

A STUDY OF HEALTH SERVICES IN KATHLA TRIBAL DEVELOPMENT BLOCK

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FOREWORD

In order to acquaint those who are interested about the research works conducted at Tribal Research and Training Institute, this research report is being released in mimeographed form. If researchers, social workers, administrators, students and other scholars who are involved in tribal development works make certain suggestions after going through this report, this will help the Institute in its future works. I congratulate the researchers who have conducted this research work.

R. D. ADATIA
Mahamatra

P R E F A C E

At the instance of Ministry of Home Affairs, Government of India, this survey of Health services in a tribal area was undertaken by the Institute in March 1977. From Kathla Tribal Development Block in Panchmahals district in all 554 households from eleven selected villages were contacted for the survey. The Institute acknowledges with thanks the help received from all the villagers as well as from the medical institutions of the block.

Siddharaj Solanki
Acting Director.

According to 1971 census the population of Gujarat State was 266.9 lakhs of which 37.3 lakhs were scheduled tribes. Thus, about 13.99 per cent of the State population belonged to scheduled tribes. The Scheduled tribe population of the State comprised 9.83 per cent of the total tribal population of the country. The State ranked fourth amongst other States of the country so far tribal population was concerned. The heavy concentration of the scheduled tribe communities in the State necessitated special attention for the problems of their welfare. This was being done under the five years plans. One of the ameliorative measures was regarding the scheme of medical and health facilities for scheduled tribes alongwith other programmes. One of the major responsibilities of any welfare oriented government was to guard and promote the health of the people which it governed.

Several studies in various parts of our country have revealed that malnutrition and undernutrition were very common in a large section of our population. Prolonged undernutrition was responsible for a variety of nutritional deficiency diseases. Due to poor economic condition, a majority of tribal population have been receiving inadequate nutrition, which consequently resulted in protein and calorie deficiency diseases. "Recent surveys by the Indian Council of Medical Research, indicate that 50 per cent of the children in the age group one to six years suffer from

protein and calorie malnutrition in one form of the other. The incidence of blindness caused by vitamin 'A' deficiency was also very high. It was estimated that atleast 60 per cent of all the children in our country have nutritional anaemia. Surveys in the country have identified that the problem of malnutrition was more severe among tribal communities and slum dwellers in urban areas".¹ Generally the tribals suffered from many chronic diseases, the most prevalent of which were water borne. The drinking water supply in many of the tribal areas of Gujarat was very poor. Even when water was available, it was often dirty and contaminated. Consequently, the tribals were easily susceptible to intestinal and skin diseases. Incidence of Diarrhoea, Dysentary, Cholera, Guinea worm was not uncommon. Tuberculosis was intensified by nutritional deficiency so common among the tribals. The tribals have not yet developed an immunity and when they came in contact with new diseases they fell an easy prey to them. The incidence of T.B. seemed to be more for that reason. Scabies, ring-worm, anaemia, were also common in tribal areas.

OBJECTIVES:

The objectives of this survey have been:

- (1) To know how many people utilise the medical and preventive facilities available to them.
- (2) To find out the causes of resistance towards acceptance of modern medical facilities.

¹ Gopalan C. and Balasubramanian: The Nutritive value of Indian foods and the planning of satisfactory Diets - Indian Council of Medical Research, New Delhi, Special Report Series No.42.

- (3) To have an idea of the infra-structural built of medical institutions and utilization of the infra-structure.
- (4) To gauge the extent of perception and utilization of the medical facilities by different sections of the community.

AREA OF THE STUDY:

The present survey was undertaken in the areas of former Kathla tribal development block of Dahod taluka of Panchmahal district. Earlier there were three tribal development blocks viz., Bhatiwada, Garbada and Kathla in Dahod taluka. Under the new Tribal Area Sub-Plan, the block units have been dissolved in the larger unit of project area. This was one of the block started during third five year plans. It had been working since 1964. The taluka headquarter at Dahod had been also the headquarter of Kathla tribal development block. The block covered 45 villages of Dahod taluka. The total area covered by the block was 281 sq. kilometers. According to 1971 census the population of the block was 55838 out of which 89.8 per cent were tribals. According to 1971 census, population per village in the block was 1240 and the density of population per sq. kilometere was 1996.

The block was situated at the eastern end of the taluka being surrounded by the Jabua district of Madhya Pradesh in the east and south, Limkheda taluka in the west, Rajasthan and Jhalod taluka in the north. Much of the area of the block was hilly and the soils were goradu (sandy loam). The Kali and Par rivers flowed through the block.

The major tribes of this block have been Bhils and Patelias. Even from a cursory look it was evident that the villages of the block were under developed and impoverished. The main occupation of the tribals was agriculture. Forest produce and forest labour have been their subsidiary occupations. They have been also working as labourers in railway, road construction and other wage labour works. In search of labour work they have to migrate from one place to another. Due to low level of technology and traditional method of doing agriculture, they could not derive enough yield from their cultivable lands in order to meet the requirements of food round the year. So they had to supplement their income from many other sources. Rearing of cattle was not very popular but poultry and goats were raised by some households. The dog was an inseparable companion which also guarded their homes at night. The households who reared cattle and goats kept them in cattle-shed raised just by the side of their house or even inside in a part of the house, a practice which was not conducive for sanitation.

Maize, rice and gram constituted the staple food for the tribal communities of this area. Use of ghee and milk was negligible in their diet. Vegetable consumption was also not very popular in this area. Forest played a significant role in influencing the dietary patterns round the year. It came to their rescue during lean seasons. The habit of drinking intoxicants has been quite widespread. Liquor was a part

and parcel of their life and was must in all their social and religious functions. It was observed during the field work that most of the households have been consuming liquor as that was the season of mahua, from which they prepared their own liquor. They also purchased liquor from the wages earned.

In the matter of health and sanitation the tribals of this area appeared to have been very backward. Their knowledge in the matter of health was rudimentary. Tribals to-day no longer lived in primitive conditions, they cultivated land and grew their food, but it was never sufficient for their own requirements. Sometimes they lived on wild roots, fruits and leaves of edible plants. For most people there was not enough food and malnutrition was common. Consciousness regarding bodily cleanliness was lacking among them. Lack of personal hygiene caused large number of diseases from which the tribals suffered.² One of the most evident things observed regarding personal hygiene was that many of the tribals of the area did not take bath for days together and children did not brush their teeth. This, in turn, caused large number of skin and other diseases from which the tribals suffered.

