CHAPTER-6

ACCESS TO HEALTH CARE SERVICES

The British Administration, in the earlier phase of their rule was primarily concerned with law and order of the northeast region only. The British policy kept Arunachal Pradesh isolated and totally cut off from the rest of India. This region suffered with lack of road communication, absence of regular administration. So, the facility of modern medicine did reach to these people lately. The British administration paid little attention to medical care of the people. Besides, the tribal people living in the state had their own medical system for treatment. They depend on their traditional priest or medicine man who plays a major role in the sphere of health care. But the tribal people sometimes want modern medical help when traditional method of cure became ineffective. This has been mentioned in the tour dairy notes of captain Nevil, Political Officer in 1914. Nevil (1983:289) in his note expressed," A very great want in all parts of the Tawang country and even throughout the whole of the North East Frontier is treatment for the sick. Everywhere I went a great cry was for the Doctor and medicine. While among Monpa, Captain Kennedy was constantly surrounded by people suffering from real and often imaginary diseases and clamoring for medicine. I am very sure the establishment of dispensaries will form a very large factor in gaining confidence of the people and a peaceful settlement of the country."

Before Independence, modern health facilities in Arunachal Pradesh were found limited, only in few administrative centres and were serving only limited populations. The people of rural and interior areas of Arunachal Pradesh were dependent on traditional medicine.

They can get access of Doctors in their villages once in a blue moon when he used to visit them along with the Political Officer. Elwin(1964:14) stated," the only opportunity for the people at large to get some medical aids were the occasions when doctors went to the interior areas as members of the expeditionary parties or with the political officers on their column tours. The lack of medical facilities in the past has meant that there have been hundreds, thousands of unrecorded tragedies, the sick living out their days in pain and misery unnoticed in their little huts. I think of the children with soar and inflamed eyes, their little limbs distorted by rickets, their stomachs grossly swollen with enlarged spleens. I have seen many people shockingly disfigured by untreated burns."

After Independence, health status of the people of Arunachal Pradesh has started improving gradually. The incidence of morbidity and mortality has declined, and the length of the life of the people has increased. In Post-Independence Period Government have taken much effort to eradicate problems of health in Arunachal Pradesh. Prior to Independence there were only 13 medical units located mainly in the areas now in Assam. Few medical units were located in Arunachal Pradesh; even those established were located in the plains areas or foothills. In the hilly areas especially in the upper regions where a majority of the population lived, there was no health unit. In the initial period after Independence the health service remained very poor inspite of the Government's efforts to expand it rapidly. In 1952-53, there were only 48 doctors serving in the entire Arunachal Pradesh, an area of more than 83 thousand sq km. A Doctor had to extend services, on average, in an area of 1.74 thousand sq km and to a population of more than six thousand. The number of medical units, which include hospitals, dispensaries etc were 52 in 1952-53. A total of 101 health personnel- doctors, compounders and midwives- staffed 52 medical units catering to the health services in Arunachal Pradesh during 1952-53. Gradually the numbers increased. (NFHS-3)

6.1 HEALTH SERVICES IN WEST KAMENG DISTRICT

The first dispensary was opened at Rupa in the present Kameng district in 1943 where only curative medical services were provided. Later on number of health units were established in the district. Till the year 1951, only curative medical services were provided. Curative and preventive services were clubbed together in the year 1956 for providing better

medical services to the people of the district (Shyam, 1997). During the period from 1943 to 1957, a number of health units as shown in the following table were opened in Kameng area:

Table 6.1

Number of health Units (1943-1957)

SL No	Location of Health units	Year of opening	Remarks(if any)
1	Rupa	1943	
2	Dirangzong	1944	
3	Foothills	1948	Foothills Unit closed in 1957
4	But	1949	
5	Tawang	1951	
6	Charduar	1952	
7	Bomdila	1952	
8	Seppa	1952	Mobile Health Unit of Seppa and Bameng were amalgamated with the respective Health unit in 1955
9	Bameng	1952	
10	Buragaon	1952	The Ayurvedic Dispensary at Buragaon was converted into a health unit in 1958
11	Kalaktang	1953	
12	Tawang	1953	
13	Chako	1957	
14	Lumla	1957	Mobile Health Unit became a regular Health unit in 1957

Source: District Gazetteer of India

Since 1956, both curative and preventive medicines were made available in the dispensary. Although the medical facilities to the people of the rural areas of the then NEFA began, the overall administrative control rested with the Inspector General of Civil Hospital, Assam, later redesignated as Director of Health Services, Assam. The Civil Surgeon posted at Sadiya was in full charge of the medical facilities provided in the NEFA. Due to non-availability of suitable road communication, the existing arrangement appeared to be

unsatisfactory and therefore a separate office designated as Chief Medical Officer with headquarters at Pasighat was created in 1956. The office was shifted to the state capital at Shillong and redesigned as the Director of Health Services.

The district of Kameng in those days was almost unapproachable. However, an office of District Medical Officer with headquarters at Bomdila was created in 1955. The task of the Medical Officer was not easy as the people were initially reluctant to accept modern treatment of diseases. It was the duty of the Medical Officer, besides treatment of diseases; to create awareness among tribal people regarding hygiene and sanitation which are requisites for a healthy life. But gradually the tribal people were accustomed to medical treatment and showed willingness to approach doctors for their ailments. In course of time medical facilities were extended to very interior areas like Rupa, Dirang Zong, Foot hill areas, Tawang, But, Charduar, Bomdila, Seppa, Bameng, Buragaon, Kalaktang, Chako, Bumla, by establishing mobile health units.

In view of people's dependence on traditional medicine based on roots, creepers, herbs etc, the Political Officer of Bomdila took steps to open an Ayurvedic dispensary at Buragaon in 1952. The villagers took keen interest on less expensive Ayurvedic medicine. But when Allopathic medicine proved to be quick relief medicine, the people started accepting to modern medicine which led to the upgradation of the dispensary to a health unit in 1958.

The data on health showed considerable improvement in life expectancy, provision of modern health care facilities since Independence**.** The modern health infrastructures were constructed and the health personnels were trained up to bring better result in healthcare system. But still a lot remains to be done in this respect. Several recent reports on the Indian Health delivery clearly pointed many loop holes. (World Bank Report, 1995; Planning Commission, 1996) These studies have documented many serious problems with respect to the accessibility, efficiency and quality of the health delivery system. They have also made several policy recommendations to alleviate these problems.

India's Health care delivery works in a network of hospitals, primary health care centers, and Community health centers, dispensaries and special facilities financed and managed by

the central and State Government. People can avail these facilities either free of cost or at nominal charges.

