CHAPTER I

INTRODUCTION AND REVIEW OF LITERATURE

In the international conference on Primary Health Care, jointly organised by the WHO and UNICEF in Alma Ata, USSR in September 1978, the following decision was taken:

> Health, which is the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, is a fundamental human right and the attainment of highest possible level of health is a most important social goal whose realisation requires the action of many other social and economic sectors in addition to health sector.

The Government of India is a signatory to the Alma Ata Declaration and has also signed the South East Asian Health Charter with the WHO for achieving the goal of health for all by 2000 A.D. The goal set by WHO (1981) is as follows:

> The attainment by all citizens of the world by the year 2000 at a level of health that will permit them to lead a socially and economically productive life.

This mighty goal stems from the knowledge that today, hundreds and millions of people in the world suffer from poor health.

According to Roy, S. (1983), The Director of the National Institute of Health and Family Welfare,

> The fundamental objectives of the State and National Health Plans should be to organise and provide universal primary health care and medical services to all sections of the society with special attention to the needs of those living in tribal, hilly and remote rural areas.

This statement indicates the recognition of the fact that the difficult-to-reach population such as tribals are on the

priority list of the Indian Government for catering to their health needs.

The Tribal Situation in India

India has the largest tribal population compared to any other single country in the world. There are about 550 tribes and sub-tribes in different parts of the country classified as 'Schedule Tribes' (Srikant, 1972).

Desai (1980), points out that the tribal populations belong to one of the following categories:

1. Tribal communities or those who are still confined to the original forest habitats and follow the old pattern of life.
2. Semi-tribal communities or those who have more or less settled down in rural areas and have taken to agriculture and allied occupations.
3. Accultured Tribal Communities or those who have migrated to urban or semi-urban areas and are engaged in modern industries, vocations and have adapted modern cultural traits.
4. Totally assimilated tribals in the Indian population.

The problems of the tribal population belonging to various categories are qualitatively different and demand different solutions. On one hand, a small privileged section has been emerging as a result of the advantages of special privileges, education, land owning or other factors, while on the other hand, the vast bulk of the tribals are being hurled into the

ranks of the lowest, toiling, exploited classes of the contemporary Indian society.

Special programmes and movements are launched in the name of the tribal people, but in reality they fail to cater to the specific needs of the tribals belonging to the specific category of the classification mentioned earlier.

The Government of the Indian Union has launched various projects for tribal welfare. The principal among them are:

1. A number of multipurpose blocks for the tribals for their intensive development.
2. Training-cum-production centres and subsidies for the development of cottage and village industries in tribal areas with a view to providing them with employment.
3. Colonization of tribal setting, of the tribals who are practising shifting cultivation on land.
4. Educational facilities- scholarships, free-studentships and other educational aids.
5. Establishment of tribal cultural institutes for studying the various cultural problems affecting tribal life.
6. Reservation of posts in Government services for the tribals.
7. Enactment of regulation acts to counteract exorbitant rates of interest of money lenders.
8. Establishment of the office of the Commissioner for schedule castes and scheduled tribes for the enforcement of the safeguards provided for the tribals in the

constitution, and for the evaluation of various welfare schemes.

According to Desai (1980[78]), the findings of the reports of the Commissioner for the scheduled castes and scheduled tribes and a report of the study team on social welfare for welfare of the backward classes are as follows:

1. The benefits of the schemes mostly accrued to the vocal section of the population only.
2. Failure of the employment exchange in providing jobs to a number of educated and uneducated tribals was enrolled in the register.
3. Failure of the tribal research institutes in playing a functional role in bringing about the coordination of research with the formulation of welfare planning.
4. Persistence of exploitation of the tribals by money lenders and contractors.
5. Total failure at the training-cum-production centres in either providing successful training or even functioning as production units, thus resulting in the wastage of money.
6. Meagre provision of cultivable land with other facilities in setting the tribals.
7. Red-tapism, lack of coordination among different departments resulting in the lapse of grants and ultimately supply of material etc.