2. See Rash Bihari Lal : Health and Sanitation Programme in a Tribal Block - Tribal Research and Training Institute, Gujarat Vidyapith, Ahmedabad 380 014.

According to the Medical Officer's report, disease like fevers, coughs, colds, diarrhoea, dysentary, constipation, malaria, scabies, night blindness, tuberculosis and venereal diseases were very common, while leprosy was very rare. Malaria was rampant in this area, inspite of antimalarial operations. Skin disease like scabies and boils were very common among children. Running noses also was very common among children during the cold and rainy seasons.

The tribals of this area were used to depend on native medicine. It was observed that they were slowly accepting modern medicines. It was heartening to note that many tribals complained about the irregular visits and absence of Medical Officer at government dispensaries.

METHODOLOGY:

According to the direction of Govt. of India the survey was conducted from two directions, viz., the institution's side and the people's side. In the first aspect all the medical institutions in the block were covered. In relation to other aspect, a number of sample villages in 3 or 4 clusters were selected. The criteria laid down for selecting the villages have been: (a) around the Primary Health Centre; (b) around the sub Centre; (c) around other medical institutions like ayurvedic dispensary, if any and (d) area not covered by any of these institutions. In each of these clusters, 3 villages were taken up for study, viz., the headquarter village of the institution, another village

less than 5 miles away and third village located at more than 5 miles away from the institution. In the last cluster, 2 villages were sufficient since there was no medical institution. In this way it was conceived that it would be possible to have an idea of the benefit from each type of institution accruing in the villages of its location, in the villages located at a small distance from the institution and in villages far off from the institution. The last two villages, where no institution has been established would represent the prevailing situation in the area, prior to the establishment of the medical institutions.

For present study, the Katwara Primary Health Centre was selected. From around this Primary Health Centre Khaparia (within 5 miles) and Lindabara (more than 5 miles) villages were selected, Panchwada, a sub centre was selected and from the villages around this sub-centre, Nimach (within 5 miles) and Sahada (more than 5 miles) villages were selected. Kathla, where an Ayurvedic dispensary was located was also selected and around this cluster, Valoba (within 5 miles) and Kotdakhurd (more than 5 miles) villages were selected. From the last cluster where there was no medical institution, Kheng and Udar villages were selected.

Each selected village had a sizeable population, so a sample was drawn from each village. From these villages the households were selected on the basis of random sample. The sample was drawn from each village in the proportion of

50 per cent from villages having less than 100 households, 30 per cent from villages having 101 to 200 households, 20 per cent from villages having 201 to 300 households and 15 per cent from the villages having more than 300 households. The difference in the proportion of selection was made because the difference enabled us to get a sufficient size of sample from each selected villages. The details of selected households have been given in Table I. Thus, altogether 554 households were covered in the study. The number of selected households to the total number of households in selected villages was 27 per cent.

TABLE I

Village-wise number of selected households

Sr. No.	Name of the village	Total No. of households in selected villages	No. of selected households	Percentage to total households
1	2	3	4	5
I	Katwara	441	66	14.9
	Khaparia	127	40	31.5
	Limdabara	175	52	29.7
II	Panchwada	154	50	32.5
	Nimach	106	51	48.1
	Sahada	211	51	24.2
III	Kathla	270	56	20.7
	Varbada	145	46	31.7
	Kotdakhurd	167	40	23.9
IV	Kheng	134	50	37.3
	Udar	89	52	58.4
	TOTAL.....	2019	554	27.4

In all 554 households from 11 selected villages have been covered in this survey. The interviewing was conducted by a field team of five interviewers under the supervision of the author of the report. The field work was conducted during the entire month of March, 1977. Out of total 554 households, 20 (3.8 per cent) belonged to scheduled castes and 29 (5.2 per cent) to other communities while 91 per cent were tribals. Village-wise and community-wise number of selected households have been given in Table 2.

TABLE 2

Village-wise and Community-wise number of selected households

Name of the village	Scheduled castes	Tribals	Other communities	Total
1	2	3	4	5
Katwara	13 (65.00)	37 (07.32)	16 (55.17)	66 (11.91)
Khaparia	--	40 (07.92)	--	40 (07.21)
Limdabara	--	52 (10.30)	--	52 (09.39)
Kathla	04 (20.00)	39 (07.72)	13 (44.83)	56 (10.11)
Varbada	--	46 (09.11)	--	46 (08.30)
Kotdakhurd	--	40 (07.92)	--	40 (07.21)
Panchwada	03 (15.00)	47 (09.31)	--	50 (09.03)
Nimach	--	51 (10.10)	--	51 (09.21)
Sahada	--	51 (10.10)	--	51 (09.21)
Kheng	--	50 (09.90)	--	50 (09.03)
Udar	--	52 (10.30)	--	52 (09.39)
TOTAL.....	20 (100.00)	505 (100.0)	29 (100.00)	554 (100.00)

(The figures in brackets show percentages to total families)

The community-wise and sex-wise population figures have been given in Table 3.

TABLE 3

Community-wise and Sex-wise population of Sample villages

Community	Male	Female	Children (Below 12 years)	Total
1	2	3	4	5
Schedule caste	41 (28.4)	46 (31.9)	57 (39.7)	144 (100.0)
Schedule tribe	1126 (29.1)	1105 (28.5)	1642 (42.4)	3873 (100.0)
Other communities	84 (35.7)	72 (30.1)	79 (34.2)	235 (100.0)
TOTAL.....	1251 (29.4)	1223 (28.7)	1778 (41.9)	4252 (100.0)

(The figures in bracket indicate percentages).

The figures in Table 3 indicates that of total individuals there was a large number of children (below 12 years age) which came to about 42 per cent of the total population. The number of males and females were almost the same. (29.00 per cent each). The average size of household was 7.7. The size of household among scheduled castes and other communities were 7.2 and 8 respectively. The size of household among the tribals was 7.6.