Although Health occupies a very important sector and is considered as a basic right of every individual, but the rural areas provide a very dismal picture of the health scenario. People living in the interior tribal areas, do not get proper government medical facilities or private medical practitioners. Thus they have to depend on services provided by local traditional practitioners and faith healers. It is very unfortunate that the government investment in the public health sector in India is continuously declining. Because of the inadequacy of Public Health facilities it has been estimated that only less than 20 percent of the population in the country seek out patient department services and less than 45 percent of the people seek indoor treatment to avail the services from public health facilities. (National Health Policy,2002)

There has been constant effort to provide health services:

- Accessible to the people.
- Availability of service.
- Socially acceptable.
- Affordable by most of the people

The delivery of primary health care is the most important objective of health care system, and thus it forms an integral part of our total health care system. Primary health care system is regarded as one of the main instruments for developing the country's human resources and to accelerate the pace of socio-economic development of the country by improving the quality of life. Primary health care provides essential services to all citizens and it is easily accessible at a cost, which the community and citizen can afford. In rural areas of our country, primary health care facilities are provided through a network of integrated health and Family welfare delivery system. Primary health care programme have been restructured and reoriented from time to time for attaining the objectives of National Health Policy and the goal of "Health for All by 2000 AD". This has led to the opening and expansion of rural health infrastructure through establishing a number of Sub Centres, Primary Health Centres, Community Health centre or rural hospital, training of dais, village health guides, multipurpose workers, Auxiliary nurses/ mid wives, lady health

visitors etc. Accordingly, emphasis has been given in achieving the following "National Norms" for the provision of health services in the rural areas.

Table 6.2

' NATIONAL NORMS 'for the provision of health services in the rural areas

1	At least one trained Dai	For each village
2	One trained village Health Guide	For each village/1000 population
3	One Sub Centre	For 5000 population in Plain areas/ for 3000 population in tribal hilly and backward areas.
4	One Primary Health Centre	For every 30,000 population in Plain areas/ for 20,000 population in tribal hilly and backward areas
5	One Community Health Centre	For 1 to 1.20 lakhs population serving as a referral institution for four PHC For 80000 population in tribal hilly and backward areas

To provide the health service facilities in the doorstep, attempt has been made for the introduction of 'Referral system' as shown below:

REFERRAL SYSTEM

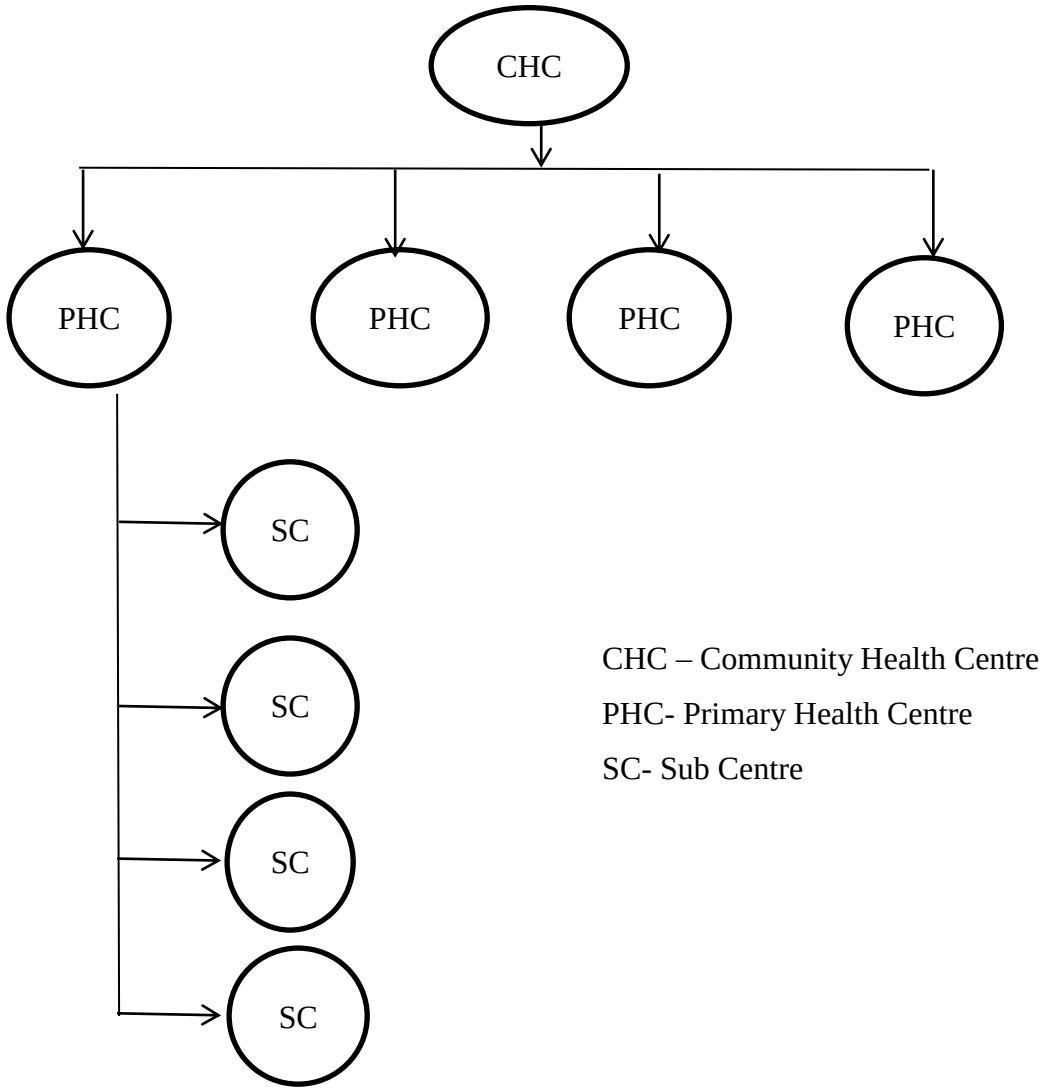

Fig-6.1: Diagramatic representation of the Referral system.

To achieve the national target and objectives, the various state Governments in the country have been making lot of efforts to provide the health facilities through proper planning. Expansion of the preventive and curative primary health service, development of medical education and training, control and eradication of communicable diseases, Family Welfare including maternity and child health programme etc, have been regarded as the major objectives of the health sector of the states and Union Territory in our country since the beginning of the Five Year Plans in India. Many communicable diseases like small pox, cholera, malaria, leprosy etc have been eradicated, reduced or controlled to some extent in our country. Moreover, it results bit improvements in Health related statistics, quality and

quantity of human lives and so on. In addition to these, the number of doctors and other para-medical personnel including nurses, mid-wives, health workers, trained dais, ASHA workers etc were appointed leading to rapid increase in their numbers .

Thus, it has been seen that the government is formulating policies for the improvement of the health sector since the time of Independence. Different policies and measures were taken up for strengthening the health sector. The infrastructure in the Health care sector of rural areas has started. In Arunachal Pradesh the three tier system of Health care based on the population norms fulfills the required number.

The tribal populations of Arunachal Pradesh that mostly live in the rural areas require special attention in the case of health care. In Arunachal Pradesh, the Primary Health Care infrastructure rests in three pillars – SC (Sub centre), PHC (Primary Health Centre) and CHC (Community Health centre).

After Independence, Government has taken much effort to eradicate health problems of Arunachal Pradesh. No health unit existed in the hilly areas especially in the upper regions where a majority of the population lived. In Post-Independence period , Government has been successful in eradicating many health problems in Arunachal Pradesh. The table No 6.3 gives an overview of the increasing numbers of health infrastructure during Five Year Plans.