The above observations reveal the superficial and uncoordinated nature of the aid provided to the tribal population.

Besides, it is not only enough to base the programmes on general trends and characteristics of the tribals, it is essential to conduct a baseline survey to assess the needs of specific tribal group to make the programme relevant and meaningful.

While thinking about the needs of a specific tribal group, the most vulnerable seems to be young children. It is well recognised that infants and preschoolers are very vulnerable to health hazards and therefore should be paid due attention, while planning and implementing health services. As we have already reviewed the tribal situation in general, it would be worthwhile exploring the health status of tribal children and what is being done for them.

Factors Affecting Health Status of Tribal Children

It is indeed tragic that every child cannot be provided with even the basic requirements to ensure healthy growth and development leading to a productive and satisfactory adult life.

Fertility and mortality are key indicators of the health status of a population. The birth rate according to the statistical profile of the Government of India (1985) is 35/1000 population and death rate is 12.3/1000 population. However the infant mortality rate is 120/1000. These fitures indicates that India still faces the problems of both high birth rate and high infant mortality. It is listed in the UNICEF report (1984) under 'very high infant mortality countries'. Further according to the report, 30 per cent of the infants in India are both with low birth-weight (1979) which is the second

highest i.e. only next to Bangladesh. The health status of the tribal children is likely to be even poorer.

The results of studies in tribal areas indicate that the health and nutritional status of children are affected by various factors.

Gupta and Bhandari (1973), conducted a nutritional survey of 1061 tribal and non-tribal rural preschool children around Udaipur and revealed widespread malnutrition. Thirty per cent of children had one or more nutritional deficiency signs. PCM was the most common deficiency. Severe marasmus and Kwashiokar were observed in 7.3 per cent and 2.1 per cent of the population respectively. Vitamin A deficiency was observed in 11.3 per cent tribals and 5.1 per cent non-tribal preschool children. Factors such as prolonged breast feeding, delayed and faulty weaning, poor maternal health, recurrent infections, lack of medical facilities and lack of health education were considered responsible for these problems.

In another study by Luwang and Singh (1981), PEM was studied amongst 300 Tangkhul hill tribal underfives at Manipur. It was found that 42.67 per cent of PEM was prevalent and the highest incidence was during the second year and the lowest in the first six months. This emphasizes the need for introducing supplementary feeding along with breast feeding as the breast milk is not sufficient especially during the second year.

A study by Prema (1982), in Kerala, on dietary habits of a tribal population, revealed the following factors as related to health status.

1. Low literacy rate.
2. Only 7 per cent of the tribals consumed three meals a day, while 42 per cent consumed one meal a day.
3. Pulses, vegetables etc. were only occassionaly consumed.
4. No special food was given during pregnancy, lactation of preschool period.
5. Boiling was the common method of cooking.
6. Tribals in general, were not in the habit of following hygienic methods.
7. They were ignorant about the importance of drinking safe water.
8. During illness, majority of the families sought treatment from 'witch' doctors.

In Kinwat Tehsil of Maharashtra, a food consumption study was done by Ingle, Pawar and Wankhede (1982). The analysis revealed that except for cereals and millets, the intake of all food items was much less than those recommended by ICMR (1971). Feeding habits of infants revealed that they were breast fed till 16-20 months and only later strachy foods were provided as supplements. The study further demonstrated the lack of proper facilities for drinking water, particularly from the month of November and December. The water was contaminated and caused water borne diseases eg. diarrhoea, jaundice and amoebic dysentry. Moreover children were not immunised and this resulted in major health problems and extensive growth retardation. Anthropometric studies revealed that only 10-18 per cent of the preschool children had normal weight for their

age, while mild and moderate undernutrition was noted in 75-80 per cent of the children.

Dogramuci (1979), in his article, 'Key stone of the community world health' emphasises the contribution of the family unit to child health and considers nutrition, the reduction of infant and maternal mortality, better antenatal and delivery care, integrated programmes in family planning, and immunization as priority needs.