FINDINGS AND DISCUSSIONS:

Small Pox Vaccination: Information was collected from the head of the households regarding the medical care of their family members, when they suffered either from major or minor illness and the availability of medical personnel within a distance of their houses. The respondents were asked whether they have been vaccinated or not.

All informants responded in affirmative. Most of the tribals informants who knew that vaccination was done as a preventive measure against Small-Pox but they did not evince much faith in it. It was commonly thought that vaccination was to be got once in one's life span particularly in early infancy. Some informants argued against vaccination. It was true that cases of Small-Pox did occur and sometimes in menacing form, but they did not know and were not inclined to understand that vaccination was considered to be necessary to build up immunity. Most of the tribals did not like to be vaccinated. Regarding vaccination some of the informants even expressed the opinion that inoculation was administered so as to make men and women sterile because the government wanted to check the population growth.

The tribals of this area regarded certain diseases as due to the wrath of some Goddess or God. For example Mata was considered to be the Goddess which inflicted disease of Small-Pox upon human beings. It was also believed that no treatment could be useful in small-pox, on the contrary it was firmly believed that administration of drugs might bring adverse result. Generally in Small-pox the tribals of this region, like the Hindus, did not consult allopathic doctor. These were but a few examples of the attitude of tribal people. The fact of the matter was that such considerations would apply to any other Public Health Programme we might initiate in future. From the tangles of such numerous traditional beliefs people would have to be rescued and that should be achieved not by ridiculing them

for holding those beliefs, but by enlightening them in regard to the true nature of diseases and the measure for its prevention.

TABLE 4

Community-wise Cholera inoculation

Community	Total No. of persons	Cholera inoculation taken	Percentage
1	2	3	4
Scheduled caste	144	87	60.4
Scheduled tribe	3873	2231	57.6
Other communities	235	153	65.1
TOTAL.....	4252	2471	58.1

The data given in Table 4 regarding Cholera inoculation indicated that out of total 4252 individuals 58 per cent had taken the Cholera inoculation. The corresponding figures for scheduled caste was 60.4 per cent, for scheduled tribe 57.6 per cent and other communities 65 per cent. Not a single child had been given Cholera inoculation. Some of the informants explained that the Cholera inoculations were given at the time of famine relief work. Generally most of the people did not know when and where Cholera inoculation was given. Immunization programmes had been started for protection against most of diseases of childhood. The Auxiliary Nurse Midwife (ANM) of sub-centres had reported that they administered DPT (Diphtheria, Pertussis, Tetanus) DT (Diphtheria, Tetanus), TT (Tetanus Toxoid) and Polio-myelitis. But the people of this area had no idea about DPT and other vaccines which was used for the multiple immunization of children. They also did not know about the BCG vaccine against tuberculosis.

SEVERE DISEASES DURING LAST ONE YEAR:

The field data (see table 5) regarding severe diseases during last one year indicated that in all 130 individuals were suffering from one or other major type of illness. Amongst them, 89 were males and 36 females while 5 were only children. Of the total 130 individuals, majority (48 per cent) were found to be suffering from tuberculosis. Semi-starvation condition or inferior diet consumption, coupled with unhygienic conditions do result in contracting tuberculosis. As the tribals were having both these factors in greater percentage, therefore, the incidence of T.B. among if tribals was found to be more. The tribal T.B. patients do not avoid close contacts of their family members and as such others were also affected by this disease. Next in order was Asthama (20 per cent), while 4 from Paralysis, one from Cancer and 5 from Leprosy.

TABLE 5

Diseases-wise and sex-wise illness during last one year.

Diseases	Male	Female	Children	Total
1	2	3	4	5
Tuberculosis	42 (47.2)	20 (55.5)	1 (20.0)	63 (48.46)
Asthama	24 (26.9)	1 (02.8)	1 (20.0)	26 (20.00)
Paralysis	4 (04.5)	-	-	4 (03.08)
Elephantiasis	--	1 (02.8)	-	1 (00.77)
Cancer	--	1 (02.8)	-	1 (00.77)
Apoplexy	1 (01.1)	1 (02.8)	-	2 (01.54)
Rheumatism	--	2 (05.5)	1 (20.0)	3 (02.30)
Leprosy	3 (03.4)	1 (02.8)	1 (20.0)	5 (03.85)
Others	15 (16.9)	9 (25.0)	1 (20.0)	25 (19.23)
TOTAL.....	89 (100.0)	36 (100.0)	5 (100.0)	130 (100.00)

(The figures in brackets indicate percentages).

AGENCY FOR GETTING TREATMENT:

TABLE 6

Number of Patients treated at different dispensaries

Agency	Male	Female	Children	Total
Private Dispensary	51	18	4	73 (56.15)
Government Dispensary	41	10	2	53 (40.77)
Bhagat & Bhopa	3	1	-	4 (03.08)
TOTAL.....	95	29	6	130 (100.00)

(The figures in brackets indicate percentages).

On inquiry ^{regarding} the treatment it was learnt that generally the tribals did not care much for minor ailments and unless seriously ill they did not seek medical treatment. The data regarding treatment given in Table 6 revealed that of total 130 patients, 73 (56.2 per cent) patients were getting their treatment from private dispensaries or from private doctors, while 53 (40.77 per cent) patients were getting treatment from government dispensaries while 4 elderly persons proudly claimed that so far, they had never visited any physician inspite of several illness they faced in their lives. 73 patients confirmed that they were satisfied with the private physician because the treatment given there was much good and to their satisfaction.