Table 6.3

Establishment of Sub-Centres, Primary Health Centre and Community Health Centre during Five Year Plans

	Sixth Plan (1981-85)	Seventh Plan (1985-90)	Eight Plan (1992-97)	Ninth Plan (1997-2002)	Tenth Plan (2002-2007)	Eleventh Plan (2007-12)	Twenth plan (as on 31st March,2017
Sub-centres	55	155	223	273	379	286	312
PHC	0	24	45	65	85	97	143
CHC	0	6	9	20	31	48	63

Source- Rural Health Statistics, 2017

From the table no 6.3 it is seen that the Health infrastructure started developing rapidly in Arunachal Pradesh and the number is increasing in every Five Year Plan**.** As on Twelfth Plan, there are 312 sub-centres, 143 Primary Health Centres and 63 Community Health Centres functioning in Arunachal Pradesh.The number of sub centre are less in Eleventh Plan .It was 286 and in Tenth plan it was 379. The reason is due to upgradation of Sub centres to Primary Health Centres, which is evident from the fact that the number of Sub Centres reduced and number of Primary Health Centres increased.

As per the population coverage norms of establishing health infrastructure in Hilly/tribal areas, Arunachal Pradesh has fulfilled the criteria and there is just 2 percent shortfall in Sub centres in this regard. It is to be mentioned here that Arunachal Pradesh has 587 Sub centres, out of which 312 are functional as per Directorate of Health and Family Planning, Government of Arunachal Pradesh. The table No 6.4 shows the picture.

Table 6.4

Number of Sub-centre, Primary Health Centre and Community Health Centre

Item	Required	In Position	Shortfall	% shortfall
Sub-centre	318	312	6	2%
Primary Health Centre	48	143	Surplus	-
Community Health Centre	12	63	Surplus	-

(Source: RHS Bulletin, March 2017, M/O Health & F.W., GOI)

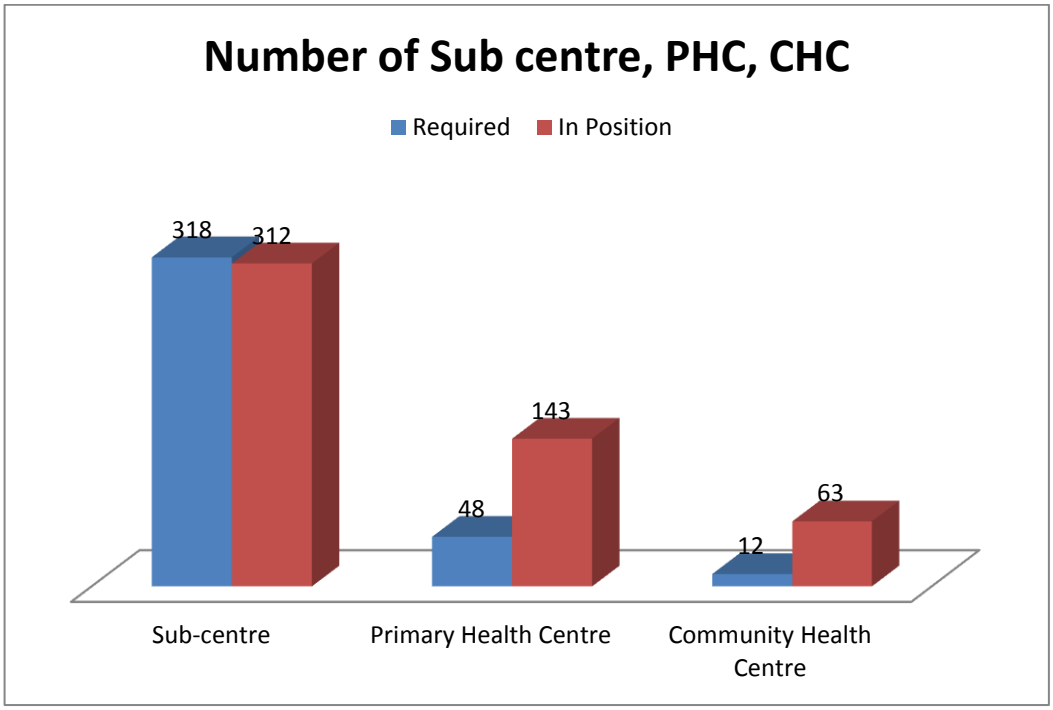

Figure 6.2: Bar Diagram showing the comparision of required and in position number of Sub-centre, Primary Health Centre and Community Health Centre

The health institutions are located in various districts of Arunachal Pradesh. The table below shows the distribution of health centres in the whole state. It is noted that the number of Sub Centres in some districts are not as per the required norms. As per the National norms for every 5000 population in Plain areas/ for 3000 population in tribal hilly and backward areas, a Sub Centre should be there.

Table 6.5

Districtwise Health Infrastructure of Arunachal Pradesh

Sl no	Name of District	Population	Density of population	SC	PHC	CHC	SDH	DH
1	Anjaw	21167	3	7	7	5	0	1
2	Changlang	148226	32	22	8	5	0	1
3	Dibang	8004	1	3	1	0	0	1
4	East Kameng	78690	19	26	11	3	0	1
5	East Siang	99214	28	22	10	4	0	1
6	Kra Daadi	NA		8	7	1	0	0
7	Kurung Kumey	92076	15	11	6	2	0	1
8	Lohit	145726	28	11	5	2	0	1
9	Longding	NA		5	3	3	0	1
10	Lower Dibang valley	54080	14	11	6	4	0	1
11	Lower Subansiri	83030	24	31	8	3	0	1
12	Namsai			11	4	3	0	0
13	Papumpare	176573	51	22	14	3	0	2
14	Siang	NA		20	4	1	0	0
15	Tawang	49977	23	9	6	2	0	1
16	Tirap	111975	47	7	8	1	0	1
17	Upper Siang	35320	5	13	2	4	0	1
18	Upper Subansiri	83448	12	32	15	5	0	1
19	West Kameng	83947	11	18	5	5	0	1
20	West Siang	112274	13	23	13	7	0	1
TOTAL				312	143	63	0	18

Source: RHS, 2018

The table 6.5 shows districtwise health infrastructure of Arunachal Pradesh. It is noted from the table that most of the district have health infrastructure. Three districts- Anjaw, Dibang valley and East Kameng fulfilled the National norms criteria. Lower Subansiri, Upper Siang and Upper Subansiri have more number of Sub Centres than the required. But eleven districts including two district of study- Tawang and West Kameng has less number of Sub Centres. In Tawang district for a population of 49977, there are 9 Sub Centres, 6 number of Primary Health Centres and 2 number of Community Health Centre. For West Kameng, there are 18 Sub centres, 5 Primary Health Centres and 5 Community Health Centre

TABLE: 6.6

Number of Sub centres, Primary Health centre and Community Health centre in Tawang and West Kameng District of Arunachal Pradesh