All these studies bring out the necessity of educating the tribal parents besides providing them the services. Factors such as faith in 'witch' doctors, lower literacy rate, desire for having large family due to high infant mortality rate are responsible for under-utilization of the various health programmes.

Recognizing the health needs of children from deprived areas, the Government of India has launched various welfare programmes.

Programmes Concerning Young Children

A brief historical review of the development of children's programmes in India is presented by Baig (1980). Only the ones which have any relevance to the present discussion are presented here.

Since independence, with the introduction of the strategy of planned national development, India resolved to focus primary attention on the child. Unfortunately, the allocations for child development programmes have been very inadequate compared to the requirements.

In 1952 the Indian Council for Child Welfare was formed, the first national organization to mobilities voluntary activity in every state in all aspects of children's needs. In 1953, the Central Social Welfare Board was formed which initiated the child care programmes and projects such as rural balwadis. Children have benefited from programmes in other social service sections such as education, health, nutrition, water supply and housing.

The 'minimum needs' programmes, particularly, includes services which benefit children from disadvantaged sections of society. Nutrition programmes such as mid-day meals, applied nutrition projects and supplementary nutrition programmes were also started.

It was in the third year plan that the child welfare activity adopted a more regulated and coordinated plan. The basic premise of this plan was to train man power at every level, for which the earlier plans had indicated an urgent need. This was especially important with India's vast religious, caste and ethnic differences. Demonstration projects were set up in each state covering an administrative block to integrate all services for children from birth to adolescence.

The Fifth Five Year Plan saw the emergence of an important new package of Integrated Child Development Scheme (ICDS) in urban slums, rural and tribal covering children below six years, nursing and expectant mothers. Each urban and rural project covers 17,000 children, whereas a tribal project covers

a lesser number on account of lower population density in these areas.

The already existing Primary Health Centre catered to the population's health needs by having one PHC for every 100,000 people, one multipurpose health worker for every 5000 people and one ANM for every 10,000 people. They are redesignated as health workers male and female posted at PHCs and sub-centres.

Besides the programmes mentioned earlier, the health inputs are delivered through the Community Health Worker scheme (CHW) launched on 12th October 1977. This scheme aims to take health care to every village through trained workers recruited from the villages themselves. It is hoped there will be one CHW trained in maternal and child care, environmental sanitation and first aid treatment for every 1000 people.

~~According to Grant (1984)~~, "The Primary Health Care has been defined as "essential health care based on practical, scientifically sound and socially acceptable methods and technologies made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self determination". UNICEF and WHO (1978).

The Alma Ata Declaration has stated that atleast the following should be included in Primary Health Care:

1. Education of the people concerning prevailing health problems and methods of preventing and controlling them.
2. Promotion of food supply and proper nutrition.

3. Adequate supply of safe water and basic sanitation.
4. Maternal and child health care and family planning.
5. Immunization against major infectious diseases.
6. Prevention and control of local endemic diseases.
7. Appropriate treatment of common diseases.
8. Provision of essential drugs.

Considering the first point regarding education of the people, it is also necessary to involve them in various programmes right from the planning stage to evaluation of the programmes. Unless they participate with full realisation of their role, the services may remain underutilised as Khalakdina (1979), points out, "The major concern of parents is the survival and physical well being of the child especially in the underprivileged sections of the society. To cater to this need, Primary Health Care infrastructures do exist. But why do these people avoid seeking their services? Change is a threat because of the lack of predictive success".

Besides the lack of predictive success, other reasons put forward by the working group on health constituted by the Planning Commission, Government of India (1980) are:

1. The emphasis on health is on curative measures rather than preventive, promotive, curative and rehabilitative aspects of health care.
2. Orientation, training and retraining of health and family welfare personnel at different levels are not properly organised.

To sum up, the major reasons for underutilisation of services seem to be lack of predictive success, health care mainly

encompassing curative aspect, lack of parent education and lack of appropriate training of health functionaries to orient the parents for participating in the health care programmes.