TABLE 7

Number of persons treated at different places

Name of the places	No. of Patients	Percentage
1	2	3
Katwara	38	30.16
Dahod	54	42.85
Godhara	19	15.08
Amdavad	5	03.97
Anand	6	04.76
Vadodara	2	01.59
Ratlam	2	01.59
TOTAL.....	126	100.00

The data in Table 7 pointed out that of total 126, 38 (30.2 per cent) were receiving treatment from Primary Health Centre, Katwara while 54 (42.3 per cent) from Dahod Cottage Dispensaries as well as Dawoodi Bohra Anjuman Dawakhana of Dahod. Quite a sizeable number of the patients had been compelled to go to far away cities for getting themselves treated. Amongst such cases, 19 (15.1 per cent) got treatment at Godhara, 5 at Amdavad, 6 at Anand and 2 at Vadodara while 2 patients at Ratlam in Madhya Pradesh. It was apparent that for cure of severe and serious ailments the tribals of this region had no facilities within easy reach. During the Survey it was found that of the total 126 patients, 38 (30.2 per cent) had been admitted as indoor patients whereas 78 (69.8 per cent) were outdoor patients. Both type of patients were getting oral medicines as well as injection during their treatment. When respondents were asked about the result it was found that 44 were having improvement and thus were satisfied with the treatment whereas 82 persons

were not satisfied with the treatment as they did not evince much improvement in their conditions.

SEASONAL AND ACCIDENTAL AILMENTS:

TABLE 8

Number of Patients suffering from seasonal and accidental illness

Name of the Disease	No. of Patients	Percentage
1	2	3
Malaria	225	87.21
Cholera	18	06.98
Typhoid	3	01.16
Pneumonia	1	00.39
Guineaworm	9	03.49
Others	2	00.77
TOTAL.....	258	100.00

It had been gathered during the survey that 258 persons were suffering from seasonal and accidental illness (See Table 8). Of total 258, majority of them were suffering from Malaria (87.2 per cent), 18 persons were suffering from Cholera, 3 from Typhoid and 9 from Guineaworm infection. Of total 258, 65 per cent approached private physicians for treatment while 32 per cent got themselves treated at government dispensaries. 5 persons, however, were found to have approached Bhagat or Bhopa of the village. 3 patients of Panchwada village were unable to get any sort of treatment because of their poor economic conditions. On being asked as to why they approached private physician, 168 patients answered that the private physician properly and correctly diagnosed the ailment and prescribed effective medicines in comparison with the doctors of government dispensaries.

CASES OF MATERNITY

TABLE 9

Village-wise number of Maternity Cases

Name of the village	Who performed		Where		Total No. of cases
	Nurse	Dai	Home	Dispensary	
1	2	3	4	5	6
Katwara	5	1	1	5	6 (05.50)
Khaparia	-	2	2	-	2 (01.03)
Limdabara	7	9	9	7	16 (14.68)
Kathla	7	2	7	2	9 (08.26)
Verbada	1	2	3	-	3 (02.75)
Kotdakhurd	-	4	4	-	4 (03.67)
Panchwada	3	9	10	2	12 (11.01)
Nimach	10	8	11	7	18 (16.51)
Sahada	-	7	7	-	7 (06.42)
Kheng	6	11	11	6	17 (15.60)
Udar	3	12	13	2	15 (13.77)
TOTAL.....	42	67	78	31	109 (100.00)
	(38.53)	(51.47)	(71.56)	(28.44)	

(The figures in brackets show percentages).

109 cases of maternity had been registered during the survey (See Table 9). The data revealed that of the total 109 cases, 42 (38.5 per cent) cases were attended by a trained nurse of Primary Health Centre as well as sub-centres. While 67 (51.5 per cent) cases were by the community Dai. Of the total 109 cases of pregnancy, in case of 78 (71.6 per cent) the delivery of the child had taken place at their respective homes whereas in 31 cases (28.4 per cent) it had taken place at dispensaries. On being asked why they had not utilised the services of a trained Nurse of Primary Health Centre or sub-centres for delivery, the following answers had been

provided by the respondents; (1) In 30 cases the nurse had not been approached because the cases were normal ones. Only in complicated cases they preferred to call Auxiliary Nurse Midwife. (2) 71 respondents replied that they had been regularly taking benefit of the service of Community Dai. Only in difficult situation the trained nurse was called. In 3 cases their poor economic conditions did not permit them to call a Mid-wife. In 5 cases the pregnant women had more faith on traditional village mid-wife than upon governments mid-wife.

EXPENDITURE ON MEDICAL CARE:

TABLE 10

Distribution of Households by amount spent on medical care, consulting and travelling, lodging and boarding.

Amount of Money spent yearly	Medical expenses	Consulting expenses	Travelling expenses
1	2	3	4
Upto Rs.100/-	222 (75.8)	147 (90.7)	262 (90.7)
Rs.101 to 250/-	27 (09.2)	9 (05.6)	14 (04.8)
Rs.251 to 500/-	16 (05.5)	6 (03.7)	13 (04.5)
Rs.501 to 750/-	5 (01.7)	-	-
Rs.751 to 1000/-	10 (03.7)	-	-
Above Rs.1000/-	13 (04.1)	-	-
TOTAL.....	293 (100.0)	162 (100.0)	289 (100.0)

(The figures in bracket indicate percentages)

To the query regarding the expenditure incurred towards medical care, 293 households had been able to provide information. Of the total 293, 55 per cent had also accounted for the consulting expenses. 289 (99 per cent) had included travelling, boarding and lodging expenses too. The figures given in Table 10 revealed that of the total 292, 76 per cent

had incurred medical expenses for less than Rs.100/-. 27 household had spent an amount somewhere between Rs.101 and Rs.250/-. 31 households had incurred expenses between Rs.251 to Rs.1000/-, whereas 13 households had spent more than Rs.1000/- on medical treatment. About expenses for consulting physician, it had been found that 147 households had incurred expenses for less than Rs.100/- while 9 households spent in the range of Rs.101 and 250/- and 6 households between Rs.251 and 500/-. Regarding travelling expenses it was found that of total 289 households 90 per cent had incurred less than Rs.100/- towards expenditure on travelling. The average annual expenditure on medical care was found to be Rs.216/- per household. This meant that the annual expenditure on medical care for each member was Rs.28.05 per year. (Average household size being 7.7, See Table No.3). It shows that the annual expenditure on medical care in relation to their economic condition was quite burdensome on them.

SUPERNATURAL CAUSES AND MAGICO RELIGIOUS MEDICINE:

As mentioned earlier tribals of this region attributed certain supernatural to be causes for certain type of illness in the villages. The physicians, surgeons and educated people regarded the recognition of such causes of diseases as unusual and primitive and their methods of diagnosis and treatment irrational. But what seemed to be supernatural and illogical to westernized and elite was quite natural to tribals. For supernatural causes of illness magical methods of diagnosis and treatment were followed. Breach of certain taboos was believed by tribals to be responsible for certain diseases.

