintendent	01
9.	Sister	28
10.	Group D	40
11.	Sweeper	05

Source: field study 2010

Doctors were attending the hospital according to their duty chart. There was 24 hours emergency duty for the nurses and doctors in terms of shifting. Nurses handled less critical patients but they had to call the doctor for the treatment of critical patients.

Regarding the medical instruments Ultra-sound machine (2), X-ray machine (2), and other necessary operative instruments were available. Oxygen cylinders were also readily available. Various categories of diagnosis were possible inside the hospital viz.

- (a) Routine examination of blood
- (b) Routine examination of urine
- (c) Detection of malaria
- (d) Pregnancy profile investigation
- (e) Sputum test for detecting tuberculosis
- (f) Detection of AIDS i.e. HIV test

But in case of biopsy or FNAC test they had to refer all the suspected patients to Jalpaiguri District hospital. According to the Super, there was an urgent need of auto-analyzer for further blood investigation. Apart from that all the immunization facilities for mother and child were available. One point should be mentioned here that there was no such infrastructure for major operations as reported by the Super. Only cesarian deliveries and some minor operations were possible with that infrastructure. Regarding permanent family planning facilities, tubectomy and vasectomy operations were done.

Regarding the wards, there was one male general ward, one female ward (both paying and general), one labor ward (gyne ward), one labor room, two operation theaters, and one emergency ward. According to the doctors, there was a need of burning ward and children ward which was absent in the hospital. Burn cases were generally referred to Jalpaiguri District hospital. Apart from that specialist eye department was not available in the hospital. General eye problems were only treated by the doctors. Critical cases were either referred to Jalpaiguri or North Bengal Medical College.

OPD timings were from 9.00 a.m. to 2.00 p.m. in each day of the week except Sunday. As reported, doctor and nurses had to check minimum 150-200 patients during the OPD hours in each day. All the major medicines were supplied from the hospital but it was not possible to supply full courses of medicines due to scarcity of it and the patient had to purchase the rest from outside. Full courses of medicine were supplied in case of leprosy and tuberculosis. The diagnosis of malaria, tuberculosis and supplied medicines for those patients were totally free of cost. Each patient had to purchase an outdoor ticket at a cost of Rs. 5/-. All the medicines, vaccines were supplied from District Reserve Store. A continuous and steady preservation of tetanus vaccine was reported. But it was not noticed in case of anti-venom. Scarcity of anti-venom was a regular problem as reported by the health workers although there was no such infrastructural defect in terms of preservation of it. Medicines were supplied quarterly from the District Reserve Store. According to the Super, medicine strength was sufficient.

During the study days various categories of patients were admitted and majority of them were the pregnant women for their delivery purpose. Apart from that some diarrhea patients and two suspected malaria patients were admitted. As there was scarcity of beds, so the patients had to stay in the above said veranda. In case of pregnant mother, they were generally advised to visit the hospital one day before the delivery date. Caesarian deliveries were regularly done. Patients could stay one day to one week there as per the requirement of the patients. But the administrative authority tried to release the cured patients as early as possible because of the huge demand of the beds. There were three to six deliveries took place in each day. As reported, patient party had to purchase costly as well as valuable medicines from outside and sometimes the required medicine for injection and saline also included an added purchased medical aid from the outside shop. Hospital generally supplied one or two bottle of saline. If required the patient party had to purchase saline from outside. The serious patients were referred to Jalpaiguri District hospital or directly to the North

Bengal Medical College. There was an ambulance for shifting critical patients to the said hospitals in lieu of the payment of Rs.250/- to Rs 500/- for each journey.

B.4.4 Quack:

Existence of the quack can be noticed in many of the rural areas of India in general and West Bengal in particular. The present studied village was also not an exception. It was found from the detailed field study that, to recover from various general as well as casual diseases number of villagers preferred to visit a quack as his remuneration was very nominal and he was easily accessible to the villagers. As the quack offered the necessary medicines to the patients, so it was an additional facility for the villagers and there was no question to go to any outside medicine shops for medicines. In due course, researcher met the only quack of the village Totopara who treated the patients of all the studied six sectors of Totopara village. Narrative form of his interview can represent the thinking pattern of the person, emphasizing his educational as well as family background, intension of treatment and problems facing during treatment procedure.

Mr Hirendra Mankhin Sangma, an 85 years old man was the only quack of the Totopara village. He was well-known and found to be very much accepted among the studied tribe. He resided in the Panchayat gaon village sector with only his wife. They did not have any son or daughter. Along with his medical practices, he also managed a small church within the premises of his homestead land. He also claimed that, at the age of 85 he fulfilled all his requirements by himself and did not take any help from outside. His academic qualification was Matriculation and did not claim as registered medical practitioner. He also told about his experience in the village. He claimed that he came in the village Totopara nearly about 43 years ago as a member of Cooch Behar Swedish Mission (Luthar and World Service). At that time soreasis and other various types of skin infections including leprosy were prevalent among the Totos. Eight to ten people had been expiring due to only various types of skin infections. As part of their welfare work, one Bengali doctor had come from Cooch Behar once a week. He also told that, at that time the Totos did not have any conception regarding the modern medical treatment. If a medicine was given with an instruction that the medicine has to be taken thrice a week, the patient may took that total file just in one dose. According to Mr. Sangma, prescribing medicines and made them cure from any disease was very difficult at that time. He also narrated the fact that, Totopara had always been a malaria,

tuberculosis and jaundice prone zone and there was no facility for detecting the disease. As pathological examinations were not possible, medicines were prescribed on the basis of statement of the patient or the statement of the relatives of the patients. Mr Sangma reported that he continued his work with that organization at Totopara for five years. After that, he decided to settle at Totopara permanently. Since onward, he was residing at Totopara. One point should be mentioned here that he also not reported any case of polio among the Totos.

As reported by him, he was not specialized in any particular type of treatment but treated all types of common diseases. He diagnosed the disease on the basis of his observation and experience. Clinical diagnosis only helped him for prescribing the medicines. He carried out his medical practice in his own medicine shop which was situated at Bajar line in Subba gaon i.e. the only market place in the Totopara village. He stocked all the necessary medicines for minor ailments such as fever, cough and cold, dysentery, diarrhea, stomach ache, head ache, minor respiratory tract infection, eye infection etc. Apart from that bandage, cotton, seizer, injections were also seen in his dispensary. He claimed that he supplied all the medicines at a very reasonable price. He never performed any kind of surgical operation but was able to stitch small injuries or wounds. As reported he had to check average 5-7 patients in a day including all the categories of diseases. His practice time was 9.00 a.m. to 1.00 p.m. in the morning and 4.00 p.m. to 6.00 p.m. in the evening. His remuneration was Rs 15/- excluding the price of medicines. But in many cases villagers were not able to pay the said amount. So he had to take the offerings as people can afford. In some cases people paid his remuneration and cost of medicine in installments. He reported that in some circumstances free treatment along with the medicines was given to the poor patients. He also narrated the fact that before the establishment of Totopara Primary Health Centre (in the year 1993) he had to check large number of patients because there was no other option. At that time he referred all the critical patients to Cooch Behar. Now a day, he referred all the critical patients to local PHC, but in case of PHC returned patients, he advised them to consult the doctor in Cooch Behar or Siliguri. He purchased all his required medicines in a particular medicine shop at Madarihat but he did not himself visit the shop. One sales boy came to Totopara with all the medicines and collected the bill against those medicines.

B.4.5 Modern Medical Personnel: Role and Activities

While discussing about the modern medical facilities in an area, inevitably the role and activities of the modern medical personnel would arise. They are the specialist in western medical treatment process and have detail knowledge regarding the benefits of modern medical treatment.

During the field study researcher met doctors working in Totopara Primary Health Centre (PHC), Madarihat Block Primary Health Centre (BPHC) and Birpara State General Hospital. In due course with the help of an open structured schedule they were interviewed. Narrative form of interviews is given in this sub-section.

Dr. Abhishek Naha, 35 years aged man was the only doctor of Totopara Primary Health Centre. He was the original inhabitant of Kolkata and the second generation doctor of his family. He completed his MBBS degree from the Calcutta Medical Collage and got his first posting in B.C. ROY Hospital after joining West Bengal Health Service (WBHS). He was posted in Totopara Primary Health Centre just before three months ago. He was actually the residential doctor of Totopara PHC and had to attend the outdoor of the PHC from 09:00AM to 01:00PM on all the working days in a week. But unofficially he had to attend patients after 1:00 PM.

Whenever asked about the treatment procedure inside the PHC, he answered that basically clinical diagnosis was the main procedure of treatment. He also told that malaria, tuberculosis and jaundice were very much found among the studied population. If malaria was suspected, he suggested for blood test and the health worker collected the blood for the examination purpose. PHC had the infrastructure for the said examination and took just one day for the report. After confirmation he prescribed medicines. Apart from malaria, detection and treatment of tuberculosis was also possible in Totopara PHC. According to him, there was no infrastructure for any other pathological test and X-ray and that was the main constrain of his treatment procedure. He was also not very much satisfied with the supply of medicines because he had to give medicines 30-40 patients per day on an average which was not manageable by the medicines supplied through District Reserve Store. Shortage of Anti-venom was also reported by him. Apart from malaria, tuberculosis, he informed about the high frequency of skin infection, diarrhea, tooth cavity and anemia among the studied tribe.

He also added that malnutrition was another crucial health problem of the village people. Poor economy education and lack of awareness may be the probable cause behind the problem. According to him, the Toto people did not suffer from any particular kind of food deficiency. They did not found to suffer from protein or vitamin or mineral deficiency at all. But the main problem was that they did not get sufficient amount of balanced food which was necessary to overcome malnutrition.

As he was specialized in child studies, he also showed the researcher number of Toto child with ample signs of under feeding. He also reported that, many Toto patients himself tried to replace prescribed medicine with particular traditional medicine. Just after few days, again they started to take the previously prescribed modern medicine. He also reported that, improper and irregular taking of medicines was very much found among them. As a result, they did not get the expected recovery and blamed the doctor. According to him, lack of awareness was the main problem among the studied tribe.

Dr. Debojyoti Chakraborty, a 42 years old man was the Block Medical Officer of Health at Madarihat Block. He resided in the Government quarter with in the campus of Madarihat Block Primary Health Centre. He was the original inhabitant of district Hoogly and became the first doctor of his family. After completing the MBBS degree he joined West Bengal Health Service and posted in Madarihat BPHC in 2010. He had to attend the outdoor of Madarihat BPHC almost regularly from 9.00 a.m. to 2.00 p.m. because of scarcity of doctors and maximum patient pressure. He also reported that he did not attach with any private dispensary or medical shop.

Whenever asked about his treatment procedure inside the BPHC when he replied that basically clinical diagnosis was the main procedure of treatment except some specific disease. During the study days, he had to treat maximum number of fever patients as reported by him. If malaria was suspected then he suggested for blood test and the laboratory technician collected the blood. Blood was examined in the BPHC lab itself and the patient party had to wait for only one day for collecting the report. According to him, he had to start treatment on the basis of clinical examination prior to the report. He reported that there were no infrastructure for any other pathological tests except malaria, T.B. and AIDS. Lack of X-ray and ultrasound machine were the main constrain of his treatment procedure. He also reported that during those days, majority of the patients were coming with high fever (60-65

days on an average) and he had to check all the patients. The required medicines which had to be distributed among the patients were not manageable by the medicines supplied through District Reserve Store. He opined that large number of tribal patients visited to him including the studied tribe and their health consciousness was increasing day by day. He informed about the high frequency of malaria and dysentery in that zone. Apart from that he also mentioned about the malnutrition particularly among the mother and child. According to him very poor economic condition and educational backwardness could be the possible cause of that problem.

Dr. Joydeb Barman, 48 years aged man was the Superintendent of Birpara State General Hospital. As he told, he was very much administrator than a doctor. Because, as a superintendent he had to look after every aspect of administrative machinery, he had to solve the problem of infrastructure, problems of doctors, patients, nursing staff, administrative staff even group D staff also. Even he had to interfere, when even tension arises between the doctor or administrative staffs and patients party. Naturally he did not get time to treat the patients except some emergency cases. He also told that sometimes he had to attend the OPD patients at the time of scarcity of doctors.

So, he did not involved directly to the clinical diagnosis or prescribing medicines. Although he had a permanent house at Cooch Behar but during the service days he was residing at the doctor quarter inside the hospital. His qualification as a doctor is MBBS. According to him he did not attached with the private dispensary.

Whenever he was asked about the disease frequency, treatment procedure, patient's socio-economic condition, he told that, there was no way to give special attention to the Toto patients although he always tried to do that. As the studied area and the Madaribat block itself was a tribal dominated zone not only the Totos, majority of the tribal patients came to Birpara hospital belong to poor socio-economic background. But he also reported that, there were many Toto patients treating themselves as our patients and in patient. Dr. Barman also reported that inspire having various infrastructural dispute and short fall of doctor and nurses, he tried to provide optimum service to the patients, particularly to the tribals. He also informed about the urgent requirement of burn unit and child intensive care unit in the Birpara Hospital, because many tribal as well as general patients came with serious burn injuries. Apart from that there was an urgent demand of ultra sound machine.

