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Research Report No. 251P



**HEALTH SERVICES IN SUB-PLAN AREAS
OF
ANDHRA PRADESH**

**TRIBAL CULTURAL RESEARCH AND TRAINING INSTITUTE
TRIBAL WELFARE DEPARTMENT
GOVERNMENT OF ANDHRA PRADESH
HYDERABAD - 500 034.
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OF

ANDHRA PRADESH

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I N T R O D U C T I O N

HEALTH is wealth is an old adage. A war on ill health and disease is essentially a war on poverty and all its evil brood. The development programmes have no meaning if they do not raise the health standards of the people. Disease and poverty go hand in hand. Epidemics, malnutrition, communicable diseases and lack of public sanitation, result in high infant mortality, lower life expectancy, reduced working capacity and poor resistance to diseases, indirectly affect the national economy. To wipe out ill health, the Central and State Governments have been undertaking many curative and preventive schemes.

Prior to independence the medical services were aimed at curative aspect only. In order to raise the standard of health of the nation, prevention is far superior to curing. Realising this, the Government is evolving appropriate strategies for health services

in the five year plans. The emphasis is on control of communicable diseases, improvement of environmental sanitation, provision of maternity and child health services etc.

Though 80% of the population were living in rural areas, the medical services prior to independence and even in the first 2 five year plans were mostly confined to urban areas. Consequently the villagers and the people living in the inaccessible tribal areas were forced to depend upon native cures, magical remedies, prayers and quacks. Poor communications, lack of hygienic drinking water, drainage, housing and environmental **Sanitation** complicated the matter. The per capita income in these areas was so low that they could not afford to improve their socio-economic conditions for a very long time to come. Hence they have to depend solely on Government medical institutions. As most of the people living in these areas were illiterate, they lack any idea about communicable diseases and neglect medical advice. To overcome these difficulties and to provide basic medical facilities and to take up effective preventive measures against communicable

diseases, it was mooted to establish primary health centres in rural areas at the rate of one for every 40,000 population. When the whole country was divided into community development blocks, health became an integral part of community development, as health standards are closely linked with socio-economic development of the community. It was proposed to start atleast one primary health centre and three sub-centres in each block to provide health care to rural people at their homes.

The tribal areas of Andhra Pradesh lacked proper medical institutions and infrastructure before the establishment of primary health centres, except a few dispensaries and Taluk hospitals. Even these institutions were not equipped with modern instruments, lacked trained staff and vehicles and could not make any dent into tribal life. A beginning was made to develop medical institutions in a planned manner during the 1st plan, and during the IIInd, IIIrd plans, expansion of health services and maximising their efficiency took precedence. In the fourth plan the objective was to strengthen the primary health centres

as an effective base for curative and preventive services. The first, second and third five year plans brought a ray of hope to the tribal areas. During the IInd plan health centres were started in 4 Blocks in Andhra Pradesh at Araku, in Visakhapatnam district, Narsampet in Warangal district, and Utnoor in Adilabad district with an allocation of Rs.2 lakhs each. During ^{/the} IIIrd plan period 24 tribal development blocks were formed for around development of tribal areas. The pattern of the Tribal Development Blocks proposed one primary health centre for each block with one medical officer, health visitor, compounder and maternity assistant. Each primary health centre, has 3 sub-centres, where an auxiliary nurse cum midwife is posted to look after the maternity and child care, public health etc. During the III and IV plans mobile medical units, health centres and maternity and child welfare units, sprang up in Tribal Development Blocks. There were 4 health units, 6 medical dispensaries and 3 medical units, during the 1st plan period. In the II five year plan 5 M.C.H. Centres, 2 antimalaria units, 8 dispensaries and 4 mobile medical units were added. By the end of III plan period 14 out of the 24 Tribal Development Blocks had primary health centres and during

the IV plan period 6 more primary health centres were added, besides posting an additional medical officer at each primary health centre to look after the family welfare needs of the tribals. But these facilities were not adequate by any standard. It was evident that there were many gaps. The uneven dispersal of health infrastructure between different areas, absence of referral services at the taluk level and too large an area coverage fixed for each primary health centre were some of the factors contributing to imbalance in medical and health care. To overcome these anomalies, a programme known as minimum needs programme has been suggested, to establish one primary health centre for every 25,000 population and one sub-centre for every 5,000 population, upgrading of many primary health centres into 30 bedded hospitals and provision of basic health workers and auxiliary nurse midwives at the rate of one for every 5,000 population. To eradicate endemic diseases special programmes such as N.M.E.P.; N.S.E.P.; N.F.E.P.; etc., were extended to tribal areas. It was during the IVth plan period that massive programmes were devised to provide cheap and nutritious diets to tribal children,

pregnant and lactating mothers. The primary health centres were made responsible for the over all improvement of the health standards in tribal areas. However, these institutional facilities were not properly utilised by the tribals in view of the long standing belief systems, unflinching faith in native cures, illiteracy, and fatalistic attitude. It was also a general feeling that the medical officers were not willing to work in the remote tribal areas due to lack of amenities for housing, education for children and recreation. As such some of the posts were kept vacant for long periods. Further there is a communication gap between the medical and health personnel and the tribal beneficiaries. It is also true that the medical institutions were mostly utilised by the people around the medical institutions. The innocent and illiterate tribals of interior villages were not aware of the modern medical facilities, even if they were aware, they do not like to visit medical institutions which are located at a distance. Mobile medical institutions were supposed to overcome this difficulty. However, it was also difficult for mobile medical units to cover all the villages at least once in a month due

to several constraints. However, certain preventive measures such as small pox vaccination, malaria surveillance, and anticholera operations and family planning proved successful even in remote tribal areas.

During the fifth plan period, sub-plans were prepared to bridge the development gap between the tribal and non-tribal areas by establishing integrated tribal development agencies. A review by the Government of India of health services in tribal areas showed that coverage in some of the regions is extremely poor. In pursuance of the decision in the Chief Ministers conference a working group is being setup under the aegis of the Health Ministry to have a special look at these problems and to take concrete measures in future. It was also observed that the extent of utilisation of services, the **precise** reasons for non-acceptance of the modern medicine in some areas is not adequate. Hence the Government proposed to consider the various aspects relating to health services and plan the health institutions according to the local needs. The Government of India suggested a sample study in tribal areas to assess the present situation in rela-

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OBJECTIVES, METHODOLOGY AND SAMPLE SELECTION

THE aim of the present study is to understand the present situation of health facilities and utilisation, in tribal areas. The objectives are;

- 1) To assess the geographical coverage of the tribal areas by curative and para-medical institutions.
- 2) To examine the existing infrastructure at these centres.
- 3) To study the extent of coverage of the medical and health institutions, in relation to the area, type of population and disease coverage.
- 4) To study the extent of utilisation of available medical and health services by different cross sections of the popula-

tion and their attitude towards modern medical and health services.

- 5) To study the tribal man in relation to magico-religious practices and use of native medicines for different diseases.

METHODOLOGY:

Primary and secondary data is collected through the following schedules.

- 1) Institutional infrastructure.
- 2) Facilities available in medical institutions. (Curative Centres).
- 3) Household schedule (Universal).
- 4) Household schedule (Sample households).

So far as geographical coverage of the tribal areas through medical facilities, is concerned, information was collected for the entire sub-plan area. In respect of the utilisation, perception and role of different functionaries as sample study was conducted.

SAMPLE SELECTION:

The universe for this study is the entire Integrated Tribal Development Project Areas spread over seven districts of the State. These areas are divided into two economic regions, namely Eastern and Western regions. Each region is composed of the following Integrated Tribal Development Agencies.

- | | |
|--------------------|------------------|
| 1. Eastern Region: | 1. Srikakulam |
| | 2. Visakhapatnam |
| | 3. East Godavari |
| | 4. West Godavari |
| 2. Western Region: | 1. Khammam |
| | 2. Warangal |
| | 3. Adilabad |

As per guidelines of the Government of India, two Tribal development blocks, one in a comparatively developed tribal area and the other in a relatively backward tribal area are selected in each of the two regions as follows:

	<u>EASTERN REGION:</u>	<u>WESTERN REGION:</u>
Comparatively Developed Tribal Development Block.	Polavaram (West Godavari)	Utnoor (Adilabad)
Relatively Backward Tribal Development Block.	Munchingiput. (Visakhapatnam)	Vararamachandrapuram (Khammam)

The Tribal Development Blocks selected as comparatively developed blocks namely Utnoor and Polavaram are well connected by regular bus services, Taluk Hospitals, fertile lands and also enjoy the benefits of tribal development programmes since a long time. But Munchingput Block has yet to see a bus service, and only a few villages of the V.R.Puram/Block have bus facility. The lands of these blocks are poor and the development programmes are extended comparatively later.

In each of the sample blocks information pertaining to the medical institutions is collected. To find out the opinion of the people utilisation of medical facilities and their attitude towards different systems of medicine, each sample block is divided into 4 clusters on the basis of the following criteria.

- a) Around the Primary Health Centres.
- b) Around a sub-centre.
- c) Around other medical institutions like Ayurvedic Dispensary.
- d) Area not covered by any of the medical institutions.

In each of the above clusters 3 villages are selected based on the following criteria.

- a) The head quarters village of the institution.
- b) Second sample village situated less than 5 miles from the institution.
- c) Third sample village situated more than 5 miles from the institution.

In the fourth cluster only two villages are selected at random since there is no medical institution. In this way it was expected to have an idea of the benefit from each type of institution accruing in the village of its location, at a small distance from the institution and in villages far off from the institution.

The last two villages where there is no institution will represent the general situation in the area.

In each of the selected sample villages 25 households are selected at random for coverage under universal household schedule and 10 households for opinion (Sample) Survey. Where the villages do not have 25 households all the households of the village are covered.

The blocks, clusters, villages and number of households covered by the study are presented in Table No. 2.1.

2.1 STUDY OF HEALTH SERVICES IN TRIBAL AREAS

BLOCKS, CLUSTERS, SAMPLE VILLAGES AND SAMPLE HOUSEHOLDS COVERED IN THE STUDY

Sl. No.	I.T.D.A.	T.D. Block	Cluster No.	Name of the Sample village.	No. of households covered	Universal Sample
1		3	4	5	6	7
	1. Adilabad	Uttnoor	No.1 P.H.C.	Jainoor	25	10
				Jamni	25	10
				Shivnoor	25	10
			No.2 Sub-Centre	Indervalli	25	10
				Ginnera	25	10
				Keslaguda	25	10
			No.3 Ayurvedi Dispensary	Narnoor	25	10
				Bhimpur	25	10
				Gangapur	25	10
			No.4 Not covered by an institution.	Lokhari 'B'	25	10
				Dhaba	25	10
				Total:	275	110

1	2	3	4	5	6	7
2. West Godavari	Polavaram					
	No. 1 Lakshmi-Narayana Devi peta.		L.N.D.Peta	25	10	
			Muddappagudem	25	10	
			Rajanagaram	25	10	
	No. 2 Sub-Centre (Repalliwada)		Repalliwada	25	10	
			Gunjaram	25	10	
			Vinjaram	25	10	
	No. 3 M.M. Unit. (Polavaram)		Itikalakota	25	10	
			Singanapalli	25	10	
			Kondrukota	25	10	
	No. 4 Not covered by any Institution.		Chintapalli	16	7	
			Munjuluru	25	10	
			Total:	266	107	

1	2	3	4	5	6	7
21	3. Khammam	Vararamachandra- pura	No.1 P.H.C.	Rekhepalli Annayaram D. T. Gudem	25 25 25	10 10 10
		No.2 Sub- Centre		Kundulur Kokkaragudem K. Varigudem	13 15 15	5 7 7
		No.3 M.M. Unit		Chintoor Koigur Kolleru	25 15 25	10 7 10
		No.4 Unco- vered by any Institution.		Gummupadu Chutur	25 25	10 10
				Total:	233	96

1	2	3	4	5	6	7
4. Visakhapatnam	Munchingputtu	No.1 P.H.C. (Jolaput)	Jolaput	25	10	
			Kulaibeeru	19	8	
			Bondruguda	25	13	
		No.2 Sub-Centre (Munchingputtu)	Munchingputt	25	10	
			Saraiput	15	7	
			Kinchaiput	15	7	
		No.3 M.M. Unit (Kilagada)	Kilagada	25	10	
			Mettaveedhi	14	8	
			Bangarumetta	25	10	
		No.4 Unco- vered by any Institution.	Jaffarru	26	11	
			Makavaram	13	8	
			Total:	227	102	

CHAPTER - III

EXISTING MEDICAL INSTITUTIONS IN TRIBAL SUB-PLAN AREAS

BEFORE the advent of Five Year Plans the tribal areas lacked any medical attention worth mentioning. Medical relief was aimed at controlling epidemic diseases like cholera, small-pox and malaria, but preventive aspect was not given much importance. During the third five year plan 24 Tribal Development Blocks were formed to focus attention on the allround development of tribal areas. The Tribal Development Block pattern has proposed one Primary Health Centre for each block. However upto the end of the III five year plan period primary health centres could be established only at 14 out of the 24 Tribal Development Blocks. Even before the launching of the sub-plan and Integrated Tribal Development Agencies 4 out of the 24 Tribal Development Blocks have no primary health centres. During the plan period development projects, such as mining, hydroelectric projects etc., penetrated into

the interior agency areas. The project hospitals established mainly to cater to the needs of the project staff and workers.

A new strategy was adopted during the V Five Year Plan, by evolving a sub-plan at Macro-level and Integrated Tribal Development Projects at Meso-level to take up an integrated and comprehensive view of the tribal problems to be solved. The Sub-Plan aims at narrowing the gap in levels of development between the tribal and other areas and to improve the quality of life of tribal communities in the regions of tribal concentration. Seven tribal regions have been identified within the sub-plan area and perspective plans have been drawn up for integrated development of these regions. It will be very helpful to know the state of coverage of the Medical and Health Services in the sub-plan areas as on March, 1976.

SUB-PLAN AREA AND POPULATION:

The sub-plan is spread over an area of 30,293 Sq.Kms., covering 7,078 villages (Scheduled 6,172 , non-scheduled 906) in seven districts and serves a total

population of 17,87,887, out of which 9,11,167 are scheduled tribes (Table No.3.1).

EXISTING MEDICAL CENTRES AND FACILITIES:

The various types of Medical and Health institutions and the number of beds available in the seven Integrated Tribal Development Agencies are presented in table No.3.2.

MEDICAL INSTITUTIONS:

In the entire sub-plan there are 22 hospitals, 28 primary health centres, 23 allopathic dispensaries and 16 Ayurvedic/Unani dispensaries. Besides, there are 17 mobile medical units, which take the medical services to the door steps of the tribals. These institutions have a sanctioned strength of 121 allopathic doctors and 16 Ayurvedic/Unani doctors (Table No.3.3).

GEOGRAPHIC COVERAGE:

The geographical area of the entire State of Andhra Pradesh is 2,76,754 Sq.Kms., while the Sub-Plan area spreads over 30,293 Sq.Kms., and constitutes 10.9% of the total geographic area of the State. The entire State has 1,423 allopathic medical institutions with qualified doctors out of which only 90 are located in the Sub-Plan area constituting 6.32% of the total institutions. Thus the tribal area which constitute 10.9% of the State area is having only 6.32% of the institutions indicating that a medical institution in tribal area has to cover larger area than the medical institutions in the plains area.

But actually it is the primary health centres located in rural areas and not the other hospitals located in urban areas which serve the real needs of the rural and tribal populations. Hence it is appropriate to compare the primary health centre area coverage in tribal areas and non-tribal areas. In the whole State there are 416 primary health centres at the rate of 1 primary health centre per 672 Sq.Kms., while in the

Sub-Plan area there are 28 primary health centres at the rate of 1 primary health centre per 1,082 Sq.Kms., The comparative health facilities also can be gauged from the number of villages a primary health centre covers in tribal and non-tribal areas. In the State there are 27,226 villages which are served by 416 primary health centres at the rate of 1 primary health centre per 65 villages, while in the tribal areas there are 28 primary health centres serving 7,078 villages at the rate of 1 primary health centre per 252 villages. As the tribal areas are not well connected by road and most of the primary health centres in these areas are not provided with Jeeps, it is not possible for the medical officers to cover the vast areas and large number of villages even once in a month. The medical institution population ratio, geographic area population ratio, indoor bed population ratio, sub-centre population ratio, doctor population ratio per allopathic institutions, are presented in Table No.(3.4) and medical institutions population ratio, medical institution geographical area ratio, doctor population ratio for all the institutions allopathic and indigenous are presented table No.(3.5).

POPULATION COVERAGE AND BED AVAILABILITY:

With reference to population now there is one government allopathic institution for a population of about 33,000 in the whole State while in the sub-plan area there is one institution for a population of about 20,000. This may sound very good, that the tribal populations are better served than the other parts of the state, but the tribal villages are thinly populated and scattered over large areas. Hence a doctor can cover a relatively smaller population with more difficulty. Similarly there is one Primary Health Centre for a population of about 1,00,000 in the state as against a population of about 63,853 in the tribal areas. The facilities available at the medical institutions in tribal areas are very inadequate and many of the institutions are not provided with the bare needs. As against one indoor bed for a population of 2,000 in the state there is one bed for a population of about 3,812 in the tribal areas. One allopathic doctor is sanctioned for a population of 13,000 in the state, and only one allopathic doctor is sanctioned for population 14,775 in

the sub-plan area. The inadequacy of doctors is very acute when compared to the vast area, each doctor has to attend in tribal areas.

According to the norms of community development, each block should have atleast one primary health centre or at the rate of the one Primary Health Centre per 1,00,000 population, which ever is less. While this objective has been achieved in the plains areas of the state, 4 tribal development blocks in the sub-plan area have no primary health centres at the end of the IV five year plan period. One of the Tribal Development Blocks, Pedabayalu in Visakhapatnam the most backward area of the state has neither a primary health centre nor a dispensary and is served only by a mobile medical unit with only one doctor, to serve a population of 25,726 scattered over an area of 512 Sq.Kms. without any road communication. Three other Tribal Development Blocks namely Rajavommangi in East Godavari district, Anantagiri and G.Madugula in Visakhapatnam district are each served only by an allopathic dispensary. All these four blocks are situated in the eastern region only. Thus it is evident that due to lack of

communication facilities the most backward areas which would have got top priority got the least priority in starting primary health centres.

The coverage of Medical Institutions is not uniform even among the various blocks of the different Integrated Tribal Development Agencies.

The existing institutions and available facilities in the various Integrated Tribal Development Agencies are presented in table No.3.6.

MEDICAL INSTITUTIONS AND GEOGRAPHIC AREA I.T.D.A.-WISE:

The maximum geographic area covered per medical institution (including Ayurvedic dispensaries) ranges between 446 Sq.Kms., in Warangal Integrated Tribal Development Agency to 167 Sq.Kms., in West Godavari Integrated Tribal Development Agency with an average area of 285 Sq.Kms., in the entire sub-plan area. The Medical Institutions in East Godavari, Adilabad and Srikakulam Integrated Tribal Development Agencies have to cover more geographic area than the sub-plan average, while in the Visakhapatnam and Khammam Integrated

Tribal Development Agencies the geographic area covered is less than the sub-plan average.

MEDICAL INSTITUTIONS POPULATION RATIO (I.T.D.A.-WISE):

The population that has to be covered per medical institution also show wide variation in different districts. As against an average coverage of 16,866 population per institution in the entire sub-plan area, there is one institution per 20,027 in Khammam, 19,665 in Srikakulam, 17,626 in Adilabad which cover more population than the average. The East Godavari, Visakhapatnam and Warangal Integrated Tribal Development Agencies cover a population between 14,000 to 16,000. The least population per institution is covered in West Godavari with one institution per 9,503 population. Thus West Godavari Integrated Tribal Development Agency is more advanced in medical facilities, as it has to cover a comparatively lesser area and lesser population. The other Integrated Tribal Development Agencies such as Warangal and East Godavari have to cover a large area, but the population coverage is equal to the sub-plan

average. In Adilabad, Visakhapatnam and Srikakulam, the institutions have to cover large area as well as large populations.

INDOOR BED POPULATION RATIO (I.T.D.A.-WISE):

The bed availability population ratio is the best in West Godavari with one bed per 2,036 population as against an average of 3,812 in the sub-plan area. Visakhapatnam comes next with one bed per 2,943 population, while East Godavari and Khammam have one bed per 5,513 and 3,708 population respectively. Warangal Integrated Tribal Development Agency is the most backward with one bed per 9,279 population. The Adilabad and Srikakulam Integrated Tribal Development Agencies have fewer beds than the sub-plan average. Thus in the matter of beds, Warangal Integrated Tribal Development Agency lags far behind other areas, while West Godavari Integrated Tribal Development Agency is advanced.

The availability of beds in the respective districts and in the Integrated Tribal Development Agencies are as follows:-

AVERAGE POPULATION PER BED

District	District	I.T.D.A.
Srikakulam (G.D.A.)	5,291	4,275
Visakhapatnam	1,284	2,943
East Godavari	2,467	3,513
West Godavari	3,937	2,036
Khammam	3,890	3,708
Warangal	1,787	9,279
Adilabad	2,848	5,036

Excepting West Godavari and Srikakulam the population per bed is lesser than the district average. In all the other Integrated Tribal Development Agencies the population per bed is relatively larger than the district average. But in Khammam district the availability in the district as well as the Integrated Tribal Development Agency area are almost equal.

INSTITUTION WISE AVAILABILITY OF INDOOR BEDS:

All the Primary Health centres in the sub-plan area have an uniform bed strength of six each. But, the 22 hospitals located in the area have different bed strengths based on the local needs and relative importance of the respective places. There are four project hospitals in the area and they have got a bed strength of 10 each excepting project hospital Mothugudem in Khammam district which has 12 beds. There are 8 taluk hospitals in the sub-plan area. The taluk hospital Bhadrachalam, being an important trade and pilgrim centre has the maximum bed strength of 56. The hospitals at Addateegala and Polavaram have 8 beds each, at Utnoor, Boorgampad have 10 beds and at Chintapalli and Rampechodavaram have 12 beds each. Among the other hospitals, Yellandu has 31, Araku Valley and Wankidi have 30 beds each. Saving this, all other hospitals have less than 10 beds. In general, excepting a few, the hospitals in the sub-plan areas have about 10 beds.

The dispensaries are not having indoor bed facility in general. However, the dispensary at G.Madugula

in Visakhapatnam Integrated Tribal Development Agency has 3 beds, Doramamidi and Jeelugumilli in West Godavari have 4 beds each. The Mobile Medical Units, Sub-Centres and Ayurvedic dispensaries are not provided with indoor beds any where.

AVERAGE DAILY UTILISATION:

The average utilisation of out patient services at various types of medical institutions shows wide variation in different Integrated Tribal Development Agencies.

Among the hospitals, Visakhapatnam recorded the maximum average utilisation of 150, followed by 130 in West Godavari and 101 in East Godavari. The least utilisation is observed in Srikakulam. The average utilisation ranges between 75 and 125.

Among the Primary Health Centres, the average utilisation is maximum 125.5 in Warangal and minimum in Srikakulam with 28. The average daily primary health centre out patient utilisation ranges from 5 to 156.

sub-centre naturally differs according to the population of the block. In the entire sub-plan area there is one sub-centre for a population of 18,431 on the average. In the West Godavari Integrated Tribal Development Agency each sub-centre covers an average population of 9,503, while in East Godavari it is 10,305 and in Warangal it is 13,919. The Integrated Tribal Development Agencies of Khammam, Srikakulam, Visakhapatnam and Adilabad cover more population per sub-centre than the sub-plan average.

Judging from all the parameters viz., Institution population ratio, Institution area ratio, bed-population ratio, doctor-population ratio, the western region is more backward than the eastern region. West Godavari Integrated Tribal Development Agency has got the best facilities ranking first in all the parameters. The next advantageous area is Visakhapatnam, while Srikakulam and East Godavari occupy a middle position. Warangal Integrated Tribal Development Agency is the most backward in all respects closely followed by Adilabad. In many respects the West Godavari Integrated Tribal Development Agency has better facilities on par with non-tribal areas.

However, it appears that the composition of the tribal and non-tribal population in the respective Integrated Tribal Development Agencies have got an important relationship to the available facilities. Ever since, special programmes for tribal development were incepted, more emphasis was given to areas of maximum tribal concentration. Hence areas which have got more tribal concentration have also more medical institutions started from special tribal welfare funds. The eastern region has got a tribal population ranging from 87.61% in Visakhapatnam to 54.31% in West Godavari, while in the western region the tribal population constitutes 29.37% in Warangal, 31.19% in Khammam 37.19% in Adilabad Integrated Tribal Development Agencies. Hence when the institutional facilities are compared for the entire population of the respective Integrated Tribal Development Agencies, the western region which has lesser concentration of tribal population presents a backward position. Because of the smallest area and smallest population with 2 tribal development blocks which both have primary health centres and as there is a taluk hospital, West Godavari Integrated Tribal Development Agency presents the most advantageous position.

ROADS, BUILDINGS, WATER & ELECTRICITY FACILITIES:

The communication, building, electricity and water facilities available in the medical institutions in sub-plan area are presented in Table No. 3.6.

COMMUNICATIONS:

Regarding communication facilities all the 22 hospitals are connected by black topped roads with regular bus services from the respective district headquarters. But out of the 28 primary health centres 25 are located on the road point while 3 primary health centres namely Mangapet in Eturnagaram Block of Warangal district is located at a distance of 12 Kms., Kasipet and Hutnoor primary health centres in Adilabad Integrated Tribal Development Agency are located at a distance of 8 Kms. These three primary health centres are located in the western region. Out of the 17 mobile medical units, 4 units located at, Kilagada and Pedabayalu in Visakhapatnam Integrated Tribal Development Agency are connected by kucha road, while Chelpaka in Eturnagaram is 19 Kms.,

and Ginnedari in Adilabad is 32 Kms., from all weather road points. Excepting two allopathic dispensaries in Warangal and one in Adilabad which are located at a distance of 30 Kms., and 8 Kms., all the others are located on the road point. Out of the 16 Ayurvedic institutions, 8 institutions in Adilabad Integrated Tribal Development Agency do not have road communications.