If people failed to make necessary and timely sacrifices to propitiate Goddesses or malevolent spirits or failed to install a 'Paria' for his deceased forefathers they would be punished with infliction of certain diseases.

Sorcery was another reason especially linked with causing and curing disease. A person, usually female, who had acquired black magical powers and had become sorceress, in course of time, to do evil, was called Churail (Witch). According to Bhils, the witch could look into the future, escape harm and transform itself into various inhuman form. It was believed that the eyes of a sorceress was so powerful that as soon as she looked at a child, with some evil design on the head, the latter would start developing some ailment and in course of time would eventually be dead. Another interesting and widely accepted belief connected with health and disease was the effect of evil eye. Children were considered to be most susceptible to the effect of evil eye. In a suspected case of sorcery, the services of exorcist (Bhopa) were obtained. An exorcist was usually a Bhopa or Bhagat who was considered to be in the possession of specialized knowledge of chasing away the evil-spirit or nullifying the effects of sorcery by means of consultations. According to the belief of the tribals, the medicine man had the proper knowledge to locate the nature of the diseases and to fix the type of sacrifice needed to appease the concerned deity or evil spirits. Minor diseases might be cured by enchanting mantras and offering one or two eggs or fowl in the name of the concerned deity or evil spirit. But during the field work

it had been found that this kind of belief was now slowly and gradually disappearing from the minds of tribals.

It has been gratifying to find that majority of the tribals in this region have been found to go for modern allopathic treatment. 320 of the total informants, i.e. 58 per cent gave the information that they have been getting allopathic treatment in case of ailments in their families. Out of the rest 234, for 221 (94.9 per cent) did not have to face grave ailments which would have warranted allopathic treatment while 7 (3.0 per cent) unable to take allopathic treatment on account of their poor economic conditions. Only 6 (2.6 per cent) households complained that as government dispensaries was not providing effective medicines they did not like to take allopathic treatment.

KATWARA PRIMARY HEALTH CENTER:

The set up of health programme in the Kathla Tribal Development block has been on the same line as in other Tribal Development block of India. There was one Primary Health Centre at Katwara. Katwara was situated at a distance of 12 kms. from Dahod, the block headquarter. Besides Primary Health Centre at Katwara there was one maternity child health centre which was under direct control of Auxiliary Nurse Midwife and there was also one family planning centre which was under the charge of a Field Worker. There were altogether seven sub-centres Panchwada, Agawada, Kathla, Timarda, Garbada, Uchwania and Himala in Kathla Tribal Development Block. Excepting Himala Health sub-centre, at each of six sub-centres there has been one trained Auxiliary Nurse Midwife who alone

looks after the entire affairs of the respective centres. Himala Health sub-centre was under the charge of Field Worker.

There has been two Medical Officers at the time of survey at the Katwara Primary Health Centre one Medical Officer was for health work and other Medical Officer for family planning work. Besides them, there was one Compounder, one midwife, two trained nurses, one Laboratory Technician, two Clerks and one Peon. All sanctioned staff for last five years have been filled in. At the time of survey not a single post has been vacant in the centre. The building of primary health centre came into existence during 1970. The building was pucca one having nine spacious rooms. The building was quite adequate. Besides Primary Health Centre building there has been three residential quarters each for Medical officer for Auxiliary Nurse Midwife and for compounder. There was also a mobile van presented by UNICEF.

The expenditure incurred during last three years was on building Rs.70,000/-, on equipment Rs.15,000/- and salary of staff Rs.5,04,000/-. The figures indicated that the expenditure on equipment was much less. At the Primary Health Centre, 6 beds have been available, two for males and four for females. The data regarding utilisation of indoor and outdoor facilities revealed that during last three years (from 1974-76) 350 patients had utilized the indoor facilities whereas altogether 20,423 cases have been treated outdoor during the same period.

Regarding linkage with higher level and lower level institutions it was found that during last 2 years a District Health Officer had visited the Primary Health Centre 12 times and had given guidance for improvement of MCH family planning work. At lower level the Taluka Development Officer had visited Primary Health Centre 8 times during the last two years. The frequency of visit of doctor to the villages was 18 times monthly and visit of paramedical staff was 20 times monthly. During last three years no preventive work regarding cholera, small-pox or any other disease was organised at Primary Health Centre.

The family planning performance under different strategies during last three years has been given in Table 11.

TABLE 11

Comparative performance of Family Planning

Year	Sterilisation		Use of prophylactis		
	VT	IT	Condom	IUCD	Oral pills
1	2	3	4	5	6
1974	12	19	2454	-	-
1975	156	24	14916	3	-
1976	311	25	31652	-	-

(Source Primary Health Centre Katwara)

According to the figures available from the Primary Health Centre, Katwara the main diseases prevalent in this area were in the group of (i) Disease of digestive system, (ii) Cold, cough and Fever, (iii) Blood and Lymphatic, (iv) Respiratory system, (v) Eye diseases and (vi) Ear, Nose and Throat diseases. During the survey data regarding the number of patients attending Katwara Primary Health Centre

were obtained for the month of January 1977. The age-wise and community-wise number of patients treated at Primary Health Centre are given in Table 12.