B.4.6 Analysis:

B.4.6.1 Sub-Centre:

As reported, there was not a single studied patient treated by the sub-centre during last five years. It is also supported by the quantitative data that not a single villager attends the centre for their ailment. This fact was supported by the villagers of all the studied six sectors of the village Totopara.

The Totopara sub-centre was situated on the same building of Totopara Health Centre (PHC). According to the studied villagers, the sub-centre was actually an additional medical centre because people could get their overall medical requirement from the Totopara Primary Health Centre (PHC). So, they did not depend upon the Sub-centre but directly went to the Totopara PHC for treating their general ailments. Villagers (both category-1 and category-2 village sectors) used to prefer Sub-centre for collecting contraceptives. Apart from that, at the time of immunization they had to go to the Sub-centre along with their babies. Vaccination of pregnant mother had also been carried out by the only Sub-centre of Totopara village. The multipurpose health workers and ASHA workers of Sub-centre were very particular regarding their work both inside the Sub-centre as well as in the field. They were mainly found to concentrate in various immunization programmes. As per the Government rule, they regularly visited distant as well as close village sectors for the awareness of the villagers.

B.4.6.2 Primary Health Centre:

As stated earlier, there was only one Primary Health Centre for serving the people of whole Totopara village. In few exceptional cases, the concerned PHC also served some Bhutanese people belonging to Doya community who came to Totopara for their business purpose. According to the studied tribe, Totopara Primary Health Centre was their first choice whenever they required any kind of medical assistance. This fact was also supported by the accumulated field data (table 4.1- 4.1.1).

There were instances to regular visit of Totopara Primary Health Centre by the villagers of both category-1 and category-2 village sectors. In category-1 village sectors, nineteen (46.34%) males and twenty five (62.50%) females were reported to visit there for getting

relief from their ailments. Majority of them were suffered from malaria, dysentery and tuberculosis. Among those nineteen males, there were two critical cases which were referred from PHC as there was no such medicine and infrastructural set up for treating those two patients. One was referred to Jalpaiguri District Hospital and another was referred to North Bengal Medical College (NBMC). One patient was suffering from multiple tumour and another patient was suffering from tetanus. Four snake bite cases were also referred to Madarihat BPHC. Twenty-five number of female patients who took treatment from PHC for their ailments and twenty three were completely cured. As per the record of PHC, two critical female patients were referred from PHC. One was a child with retino carcinoma (later detected in North Bengal Medical College), another was a case of multiple tumour.

In category-2 village sectors, fifty five males (40.74%) and seventy one (60.68%) females were reported to visit the PHC for their medical assistance. Among the male patients forty nine (49) males were completely cured after taking treatment from PHC and six patients were referred to either Birpara State General Hospital or Jalpaiguri District Hospital. Among the female patients, sixty five (65) females were completely cured from their ailments.

As reported there were many reasons for the people choice about the Totopara Primary Health Centre (PHC)

- (a) The doctor attendance was very good and nurses were very much competent for the clinical diagnosis.
- (b) Required medicines were almost readily available.
- (c) All the medicines were given free of cost if the required medicines were available.
- (d) Primary Health Centre provided almost 24 hours service to the villagers of Totopara village. In the absence of doctor, pharmacist took the responsibility for providing primary treatment to the patients.
- (e) The timing of outdoor was widely accepted by the villagers. At the same time, timing was flexible and in some cases was adjusted as per the requirement of the patients.
- (f) As the Primary Health Centre (PHC) had the ambulance facility, emergency patients could easily be taken to Madarihat BPHC or Birpara State General Hospital if required.

- (g) The PHC provided diagnostic facilities and treatment of malaria as well as tuberculosis which was very much prevalent among the studied population. Quantitative data also supported the fact.
- (h) Immunization and vaccination facilities of mother and child were executed very properly by the PHC with the help of Sub-centre.
- (i) Finally, last 15 years of health service provided by Totopara Primary Health Centre gained the confidence of Toto people that the concerned PHC could be able to satisfy their primary health need.
- (j) Totopara Primary Health Centre (PHC) with the help of the Sub-centre almost provided door to door health service as per the requirement of the patient belonging to the Toto community (particularly in case of endemic disease).

Thus, it was found that nearly situated only PHC was able to meet the minimum requirements of the studied tribe as said by them. That's why maximum percentage of patients was reported to visit there irrespective of sex and economic status. It was clear from the above study that, whenever they seek for modern medical aid, Totopara PHC was found to be their first choice.

B.4.6.3 Block Primary Health Centre (Madarihat): (Upgrade Rural Hospital)

From the analysis of table 4.1.2 it can be noticed very few patient from the studied population visited the Madarihat Block Primary Health Centre for the modern way of treatment. Only one male from category-1 village sector Dhumci gaon was reported to visit there. On the other hand only one female from category-1 village sector visited the hospital. In case of category- 2 village sectors, altogether eight males and three females visited the said institution. Majority of the patients were snake bite cases. Only two males (one from Panchayat gaon and one male from Subba gaon) suffering from diarrhea took the admission in Block Primary Health Centre. As reported by the villagers, Madarihat Block Primary Health Centre provided almost the similar kind of facilities as provided by the Totopara Primary Health Centre. That was the only reason found not to visit the Madarihat BPHC. Only the snake bite cases were taken to Madarihat BPHC because anti-venom was generally available in the said institution. There was different positive and negative opinion by the studied villagers regarding Madarihat BPHC.

Positive Opinion:

- After Totopara PHC, the closest situated Government medical institution
- Institution can be accessed at any time (24 hrs)
- Availability of more than one doctor and also nurses round the clock
- Detection and treatment of malaria and tuberculosis is possible.
- Clinical testing of and treatment of leprosy is possible.
- Immunization and vaccination to the pregnant mother and new born babies can be possible.
- Counseling of adolescent problems and treatment of some sexually transmitted disease is done.
- Population control aids are distributed. Surgical ligation is also possible.

Negative Opinion:

- Proper attention is not always given to the tribal patients at OPD.
- Costly drugs are not always supplied. Poor villagers have to purchase them from outside.
- No major diagnosis is possible in the institution.
- There was no separate gynecology ward and cesarian deliveries were not possible with that limited infrastructure. Operation Theater was not available.
- Any kind of treatment of burn cases was not possible.
- No major or critical cases can be treated there; villagers have to go to Birpara State General Hospital.

Considering the above said issues villagers did not prefer to go to Madarihat BPHC (upgraded rural hospital). According to the said people, instead of visiting Madarihat BPHC, they preferred to visit Birpara State General Hospital directly.

B.4.6.4 Birpara State General Hospital:

From analyzing table 4.1 and 4.1.3, it can be realized that there were conspicuous percentage of villagers from each studied village sector who visited the Birpara State General Hospital for their treatment. The table also shows separate percentage of males and females in the said context. Along with the above said percentage there are valuable qualitative interpretations that can help to understand the overall situation in different circumstances. While studying table 4.1.3 one can see the percentage of villagers who got remedy after taking treatment in the hospital.

In category-1 village sectors (distant village sectors) eight males and four females visited Birpara State General Hospital for various purposes. Among them, seven males and three females were cured. On the other hand, in category-2 village sector, 34 males and 14 females took the modern way of treatment in the hospital. Among them, 30 males and 14 females were found totally cured. It was noticed that, when the villagers realized that the doctor of Totopara PHC could not be able to cure the disease, then only they visited the hospital. The distance between Totopara and Birpara was almost 40km and it took almost 2hr. Until emergency arises they do not prefer to go Birpara. As reported both from the category-1 and category-2 village sector the in patients were more than the out patients because all the cases were critical and needed extensive attention. Patient party also preferred admission of the patient because admitted cases only could get a total treatment from the hospital. In another situation villagers had to face problem regarding their diagnostic and pathological tests. As reported, they did not get chance to do many of the diagnostic as well as pathological tests in the hospital as they were very late to take entry inside there. Because, after travelling such a long distance from Totopara they could not reach within the scheduled time. Various times they were simply informed by the authority that the test could not be possible because the instruments were out of order. After travelling such a long distance they had to return back home without getting any faithful result. So, in various situations they had to go to the private clinic for those tests and had to spend extra money for the same purpose. Villagers also reported that, various times they did not get the required medicines from the hospital, instead of that, they had to purchase many costly medicines from outside the hospital. As reported, not all but number of doctor was found less attentive and did not spend much more time to listen the exact problem of the patient. Medium of communication sometimes caused problem particularly for the aged population.

The villagers visited to the hospital not only for the treatment of major diseases but they used to go there even for the cesarian delivery purpose; because separate gyne department was available in the hospital. Villagers were more or less satisfied with the facilities provided in gyne ward. But they also complained that, pregnant mother and her relatives had to face difficulties for managing free beds. Sometimes it was also very difficult for a new mother and child to return home within one or two days after delivery as directed by the hospital authority.

B.4.7 Child Health Care:

Children are a critical resource whose growth, nourishment and well being will determine to large extent the course of a country's socio- economic and demographic feature. Discussion about the health issues of any community without discussing aspect of child health care is incomplete. Because the health status of a human can only be improved as well as protected only if he is protected from his childhood. Further the childhood protection entirely depended upon the consciousness of the family members particularly the parents.

B.4.7.1. Place of Birth:

As it is mentioned that the protection should be taken from the conception of baby, so where the birth is taken place is one of the crucial factor for child protection. Among the rural India, there is a trend for home birth.

In this sub-section there will be a discussion about child-birth place in the studied villages. This sub-section will also discuss about the causes of choosing homebirth and also the hospital delivery. The changing scenario will also be discussed in the present context. The table 4.5 to 4.5.6 will represent the quantitative data touching all the studied village sectors and categories of places.

In case of category-1 village sectors (farthest from the market place and Totopara Primary Health Centre) 86.88 percent home birth was recorded. In case of category- 2 village sectors (nearest from the market place and modern health facility in close proximity) 91.35 percent homebirth was recorded. According to the elderly villagers of the studied village, home birth

was safe and most wanted procedure of birth. According to them, there was no problem and risk in such type of procedure. There was an important role of elderly mid-wives at the time of birth. Although, some educated and well to do families (particularly the Government service holder) did not prefer that type of procedure. They opined that, safe birth could not be possible inside home. That categories of families preferred continuous checking and delivery at hospital (either Totopara PHC or Madarihat BPHC and few exceptional cases Birpara State General Hospital). Because of regular checking one can get the exact delivery date and get sufficient time for taking admission. There was not a single case recorded who took admission in nursing home for the child birth purpose.

In case of emergency the patient was taken to hospital. During last 12 to 15 years there was a trend of hospital birth. This trend was particularly prevalent among the young parents who preferred hospital birth irrespective of economic status and sector. After the establishment of Totopara Primary Health Centre in 1993, the concept of safe child birth was gradually changing among the studied tribe. The villagers who reported that the facilities provided by Totopara PHC during the pregnancy period (such as immunization of would be mother, vitamin tonic, iron capsules) was quite satisfactory. Most of the villagers irrespective of sector were found to be influenced by the ASHA, multipurpose health workers and Anganwadi teachers for opting Totopara Health Centre for child birth. From the very beginning of pregnancy they were under the continuous checkup and treatment of Totopara PHC and were timely informed about the exact date of delivery. Apart from that, Janani Suraksha Jozona scheme of Central Government was another important factor for choosing hospital birth. In 'Janani Suraksha Jozona Scheme' each parent was paid Rs. 1200/- for their first child birth, provided the birth took place in the hospital. This scheme was launched in 2008, particularly for the people belong to the BPL category. The main reasons for choosing Totopara PHC for delivery purpose –

- (1) Doctor was always available for taking up the patients.
- (2) Pregnancy card gave all the facilities (like immunization, vitamin capsule, iron tablets)
- (3) Ambulance facility was available for shifting emergency cases (particularly in case of cesarean deliveries)
- (4) Separate gyne kind of ward was provided for pregnant women.

The only constrain faced by the village people that cesarean delivery was not possible in the Totopara Primary Health Centre. It was an urgent need of Totopara PHC. Particularly in rainy season Totopara village was simply cut off from the outside world. At that time if emergency arose, the patient party had to face maximum difficulties.

B.4.7.2 Polio and Pulse Polio:

Infant mortality rate is a good indicator of socio-economic and health status of a community. Immunization is one of the most cost-effective and surest means to give protection against vaccine preventable diseases. Poliomyelitis or Polio is the highly infectious viral disease which had been a threat to Indian children below 5 years of age. Polio mainly affects children under the age of 5 years. Older people with lower immunity levels are also vulnerable. There is no cure for polio. So it was said that polio have only prevention and prevention is to be only through vaccination. Polio vaccines are of two types – the Oral Polio Vaccine (OPV) and the Inactivated Polio Vaccine (IPV). OPV protects not only the person who has taken them but who others living around him. On the other hand IPV is highly effective, only protects the vaccinated person.