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All the 22 hospitals, excepting Wankidi in Adilabad Integrated Tribal Development Agency are provided with permanent buildings, while buildings are under construction for Wankidi hospital. However, none of the 9 hospitals

in Khammam district, two in East Godavari, one each in Visakhapatnam and Srikakulam lack residential accommodation for the staff. Hutnoor primary health centre in Adilabad Integrated Tribal Development Agency has neither institutional building nor residential quarters. Though almost all the primary health centres have institutional buildings, residential accommodation, is available only at one institution, located at Jainoor.

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On the whole, the hospitals, primary health centres and allopathic dispensaries were provided with

institutional buildings, but the Mobile Medical Units and Ayurvedic dispensaries lack buildings. Residential accommodation is an exception to all the institutions.

WATER AND ELECTRICITY:

Water and electricity is available at all the hospitals in the sub-plan area and all the primary health centres in the eastern region, viz., Srikakulam, Visakhapatnam, East Godavari and West Godavari, However, in the Western region, only five out of the nine primary health centres in Khammam, two out of three in Adilabad have electricity. None of the primary health centres in Warangal are electrified. Water is available in all primary health centres except Rekhapalli in Khammam district. Thus 50% of the primary health centres in the western region lack electricity. Of the 23 allopathic dispensaries 12 and out of 16 ayurvedic dispensaries 7 are electrified. Saving one allopathic dispensary each in West Godavari and Khammam, two ayurvedic dispensaries in Adilabad all others have adequate water facility. Only one Mobile Medical Unit in Adilabad has electrify and all the Mobile Medical Units in Adilabad

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Dumbriguda primary health centre in Visakhapatnam Integrated Tribal Development Agency recorded the lowest utilisation.

The maximum utilisation of dispensary out patients facilities is recorded in West Godavari and the least utilisation is observed in Visakhapatnam. It ranges between 15 and 102.

The Mobile Medical Units in West Godavari are serving 97.7 out patients in Warangal 67.5, East Godavari 40 and Srikakulam 35 and the least in Visakhapatnam 10 on the average. Thus, the institutions are best utilised in West Godavari, Warangal, and East Godavari. The particulars regarding average daily utilisation of the institutions located in Khammam and Adilabad are not available.

The facilities in Visakhapatnam and Warangal districts are far better as these districts have teaching hospitals at the district headquarters. In Adilabad and East Godavari the tribal areas lag behind the other areas of the district. The tribal area in Warangal district is highly neglected as it has only 1/5th of the average bed availability of the district.

DOCTOR POPULATION RATIO (I.T.D.A.-WISE)

In the matter of allopathic doctors per population West Godavari Integrated Tribal Development Agency presents the most advantageous position with one doctor per a population of 6,335 against an average population of 14,775 in the sub-plan area. The other Integrated Tribal Development Agencies in the eastern region namely Srikakulam, Visakhapatnam and East Godavari also have one doctor per a population less than the sub-plan average ranging 10,858 to 12,291. The doctors available are comparatively less in the Western region with Adilabad presenting the most **disadvan-**tageous position with one doctor per a population of 23,501 while Warangal and Khammam have one doctor per 18,559 and 18,207 respectively.

SUB-CENTRE POPULATION RATIO:

According to the primary health centre pattern every Primary Health Centre has 3 sub-centres **irrespective** of the population covered by the primary health centre. Hence the population coverage per

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SUB-CENTRE POPULATION RATIO:

According to the primary health centre pattern every Primary Health Centre has 3 sub-centres irrespective of the population covered by the primary health centre. Hence the population coverage per

sub-centre naturally differs according to the population of the block. In the entire sub-plan area there is one sub-centre for a population of 18,431 on the average. In the West Godavari Integrated Tribal Development Agency each sub-centre covers an average population of 9,503, while in East Godavari it is 10,305 and in Warangal it is 13,919. The Integrated Tribal Development Agencies of Khammam, Srikakulam, Visakhapatnam and Adilabad cover more population per sub-centre than the sub-plan average.

Judging from all the parameters viz., Institution population ratio, Institution area ratio, bed-population ratio, doctor-population ratio, the western region is more backward than the eastern region. West Godavari Integrated Tribal Development Agency has got the best facilities ranking first in all the parameters. The next advantageous area is Visakhapatnam, while Srikakulam and East Godavari occupy a middle position. Warangal Integrated Tribal Development Agency is the most backward in all respects closely followed by Adilabad. In many respects the West Godavari Integrated Tribal Development Agency has better facilities on par with non-tribal areas.

However, it appears that the composition of the tribal and non-tribal population in the respective Integrated Tribal Development Agencies have got an important relationship to the available facilities. Ever since, special programmes for tribal development were incepted, more emphasis was given to areas of maximum tribal concentration. Hence areas which have got more tribal concentration have also more medical institutions started from special tribal welfare funds. The eastern region has got a tribal population ranging from 87.61% in Visakhapatnam to 54.31% in West Godavari, while in the western region the tribal population constitutes 29.37% in Warangal, 31.19% in Khammam 37.19% in Adilabad Integrated Tribal Development Agencies. Hence when the institutional facilities are compared for the entire population of the respective Integrated Tribal Development Agencies, the western region which has lesser concentration of tribal population presents a backward position. Because of the smallest area and smallest population with 2 tribal development blocks which both have primary health centres and as there is a taluk hospital, West Godavari Integrated Tribal Development Agency presents the most advantageous position.

ROADS, BUILDINGS, WATER & ELECTRICITY FACILITIES:

The communication, building, electricity and water facilities available in the medical institutions in sub-plan area are presented in Table No. 3.6.

COMMUNICATIONS:

Regarding communication facilities all the 22 hospitals are connected by black topped roads with regular bus services from the respective district headquarters. But out of the 28 primary health centres 25 are located on the road point while 3 primary health centres namely Mangapet in Eturnagaram Block of Warangal district is located at a distance of 12 Kms., Kasipet and Hutnoor primary health centres in Adilabad Integrated Tribal Development Agency are located at a distance of 8 Kms. These three primary health centres are located in the western region. Out of the 17 mobile medical units, 4 units located at, Kilagada and Pedabayalu in Visakhapatnam Integrated Tribal Development Agency are connected by kuche road, while Chelpaka in Eturnagaram is 19 Kms.,

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of malaria is on the increase. Still it is one of the major diseases of the tribal areas.

FILARIA:

Excepting a few areas in Srikakulam, the agency areas are free from filaria. Detected cases are sent to the district headquarters hospitals for treatment.

LEPROSY:

The agency areas of Srikakulam and East Godavari are more prone to this disease. Special leprosy clinics are functioning at Saluru in Srikakulam district and at Polavaram in West Godavari district.

TUBERCULOSIS:

The agency areas of Khammam, East and West Godavari are endemic for tuberculosis. In other areas also Tuberculosis is on the increase. The primary health centres are taking control measures like case finding, treatment and B.C.G. vaccination. The Medical

College at Kakinada and Visakhapatnam are also taking measures for mass B.C.G. vaccination of tribal children. However, there are no special clinics for Tuberculosis in tribal areas. The patients have to be sent to the district Tuberculosis clinics.

VENERAL DISEASES:

There are no special venereal disease clinics and the primary health centres treat the patients as and when they report for treatment.

MATERNITY AND CHILD HEALTH SERVICES:

Considerable progress has been achieved in the provision of maternity and child health services through the sub-centres. The A.N.Ms attend to the anti-natal and prenatal cases. Besides, the local dayas are also trained in modern methods of delivery. These services are integrated with family welfare and nutrition. Special nutrition programme, mid-day meal programme etc., are functioning in all the Tribal Development Blocks. Under the package programme, besides

nutritious diets immunization against infectious diseases, primary vaccination, poliodrops and D.P.T. are given to all the children. Iron and folic acid tablets are supplied to pregnant and lactating mothers to fight anaemia. Vitamin tablet are supplied to the needy mothers and children. Under this programme the Primary Health Centre Medical Officer has to visit each feeding centre atleast once in three months and examine the children and mothers.

HEALTH EDUCATION:

The paramedical staff as well as the medical officers have to educate the tribals about the prevention of diseases and health care.

PROPOSED MEDICAL INSTITUTIONS:

With the advent of the sub-plan, it was decided to establish primary health centres for a smaller population than now, and one sub-centre for a population of 5,000. Under this scheme, Primary health centres were already sanctioned at Rajavommangi in East

Godavari District, Anantagiri, Pedabayalu and G.Madugula in Visakhapatnam district. The buildings are under construction and the institutions may start functioning soon. With the opening of these institutions, every block in tribal areas will have atleast one primary health centre.

One tenth of the existing primary health centres are proposed to be converted into 30 bedded hospitals in due course. Under this programme the conversion of the existing Primary Health Centres into 30 bedded hospitals at Wankidi in Adilabad district and Hukumpet in Visakhapatnam district have gone ahead. Several dispensaries are also proposed to be converted into 10 bedded hospitals. It is proposed to bring the medical services in tribal areas on par with the facilities available in the other rural areas of the State within a period of 5 years.

STUDY OF 4 SELECTED PRIMARY HEALTH CENTRES

IN the previous Chapter, the institutional infrastructure of the State has been discussed. However, it may be possible, that the infrastructure, which has already been built-up, may not be properly utilised and may remain idle. In such circumstances, there is no point, in comparing the available institutional infrastructure in tribal areas, with more advanced areas and making recommendations for a still-better infrastructure with a view to bridge the gap. Thus, if the six bedded primary health centre remains unutilised, there is no point in elevating it to a 30 bedded hospital, without properly understanding the reasons for not availing the available infrastructure. Similarly even if the posts of Medical Officers and other paramedical staff were sanctioned on par with the other areas of the State, the doctors and other personnel might not have established themselves or the posts may remain vacant for considerably longer period. Further, the medical institutions, in

tribal areas are usually located in comparatively developed centres, where several migrants also live. It may be possible that the services rendered might have been going to the migrants of advanced sections, by-passing the weaker tribal populations. It is essential to know how far the available facilities are utilised in actual practice. Hence four sample Primary Health Centres were selected, in four blocks, two in the western region, Utnoor and V.R.Puram and two in the eastern region, Polavaram and Munchingput. The available facilities and utilisation at the Primary Health Centres of these blocks are discussed below:

BUILDINGS:

As the tribal areas, are very backward and lack any buildings to locate the hospitals or for residential purposes, it is a pre-requisite to construct institutional and residential buildings for effective functioning of medical institutions. It is not possible to get any rented buildings and the staff may not be willing to serve if accommodation is not available. It was observed that, three out of the four primary health

centres have permanent institutional buildings, constructed on modern primary health centre pattern, with adequate accommodation. The buildings for the fourth primary health centre at Munchingput, are under construction and the institution is presently located in a temporary building at Jolaput, which is at a corner of the block and is also the headquarters of hydro-electric project. The buildings of Jainoor and L.N.D.Peta were constructed during 2nd and 3rd five year plans, while that of Rekhapalli is recently constructed. This indicates that the more advanced areas got priority in construction of buildings. Except Rekhapalli and Munchingput which are not connected by regular bus service, the other two primary health centres are connected by pucca road.

The primary health centres of L.N.D.Peta and Jolaput are electrified. While the other two have no electricity. Rekhapalli primary health centre has neither water nor electricity, while the other 3 primary health centres have drinking water wells in the health centre compounds. However, at Jainoor the well dries-up during the summer and water has to be carried from a

distance of nearly $1\frac{1}{2}$ Kms. Excepting the primary health centre at Jainoor, residential quarters were not provided at any of the primary health centres. This clearly indicates that many of the primary health centres lack communication facilities and staff-quarters even now.

In the scattered, thinly populated, villages, lacking proper roads it will not be possible for a medical officer to render proper medical aid to interior villages without a jeep. Among the four primary health centres Jainoor was provided with a Government Jeep, and L.N.D.Peta primary health centre was provided with a jeep from UNICEF Funds. Thus, in the matter of vehicles also most backward areas are neglected.

STAFF:

Usual pattern of the primary health centres provided for 2 medical officers, one for regular clinical duties and the other for family planning, besides A.N.Ms, Health Inspectors and compounders are sanctioned. Each Sub-Centre under the primary health centre is provided with an A.N.M. while the Mobile Medical Units are provided

with one doctor and one compounder. The sanctioned staff and staff that was in position during the previous year is presented in Table No.4.1.

Though two medical officers were sanctioned for each primary health centre, only one medical officer is in position at all the places. It seems that the posts are kept vacant for considerably longer periods or the services of medical officers are utilised for some other purposes. In Jainoor, one of the medical officers was posted to look after the sub-centre at Indervally, while at Jolaput, the lone doctor went for a medical conference at the time of the study and the hospital is running with the paramedical staff. The posts of compounders are also lying vacant at V.R.Puram and Munchingput. But the A.N.Ms, Health Inspectors and health visitors are in position every where. While Polavaram and Jainoor have vaccinators, Rekhapalli and Munchingput have no posts of vaccinators. Thus the backward areas of Munchingput and V.R.Puram are denied the services of compounders and vaccinators.

All the mobile medical units have a sanctioned strength of one doctor, one compounder and a driver. In both the mobile medical units covered under this study, the mobile medical officers are holding additional charge of the hospital in addition to their regular duties. The compounders and drivers are in position.

The Ayurvedic dispensary has also sanctioned staff of one Ayurvedic doctor, one compounder and both of them are in position.

The sub-centres have a sanctioned strength of one Auxillary Nurse-cum-Midwife and they are in position every where.

INDOOR FACILITIES:

According to the primary health centre pattern each institution should have 6 indoor beds. Excepting, Jolaput which has no building, the other primary health centres have 6 beds each. But as there is no provision for diet to the indoor patients, the actual utilisation of beds is very poor. During the last 3 years, a total number of 240,110 and 108 persons have

utilised the indoor facilities at Jainoor, L.N.D.Peta and Rekhapalli primary health centres respectively. So the average annual utilisation is 80 at Jainoor, 37 at L.N.D.Peta and 36 at Rekhapalli. Thus on the average about 3 persons utilise the indoor services per month against the available facility for 180 persons per month. It was observed that the beds were lying idle at all the institutions for most of the year. (Table 4.2)

UTILISATION OF OUT DOOR FACILITIES:

While it was observed that the available indoor beds are not utilised to the full extent, the primary health centres are mainly serving the out-patients, casual as well as repeated. The utilisation over the last three years 1974-75; 1975-76; and 1976-77 are presented in table no.4.3.1.

The table reveals that the L.N.D.Peta primary health centre which is located in a comparatively advanced area than all the other primary health centres treated the maximum number of out patients throughout

the period. In the eastern region the primary health centre in the comparatively advanced block was attracting more patients than the primary health centre in the comparatively backward block, but in the western region, the average number of patients attended at the primary health centre in the comparatively advanced block and backward block did not show any appreciable difference.

The primary health centres in the western region recorded a steady increase in the number of patients from 1974-75 to 1976-77, while in the eastern region the comparatively advanced block recorded a sharp increase during 1975-76 but recorded a decrease during 1976-77, while the comparatively backward block did not record any increase during 1975-76, but recorded an increase in 1976-77. As the medical officers at L.M.D.Peta primary health centre were involved in the intensive family planning campaign during 1976-77, they could not treat as many patients as they have treated during the previous year. However, the number of outpatients attended at all the 4 primary health centres together recorded an increase from 40,994 during 1974-75 to 48,065 during 1975-76 and 55,366 during 1976-77.

The average daily utilisation during the past three years ranges between 20 to 38.19 at Jainoor, 22.14 to 37.15 at Rekhapalli, 48.47 to 58.27 at L.N.D. Peta and 20.99 to 26.21 at Jolaput. The average daily utilisation is very similar in both the primary health centres of western region, while in the eastern region the primary health centre in the backward area could treat only half or less than half the number of patients treated by the primary health centre in the advanced area. The number of patients treated on the average per day per primary health centre taking all the patients treated at the four primary health centres together is 28 during 1974-75, 33 during 1975-76 and 38 during 1976-77.

The primary health centres at Jainoor, Rekhapalli and Jolaput treated lesser number of patients than the average for all the primary health centres during 1974-75 and 1975-76. During 1976-77 Jolaput primary health centre treated comparatively lesser number of patients than the average, while Jainoor and Rekhapalli treated almost similar number of patients as the average for the four primary health centres. L.N.D.Peta primary health centre treated more patients than the average throughout the three years.

The daily average number of old cases treated by the Jainoor primary health centre is very low during 1974-75 (1.60) and 1975-76 (2.19). Rekhapalli primary health centre did not keep records regarding new and old cases. The primary health centres at L.N.D.Peta and Jolaput were treating a good number of old cases along with new cases throughout. During 1976-77 the number of old cases treated increased at all the primary health centres and constitute $\frac{1}{3}$ of the total cases treated during the year at Jainoor, and more than $\frac{1}{2}$ at L.N.D.Peta and Jolaput. It is interesting to note that the number of new and old cases treated at Jolaput primary health centre are nearly equal.

The average daily outpatient utilisation over the last three years at L.N.D.Peta/primary health centre is 52, at Utnoor and Rekhapalli is 28 each and at Jolaput 23. The low utilisation of the Jolaput primary health centre is due to the location of the Project hospital at the same place, which has better facilities, where most of the project staff take medical treatment and also the location of the primary health centre in a corner of

the block and far away from many of the tribal villages. The location of weekly shandies at Jainoor and Vara Ramachandrapuram attract a good number of patients especially on shandy days.

AVERAGE MONTHLY OUT-PATIENT UTILISATION DURING THE PAST ONE YEAR:

The average monthly utilisation during 1976-77 at the various primary health centres is presented in table No.4.3.2.

During this period a total of 55,276 patients availed the services of these 4 primary health centres, out of whom 51.84% are new cases and 48.16% are old cases. The average monthly cases treated per primary health centre taking all the four primary health centres together 1,152 patients per month. On the average L.N.D.Peta primary health centre treated 1,517 patients per month, while Jainoor primary health centre treated 1,162 patients, Rekha-palli primary health centre treated 1,130 patients and Jolaput primary health centre treated only 797 patients per month. Thus the number of patients treated by L.N. D.Peta primary health centre is more than the average,

while the average number of patients treated at Jainoor and Rekhapalli are very close to the total average. The number of patients treated by Jolaput primary health centre is far lower than the average.

An average number of 597 new cases and 554 old cases per month per primary health centre were treated at the four primary health centres. The maximum average number of new cases (790) were treated by Jainoor Primary Health Centre and the minimum number (393) by Jolaput primary health centre while the maximum average number of old cases (808) were treated by L.N.D.Peta primary health centre and minimum (371.5) by Jainoor primary health centre. The average monthly number of new cases treated by primary health centres in the advanced areas are more than the cases treated by the primary health centres in the backward areas, but in the case of old patients the primary health centre in the backward area (Rekhapalli) in the western region treated more old cases than the primary health centre in the advanced area (Jainoor). In the eastern region the backward primary health centre (Jolaput) is treating only $\frac{1}{2}$ the number of patients attended by the primary health centre in the advanced area (L.N.D.Peta).

The utilisation of the out-door facilities in the course of the year does not show a uniform pattern in all the four blocks. However, when all the cases treated by the four primary health centres are considered together the month of September seems to be the peak period when the primary health centres in tribal areas get the maximum number of old as well as new patients. The next higher percentage of patients attend during the month of June, May, August and November. The months of January, February, and March get the least number of patients.

At Jainoor and Jolaput primary health centres the maximum number of patients attended the primary health centres during the month of September in tune with the general observation, but at L.N.D.Peta and Rekhapalli primary health centres more patients attended during the months of May and June. Perhaps the location of these two primary health centres on the banks of the river Godavari which usually gets floods during the months of late May, June, resulting in a number of water borne diseases might be the reason for the peak incidence of diseases during these months. Otherwise the months of

August and September are the usual months when most of the tribals fall sick. It was observed that the attendance at the hospitals gradually increased from April to September and then decreased.

August and September experience the maximum rains inundating the tribal areas and forming breeding grounds for many sorts of diseases. Further the food situation during these months is the worst and the tribals mainly depend upon the wild leaves for sustenance. April to June experience extreme climatic conditions, and the change of climate makes the tribals more prone to diseases.

It was interesting to observe that the incidence of diseases has a direct relationship with the availability of food. The tribals complete their harvesting by December and begin to consume better food from that time onwards. Further the minor forest produce like tamarind, etc., comes to their rescue around February and constantly fetch them some money till April. It is during this period that they are gainfully employed in forest works. Hence, the tribals are more healthy during this

periods As soon as the rainy season starts the granaries become empty, the sources of employment recede and the tribals have to depend upon unusual foods or have to starve. The worst period is August and September. From September onwards the rains recede and some varieties of crops like Jowar and Maize began to be harvested. Further the forest also provide some roots and tubers. The tribals suffer more during times of food scarcity.

CASES TREATED BY MOBILE MEDICAL UNITS:

The number of patients treated by the Mobile Medical Units at Chintoor in Rekhapalli block and Polavaram in Polavaram block are presented in Table No.4.3.3.

It was observed that the Polavaram Mobile Medical Unit treated an average number of 918 patients per month as against 408 by Chintoor Mobile Medical Unit. The Mobile Medical Officer, Chintoor was posted for flood duty during three months. It seems that the mobile medical unit, Polavaram was treating almost an equal number of patients throughout the year, but the Chintoor Mobile Medical Unit shows extreme variations. While it treated

846 cases during December only 249 cases were treated during July.

It was interesting to note that the Mobile Medical Units were able to treat as many patients as treated by the primary health centres in their respective blocks.

M.C.H.SERVICES:

Besides, treating the sick people, the primary health centres also attended to maternity cases. During the last one year, Uthoor primary health centre has attended to 3,418 pre-natal cases and 796 post-natal cases while Polavaram primary health centre attended to 490 pre-natal cases and 280 post-natal cases, V.R.Puram attended to 366 pre-natal cases and 204 post-natal cases while Munchingput primary health centre attended to 224 pre-natal cases and 123 post-natal cases. (Table No: 4.4)

The sub-centres attached to the primary health centres are also attending to maternity cases in their areas. The sub-centres of Uthoor, V.R.Puram, Polavaram and Munchingput have attended to (238), (95), (127), and (60) cases respectively, during the last one year.

The Utnoor block is providing more maternity services, as it is covered by Integrated Child Development scheme with nearly 30 A.N.Ms, who attend to almost all delivery cases in their areas. In other places, usually, the sub-centres attend to some 60 to 100 cases, i.e., an average of 5 to 8 cases per month.

FAMILY WELFARE PROGRAMME:

All the 4 primary health centres have done very good work regarding family welfare operations, in their areas. Besides, educating the tribal couples, about the need for family limitation and improving their health standards, the primary health centres also conducted a good number of sterilisations. The particulars are presented in table No.4.5.

It was observed from the table that vasectomy, is the most popular method adopted by the tribal couples. Due to inadequate surgical facilities, the primary health centres could not do tubectomy operations except at L.N. D.Peta. In V.T.Operations, Jainoor primary health centre stands first by conducting 1,099 operations at the primary

health centre and 516 through subcentres, followed by Rekhapalli with 716 at primary health centre, 6 at the sub-centres. Jolaput primary health centre conducted 697 operations, at the primary health centre, 67 operations at sub-centres and 35 operations through the Mobile Medical Units. Besides conducting the operations, the primary health centres in the eastern region also distributed NIRODHS and inserted I.U.D.S., Munchingput primary health centre has distributed the maximum number of NIRODHS. The Distribution of I.U.D.S. and Oral Pills as well as tubectomy operations are confined to L.N.D.Peta primary health centre, which is located in a comparatively advanced area. This reveals that the tribal women are not yet coming forward to adopt family planning measures and the entire family planning measures are confined to tribal males only.

PREVENTIVE WORK:

Besides, curing the diseases the primary health centres were also undertaking the prevention of communicable diseases and prophylaxis against diphtheria, Tetanus, Polio, Tuberculosis and Nutritional diseases. The primary health centres were carrying anti-cholera

innoculations, Chlorination of wells, primary and re-vaccination against small-pox, immunization such as D.P.T., D.T., T.T, Polio and B.C.G. and also supplying vitamin and mineral supplements.

The particulars of preventive work carried at the 4 primary health centres are presented in table No. 4.6.

It is observed that the primary health centres in the eastern region have attended to comparatively more anti-cholera inoculations than the western region. Maximum number of inoculations, were conducted by the most backward block, Munchingput. In both the regions more anti-cholera inoculations were conducted by the backward primary health centres. As the incidence of cholera is more in the most interior and inaccessible areas, it is natural that the primary health centres located in the backward areas have inoculated more people. Chlorination of wells was confined only to the eastern region.

Regarding small-pox vaccination all the primary health centres were rendering appreciable service. The Jainoor primary health centre has done the maximum number

of vaccinations (8,041 P.V. and 6,241 R.V.) followed by L.N.D.Peta (1,768 P.V., 3,743 R.V.) Jolaput (664 P.V., 2,099 R.V.) and Rekhapalli (479 P.V. and 591 R.V.). In Polavaram and V.R.Puram blocks the vaccination campaign is also carried through the sub-centres. The difference in the number of cases vaccinated in various blocks is due to the differences in the population of the respective blocks.