District	Sub centre		Primary Health centre	Community Health centre
	Functional	Non Functional		
Tawang	Mago	Boghar	Jang	Jang
	Thingbu	Shyaro	Lumla	Lumla
	Thonglang	Khet	Khou	
	Seru	Kharung	Kitpi	
	Rho	Karleng	Mukto	
	Shakti	Mangnam	Zemithang	
	Jangda			
	Lemberdung			
	Tesiharh (Tigor)			
West Kameng	Morshing	Doimara	Kalaktang	Kalaktang
	Mandalapudung	Sange	Dirang	Dirang
	Mukuthing	Nyukmadume	Rupa	Rupa
	Boha	Darbu	Nafra	Nafra
	Salari	Janaching	Bhalukpong	Bhalukpong
	Palazi	Khupi		
	Buragaon	Subu		
	Bichom	New Kaspi		
	Wanghoo	Barchi		
	Jigaon			
	Kamengbari			
	Tipi			
	Ankaling			
	Jamiri			
	Sangti			
	Namsu			
	Jerigaon			

Source: Department of Health & Family Welfare.Government of Arunachal Pradesh

According to the Department of Health and Family Welfare, Government of Arunachal Pradesh, Tawang has 9 fuctional Sub Centre situated in Mago, Thingbu, Thonglang, Seru, Rho, Shakti, Jangda, Lemberdung and Tesiharh. There are also 6 non-functional sub Centres- Boghar, Shyaro, Khet, Kharung, Karleng and Mangnam. .In Tawang district there are 6 Primary Health Centre and 2 Community Health Centre.

In West Kameng district there are 18 functional Sub Centres as mentioned in the table and 6 are non-functional Sub Centres .The functional Sub Centres are Morshing, Mandalpudung, Mukuthing, Boha, Salari, Palazi, Buragaon, Bichom, Wanghoo, Jigaon, Kamengbari, Tipi, Ankaling, Jamiri, Sangti, Namsu and Jerigaon.Though the Sub centres are functioning still they lack facilities. The non - functional are fully closed one. The facilities of the existing sub centres are also not up to the mark. In West Kameng district there are 5 PHC and 5CHC.

In a state like Arunachal Pradesh due to low density of population the presence of required number of health infrastructure doesnot always provide the positive picture.This is because the establishment of Sub Centres, Primary Health Centres and Community Health Centre depends on population norms rather than on area basis. Arunachal Pradesh is large state on the basis of area, but has low density of population and the people live in scattered way. These health infrastructures are less accessible to them as the people living in remote and scattered and hilly terrain find it difficult to avail the health facility.

6.2 ACCESSIBILITY OF HEALTHCARE FACILITY

The infrastructural presence of Health institution only cannot determine the Health development. The accessibility to these health infrastructures is an important point to determine health scenario. Arunachal Pradesh is a hilly terrain state with lot of altitudanal variation. The data reveals the poor accessibility to health care services

Table-6.7

Accessibility of the rural health centres

	Sub centres without all weather motorable approach road	Primary Health Centres without all weather motorable road	Community Health Centres with referral services
Arunachal Pradesh	33.2 %	11.3%	83.33%
India	6.9%	6.6%	88.79%

Source: Bulletin on Rural Health Statistics in India, 2011

In the table 6.7 is seen that when compared with the national level, the accessibility to these health infrastructure is poor. The percentage of Sub centres without all weather motorable approach road is 33.2% which is quite high than national average of 6.9%. . 11.3% of PHC is without all weather motorable roads higher than the national rate of 6.6%. The percentage of CHC with referral services is 83.33% less than the national percentage of 88.79%.

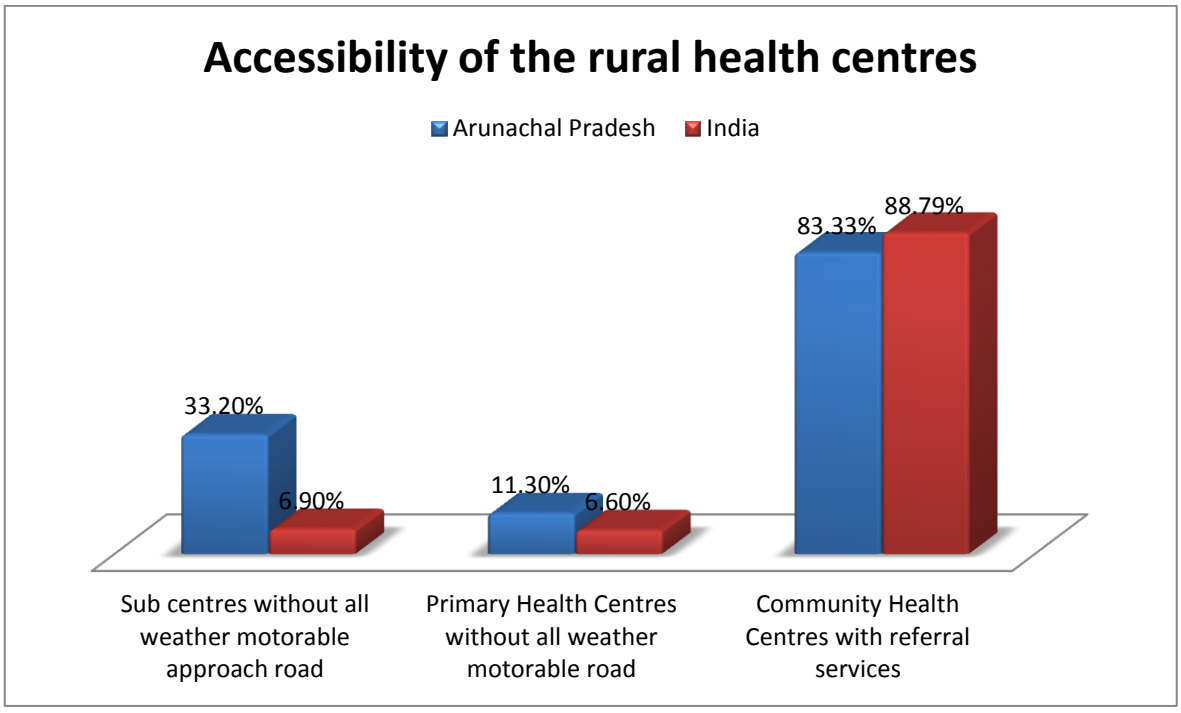

Figure 6.3: Bar diagram showing the Accessibility of the rural Health centres of Arunachal Pradesh and India

Table 6.8

Distance from the nearest health facility of Arunachal Pradesh

Sl no	Health Facility	Within village	Distance from the village			More than 10km
			Within 3 kms	Within 5kms	Within 10kms	
1	Sub Health centre	27.7%	59.1%	67.7%	63.1%	19.3%
2	Primary Health Centre	13.2%	39.6%	45.7%	59.7%	40.7%
3	Community Health Centre	9.6%	28.3%	32.3%	43.8%	56.2%
4	Dist/ Govt hospital	0.6%	12.2%	15.3%	21.0%	79.5%
5	Government Dispensary	3.4%	13.4%	17.8%	23.7%	77.6%
6	Private clinic	3.8%	12.6%	16.6%	24.9%	75.5%
7	Private Hospital	0.6%	8.2%	10.3%	13.8%	86.4%
8	AYUSH Health facility	0.2%	23.3%	25.2%	29.8%	70.4%

Source: DLHS 4

The table 6.8 shows that 59.1 % of Sub centres are mostly located within 3 kms. And 59.7% Primary Health Centres are mostly located within 10kms, 56.2% of Community Health Centre are mostly located more than 10kms distance. The geographically steep, hilly terrain, scattered habitation acts as a barrier in delivering Health facility. Due to the bottleneck in transport for travelling 10kms also, the people face problems to access medical facility.