In India, vaccination against polio was initiated in 1978 under Expanded Programme on Immunization (EPI) with the aim that all infants should be given 3 doses of oral polio vaccine. In 1985, the Universal Immunization Programme (UIP) was launched and implemented in phased manner to cover all type of population of all district. Following the Global Polio Eradication Initiative of WHO in 1988, the Government of India launched the Pulse Polio Immunization (PPI) Programme in 1995 in addition to UIP. Under this programme all children under 5 years are to be administered 2 doses of OPV in each National Immunization Day (NID) in December and January every year during National and Sub-national immunization rounds (in high risk areas) until polio is eradicated.

Schedule OPV

It was also advised that, if a child is regularly being given OPV as per the scheduled date, then also the child should be administered with OPV at pulse polio camp.

During the period of the study and considering the situation it was needed to give emphasis upon the date about immunization particularly about the polio takers. Government of India

and specifically government of West Bengal gave priority on polio dose, particularly after the failure the drive of eradication of polio by 2000 A.D.

Table 4.7 represents number and percentage of polio taker from the studied village sectors and through Table 4.8 the result of pulse polio drive can be noticed. All the quantitative data on Table 4.7 and 4.8 were given on the basis of field survey among the studied villagers, only depending on their answers. The analysis of different circumstances along with the qualitative formulation is also given in this sub-section in the context of all the studied village sectors.

In case of polio takers quantification, age group of 0-18 years was considered, because there was no such remarkable regular polio taker who took polio according to scheduled date among the studied tribe. Only after the establishment of Totopara Primary Health Centre (year 1993), polio vaccines were regularly available to them. Before that, there was no such consciousness among the studied people about the disease of polio. They could not even be able to distinguish between a child born physically challenged (genetically deformed) or suffering from poliomyelitis. So there was no question of taking polio vaccines regularly before the establishment of Primary Health Centre (PHC) in the village.

It is shown that 46.48 percent male and 49.12 percent female polio taker were recorded from category-1 (farthest from the market place and Totopara Primary Health Centre). Among the three studied village segments from category-1 village sectors, smallest number of polio takers was recorded in Mitran gaon, 32.56 percent male and 42.86 percent female polio takers were recorded in Mitran gaon. Both the percentages were lower in comparison to the other two sectors of category-1 village sectors viz. Dhumci gaon and Puja gaon. Many of the villagers had simply no concept about the disease of poliomyelitis; so, they did not feel any urge of taking polio dose. Many of the villagers had a concept that side effects can be emerged after taking of polio and even death can be occurred as they saw in few exceptional cases polio taker baby were found to suffer from high fever. They were not able to realize the long term positive effect of taking polio dose (OPV). So, they avoided giving polio to their children. One point should be mentioned here that there was no record of taking Inactivated Polio Vaccine (IPV). In general all the villagers of category-1 village sectors had to go Totopara Primary Health Centre after travelling two to three Kilometers of hilly distance. It was particularly difficult during heavy rainy season. Only two female children of those village sectors were not given the last pulse polio dose. Among them one female child was

out of station along with their parents and another was ill. She was suffering from jaundice and was unable to attend the polio camp. During those study days, all the category-1 villagers had already grown the concept that pulse polio was an essential vaccine and their babies could not be able to survive properly if they had not taken the polio dose regularly. But many of them did not know that they could get a pulse polio dose whenever they were outside from their original habitat. Some of them also had the misconception that if they took polio dose outside their village, they have to pay money for that purpose. Apart from that two female child, all the children from category-1 village sectors were given pulse polio dose regularly.

Among the category-2 village sectors (Mondal gaon, Panchayat gaon, Subba gaon) 61.58 percent males and 62.42 percent females were recorded as polio taker. After introducing polio vaccine people of said village sectors (adjacent to market place and Totopara Primary Health Centre) could get their dose from adjacent Totopara PHC which was easily accessible to them. It was also found during the field study that the parents of Category-2 village sectors were much more conscious about regular polio vaccination, although villagers confessed that in past people had very scanty idea about polio vaccine. Not only that they were also very much confused about the consequences and safety of taking polio dose.

In Category-2 village sectors, 96.88 percent male and 98.15 percent female child were found to be the regular polio taker. Two male children from Subba gaon and one female child from Panchayat gaon did not attend the last pulse polio drive. All three of them were ill during that period and their parents were not able to take them into polio camp. The overall scenario of pulse polio drive in Totopara village was satisfactory. Among the studied tribe, 98.21 percent male and 96.81 percent female children were covered properly. Regular campaign helped the villagers to grow proper concept about the polio vaccination. In very few exceptional cases some villagers had grown wrong conception that if a baby took regular polio doses then there was no need to give pulse polio dose. One point should be mentioned here that pulse polio was given in the Anganwadi centres also. Many villagers also thanked the Anganwadi teacher, worker, ASHA workers for giving the exact idea and concepts about the pulse polio. Many villagers also told that mainly ASHA workers covered all the houses of the studied tribe for giving regular polio dose. They also maintained the record who was given the dose and who was not. The exact date of pulse polio drive was also informed by the ASHA workers, Anganwadi teachers and workers. One point should be mentioned here that there

was no sex biasness found among the studied tribe regarding the attendance of polio camp. No preference would be given for the male babies.

B.4.7.3 Integrated Child Development Services:

(Anganwadi Centres)

Majority of children in India have underprivileged childhoods starting from birth. The infant mortality rate of Indian children is 47 and the under five mortality rate is 93 and 25% of new born children are under weight among the nutritional, immunization and educational deficiencies of children in India. To fight against these daunting challenges, Integrated Child Development Scheme was launched in 1975 in accordance to the National Policy for children in India. Over the years it has grown into one of the largest integrated family and community welfare schemes in the world.

Objectives:

The predefined objectives of ICDS are-

- (a) To raise the health and nutritional level of poor Indian children below 6 years of age.
- (b) To create a base for proper mental, physical and social development of children in India.
- (c) To reduce instances of mortality, malnutrition and school drop outs among Indian children.
- (d) To co-ordinate activities of policy formulation and implementation among all departments of various ministries involved in the different Government programmes and schemes aimed at child development across India.
- (e) To provide health and nutritional information and education to mothers of young children to enhance child rearing capabilities of mothers in country of India.

Scope of services:

The following services are sponsored under ICDS to help to achieve its objectives-

- (a) Immunization
- (b) Supplementary nutrition
- (c) Health check up
- (d) Referral services

- (e) Pre-school non formal education
- (f) Nutrition and health education

Delivery of services under ICDS scheme is managed in an integrated manner through Anganwadi centres, its workers and helpers. The services of immunization, health check up and referral services delivered through public health infrastructure under the Ministry of Health and Family Welfare. UNICEF has provided essential supplies for the ICDS scheme since 1975. World Bank has also assisted with the financial and technical support for the programme.

The ICDS team comprises the Anganwadi workers, Anganwadi Helpers, Supervisors, Child Development Project Officers (CDPOs) and District Program Officers (DPOs). Anganwadi Workers, a lady selected from the local community is a community based frontline honorary worker of the of the ICDS program. She is also an agent of social change, mobilizing community support for better care of young children, girls and women. Besides the Medical Officers, Auxiliary Nurse Midwife (ANM) and Accredited Social Health Activist (ASHA) form a team with the ICDS functionaries to achieve convergence of different services.

Integrated Child Development Service (ICDS) scheme was available in all the studied sectors in Totopara village and the scheme was implemented through Anganwadi Centers (AWCs). There were 12 Anganwadi Centre in Totopara village for giving health protection for children up to 6 years and pregnant mothers. The purpose of the centers was to provide nutritional feeding for those persons along with basic education (Pre Primary) for the children of 3-6 age groups. Each centre comprises with two staff as recommended by the Government – One teacher and one helper. Teacher was responsible for giving education along with primary medical aids whenever necessary. An important point should mention in this context that a medicine kit along with nutrition book was given to the teachers which cover the preliminary treatment of minor ailments. Helper was appointed mainly for conducting the nutritional feeding programme. According to the instruction of the Government, cooked food must be supplied to the children and mothers. Cooking materials and medicine kit were supplied to each centre after a periodic interval. There was a post of Supervisor who is also an investigator of the said centers. Generally the Supervisor conducted a monthly field visit to each of the centre for evaluating the activities of the concerned centre. For detailed discussion about the problems and outcome, a monthly zonal meeting was held between the

Supervisor, Staff (Teacher) and Helper. The centre Workers were also responsible for providing information to the villagers about the dates of a vaccination and pulse polio for the children and pregnant mother. There is a Government rule that a child cannot get admission to the primary school without the certificate issued by the Anaganwadi centre. Anganwadi staff had to keep a continuous touch with the multipurpose worker of the Sub centre and Medical Officer and staff of Primary Health Centre (PHC). Joint program of Anganwadi and Sub centre was conducted for giving regular vaccines to the children. Growth monitoring of the children was another important task to be performed by the workers. In the three tier system of health, Anganwadi of first tier, Health Sub- centre at second and PHC was at third step. As reported, at the time critical diseases or emergency the teachers of Anganwadi centers were found to consult the doctor of PHC immediately. Only females were appointed as Supervisors, Teachers and Workers. The educational qualifications were Higher Secondary, Secondary and class VIII passed respectively. All of them were trained by special ICDS instructors.

It was found in field survey that all the ICDS centers worked together and organized health education programme especially for the children and women of Toto society 1st and 2nd Tuesday of every month. Meeting of mothers were also held under ICDS Anganwadi centre. Immunization process like pulse polio programme, Polio drops were given through ICDS centers with the help of Anganwari workers and helpers and ANM. It was found from the field survey that Anganwadi centers played a very important role for achieving good health of the concerned population.

Table: B.4.7.3 (a) Studied Anganwari Centre

SN	Centre Name	Workers Name	Centre No.
1.	Gai Gaon	Malati Tamang	312
2.	Hospital Line	Sanobala Roy	317
3.	Gaitring Line	Bani Toto	324
4.	Puja Gaon	Nita Toto	313
5.	Chandba Line	Sadhana Toto	562
6.	School Line (Panchayet)	Rupa Rana	49
7.	Post Office Gaon	Beauty Sarkar	50
8.	Rai Gaon	Pratima Indua	561
9.	Mangan Gaon	Pinky Deuri	163
10.	Bazaar Line	Rinu Monpal	314
11.	Mitran Gaon	Julia Khawas	315
12.	Pakha Gaon	Banti Toto	316

Table: B.4.7.3 (b) List of Medicines and allied Materials in Anganwadi Kit

Sl. No.	Materials	Power	Quantity / Pack
1	Paracetamol Tablet I.P	500 Mg.	500 Tab 1Jar
2	Paracetamol Syrup I.P	125 Mg/5ML.	50 MI Bottle.

Sl. No.	Medicines
1	Oral Rehydration Salt (ORS) Pkt. (Wt 27.9 Gm)
2	Vitamin A Solution (100,000 I.U/ML)
3	Iron and Folic Acid Tablets
4	Chloroquine Tablet

There are some instructions to Anganwadi Teacher for application of those medicines.

- Receive medicines after checking proper label. Don't take any medicine without label. Try to recognize them with label.
- Keep the medicine in dry and cool place and far from the children.
- After supplying new stock of medicine please check its power.
- Keep separate medicine in separate container.
- Don't use an expiry date over medicine.
- During distribution of medicine keep proper notes including the name, dose and quantity of medicine.

Anganwadi Centers were established not only to serve the Toto people but also covered the non Toto population. Among the above said ICDS centres, Hospital Line, Puja gaon, Chandba line, School line, Post Office line, Bazar line and Mitran gaon Anganwari Centres mainly covered the Toto population. According to the teachers (i.e Workers) of Anganwadi Centres, children belonging to BPL families mainly attended the centres. Parents belonging to Toto community were not very much reluctant regarding registering the name of their children in ICDS Centres. But their attendance was not regular. This was also supported by the accumulated qualitative data. The timing of the centres was from 8:00 AM to 11:00 AM. Parents also agreed that feeding is one of the main attractions of the centre, but the quality of food was not very good. Therefore they did not feel interest to send their children regularly. Many of the parents were also aware that their children could not get admission in the Primary School without the certificate issued by Anganwadi Centre. So they tried to send their children at least twice or trice in a week. Parents who did not bother about their

children's education were reluctant to send. Many of the villagers were not also aware about the medicine kit of Anganwadi Centre. This was the scenario of the whole Totopara village irrespective of the sectors.

According to the villagers, worker and helpers were sincere in their job and tried to attend centres regularly in each working day. Workers regularly organized the scheduled programme and informed the villagers about pulse polio date and routine data.