Immunization of children is also carried out by all the blocks with great enthusiasm. Uttoor block which is covered by Integrated Child Development Scheme occupies a commanding position by carrying out 8,871 D.P.T., 1,000 Polio and 12,013 B.C.G.vaccinations. Similarly the Polavaram block, which the Rangaraya Medical College, Kakinada adopted under N.S.S. scheme got appreciable benefits in immunization with 1,786 D.P.T., 70 D.T., 80 T.T., 2,127 Polio and 4,697 B.C.G. vaccinations. But the Rekhapalli and Jolaput primary health centres which were not covered by any special schemes could cover a comparatively smaller number of population, with 412 D.P.T., 389 D.T. and 229 T.T., at Rekhapalli, 200 D.P.T., 300 D.T., and T.T. each. At Jolaput and

Rekhapalli there was no B.C.G. campaign. These blocks could neither give B.C.G. nor polio vaccination. Thus still the backward areas are not getting the maximum benefits regarding immunization.

As part of the Nutrition Programmes, the Medical Officers of the primary health centres have to examine the beneficiary children and pregnant and lactating mothers and distribute vitamin-A, iron and Folic Acid tablets according to needs. It was observed that this work was not carried out properly in all the areas. During, the past one year, L.N.D.Peta, primary health centre has distributed 850 Vitamin-A tablets, while Jolaput primary health centre has distributed 265 iron tablets. The other blocks have not distributed any vitamin or mineral supplements. Perhaps, the vitamin and mineral supplements at Utnoor block are supplied through I.C.D.S. for which the primary health centre does not keep any records. In V.R.Puram the primary health centre did not receive any stock.

WELFARE OF SCHOOL GOING CHILDREN:

The Medical Officers of the primary health centres are also entrusted with the care of the school going children attending to Ashram Schools, High Schools, Mid-day meal centres etc., located in their respective blocks.

During the last one year, the Medical Officer of Rekhapalli primary health centre examined 2,502 school children, at 29 Ashram Schools; the Medical Officer of I.N.D.Peta examined 200 at 4 schools and Medical Officer Jolaput attended to 440 children at 18 schools. The Medical Officer at Jainoor primary health centre did not keep any records about the number of schools visited, but informed that usually he will visit atleast once in 6 months every Ashram School in that area. Excepting the primary health centre at Rekhapalli the coverage of school children is not adequate in other blocks.

VISITS TO HINTER LAND:

The primary health centres have to cover the health needs of ignorant, illiterate, poverty stricken,

conservative and shy tribals, who lack any communications and do not care to visit the hospitals except at the last moment. In order to make a dent into the tribal life and to convince the tribal patients to take modern medical aid, it is essential that the medical officers of primary health centres should visit the hinter land at regular intervals.

According to the particulars provided by the various primary health centres the Medical Officers are visiting the sub-centres once in 15 days and the villages at least once in 3 months, which is very inadequate and usually the medical officers could not make good rapport with the tribals.

However, the paramedical staff such as health visitors, A.N.Ms and maternity assistants, are regularly visiting the villages at least once in 15 days. It is actually through these functionaries that some medical aid is reaching the tribal households.

The Mobile Medical Units are making at least one visit in 10 days to every village. But Mobile Medical Units are not functioning in two of the blocks namely Utnoor and Munchingput.

GUIDANCE:

The primary health centres are required to keep linkage with high level institutions for guidance, to treat the complicated cases or to refer the patients for special treatment at district headquarters hospitals etc. Similarly they have to render such services to the dispensaries under their control. To assess the effective functioning of the institutions and to correct the anomalies if any, the institutions have to be inspected by the higher authorities. The particulars of linkage with the low level and higher level institutions in the 4 selected primary health centres are presented below Table No.4.7.

The table reveals that, the inspections, visits and guidance with low, as well as high level institutions are very poor in the western region. The only linkage observed in this region is the visits of Medical Officer to the subcentres. But in the eastern region, the institutions are inspected twice in a year and in addition six visits were made by high level authorities. During this period the L.N.D.Peta, primary

health centre, Medical Officer made 48 visits to sub-centres, under his control and the Medical Officer, Jolaput made 12 visits.

However, the purpose of these visits in all these blocks is confined to achieve F.P.targets. Excepting the D.M. & H.O. no other high level official visited the institutions. It was informed that the Medical Officers seek the guidance of D.M. & H.O. in matters of rolling communicable disease and to achieve Family ing targets etc.

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HEALTH COVERAGE AMONG SAMPLE HOUSEHOLDS

TO have a general idea of the prevalence of various diseases and the type of treatment adopted by the tribal households of the State, a sample household study was conducted in the 4 selected Tribal Development Blocks. In each of the four clusters three villages were selected on the basis of the criteria discussed in Chapter-II. In each of the selected villages, a sample of 25 households or all the households of the village if the total households of the village are less than 25 were covered with reference to immunization, disease pattern, chronic and seasonal diseases, and maternity cases. This survey will reveal the real situation prevailing in the tribal areas situated at various distances from the medical institutions.

In the four selected Tribal Development Blocks, altogether 1,001 households were contacted during the survey. Out of which 275 households were from Utnoor block,

266 households from Polavaram block, 233 households from V.R.Puram and 227 from Munchingput block. These households have a total population of 5,026 of whom 1,622 were males, 1,555 were females and 1,849 were children. The block-wise coverage was as follows:

TABLE NO.5.1

B l o c k	Males	Females	Children	Total
Utnoor	523	500	639	1,662
Polavaram	396	391	409	1,196
V.R.Puram	364	333	436	1,133
Munchingput	339	331	365	1,035
Total:	1,622	1,555	1,849	5,026

As the number of households covered was more and the size of family was also comparatively big in Utnoor block, this block presented a higher percentage of population than the other three blocks.

The sample consisted of 16 tribal communities of 800 households, 3 scheduled caste communities of 76 households, 18 backward class communities of 84 households and 9 other caste communities of 41 households. The block-wise community wise coverage of the sample households is presented in table No.5.2.

The household coverage consists of 79.92% tribals, 7.60% scheduled castes, 8.40% backward classes and 4.08% other castes. The population coverage among these households is 80.48% tribals, 7.56% scheduled castes, 7.98% Backward classes and 3.98% other castes. The principal communities covered are Gonds in Utnoor block, Koyas in V.R.Puram and Polavaram and Bagathas in Munchinput block. The second largest communities covered are Banjaras in Utnoor, Kondareddis in Polavaram, Nayaks in V.R.Puram and Porjas in Munchinput blocks.

HEALTH COVERAGE:

During the IV plan period, much importance was given to the prevention of communicable and nutritional diseases among the tribal populations. Besides

the primary health centres, the Medical Colleges, situated in the different regions have also selected certain tribal areas for intensive prophylactic measures. As part of Special Nutrition Programmes, Integrated Health Coverage was also provided. Intensive search campaign against small pox, mass B.C.G. vaccination etc., were also undertaken in the tribal areas. During the course of this survey, it was observed that inoculation against cholera, primary vaccination and revaccination against small pox, immunization such as D.P.T., Polio and B.C.G. were undertaken by the different blocks.

The cluster wise percentage of population benefitted from different prophylactic measures at the 4 selected blocks are presented in Table No.5.3.

INNOCULATION AGAINST CHOLERA:

It was evident from the table that inoculation against Cholera was undertaken in all the clusters in all blocks except in V.R.Puram, where in cluster number 3 and 4, only children were inoculated. Taking the four blocks as a whole the percentage of inoculated

ranges from 48.88 to 58.31. The highest coverage is in cluster No.2, followed by cluster-3, and the least coverage is in cluster 1 and cluster 4, perhaps the difference in coverage is due to the differential incidence of Cholera out break in different regions during the year.

In all the four clusters children appear to have received maximum attention as their percentage inoculated ranges from 66.99 to 78.96 as against 32.99 to 43.22 among the males and 32.76 to 42.86 among the females..

The percentage of population inoculated is not uniform in the four blocks covered. They show extreme divergence. The L.N.D.Peta primary health centre of Polaveram block achieved the highest coverage of 100 percent in all the four clusters, while V.R.Puram block presented the least coverage.

In cluster No.1, Utnoor block covered 47.09% of the total population, with 69.28% children, 33.87% females and 33.97% males, while in Jolaput primary health centre of Munchingput block a total population of 39.35%

were covered. Here as against cent per cent coverage of children, only 20.53% of males and 8.79% of females were inoculated. In Rekhapalli primary health centre of V.R.Puram block, the percentage of population inoculated is only 7.16%. The percentage of adults inoculated is almost negligible.

In cluster No.2, the coverage at V.R.Puram and Rekhapalli blocks are better than in cluster No.1 of those blocks. Utnoor block inoculated 74.64% of the population and V.R.Puram block 38.82%. The percentage of children inoculated in these two blocks are 97.07% and 79.63% respectively. V.R.Puram block covered only 20.66% of the total population. In this cluster, Utnoor block covered 58.96% of males and 57.04% of females. But V.R.Puram and Munchingput blocks covered only a negligible percentage of adults.

In cluster No.3, Utnoor block inoculated 67.47% of the population as against 29.03% in V.R.Puram and 28.57% in Munchingput. The coverage is confined only to children in V.R.Puram and almost to children in Munchingput. However, Utnoor block covered about 54% of adult population also.

In cluster No.4, Uthoor block covered about 55.59% of the population, Munchingput 31.97% and V.R. Puram only 9.28%. Excepting Uthoor and Polavaram, the backward blocks did not extend immunization to adults.

Thus it is evident that the inoculation programme was mainly carried among the children in the backward regions. But in the advanced areas, a large percentage of adults also were covered. The coverage was comparatively better in the eastern region than in the western region. Distance from the Medical institutions does not appear to influence the percentage of population inoculated.

PRIMARY VACCINATION AND REVACCINATION:

During the past one year, L.N.D.Peta primary health center of Polavaram block, covered the entire tribal population either by primary vaccination or revaccination. All the children of this block received primary vaccination and it was also observed that the entire adult population is revaccinated.

Primary vaccination is mostly confined to children. However, in Utnoor block a sizeable percentage of adults 40,38, 28.81, 18.79, 23.80 percentage of males; 39.52, 34.51, 16.90, 27.17, percentage of females respectively in cluster Nos. 1,2,3 and 4 have received primary vaccination, indicating that these people who were not vaccinated previously were detected during the intensive search campaigns. It is also observed that in Utnoor block, the percentage of children who received primary vaccination in the interior areas (about 77%) is slightly less than the areas near the institutions (about 89%). But in the backward blocks of V.R. Purem and Munchingput, maximum coverage, was done in the interior areas.

Just as in the case of primary vaccination, revaccination is also mostly confined to children.

D.P.T.:

Triple antigen was administered to children in all the clusters in all blocks. Cent per cent coverage of children was achieved in Polavaram block, while in

Uttoor block the coverage ranges from 69.28% to 80.19%. In Munchingput block the coverage ranges between 50% to 84.62% in different clusters. The coverage at V.R.Puram block was comparatively poor compared to other blocks, where in the first cluster only 2.10% of the children were covered, and in the 4th cluster 32.82% were covered. However, in cluster 2 and 3, 63.89% and 71.19% of the children were covered. Thus in this block the villages around the primary health centre and interior villages not covered by any institution received poor coverage. In Uttoor and Munchingput blocks, a few adults also received immunization against D.P.T. As the immunization is mostly given to children below 6 years, it may be assumed that most of the children of this age were immunized with D.P.T. and the percentage left are children above this age. The coverage as a whole is better in the eastern region.

POLIO:

Immunization against Polio was administered on all the children in Polavaram block, and few children in cluster No.1 of V.R.Puram block. Other blocks did not administer Polio drops during this year.

B.C.G.:

Tuberculosis is one of the serious diseases of the tribal areas. Concerted efforts are made to prevent and cure this dreaded disease among the poor and illiterate tribal populations, who are ignorant of the communicable nature of tuberculosis. Mass B.C.G., campaigns are organised in most of the tribal areas. In Polavaram block, all children were given B.C.G. vaccination. In Utnoor block also nearly 90% of the children received B.C.G. vaccination. In Munchingput block 93.41% of the children in cluster-1 and a little more than 78% in cluster 3 and 4, were given B.C.G. vaccination. But cluster-2 covered only 55.56% of the children. V.R.Puram block lags behind the other blocks. Here the coverage is only 8.39% in cluster-1. However, the interior areas received a better deal with 53.70%; 67.80% and 62.68% coverage in cluster-2, 3 and 4 respectively.

Thus it is observed that the advanced blocks of Polavaram and Utnoor were giving better coverage than the backward blocks of V.R.Puram and Munchingput. Polavaram block was adopted by the Rangaraya Medical College,

Kakinada, which organized medical camps in the interior tribal areas and achieved cent. per cent immunization.

In Utnoor block "Integrated Child Development Scheme" is functioning under which all children were receiving special medical care. The Munchingput and V.R.Puram blocks depend entirely on primary health centre which have to look after curative as well as preventive aspects of the areas.

Hence the coverage is comparatively less. V.R.Puram is the most backward in respect of immunization.

HOUSEHOLD WISE INCIDENCE OF SICKNESS (TABLE NO.5.4):

Out of the 1,001 households covered in the study, 757 households reported one or more family members suffering with some disease during the past one year. Thus 75.62% of the households have some members suffering with diseases, leaving 24.38% of the households without any sufferers. The percentage of households with sufferers varies in different blocks and different clusters. The highest percentage of households with sufferers (93.23%) was observed in Polavaram block. While the least percentage was observed in Utnoor block. Thus the two forward blocks of Polavaram and Utnoor report the two extremes

and in the backward blocks of V.R.Puram and Munchingput the percentage of households with sufferers is 76.39 and 71.36 respectively. Regional, climatic, nutritional, economic and out side contacts may influence the incidence of diseases in different areas. Polavaram block which reported the highest incidence has the maximum contacts with plains population, while the other three blocks have lesser contacts.

The cluster wise analysis in different blocks does not show any relevance between the number of households with sufferers and the distance from the medical institution. In Polavaram block, a percentage ranging between 89 and 96 is observed indicating no appreciable difference between the different clusters. In Utnoor block, cluster-1 reports the least incidence while clusters 2 and 3 report an intermediate position. Among the backward blocks the incidence is comparatively less in cluster-4, while the reverse is observed in Munchingput.

PERCENTAGE OF SUFFERERS IN THE POPULATION: (TABLE NO.5.5)

Out of the total number of 5,026 individuals covered in this sample study 1,037 individuals suffered with one or more ailments during the past one year. Thus 20.63% of the total population suffered from diseases during the last one year. The maximum percentage of sufferers (28.09) is reported in Polavaram block followed by 23.74% in V.R.Puram block, 19.13% in Munchingput block and 14.07% in Utnoor block.

SEX-WISE DIFFERENTIATION OF SUFFERERS:

Out of the 1,622 males covered 486 (29.96%) and out of 1,555 females 302 (19.42%) and out of the 1,849 children 249 (13.46%) suffered with some disease. This reveals that the incidence of diseases are more among the males than females. Children are comparatively less susceptible to common ailments. As males will be going for difficult work such as labour works and hunting, felling trees etc., they suffer more from wounds, cuts and animal attacks etc., with some degree of divergence this phenomenon is observed in all the blocks.

DISEASE PATTERN IN THE SAMPLE POPULATION (Table No.5.6):

The common diseases reported by the sample population during the past one year are presented in table no.5.6. It is observed from the table that fevers are the most common diseases in all the areas. Fevers account for 14.62% in Polavaram block, 10.32 in V.R.Puram, 9.36% in Munchingput block and 4.64% in Utnoor block. Among the fevers malaria is the most common, accounting for 14.13% in Polavaram, 9.62% in V.R.Puram, 8.50% in Munchingput, and 2.52% in Utnoor. Other non-specific fevers are also reported in all blocks. The incidence of Malaria is more in interior areas i.e., cluster 4 in all the blocks. Next to Malarial fevers, skin diseases especially scabies is also observed in all the selected blocks. The incidence of scabies is high in the backward blocks, of V.R.Puram (8.18%) and Munchingput (5.17%) as against 2.46% in Utnoor and 1.82% in Polavaram. Cluster 4 in V.R.Puram block reported 21.16% of persons suffering with scabies. Respiratory tract diseases also account for 2.21% to 3.60%. The highest incidence is observed in Utnoor block (3.60%). Tuberculosis is observed in clusters No.1 and 2 in most of the areas, revealing that people

having outside contacts are more prone to this disease. Other common respiratory diseases are cough and cold. Next in importance are the digestive tract diseases such as dysentery and diarrhoea, stomach-ache, constipation etc., which account for 2.67% in Polavaram, 1.62% in Munchingput, 1.22% in Utnoor and 0.87% in V.R.Puram. Other common ailments like head ache, back ache, muscular pains, account for 2.40% in Utnoor, 1.75% in Polavaram, 0.78% in V.R.Puram and 0.77% in Munchingput. Apart from these diseases E.N.T.diseases, Ophthalmic diseases, wound etc., are also reported.

Thus the most common diseases in tribal areas are malaria fever, scabies, respiratory tract diseases and digestive tract diseases. Malaria and scabies are more prevalent in interior areas, while common ailments like head-ache, tuberculosis etc., are more in the advanced areas.

INSTITUTIONS WHERE TREATMENT IS TAKEN:

The type of treatment taken by the sufferers at the various institutions such as primary health centre, sub-centre, Mobile medical units, Government hospital and

private doctors, native doctors, home remedy etc., is presented in Table No.5.7 (Cluster-wise).

It is observed that in cluster No.1; (which is the headquarters of the primary health centre) the sufferers were taking treatment mainly from the primary health centres. As against an average utilisation of 56.52%, the Polavaram block utilisation is 58.22% in Munchingput block 58.14, and in V.R.Puram, it is 57.14%. Thus the number of sufferers attending the primary health centres are good even in the backward regions. The Mobile Medical Units and sub-centres are not serving the patients in this cluster, as this task is left to the primary health centres. A few cases which attended the Government hospital are also observed. Apart from attending the Government institutions these sufferers are also utilising the services of private doctors (5.43%), native doctors (5.43%). The utilisation of services of private doctors is mostly observed in the advanced areas of Uttoor and Polavaram. While in the most backward areas of Munchingput no body has consulted private practitioners. The role of native doctors or quack doctors is more in the backward regions. Nealy 17.20%

of the sufferers did not take any medicine. This percentage is more in the western region.

In cluster No.2 which is the headquarters of the primary health centre, sub-centre, the role of primary health centre and Mobile Medical Unit are negligible. In Utnoor, and Munchingput blocks, none of the sufferers attended either primary health centre or Mobile Medical Unit. In the advanced block of Utnoor and Polavaram, the sufferers are not utilizing the services of the sub-centre, but in the backward regions the sufferers are taking treatment from the sub-centres. In this cluster the treatment is usually taken either from private doctor or from the native quacks. In Utnoor block, as many as 67.56% of the patients were taking treatment from private doctors and in Polavaram it is 11.22%. But in the backward area of V.R.Puram and Munchingput very few people are attending private practitioners. Here the native doctors assume major role. In Munchingput 26.78% of the patients took treatment from native doctors and nearly 1/3rd of the sufferers have not taken any medicine. However, in Utnoor block, those who have not taken any medicine is only 6.76% as missionaries and private practitioners are doing good service, here. Home

remedy is resorted to a large extent in the interior blocks.

In cluster No.3, which is the headquarters of Mobile Medical Unit or other medical institutions like Ayurvedic dispensaries, also very few were attending the primary health centre but the Mobile Medical Units are serving about 10.64% of the people. The utilization of the services of the Mobile Medical Units is better in the western region. Excepting Munchinput, where there is no other institutions the patients are also attending to government hospitals as these are located within easy reach of the tribal population at Utnoor, Polavaram and Chintoor. Private practitioners were attending about 1/5th of the patients in Munchingput and nearly 1/4th in Utnoor. But in V.R.Puram block, very few people are attending to private practitioners, and are resorting mostly to home remedies. Native doctors attend on 22.41% in Munchingput. As observed in cluster-2, here also 28.39% of the persons did not take any medicine.

In cluster No.4, that is villages not covered by any institution, none has attended either primary health centre or sub-centre. The Mobile Medical Units attended on 11.96% of the patients. V.R.Puram block Mobile Medical Unit has covered the maximum number of 30.60% followed by 7.51% in Munchingput, revealing that in interior areas, the tribals readily utilise the services of Mobile Medical Units. In this cluster the patients in the backward blocks, did not go to private practitioners, but take recourse to native doctors or home remedies. A majority of the population did not take any medicine.

The analysis reveals that the government medical institutions in tribal areas are serving the needs of the patients in and around the medical institutions. The interior areas are mainly depending on the Mobile Medical Units. Many of the tribal patients did not take any treatment, leaving it to fate. The percentage of patients who did not take treatment increases from the primary health centre headquarters to the interior areas. The role of native doctors is very high in the Munchingput block. Private practitioners are consulted for serious ailments in advanced areas.

The above analysis does not reveal the community wise utilisation of the medical institutions in tribal areas. As the tribal areas are also inhabited by some scheduled castes, backward classes and other communities, who are mostly migrants into the tribal area in search of Government employment, forest labour etc., it will be appropriate to analyse the extent of utilisation of medical institutions by the different communities. The percentage of population utilizing various types of treatment, block-wise, cluster-wise, community-wise is presented in Table No.5.8.

It is observed that in cluster-1, which is the primary health centre headquarters and surrounding villages, a large number of sufferers are attending to the primary health centres. In Munchingput, Polavaram and V.R.Puram all the patients of the backward classes and other communities attended the primary health centre. The tribal patients attending primary health centre are 46.87%^{w/at}, Uttoor-51.25% in V.R.Puram, 31.91% in Polavaram and 48% in Munchingput. The scheduled caste patients of Polavaram block, well utilized the primary health centre, but

in V.R.Puram only 76.20% and in Munchingput 28.57% of the scheduled caste patients attended the primary health centre. Apart from the primary health centre, considerable number of scheduled tribe (24.00%) and scheduled caste (28.57%) patients in Munchingput block took treatment from the malaria surveillance worker. A few scheduled caste patients from V.R.Puram block also took treatment from M.S.W. In Utnoor block, about 12.50% of the tribal patients took treatment from private doctors. Many of the patients did not take any treatment or resorted to home treatment. The number of tribal patients who did not take any treatment is high in the western region (Utnoor 28.12%, V.R.Puram 27.50%). In the eastern region however the tribal patients were resorting to home remedies (Polavaram 14.90%), Munchingput 28.57%) and native doctors (Polavaram 12.76%) Munchingput (24.00%) on a large scale.

In cluster No.2, the role of Government institutions in treating the patients is comparatively less. Here also, the patients belonging to backward classes and other communities were getting better utilization of the Government institutions. Private practitioners were

treating more patients than in cluster-1. Nearly 37% of the patients did not take any treatment. The number of persons resorting to native and home remedies are more in Munchingput, Utnoor and V.R.Puram.

In cluster No.3, also the utilisation of the Mobile Medical Units services are more among the other caste patients. The utilisation of Government hospitals is more by the scheduled castes than the scheduled tribes. Backward Classes patients attended in more numbers than both scheduled castes and scheduled tribe patients. It is interesting to note that more tribal patients are going to private doctors (15%) than scheduled castes (4.28%) and Backward Classes (10.53%). All the other caste patients received treatment from Government institutions only. Native doctors and home remedies are resorted to by many patients in Munchingput (31.48%), V.R.Puram (22.22%) and Utnoor (17.54%). The influence of native doctors and home remedies is more pronounced in the backward regions.

The cluster No.4, which consists of villages not covered by any institutions have very few non-tribals. Here the tribals are getting treatment from Mobile Medical

and M.S.W.S. The M.M Units
 Units in backward areas are treating more patients than the forward areas. Malaria surveillance workers are treating more patients in the eastern region. The role of private practitioners is negligible in this cluster. A majority of the patients in this cluster did not bother to take any treatment. The percentage of patients who did not take any treatment is 51.78% in V.R.Puram, 36.17% in Polavaram, 29.73% in Uttoor and 19.51% in Munchingput. As the backward region of Munchingput presents the least percentage of patients who did not take any treatment, it makes no difference whether the remote villages are situated in advanced or backward blocks. In the eastern region native treatment appears to be more dominant with 34.14% of the patients in Munchingput and 19.15% in Polavaram, resorting to it. However, home remedies are comparatively more in the western region.

Irrespective of the clusters, the percentage of patients attending Government medical institutions is 36.62% among tribals, 69.66% among scheduled castes, 61.11% among Backward Classes and 92.85% among other castes. This reveals that the non-tribals and especially

high caste migrants who are more influential are getting a better deal from the government institutions. Apart from the government institutions private practitioners treated 12.04% of the tribal patients, 8.98% of the scheduled caste patients 21.30% of backward classes and 7.14% of other caste patients. As more tribal patients than scheduled caste and other caste patients are observed to visit private practitioners, it may be assumed that at times of incurable ailments, the poor tribal goes to the private practitioner spending his meagre resources to get relief.

Native doctors and home remedies are resorted mainly by the tribals (20.07%) and scheduled castes (10.11%) as against 4.63% among the backward communities. The patients who have not taken any treatment is alarmingly high among the tribals (31.26%) as against (11.23%) among scheduled castes and (12.95%) among backward classes. Thus more than 51% of the tribal patients resort either to native and home remedies or leave the ailment to fate.

PREFERENCE FOR VARIOUS TYPES OF AILMENTS:

The preference for attending various types of medical institutions for seasonal, chronic, maternity, accidents and other common diseases (cluster-wise) is presented in Table No.5.9.