TABLE 12

Age-wise and Community-wise number of patients

Age groups	Name of the community							
	Tribals		Scheduled caste		Other communities		Total	
	M	F	M	F	M	F	M	F
1	2		3		4		5	
0 - 4	30	27	1	2	10	5	41	34
5 -14	25	24	3	1	9	7	37	32
15 -30	38	48	6	3	14	8	58	59
31 -55	61	45	2	1	14	11	77	57
Above 55	3	4	-	-	2	1	5	5
TOTAL.....	157	148	12	7	49	32	218	187
GRAND TOTAL..	305 (75.3)		19 (04.7)		81 (20.0)		405 (100.0)	

M=Male, F = Female (The figures in bracket represent the percentages)

The figures in the table 12 indicated that out of total 405 patients 75.3 belonged to tribal community whereas 4.7 per cent belonged to scheduled castes and 20.0 per cent belonged to other communities. Compared to the total population of the sample villages for the different communities in Kathla Block 7.9 per cent tribals ^{were} utilising services of Primary Health Centre whereas 13.2 per cent population of scheduled caste and 34.5 per cent population of other communities were utilising Primary Health Centre services. The figures obviously indicated that people of the other communities were taking much benefit from the Primary Health Centre

than the tribals. Of the population of block only 0.6 per cent tribal population utilised Primary Health Centre services whereas the corresponding figures for each scheduled caste and other communities were 1.8 per cent. Sex-wise and age-wise data revealed that of the total 405 patients 53.8 per cent were males and 46.2 per cent were females. Age-wise data indicated that child patients were more than the younger groups. Of total 405 patients treated 35.5 per cent were in the age group of below 14 years while 28.8 per cent in age group of 15-30 years, 33.1 per cent in age group of 31-55 years and only 2.6 per cent in the age group of above 55 years.

As it would be obvious from the figures presented in Table 13 that cold, cough, malaria, diseases of digestive system, diseases due to malnutrition, skin diseases, and eye diseases had been more frequent amongst the adult population, male and females of this area. Gastro-intestinal, various forms of anaemia, rickets, pellagra and night blindness had also been recorded in this area. All these have been attributed due to nutritional maladjustments. Majority of the tribals particularly women and children, suffered from general debility and anaemia and thus have to live in poor state of health. This was responsible for clinical abnormalities of metabolism and malnutrition in them, which caused diseases like rickets, pellagra, B complex deficiency. Some of the skin diseases and eye diseases were associated with vitamin A deficiency.

TABLE 13

Distribution of patients treated at Primary Health Centre, Katwara.

Name of diseases	Patients			Total
	Tribals	Scheduled caste	Other communities	
1	2	3	4	5
Disease of digestive system	60 (19.7)	3 (15.8)	15 (18.6)	78 (19.2)
Cold, Cough, Fever and Malaria	57 (18.7)	6 (31.6)	23 (28.4)	86 (21.2)
Meta Bolism	30 (09.9)	-	8 (09.8)	38 (09.4)
Respiratory system	27 (08.9)	2 (10.5)	9 (11.2)	38 (09.4)
Blood and Lymphatical	50 (16.4)	7 (36.9)	13 (16.1)	70 (17.4)
Skin diseases	30 (09.9)	1 (05.2)	4 (04.9)	35 (08.6)
Eye diseases	17 (05.7)	-	3 (03.7)	20 (04.9)
Ear, Nose, Throat diseases	10 (03.2)	-	3 (03.7)	13 (03.2)
Teeth diseases	5 (01.6)	-	1 (01.2)	6 (01.4)
Allergic diseases	6 (01.9)	-	2 (02.4)	8 (01.9)
Urogenital diseases	3 (00.9)	-	-	3 (00.8)
Others	10 (03.2)	-	-	10 (02.6)
TOTAL.....	305 (100.0)	19 (100.0)	81 (100.0)	405 (100.0)

(Figures in brackets show the percentage)

The figures revealed that 21 per cent of the total number of patient treated have been found to be suffering from malaria, cold and cough, 19 per cent from digestive system and 17 per cent from anaemia. Amongst the diseases of digestive system diarrhoea, dysentery and constipation have been quite frequent. Among the adults dysentery and constipation had been much common while among children diarrhoea was much common. Amongst eye diseases, night blindness and conjunctivitis had been the most frequently, reported diseases.

Conjunctivitis had been found in 6 children while night blindness had been found in 14 males and females. Amongst skin diseases ringworm and scabies had been quite common. The incidence of ringworm and scabies had been found more in children. 23 children were suffering from rickets. Vitamin D was one of the factors directly concerned in the prevention of rickets. Children suffering from this disease often developed a tendency to nasal and bronchial ailments. As had been indicated earlier maize was staple food of the people of this area which was likely to produce rickets, as it was reported to bring growth without supplying to the ones a sufficiency of calcium phosphorus and vitamin D. Dysentery, malaria, cold cough, anaemia and rickets had been also found in maximum number among other communities. Amongst scheduled castes patients malaria and dysentery had been found. The great frequency of skin diseases, eye diseases and dysentery clearly reflected an unhygienic conditions of living and health habits in the tribal population of this area.

The dispensary records regarding the number of patients attending the dispensary from different villages were obtained. The figures in Table 14 shows that majority of the patients (35 per cent) were coming from the Katwara Primary Health Centre village itself, 25 per cent within 1-2 kilometers distance, 13 per cent within 3-5 kilometers distance, 23 per cent 6-10 kilometers distance, 2 per cent between 11-15 kilometers distance and only 2 per cent had to travel 15 kilometers or above. Thus, the analysis reveals that more households seek medical help. It is also seen that one fourth of the patients

which consulted the Primary Health Centre doctors for minor and major illness even if some of them had to travel a long distance.

TABLE 14

Utilisation of the services available at the Primary Health Centre by the community in different category of villages.

Category of village	No. of using services			Total
	Tribal	Scheduled castes	Other communities	
1	2	3	4	4
PHC village	68 (22.30)	15 (78.94)	59 (72.84)	142 (35.07)
Villages within 2 kms. from PHC	92 (30.16)	2 (10.53)	9 (11.11)	103 (25.43)
Villages within 3 to 5 kms. from PHC	49 (16.07)	-	3 (03.70)	52 (12.84)
Villages within 6 to 10 kms. from PHC	81 (26.56)	2 (10.53)	10 (12.35)	93 (22.96)
Villages within 11 to 15 kms. from PHC	9 (02.95)	-	-	9 (02.22)
Villages more than 15 kms. from PHC	6 (01.96)	-	-	6 (01.48)
TOTAL.....	305 (100.00)	19 (100.00)	81 (100.00)	405 (100.00)

AYURVEDIC DISPENSARY

There was one Ayurvedic dispensary at Kathla. Formerly, the Ayurvedic dispensary was managed by Bhil Seva Mandal, a voluntary organisation. Now it was under direct control of State Government. The building of the dispensary had still not been transferred to Government. At the time of survey one Medical Officer and one Peon had been working in the dispensary. The working hours of the dispensary was from 8 a.m. to 12 p.m. in the morning and again in the afternoon from 3 p.m. to 5 p.m. During the survey, data regarding number of patients attending Ayurvedic dispensary were obtained for the month of January 1977. The age-wise and sex-wise number of patients treated at dispensary are given in Table 15.