In reality, however the positive aspect of this impressive spread of infrastructure has got negated by the highly dispersed nature of the populations. (Rao, 1998) The Primary Health Centres and sub-centrs have been so located that the distance to be covered is just around 10 km but the geographical location with hilly terrain, weather condition acts as a major barrier for the utilization of health care services.

Numerous studies of Duggal and Amin (1993), Sunder (1995), Shariff (1995) have indicated that though there are many infrastrucal development but these facilities are mostly nonfunctional or ill functional due to less funding, less staff than required and non - availability or shortages of drugs and essential supplies. Many household surveys consistently report on the quality of these public facilities as one of the reasons why people seek treatment elsewhere.

6.3 FACILITIES AT SUB-CENTRE

The Sub-centre is the first connecting unit between the primary health care system and the community. Each Sub-centre is run by one Auxiliary Nurse Midwife (ANM) and one Male Health worker. The assigned tasks of the Sub centres are creating awareness related to health and diseases and to bring about behavioural change in health and hygiene. It also provide services of maternal and child health, family welfare, nutrition, immunization, diarrhoea control and control of communicable diseases programmes. In Sub-Centres, there are basic medicines for minor ailments are kept. The Ministry of Health and Family Welfare provides 100% Central assistance to all sub-centres in the country since April 2000. As per the figures provided by RHS BULLETIN, 2017, there are 312 Sub Centres in Arunachal Pradesh as on March 2017.

TABLE 6.9

Facilities at Sub-centre

Number of Sub centre functioning	Without regular water supply		Without electric supply		Without All-weather Motorable Approach Road	
	Number	Percentage	Number	Percentage	Number	Percentage
312	134	42.9	144	46.2	118	37.8

(Source: RHS Bulletin, March 2017, M/O Health & F.W., GOI)

In table 6.9 the facilities of the Sub Centre is discussed. It is seen that though in Arunachal Pradesh, there are 312 sub-centres available but 46.2% of Sub Centres are without electric

supply, 42.9% of sub centres are without regular water supply and 37.8% of sub centres are without all weather motorable approach road.

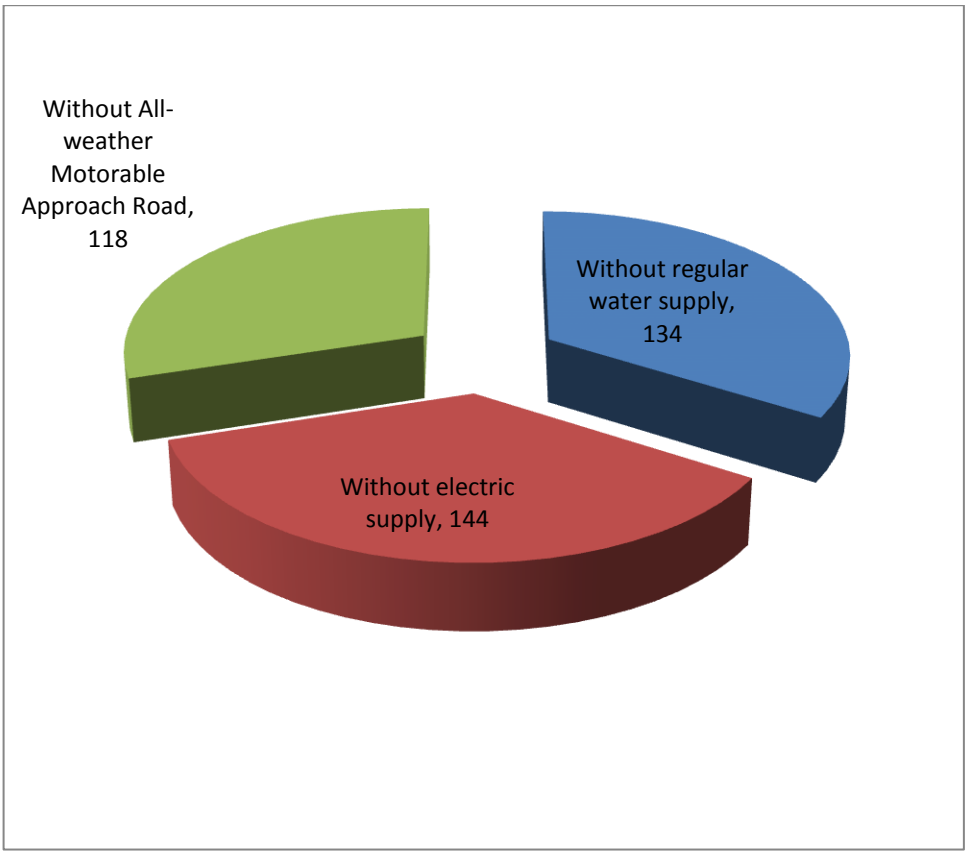

Figure 6.4: Pie diagram to show the Facilities at Sub-centre

6.4 FACILITIES AT PRIMARY HEALTH CENTRE

Primary Health Centre is the first health unit where community can get the access of a Medical officer. The Primary Health Centre is supposed to provide both curative and preventive health care to the rural population. The Primary Health Centre are created and maintained by the state governments under the Minimum Needs Programme. At present, a Primary Health Centre is maintained by a Medical Officer supported by 14 paramedical and other staffs. It acts as a referral unit for 6 Sub-Centres. In Arunachal Pradesh there are 143 Primary Health Care functioning till March 2017.

Although there is some improvement in the infrastructure of health in Arunachal Pradesh as shown in the table No 6.3 but most of these institutions are ill functioning. A look into

the facilities can be had from table no 6.9 available in the Primary Health Centre in Arunachal Pradesh.

TABLE 6.10

Facilities at Primary Health Centre

No of existing Primary Health Care	With Labour room	With OT	With at least 4 beds	PHC functioning on 24X7 basis	Without electricity	Without regular water supply	Without all weather motorable road
143	72 (50.3%)	20 (14.0%)	54 (37.8%)	64 (44.7%)	15 (10.5%)	24 (16.8%)	26 (18.2%)

Source: RHS (as on March 2017)

The table 6.10 shows the pitiable condition of health care institutions. Out of the total of 143 Primary Health Care - only 20(14.0%) has OT, 72(50.3%) has labour room. 64(44.7%) Primary Health Care are functioning on 24X7 basis. Many Primary Health Care lack basic amenities like electricity and water. 26 (18.2%) Primary Health Care out of 143 are without all-weather motorable roads.