In cluster No.1, about 65% of the patients preferred the primary health centre for seasonal, chronic and other common diseases. Nearly 50% of the patients involved in accidents also preferred primary health centre. The hospital and missionary hospitals were preferred only for chronic diseases. In respect of maternity cases, still the tribals prefer home delivery, (75%). Only 25% preferred the A.N.Ms. About 13 to 26% of the patients excluding maternity cases prefer to consult private practitioners. Native treatment is preferred by about 20% for seasonal diseases, and accidents,

In cluster No.2, 3, and 4 also the hospitals are preferred for chronic diseases and accidents. All the maternity cases in these clusters preferred to be attended at home only.

More people in cluster No.4 depended on native doctors and home remedies.

MATERNITY CASES:

In the sample households 216 deliveries occurred during the past one year. The cases attended by the A.N.M., hospital, native dayas and by own family members are presented in Table No.5.10.

In spite of providing M.C.H. services and intensive health education campaigns, it appears that the tribals do not bother to utilize the services of auxillary nurse midwives or native dayas. In the total sample, 71.75% of the deliveries were attended by elderly women, family members and relatives only. Excepting in cluster-2, the native dayas attended on about 10% of the deliveries. Only 2 cases which were considered difficult were attended at the hospital. The services of the A.N.M. seems to be utilized in villages where medical institutions are located. A.N.Ms attended on 22% of the deliveries in cluster No.1 and 2 and about 16% in cluster No.3. In cluster No.4, where no medical

institutions are located all the cases were attended by family members and elderly women only. It is interesting to note that more women were utilizing institutional services in cluster Nos. 1, 2 in comparison to 3 and 4. The number of cases attended by family members increased from cluster number 1 to 4.

Irrespective of the type of assistance taken for delivery, the deliveries took place at their own homes excepting two cases which were admitted in the hospital.

BELIEF SYSTEM AND REASONS FOR NOT AVAILING
MODERN MEDICINES

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BELIEF SYSTEM REGARDING DISEASES:

THE belief regarding the causation of various diseases plays an important role in the type of treatment resorted. The people may attribute natural causes, or anger of supernatural powers, minor gods and goddesses and black magic as the causes of various diseases. A broad outline of the various causes attributed by the sample households for different ailments is presented below.

SEASONAL DISEASES: (Table No.6.1)

A majority did not attribute any causes for seasonal diseases. The percentage of such people range from 73.33 to 32.50 in different types of villages. Usually villages situated at a distance from medical

institutions did not attribute any specific cause. Apart from those who did not attribute any cause, others have two major reasons (1) change of climate and (2) unhygienic conditions. A majority of people from villages near the Primary Health Centre attributed change of climate as the principal cause of seasonal diseases. Those who attributed unhygienic conditions range from 6.66 to 19.75% in different types of villages.

CHRONIC DISEASES: (Table No.6.2)

Regarding chronic diseases which take a long course and trouble the patient constantly without giving any relief, the people of the tribal areas attribute reasons different from seasonal diseases. A majority attributed these diseases to anger of gods and spirits (25.00%); dead persons, ghosts and black magic (20.00%) and ones karma or fate (15.00%). However, nearly 40% attributed unhygienic conditions, unwholesome food or negligence of the disease as the cause of chronic diseases. It seems that when diseases take a long course and are not cured by common remedies, supernatural causes and black magic are attributed.

EPIDEMIC DISEASES: (Table No.6.3)

The belief that epidemic diseases are the result of the wrath of many spirits, ghosts and village goddesses existed in some form or other in all the tribal areas. Epidemics such as cholera, Small-pox, chicken pox and other diseases for which they cannot find a remedy are attributed to malevolent gods, goddesses and evil spirits. Among the sample households the belief that anger of gods, goddesses and spirits are the cause of epidemic disease is so great that from 65.00 to 90% of the people in different types of villages attributed this as the principal cause of epidemics. There is very little difference in the prevalence of this opinion among villages situated at some distance from the medical institutions and the headquarters villages. However, in primary health centre headquarters villages about 17.5% of the people attributed bad hygiene and polluted water as some of the causes. Villages not covered by any institution have more belief on the gods than other villages. Apart from the wrath of gods, fate or karma (fatalistic attitude) also was attributed by many, especially among villages

which are at some distance from the medical institutions, ranging from 10% to 25%, 20 to 25% of the villagers situated at a distance of 5- to 10 Kms., from medical institutions attributed this reason.

REASONS FOR NOT AVAILING MODERN MEDICINE:

In spite of the availability of primary health centres and sub-centres, several tribal patients were unable to avail modern medical services. An attempt was made to find out the reasons by contacting heads of households in different blocks. It was observed that 24.19% of them have immense faith in the efficacy of native cures and home remedies and have no belief in modern medicine. These people are not willing to go for modern medicine under any circumstances. Another 9.16% could not give any specific reasons. The rest of 66.57% of the people believe that modern medicine is more effective in treating diseases. Out of whom 32.77% had actually availed modern medical institutions for different ailments. Another 33.80% of the tribal households could not avail the services of the medical institutions for different reasons though they have belief in modern medicine.

The various reasons given by those who could not attend medical institutions in spite of having belief are as follows.

Out of the 141 members, 66 (46.81%) could not attend the hospital due to financial troubles, 49 (34.75%) could not attend, as the institutions are situated in distant places, 15 (10.64%) feared that the doctors will not treat them well, 9 (6.38%) have no other members to look after their family if they go for hospital treatment, and 2 (1.42%) have fear complex to meet the doctors. Thus financial troubles and distance are the main reasons for not availing medical institutions apart from blind faith in native cures.

CASE HISTORIES:

A few case histories and attitudes collected from different clusters in different blocks are presented, to understand the causes, beliefs and reasons for availing and not availing different types of remedies.

Case Histories:

Block: Utnoor
 Village: Jainoor
 Cluster: 1

Name: Konala Isuru
 Tribe : Gond

He is not interested to visit the primary health centre, as the medical officer is giving the same pills which do not cure his disease. He says that the native herbal medicines are cheap and give more relief for various ailments and diseases.

He worships goddess Pochamma for Cholera, Small-pox, and Tuberculosis.

Block: Utnoor
 Village: Jamini
 Cluster : 1

Name : Govinda Rao
 Tribe: Banjara

He is suffering with gastric ulcer. He is not willing to visit the hospital for operation as he is poor and cannot bear the expenses. He has three young children and there is nobody to look after them if he goes for operation. Further, he has lot of fear to undergo operation.

Block:-Vara Ramachandrapuram Name:-Kooru Butchaiah
 Village:-Annaram Tribe:-Koya
 Cluster:-1

He says that diseases are caused by black magic. Such diseases can be cured only by counter magic. Here a magician-cum-medicine man known as "Veju" treats, by incanting mantras, offering chicken and a bottle of country liquor. If the disease is cured the Veju receives a good reward of money. They will invariably approach the "Veju" for all incurable diseases.

Block:-Vara Ramachandrapuram Name:-Karam Kannamma
 Village:-Dharmatallagudem. Tribe:-Koya
 Cluster:-1

She is suffering with Tuberculosis for more than a year. She is taking some bark medicines and getting the services of "VEJU" to counter evil magic. She is not willing to take modern medicine.

Block:-Polavaram Name:-Konja Reddimma.
 Village:-Muddappagudem. Tribe:-Koya.
 Cluster:-2.

She is suffering with T.B. On the advice of a family friend who convinced her to go for modern treatment she took treatment at Eluru and Bhimavaram towns and got cured. But it costed more than Rs.1,000/- to her family.

Block : Munchingput

Village : Sariaput

Cluster : 2

Name : Kata Ramudu

Caste : Neyyalavadu

Suffering with acidity for more than 6 months and he is taking poppy seed decoction only.

Block : V.R.Puram

Village : Kunduluru

Cluster : 2

Name : Posam Chinnaiyah

Tribe : Koya

He says that modern medicine is more effective in curing diseases. But the medical institutions are not within their reach and they are unable to utilise them. He takes treatment from the A.N.M. or from the Mobile Medical Unit when it visits their village.

Block : Polavarani

Village : Repalliwada

Cluster : 2

Name : Vattikuti Samuel

Caste/Tribe: Harijan

He lives on daily labour and has no opportunity to visit any place. Whenever he suffers from disease he approaches the veterinary Assistant or compounder in his village.

Block : V.R.Puram Name : Mosam Chinalaxmiah
Village : Kunjamvarigudem Tribe/ :Koyadora
Cluster : 2

He is suffering with Tuberculosis since six years. He was so much emasciated that he cannot move out of bed. Virtually he is on the verge of death. He took only native remedies so far. Though he is not getting any relief, still he is not willing to visit the hospital. The reasons for not availing modern medicines are;

- 1) The hospital is far away.
- 2) He cannot bear expenses.
- 3) He has no belief on Government doctors and hospitals.
- 4) His negligence has already aggravated the disease, and he has no hope of any cure.

He says that it is a waste to go to Government hospitals. Even if he goes there he feels that the doctors will not treat him properly as he has no money.——

Block : V.R.Puram
 Village: Kunjamvarigudem

Name: Madimi Kannaiah
 Tribe: Koya

He has visited the Government hospital but could not get any cure. The doctor told that there is no stock of medicines and asked him to purchase them outside. As he is poor he could not purchase medicines. He believes that the same episode will be repeated even if he visit the hospital again.

Block: Polavaram
 Village: Gunjaram
 Cluster: 2

Name: Vada Venkataratnam
 Tribe/Caste: Muthrasi

He underwent vasectomy operation in a camp. After the operation no body cared to see his condition again. He developed a very painful abscess. He went as far as Eluru and Visakhapatnam to get it treated. Finally at Dharmavaram near Kunta, in Madhya Pradesh one of his testicles was removed by surgical operation and he was cured.

Block : Munchingput
 Village: Munchingput
 Cluster : 2

Name: K.Chinna Babu
 Tribe/Caste: Veddi

Two of his daughters suffered with Chicken-pox during the last year. No medicines or medical advice was taken, as he knew that the disease is caused by goddess "Ammatalli". He offered a chicken to her.

Block : Utnoor
 Village: Narnoor
 Cluster : 2

Name: Shaik Mahboob
 Caste: Muslim

Suffering from Tuberculosis. He took treatment from the Ayurvedic doctor at Narnoor dispensary. As he did not get any cure, went to private doctor at Adilabad and got cured.

All deliveries in their home are conducted by elderly women. Once they called the A.N.M. to attend but she demanded Rs.10/- to make the delivery and hence they are not calling her.

Block : Utnoor Name : Bheemu
 Village: Keslaguda Tribe: Gond
 Cluster: 3

Says that diseases are caused due to ones fate or Karma. If the fate is not good no amount of medicine can cure them.

Block : Utnoor Name : Chikram Ramsya
 Village: Gangapur Tribe/Caste:Gond
 Cluster : 3

He is suffering with Tuberculosis since one year. Due to financial trouble, he could not take any treatment.

Block : Utnoor Name: Sungubai w/o Ramsya
 Village: Gangapur Tribe: Gond
 Cluster : 3

She is suffering from severe Asthma. She fears that the Government doctor at Narnoor demands money if she approaches him for treatment.

Block : Munchingput Name : Gongngi Bojjaiah
Village: Bangarumetta Tribe: Bagatha
Cluster: 3

He has not taken any medicine in his life time from outsiders. He will not go for any treatment other than native medicine.

Block : Utnoor Name: Yermal Atchu
Village: Dhaba (uncovered) Tribe: Gond
Cluster: 4

The treatment taken by his family for seasonal diseases are decoctions of local barks and herbs, and for wounds applies a paste of Turmeric and Oil.

Reasons for not availing modern medicines; 2

He says that poverty is the main cause for not availing modern medicine. He is not aware of medical institutions. Whenever the malaria surveillance worker visits the village, these people approaching him for allopathic tablets and injections.

Block : Utanoor Name: Kinaka Karun
Village: Jokari (Uncovered) Tribe: Gond
Cluster: 4

He is suffering with reingworm since two years, but could not take medicine. When approached the A.N.M. demanded money. He says that the Ayurvedic doctor at Narnoor is asking money for medicines, saying that medicines are not available.

Block: Polavaram Name: Raja Bheem Reddy
Village: Chintapalli (Uncovered) Tribe: Konda Reddy
Cluster: 4

Reasons for not availing modern medicine;

The primary health centre is situated at a distance of 32 Kms., and there was no sub-centre to cover the villages. Diseases are treated by old women with native herbs and barks. He wants to take modern medicine but the primary health centre is far away.

Block: Polavaram
 Village: Chintapalli

Name: Rajdev Reddy
 Tribe/Caste: Konda Reddy

The respondent is not interested in modern medical practices. Feels that native medicines do better than modern medicines.

Block: Polavaram
 Village: Munjuluru (uncovered)

Name: N. Penta Reddy
 Tribe: Konda Reddy

Though he is suffering with chronic disease, he does not want to go to the hospital. If god ordained that he should die, he would die at his home rather than at the hospital. He has no belief in modern medicines.

Block: Munchingput
 Village: Jaffarru
 Cluster: 4

Name: Seesa Mussaiah
 Tribe/Caste: Porja

He says that he has more belief on native or agency drugs than modern drugs. The agency people respond more quickly to native drugs. However, in cases of serious diseases he is prepared to visit the hospital.

BELIEFS THAT PREVENT TRIBAL PATIENTS TO VISIT HOSPITALS:

ORDINARY diseases like cold, head-ache abdominal pain, small wounds are treated by the tribal, as a natural phenomena and does not bother to attribute any cause. From times immemorial they used to apply a number of jungle medicines, herbs, roots and barks, from which they prepare concoctions, which are effective. In fact the tribals knew remedies for all the common diseases, and the knowledge is handed over from generation to generation. These remedies are known to several people and they can easily collect them without much effort. Further, such diseases as cold, cough and fevers are so common and treated as a seasonal phenomena and several tribal communities do not bother to apply any medicines and allow them to be cured by nature.

However, the situation is different with chronic and epidemic diseases, for such diseases in the first instance they apply natural remedies, if no relief, is observed, attribute the disease to black magic,

supernatural powers or ones fate. Still they have immense faith in magical cures. They believe that sickness is caused in most cases by evil spirits or by gods, who have been offended or wish to be worshipped. Such beliefs drive them to the sooth sayer or magician. When a patient approaches a sooth sayer, he will try to find out the cause of the disease by divination. The "Guru" or magician is both a physician and a magician. He will apply medicines known to him and also does some magic. Sometimes, the diseases respond to the treatment and the patient feels that he was cured by the magical powers of the Guru. The tribals believe that every thing depends upon the ability of the sooth sayers ability to find the real cause of the disease. A magic cure is therefore largely a matter of the right diagnosis.

The aboriginals generally have not much faith in the efficacy of modern medicine. Surgical operation is unknown to them and they prefer death to any kind of operation at the hospitals. However, once they get over their fear and realise the efficacy of the modern medicines which bring them quick relief, they will quickly accept the drugs given by the hospitals.

Epidemic diseases like cholera, small-pox, etc., are believed to be brought into their village by certain village goddesses or evil spirits, who for some reason feels offended. The deities are many and differ from place to place and called by different names such as Pochamma, Maremma, Ammatalli, Balamma, Peddamma, etc., usually they try to avert epidemics by offering animal sacrifices. Some goat or cock will be offered to the deity and it will be allowed to graze as it likes, and get itself fattened. On an appointed day, the animal with turmeric, Kumkum and flower and margosa garlands will be decorated and killed at the temple of the deity. The priest drives the evil spirits with magical hymns out of the village. It is believed that application of natural remedies in small-pox and cholera will offend the goddesses, and will treat it as lack of faith in her, and hence they are avoided.

Whenever an individual feels sickness, and applies known remedies and inspite of that goes on becoming weaker and weaker, it will be believed that the individual has become the victim of a ghost or some magician. Any such magic infliction of disease is strongly believed can be cured or neutralised by another

magician more powerful than the inflictor, by magical rite and spells. Even emasinating diseases such as Tuberculosis and consumption are believed to be due to the wrath of evil spirits and black magic. It was observed that some patients in V.R.Puram and Munchingput blocks which are very backward and comparatively less contacts with modern civilisation are still resorting to bark medicines and magical cures through sooth sayers locally called "Veju" or "Guru".

Thus due to age old beliefs, conservatism and living in tradition bound society, at the appearance of the first symptoms of any disease, the ignorant tribal patient tries various cures, starting from simple household remedies to quack doctors, while simultaneously seeking protection and cure from the evils of black magic and angered supernatural powers with the help of witch doctors and priests. Both the quack and witch doctors take advantage of the ignorance and timidity of the tribal patient and prevent him from taking advantage of modern medicine and visit new places for treatment, by making tall claims of curing even those diseases considered incurable by the best modern doctors and promising treatment at a nominal cost at his home. In the

process the innocent patient reaches an incurable stage and the quack doctor or magician escapes by attributing the worsening of the illness to the wrath of gods or the fate of the person or the inability of the patient to properly follow the instructions in performing magico-religious rites. Thus valuable time is lost and the meagre financial resources which would have been usefully diverted for the purchase of necessary medicines or proper food are wasted. Disgusted for his fate and loosing all hopes, the patient visits the hospital as a last resort and if the patient dies, the quacks spread false rumours and create the opinion, that the death is caused as a result of taking modern medicines, and prevent others to visit hospitals.

However, due to the untiring efforts of the Government and sympathetic attitude of the some humane doctors, a large section of tribals realised the importance and efficacy of modern medicine. In spite of realising the effectiveness, several factors are preventing them from utilising the services of the modern medical institutions on a large scale.

The tribals are still shy to visit hospitals away from their native place. They fear that even if the Government hospitals provide free treatment, they will not be able to visit the hospitals at a distance frequently, as there will be nobody to look after their children or to earn their daily bread. Further, at times of crisis like disease, death and social and economic disasters, the tribals try to be in the company of their kith and kin and receive their consolation and assurance. Such association, kinship obligation and extreme poverty prevent them from utilising the services of the hospitals.

The primary health centres are not properly equipped and adequately supplied with necessary drugs. The tribal patients who visit such hospitals are advised to purchase necessary drugs or referred to the headquarters hospitals which are far away, not easily accessible to tribals. In the process they feel that the doctors do not care to treat the poor tribals. Thus even those who resort to the primary health centres often return disappointed, unable to visit far off places,

foregoing daily wages. This situation comes in the way of attracting the tribal patients, as they feel that they cannot get good attention from the hospitals.

Even those patients, who somehow attend the hospitals for long treatment for chronic diseases, discontinue treatment after getting some initial relief unable to bear the agony of living away from their kith and kin for long periods. They will not be able to continue treatment at home and if the disease again aggravates, they feel that modern medicines cannot cure the diseases.

Most of the tribals also feel that the staff in the government hospitals demand money for treatment and will not pay any attention to poor people. This feeling has developed among them, due to the ethnocentric attitude of some hospital staff who fail to treat the tribal patients kindly, and the fear complex of the tribals towards new people. Consequently the tribal patients are not able to avail the medical facilities provided by the Government to the maximum extent and are still falling a prey to the quack doctors.

SUMMARY & SUGGESTIONS

The study reveals that the tribal sub-plan areas which constitute 10.9% of the geographical area of Andhra Pradesh state have only 6.32% of the total medical institutions. Primary Health Centres which really serve the tribal areas also have to cover a larger area than in the plains. As against 1 P.H.C. per 665 sq.K.M. in the state there is only 1 P.H.C. per 1,082 Sq.K.M. in tribal area. Though the tribal areas lag behind the state with reference to area, an institution in tribal area covers a lesser population than in the plains areas. As against 1 medical institution per 30,000 population in the state there is 1 medical institution per 20,000 population in tribal areas and as against one P.H.C. per 1,00,000 population in the state, the tribal areas have one P.H.C. per 68,853 population. While there is 1 hospital bed for a population of 2,000 and one doctor for a population 13,000 in the state the tribal areas have one bed per a population of 3,812 and one doctor for a population of 14,775.

The present situation thus reveals that the health institutions in tribal areas have to cover a larger area nearly $1\frac{1}{2}$ times and large number of villages nearly 4 times, than the other areas of the state. The tribal villages are thinly populated and scattered over large distances and lack proper communication facilities. Hence it will be difficult for the doctor as well as the tribal patients to utilise the services as in the plains areas.

However, the medical institutions in tribal areas have to cover lesser population than in the plains areas. Patients in plains areas who ^{are} economically far better than the tribals utilise the services of private practitioners, besides Government doctors, whereas the tribal patients have to depend entirely on the Government institutions or native cures and home remedies. Hence the lesser population per institution in tribal areas does not give any advantage.

The number of doctors and available beds in tribal areas are also comparatively less and a number of sanctioned posts are kept vacant for longer periods, thereby drastically affecting the utility of the institutions.

Even at the end of the IVth plan period 4 out of the 24 T.D.Blocks have no primary Health Centres, there

by denying the minimum health needs. These 4 blocks have been sanctioned primary health centres in the Vth plan period under minimum needs programme. Some of the primary health centres are located at a corner of the block and are not within the reach of the tribal patients.

Many of the hospitals and P.H.Cs have no permanent buildings and electricity and as such they were unable to function properly. Excepting a few M.M. Units others are located in temporary buildings.

Residential accommodation which is highly essential for personnel working in tribal areas was badly neglected and this is one of the reasons detracting the medical personnel to serve in tribal areas.

A survey of the 4 selected T.D.Blocks reveals that in the matter of buildings, transport and personnel, the backward areas among the tribal blocks are neglected. In the absence of a vehicle, the activities of the medical institutions are actually confined to the villages in and around the institutions.

Though 6 indoor beds are provided at each P.H.C. actual utilisation was found to be very poor, due to the absence of doctors from the head quarters and as there

is no provision for diet to the patients. The poor tribals who live upon their day to day earnings cannot afford to maintain themselves during the times of hospitalisation, even if medicines are supplied free. Further some other earning members of the family have to stay with the patient during the hospitalisation, still rendering it more difficult for their family maintenance.

Though 2 medical officers were sanctioned for all the P.H.C's only one medical officer was actually in position at many of the P.H.Cs. The services of the Medical Officers are utilised for emergency duties in other areas. Even the posts of compounders were kept vacant for longer periods. Consequently at such times the institutions are run with the paramedical staff only.

The P.H.Cs have been observed to carry on the preventive work in a better way. As the tribal areas are covered by special nutrition programme and other child health programmes; it was observed that immunisation was carried satisfactorily in tribal areas. As the forward areas among the tribal blocks were selected for special coverage by medical colleges, as well as for starting special programmes like I.C.D.S., the immunisation programme in the advanced blocks was far better than in

the backward blocks.

One of the major draw backs in the infrastructure of the medical institutions in tribal areas is lack of specialist services. There are no arrangements for treating diseases like T.B., Surgical diseases and diseases of women. The medical officer has to refer such cases to the district head quarters hospital, which the innocent, poor tribal patient cannot afford to attend. The ignorant tribal patients do not understand the difficulty and feel that the medical officer does not like to treat them and loose faith in the institutions.

Most of the tribals invariably attend the weekly shandies to purchase their daily requirements and for recreation. It is the meeting ground for tribals from different areas. It was observed that the medical Officers of the M.M.Units were very successful in attracting patients at shandy points.

The survey among sample households reveals that the interior areas in all the four sample blocks, received preference in immunisation activities. The medical officers of the P.H.Cs are taking special care to immunize children in the interior regions. 75% of the households reported some disease in their families during the past one Year. 20.63% of the population covered reported some

disease or other. The percentage of male sufferers is more than the females.

The common diseases in tribal areas are fevers especially malaria; scabies; T.B. and other respiratory tract diseases and digestive tract ailments. Poor hygienic conditions, bad nutrition and environmental sanitation are aggravating the diseases.

The tribal patients in and around the institutions are better utilising the modern medical services than the interior villages. The role of M.M.Units was better in the interior areas. Actually the tribal patients do not like to leave their homes, but are prepared to take treatment if provided at their homes. It was pathetic to note that a large number of tribal patients do not take any treatment, leaving it to fate. The role of native doctors and home remedies is more in the interior areas. The tribal still prefers native or home remedies for seasonal and casual ailments, but in case of long and intractable diseases, some prefer to go to the hospitals and private practitioners perhaps as a last resort.

In spite of the existence of sub-centres with A.N.Ms., very few tribals are utilising their services

for deliveries. The Tribals consider that the delivery is a natural phenomenon and does not require any medical assistance. Further, they fear that the outside women pollute their house-holds. None of the women were preferred to go to the hospital for delivery. However more number of women near the institutions are utilising the services of A.N.Ms. Perhaps lack of education and contacts are the main reasons for not utilising the services of A.N.Ms.

The tribals usually believe that change of climate and unhygienic conditions as the cause of seasonal disease. they feel that seasonal diseases can be cured by home remedies. Regarding epidemics there was a strong belief that gods and goddesses are responsible for inflicting the disease and also fear that the deity will be offended if any medicine is applied. They usually believe that there is no known cure for epidemic diseases, except prayers and offerings to deities. Similarly, diseases which could not be cured are attributed to ones fate, ghosts or angered gods, and black magic. In such circumstances, they spend all their energies to get magical cures.

Only 36.62% of the tribal patients are attending Government medical institutions, as against 69.66% among scheduled Castes, 61.11% among backward classes and 92.85% among the other castes. The high caste migrants who are more influential, aware of the medical institutions and keep better contacts with officials are better utilising the institutions than the tribals. The tribal patients are attending in more numbers to the private practitioners than scheduled castes and other castes. It seems that the tribals are feeling shy and also fearing

that they will not get a better deal at Government institutions. As such when they suffer from chronic incurable diseases, the tribal patients prefer the private practitioners as a last resort. Many tribals still resort to native cures and home remedies. Some of them will not bother even to take home remedies or native cures and leave the disease to its fate. More than 50% of the tribals resort either to native cures and home remedies or leave the ailment to fate.