TABLE 15

Age-wise number of patients treated at Kathla Ayurvedic dispensary

Age group	Tribals		Other communities		Total		
	M	F	M	F	M	F	T
1	2	3	4	5	6	7	8
0 - 4	12	15	1	2	13 (12.38)	17 (40.48)	30 (20.41)
5 - 14	27	9	1	-	28 (26.67)	9 (21.43)	37 (25.17)
15 - 30	25	7	3	1	28 (26.67)	8 (19.05)	36 (24.49)
31 - 55	32	7	1	-	33 (31.43)	7 (16.67)	40 (27.21)
Above 55	3	1	-	-	3 (02.85)	1 (02.37)	4 (02.72)
TOTAL...	99	39	6	3	105 (100.00)	42 (100.00)	147 (100.00)

The figures in the Table 15 revealed that out of total patient, nine belonged to other communities. The figures also revealed that the average number of patients per day was less than five. Sex-wise and age-wise data showed that more male patients visited than females. The data also showed that the number of child patients coming for treatment was better than the number of young persons.

So far type of diseases was concerned the records at the Ayurvedic dispensary Kathla given in Table 16 pointed out similar trends. In this dispensary too, cases of fever, cold, cough, malaria, anaemia and diarrhoea formed a large majority. Next, the cases of injury, night blindness, skin diseases were found to trouble, the tribals. The data also revealed that the large number of children were suffering from anaemia. It was found from the record that the cases of leprosy, T.B. was very low among the people of this area.

The figures regarding the utilisation of dispensary indicated that most of the patients treated at dispensary were native of Kathla village itself. Of total 147 patients, 97 were from Kathla, 33 were from villages lying at a distance nearly 4 kms. away from the dispensary, and 15 patients were coming from the village Khongela a border village of the district, 8 kms. away from the dispensary.

TABLE 16

Distribution of patients treated at Kathla Ayurvedic dispensary according to major group of diseases

Diseases	Tribals	Other communities	Total
1	2	3	4
Skin diseases	8 (05.80)	1 (11.11)	9 (06.2)
Diseases of Digestive system	14 (10.14)	1 (11.11)	15 (10.2)
Cold, Cough and Fever	34 (24.65)	7 (77.78)	41 (27.9)
Anaemia	37 (26.82)	-	37 (25.1)
Asthama	1 (00.72)	-	1 (00.7)
Ear diseases	8 (05.80)	-	8 (05.4)
Tonsilitis	1 (00.72)	-	1 (00.7)
Injury	20 (14.49)	-	20 (13.6)
Zondice	1 (00.72)	-	1 (00.7)
Teeth diseases	4 (02.90)	-	4 (02.7)
Eye diseases	9 (06.52)	-	9 (06.1)
Guinea worm	1 (00.72)	-	1 (00.7)
TOTAL.....	138 (100.00)	9 (100.00)	147 (100.0)

The figures in brackets show the percentages.

In the course of our interrogation with the villagers it became clear to us that the villagers were not much satisfied with the Medical Officer of the Ayurvedic dispensary and that they had not much faith in Ayurvedic treatment. The villagers complained that the Doctor simply supplied them "dust" (An Ayurvedic mixture). They also complained that the Doctor was irregular in his attendance at the dispensary even though he was residing right in the village. Certain villagers even complained that the Doctor was also doing some other kind of private business. It was also alleged that the Doctor and Peon (Compounder) charged money from the patients. During our visit to the dispensary several times we found that the

Doctor was not present in the dispensary. Several villagers felt that "why the government was wasting money after this dispensary, it should be closed down". It was also argued that when there was a Primary Health Centre situated nearby at a distance of 4 kms what was the use of running this Ayurvedic dispensary at Kathla.

Although the functioning of Primary Health Centre Katwara appeared to be satisfactory the people have lot of dissatisfaction regarding Primary Health Centre. Most of the people complained that the Primary Health Centre Doctor had been paying little attention to patients and he was in habit of making prescriptions without making proper and careful diagnosis.

They told that the Primary Health Centre Doctor simply gave 'water' (mixture was regarded as water) and not injections. During our observations it had been found that the tribals of this area had developed their preferences for certain methods of diagnosis and treatment while seeking medical aid from the allopathic doctor. They preferred to be examined with the help of stethoscope and to be asked a number of questions by doctor. They also attached greater curative value to the injections and then to tablets and mixture in their preference scale. Tribal people of this area also demanded free injection from the Primary Health Centre. This created a complicating situation for the doctor. As Primary Health Centre Doctor reported that due to limited stock of injection he could not provide injection to all

patients, only in serious cases doctor prescribed injection to the patients otherwise he had to prescribe only mixture.

Apart from the Primary Health Centre at Katwara there were two private dispensaries at Katwara. Both private dispensaries had been running well. The qualification of both the Doctors who were running the dispensary was only Gramya Medical Practitioner (G.M.P.) but their medical practices was fairly good. People were generally much satisfied with the Doctor. During our survey we observed that all the time the dispensaries were full with the patients. Our interviews with one of the private Ayurvedic practitioner helped us in analysing the factors that helped him in gaining the confidence of people. The doctor told us that the tribal people very much felt satisfied when they were asked questions and their bodies were examined with stethoscope. By being examined with stethoscope they derived psychological satisfaction, for they believed that the doctor had paid considerable attention and would have understood the root cause of trouble. Tribals also demanded shots of injection (sui) because injections, they believed, provided immediate relief and offered quick treatment. Thus, this Doctor had adopted method which gave maximum satisfaction to his patients. This helped him considerably in reducing the distance between the patients and himself. He also told the researcher that his daily earning was Rs.70/- to 90/-. During course of observation it had been found that he often gave shots of injection to the patients, and charged Rs.5 to 7 per injection.