UNICEF (1984) has outlined four major areas in which health functionaries can encourage the parents of young children to fight malnutrition and infection.

1. Child growth moniteering.
2. Oral rehydration therapy.
3. Expanded programmes of immunization.
4. Promotion of breast feeding and timely weaning.

Unless the health functionaries are trained appropriately in imparting health education to tribal parents, the objectives may not be achieved fully. It is necessary fo review some of the successful and unsuccessful programmes.

Programme Assessment with Focus on Training of Health Functionaries

Success or failure of a given programme will depend on many variables. As the focus of the present project is on the training of health functionaries a few relevant experiences and researches are presented to highlight the points such as how the functionary perceives his role, what problems does he face and what content and approaches would be suitable for his pre-training programme.

Gopaldas (1980), reviewed comprehensive health and nutrition programmes in India and while discussing SNP, points out that the unsuitability of foods and delivery, chaotic distributions where the food supplements are carried home are some of

the major factors responsible for the failure. To this can be added some other problems:

1. The workers not being able to explain and motivate people.
2. When the food stuff gets exhausted in between, the worker has to supply it, for which neither transport nor finance is provided immediately.
3. Villagers complain about worker consuming the food stuffs for his/her own family.
4. The worker is expected mainly to motivate and bring eligible couples for family planning surgical camps.
5. Regular check ups/anthropometric measurements are not done to motivate parents.

In an All India Survey of Family Planning by Khan and Prasad (1983), it was revealed that family planning workers do not devote their time effectively in extension work and their coverage as well as contact rate with eligible couples is very low. It was found that 89 per cent of the couples, or their family members, had never been visited by any health or family planning workers. The nature of the messages given by the health functionaries who visited the target groups were as follows:

Area covered	Use of specific method	Pursuade for sterilization	Talked about family planning and incentive for operation
Rural all India	35.00%	27.90%	15.50%
Rural West zone	22.90%	24.90%	25.20%

The percentages in other columns such as information on family welfare or other methods of family planning were less than 10.

The reasons for the failure of these programmes can be that the training of health functionaries, both pre-service and in-service seem inadequate in imparting health education to the parents. More specifically, the content is saturated with theories related to health, nutrition and family planning, but surprisingly there is very little or no weightage on parent education, though it is a major responsibility in their job charts.

Some of the voluntary efforts seem to have produced satisfactory outcomes in health projects. Jamkhed and Dahanu in Maharashtra and Lalitpur in U.P. are examples of few successful programmes where the health services are fully utilised.

Arole (1976), points out one of the main reasons for the success of the Jamkhed comprehensive Rural Health project as follows: "In addition to MCH services and Primary Health Care the Visiting Health Worker (VHW) collects vital statistics of the village, and assists in surveys, and follow ups of leprosy and tuberculosis patients. Her most important function is to bring about change in attitude, remove taboos, and to prepare the minds of the people to accept remedies which are easily and cheaply available". This indicates involvement of the field level functionaries in an integrated manner and in the total project. Further, it reflects the type of training they must have received to be able to change the attitude of people.

In another community health project in Lalitpur, U.P., Bachan (1976) suggests methods of reinforcement of control. Two of which seem relevant for the present discussion are:

1. The VHW's knowledge will be tested every month and if a VHW is progressing dissatisfactorily, he/she will be replaced.
2. During the clinic hours VHWs will be given continuous training and will be tested regularly on their abilities to diagnose and treat patients, and to judge when to refer patients to a doctor.

Shah (1976), based on the experience of training the field-level workers in Dahanu Taluka, Maharashtra, comments, "It was experienced that these workers have limited retension capacity and hence it is recommended that training be for a short period and should be supplemented and reinforced with built-in and ongoing training.