The study also reveals that excepting 24.19% of the tribals who do not like to take any treatment other than native or home remedies, others are not averse to modern medicine. About 9.16% of the tribals could not give any preference either for modern or native medicine. Though 66.5% of the tribals believe that modern medicine is more effective than native remedies; only 32.77% of them could actually avail modern medical institutions. It was observed that financial troubles, situation of the medical institution far from their villages are the principal reasons detracting them from utilising medical institutions. The other reasons are fear that doctors will not treat the tribals properly; no other members to look after their family if earning members go for treatment and fear to meet outsiders.

SUGGESTINGS:-

The location of the medical institutions is the most important factor in attracting tribal patients. The primary health Centres at some blocks are located in predominately non-tribal areas, or at a corner of the block and could not attract the tribal patients. Wherever permanent buildings were not yet constructed, steps may be taken to shift the primary health centres to places where there is a large concentration of tribals and easily accessible to most of them.

Still some of the primary health centres and mobile medical units have no pucca buildings or residential quarters. It is very difficult to get a suitable rented building for the hospitals in tribal areas. Electricity is not available at many institutions. Lack of buildings and electricity restrict the utility of the institution. The equipment could not be properly utilised in the absence of suitable buildings. Hence all the medical institutions should be provided with suitable buildings.

Residential accommodation was not provided even where buildings are constructed. The major reasons which detract the medical officers to serve in tribal

tribal areas, are lack of accommodation, facilities for educating children and recreation. As such it is essential to construct residential quarters and give special incentives for medical personnel working in tribal areas.

At present the primary health centres are not maintaining a record of the village wise patients, tribal and non-tribal utilising the services. As such it is not possible to find out how far the institutions are really serving the needs of the tribal populations. Hence arrangements may be made to maintain village-wise statistics.

The primary health centres were able to cater to the needs of the patients in and around the institutions only. As some of the institutions still have no vehicles the medical personnel could not extend their activities to the interior areas. Hence, all the primary health centres should be provided with a vehicle.

The mobile units were found to be more popular in interior areas. One of the major reasons attributed by the tribal patients being distance of the medical institutions, mobile medical units can overcome this difficulty by making regular tours in tribal areas. Hence, every tribal development block should be provided

with one or more mobile medical units. This will solve the problems of covering large areas and scattered village.

Though two posts of medical officers are sanctioned for every primary health centre only one doctor is usually in position. As one of the medical officers has to attend regular out patient duties at the headquarters, in it is interior villages which are usually neglected. Hence the absence of the second medical officer, it may be made compulsory to post two medical officers., for every Primary health centre in tribal areas. If one of the medical officer will be a lady more tribal women also will be attracted to attend the primary health centre.

Though indoor beds were provided at all the primary health centres they are lying un-utilised, as there is no provision for diet. All the tribal patients hospitalised may be provided diet allowance, so as to enable them to take treatment without bothering for food.

Weekly shandies attract large number of tribals from different places. Shandy is a part and parcel of tribal life and every tribal invariably attend the shandy atleast once in a month. The mobile medical units were able to do more service at the shandy points. Hence, primary health centre, hospital or mobile units should be located at shandy places to do more effective

service to the tribals.

Even if the mobile units are strengthened they will not be able to cover all the villages more than once in a week. As treatment for common ailments like malaria, diarrhea and cough and cold can be given by paramedical staff, some stocks of medicines may be kept with local teachers, A.N.Ms and V.D.O's to be distributed to the needy tribals.

It was observed that the medical officers were asking the patients to purchase medicines outside on the plea that necessary medicines are not available. Steps may be taken to keep adequate stocks of medicines for malaria, scabies, wounds and respiratory tract diseases and other common diseases of the particular area.

Most of the tribals feel that the doctors at the Government institutions demand money to render proper medical aid. If they cannot pay money they feel that some useless pills will be administered. As such they feel that it is useless to go to Government institutions, if they could not afford to pay some money. It may be true that some unscrupulous officials may demand money and are responsible for such situation. It is essential to post dedicated personnel and to keep a constant watch by higher authorities. Incentives for good service and deterrent punishments for neglecting tribal

patients should be initiated. The tribal women are not utilising the services of the A.N.Ms, as they are outsiders and have little knowledge of the area. More emphasis should be given on giving modern training to native midwives and to appoint tribal women as A.N.Ms. Similarly to overcome the fear complex of the tribals to attend the hospitals, some tribals may be appointed in the medical centres. They will be able to contact the tribals with much ease and carry the services more effectively.

Lack of knowledge about diseases and ignorance are still playing their role in driving some tribals to quacks. However they are resorting to home remedies as they are cheap and within their reach. If the medical personnel take keen interest in educating the tribals about diseases and sympathetically treat them, most of them can be attracted to modern medicine. To achieve this goal a cadre of dedicated and sympathetic workers may be organised to man the medical institutions in tribal areas.

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TABLE NO.3.1

SUB-PLAN AREA AND POPULATION

Sl. No.	I.T.D.A.	Area in Sq.Kms.	Total No.of villages	Population			
				Total	Scheduled Tribe		
1.	Srikakulam (G.D.A.)	3,030.30	821	1,96,657	1,52,425		
2.	Visakhapatnam	5,904.51	3,538	3,14,908	2,75,921		
3.	East Godavari	4,191.65	775	1,54,586	1,00,271		
4.	West Godavari	1,006.10	106	57,019	30,970		
5.	Khammam	6,899.92	911	6,00,833	1,87,421		
6.	Warangal	3,122.46	285	1,11,358	32,640		
7.	Adilabad	6,138.50	6,422	3,52,526	1,31,519		
Total:				30,293.44	7,078	17,87,887	9,11,167

G.D.A: Girijan Development Agency

TABLE NO.3.2

EXISTING HEALTH FACILITIES IN TRIBAL SUB-PLAN AREAS
(1976)

Sl. No.	I.T.D.A.	No. of Curative Centres		Indoor Beds	Sub-Centres	Ayurvedic and Unani Dispensaries etc.
		Hospitals	P.H.Cs. Dispensaries.			
1.	Srikakulam	3	3	46	9	--
2.	Visakhapatnam	5	5	107	15	--
3.	East Godavari	2	4	44	15	1
4.	West Godavari	1	2	28	6	--
5.	Khammam	9	9	162	27	2
6.	Warangal	--	2	12	8	3
7.	Adilabad	2	3	70	17	10
Total:		22	28	469	97	16

TABLE NO.3.3

TOTAL NUMBER OF MEDICAL INSTITUTIONS & DOCTORS IN THE TRIBAL SUB-PLAN AREA

Sl. No.	I.T.D.A.	Total No. of Medical Institutions		Total No. of Doctors	
		Allopathic	Ayurvedic, Unani etc.	Allopathic	Ayurvedic, Unani etc.
1.	Srikakulam	10	--	16	--
2.	Visakhapatnam	22	--	29	--
3.	East Godavari	10	1	13	1
4.	West Godavari	6	--	9	--
5.	Khammam	28	2	33	2
6.	Warangal	4	3	6	3
7.	Adilabad	10	10	15	10
Total:		90	16	121	16

TABLE NO.3.4

ALLOPATHIC MEDICAL INSTITUTIONS

Sl. No.	I.T.D.A.	Medical Institution Population ratio	* Medical Institutions and Geographical area ratio	Indoor beds and population ratio.	Sub-Centres and Population ratio	Doctors and population ratio.
1.	Srikakulam(GDA)	1 : 19,665	1 : 303	1 : 4,275	1 : 21,850	1 : 12,291
2.	Visakhapatnam	1 : 14,314	1 : 268	1 : 2,943	1 : 20,993	1 : 10,858
3.	East Godavari	1 : 15,458	1 : 419	1 : 3,513	1 : 10,305	1 : 11,891
4.	West Godavari	1 : 9,503	1 : 167	1 : 2,036	1 : 9,503	1 : 6,335
5.	Khammam	1 : 21,458	1 : 246	1 : 3,708	1 : 22,253	1 : 18,207
6.	Warangal	1 : 27,839	1 : 780	1 : 9,279	1 : 13,919	1 : 18,559
7.	Adilabad	1 : 35,252	1 : 613	1 : 5,036	1 : 20,736	1 : 23,501
Total:		1 : 19,865	1 : 336	1 : 3,812	1 : 18,431	1 : 14,775

* Excluding Ayurvedic Dispensaries

GDA : Girijan Development Agency

ALLOPATHIC, AYUVEDIC AND UNANI MEDICAL INSTITUTIONS

Sl. No.	I.T.D.A.	Medical Institutions and population ratio.	Medical Institutions and Geographical area ratio	Doctors and population ratio.
1.	Srikakulam	1 : 19,665	1 : 303	1 : 12,291
2.	Visakhapatnam	1 : 14,314	1 : 268	1 : 10,858
3.	East Godavari	1 : 14,053	1 : 381	1 : 11,041
4.	West Godavari	1 : 9,503	1 : 167	1 : 6,335
5.	Khammam	1 : 20,027	1 : 229	1 : 17,166
6.	Marangal	1 : 15,908	1 : 446	1 : 12,373
7.	Adilabad	1 : 17,626	1 : 306	1 : 14,101
Total:		1 : 16,866	1 : 285	1 : 13,050

TABLE NO. 3.6.

FACILITIES AVAILABLE IN MEDICAL INSTITUTIONS

Sl. District No. (I.T.J...)	Medical Institutions (No.)	Distance from the road.	Buildings Inst.	Res.	Electri-fied or not.	Water Yes/No	No. of indoor beds.
1.	2.	4.	5.	6.	7.	8.	9.
1. Srikakulam	Hospitals 3	all on Road Point	Yes	Yes (2) No. (1)	Yes (3)	Yes (3)	10
	P.H.Cs. 3	-do-	Yes (3)	No. (3)	Yes (3)	Yes (3)	3 10 6 6 6
	M.M.Units 3	-do-	No. (3)	No. (3)	--	--	--
	Dispensaries 1	-do-	Yes (1)	No. (1)	Yes (1)	Yes (1)	N.A.
2. Visakhapatnam	Hospitals 5	-do-	Yes (5)		Yes (5)	Yes (5)	31 12 10 12 10
	P.H.Cs. 5	-do-	Yes (4) No. (1) (Jolaput)	No. (5)	Yes (5)	Yes (5)	6 6 6 (Jolaput) 3
	M.M.Units 4	Road Point (2) Kilagada and Pedabayalu not connected by road	Yes (2) Kilagada & Pedabayalu (No.)		--	--	

Stt. Contd....

1.	2.	3.	4.	5.	6.	7.	8.	9.
3.	East Godavari	Hospitals 2	All on Road Point	Yes(2)	No. (2)	Yes(2)	Yes(2)	8 12
		P.H.C 4	-do-	Yes(3) One U.C.	Yes (2) No. (2)	No.(4)	Yes(4)	6 6
		Allopathic Dispensaries 3	Road Point 8 K.Ms. from road point(1)	Yes (3)	No.(3)	Yes(2) No.(1)	Yes(3)	-- 6
		M.M.Unit 1	Road Point	No.(1)	No.(1)	--	--	--
		Ayurvedic Dispensary 1	Road Point	--	--	--	--	NA
4.	West Godavari	Hospitals 1	-do-	Yes(1)	No.(1)	Yes	Yes	8
		P.H.C.2	-do-	Yes(1) U.C.(1)	Yes(1) No.(1)	Yes(2)	Yes(2)	6 6
		Allopathic Dispensaries (3)	-do-	Yes(2) No.(1)	No.(2) Construction(1)	Yes(2) No.(1)	Yes(2) No.(1)	-- 4 4
5.	Khammam	Hospitals 9	-do-	Yes(9)	No.(9)	Yes(9)	Yes(9)	56 -- NA 10 10 NA 26 NA 6

(140)

Stt. Contd.....

1.	2.	3.	4.	5.	6.	7.	8.	9.
		P.H.Cs 9	All on Road point	Yes(9)	No.(9)	Yes(5) No.(4)	Yes(9) having 6 beds	
		Allopathic Dispensaries (including one Mobile Dispensary)	All on Road Point	Yes(1) Not Available (5)	No.(1) Not available (5)	Nos(1) No.(4)	Yes(5)	--
		Ayurvedic Dispensaries 2	-do-	Yes (2)	No.(2)	Yes(2)	Yes(2)	--
		M.M.Units/4	-do-	--	--	--	--	--
6.	Warengal	Hospitals	--	--	--	--	--	--
		P.H.Cs./2	One is 12 Kms from road; One is on road point	Yes (2)	Yes(2) No.(1)	No.(2)	Yes(2)	10 6
		M.M.Units: 2	One is 19 Kms from road Road side	No.(2)	No.(2)	Nil	Yes(2)	--
		Ayurvedic & Unani Dispensaries. 3	One is 30 Kms from road side; one is road point; one is 8 Kms. from road point	No.(3)	No.(3)	No.(3)	Yes(3)	Nil

Stt. Contd.....

1.	2.	3.	4.	5.	6.	7.	8.	9.
7.	Adilabad	Hospitals 2	Road Point	Yes(1) U.C.(1)	Yes(1) --	Yes(1) -- (1)	Yes(2)	10 30
		P.H.Cs/3	One is on road point; Two at 8 Kms Distance.	Yes(1) N.A.(1) No.(1)	Yes(1) N.A.(1) No.(1)	Yes(2) No.(1)	Yes(3)	NA Nil Nil
		Allopathic Dispensaries 3	Two in road point; One about 8 Kms. distance.	N.A.(3)	N.A.(3)	Yes(1) No.(2)	Yes(3)	10 10 NA
		Ayurvedic Institutions 10	10 Kms. 18 Kms; 3 Kms. Road Point 5 Kms; 4 Kms. 9 Kms; 3 Kms. 4 Kms; 4 Kms.	N.A.(10)	N.A.(10)	Yes(5) No.(2) NA (3)	Yes(8) No.(1) NA (1)	NA(10)
		M.M. Units 2	32 Kms. Road Point	Yes(1) N.A.(1)	-- --	No.(1) Yes(1)	Yes(2)	--

Yes : Buildings available.
No. : Buildings not available.
UC : Under construction.

TABLE NO. 4.1.1. (A)

STAFF SANCTIONED AND IN POSITION AT THE PRIMARY HEALTH CENTRES

	Jainoor		Rekhapalli		L.N.D. Peta		Jolaput	
	Sanc- tioned	In posi- tion	Sanc- tioned	In po- sition	Sanc- tioned	In Posi- tion	Sanc- tioned	In Posi- tion
Medical Officer (Regular)	1	1	1	1	1	1	1	1
Medical Officer (F.P)	1	Vacant	1	Vacant	1	Vacant	1	Vacant
A.N.M. (F.P)	1	1	2	2	1	1	1	1
A.N.M. (M.P)	3	3	3	3	1	1	3	3
Health Inspector	1	1	2	2	1	1	4	4
Health Visitor	1	1	-	-	-	-	3	3
Compounder	1	Vacant	1	Vacant	1	1	1	Vacant
Health Assistant	-	-	-	-	-	-	2	2
A.H.V.	-	-	1	1	-	-	1	1
Maternity Assistant	-	-	-	-	5	5	-	-
Cholera Worker	-	-	-	-	-	-	1	1
Vaccinators	4	4	-	-	2	2	-	-
Ayas	-	-	-	-	3	3	-	-

TABLE NO.4.1.1.(B)

STAFF SANCTIONED AND IN POSITION
(Mobile Medical Units and Ayurvedic Dispensary)

	Ayurvedic Dispensary		M.M.Unit Chintoor/ M.M.Unit, Polavaram		M.M.Unit, Kilahada, MunchingputBlock	
	Narnoor/Utnoor Block		V.R. Puram Block Polavaram Block.			
	Sanctioned	In Position.	Sanctioned	In Position.	Sanctioned	In Position.
Medical Officer	1	1	1	1	1	1
Compounder	1	Vacant	1	1	1	1
<u>SUB-CENTRES</u>						
	Indervalley		Kundulur		Repalliwada Munchingput	
A.N.M.	1	1	1	1	1	1

TABLE NO. 4.2

UTILISATION OF INDOOR FACILITIES AT THE FOUR PRIMARY HEALTH CENTRES FROM

1974 TO 1977

Block:	Utnoor		V.R. Purāḥi		Polavaram		Munchingput			
	M.	F.	T.	M.	F.	T.	M.	F.		
P.H.C:	Jainoor		Rekhapalli		L.N.D.Peta		Jolaput			
1974-76	108	132	240	66	42	108	37	73	110	No Indoor Facilities
	M: Male		F: Female		T: Total					

TABLE NO. 4.3.1.

NUMBER OF PATIENTS TREATED BY THE PRIMARY HEALTH CENTRES 1974 TO 1977

(ANNUAL)

Year	Block: P.H.C:	Uthoor Jainoor		V.R. Puram Rakhapalli		Polavaram L.N.D. Peta		Munchingput Jolaput				
		New	Old	Total New	Old	Total New	Old	Total New	Old	Total		
1974-75	6,720	685	7,305	--	--	8,082	11,062	6,630	17,692	4,632	3,283	7,915
1975-76	8,658	801	9,459	--	--	9,674	12,109	9,131	21,270	3,736	3,926	7,662
1976-77	9,484	4,458	13,942	--	--	13,561	8,510	9,695	18,205	1,727	4,841	9,568
1974-75	18.41	1.60	20.00	Average Daily Utilisation		22.14	30.30	18.16	48.47	12.69	8.99	21.68
1975-76	23.72	2.19	25.91			26.50	33.17	25.09	58.27	10.23	10.75	20.99
1976-77	25.98	12.21	38.19			37.15	23.31	26.56	49.87	12.95	13.26	26.21

Total No. of Cases treated by the 4 P.H.Cs.	
Total cases treated	Average Daily cases treated.
1974-75 40,994	28.07
1975-76 48,065	32.92
1976-77 55,366	37.92

TABLE NO. 4.3.2.

NUMBER OF CASES TREATED BY PRIMARY HEALTH CENTRES - 1976-77 (MONTHWISE)

Month & Year	Jainoor		Rakhapalli		L.N.D.Peta		Jolaput		All P.H.Cs.		Total
	New	Old	New	Old	New	Old	New	Old	New	Old	
April 1976	946	147	657	490	733	683	387	421	3,723	1,741	4,464
May "	771	231	853	547	923	1,083	345	350	2,902	2,221	5,123
June "	751	359	663	537	1,023	1,144	529	511	2,966	2,551	5,517
July "	686	499	378	838	716	855	285	350	2,066	2,542	4,608
August "	954	554	351	731	679	683	513	518	2,497	2,486	4,983
Sept. "	1,339	687	538	1,013	774	945	877	813	3,578	3,458	7,036
Oct. "	847	456	273	556	655	926	456	412	2,231	2,350	4,581
Nov. "	812	386	320	1,183	699	777	374	431	2,205	2,777	4,982
Dec. "	542	218	328	451	735	862	247	281	1,852	1,812	3,664
Jan. 1977	644	416	677	557	569	783	175	190	2,065	1,946	4,011
Feb. "	476	216	472	331	506	520	212	201	1,655	1,268	2,923
March "	666	289	417	390	498	434	323	353	1,907	1,466	3,373
Total	9,184	4,458	5,937	7,624	8,510	9,695	4,727	4,841	28,658	26,518	55,276
Average	790.33	371.50	494.75	635.33	709.16	807.91	393.91	403.41	597.04	554.54	1151.58
Average Old and New	(1130.08)	(1517.08)	(797.33)	(1151.58)							

TABLE NO. 4.3.3.

NUMBER OF CASES TREATED BY MOBILE MEDICAL UNITS
1976-77

Month and Year	Mobile Medical Unit Chintoor		Mobile Medical Unit Polavaram	
	New	Old	New	Old
April 1976	Flood Duty		837	1,041
May "	592		989	1,177
June "	487		976	1,171
July "	249		968	1,013
August "	Flood Duty		987	1,113
September "	-do-		928	958
October "	321		967	976
November "	337		892	991
December "	846		838	814
January 1977	311		723	708
February "	257		932	1,083
March "	269		981	647
Total:	3,669		11,023	11,692
Average	407.56		918.58	974.33

TABLE NO. 4.4

MATERNITY AND CHILD WELFARE ACTIVITIES (1976-77)

Cases Attended	Jainoor		Rekhapalli		L.N.D. Peta		Jolaput	
	P.H.C.	S.C.	P.H.C.	S.C.	P.H.C.	S.C.	P.H.C.	S.C.
Pre-natal	3,418	194	356	69	490	76	224	35
Post-natal	796	144	204	26	280	51	123	25
Total:	4,214	338	570	95	770	127	347	60

P.H.C.: Primary Health Centre.

S.C. : Sub-Centre.

TABLE NO. 4.5.

FAMILY PLANNING WORK AT THE FOUR PRIMARY HEALTH CENTRES (1976-77)

	Uttoor		V.R. Puram		Polavaram		Jolaput					
	PHC	Sub- MM Unit/ Centra Dispen- sary	PHC	SC	MMU	PHC	SC	MMU. P.H.C.	SC	MMU		
Vasectomy	1099	516	--	716	6	--	243	22	--	697	37	35
Tubectomy	--	--	--	--	--	--	88	16	--	--	--	--
Supply of Nirodhs	--	--	--	--	--	--	200	--	--	2880	36	--
I.U.D.S.	--	--	--	--	--	--	50	13	--	--	--	--
Oral Pills	--	--	--	--	--	--	14	5	--	--	--	--

TABLE NO. 4.6

PREVENTIVE MEASURES AND IMMUNISATIONS IN THE FOUR PRIMARY HEALTH CENTRES
(1976-77)

	Jainoor	Rekhapalli	L.N.D. Peta	Joleput
	PHC	S.C P.H.C.	S.C. P.H.C.	S.C. P.H.C.
	S.C	P.H.C.	S.C.	S.C.
Anti-Cholera inoculations	3,814	4,044	885	6,156
Wells Chlorinated	--	--	--	672
Small Pox Vaccination	8,041	479	79	1,768
P.V.	6,241	591	32	3,743
Immunisation				
D.P.T.	8,871	412	275	1,786
Polio Drops	1,000	--	--	2,127
D.T.	--	389	165	70
T.T.	--	229	121	80
B.C.G.	12,013	--	--	4,697
Vitamin Supplements				
Vitamin 'A'	--	--	--	80
Iron Tablets	--	--	--	850
				220
				45

TABLE NO. 4.7

WELFARE OF PRE-SCHOOL AND SCHOOL GOING CHILDREN

P.H.C:	Jainoor	Rekhepalli	L.N.D.Peta	Jolaput
	PHC	MMU		
No. of Schools visited	Medical Officer visits every Ashram School once in 6 months	29	4	18
No. of Children examined	--	2502	200	440
No. of S.N.P. Centres visited	--	2 S.N.P. centres	32 S.N.P. Centres	22 S.N.P. Centres.
Feeding Programme assessment.	Covered under I.C.D.S. Programme	--	29 Mid-day meal centres	--

TABLE NO. 5.3.

PERCENTAGE OF POPULATION INOCULATED IN THE SAMPLE HOUSEHOLDS FOR THE PAST ONE YEAR
(ALL THE FOUR BLOCKS)

Sl. Cluster No.	No. of H.Hs. covered.	Population of the H.Hs.			% of population inoculated.			% of Population vaccinated (P.V.)				
		M.	F.	Total	M.	F.	Total	M.	F.	Total		
1. 2.	3.	4.	5.	7.	8.	9.	10.	11.	12.	13.	14.	15.
A) CLUSTER I												
1. Polavaram	75	116	105	121	342	100.00	100.00	100.00	--	--	100.00	35.38
2. Munchingput	69	95	91	91	277	10.53	8.79	100.00	39.35	4.21	6.59	97.80
3. Utnoor	75	156	124	156	446	33.97	33.87	69.28	47.09	40.38	39.52	89.16
4. V.R.Puram	75	105	101	143	349	1.90	0.99	15.38	7.16	2.86	1.90	41.96
Total:		472	421	521	1414	38.35	37.05	66.99	48.51	14.83	13.54	80.23
B) CLUSTER II												
1. L.N.D.Peta	75	111	123	118	352	100.00	100.00	99.15	99.76	--	--	100.00
2. V.R.Puram	45	64	65	108	237	4.38	4.52	79.53	38.82	5.25	4.61	79.63
3. Utnoor	75	134	142	205	481	58.96	57.04	97.07	74.64	38.81	34.51	88.78
4. Jolapur	55	82	83	106	271	3.56	2.41	48.11	20.66	5.10	6.02	46.22
Total:		391	413	503	1402	43.22	42.85	81.12	58.31	12.28	10.65	73.71
C) CLUSTER III												
1. L.N.D.Peta	75	107	101	90	298	100.00	100.00	100.00	100.00	--	--	100.00
2. V.R.Puram	65	107	85	118	310	--	--	76.27	29.03	--	--	77.97
3. Utnoor	75	149	142	167	458	53.69	53.52	91.62	67.47	18.79	16.90	81.44
4. Jolapur	64	105	103	128	336	1.83	0.97	72.65	28.57	3.81	3.88	76.56
Total:		468	431	503	1402	40.38	41.30	75.54	53.28	6.83	6.50	73.16
D) CLUSTER IV												
1. L.N.D.Peta	41	62	62	80	204	100.00	100.00	100.00	100.00	--	--	100.00
2. V.R.Puram	50	88	82	67	237	--	--	32.83	9.28	--	--	64.17
3. Utnoor	50	84	92	101	277	40.47	35.85	83.13	55.59	23.80	27.17	76.23
4. Jolapur	39	57	54	61	172	--	--	90.16	31.97	--	--	88.52
Total:		291	290	309	890	32.99	32.76	78.96	48.88	6.87	8.62	82.20

contd... T.No.5.3

%		of Population vaccinated (R.V)		%		of population immunized (D.P.T)		%		of population immunized (Polio)		%		of population immunized (B.C.G.)	
M.	F.	C.	Total	M.	F.	C.	Total	M.	F.	C.	Total	M.	F.	C.	Total
16.	17.	18.	19.	20.	21.	22.	23.	24.	25.	26.	27.	28.	29.	30.	31.
100.00	100.00	--	(64.62)	--	--	100.00	(64.62)	--	--	100.00	64.62	--	--	100.00	64.62
1.10	76.92	25.63	3.16	4.40	84.62	30.32	37.18	33.87	80.12	51.57	0.64	0.81	69.28	26.23	2.86
1.98	26.57	12.32	--	--	2.10	0.86	37.50	24.36	46.26	40.17	0.84	1.18	60.65	22.98	100.00
100.00	100.00	--	66.48	--	--	100.00	33.52	--	--	100.00	33.52	--	--	100.00	33.52
29.10	25.35	69.73	45.32	17.91	15.90	78.05	43.24	--	--	--	1.56	1.56	27.61	26.06	6.10
5.02	46.22	21.77	--	--	50.00	19.56	35.80	36.80	54.93	43.77	6.39	5.05	74.48	33.55	35.80
100.00	100.00	--	69.80	--	--	100.00	30.20	--	--	100.00	30.20	--	--	100.00	30.20
11.41	14.79	71.86	34.50	8.05	7.75	65.25	28.82	--	--	--	18.01	19.01	67.80	25.81	1.90
1.94	75.00	29.76	--	--	76.53	29.16	26.92	28.77	51.59	35.38	2.56	2.55	75.54	28.81	17.89
100.00	100.00	--	60.78	--	--	100.00	39.21	--	--	100.00	39.21	--	--	100.00	39.21
62.68	17.72	--	35.82	10.12	19.04	14.13	74.25	37.54	14.28	14.13	80.19	38.26	78.68	27.90	19.04
25.86	53.39	35.73	4.12	4.48	75.40	28.98	24.90	25.86	53.39	35.73	4.12	4.48	75.40	28.98	25.86
25.88	8.98	3.09	5.17	84.14	31.91	84.14	31.91	84.14	31.91	84.14	31.91	84.14	31.91	84.14	31.91

M.=Males F= Females C= Children T= Total

TABLE NO. 5.4.