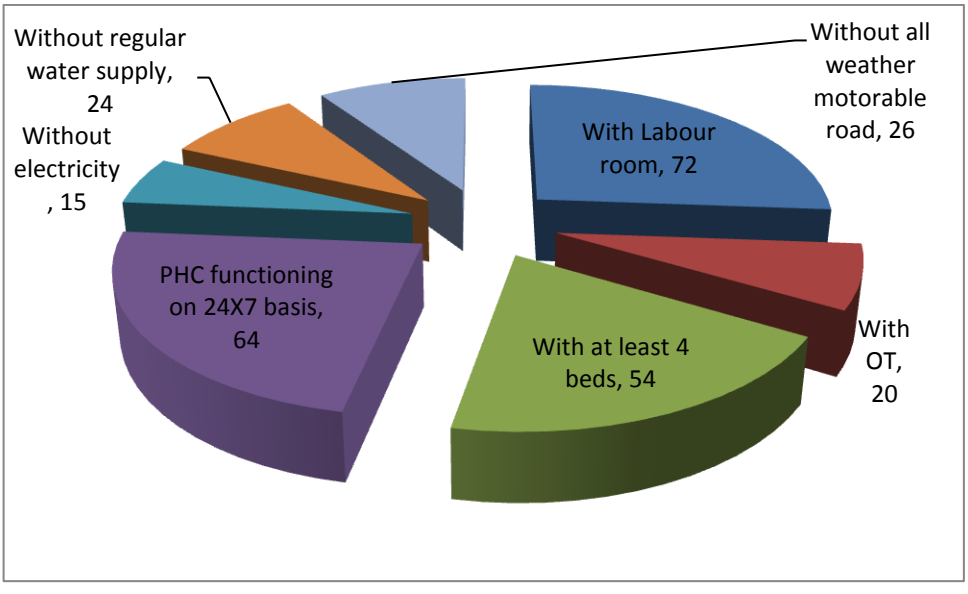

Figure 6.5: Pie Diagram to show the facilities at Primary Health Centre

6.5 FACILITY IN COMMUNITY HEALTH CENTRE

Community Health Centres under the state Government consists of 4 Medical Specialists ie Surgeon, Physician, Gynecologist and Pediatricians supported by 21 paramedical and other staff. It has to be 30 indoor beds with one OT, X-ray, Labour room and laboratory facilities. It serves as a Referral centre for 4 PHCs and also provides facilities for Obstetrics care and specialist consultation. In Arunachal Pradesh there are 63 CHCs functioning till March 2017.

TABLE 6.11

Facilities at Community Health Care

No of existing Community Health Centre	With functional laboratory	With functional IOT	With functional Labor room	With functioning Stabilization unit for new born	With New born care corner	With at least 30 beds
63	50 (79.4%)	29 (46.0%)	57 (90.4%)	21 (33.3%)	48 (76.1%)	13 (20.6%)

Source: RHS Bulletin **(**as on March 2017)

The table 6.11 shows that out of 63 Community Health Centre, only 13(20.6%) numbers of them have 30 beds; 50 (79.4%) have functional laboratory; 21 (33.3%) have functional stabilization unit for new born .

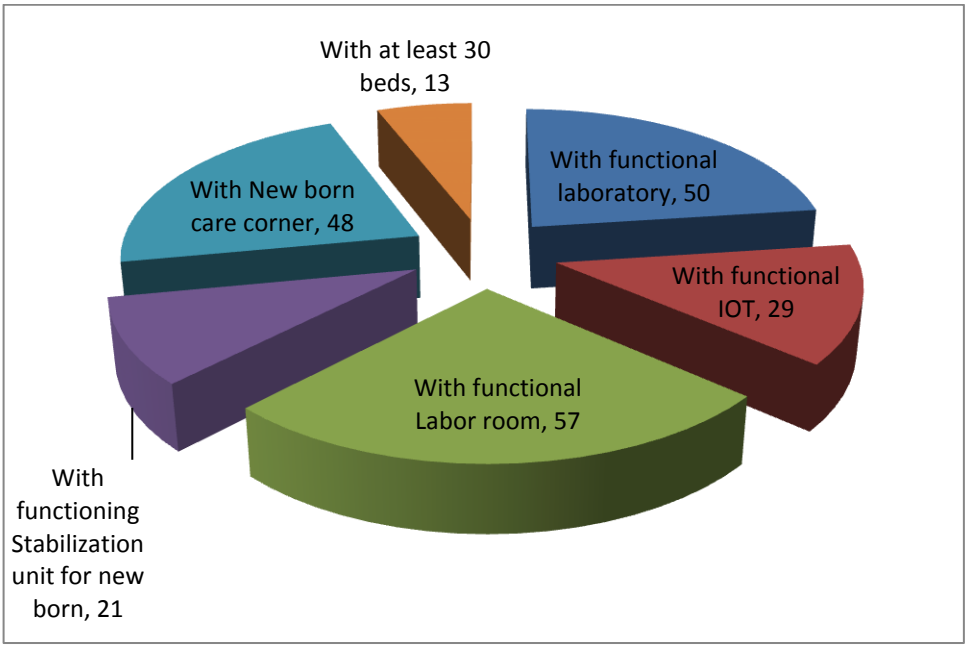

Figure 6.6: Pie Diagram to show the facilities at Community Health Centre

6.6 MANPOWER SHORTFALL

Rural Government health facilities across the country mosthly face difficulties in retaining the regular presence of trained medical professionals. The shortfall of trained medical practioners in rural areas is the key reason for dismal picture of rural health sector. The rural areas are still unable to have access to the services of trained doctors. Studies pointed out that 74% of the graduate doctors serve in the urban areas. (Patel, 2008).

In the state of Arunachal Pradesh also, due to lack of qualified health practioners, there is poor quality of health services. In the initial years after Independence the doctor patient ratio remained very poor. In 1952-53, there were only 48 doctors serving in the entire Arunachal Pradesh, an area of more than 83 thousand sq Km. A doctor had to extend services, on average, in an area of 1.74 thousand sq km and to a population of more than six thousand. In 1952-53, a total of 101 health personnel- doctor, compounders and midwives – staffed 52 medical units catering to the health services in Arunachal Pradesh. After that, more doctors and health personnel were appointed but still there are shortfalls of health personnel.

6.6.1 Manpower in Sub centre:

Table 6.12

Number of Subcentre without Auxiliary Nurse Midwifery or Health Worker

Number of Sub centre Functioning	Without Health worker (Female) / Auxiliary Nurse Midwifery	Without Health worker (Male)	Without both
312	278(89.1%)	166(53.2%)	61(19.5%)

Source: RHS Bulletin, March 2017, M/O Health & F.W., GOI)

Though the numbers of Subcentres has almost fulfilled the required norms but there is acute shortfall of manpower. At the Subcentre level the extent of existing manpower can be assessed from the fact that 278(89.1%) subcentres out of 312 subcentres were without Auxiliary Nurse Midwifery, 166 (53.2%) subcentres were without Health worker (Male) and 61(19.5%) subcentres were without both. This indicates a large shortfall in health workers resulting into poor delivery of health services.