A Family Nutrition Improvement Programme was conducted in Indonesia (1981). They trained the local health centre staff in five major areas—growth of children, children's food, eye health, anemia and diarrhoea. For each subject, worker was helped to develop skills and is equipped with a copy of communication materials such as flip charts, base scale, growth charts, oral rehydration solution, Vitamin A capsules, etc.

The above mentioned studies indicate that, the role of field level worker is crucial in serving as a link between the target group and the supervising staff. An important item on the list of duties to be performed by a field level worker is that of providing better health education to parents. This demands more intensive training with emphasis on developing skills in communication and in imparting relevant information to the target group on areas related to health and welfare in an effective

manner.

Singh (1975), Joint Secretary, Ministry of Home Affairs, Government of India, placed emphasis on the selection and training of the functionaries - "The implementation aspect of the programme calls for the most urgent attention. We are capable of turning out excellent blue prints but the process of their conversion in the field is fraught with the highest dilution factor. The right personnel does not appear in the appropriate jobs. The training aspect does not seem to have received adequate attention. The field worker should be in tune with the correct ideas of tribal welfare, should know the tribal needs, and understand their psychology. Unless this happens and the attitudes change, hundred and crores worth of plans will be of little avail".

The review clearly indicates a need to prepare a module for training health functionaries in the areas of health, nutrition and family planning with relevant methods and approaches especially useful in a tribal set up to educate the parents. The idea is that ultimately a young tribal child will enjoy better health as a result of his/her caretakers being better oriented.

It is also essential to have a better coordination in terms of role expectations by the supervisors and the role performance by the field level worker so that ultimately the children and parents needs are catered to effectively and appropriately.

Shrikant (1973), while discussing the issue as to who should be trained states that ideally the training programme should be at three levels.

17

1. At the national level for top administrators, these administrators should be from Government and voluntary organizations all over India.
2. At the regional level for Block Development Officers, supervisory officers, presidents of panchayats etc.
3. At the field level for Gram Sevikas, Health Visitors, Auxillary Nurse Midwives and Primary School teachers.

It is beyond the purview of the present project to conduct training programmes at all the three levels; an attempt was made to combine at least two levels - field level health functionaries and their supervisors. However, for the administrators the recommendations are prepared and presented on the basis of the evaluation of the project. The present project was planned with the following two sets of objectives. For the field level health functionaries such as MPHW, ANM, HV and BEE the objectives were as follows:

Broad Objective

The plan, implement and evaluate an in-service training programme for the health functionaries associated with services and scheme for young children in tribal areas.

Specific Objectives

1. To re-orient them to the priorities, respective roles and duties in their projects.
2. To help them identify gaps and overlaps in the duties of various functionaries.
3. To equip them with necessary knowledge in the specific areas of their work.

4. To help them identify the skills and competencies necessary for carrying out their jobs.
5. To acquant them with the role of supervisors in providing guidance while evaluating.
6. To enable them to discuss and find solutions/alternatives to the professional and personal problems related to their own job performance.

The second group consisted of supervisors such as M.O., P.H.C., M.S. and CDPO of ICDS. The objectives set for their training were:

Broad Objective

To plan, implement and evaluate in-service training programme for the supervisors associated with services and schemes for young tribal children.

Specific Objectives

1. To increase their level of insight into the framework of services in specific areas concerning welfare of young children.
2. To enable them to discuss the problems related to the Government and voluntary welfare agencies in terms of coordination and supervision.
3. To furnish them with the knowledge of effective supervision and guidance.
4. To help them to trace the scope of supervision and find appropriate strategies for the same.
5. To identify and strengthen their own role as a link between the planners and the field level workers.

19

An introduction and review of relevant researches along with the objectives of the present project (in-service training programme of the health functionaries) is included in this chapter. However, it is essential to know how the present project was derived from the larger project, entitled "Utilisation of health and welfare services in Panchmahals with special reference to infants and preschoolers". In the second chapter, the highlights of the results/findings of the earlier studies of the total project are presented. The third chapter deals specifically with the design of the present project and the fourth chapter presents the evaluation and outcome of the in-service training programme.