PERCENTAGE OF HOUSEHOLDS HAVING ONE OR MORE DISEASED PERSONS DURING THE PAST ONE YEAR

Block and District.	Cluster	Total Households covered.	No. of Households reported disease.	Percentage
1.	2.	3.	4.	5.
Utnoor Adilabad	1. Jainoor P.H.C.	76	32	42.66
	2. Indervalley Sub-Centre	75	51	68.00
	3. Narnoor Ayurvedic Dispensary	75	56	74.66
	4. Village not covered by any Institution	50	30	60.00
	Total:	275	160	58.18
V.R. Puram Khammam	1. Rekhapalli P.H.C.	75	65	86.66
	2. Kundalur Sub-Centre	43	32	74.41
	3. Chintur (M.M. Unit)	65	51	78.46
	4. Villages not covered by any Institution	50	30	60.00
	Total:	233	178	76.39

Stt. Contd...

1.	2.	3.	4.	5.
	Polavaram	75	71	94.66
	West Godavari	75	67	89.33
	2. Repallewada Sub-Centre	75	72	96.00
	3. M.M.Unit, Polavaram	41	38	92.68
	4. Villages not covered by any institution.	266	248	93.23
	Total:	69	40	57.97
	Munchingput, Jolaput P.H.C.	55	46	83.63
	Visakhapatnam	64	43	67.18
	2. Munchingput Sub-Centre	39	33	84.61
	3. Kilagada M.M.Unit	227	162	71.36
	4. Villages not covered by any institution.	1001	757	75.62
	Total:			
	All four Blocks			

TABLE NO. 5.5.

**PERCENTAGE OF POPULATION SUFFERING WITH DISEASES AMONG MALES, FEMALES AND CHILDREN
BLOCKWISE, CLUSTERWISE**

Cluster No.	Total persons covered	Total sufferers	Total males covered	Total female sufferers covered	Total male sufferers covered	Total female sufferers covered	Total children covered	Total child sufferers.
UINOOOR BLOCK (ADILABAD DISTRICT)								
1.	446	49(10.98)	156	29(18.60)	124	13(9.58)	168	8(4.82)
2.	481	74(15.38)	124	32(23.88)	142	15(10.56)	205	27(13.17)
3.	458	73(15.93)	149	38(25.50)	142	20(14.08)	167	15(8.98)
4.	277	38(13.72)	84	20(23.81)	92	3(8.59)	101	10(9.90)
Total:	1662	234(14.07)	523	119(22.75)	500	55(11.00)	639	60(9.38)
V. R. PURAM BLOCK (KHAMMAM DISTRICT)								
1.	349	105(30.08)	105	43(40.95)	101	31(30.59)	143	31(26.57)
2.	237	36(15.18)	64	17(26.55)	65	8(12.30)	208	11(10.13)
3.	310	72(23.22)	107	35(32.71)	85	17(20.00)	118	20(16.95)
4.	237	55(23.52)	88	31(35.22)	82	11(13.41)	67	14(20.89)
Total:	1133	269(23.74)	364	126(34.51)	333	67(20.12)	436	76(17.43)
POLAVARAM BLOCK (WEST GODAVARI DIST.)								
1.	342	82(23.97)	116	38(32.73)	105	35(33.33)	121	9(7.44)
2.	352	98(27.84)	111	42(37.83)	123	41(33.33)	118	15(12.71)
3.	298	107(39.90)	107	43(40.18)	101	4(39.50)	90	24(26.56)
4.	204	49(24.01)	62	19(30.64)	62	13(29.03)	80	12(15.00)
Total	1196	336(28.09)	396	142(35.85)	391	13(34.27)	409	60(14.66)
MUNCHINGUP BLOCK (VISAKHAPATNAM DIST.)								
1.	277	43(15.52)	95	22(23.15)	91	9(9.39)	91	12(13.18)
2.	250	56(22.40)	82	26(31.70)	33	11(16.85)	35	16(13.82)
3.	336	58(17.26)	105	33(31.42)	103	13(12.52)	123	12(9.37)
4.	172	41(23.83)	57	18(31.57)	54	10(18.51)	61	13(21.31)
Total:	1035	198(19.13)	339	99(29.20)	351	43(13.39)	365	53(14.52)
Grand Total:	5026	1037(20.63)	1662	436(29.96)	1555	302(19.42)	1349	243(13.46)

(Numbers in brackets denote percentage)

TABLE NO.5.6

PERCENTAGE OF POPULATION SUFFERING WITH DIFFERENT DISEASES

(UTWOOB BLOCK)

Sl. No.	Disease	Cluster I % (446)	Cluster II % (481)	Cluster III % (446)	Cluster IV % (227)	Cluster V % (446)	Cluster VI % (227)
1.	2.						
1.	Digestive Tract Diseases--						
	1) Dysentery & Diachorea	0.22	0.62	0.44	--	0.35	
	2) Constipation	--	--	--	--	--	
	3) Stomach Ache	0.22	0.41	1.56	2.16	0.36	
	4) Other diseases	--	--	--	--	--	
2.	Physically Handicapped	0.22	0.20	--	--	0.10	
3.	Respiratory Tract Diseases	--	--	--	--	--	
	1) T.B.	0.89	1.03	--	--	0.04	
	2) Cough	--	0.41	--	--	0.04	
	3) Acute respiratory infection	--	--	--	--	--	
	4) Pneumonia	--	--	--	--	--	
	5) Asthma	--	1.24	0.89	--	--	
	6. Other respiratory diseases	--	--	--	--	--	
4.	Fevers etc.	--	--	--	--	--	
	1) Malaria	2.24	2.91	1.56	3.97	--	
	2) Pharyngeal fever	--	--	--	--	--	
	3) Infective hepatitis	--	--	--	--	--	
	4) Urinary infections	--	--	--	--	--	

Stt. Contd.....

1.	2.	3.	4.	5.	6.	7.
5)	Non-specific fever	0.67	2.28	2.91	1.08	1.74
6)	Typhoid fever	--	0.62	0.22	0.72	0.39
7)	Fits	--	--	0.22	--	0.62
5.	E.N.T. Diseases	--	0.20	--	0.36	0.12
6.	Chicken-Pox	--	--	0.22	0.36	1.12
7.	Ophthalmic Diseases	--	--	--	--	--
	1) Conjunctivitis	--	--	--	0.36	0.12
	2) Injuries	--	--	--	--	--
	3) Cataract	--	0.41	--	--	0.33
	4) Blindness	--	--	0.22	--	--
8 a)	Burning sensation in feet	--	--	0.22	--	0.05
8 b)	Other Common ailments (Head-ache; Body-pains; Joint- pains and Muscle-pains etc.)	2.46	1.86	0.44	1.44	0.12
9.	Arthritis	--	0.62	0.89	0.36	0.12
10.	Paralysis	--	--	0.44	--	0.12
11.	Chest Pain	--	--	0.44	--	0.06
12.	Goiter	--	--	--	--	0.12
13.	Swelling of legs	--	0.41	0.22	0.36	--
14.	Skin infections	--	--	--	--	--
	1.Scabies	--	1.45	2.24	2.16	2.16
	2.Ulcers	0.22	--	--	--	0.06
	3.Boils	--	0.20	--	--	0.12

Stt. Contd.....

1.	2.	3.	4.	5.	6.	7.
15. Surgical diseases						
1. Wounds & Burns						
16. Nutritional diseases			0.20	--	--	0.00
1. Anemia		--	--	--	0.36	3.05
2. A Vitaminosis		--	--	--	--	--
17. Women's Diseases (Leucorrhoea etc)		0.89	--	--	--	0.24
18. Liver enlargement.		--	0.20	--	--	0.06

PERCENTAGE OF POPULATION SUFFERING FROM DISEASES

(POLAVARAM BLOCK)

Sl.No.	Disease	Cluster 1 %	Cluster-2 %	Cluster-3 %	Cluster-4 %
1.	2.	(342)	(352)	(298)	(204)
1.	<u>Digestive Tract Disease:-</u>				
	1. Dysentery & Diarrhoea	1.16	0.56	1.34	0.49
	2. Constipation	--	--	--	--
	3. Stomach Ache	2.33	1.13	3.02	--
	4. Other Diseases	--	--	--	--
2.	Physically Handicapped	--	1.13	0.34	--
3.	Respiratory Tract Diseases	--	--	--	--
	1. T.B.	1.16	--	0.67	--
	2. Cough	1.04	--	--	--
	3. Acute respiratory infection	--	--	--	--
	4. Pneumonia	--	--	--	--
	5. Astma	--	0.28	--	--
	6. Other respiratory diseases	--	--	--	--
4.	Fevers etc.				
	1. Malaria	7.39	14.77	18.79	16.66
	2. Rheumatic fever	0.87	--	--	0.98
	3. Infective hepatitis	--	--	--	--
	4. Urinary infections	--	--	--	--
	5. Non-specific fever	0.29	3.69	--	--
	6. Typhoid fever	--	--	--	--
	7. Fits	0.87	--	--	--
5.	M.N.I. Diseases	0.29	0.28	0.34	--

1.	2.	3.	4.	5.	6.
6. a.	Leprosy	1.16	2.27	--	--
7. b.	Heart disease	0.58	--	--	--
8. 3.	Hypertension	0.58	--	--	--
8.	Chicken-Pox	0.58	--	1.00	0.98
12.	Ophthalmic Diseases	--	--	--	--
	1. Conjunctivitis	--	--	--	--
	2. Injuries	--	--	--	--
	3. Cataract	--	0.56	1.34	--
	4. Blindness	--	--	--	--
11 a.	Burning sensation in feet	--	--	--	--
	b) Other Common ailments (Head-ache; Body-pains; Joint- pains and Muscle-pains etc.)	1.46	1.13	3.69	0.49
12.	Arthritis	0.29	--	--	0.49
13.	Paralysis	0.58	--	0.67	--
14.	Chest Pain	--	--	--	--
15.	Goiter	--	--	--	--
16.	Swelling of legs	0.29	--	--	--
17.	Skin infections	0.59	0.28	--	--
	1. Scabies	--	0.56	3.69	2.94
	2. Ulcers	--	--	--	--
	3. Boils	--	0.28	--	0.49
18.	Surgical diseases	--	--	--	--
	1. Wounds and Burns	--	--	--	--

1.	2.	3.	4.	5.	6.	7.
19.	Nutritional Disease					
	1. Anæmia	--	--	--	--	
	2. A. Vitaminosis	--	--	--	--	
20.	Women's Diseases (Leucorrhœa etc.)	0.29	0.85	1.00	--	0.9
21b.	Liver enlargement	--	--	--	--	
22.	Yaws	--	--	--	0.49	0.1

PERCENTAGE OF POPULATION SUFFERING FROM DISEASES

(V.R. Puram)

Sl.No.	Disease	Cluster I %	Cluster-2 %	Cluster-3 %	Cluster-4 %
1.	2.	3.	4.	5.	6.
		(349)	(237)	(310)	(204)
1.	<u>Digestive Tract Disease:</u>				
	1. Dysentery and Diarrhoea	0.28	--	0.32	--
	2. Constipation	--	--	--	--
	3. Stomach Ache	--	0.42	2.25	--
	4. Other diseases	--	--	--	--
2.	<u>Physically Handicapped</u>	--	--	--	--
3.	<u>Respiratory Tract Diseases</u>				
	1. T.B.	1.71	0.42	--	--
	2. Cough	0.57	1.68	--	--
	3. Acute respiratory infection	--	--	--	--
	4. Pneumonia	--	--	--	--
	5. Asthma	0.28	0.42	1.29	--
	6. Other respiratory diseases	--	--	--	--
4.	<u>Fevers etc.</u>				
	1. Malaria	17.47	9.43	7.41	2.45
	2. Rheumatic fever	--	--	--	--
2.	3. Infective hepatitis	--	--	--	--
4.	<u>Urinary infections</u>				
	5. Non-specific fever	--	--	1.11	1.47
	6. Typhoid fever	2.57	--	--	--
7.	<u>Fits</u>	--	--	--	--
5.	<u>S.N.T. Diseases</u>	--	--	--	--

Contd....Stt.

	3	4	5	6
1				
2				
3				
4				
5				
6. Chicken-pox	1.45	--	--	--
7. Ophthalmic diseases	--	--	--	--
1. Conjunctivities	--	--	--	--
2. Injuries	--	--	--	--
3. Cataract	--	--	--	--
4. Blindness	--	--	--	--
5. Wandering cataract in infant	--	--	--	--
8. Other Common ailments. (Head-ache; body-pains; joint-pains and muscle-pains etc.)	1.14	--	0.32	1.96
9. Arthrities	1.14	--	--	--
10. Paralysis	--	--	0.64	--
11. Chest pain	0.28	--	--	--
12. Gciter	0.29	--	--	--
13. Swelling of legs	--	--	--	--
14. Skin infections	--	--	--	--
1. Scabies	2.29	3.37	8.70	21.56
2. Ulcers	--	--	--	--
3. Soils	0.57	--	0.64	--

Contd.....Stt.

	1	2	3	4	5	6
15. Surgical diseases wounds & Burns						
16. Nutritional diseases						
1. Anemia						
2. Avitaminosis						
17. Women's diseases (Leucorrhoea etc.)						
18. Liver enlargement						

PERCENTAGE OF POPULATION SUFFERING FROM DISEASES

(MUNCHINGPUT BLOCK)

Sl.No.	Disease	Cluster-1 %	Cluster-2 %	Cluster-3 %	Cluster-4 %
1.	2.	3.	4.	5.	6.
		(277)	(250)	(336)	(172)
1.	<u>Digestive Tract Disease:</u>				
	1. Dysentery and Diarrhoea	3.61	--	--	--
	2. Constipation	--	--	--	--
	3. Stomach Ache	3.61	3.20	1.19	1.74
	4. Other diseases	--	--	--	--
2.	Physically Handicapped	--	--	--	--
3.	Respiratory Tract Diseases	--	--	0.59	--
	1. T.B.	3.24	0.80	--	--
	2. Cough	--	--	--	--
	3. Acute respiratory infection	--	--	--	--
	4. Pneumonia	--	0.40	--	--
	5. Asthma	--	--	--	--
	6. Other respiratory diseases	--	--	--	--
4.	Fevers etc.	4.69	9.20	8.92	12.79
	1. Malaria	--	0.40	--	--
	2. Rheumatic fever	--	--	--	--
	3. Infective hepatitis	--	--	--	--
	4. Urinary infections	--	--	1.48	2.32
	5. Non-specific fever	--	--	--	--
	6. Typhoid fever	--	--	--	--
	7. Fits	--	--	--	--
5.	M.N.T. Diseases	--	--	--	--

Contd....Stt.

	1	2	3	4	5	6
6. Chicken-pox	--	--	--	--	0.29	--
7. Ophthalmic diseases	--	--	--	--	--	--
1. Conjunctivitis	3.61	--	--	--	0.89	1.74
2. Injuries	--	--	--	--	--	--
3. Cataract	--	--	--	--	--	--
4. Blindness	--	--	--	--	--	--
8. Other common ailments (Head-ache; body-pains; joint- pains and muscle-pains etc.)	2.16	0.40	--	--	--	0.58
9. Arthritis	--	--	--	--	0.29	--
10. Paralysis	--	--	--	--	0.29	--
11. Chest pain	--	--	--	--	--	--
12. Goiter	--	--	--	--	--	--
13. Swelling of legs	--	--	--	--	--	--
14. Skin infections	--	4.20	--	--	--	--
1. Scabies	3.24	5.60	--	--	2.97	4.65
2. Ulcers	--	--	--	--	--	--
3. Boils	3.61	0.40	--	--	--	--

Contd.....Stt.

	1	2	3	4	5	6
15. Surgical diseases Wounds & Burns						
16. Nutritional diseases						
1. Anameia				0.40		
2. Vitaminosis						
17. Women's diseases (Leucorrea etc.)			3.61		0.29	
18. Liver enlargements						
19. Ring worm						
20. Meningitis				0.40		

PERCENTAGE OF POPULATION SUFFERING FROM DISEASES.

(All the Four Blocks)

Disease.	1.	2.	3.	4.	5.
	UTNOOR	POLAVARAM.	V. R. PURAM	MUNCHINGPUTTU.	
	(1662)	(1196)	(1133)	(1035)	
1. Dysentery & Diarrhoea	0.36	0.91	0.17	0.09	
2. Constipation.	--	--	--	--	
3. Stomach ache.	0.85	1.76	0.70	1.53	
4. Other diseases.	--	--	--	--	
2. Physically Handicapped.	0.18	0.41	--	--	
3. Respiratory Tract Diseases.					
1. T.B.	0.54	0.50	0.70	0.19	
2. Cough.	2.46	1.67	1.23	1.93	
3. Acute respiratory Infection.	--	--	--	--	
4. Pneumonia	--	--	--	--	
5. Asthma.	0.60	0.08	0.52	0.09	
6. Other respiratory Diseases.	--	--	--	--	

1.	2.	3.	4.	5.
4. Fevers etc.				
1. Malaria.	2.52	14.13	9.62	8.40
2. Rheumatic fever.	--	0.41	--	0.09
3. Infective hepatitis.	--	--	--	--
4. Urinary infections.	--	--	--	--
5. Non-specific fever.	1.74	0.08	0.70	0.87
6. Typhoid fever.	0.38	--	--	--
7. Fits.	0.06	0.25	0.79	--
5. E.N.T. Diseases.	0.12	0.24	--	--
6. Chicken-pox.	0.36	0.75	--	0.09
7. Ophthalmic diseases.				
1. Conjunctivitis.	0.06	--	--	0.98
2. Injuries.	--	--	--	--
3. Cataract. X				
4. Blindness. X	0.28	0.50	--	--
8. Other Common ailments. (Head-ache; Body-Pains; Joint-pains and Muscle-pains etc.)	2.40	1.75	0.78	0.77
9. Arthritis	0.48	0.16	0.35	0.08

1.	2.	3.	4.	5.
10. Paralysis.	0.12	0.32	0.17	0.09
11. Chest Pain.	0.12	--	0.08	--
12. Goiter.	0.06	--	0.08	--
13. Swelling of legs.	0.12	0.08	--	--
14. Skin infections.	--	0.08	--	0.08
1. Scabies.	2.16	1.58	7.67	3.94
2. Ulcers.	0.06	--	--	--
3. Boils.	0.12	0.16	0.34	0.28
15. Surgical diseases.				
Wounds & Burns.	0.06	--	--	--
16. Nutritional disease.				
1. Anemia.	0.06	--	--	0.09
2. A. Vitiminosis.	--	--	--	--
17. Women's Diseases (Leucorrhoea etc)	0.24	0.91	--	0.19
18. Liver enlargement.	0.06	--	--	--
19. Hypertension.	--	0.16	--	--
20. Leprosy.	--	1.00	--	--
21. Heart Disease.	--	0.16	--	--
22. Measles.	--	--	--	0.09
23. Yaws.	--	0.08	--	--
24. Ring worm.	--	--	0.08	--

Table No.5.7

Cluster No.1(P.H.C)

PERCENTAGE OF SUFFERERS ATTENDED TO VARIOUS INSTITUTIONS.

Block	P.H.C.	Sub-Centre.	M.M.Unit	Govt. Hospital.	Native Doctor.	Home Remedy.	Private Doctor.	M.S.W.	Not used any medicine
1. Uttnoor (Jainoor)	51.03 (25)	--	--	--	6.12 (3)	2.04 (1)	16.33 (8)	--	24.48 (12)
2. Polavaram (L.N.D.Peta)	58.22 (46)	--	--	10.13 (8)	7.60 (6)	8.86 (7)	1.26 (1)	1.26 (1)	12.66 (10)
3. V.R.Puram. (Reknapalli)	57.14 (60)	1.90 (2)	--	1.90 (2)	--	6.66 (7)	5.71 (6)	3.80 (4)	22.86 (24)
4. Munchingput (Jolaput)	58.14 (25)	--	--	--	13.95 (6)	4.65 (2)	--	18.60 (8)	4.65 (2)
Total.	56.52 (156)	0.72 (2)	--	3.62 (10)	5.43 (15)	6.16 (17)	5.43 (15)	4.71 (13)	17.40 (48)

(174)

The numbers in brackets denote a ctual numbers of persons attended to various Institutions.

Cluster No.2 (Sub-Centre)

PERCENTAGE OF SUFFERERS ATTENDED TO VARIOUS INSTITUTIONS.

Block	P.H.C.	Sub-Centre.	M.M.Unit	Govt. Hospital.	Native Doctor.	Home Remedy.	Private doctor.	Not any medicine.
1. Uttoor (Indervally)	--	--	12.16 (9)	10.82 (8)	1.35 (1)	67.56 (50)	1.35 (1)	6.76 (5)
2. Polavaram (Repallewada)	6.12 (6)	2.04 (2)	21.43 (21)	4.08 (4)	2.04 (2)	11.22 (11)	7.14 (7)	39.80 (39)
3. V.R.Puram (Kundulur)	2.78 (1)	13.89 (5)	2.78 (1)	11.11 (4)	25.00 (9)	2.78 (1)	--	41.67 (15)
4. Munchingput (Kinchaiputtu)	--	17.86 (10)	--	26.78 (15)	--	1.79 (1)	16.07 (9)	37.50 (21)
Total.	2.65 (7)	6.44 (17)	11.74 (31)	11.74 (31)	4.55 (12)	23.86 (63)	6.44 (17)	30.30 (80)

The numbers in the brackets denote actual number of persons attended to various institutions.

Cluster No.3
M.M.Unit and Ayurvedic Centre.

PERCENTAGE OF SUFFERERS ATTENDED TO VARIOUS INSTITUTIONS.

B l o c k.	P.H.C.	Sub-Centre.	M.M.Unit.	Govt. Hospital.	Native Doctor.	Home Remedy.	Private Doctor.	M.S.W.	Not used any medicine
1. Uttnoor (Narnoor)	--	--	21.92 (16)	15.07 (11)	8.22 (6)	6.84 (5)	23.29 (17)	--	24.66 (18)
2. Polavaram (Polevaram)	--	15.89 (17)	2.80 (3)	11.21 (12)	5.61 (5)	4.67 (5)	11.21 (12)	15.89 (17)	32.71 (35)
3. V.R.Puram (Chintoor)	--	--	15.28 (11)	22.22 (16)	4.17 (3)	15.28 (11)	5.55 (4)	1.39 (1)	36.11 (26)
4. Munchingput (Kilagada)	3.45 (2)	13.79 (8)	5.17 (3)	--	22.41 (13)	8.62 (5)	20.69 (12)	10.34 (5)	15.52 (9)
Total	0.64 (2)	8.06 (25)	10.64 (33)	12.60 (39)	9.03 (28)	8.39 (25)	14.51 (45)	7.74 (24)	28.39 (88)

The numbers in brackets denotes actual number of persons attended to various institutions.

Cluster No. 4
(Un-covered)
(Villages)

PERCENTAGE OF SUFFERERS ATTENDED TO VARIOUS INSTITUTIONS.

B l o c k.	P.H.C.	Sub-Centre	M.M.Unit	Govt. Hospital.	Native Doctor.	Home Remedy.	Private Doctor.	M.S.W.	Not used any medicine
1. Utnoor.	--	--	2.63 (1)	5.26 (2)	10.53 (4)	18.42 (7)	18.42 (7)	15.79 (6)	28.95 (11)
2. Polavaram	--	--	2.04 (1)	2.04 (1)	18.37 (9)	4.08 (2)	4.08 (2)	34.70 (17)	34.70 (17)
3. V.R.Puram.	--	--	30.36 (17)	1.78 (1)	1.78 (1)	14.29 (8)	--	--	51.79 (29)
4. Munchingput.	--	--	7.31 (3)	--	34.14 (14)	12.19 (5)	--	26.86 (11)	19.51 (8)
Total.	--	--	11.96 (22)	2.17 (4)	15.22 (28)	11.96 (22)	4.90 (9)	18.48 (34)	35.33 (65)

The numbers in brackets denote actual number of persons attended to various institutions.