SUB CENTRES:

There were seven sub-centres which were under control of Auxiliary Nurse Midwife. There was one Maternity Child Health Centre at Katwara. Beside this, there was two field work Centre which were run by the Field Workers. The state of affairs of all the sub-centres was not satisfactory. There had been of course one difficulty on the part of the Auxiliary Nurse Midwife. They had been alone in each centre and without the assistance of a compounder and a trained Dai it was difficult for each of them to manage the entire affair of the sub-centres by themselves. It was expected that the Medical Officer should pay a visit to these sub-centres once a week to attend to the patients. No doubt, the Medical Officer did use to visit every sub-centre once a week to attend to the patients. As observed the only job the Medical Officer had been doing at the sub-centres has been to take the stock of medicines and signing the registers.

During course of study it had been found that the registers maintained at each sub-centre were mostly incomplete and the information contained was not up to date. The reasons for the deficiency in the recording of registers had been identified. It was stated that it was extremely difficult for the Auxiliary Nurse Midwife to cover the entire geographical area allotted to her, because of the scattered villages, the distances to be covered and lack of transportation facilities. It was observed that the area and number of villages allotted to each Auxiliary Nurse Midwife were too large and unevenly

located. The distribution of the area and the population allotted to each Auxiliary Nurse Midwife appeared unrealistic, so nearly 40 per cent of time of the Auxiliary Nurse Midwife was spent on travelling. At present one helper was to be given to each Auxiliary Nurse Midwife for carrying instrument box but the salary of helper was very meager i.e. Rs.15/- per month.

WELFARE OF SCHOOL GOING CHILDREN:

To combat malnutrition among children of poorer sections the Government of India has started various programmes such as

1. Special Nutrition Programme;
2. Mid-day meal programme;
3. Applied Nutrition programme;
4. Family and child welfare programme, etc.

as short term measures, till the economic conditions of these communities are brought to a satisfactory level.

The special nutrition programme for feeding pre-school children in tribal areas and urban slums was taken up in 1970-71 to cover about 6-8 lakh children in the age-group of 0-3 years. During 1971-72 the benefits of this programme was extended to cover children in the age-group of 0-6 years as well as pregnant women and lactating mothers. At present in Kathla tribal development block in 35 villages feeding centres were serving 1427 children. Mid-day meal programmes

have been going on in almost all the 45 villages in the block. Moreover MTP Centre and Dias Training Programme have been also running through the Primary Health Centre in the block.

CONCLUSIONS:

On the basis of this survey it could be inferred that more and more tribal households now seek medical help when someone in the family suffers from major illness but in case of minor illness of the family members, they normally do not approach Primary Health Centres or any private medical practitioner. In case of major illness, the tendency is to look for allopathic Doctors and get help from them even if the patient has to travel a long distance. It also indicates that tribals of this region have been taking advantage of Primary Health Centres to a certain extent. About the knowledge of the factors causing their illness most of the patients expressed almost complete ignorance as such there is a strong need for providing health education. No doubt, the curing of diseases is part of the health programme but equally important is to keep the tribals healthy, the programme of making them conscious about the environmental sanitation and bodily cleanness. This being a matter of vital concern should get utmost priority.

The Primary Health Centres have been in existence for the last 12 years, but so far its utilisation of this facility by the tribals is concerned it has been rather poor. These peripheral health services have a battery of paramedical personnel like basic health workers, malaria workers, vaccinators, auxiliary nurse midwives, family planning workers, who are supposed to pay domiciliary visits regularly in all the villages of the block. According to their job descriptions Medical Officers of the Primary Health Centres are also supposed to make regular periodic visits to the sub-centres. In spite of all that, a good percentage of people have been found to be unaware of the existence of these services. Awareness and use have been rather limited to the villages where Primary Health Centre or sub-centres were located. People living in peripheral villages are either unaware of these services or find it difficult to reach the health centres because of communication difficulties and distance.

Image of the Primary Health Centre has also not been found upto the mark, the factors concerned are mainly non-availability of medicines and injections. Those who have utilised the services of Primary Health Centre (60.5 per cent), majority belonged to the villages where Primary Health Centre was located or from the villages located within the radius distance of 2 kms. Only 40 per cent of the total beneficiaries belonged to other villages who used these services. Most of the patients attending health centres were dissatisfied. The main reasons for dissatisfaction were, as indicated earlier

the non-availability of medicines and injections at the Primary Health Centres/sub-centres. Another factor responsible for dissatisfaction was the impersonal and unsympathetic behaviour of the Medical Officers at Primary Health Centres. The tribals also resented the fact that the Medical Officer was not staying right at the centre even when the government has provided him a quarter. Due to these reasons it prompted them to go to the private practitioners. The reason for not using Primary Health Centre, which was mentioned mostly by the respondents from the peripheral villages, was the inconvenience of reaching to the Primary Health Centre. Distance from the Primary Health Centre proved to be a formidable deterrent for the people living in remote villages in not using the services of the Primary Health Centres. Most of the people residing in villages where the sub-centres were located and in the villages other than the sub-centre's villages who had never used the services mainly because they were not aware of the existence of these sub-centres. Some people also thought that sub-centres were only meant for family planning and maternity services. Most of the tribal people have shown dissatisfaction over the working of the sub-centre's services, the main reason was that 'the medicines or treatment provided at these centres do not give any relief'. This is quite understandable as there is no trained medical personnel placed at the sub-centres. Most of the times there is Auxiliary Nurse Midwife or a Dai posted at these centres who is not qualified to give treatment for the ailments and she is also not provided with any stock of medicines except a meagre quota of Apc, Fersolate, vitamins and sulpha tablets, etc.

On the basis of this survey, it can be safely concluded that unless we improve the availability of medicines and injections required by increasing the budgets of Primary Health Centre, there is very little scope for improvement in the rate of people's satisfaction and utilisation of services. Non-availability of medicine and injections was a factor responsible in Primary Health Centre irrespective of whether the doctors behaviour was good or bad and this definitely needs attention in planning for the future.

The real problem in the tribal areas is also that of provision of medical facilities. Doctors are reluctant to serve and stay right in the tribal villages. Unless some incentives are given to the medical personnel to serve in the tribal area, the problem will continue to be serious one. The problem is big. Its solution requires bigger efforts on this front.

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