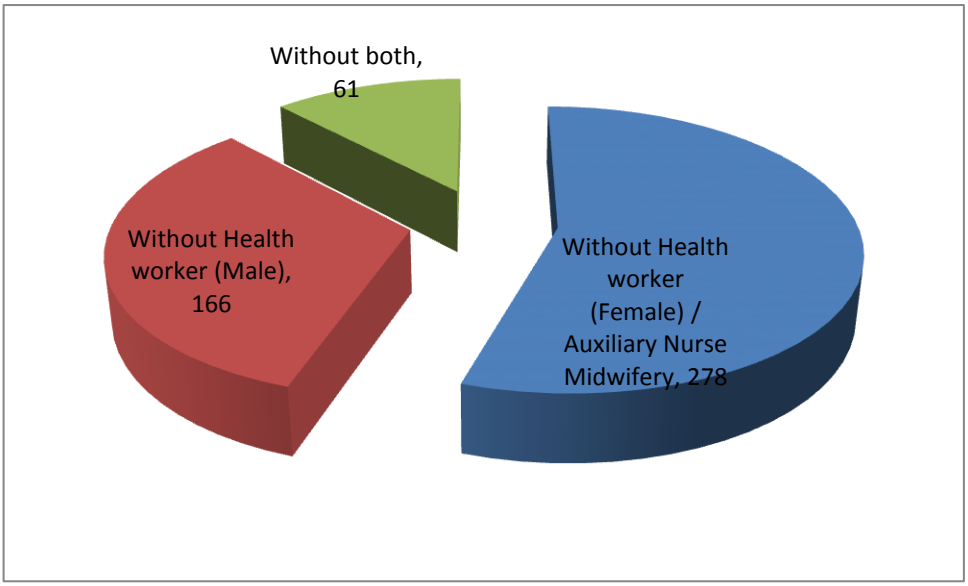

Figure 6.7: Pie Diagram to show the number of Subcentre without Auxiliary Nurse Midwifery or Health Worker

6.6.2 Manpower in Primary Health Centre:

Table 6.13

Number of Doctors / Health Assistants at Primary Health Centre

Health Personnel	Required	In Position	Shortfall
Health Assistant (Female)	143	6	137(95.8%)
Health Assistant (male)	143	81	62 (43.4%)
Doctors	143	122	21(14.7%)

(Source: RHS Bulletin, March 2017, M/O Health & F.W., GOI).

In Arunachal Pradesh, the dearth of trained doctors, Health Assistants (both male and female) is acutely felt in PHC as shown in table 6.13. The highest shortfall is seen among Health Assistant (Female). The required strength of Health Assistant (Female) is 143 but in position there are only 6. For Health Assistant (male), the number of shortfall is 62 (43.4%).

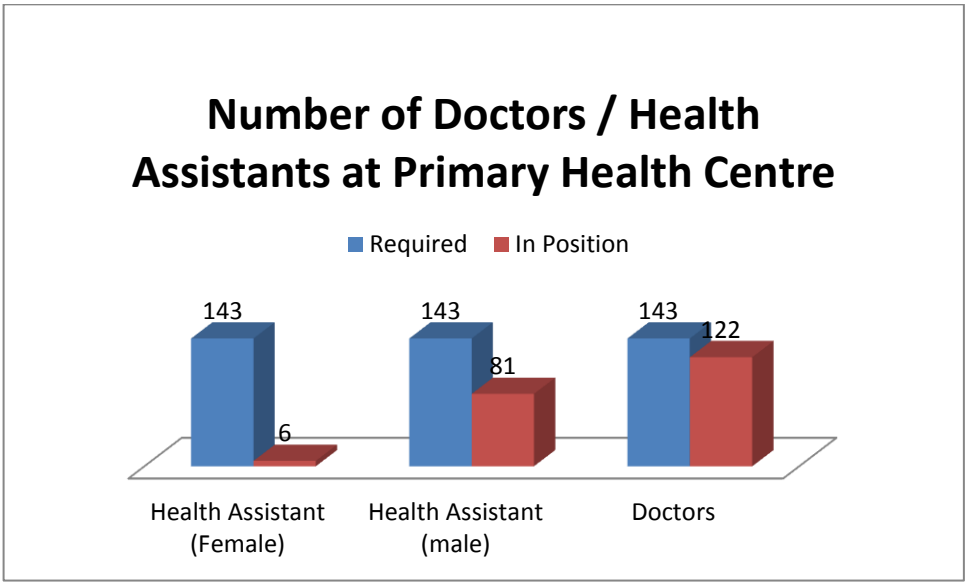

Figure 6.8: Bar diagram showing the
Number of Doctors / Health Assistants at Primary Health Centre (Required and in position)

6.6.3 Manpower in Community Health Centre:

The situation of Commumnity Health Centre is not different from the above. Though there are 63 Community Health Centres in Arunachal Pradesh in place of 12 Community Health Centres as required as per population norms, but the dearth of specialized doctors and radiographers have proved the ill functioning of these Community Health Centres.

Table 6.14
Number of Doctors / Health Assistants at CHC

	Required	In Position	Shortfall
Gynecologist	63	3	60 (95.2%)
Physician	63	1	62(98.4%)
Pediatrics	63	0	63(100%)
Surgeon	63	0	63(100%)
Radiographer	63	7	56(88.9%)

Source: RHS Bulletin, March 2017, M/O Health & F.W., GOI

From the table 6.14 it is seen that there is not a single pediatric in any CHC of Arunachal Pradesh. There is only 3 Gynecologist, 1 Physicians only whereas 63 such specialists are required against each group.