PERCENTAGE OF SUFFERERS ATTENDED TO VARIOUS INSTITUTIONS.

ALL BLOCKS.	P.H.C.	Sub-Centre.	M.M.Unit.	Govt. Hospital.	Native Doctor.	Home Remedy.	Private Doctor.	M.S.W.	Not used any medicine.
1.	56.52 (156)	0.72 (2)	--	3.62 (10)	5.43 (15)	6.16 (17)	5.43 (15)	4.71 (13)	17.40 (48)
2.	2.65 (7)	6.44 (17)	2.27 (6)	11.74 (31)	11.74 (31)	4.55 (12)	23.86 (63)	6.44 (17)	30.30 (80)
3.	0.64 (2)	8.06 (25)	10.64 (33)	12.60 (39)	9.03 (28)	8.39 (26)	14.51 (45)	7.76 (24)	28.39 (88)
4.	--	--	11.96 (22)	2.17 (4)	15.22 (28)	11.96 (22)	4.90 (9)	18.48 (34)	35.33 (65)

(178)

(The Numbers in brackets denotes the actual persons attended)

Table No.5.8

NUMBER OF PERSONS ATTENDED TO VARIOUS INSTITUTIONS (COMMUNITY-WISE)

Community.	P.H.C.	Sub-Centre.	M.M. Unit.	Govt. Hospital.	M.S.W. Doctor.	Private Doctor.	Native Doctor.	Home Remedy.	Number of Treatment.	Total.					
1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.					
<u>UTNOOR BLOCK:-</u>															
Scheduled Tribe.	15	(46.87)	--	--	--	4	(12.50)	3	(9.37)	1	(3.12)	9	(28.12)	32	
Scheduled Caste.	--	--	--	--	--	--	--	--	--	--	--	--	--	--	
Backward Classes.	10	(58.86)	--	--	--	4	(23.53)	--	--	--	--	3	(17.64)	17	
Other Castes.	--	--	--	--	--	--	--	--	--	--	--	--	--	--	
<u>V.R.PUPAM Block:-</u>															
Scheduled Tribe.	41	(51.25)	2	(2.50)	3	(3.75)	5	(6.25)	5	(6.25)	22	(27.50)	80		
Scheduled Caste.	16	(76.20)	--	--	1	(4.77)	--	--	2	(9.52)	2	(9.52)	21		
Backward Classes.	3	(100.00)	--	--	--	--	--	--	--	--	--	--	3		
Other Castes.	--	--	--	--	--	1	(100.00)	--	--	--	--	--	1		
<u>POLAVARAM BLOCK:-</u>															
Scheduled Tribe.	15	(31.91)	--	--	8	(17.02)	1	(2.13)	6	(12.76)	7	(14.90)	10	(2.12)	47
Scheduled Caste.	28	(100.00)	--	--	--	--	--	--	--	--	--	--	--	28	
Backward Classes.	3	(100.00)	--	--	--	--	--	--	--	--	--	--	--	3	
Other castes.	--	--	--	--	1	(100.00)	--	--	--	--	--	--	--	1	

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11.

MUNCHINGPUT BLOCK:

Scheduled Tribe. 12(48.00) -- -- 6(24.00) -- -- 1(4.00) 25
 Scheduled Caste. 2(28.57) -- -- 2(28.57) 2(28.57) 1(14.29) 7
 Backward Classes. 6(100.00) -- -- -- -- -- 6
 Other Castes. 5(100.00) -- -- -- -- -- 5

ALL BLOCKS:

Scheduled Tribe. 83(45.11) 2(1.08) -- -- 10(5.43)9(4.90) 10(5.43)15(8.15) 13(7.06) 42(22.82) 184
 Scheduled Caste. 46(82.14) -- -- -- -- 3(5.35) -- -- 4(7.14) 3(5.35) 56
 Backward Classes. 22(75.86) -- -- -- -- -- 4(13.80) -- -- -- 3(10.34) 29
 Other Castes. 5(71.43) -- -- -- -- 1(14.28) 1(14.28) -- -- -- -- 7

Total. 156(56.52) 2(0.72) -- -- 10(3.62)13(4.71)15(5.43) 15(5.43) 17(6.16) 48(17.40) 1276

(180)

CLUSTER - II.

UTNOOR BLOCK:

Scheduled Tribe. -- -- -- -- 8(13.11)1(1.64) 40(65.57)7(11.47) -- -- 5(8.20) 61
 Scheduled Caste. -- -- -- -- -- 22(80.00)1(20.00) -- -- -- 5
 Backward Classes. -- -- -- -- 1(12.60) -- -- 6(75.00) -- -- 1(12.50) 8
 Other Castes. -- -- -- -- -- -- -- -- -- -- -- --

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11.

V. R. PURAM BLOCK.

| | | | | | | | | | | |
|-------------------|---------|----------|----|---------|----|---------|----------|----------|-----------|----|
| Scheduled Tribe. | 1(2.85) | 5(13.88) | -- | 1(2.85) | -- | 1(2.85) | 4(11.11) | 9(25.00) | 15(41.66) | 36 |
| Scheduled Caste. | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| Backward Classes. | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| Other Castes. | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |

POLAVARAM BLOCK.

| | | | | | | | | | | |
|-------------------|----------|---------|---------|-----------|---------|----------|---------|----------|-----------|----|
| Scheduled Tribe. | 1(1.96) | -- | 2(3.92) | 6(11.76) | 4(7.84) | 2(3.92) | 3(5.88) | 10(1.96) | 32(62.74) | 51 |
| Scheduled Caste. | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| Backward Classes. | 5(10.87) | 2(4.35) | 4(8.70) | 14(30.43) | 3(6.52) | 9(19.56) | 1(2.17) | 1(2.17) | 7(15.21) | 46 |
| Other Castes. | -- | -- | -- | 1(100.00) | -- | -- | -- | -- | -- | 1 |

MUNCHINGPUT BLOCK.

| | | | | | | | | | | |
|------------------|----|-----------|----|----|----------|----------|-----------|----|-----------|----|
| Scheduled Tribe. | -- | 7(14.28) | -- | -- | 7(14.28) | -- | 14(28.57) | -- | 21(42.86) | 49 |
| Scheduled Caste. | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| Backward Class. | -- | -- | -- | -- | 2(50.00) | 1(25.00) | 1(25.00) | -- | -- | 4 |
| Other Castes. | -- | 3(100.00) | -- | -- | -- | -- | -- | -- | -- | 3 |

ALL BLOCKS:

| | | | | | | | | | | |
|-------------------|---------|----------|---------|-----------|----------|-----------|-----------|----------|-----------|-----|
| Scheduled Tribes. | 2(1.01) | 12(6.09) | 2(1.01) | 15(7.61) | 12(6.09) | 43(21.82) | 28(14.21) | 10(5.08) | 73(37.05) | 197 |
| Scheduled Castes. | -- | -- | -- | -- | -- | 4(75.00) | 1(25.00) | -- | -- | 5 |
| Backward Class. | 5(8.62) | 2(3.44) | 4(6.89) | 15(25.86) | 5(8.62) | 16(27.58) | 2(3.44) | 2(3.44) | 7(12.06) | 58 |
| Other Castes. | -- | 3(75.00) | -- | 1(25.00) | -- | -- | -- | -- | -- | 4 |

| | | | | | | | | | | |
|--------|---------|----------|---------|-----------|----------|-----------|-----------|----------|-----------|-----|
| Total. | 7(2.65) | 17(6.44) | 6(2.27) | 31(11.74) | 17(6.44) | 63(23.86) | 31(11.74) | 12(4.54) | 80(30.30) | 264 |
|--------|---------|----------|---------|-----------|----------|-----------|-----------|----------|-----------|-----|

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11.

C L U S T E R . I I I .

UTNOOR BLOCK.

| | | | | | | | | | | |
|-------------------|----|----|-----------|----------|----|-----------|----------|---------|-----------|----|
| Scheduled Tribe. | -- | -- | 16(28.07) | 4(7.02) | -- | 13(22.80) | 6(10.52) | 4(7.02) | 14(24.57) | 57 |
| Scheduled Caste. | -- | -- | -- | 7(43.75) | -- | 4(25.00) | -- | 1(6.25) | 4(25.00) | 16 |
| Backward Classes. | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| Other Castes. | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |

V. R. PURAM BLOCK.

| | | | | | | | | | | |
|-------------------|----|----|-----------|-----------|---------|----------|---------|-----------|-----------|----|
| Scheduled Tribe. | -- | -- | 11(18.46) | 11(18.46) | 1(1.58) | 3(4.76) | 3(4.76) | 11(17.46) | 23(36.51) | 63 |
| Scheduled Caste. | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| Backward Classes. | -- | -- | -- | 4(50.00) | -- | 1(22.50) | -- | -- | 3(37.50) | 8 |
| Other Castes. | -- | -- | -- | 1(100.00) | -- | -- | -- | -- | -- | 1 |

POLAVARAM BLOCK.

| | | | | | | | | | | |
|-------------------|----|-----------|-----------|----------|-----------|-----------|----------|----------|-----------|----|
| Scheduled Tribe. | -- | 17(19.76) | -- | 7(8.14) | 12(13.95) | 11(12.80) | 4(4.65) | 4(4.65) | 31(36.04) | 86 |
| Scheduled Caste. | -- | -- | -- | -- | 4(44.44) | -- | 2(22.22) | -- | 3(33.33) | 9 |
| Backward Classes. | -- | -- | 1(10.00) | 5(50.00) | 1(10.00) | 1(10.00) | -- | 1(10.00) | 1(10.00) | 10 |
| Other Castes. | -- | -- | 2(100.00) | -- | -- | -- | -- | -- | -- | 2 |

MUNCHINGPUT BLOCK.

| | | | | | | | | | | |
|-------------------|---------|----------|----------|----|-----------|-----------|-----------|----------|----------|----|
| Scheduled Tribe. | 2(3.70) | 8(14.81) | 1(1.85) | -- | 5(9.26) | 12(22.22) | 13(24.07) | 4(7.41) | 9(16.66) | 54 |
| Scheduled Caste. | -- | -- | 2(75.00) | -- | -- | -- | -- | 1(25.00) | -- | 3 |
| Backward Classes. | -- | -- | -- | -- | 1(100.00) | -- | -- | -- | -- | 1 |
| Other Castes. | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |

ALL BLOCKS:

| | | | | | | | | | | |
|-------------------|----------------|-----------------|------------------|------------------|-----------------|------------------|-----------------|-----------------|------------------|-------------|
| Scheduled Tribe. | 2(0.79) | 25(9.61) | 28(10.77) | 22(8.46) | 18(6.92) | 39(15.00) | 26(10.00) | 23(8.84) | 77(29.61) | 260 |
| Scheduled Caste. | -- | -- | 2(7.14) | 7(25.00) | 4(14.28) | 4(14.28) | 2(7.14) | 2(7.14) | 7(25.00) | 28 |
| Backward Classes. | -- | -- | 1(5.26) | 9(47.37) | 2(10.53) | 2(10.53) | -- | 1(5.26) | 4(21.05) | 19 |
| Other Castes. | -- | -- | 2(75.00) | 1(25.00) | -- | -- | -- | -- | -- | 3 |
| Total. | 2(0.64) | 25(8.06) | 33(10.64) | 39(12.58) | 24(7.74) | 45(15.51) | 28(9.03) | 35(8.38) | 88(28.38) | 310. |

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11.

CLUST ER. IV.

UTNOOR BLOCK.

| | | | | | | | | | | |
|-------------------|----|----|---------|---------|----------|----------|----------|----------|-----------|----|
| Scheduled Tribe. | -- | -- | 1(2.70) | 2(5.40) | 6(16.22) | 6(16.22) | 4(10.81) | 7(18.92) | 11(29.73) | 37 |
| Scheduled Caste. | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| Backward Classes. | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| Other Castes. | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |

V. R. PURAM. BLOCK.

| | | | | | | | | | | |
|-------------------|----|----|-----------|---------|----|----|---------|----------|-----------|----|
| Scheduled Tribe. | -- | -- | 17(30.36) | 1(1.78) | -- | -- | 1(1.78) | 8(14.28) | 29(51.78) | 56 |
| Scheduled Caste. | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| Backward Classes. | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| Other Castes. | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |

POLAVARAM BLOCK.

| | | | | | | | | | | |
|-------------------|----|----|---------|---------|-----------|----------|----------|---------|-----------|----|
| Scheduled Tribe. | -- | -- | 1(2.13) | 1(2.13) | 16(34.02) | 1(2.13) | 9(19.15) | 2(4.26) | 17(36.17) | 47 |
| Scheduled Caste. | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| Backward Classes. | -- | -- | -- | -- | 1(50.00) | 1(50.00) | -- | -- | -- | 2 |
| Other Castes. | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |

MUNCHINGPUT BLOCK.

| | | | | | | | | | | |
|-------------------|----|----|---------|----|-----------|----|-----------|----------|----------|----|
| Scheduled Tribe. | -- | -- | 3(7.32) | -- | 11(26.83) | -- | 14(31.14) | 5(12.20) | 8(19.51) | 41 |
| Scheduled Caste. | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| Backward Classes. | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| Other Castes. | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |

ALL BLOCKS.

| | | | | | | | | | | |
|-------------------|----|----|-----------|---------|-----------|----------|-----------|-----------|-----------|-----|
| Scheduled Tribe. | -- | -- | 22(12.15) | 4(2.21) | 33(18.23) | 7(3.87) | 28(15.47) | 22(12.15) | 65(35.91) | 181 |
| Scheduled Caste. | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| Backward Classes. | -- | -- | -- | -- | 1(50.00) | 1(50.00) | -- | -- | -- | 2 |
| Other Castes. | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |

Total.

| | | | | | | | | | | |
|--|----|----|-----------|---------|-----------|---------|-----------|-----------|-----------|-----|
| | -- | -- | 22(12.02) | 4(2.18) | 34(18.53) | 8(4.37) | 28(15.50) | 22(12.02) | 65(35.52) | 183 |
|--|----|----|-----------|---------|-----------|---------|-----------|-----------|-----------|-----|

Percentage of Patients attending various types of Institutions (All Blocks)

| 1. | 2. | 3. | 4. | 5. | 6. | 7. | 8. | 9. | 10. | | | | | | | | | |
|----------------------|----|-------|------|-------|------|-------|------|-------|------|------|-------|-------|-------|------|------|------|-------|-------|
| ALL CLUSTERS. | | | | | | | | | | | | | | | | | | |
| Scheduled Tribe. | 87 | 39 | 4.74 | 52 | 6.32 | 51 | 6.20 | 72 | 8.76 | 99 | 12.04 | 97 | 11.80 | 68 | 8.27 | 257 | 31.26 | |
| Scheduled Caste | 46 | 51.68 | -- | 2 | 2.27 | 7 | 7.86 | 7 | 7.86 | 8 | 8.98 | 3 | 3.37 | 6 | 6.74 | 10 | 11.23 | |
| Backward Classes. | 27 | 25.00 | 2 | 1.85 | 5 | 4.63 | 24 | 22.22 | 8 | 7.41 | 23 | 21.30 | 2 | 1.85 | 3 | 2.77 | 14 | 12.96 |
| Other Castes. | 5 | 35.72 | 3 | 21.43 | 2 | 14.30 | 2 | 14.30 | 1 | 7.12 | 1 | 7.12 | -- | -- | -- | -- | -- | |

Utilisation of Government Institutions and other Medical Services by Patients in Tribal Areas.

--000--

| | Government Institutions. | Private Doctors. | Native and Home Remedies. | No Treatment. | | | | |
|-------------------|--------------------------|------------------|---------------------------|---------------|-----|-------|-----|-------|
| Scheduled Tribe. | 301 | 36.62 | 99 | 12.04 | 165 | 20.07 | 257 | 31.26 |
| Scheduled Castes. | 62 | 69.66 | 8 | 8.98 | 9 | 10.11 | 10 | 11.23 |
| Backward Classes. | 66 | 61.11 | 23 | 21.30 | 5 | 4.63 | 14 | 12.96 |
| Other Castes. | 13 | 92.85 | 1 | 7.14 | -- | -- | -- | -- |

TABLE NO. 6.9

PREFERENCE FOR VARIOUS TYPES OF AILMENTS.

| Disease. | P.H.C. | Hospital | M.M.Unit. | Ayurvedic Dispensary. | Missionary Hospital. | Private Doctor. | Native Doctor. | Home remedy. | No Tre-
atment. | An.N.M/
M.S.W. |
|--------------------|------------|------------|------------|-----------------------|----------------------|-----------------|----------------|--------------|--------------------|-------------------|
| 1. | 2. | 3. | 4. | 5. | 6. | 7. | 8. | 9. | 10. | 11. |
| <u>CLUSTER-I</u> | | | | | | | | | | |
| Seasonal. | 79 (65.83) | -- | -- | -- | -- | 16 (13.33) | 23 (19.17) | 2 (1.67) | -- | -- |
| Chronic. | 77 (64.17) | 6 (5.00) | -- | -- | 2 (1.67) | (20.00) | 10 (8.33) | 1 (0.83) | -- | -- |
| Maternity. | -- | -- | -- | -- | -- | -- | -- | 90 (75.00) | -- | 30 (25.00) |
| Accidents. | 62 (51.67) | -- | -- | -- | -- | 32 (26.67) | 26 (21.66) | -- | -- | -- |
| Others. | 78 (65.00) | -- | -- | -- | -- | 22 (18.33) | 20 (16.67) | -- | -- | -- |
| <u>CLUSTER-II</u> | | | | | | | | | | |
| Seasonal. | 14 (13.59) | 13 (12.75) | 3 (2.91) | -- | 1 (0.99) | 23 (22.33) | 36 (34.95) | 3 (2.91) | -- | 10 (9.70) |
| Chronic. | 12 (11.65) | 26 (25.24) | 2 (1.94) | -- | 11 (10.67) | 17 (16.50) | 29 (28.15) | 1 (0.99) | 1 (0.99) | 4 (3.88) |
| Maternity. | -- | -- | -- | -- | -- | -- | -- | 103 (100.00) | -- | -- |
| Accidents. | 28 (27.18) | 26 (25.24) | 1 (0.99) | -- | 2 (1.94) | 21 (20.38) | 23 (22.33) | 1 (0.99) | -- | 1 (0.99) |
| Others. | 17 (15.50) | 16 (15.53) | -- | -- | 4 (3.88) | 26 (25.24) | 25 (24.27) | 7 (0.99) | -- | 15 (14.56) |
| <u>CLUSTER-III</u> | | | | | | | | | | |
| Seasonal. | -- | 19 (16.52) | 26 (22.60) | 4 (3.47) | -- | 21 (18.26) | 36 (31.30) | 2 (1.73) | 1 (0.86) | 6 (5.21) |
| Chronic. | 8 (6.95) | 37 (32.17) | 12 (10.43) | 3 (2.60) | -- | 15 (13.04) | 27 (23.47) | 2 (1.73) | 1 (0.86) | 10 (MSW) |
| Maternity. | -- | -- | -- | -- | -- | -- | -- | -- | -- | (8.69) |
| Accidents. | 13 (11.30) | 38 (33.04) | 12 (11.30) | 5 (4.34) | -- | 19 (16.52) | 23 (20.00) | 1 (0.86) | 1 (0.86) | 2 (1.73) |
| Others. | 1 (0.95) | 10 (8.69) | 34 (29.56) | 3 (2.60) | -- | 23 (20.00) | 32 (27.82) | -- | 1 (0.86) | 11 (9.56) |

| | 1. | 2. | 3. | 4. | 5. | 6. | 7. | 8. | 9. | 10. | 11. | | | | | | | |
|--------------------|----|---------|----|---------|----|---------|----|--------|----|-----|---------|----|---------|----|----------|----|----|---------|
| <u>CLUSTER-IV.</u> | | | | | | | | | | | | | | | | | | |
| Seasonal. | 2 | (2.66) | 8 | (10.66) | 4 | (5.33) | 1 | (1.33) | -- | 8 | (10.66) | 33 | (44.00) | 14 | (18.66) | -- | 5 | (6.66) |
| Chronic. | 4 | (5.33) | 13 | (17.33) | 6 | (8.00) | 1 | (1.33) | -- | 8 | (10.66) | 27 | (36.00) | 2 | (2.66) | -- | 14 | (18.66) |
| Maternity. | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | 75 | (100.00) | -- | -- | -- |
| Accidental. | 10 | (13.33) | 11 | (14.66) | 8 | (10.66) | 3 | (4.00) | -- | 6 | (8.00) | 23 | (30.66) | 14 | (18.66) | -- | -- | -- |
| Others. | 3 | (4.00) | 5 | (6.66) | 4 | (5.33) | -- | -- | -- | 16 | (21.33) | 34 | (45.33) | 13 | (17.33) | -- | -- | -- |

Table No.5.10

MATERNITY CASES (ALL FOUR BLOCKS)

| Cluster | No. of Deliveries. | Cases attended by | | Elderly woman family members relatives et c. | Nature of births. | Place of Delivery. |
|---------------------------------|--------------------|-------------------|-----------------|--|-------------------|---|
| | | A.N.M. | Native Hospital | | | |
| Cluster-I | 53 | 12 (22.64) | -- | 5 (9.43) | 36 (67.92) | Normal All at Home |
| Cluster-II | 63 | 14 (22.22) | 1 (1.59) | 12 (19.05) | 36 (57.14) | Normal All except one at Hospital at Jolaput. |
| Cluster-III | 62 | 10 (16.13) | 1 (1.61) | 6 (9.68) | 45 (72.58) | Normal One at Hospital at Adilabad. |
| Cluster-IV | 38 | -- | -- | -- | 38 (100.00) | Normal All at home. |
| Total of Clusters from I to IV. | 216 | 36 (16.67) | 2 (0.93) | 23 (10.65) | 155 (71.74) | Normal. -- |

BELIEF SYSTEM.

SEASONAL DISEASES.