It is already stated that the activities of Anganwadi also extends benefits to the pregnant mothers. The workers noticed about the pregnancy cases and their dates along with the delivery dates with the help of ASHA Workers. Nutritional feeding programme also covers the pregnant mother up to 6 months after delivery. But among the studied tribe, in very rare cases they enjoyed the said facilities. In the context of immunization, pregnant mother took their required immunization vaccines in either Sub Centre or Totopara Primary Health Centre (PHC), but was not aware that immunization and nutritional feeding of Anganwadi also covered the pregnant mothers. According to the centre workers, they distributed the food to *the house of pregnant mothers but villagers opined that it was not supplied to all the needy houses among the Totos*. As many of the workers belong to Nepali Community, they preferred to distribute food items among the Nepali houses. Regarding immunization, vaccines were given mainly by the ASHA Workers.

B.4.8 Health and Hygiene:

Health, an important asset of any community is the foundation of strong nation. Health is an important determination of economic and social development because diseases creates vicious circle by depleting human energy, leading to low productivity and earning capacity, deteriorating quality and quantity of consumption and standard of living. The ability to add to the physical wealth depends on their physical and mental capabilities. Such capabilities also largely depend on the health status, including the personal hygiene concept. .

To know the overall health status of a population, it is very crucial to observe their regular health consciousness and knowledge about health and hygiene including the food and drinking habit. In the matter of hygiene the question of safe drinking water and proper sanitation are given the first priority. This section is particularly dealing with the whole

environment of the village along with the personal hygiene consciousness of the villagers, their smoking and liquor drinking habits etc.

Individual health and hygiene is largely dependent on adequate availability of drinking water and proper sanitation. There is a direct relationship between water, sanitation and health. Consumption of unsafe drinking water, improper disposal of human excreta, improper environmental sanitation and lack of personal and food hygiene have been major causes of many diseases in developing countries like India.

In the present study, it was found that the distant village sectors (category-1 village sectors) viz. Dhumci gaon, Mitran gaon and Puja gaon were far from car road and nearer to the Teeti forest. In that sense, those village sectors can be said smoke free. But dust was found to be the main problem. Mitran gaon which was situated at the sloping steps of Trading Hill was such more surrounded by trees. On the other hand Dhumci gaon and Puja gaon were surrounded by agriculture plain land. Majority of the houses were wood and bamboo made and roof was thatched with straw. Some Toto families got the concrete houses under the programme of 'Indira Abas Yojana'. According to the villagers regular cleaning of houses was not possible due to scarcity of water. The wooden floors were cleaned twice or thrice in a week by broom depending on the situation. But some well to do families used disinfectant and soap for the cleaning purpose. As noticed during the field study, very few families colored and decorated their houses. More or less all the people knew the use of shop and oil. But the use of oil was reported irregular. Scarcity of water sometimes also restricted the daily use of shop. Different categories of soda and detergent powder were used for washing the cloths. But due to economic contain many of them were unable to buy it regularly. This was commonly noticed in all the three sectors of category-1 villages. As noticed except few, villagers did not have any concept to wash hand before taking food. Accordingly to the villagers, they preferred regular bath but due to scarcity of water it was not always possible. Regular habit of nails and hair cutting was not noticed. Some of the villagers used *neem* branch for cleaning their teeth. Use of brush and toothpaste was observed in the context of economically well-to-do families. But it was also found younger generation preferred brash and tooth paste irrespective of economic class

But they had very little concept about food pollution. Many of them had no idea how the food polluted by the dust. Sometimes they cooked in verandah or courtyard. No such container

was used for keeping out of dust at the time of cooking or after. They were very much fond of dried animal protein such as dried fish and meat. Sometimes they were found to take dried meat after seven days. They also reported that, fish and meat were dried in sunlight for 2-3 days and could be preserved up to 15 days. They stocked *bhutta* or *marua* in big wooden box for next 6 months for consumption only.

It was also found that 91.67 percent families had their own domestic animal in the category-1 village sectors. Pig, hen and cow were the main domestic animal beneath the room. As noticed, particularly pigs were kept in that way. They did not have the concept that mosquito can spread through those animals. This could be one of the probable cause of wide spread malaria in Totopara (mentioned in Table No.4.14) Cows were kept simply in the courtyard. Few well-to-do families had separate animal house for keeping their domestic animal but the number was very small.

As recorded 52.94 percent of male (15-70 years) of those village sectors had regular habit of smoking *bidi*. Sometimes they also smoke cigarette, although most of them knew the harmful effect of smoking. But as reported the main reason of smoking was to minimize their daily tension, young boys smoke just for enjoyment.

Main concrete road of Totopara village went through the village sector Mondal gaon and Panchayat gaon (category-2 village sector). That was also the main bus and tracker route. So, a large segment of villagers of those two village sectors had to face a daily dust of the said road. But villagers of Subba gaon did not face such type of problem. Majority of houses in Mondal gaon and Panchayat gaon were concrete as majority of the well to do Toto families lived in Mondal gaon and Panchayat gaon. But wooden houses were also seen scatterly distributed. In case of Subba gaon, majority of the houses were wooden and bamboo made. More or less all the villagers were concerned about their personal hygiene. Habit of regular bathing and washing of cloths was noticed among them. Few villagers were devoid of regular use of soap and detergent due to their economic constrain. But their number was very small. Most of the villagers were well aware about the contamination of food and safe food taking process. It should be mentioned here that number of families of Panchayat gaon and Mandal gaon had separate concrete kitchen for cooking purpose. So regarding the food pollution concept the response of those villagers was very much better than that of the category-1 village sectors. The villagers of Mondal gaon also had the idea that domestic animal should

be kept in separate place. Nearly 70 percent families had separated animal house. But in case of Panchayat gaon and Subba gaon only the well-to-do families had separate animal house. Most of the villagers also reported that they preferred separate animal house but due to economic constrain they did not able to construct it.

In category-2 village sector 75.20 percent male were found as regular smoker, which was comparatively higher than the category-1 village sector. Consumption of *eu* (country liquor-traditional drink made from *marua*) was the daily habit of more or less all the studied villagers including females and children's above 15 years. This was considered as part of their culture. As stated earlier (Chapter 3) *eu* was essential in all the worships among the studied tribe. As noticed, they also welcomed guests by offering them *eu*. But the trend was changing during the study days. They also considered *eu* as best time passes beverages. The trend of taking *eu* was not preferred by the young generation. According to the villagers, *eu* energizes the people and also keep the body fit. Many people opined that, taking of *eu* cannot be harmful but taking of foreign liquor is harmful.

4.8.1 Drinking Water:

Drinking water supply in the rural areas in India has always been the prime concern of the Government since independence. Community managed open wells, private wells, ponds and small scale irrigation reservoirs have often been the main traditional sources of rural drinking water. The first Government installed rural water supply schemes were implemented in the 1950s as part of the Government policy to provide basic drinking water supply facilities to the rural population. The Government of India's role in the rural drinking water supply sector started in 1972-73 with the launch of Acceleration Rural Water Supply Programme (ARWRSP) to assist the State/ Union Territories for providing potable water to the rural population. The second generation programme started with the launching of Technology Mission (1986-87) later renamed as Rajiv Gandhi National Drinking Water Mission in 1991-92.

National Rural Drinking Water Programme (NRDWP) is being assigned to evolved suitable strategies for drinking water and designing appropriate cost and time effective technologies programmes and schemes which are not only necessary but have also become a strong basic of the success of the Health For All Programme.

Salient Features of the RGNDWM:

- Priority should be given to problematic villages or habitation.
- To accelerate the assumed availability of portable drinking water on a sustainable basis in SC and ST dominated habitations, the states/UTS are required to earmark at least 25% of the NRDWP funds for drinking water supply to the SC dominated habitation and minimum of 10% for the ST dominated habitations.
- Close involvement of the Community and NGO's in implementation operation and maintenance of water facilities including health education campaigns.
- Activities are to be carried out in co-ordination with SSA, ICDS, NRHM and department of Social Welfare.
- Water quality testing laboratories should be formed at Sub-divisional level.

Totopara was situated on the slop of the Tading hill. Due to the adverse soil condition and hilly region tube wells, or hand pumps could not be possible in Totopara. So, water scarcity has always been a serious problem in the village although the region was in the rain shaded area where nature pours down during monsoon. Various streams and streamlets coming from Bhutan Hill were the main drinking water source of the studied population. In 1971 Swedish Missionaries (Luther and world service) established the first water reservoir at Pakha gaon to store the water of Tading Khola. After that, Government took their first initiative in the year 1982-83. There were two another tanks were made by ITDP through Department of PHE Government of West Bengal. The water came from Tading Khola of Bhutan was reserved in those tanks for future use particularly for domestic use. Those water reservoirs were the main source of drinking water of the studied population. In should be also mentioned that, as the water came from neighboring country Bhutan, the Gram Panchayat had to pay Rs. 3500/- to Rs. 4000/- yearly to the Bhutan Government. It was also observed that, small tanks (connecting each other) were made in different village sector for the distribution of water from the main reservoirs.

In the distant village sectors (category-1 village sector viz. Dhumci gaon, Mitran gaon and Puja gaon) the number of tank or water reservoir was insufficient as reported by the villagers. There were four reservoirs in Puja gaon (including the extended Puja gaon) and one each in Dhumci gaon and Mitran gaon. According to the villagers, during monsoon many springs sprout though the hills. They put spited bamboo strips in the opening of those springs for the easy supply of water. Purification of water and cleaning of water reservoirs were also done by

the initiative of Gram Panchayat but there was no specific time frame for that purpose. Purification of water was done once in a month or once in two month. But cleaning of reservoir was very much irregular. Purification of water was done only by using bleaching powder and halogen. Generally spring water was used for regular bath and washing purpose. If spring water was not available, they had to use stored water for all the domestic purposes. Filter or any other purification system was found in the houses of economically well-to-do families. There were 2(two) families in Dhumci goan, 1(one) family in Mitran gaon and 2(two) families in Puja gaon who had their own filter for drinking water purpose.

In hospital adjacent village sector (category-2 sector viz. Mondal gaon, Panchayat gaon and Subba gaon) the number of water reservoir was also insufficient considering the population strength. There were 4(four) reservoirs in Panchayat gaon, 3(three) reservoirs in Subba gaon and 1(one) reservoir found in Mondal gaon. Villagers of these three sectors were found much more conscious regarding the purification and quality of safe drinking water. Number of economically well-to-do families had their own filter or any other own water purification system. They collected water from the common reservoir and only after purification used that water for drinking purpose.

Bathing of domestic animal was done in the nearer river. That was also not a regular practice. According to the villagers scarcity of water had always been the problem of Totopara and they wanted an initiative should be taken from the Government level to solve their problem permanently.

4.8.2 Sanitation:

Being the second most populous country of the world, providing environmentally safe sanitation to millions of people has been the most significant challenge for the Government of India since independence. The task is undoubtedly difficult in a country where the introduction of new technologies sometimes can challenge people's traditions and beliefs.

The concept of sanitation is the hygienic means of promoting health through prevention of human contact with the hazards of wastes. Hazards can be physical, microbiological, biological or chemical agents of disease. Wastes that can cause health problems are human and animal feces, solid waste, domestic waste water (sewage, sullage, grey water), and also

agricultural waste. Hygienic means of prevention can be possible by using engineering solutions (e.g. sewage and waste water treatment), simple technologies (e.g. latrines, septic tanks) or even by personal hygiene practices (e.g. simple hand washing with soap).

The impacts of improper sanitation on human health are significant. Unsafe disposal of human excreta facilitates the transmission of oral fecal diseases, including diarrhea and a range of intestinal worm infections such as hookworm and round worm. Diarrhea accounts for almost one fifth of all deaths among Indian children under five years. Also rampant worm infestation and repeated diarrhea episodes results in widespread childhood malnutrition.

Government of India started the Central Rural Sanitation Programme (CRSP) in 1986 primarily with the objective of improving the quality of life of the rural people. With the broader concept of sanitation, CRSP adopted a demand driven approach with the name 'Total Sanitation Campaign' (TSC) or community led total sanitation with effect from 1999. It actually evolved from the limited achievements of the first structured programme for rural sanitation in India, the Central Rural Sanitation Programme, which had minimum community participation. The main goal of total sanitation campaign is to eradicate the practice of open defecation by 2017. The approach emphasized more on information, education and communication, human resource development, capacity development activities to increase awareness among the rural people including the tribals and generation of demand for sanitary facilities. Community led total sanitation is not focused on building infrastructure, but preventing open defecation through peer pressure and shame. Villages that achieve this status receive monetary rewards and high publicity under a programme called 'Nirmal Gram Puraskar'.

Emergence of Demand:

It is the first and foremost ritual issue. Rural people in general and tribals in particular are habituated with their traditional natures call procedure. So it will take time to mobilize them and to convert them in new procedure. So, prior to implementation people have to aware by health education and awareness programme by various means.

Only after emergence of demand then the sanitation materials can be distributed at a minimum cost.

Regarding the awareness, villagers from category-2 village sectors (viz. Mondal gaon, Panchayat gaon, Subba gaon) some extent showed interest for installing the sanitation system. Open defecation was not common in case of Mondal gaon and to some extent Panchayat gaon. But as noticed, people from extreme ends of Panchayat gaon and Subba gaon practiced open defecation. In various cases they did not even consider open defecation as unhygienic. There was another section of population who still practiced open defecation in spite knowing open defecation was unhygienic and infectious. But many well to do families installed sanitation system by their own initiative, particularly in Mondal gaon and Panchayat gaon. Although the number was very few.

The scenario was much poorer in distant village sectors (i.e. in category-1 village sectors viz. Dhunci gaon, Mitran gaon, Puja gaon). In spite Government installed sanitation, not a single sanitation found which was constructed through private initiative. It was noticed during the field study, open defecation was very common and regular habit among the villagers of category-1 village sectors. There were also some instances where villagers used Government installed sanitation for other purposes, such as store room for fuel collection. According to the villagers economic constrain was the basic problem for installation of sanitation.

Whenever asked to the Government high official about the consequences he answered, there is less awareness among the people. He reported that, there were eighty sanitation installed among the Totos through ITDP projects till date. He also added that economic crisis could not be the problem in this matter. Even the Below Poverty Line (BPL) families can afford this just by paying only Rs 250/- for the purpose. Government subsidizes the rest. So, it could be said that, despite all the initiatives by the Government, studied villagers were not found very much concerned about the sanitation system.

B.4.9 Family Planning (Concept and Techniques):

Realizing that high population growth is inevitable during the initial phases of demographic transition just after the independence, India, the second most populous country of the world became the first country to formulate a National Family Planning Programme in 1952. Since independence, there has been massive change in demographic structure and health status of the population. In last three decades, India witnessed an unprecedented increase in the

number of persons in 15-59 age groups. Every year around 16million people are added to the population, creating more demands for additional resources like clothing, housing, food, education. So, there is an obvious need to meet health and contraceptives needs of this population. The focus of India's health service right through family welfare programme from the early 1950's has been health care for women and children and provision of contraceptive service. The Objective of the policy was reducing birth rate to the extent necessary to stabilize the population at a level consistent with requirement of national economy.

The number of birth should remain unaltered but there is also an urgent need to reduce maternal and infant mortality, so that desired level of fertility could be reduced. Because the high fertility rate leading to the rapid growth of country's population is a major hindrance towards development of a nation like India.

Successive Five-Year plans have been providing the policy framework and funding for the planned development of nationwide health care infrastructure and manpower. The centrally sponsored and hundred percent centrally funded family welfare programme provides the states the additional infrastructure, manpower and consumables needed for improving the health status of women and children and to meet all the felt needs for fertility regulation.

Approach during the Tenth Plan:

The paradigm shift, which began in the Ninth Plan, will be fully operationalized. Reduction in fertility, mortality and population growth rate will be major objectives during the Tenth Plan.

- (a) To access the needs for reproductive and child health at PHC level.
- (b) Centrally defined targets to community need assessment and decentralized areas specific micro planning and implementation of programme for health care for women and children to reduce infant mortality and high desired fertility.

The Major area of concern to achieve the major objectives of the Tenth Five Year Plan-

- (1) Effective maternal and child health care (through CHC, PHC and Anganwadi Centre)
- (2) Ensuring uninterrupted supply of essential drugs, vaccines and contraceptives adequate in quality and appropriate in quality.
- (3) Universal access to information/counseling and service for fertility regulation and contraception with a wide basket of choices.
- (4) Safe management of pregnancy and nutritional service to vulnerable groups.

From time immemorial tribal's have the concept of family planning or population control. For that reason, small size families are prevalent among them.

In the distant village Dhumci gaon (category-1 village sector) 81.48 percent couple had the concept of family planning. Among them 13.64 percent went for operation. Only two (2) Toto couples of that village were reported to use traditional method for the said purpose. There was 31.82 percent couple found to use modern method like contraceptive, particularly condom. In the context of Mitran gaon (category-1 village sector) 72.41 percent couple had clear concept of family planning. Only one (1) couple was reported to use traditional method for the purpose. On the other hand 28.57 percent couple went for operation. In the context of Puja gaon (category-1 village sector) only 40.00 percent couple had the clear concept regarding family planning. Among them 20.00 percent couple went for operation.

Hospital adjacent village sector Mondal gaon (category-2 village sector) 73.91 percent couple had the concept of family planning, among them 29.41 percent operated. Only one (1) couple was found to use traditional method. In the context of Panchayat gaon (category-2 village sector) 61.67 percent couple reported that they had the concept of family planning. Among them 18.92 percent went for any operation. Hospital adjacent village sector Mondal gaon (category-2 village sector) 73.91 percent couple had the concept of family planning, among them 29.41 percent went for any kind of surgical procedure. Although these three sectors were health centre adjacent village sector, still concept of family planning was not up to the mark. Only 49.21 percent couple had the concept of family planning. Apart from that there were some couple found (both from category-1 and category-2 village sector) who had clear concept of family planning but they did not followed any specific modern method.

There were various qualitative implications for above quantitative formulation. One of the basic causes of not choosing traditional method for family planning was unavailability of specific traditional medicines. Apart from that, death of various traditional medicine men able to prescribe those medicines compelled them to think about alternative measures. Due to population control programme campaigning villagers were also losing their faith on traditional medicines.

Regarding the surgical procedure, maximum number of couple preferred tubectomy operation. There was a specific reason for opting tubectomy. They had the concept that vasectomy operation may cause weakness to the male counterpart and they would not be able to do hard work. In search for any alternatives, number of males opined that they did not feel comfort by using condom. But still they used it because they could get that free of cost from the Local Primary Health Centre. Number of females also reported that they were not able to lead their normal life after taking oral pills like Mala D or Saheli.

So, the above said couple had the clear concept of family planning but afraid of using any of the modern method. They also did not rely upon traditional one because they changed their mind after counseling with the doctor, nurses and health workers.

It should be mentioned here that the educated section of the studies population were found to be much more conscious about their family planning. Particularly, the young couples adopted various modern family planning methods. Now-a-days number of male members of Toto Society went not only in Bhutan but also Kalachini, Hamiltonganj and many other places for their economic purpose. Apart from that, in all the village sectors of Totopara village, the studied tribe was also surrounded by immigrated Nepali community people. Various Government population control campaigning programmes in Totopara and also interaction with the outside world make them aware about different types of modern family planning method. This could be the probable cause that the couples from distant village sectors also were using various modern family planning techniques.

On the other hand as the studied tribal population belongs to Particularly Vulnerable Tribal Group category, they were not allowed to go for any permanent family planning, as per the Government rule and policy. During the study days it was found that due to economic scarcity, they were not willing to take more than 2/3 children. As a result, they went to the

private hospitals and clinics for tubectomy or vasectomy operations. Particularly, they preferred Hamiltongunj or Kalcini for that purpose. They did not disclose their identity as Toto. Their Mongoloid feature helped them to hide their indigenous identity. As their physical feature was very similar to the Nepali people, they did not get much trouble to register any Nepali name at those private institutions. This trend was particularly found among the young educated generation. But elderly population did not found to follow any unfair measure for permanent family planning purpose.

As their population is very small, Government continuously encourages them to expand their family size, still they were not responding to the appeal. According to them the main reason was unsolved land problem. Most of the people were pursuing the same view. According to the studied tribe, 2000 acre of land was recorded in the name of Late. Dhonopati Toto up to 1968 and that amount of land were distributed among all the Toto families. But in 1978, after abolition of Jamindari Act, Government official enumerated the land of Totopara once again. At that time, the Toto people showed only 333 acre of land to the Government officials in a fear that if they showed higher amount of land they had to pay more tax which was beyond *their capacity. As a result only 333 acre of land was recorded in the individual name of some* Toto families. The rest amount of land was declared vested. Apart from that, vested land was gradually encroaching by the immigrated Nepali community people. So the studied tribe was found in constant stress that they could not be able to provide accommodation to their feature generation. Apart from poverty, this was one of the most important reasons which compelled them for choosing permanent family control measure.

Chapter Summary:

Chapter: 4 was framed in two separate divisions. Section -A of the chapter discussed about health service scenario of the country, Indian system of medicine, rural health infrastructure, National drug policy etc. The health scenario of the country and the different Government policies formulated for the amelioration of socio- economic status of the Indian tribal population were discussed in detail. At a glance the health infrastructure of the country was given for understanding of the forth coming section of the entire study. A discussion was also made on the overall tribal health problem.

In the later half i.e. Section-B, detailed discussion about the health facilities and programmes of the studied areas was given. Treatment by modern medical institution and practitioners (selected case studies), the actual condition of modern medical institutions such as Primary Health Centre (PHC), Sub-centre, Block Primary Health Centre (upgraded rural hospital), and the nearest State General Hospital were given in detail. Within this chapter a small section was allotted to evaluate and discuss the role and activities of the modern medical practitioners, nurses, staff, and health workers. Case studies of those patients were also given who availed the modern medical facilities in different circumstances. Child health care practices, health hygiene, water supply and sanitation, family planning particularly among the studied people were evaluated in detail.

TABLE: 4.1 CATEGORY OF TREATMENT (MODERN)

Name of the Sectors		Male							Female						
		PHC	BPHC	Birpara SGH	District Hospital	Private Doctor	Quack	Total	PHC	BPHC	Birpara SGH	District Hospital	Private Doctor	Quack	Total
Category: 1	Dhumci gaon	10 47.62	01 04.76	04 19.05	01 04.76	01 04.76	04 19.05	21 100.00	07 41.18	01 05.88	01 05.88	01 05.88	-	07 41.18	17 100.00
	Mitran gaon	04 50.00	-	01 12.50	-	01 12.50	02 25.00	08 100.00	11 78.57	-	02 14.29	-	-	01 07.14	14 100.00
	Puja gaon	05 41.67	-	03 25.00	-	-	04 33.33	12 100.00	07 77.78	-	01 11.11	01 11.11	-	-	09 100.00
	Total	19 46.34	01 02.44	08 19.51	01 02.44	02 04.89	10 24.39	41 100.00	25 62.50	01 02.50	04 10.00	02 05.00	-	08 20.00	40 100.00
Category: 2	Mondal gaon	18 62.07	02 06.89	05 17.24	-	03 10.34	01 03.45	29 100.00	13 52.00	01 04.00	03 12.00	-	03 12.00	05 20.00	25 100.00
	Panchayat gaon	25 36.23	04 05.79	20 28.98	01 01.45	01 01.45	18 26.09	69 100.00	41 64.06	02 03.13	09 14.06	-	-	12 18.75	64 100.00
	Subba gaon	12 32.43	02 05.41	09 24.32	-	02 05.41	14 37.84	37 100.00	17 60.71	-	02 07.14	-	-	09 32.14	28 100.00
	Total	55 40.74	08 05.93	34 25.19	01 0.74	06 04.44	33 24.44	135 100.00	71 60.68	03 02.56	14 11.96	-	03 02.56	26 22.22	117 100.00
Grand Total		74 42.05	09 05.11	42 23.86	02 01.14	08 04.55	43 24.43	176 100.00	96 61.15	04 02.55	18 11.46	02 01.27	03 01.91	34 21.66	157 100.00

PHC=Primary Health Centre (Totopara), BPHC= Block Primary Health Centre (Madarihat), SGH= State General Hospital

TABLE: 4.1.1 RESULT OF TREATMENT (MODERN; PHC)

Name of the Sectors		Male			Female		
		Cured	Not cured	Total	Cured	Not cured	Total
Category : 1	Dhumci gaon	09 90.00	01 10.00	10 100.00	07 100.00	-	07 100.00
	Mitran gaon	03 90.00	01 10.00	04 100.00	11 100.00	-	11 100.00
	Puja gaon	05 100.00	-	05 100.00	05 71.43	02 28.57	07 100.00
	Total	17 89.47	02 10.53	19 100.00	23 92.00	02 08.00	25 100.00
Category : 2	Mondal gaon	16 88.89	02 11.11	18 100.00	13 100.00	-	13 100.00
	Panchayat gaon	21 84.00	04 16.00	25 100.00	37 90.24	04 9.76	41 100.00
	Subba gaon	12 100.00	-	12 100.00	15 88.24	02 11.76	17 100.00
	Total	49 89.09	06 10.91	55 100.00	65 91.55	06 08.45	71 100.00
Grand Total		66 89.19	08 10.81	74 100.00	88 91.67	08 08.33	96 100.00

TABLE: 4.1.2 RESULT OF TREATMENT (MADARIHAT BPHC)

Name of the Sectors		Male			Female		
		Cured	Not cured	Total	Cured	Not cured	Total
Category : 1	Dhumci gaon	01 100.00	-	01 100.00	01 100.00	-	01 100.00
	Mitran gaon	-	-	-	-	-	-
	Puja gaon	-	-	-	-	-	-
	Total	01 100.00	-	01 100.00	01 100.00	-	01 100.00
Category : 2	Mondal gaon	01 50.00	01 50.00	02 100.00	01 100.00	-	01 100.00
	Panchayat gaon	04 100.00	-	04 100.00	02 100.00	-	02 100.00
	Subba gaon	01 50.00	01 50.00	02 100.00	-	-	-
	Total	06 75.00	02 25.00	08 100.00	03 100.00	-	03 100.00
Grand Total		07 77.78	02 22.22	09 100.00	04 100.00	-	04 100.00