Table No. 61

| | Head-quarters villages of P.H.C. | S.C. MMU/Disp. | P.H.C. | S.C. MMU/Disp. | Villages (5KM away) from P.H.C. | S.C. MMU/Disp. | Villages (10KM away) from P.H.C. | SC MMU/Disp. | |
|------------------------|----------------------------------|----------------|--------|----------------|---------------------------------|----------------|----------------------------------|--------------|-------|
| Change of climate. | 50.00 | 30.00 | 20.00 | 32.50 | 30.00 | 30.00 | 15.00 | 20.00 | 22.50 |
| Unhygienic Conditions. | 17.50 | 17.50 | 6.66 | 7.50 | 17.50 | 17.50 | 15.00 | 10.00 | 17.50 |
| Not known. | 32.50 | 52.50 | 73.33 | 60.00 | 52.50 | 52.50 | 70.00 | 70.00 | 57.50 |

(188)

NOT COVERED BY ANY INSTITUTION.

| | |
|-----------------------|-------|
| Change of climate. | 46.25 |
| Unhygienic Condition. | 19.75 |
| Not known. | 34.00 |

TAB. NO. 6.2

CHRONIC DISEASES.

| <u>Belief</u> | <u>Percentage.</u> |
|--|--------------------|
| Unhygienic conditions/
unwhole some food and
negligence. | 40.00 |
| Fate of person. | 15.00 |
| Dead persons, and Ghosts
and Black magic. | 20.00 |
| Gods and Spirits. | 25.00 |

Table No.6.3

Belief System(Epidemics)

| Belief. | P.H.C. | | S.G. | | M.M.U. | | Villages 5 Kms.away. | | Villages 10 Kms.Away. | | Villages not covered by any institution. |
|---------|--------|---|-------|---|--------|---|----------------------|------|-----------------------|------|--|
| | Hqs. | % | Hqrs. | % | HQRS. | % | P.H.C. | S.C. | P.H.C. | S.C. | |

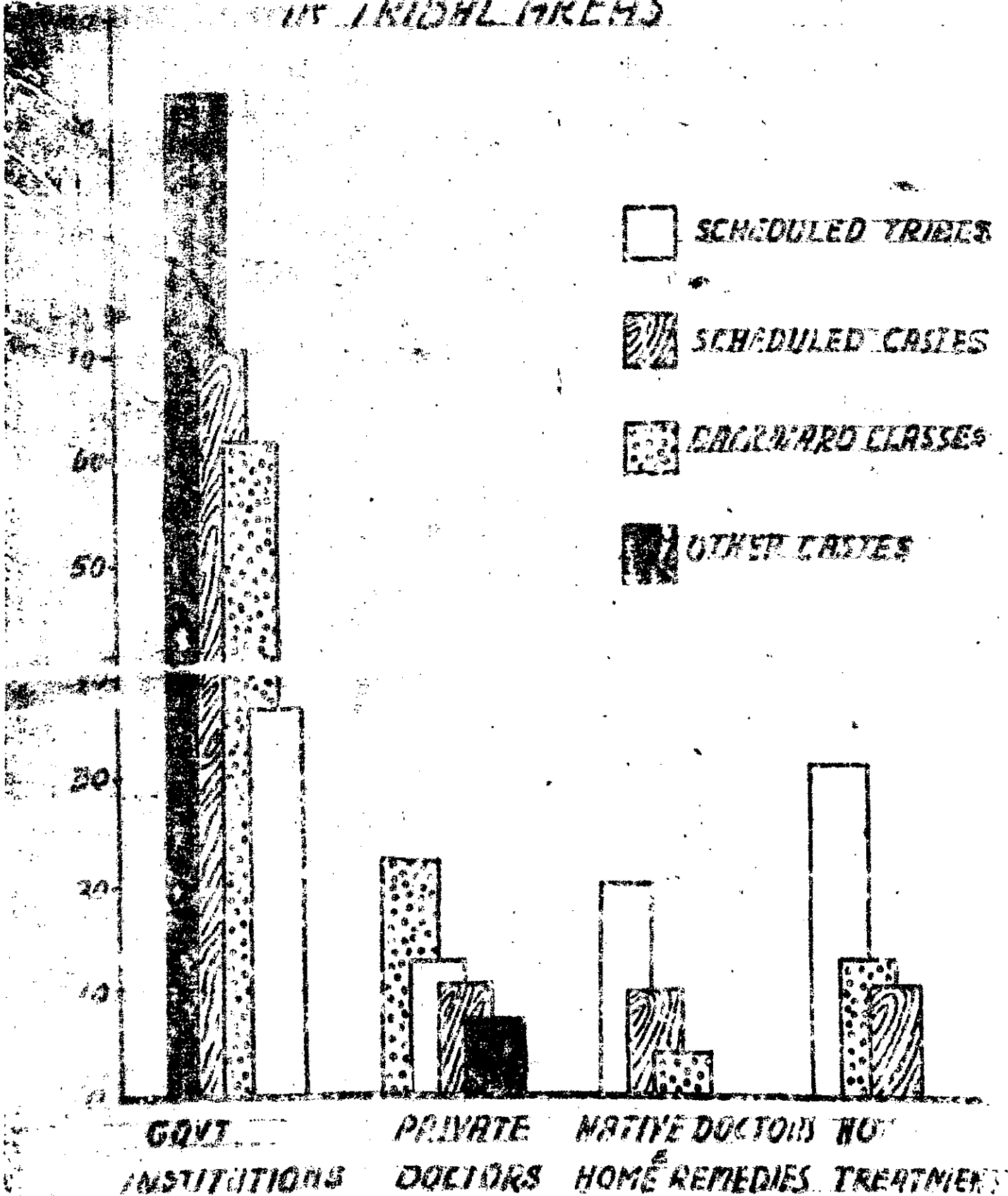
| | | | | | | | | | | | |
|---------------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Bad Hygiene and Polluted Water. | 17.5 | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| Gods, Spirits, Fate of persons. | 65.00 | -- | 70.00 | -- | 70.00 | 72.50 | 70.00 | 75.00 | 71.25 | 80.00 | 80.00 |
| Not known. | 17.5 | 30.00 | 30.00 | 10.00 | 2.50 | 5.00 | -- | 3.75 | -- | 10.00 | 10.00 |

T O T A L.

| | |
|-------------------|-------|
| Gods and Spirits. | 73.00 |
| Fate of person. | 14.00 |
| Not known. | 11.00 |

UTILISATION OF MEDICAL SERVICES IN TRIBAL AREAS

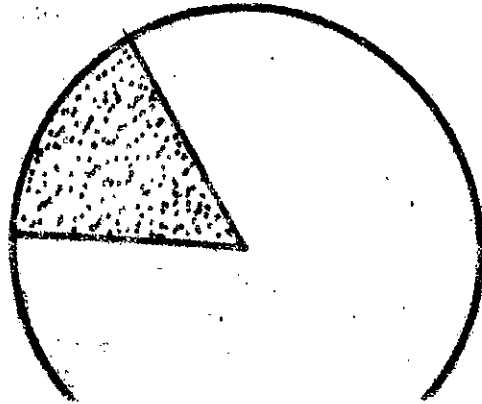
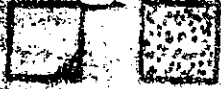
PERCENTAGE



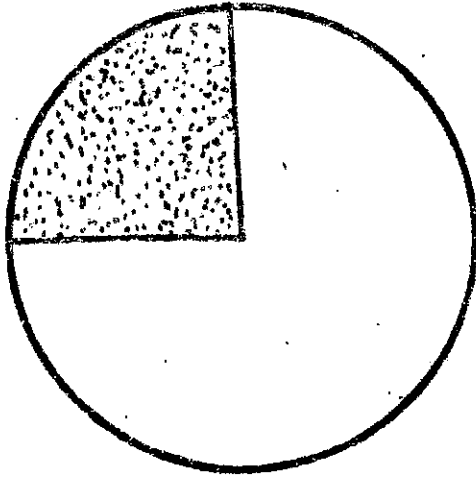
PERCENTAGE OF POPULATION SUFFERING WITH DIARRA

WITHOUT DISEASES

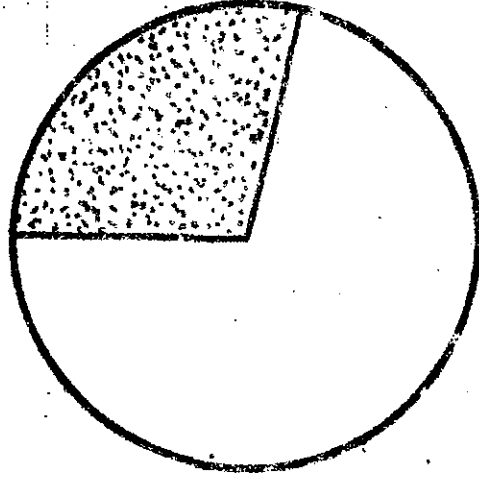
DISEASED



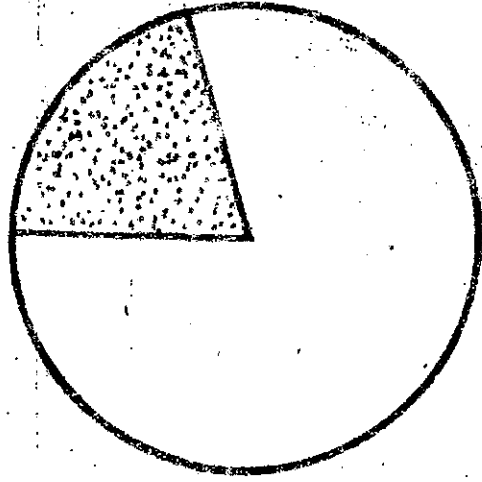
Uttoor



V.N. Puram



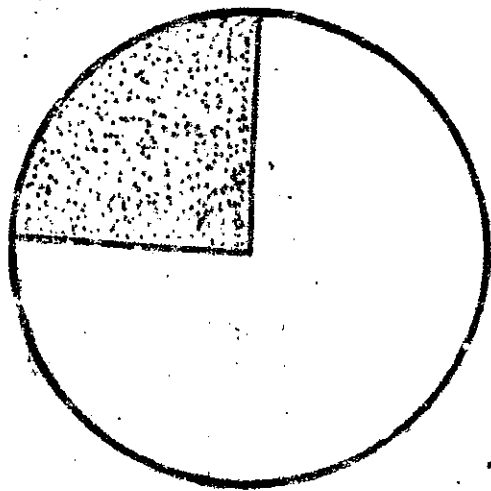
Polevaram



Manchingiput

PERCENTAGE OF HOUSEHOLDS
HAVING ONE OR MORE
DISEASED PERSONS

WITHOUT DISEASES
DISEASED

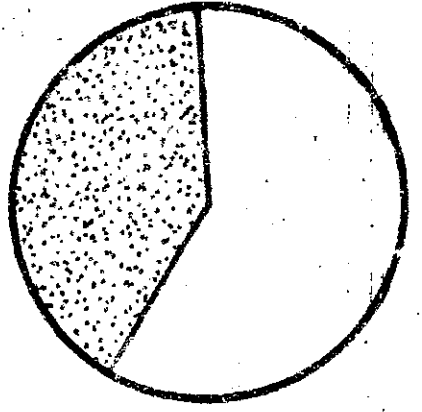
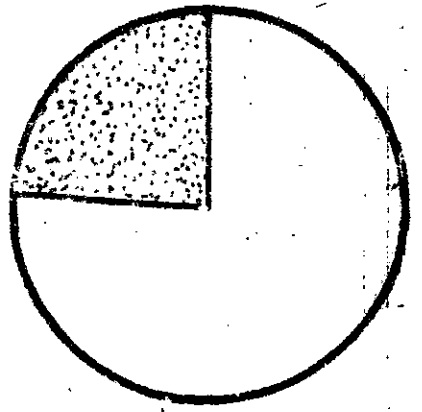
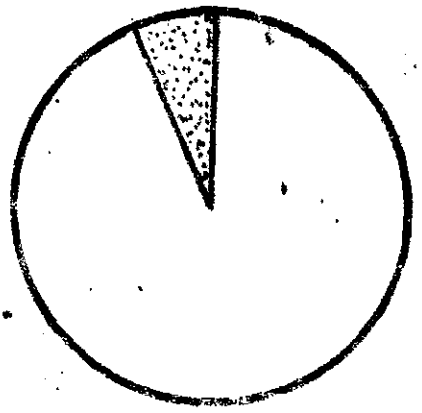
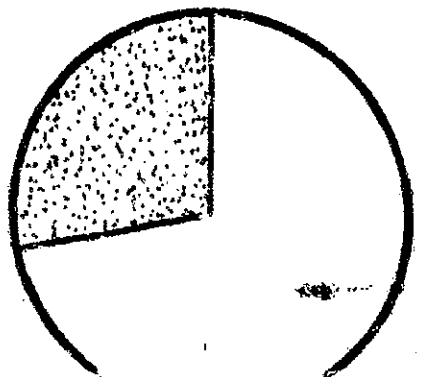


All Four Blocks

Polavaram

V.R. Puram

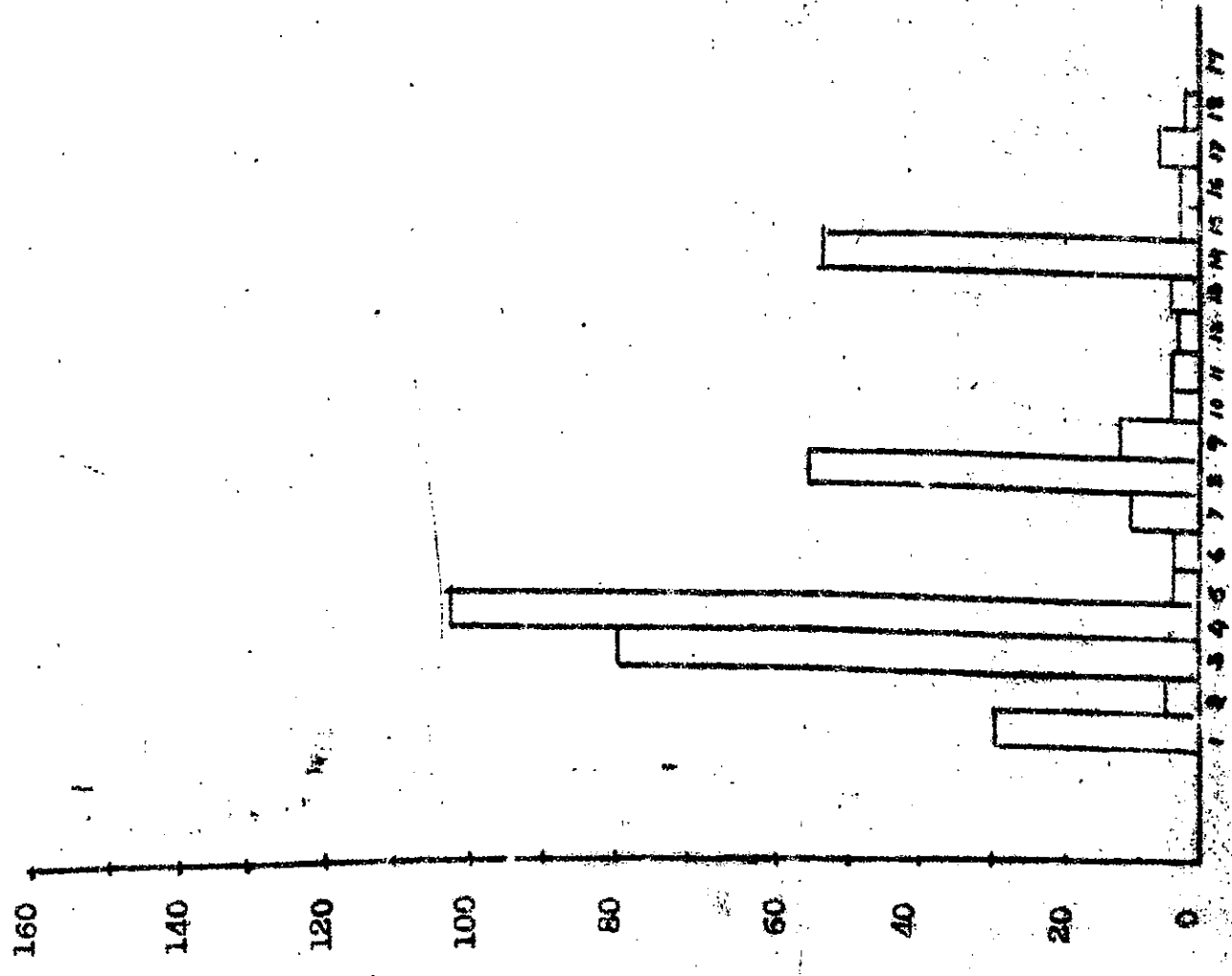
Uttnoor



UTNOR BLOCK

DISBASWISE PATTERN

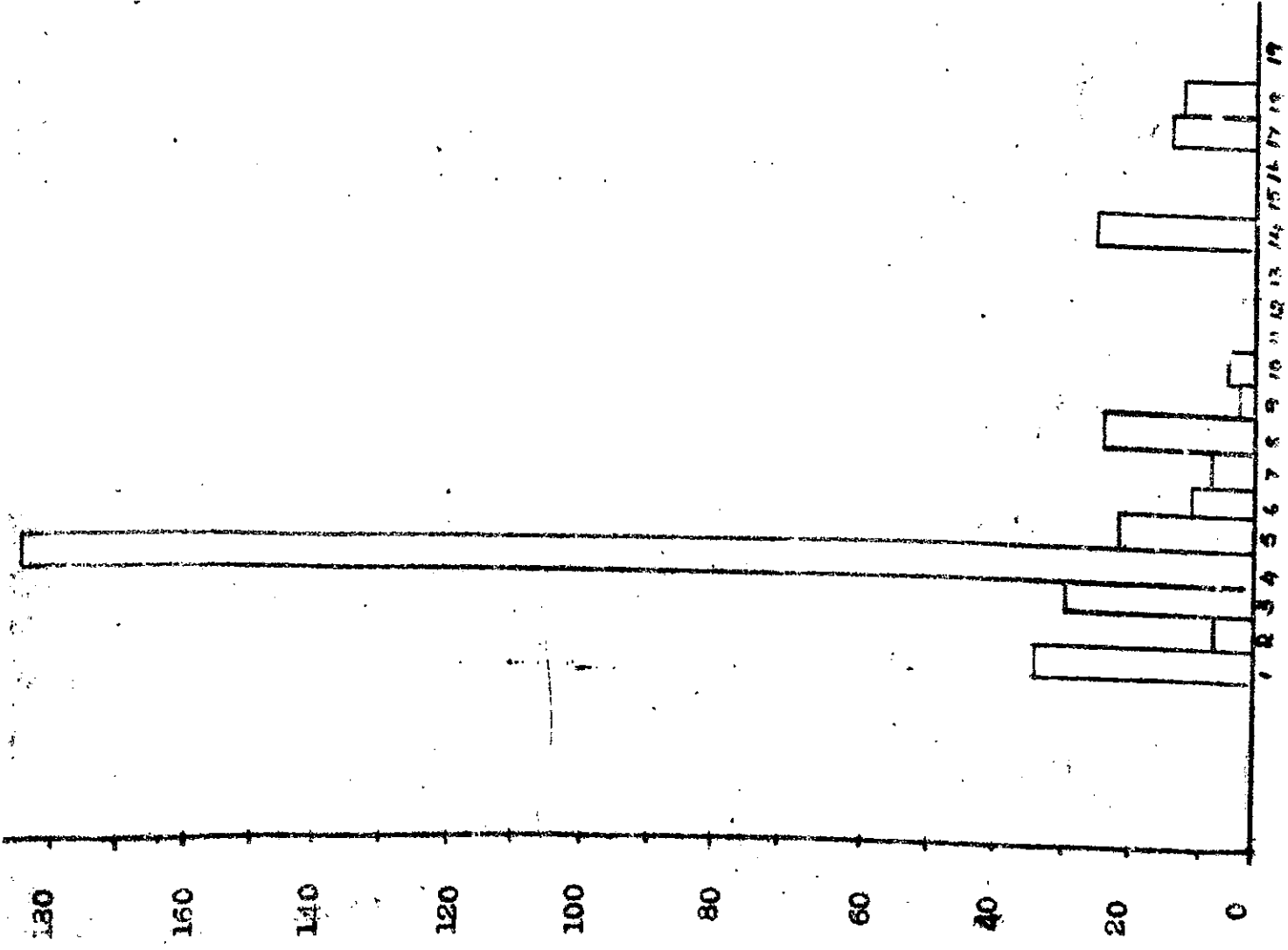
- 1. Digestive Tract Diseases
- 2. Physically Handicapped
- 3. Respiratory Tract Diseases
- 4. Fevers
- 5. E.N.T. Diseases
- 6. Chicker Pox
- 7. Ophthalmic Diseases
- 8. Other Common Ailments
- 9. Arthritis
- 10. Paralysis
- 11. Chest Pain
- 12. Goiter
- 13. Swelling of Legs
- 14. Skin Infection
- 15. Surgical Diseases
- 16. Nutritional Diseases
- 17. Women's Diseases
- 18. Liver Enlargement
- 19. Meningitis



POLAVARAM BLOCK

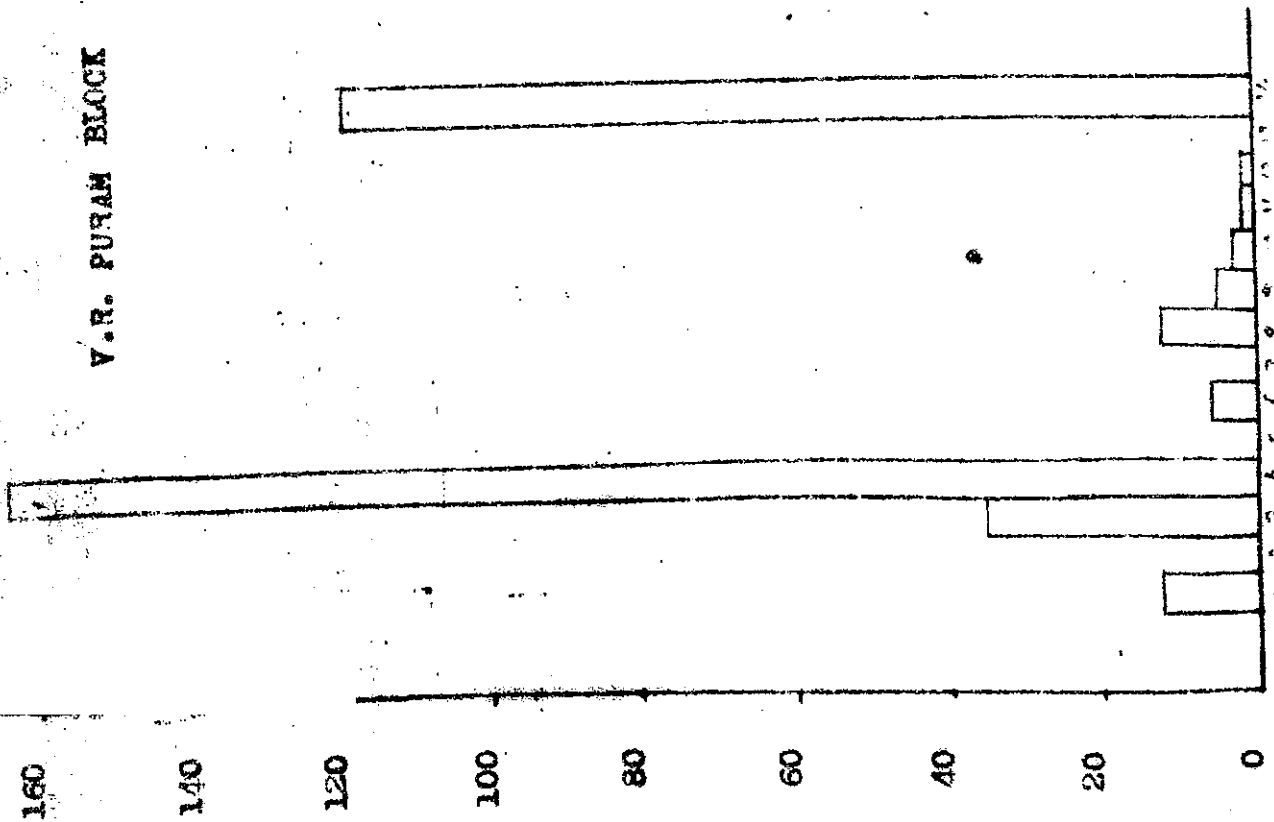
DISEASEWISE PATTERNS

1. Digestive Tract Diseases
2. Physically Handicapped
3. Respiratory Tract Diseases
4. Fevers
5. E.N.T. Diseases
6. Chicken Pox
7. Ophthalmic Diseases.
8. Other Common Ailments
9. Arthritis
10. Paralysis
11. Chest Pain
12. Goiter
13. Swelling of Legs
14. Skin Infection
15. Surgical Diseases
16. Nutritional Diseases
17. Women's Diseases
18. Liver Enlargement
19. Meningitis



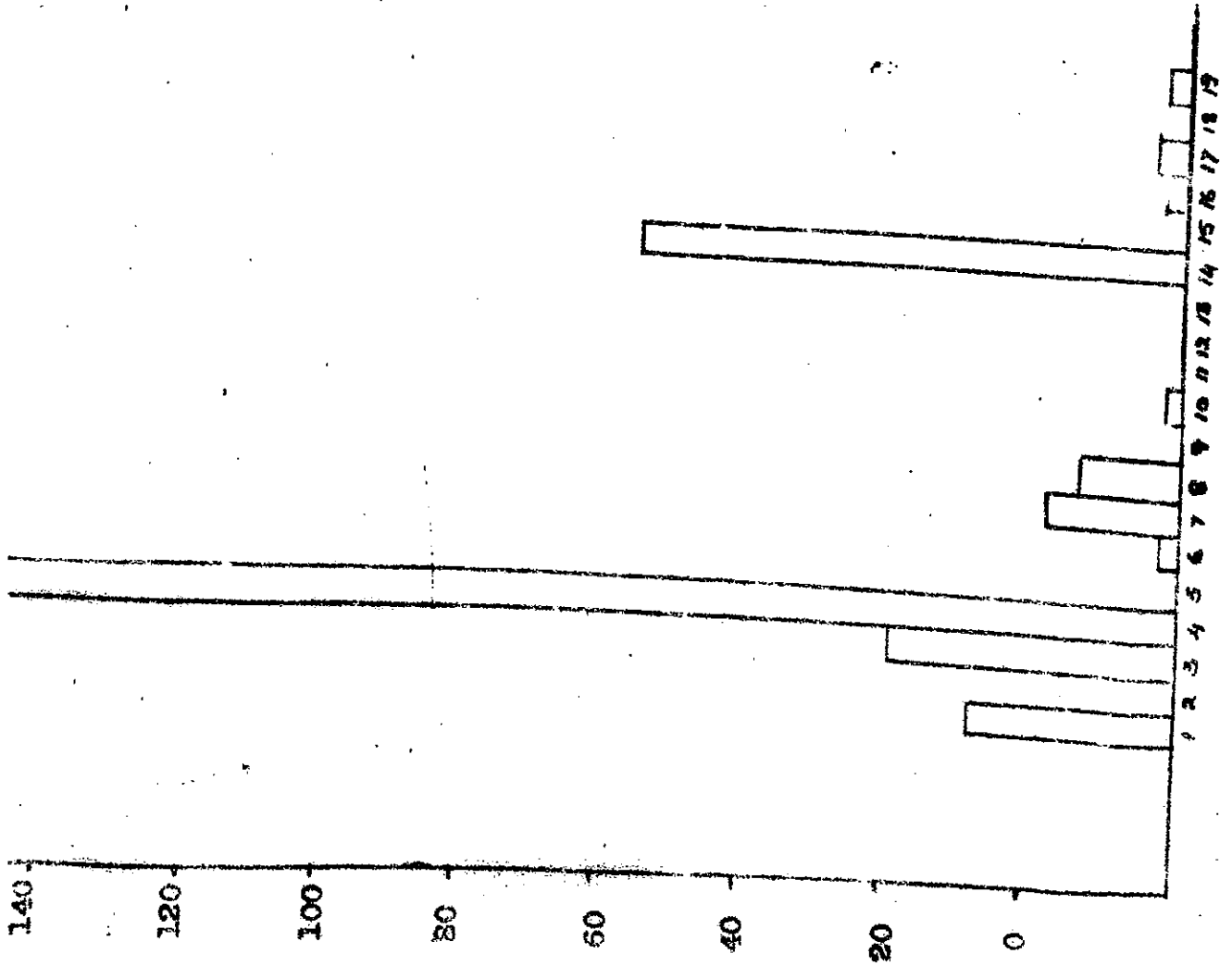
- 1. Digestive Tract Diseases
- 2. Physically Handicapped
- 3. Respiratory Tract Diseases

V.R. PURAM BLOCK



DISEASEWISE PATTERN

- 1. Digestive Tract Diseases
- 2. Physically Handicapped
- 3. Respiratory Tract Diseases
- 4. Fevers
- 5. E.N.T. Diseases
- 6. Chicken Pox
- 7. Ophthalmic Diseases
- 8. Other Common Ailments
- 9. Arthritis
- 10. Paralysis
- 11. Chest Pain
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