TABLE: 4.1.3 RESULT OF TREATMENT (MODERN; BIRPARA STATE GENERAL HOSPITAL)

Name of the Sectors		Male			Female		
		Cured	Not cured	Total	Cured	Not cured	Total
Category : 1	Dhumci gaon	03 75.00	25 25.00	04 100.00	01 100.00	-	01 100.00
	Mitran gaon	01 100.00	-	01 100.00	01 50.00	01 50.00	02 100.00
	Puja gaon	03 100.00	-	03 100.00	01 100.00	-	01 100.00
	Total	07 87.50	01 12.50	08 100.00	03 66.66	01 33.33	04 100.00
Category : 2	Mondal gaon	04 80.00	01 20.00	05 100.00	03 100.00	-	03 100.00
	Panchayat gaon	17 85.00	03 15.00	20 100.00	09 100.00	-	09 100.00
	Subba gaon	09 100.00	-	09 100.00	02 100.00	-	02 100.00
	Total	30 88.24	04 11.76	34 100.00	14 100.00	-	14 100.00
Grand Total		37 88.09	05 11.90	42 100.00	17 94.44	01 05.55	18 100.00

TABLE: 4.1.4 RESULT OF TREATMENT (JALPAIGURI DISTRICT HOSPITAL)

Name of the Sectors		Male			Female		
		Cured	Not cured	Total	Cured	Not cured	Total
Category : 1	Dhumci gaon	-	01 100.00	01 100.00	01 100.00	-	01 100.00
	Mitran gaon	-	-	-	-	-	-
	Puja gaon	-	-	-	-	01 100.00	01 100.00
	Total	-	01 100.00	01 100.00	01 50.00	01 50.00	02 100.00
Category : 2	Mondal gaon	-	-	-	-	-	-
	Panchayat gaon	01 100.00	-	01 100.00	-	-	-
	Subba gaon	-	-	-	-	-	-
	Total	01 100.00	-	01 100.00	-	-	-
Grand Total		01 50.00	01 50.00	02 100.00	01 50.00	01 50.00	02 100.00

TABLE: 4.1.5 RESULT OF TREATMENT (MODERN; PRIVATE DOCTOR)

Name of the Sectors		Male			Female		
		Cured	Not cured	Total	Cured	Not cured	Total
Category : 1	Dhumci gaon	01 100.00	-	01 100.00	-	-	-
	Mitran gaon	01 100.00	-	01 100.00	-	-	-
	Puja gaon	-	-	-	-	-	-
	Total	02 100.00	-	02 100.00	-	-	-
Category : 2	Mondal gaon	03 100.00	-	03 100.00	02 66.67	01 33.33	03 100.00
	Panchayat gaon	-	01 100.00	01 100.00	-	-	-
	Subba gaon	01 50.00	01 50.00	02 100.00	-	-	-
	Total	04 66.67	02 33.33	06 100.00	02 66.67	01 33.33	03 100.00
Grand Total		06 75.00	02 25.00	08 100.00	02 66.67	01 33.33	03 100.00

TABLE: 4.1.6 RESULT OF TREATMENT (MODERN; QUACK)

Name of the Sectors		Male			Female		
		Cured	Not cured	Total	Cured	Not cured	Total
Category : 1	Dhumci gaon	01 25.00	03 75.00	04 100.00	04 57.14	03 42.86	07 100.00
	Mitran gaon	02 100.00	-	02 100.00		01 100.00	01 100.00
	Puja gaon	04 100.00	-	04 100.00	-	-	-
	Total	07 70.00	03 30.00	10 100.00	04 50.00	04 50.00	08 100.00
Category : 2	Mondal gaon	01 100.00	-	01 100.00	05 100.00	-	05 100.00
	Panchayat gaon	13 72.22	05 27.78	18 100.00	09 75.00	03 25.00	12 100.00
	Subba gaon	12 85.71	02 14.29	14 100.00	07 77.78	02 22.22	09 100.00
	Total	26 78.79	07 21.21	33 100.00	21 80.77	05 19.23	26 100.00
Grand Total		33 76.74	10 23.26	43 100.00	25 73.53	09 26.47	34 100.00

TABLE: 4.2 RESULT OF TREATMENT (BOTH)

Name of the Sectors		Male				Female			
		Cured	Not cured	Treat-ment in progress	Total	Cured	Not cured	Treat-ment in progress	Total
Category : 1	Dhumci gaon	15 78.95	02 10.53	02 10.53	19 100.00	13 86.67	-	02 13.33	15 100.00
	Mitran gaon	04 57.14	-	03 42.86	07 100.00	02 66.67	-	01 33.33	03 100.00
	Puja gaon	03 100.00	-	-	03 100.00	-	-	02 100.00	02 100.00
	Total	22 75.86	02 6.89	05 17.24	29 100.00	15 75.00	-	05 25.00	20 100.00
Category : 2	Mondal gaon	06 66.67	01 11.11	02 22.22	09 100.00	-	01 12.50	07 87.50	08 100.00
	Panchayat gaon	07 53.85	-	06 46.15	13 100.00	09 60.00	-	06 40.00	15 100.00
	Subba gaon	07 58.33	-	05 41.67	12 100.00	05 50.00	01 10.00	04 40.00	10 100.00
	Total	20 58.82	01 2.94	13 38.24	34 100.00	14 42.42	02 6.06	17 51.52	33 100.00
Grand Total		42 66.67	03 4.76	18 28.57	63 100.00	29 54.72	02 3.77	22 41.51	53 100.00

TABLE: 4.3.1 PREFERENCE OF TREATMENT IN DHUMCI GAON

Disease related symptoms/ misfortunes	Total persons suffered		Types of treatment						No treatment	
			Traditional		Modern		Both			
	M	F	M	F	M	F	M	F	M	F
Anemia	-	02 100.00	-	01 50.00	-	01 50.00	-	-	-	-
Arthritis	-	-	-	-	-	-	-	-	-	-
Asthma	-	01 100.00	-	-	-	01 100.00	-	-	-	-
Blood Pressure	07 100.00	05 100.00	01 14.29	-	05 71.43	05 100.00	01 14.29	-	-	-
Cancer	01 100.00	-	-	-	01 100.00	-	-	-	-	-
Cough & cold	15 100.00	09 100.00	-	02 22.22	08 53.33	05 55.56	06 40.00	02 22.22	01 06.67	-
Diarrhea	04 100.00	09 100.00	-	01 11.11	04 100.00	02 22.22	-	06 66.67	-	-
Fever	05 100.00	03 100.00	03 60.00	-	02 40.00	-	-	03 100.00	-	-
Fracture	-	-	-	-	-	-	-	-	-	-
Gastric	-	01 100.00	-	-	-	-	-	01 100.00	-	-
Giddiness	-	-	-	-	-	-	-	-	-	-
Headache	-	-	-	-	-	-	-	-	-	-
Heart disease	-	-	-	-	-	-	-	-	-	-
Jaundice	04 100.00	07 100.00	04 100.00	07 100.00	-	-	-	-	-	-
Malaria	06 100.00	02 100.00	-	-	-	-	06 100.00	02 100.00	-	-
Miscarriage	-	-	-	-	-	-	-	-	-	-
Pneumonia	-	-	-	-	-	-	-	-	-	-
Skin disease	02 100.00	01 100.00	-	-	-	-	02 100.00	01 100.00	-	-
Stomach ache	-	02 100.00	-	-	-	02 100.00	-	-	-	-
Tuberculosis	02 100.00	01 100.00	-	-	-	01 100.00	02 100.00	-	-	-
Tumor	01 100.00	-	-	-	01 100.00	-	-	-	-	-
Ghost attack	01 100.00	-	01 100.00	-	-	-	-	-	-	-
Snake bite	02 100.00	-	-	-	-	-	02 100.00	-	-	-
Total	50 100.00	43 100.00	09 18.00	11 25.58	21 42.00	17 39.53	19 38.00	15 34.88	01 02.33	-

TABLE: 4.3.2 PREFERENCE OF TREATMENT IN MITRAN GAON

Disease related symptoms/ misfortunes	Total persons suffered		Types of treatment						No treatment	
			Traditional		Modern		Both			
	M	F	M	F	M	F	M	F	M	F
Anemia	-	01 100.00	-	-	-	01 100.00	-	-	-	-
Arthritis	01 100.00	02 100.00	-	-	-	02 100.00	01 100.00	-	-	-
Asthma	01 100.00	-	-	-	-	-	01 100.00	-	-	-
Blood Pressure	-	03 100.00	-	-	-	03 100.00	-	-	-	-
Cancer	-	-	-	-	-	-	-	-	-	-
Cough & cold	-	-	-	-	-	-	-	-	-	-
Diarrhea	01 100.00	02 100.00	-	-	01 100.00	02 100.00	-	-	-	-
Fever	-	-	-	-	-	-	-	-	-	-
Fracture	01 100.00	-	-	-	-	-	01 100.00	-	-	-
Gastric	-	-	-	-	-	-	-	-	-	-
Giddiness	-	-	-	-	-	-	-	-	-	-
Head ache	-	-	-	-	-	-	-	-	-	-
Heart disease	01 100.00	-	-	-	01 100.00	-	-	-	-	-
Jaundice	03 100.00	04 100.00	03 100.00	02 50.00	-	02 50.00	-	-	-	-
Malaria	04 100.00	05 100.00	-	01 20.00	02 50.00	02 40.00	02 50.00	02 40.00	-	-
Miscarriage	-	-	-	-	-	-	-	-	-	-
Pneumonia	01 100.00	-	-	-	-	-	01 100.00	-	-	-
Skin disease	-	02 100.00	-	01 50.00	-	-	-	01 50.00	-	-
Stomach ache	-	-	-	-	-	-	-	-	-	-
Tuberculosis	03 100.00	02 100.00	-	-	03 100.00	02 100.00	-	-	-	-
Tumor	03 100.00	02 100.00	-	-	03 100.00	02 100.00	-	-	-	-
Ghost attack	01 100.00	-	-	-	-	-	01 100.00	-	-	-
Snake bite	01 100.00	-	-	-	01 100.00	-	-	-	-	-
Total	18 100.00	21 100.00	03 16.67	04 19.05	08 44.44	14 66.67	07 38.89	03 14.29	-	-

TABLE: 4.3.3 PREFERENCE OF TREATMENT IN PUJA GAON

Disease related symptoms/ misfortunes	Total persons suffered		Types of treatment						No treatment		
			Traditional		Modern		Both				
	M	F	M	F	M	F	M	F	M	F	
Anemia	-	-	-	-	-	-	-	-	-	-	-
Arthritis	-	02 100.00	-	-	-	-	-	02 100.00	-	-	
Asthma	-	-	-	-	-	-	-	-	-	-	
Blood Pressure	01 100.00	-	-	-	01 100.00	-	-	-	-	-	
Cancer	-	-	-	-	-	-	-	-	-	-	
Cough & cold	-	-	-	-	-	-	-	-	-	-	
Diarrhea	02 100.00	02 100.00	-	-	02 100.00	02 100.00	-	-	-	-	
Fever	-	02 100.00	-	02 100.00	-	-	-	-	-	-	
Fracture	-	-	-	-	-	-	-	-	-	-	
Gastric	-	-	-	-	-	-	-	-	-	-	
Giddiness	-	-	-	-	-	-	-	-	-	-	
Headache	-	-	-	-	-	-	-	-	-	-	
Heart disease	-	-	-	-	-	-	-	-	-	-	
Jaundice	02 100.00	03 100.00	02 100.00	03 100.00	-	-	-	-	-	-	
Malaria	05 100.00	04 100.00	-	-	03 60.00	04 100.00	02 40.00	-	-	-	
Miscarriage	-	01 100.00	-	-	-	01 100.00	-	-	-	-	
Pneumonia	01 100.00	-	-	-	-	-	01 100.00	-	-	-	
Skin disease	03 100.00	-	03 100.00	-	-	-	-	-	-	-	
Stomach ache	01 100.00	01 100.00	01 100.00	-	-	01 100.00	-	-	-	-	
Tuberculosis	04 100.00	01 100.00	-	-	04 100.00	01 100.00	-	-	-	-	
Tumor	-	-	-	-	-	-	-	-	-	-	
Snake bite	02 100.00	-	-	-	02 100.00	-	-	-	-	-	
Ghost attack	01 100.00	-	01 100.00	-	-	-	-	-	-	-	
Total	22 100.00	16 100.00	07 31.82	05 31.25	12 54.55	09 56.25	03 13.64	02 12.50	-	-	

TABLE: 4.3.4 PREFERENCE OF TREATMENT IN MONDAL GAON

Disease related symptoms/ misfortunes	Total persons suffered		Types of treatment						No treatment	
			Traditional		Modern		Both			
	M	F	M	F	M	F	M	F	M	F
Anemia	-	09 100.00	-	-	-	07 77.78	-	02 22.22	-	-
Arthritis	-	-	-	-	-	-	-	-	-	-
Asthma	-	02 100.00	-	-	-	-	-	02 100.00	-	-
Blood Pressure	01 100.00	03 100.00	-	-	01 100.00	-	-	03 100.00	-	-
Cancer	-	-	-	-	-	-	-	-	-	-
Cough & cold	12 100.00	-	02 16.67	-	10 83.33	-	-	-	-	-
Diarrhea	04 100.00	-	-	-	04 100.00	-	-	-	-	-
Fever	06 100.00	08 100.00	-	-	-	08 100.00	06 100.00	-	-	-
Fracture	02 100.00	-	-	-	02 100.00	-	-	-	-	-
Gastric	-	-	-	-	-	-	-	-	-	-
Giddiness	-	-	-	-	-	-	-	-	-	-
Head ache	-	02 100.00	-	-	-	02 100.00	-	-	-	-
Heart disease	02 100.00	-	-	-	02 100.00	-	-	-	-	-
Jaundice	05 100.00	04 100.00	04 80.00	03 75.00	-	-	01 20.00	01 25.00	-	-
Malaria	07 100.00	04 100.00	-	-	07 100.00	04 100.00	-	-	-	-
Miscarriage	-	02 100.00	-	-	-	02 100.00	-	-	-	-
Pneumonia	-	-	-	-	-	-	-	-	-	-
Skin disease	-	-	-	-	-	-	-	-	-	-
Stomach ache	03 100.00	-	01 33.33	-	01 33.33	-	01 33.33	-	-	-
Tuberculosis	02 100.00	-	-	-	02 100.00	-	-	-	-	-
Tumor	-	-	-	-	-	-	-	-	-	-
Snake bite	01 100.00	02 100.00	-	-	-	02 100.00	01 100.00	-	-	-
Ghost attack	-	-	-	-	-	-	-	-	-	-
Total	45 100.00	36 100.00	07 15.56	03 8.33	29 64.44	25 69.44	09 20.00	08 22.22	-	-

TABLE: 4.3.5 PREFERENCE OF TREATMENT IN PANCHAYAT GAON

Disease related symptoms/ misfortunes	Total persons suffered		Types of treatment						No treatment	
			Traditional		Modern		Both			
	M	F	M	F	M	F	M	F	M	F
Anemia	-	01 100.00	-	-	-	-	-	01 100.00	-	-
Arthritis	-	01 100.00	-	-	-	-	-	01 100.00	-	-
Asthma	01 100.00	02 100.00	01 100.00	-	-	-	-	02 100.00	-	-
Blood Pressure	04 100.00	02 100.00	04 100.00	-	-	-	-	02 100.00	-	-
Cancer	-	01 100.00	-	-	-	01 100.00	-	-	-	-
Cough & cold	23 100.00	16 100.00	08 34.78	-	11 47.83	05 43.75	04 17.39	09 56.25	-	-
Diarrhea	03 100.00	-	-	-	03 100.00	-	-	-	-	-
Fever	25 100.00	28 100.00	-	07 25.00	25 100.00	21 75.00	-	-	-	-
Fracture	04 100.00	10 100.00	01 25.00	-	-	09 90.00	03 75.00	-	-	01 10.00
Gastric	02 100.00	01 100.00	01 50.00	-	-	01 100.00	01 50.00	-	-	-
Giddiness	02 100.00	-	01 50.00	-	-	-	01 50.00	-	-	-
Headache	03 100.00	-	01 33.33	-	-	-	02 66.67	-	-	-
Heart disease	-	01 100.00	-	-	-	01 100.00	-	-	-	-
Jaundice	04 100.00	02 100.00	04 100.00	02 100.00	-	-	-	-	-	-
Malaria	18 100.00	18 100.00	-	-	18 100.00	18 100.00	-	-	-	-
Miscarriage	-	-	-	-	-	-	-	-	-	-
Pneumonia	-	01 100.00	-	-	-	01 100.00	-	-	-	-
Skin disease	-	01 100.00	-	-	-	01 100.00	-	-	-	-
Stomachache	01 100.00	01 100.00	01 100.00	-	-	01 100.00	-	-	-	-
Tuberculosis	07 100.00	02 100.00	-	-	07 100.00	02 100.00	-	-	-	-
Tumor	-	-	-	-	-	-	-	-	-	-
Snake bite	05 100.00	01 100.00	-	-	05 100.00	01 100.00	-	-	-	-
Ghost attack	02 100.00	-	-	-	-	-	02 100.00	-	-	-
Total	104 100.00	89 100.00	22 21.15	09 10.11	69 66.35	64 71.91	13 12.50	15 16.85	-	01 01.12

TABLE: 4.3.6 PREFERENCE OF TREATMENT IN SUBBA GAON

Disease related symptoms/ Misfortune	Total persons suffered		Types of treatment						No treatment		
			Traditional		Modern		Both				
	M	F	M	F	M	F	M	F	M	F	
Anemia	-	-	-	-	-	-	-	-	-	-	-
Arthritis	01 100.00	01 100.00	-	-	01 100.00	-	-	01 100.00	-	-	
Asthma	-	01 100.00	-	-	-	-	-	01 100.00	-	-	
Blood Pressure	09 100.00	05 100.00	-	-	03 33.33	05 100.00	06 66.67	-	-	-	
Cancer	-	-	-	-	-	-	-	-	-	-	
Cough & cold	-	-	-	-	-	-	-	-	-	-	
Diarrhea	-	-	-	-	-	-	-	-	-	-	
Fever	03 100.00	03 100.00	-	-	01 33.33	01 33.33	02 66.67	02 66.67	-	-	
Fracture	-	-	-	-	-	-	-	-	-	-	
Gastric	02 100.00	-	-	-	-	-	02 100.00	-	-	-	
Giddiness	01 100.00	-	-	-	-	-	01 100.00	-	-	-	
Head ache	02 100.00	06 100.00	-	-	01 50.00	05 83.33	01 50.00	01 16.67	-	-	
Heart disease	-	-	-	-	-	-	-	-	-	-	
Jaundice	04 100.00	06 100.00	04 100.00	05 83.33	-	-	-	01 16.67	-	-	
Malaria	18 100.00	11 100.00	-	-	18 100.00	11 100.00	-	-	-	-	
Miscarriage	-	01 100.00	-	-	-	01 100.00	-	-	-	-	
Pneumonia	02 100.00	-	-	-	02 100.00	-	-	-	-	-	
Skin disease	01 100.00	02 100.00	-	-	01 100.00	02 100.00	-	-	-	-	
Stomach ache	02 100.00	03 100.00	-	-	02 100.00	-	-	03 100.00	-	-	
Tuberculosis	06 100.00	03 100.00	-	-	06 100.00	02 66.67	-	01 33.33	-	-	
Tumor	02 100.00	-	-	-	02 100.00	-	-	-	-	-	
Snake bite	-	01 100.00	-	-	-	01 100.00	-	-	-	-	
Ghost attack	02 100.00	04 100.00	02 100.00	04 100.00	-	-	-	-	-	-	
Total	55 100.00	47 100.00	06 10.91	09 19.15	37 67.27	28 59.57	12 21.82	10 21.28	-	-	

TABLE: 4.4 DISTRIBUTION OF POPULATION ON THE BASIS OF DELIVERY PLACES

Name of the Sectors		Total population	Delivery places		
			Home	Health Centre/ Hospital	
				P.H.C.	Hospital
Category : 1	Dhumci gaon	158 100.00	121 76.58	36 22.78	01 00.63
	Mitran gaon	132 100.00	124 93.94	04 03.03	04 03.03
	Puja gaon	152 100.00	139 91.45	08 05.26	05 03.29
	Total	442 100.00	384 86.88	48 10.86	10 04.26
Category : 2	Mondal gaon	105 100.00	81 77.142	23 21.904	01 00.95
	Panchayat gaon	296 100.00	279 94.26	14 04.73	03 01.01
	Subba gaon	327 100.00	305 93.27	09 02.75	13 03.98
	Total	728 100.00	665 91.35	46 06.32	17 02.34
Grand Total		1170 100.00	1049 89.66	94 08.03	27 02.31

TABLE: 4.4.1 DISTRIBUTION OF POPULATION ON THE BASIS OF DELIVERY PLACES (DHUMCI GAON)

Age groups	Total population	Delivery places		
		Home	Health Centre/ Hospital	
			P.H.C.	Hospital
0-4	22 100.00	10 45.45	12 54.55	-
5-9	15 100.00	03 20.00	12 80.00	-
10-14	26 100.00	16 61.54	10 38.46	-
15-19	22 100.00	20 90.91	02 09.09	-
20-24	18 100.00	18 100.00	-	-
25-29	19 100.00	18 94.74	-	01 05.26
30-34	07 100.00	07 100.00	-	-
35-39	06 100.00	06 100.00	-	-
40-44	05 100.00	05 100.00	-	-
45-49	03 100.00	03 100.00	-	-
50-54	04 100.00	04 100.00	-	-
55-59	02 100.00	02 100.00	-	-
60-64	06 100.00	06 100.00	-	-
65-69	03 100.00	03 100.00	-	-
70 & 70+	-	-	-	-
Total	158 100.00	121 76.58	36 22.78	01 00.63

TABLE: 4.4.2 DISTRIBUTION OF POPULATION ON THE BASIS OF DELIVERY PLACES (MITRAN GAON)

Age groups	Total population	Delivery places		
		Home	Health Centre/ Hospital	
			P.H.C.	Hospital
0-4	22 100.00	12 54.55	06 100.00	04 18.18
5-9	23 100.00	22 95.65	01 04.35	-
10-14	24 100.00	22 91.66	01 04.17	01 04.17
15-19	16 100.00	16 100.00	-	-
20-24	10 100.00	10 100.0	-	-
25-29	16 100.00	16 100.00	-	-
30-34	10 100.00	10 100.00	-	-
35-39	10 100.00	10 100.00	-	-
40-44	07 100.00	07 100.00	-	-
45-49	05 100.00	05 100.00	-	-
50-54	01 100.00	01 100.00	-	-
55-59	03 100.00	03 100.00	-	-
60-64	04 100.00	04 100.00	-	-
65-69	01 100.00	01 100.00	-	-
70 & 70+	-	-	-	-
Total	152 100.00	139 91.45	08 05.26	05 03.29

TABLE: 4.43 DISTRIBUTION OF POPULATION ON THE BASIS OF DELIVERY PLACES (PUJA GAON)

Age groups	Total population	Delivery places		
		Home	Health Centre/ Hospital	
			P.H.C.	Hospital
0-4	19 100.00	13 68.42	03 15.79	03 15.79
5-9	27 100.00	26 96.30	01 03.70	-
10-14	25 100.00	24 96.00	-	01 04.00
15-19	15 100.00	15 100.00	-	-
20-24	08 100.00	08 100.00	-	-
25-29	09 100.00	09 100.00	-	-
30-34	05 100.00	05 100.00	-	-
35-39	02 100.00	02 100.00	-	-
40-44	07 100.00	07 100.00	-	-
45-49	10 100.00	10 100.00	-	-
50-54	02 100.00	02 100.00	-	-
55-59	-	-	-	-
60-64	02 100.00	02 100.00	-	-
65-69	01 100.00	01 100.00	-	-
70 & 70+	-	-	-	-
Total	132 100.00	124 93.94	04 03.03	04 03.03

TABLE: 4.4.4 DISTRIBUTION OF POPULATION ON THE BASIS OF DELIVERY PLACES (MONDAL GAON)

Age groups	Total population	Delivery places		
		Home	Health Centre/ Hospital	
			P.H.C.	Hospital
0-4	02 100.00	-	02 100.00	-
5-9	17 100.00	06 35.29	10 58.82	01 05.88
10-14	13 100.00	08 61.54	05 38.46	-
15-19	13 100.00	07 53.85	06 46.15	-
20-24	15 100.00	15 100.00	-	-
25-29	09 100.00	09 100.00	-	-
30-34	09 100.00	09 100.00	-	-
35-39	07 100.00	07 100.00	-	-
40-44	05 100.00	05 100.00	-	-
45-49	04 100.00	04 100.00	-	-
50-54	05 100.00	05 100.00	-	-
55-59	02 100.00	02 100.00	-	-
60-64	04 100.00	04 100.00	-	-
65-69	-	-	-	-
70 & 70+	-	-	-	-
Total	105 100.00	81 77.14	23 21.90	01 00.95

TABLE: 4.4.5 DISTRIBUTION OF POPULATION ON THE BASIS OF DELIVERY PLACES (PANCHAYAT GAON)

Age groups	Total population	Delivery places		
		Home	Health Centre/ Hospital	
			P.H.C.	Hospital
0-4	31 100.00	22 70.97	06 19.35	03 09.68
5-9	32 100.00	28 87.50	04 12.50	-
10-14	40 100.00	38 95.00	02 05.00	-
15-19	42 100.00	41 97.62	01 02.38	-
20-24	33 100.00	32 96.97	01 03.03	-
25-29	23 100.00	23 100.00	-	-
30-34	20 100.00	20 100.00	-	-
35-39	18 100.00	18 100.00	-	-
40-44	22 100.00	22 100.00	-	-
45-49	22 100.00	22 100.00	-	-
50-54	03 100.00	03 100.00	-	-
55-59	04 100.00	04 100.00	-	-
60-64	04 100.00	04 100.00	-	-
65-69	01 100.00	01 100.00	-	-
70 & 70+	01 100.00	01 100.00	-	-
Total	296 100.00	279 94.26	14 04.73	03 01.01

TABLE: 4.4.6 DISTRIBUTION OF POPULATION ON THE BASIS OF DELIVERY PLACES (SUBBA GAON)

Age groups	Total population	Delivery places		
		Home	Health Centre/ Hospital	
			P.H.C.	Hospital
0-4	24 100.00	15 62.50	05 20.83	04 16.67
5-9	61 100.00	51 83.60	04 06.56	06 09.84
10-14	46 100.00	43 93.48	—	03 06.52
15-19	39 100.00	39 100.00	—	—
20-24	26 100.00	26 100.00	—	—
25-29	31 100.00	31 100.00	—	—
30-34	24 100.00	24 100.00	—	—
35-39	28 100.00	28 100.00	—	—
40-44	15 100.00	15 100.00	—	—
45-49	14 100.00	14 100.00	—	—
50-54	08 100.00	08 100.00	—	—
55-59	03 100.00	03 100.00	—	—
60-64	06 100.00	06 100.00	—	—
65-69	02 100.00	02 100.00	—	—
70 & 70+	—	—	—	—
Total	327 100.00	305 93.27	09 02.75	13 03.98

TABLE: 4.5 ATTENDING/ATTENDED ANGANWADI (0-9 YEARS)

Name of the Village Sectors		Male				Female			
		Yes	No	New born	Total	Yes	No	New born	Total
Category:1	Dhumci gaon	14 73.68	05 26.32	-	19 100.00	12 66.67	02 11.11	04 22.22	18 100.00
	Mitran gaon	14 66.67	05 23.81	02 09.52	21 100.00	20 83.33	01 04.17	03 12.50	24 100.00
	Puja gaon	18 66.67	06 22.22	03 11.11	27 100.00	13 68.42	05 26.32	01 05.26	19 100.00
	Total	52 77.61	10 14.93	05 07.46	67 100.00	50 81.97	03 04.92	08 13.11	61 100.00
Category: 2	Mondal gaon	05 45.45	05 45.45	01 09.09	11 100.00	06 75.00	02 25.00	-	08 100.00
	Panchayat gaon	19 50.00	17 44.74	02 05.26	38 100.00	16 64.00	09 36.00	-	25 100.00
	Subba gaon	34 72.34	13 27.66	-	47 100.00	22 57.89	16 42.11	-	38 100.00
	Total	58 60.41	35 36.46	03 03.13	96 100.00	44 61.97	27 38.03	-	71 100.00
Grand Total		110 67.46	45 27.61	08 04.91	163 100.00	94 72.73	30 22.73	08 06.06	132 100.00

TABLE: 4.6 TAKING OF POLIO

Name of the Village Sectors		Male			Female		
		Yes	No	Total	Yes	No	Total
Category: 1	Dhumci gaon	26 53.06	23 46.94	49 100.00	19 52.78	17 47.22	36 100.00
	Mitran gaon	14 32.56	29 67.44	43 100.00	18 42.86	24 57.14	42 100.00
	Puja gaon	26 52.00	24 48.00	50 100.00	19 52.78	17 47.22	36 100.00
	Total	66 46.48	76 53.52	142 100.00	56 49.12	58 50.88	114 100.00
Category: 2	Mondal gaon	13 65.00	07 35.00	20 100.00	16 64.00	09 36.00	25 100.00
	Panchayat gaon	49 59.76	33 40.24	82 100.00	37 58.73	26 41.27	63 100.00
	Subba gaon	63 62.38	38 37.62	101 100.00	45 65.22	24 34.78	69 100.00
	Total	125 61.58	78 38.42	203 100.00	98 62.42	59 37.58	157 100.00
Grand Total		191 55.36	154 44.64	345 100.00	154 56.83	117 43.17	271 100.00

Table: 4.7 TAKING OF PULSE POLIO (0-5 years)

Name of the Village Sectors		Male			Female		
		Yes	No	Total	Yes	No	Total
Category: 1	Dhumci gaon	14 100.00	-	14 100.00	12 100.00	-	12 100.00
	Mitran gaon	15 100.00	-	15 100.00	17 94.44	01 05.55	18 100.00
	Puja gaon	19 100.00	-	19 100.00	09 90.00	01 10.00	10 100.00
	Total	48 100.00	-	48 100.00	38 95.00	02 5.00	40 100.00
Category: 2	Mondal gaon	06 100.00	-	06 100.00	05 100.00	-	05 100.00
	Panchayat gaon	28 100.00	-	28 100.00	21 95.45	01 04.55	22 100.00
	Subba gaon	28 93.33	02 06.67	30 100.00	27 100.00	-	27 100.00
	Total	62 96.88	02 03.13	64 100.00	53 98.15	01 01.85	54 100.00
Grand total		110 98.21	02 01.79	112 100.00	91 96.81	03 03.19	94 100.00

TABLE: 4.8 IMMUNIZATION (UPTO 24 YEARS)

Name of the Village Sectors		Male			Female		
		Yes	No	Total	Yes	No	Total
Category: 1	Dhumci gaon	24 43.64	31 56.36	55 100.00	19 39.58	29 60.42	48 100.00
	Mitran gaon	26 55.32	21 46.81	47 100.00	27 56.25	21 43.75	48 100.00
	Puja gaon	39 75.00	13 25.00	52 100.00	23 54.76	19 45.24	42 100.00
	Total	89 57.79	65 42.21	154 100.00	69 50.00	69 50.00	138 100.00
Category: 2	Mondal gaon	18 60.00	12 40.00	30 100.00	18 60.00	12 40.00	30 100.00
	Panchayat gaon	56 54.90	46 45.09	102 100.00	36 47.37	40 52.63	76 100.00
	Subba gaon	47 40.52	69 59.48	116 100.00	37 46.25	43 53.75	80 100.00
	Total	121 46.89	127 49.22	258 100.00	91 48.92	95 51.08	186 100.00
Grand Total		210 52.23	192 47.76	402 100.00	160 49.32	164 50.62	324 100.00

TABLE: 4.10 AWARENESS ABOUT PROTECTION AND PRESERVATION OF FOOD (FAMILY WISE)

Name of the Village Sectors		Total Number of Families	Opinion	
			Yes	No
Category: 1	Dhumci gaon	33 100.00	14 42.42	19 57.58
	Mitran gaon	29 100.00	12 41.38	17 58.62
	Puja gaon	22 100.00	10 45.45	12 54.55
	Total	84 100.00	36 42.86	48 57.14
Category: 2	Mondal gaon	24 100.00	18 75.00	06 25.00
	Panchayat gaon	62 100.00	43 69.35	19 30.65
	Subba gaon	68 100.00	39 57.35	29 42.65
	Total	154 100.00	100 64.94	54 35.06
Grand Total		238 100.00	110 46.22	102 42.86

TABLE: 4.10 TAKING OF COUNTRY LIQUOR/ ALCOHOL (15 to 70 years)

Name of the Village Sectors		Male			Female		
		Yes	No	Total	Yes	No	Total
Category:1	Dhumci gaon	40 85.11	07 14.89	47 100.00	37 84.09	07 15.90	44 100.00
	Mitran gaon	34 75.55	11 24.44	45 100.00	23 60.53	15 39.47	38 100.00
	Puja gaon	26 76.47	08 23.53	34 100.00	19 70.37	08 29.63	27 100.00
	Total	100 79.37	26 20.63	126 100.00	79 72.48	30 27.52	109 100.00
Category:2	Mondal gaon	23 62.16	14 37.84	37 100.00	21 58.33	15 41.67	36 100.00
	Panchayat gaon	78 74.29	27 25.71	105 100.00	57 64.77	31 35.22	88 100.00
	Subba gaon	89 82.41	19 17.59	108 100.00	66 75.00	22 25.00	88 100.00
	Total	190 76.00	60 24.00	250 100.00	144 67.92	68 32.08	212 100.00
Grand Total		290 77.13	86 22.87	376 100.00	223 69.47	98 30.53	321 100.00

TABLE: 4.11 SMOKING HABIT (15 to 70 years)

Name of the Village Sectors		Male			Female		
		Yes	No	Total	Yes	No	Total
Category :1	Dhumci gaon	22 46.81	25 53.19	47 100.00	02 04.54	42 95.45	44 100.00
	Mitran gaon	30 66.67	15 33.33	45 100.00	-	38 100.00	38 100.00
	Puja gaon	18 52.94	16 47.06	34 100.00	-	27 100.00	27 100.00
	Total	70 55.55	56 44.44	126 100.00	02 01.83	107 98.17	109 100.00
Category :2	Mondal gaon	27 72.97	10 27.02	37 100.00	-	36 100.00	36 100.00
	Panchayat gaon	84 80.00	21 20.00	105 100.00	-	88 100.00	88 100.00
	Subba gaon	77 71.29	31 28.70	108 100.00	02 02.27	86 97.72	88 100.00
	Total	188 75.20	62 24.80	250 100.00	02 00.94	210 99.06	212 100.00
Grand Total		258 68.62	118 31.38	376 100.00	04 01.25	317 98.75	321 100.00

TABLE: 4.12 OWNERSHIP OF DOMESTIC ANIMAL (FAMILY WISE)

Name of the village Sectors		Total Number of Families	Have	Do not have
Category :1	Dhumci gaon	33 100.00	30 90.91	03 09.09
	Mitran gaon	29 100.00	26 89.66	03 10.34
	Puja gaon	22 100.00	21 95.45	01 04.55
	Total	84 100.00	77 91.67	07 08.33
Category :2	Mondal gaon	24 100.00	23 95.83	01 04.17
	Panchayat gaon	62 100.00	60 96.77	02 03.23
	Subba gaon	68 100.00	65 95.59	03 04.41
	Total	154 100.00	148 96.10	07 04.55
Grand Total		238 100.00	225 94.54	13 05.46

TABLE: 4.13 PLACE OF KEEPING DOMESTIC ANIMALS (FAMILY WISE)

Name of the Village Sectors		Separate animal house	Beneath room	Inside home	Total
Category :1	Dhumci gaon	08 26.67	22 73.33	-	30 100.00
	Mitran gaon	06 23.08	18 69.23	02 07.69	26 100.00
	Puja gaon	03 14.29	17 80.95	01 04.76	21 100.00
	Total	17 22.08	57 74.03	03 03.89	77 100.00
Category: 2	Mondal gaon	16 69.57	07 30.43	-	23 100.00
	Panchayat gaon	19 31.67	41 68.33	-	60 100.00
	Subba gaon	17 26.15	48 73.85	-	65 100.00
	Total	52 35.14	96 64.86	-	148 100.00
Grand Total		69 30.67	153 68.00	03 01.33	225 100.00

TABLE: 4.14 AWARENESS ABOUT FAMILY PLANNING

Name of the Village Sectors		Opinion		
		Yes	No	Total (couple)
Category:1	Dhumci gaon	22 81.48	05 18.52	27 100.00
	Mitran gaon	21 72.41	08 27.57	29 100.00
	Puja gaon	08 40.00	12 60.00	20 100.00
	Total	51 67.11	25 32.89	76 100.00
Category: 2	Mondal gaon	17 73.91	06 26.09	23 100.00
	Panchayat gaon	37 61.67	23 38.33	60 100.00
	Subba gaon	31 49.21	32 50.79	63 100.00
	Total	85 58.22	61 41.78	146 100.00
Grand Total		136 61.26	86 38.74	222 100.00

TABLE: 4.15 METHODS USED FOR FAMILY PLANNING

Name of the Sectors		Traditional	Operated	Modern method	Not followed any method	Newly married	No issue or First issue	Total Couple
Category:1	Dhumci gaon	02 09.09	03 13.64	07 31.82	05 22.73	03 13.64	02 09.09	22 100.00
	Mitran gaon	01 04.76	06 28.57	07 33.33	02 09.52	04 19.05	01 04.76	21 100.00
	Puja gaon	01 12.50	02 25.00	-	04 50.00	01 12.50	-	08 100.00
	Total	04 07.84	11 21.57	14 27.45	11 21.57	08 15.69	03 05.88	51 100.00
Category:2	Mondal gaon	01 05.88	05 29.41	07 41.18	02 11.76	02 11.76	-	17 100.00
	Panchayat gaon	03 08.11	07 18.92	21 56.76	03 08.11	02 05.41	01 02.70	37 100.00
	Subba gaon	01 03.23	05 16.13	18 58.06	07 22.58	-	-	31 100.00
	Total	05 05.88	17 20.00	46 54.12	12 14.12	04 04.71	01 01.18	185 100.00
Grand Total		09 06.62	28 20.59	60 44.12	23 16.91	12 08.82	04 02.94	136 100.00