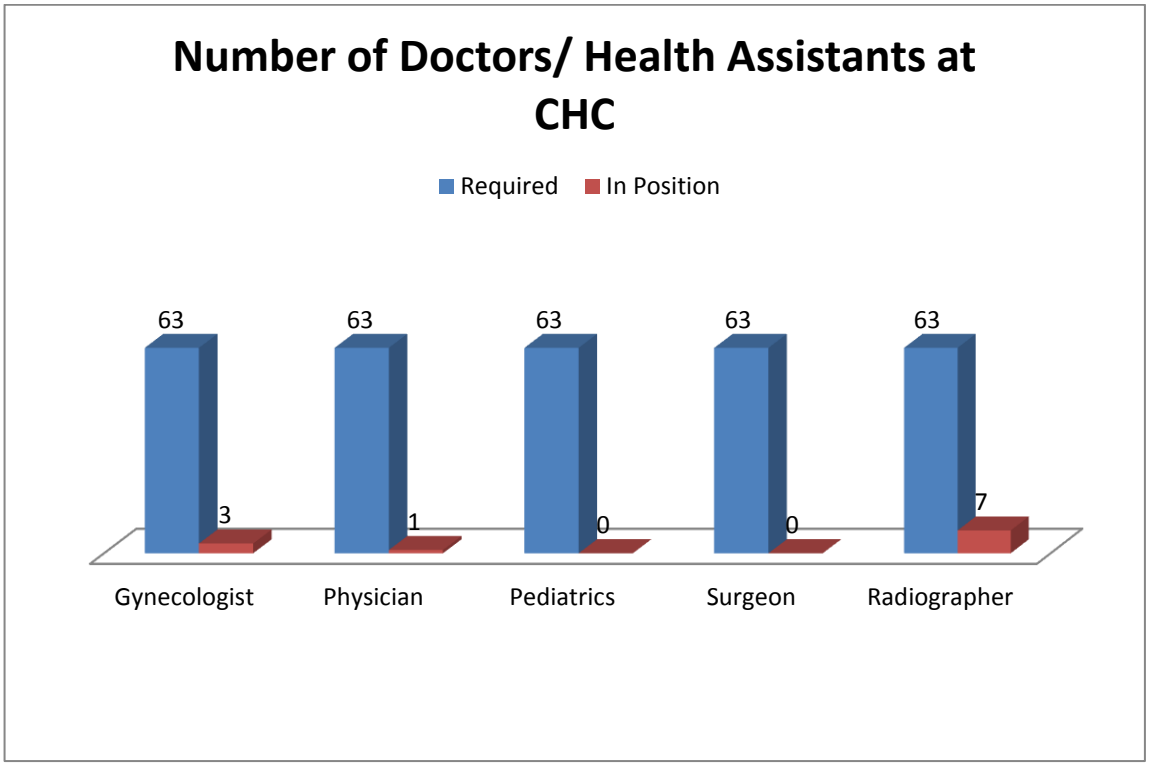

Figure 6.9: Bar diagram showing the Number of Doctors / Health Assistants at CHC

Table 6.15
Number of Technicians / Health Assistants

Technician/ Health Astt	Required	In Position	Shortfall
Pharmacist	206	89	117(56.8%)
Laboratory Technicians	206	123	83(40.2%)

(Source: RHS Bulletin, March 2017, M/O Health & F.W., GOI)

In the table 6.15, it is seen that there is shortfall of technicians/ Health assistants than the required number.There is shortfall of 117 (56.8%) posts of Pharmacist in place 206 posts. Even there is shortfall of 83(40.2%) in Laboratory Techicians.

From the above discussion, it is evident that the Modern health facilities cannot meet the requirements of the people of Arunachal Pradesh. Though the required number of health infrastructure is according to population per health institutional infrastructure norms but in reality service provided by these health institutions is ill functioning due to non availability of manpower.

6.7 PRE VALENCE OF VARIOUS DISEASES

Data provided by National Family Health Survey-IV, DHLH-2 and Human Development Report reflected the existing health scenario of Arunachal Pradesh. Infant Mortality Rate of Arunachal Pradesh is 36% which is higher than the all India rate (34.0%).

Table 6.16

Infant Mortality Rate

	IMR	Rural	Urban
Arunachal Pradesh	36	38	23
India	34	38	23

Source: SRS Bulletin, September 2017

Prevalence of various diseases also reflects the status of health of the people. However the availability of health services in semi urban and accessible settlements has reduced drastically the case fatality rate of this disease. As per Human Development Report, 2003 the death toll from Malaria was 12.20 percent, the highest among all diseases. The killer diseases as per the report are dysentery, diarrhea and gastroenteritis which together accounted for 11.22 percent of all deaths during 1998-2001. Another killer disease is influenza responsible for deaths and the fourth is tuberculosis. Among the children, various diseases like anemia, Acute Respiratory Infection (ARI) are prevalent in Arunachal Pradesh. The percentages of prevalence of these diseases are more or less equal in Arunachal Pradesh and India.

Table 6.17

Prevalence of Anemia in children age 6-59 months

	Mild	Moderate	Severe	Anemia
India	26.3	40.2	2.9	69.5
Arunachal Pradesh	27.1	29.1	0.8	56.9

Source: NFHS

In table no 6.17 it is seen that the Anemia rate is 56.9% which is lesser than the national average of 69.5%. Of the three types of anemia moderate anemia rate is 29.1% in Arunachal Pradesh against National level of 40.2%. But Arunachal Pradesh has mild anemia 27.1% which is more than National rate of 26.3%

Table 6.18

Prevalence of Acute Respiratory Infection

	Percentage of Children under 5 with Symptoms of ARI	Percentage Treatment was Sought from a Health Facility or Provider
India	5.8	69.0
Arunachal Pradesh	6.7	43.6

Source: NFHS

The treatment of disease is very important parameter for health survey. The above table shows that in case of ARI, the people of Arunachal Pradesh sought treatment mostly from non-institutional agencies.In Arunachal Pradesh the percentage of Children under 5 years with symptoms of Acute Respiratory Infection is 6.7 % which is higher than national average of 5.8%.The treatment sought in health facility for ARI is 43.6% against national rate of 69.0%. One of the reason is that in case of Acute Respiratory disease the tribal people of Arunachal Pradesh mostly depend on traditional treatment.

6.8 IMMUNIZATION

Immunization is an important aspect for good health of children. In 1986, the Government of India started the Immunization Programme ‘Universal’ and to control some diseases through vaccination .There has been some improvement in full vaccination coverage in Arunachal Pradesh. The data indicate that despite the progress made, Arunachal Pradesh is lagging behind in this regard and a large proportion of children who received some early vaccination dropped out of the program before receiving the recommended dosages of vaccinations. The table 6.18 shows the percentage of children receiving all basic vaccination.

Table 6.19

Immunization Rate 12-23 months- Fully immunized with BCG, Measles and doses of OPV and DPT

	Urban	Rural	Total
Arunachal Pradesh	44.2	36.4	38.2
India	63.9	61.3	62.0

Source: NHFS-IV

The table 6.19 reflects the scenario of child immunization. The immunization rate of India reveals that the coverage in Arunachal Pradesh is very lower. In Arunachal Pradesh the percentage is 38.2 even much lower than the national average (62.0%).

There are inter districts differentials in the coverage for different vaccinations, and for children receiving all vaccinations and those that did not receive any vaccination at all.

Table 6.20

Fully immunization coverage of children (Aged 12-23 months) by Districts of Arunachal Pradesh

Percentage	Name of Districts
40 and less	1.East Kameng 2.Upper Siang 3.Anjaw 4.Changlang 5.Tirap
40.1-50	1. West Siang 2. East Siang 3. Lohit
50.1-60	1.Tawang 2. Upper Siang 3. Kurung Kumey 4. Dibang Valley
More than 60	1.West Kameng 2.Papumpare 3.Lower Subansiri 4.Lower Dibang Valley

Source: DLHS-4

From the table 6.20 it is seen that five districts (East Kameng, Upper Siang, Anjaw, Changlang, and Tirap) of Arunachal Pradesh have less than 40% fully immunization rate. The district of Tawang has less than 60% immunization rate. But West Kameng along with other three districts (Papumpare, Lower Subansiri, Lower Dibang Valley) has more than 60% fully immunization rate.

NFHS-IV report found the reasons for non -receipt of vaccination are- most of the mothers of children were unaware of benefits of immunization , do not feel the need of vaccination, place and time inconvenient, fear of side effects, no faith in vaccination. It can be said that lack of awareness and place and time inconvient leads to incomplete vaccination among the children. The two district of study are in better stage in respect to fully vaccination Programme.

6.9 ANTENATAL CARE INDICATOR

The National Population Policy, 2000 adopted by Government of India reiterates the Government's commitments to safe motherhood programme within the wider context of reproductive health. Among the national socio-demographic goals for 2010 specified by the policy, several goals pertain to safe motherhood that 80 % of all deliveries should take place in institutions by 2010, hundred percent deliveries should be attended by trained personnel and maternal mortality ratio should be reduced to a level below 1000 per 100,000 live births.

Table 6.21

Antenatal Care Indicator

Percentage distribution of women (15-49age group) who gave a live birth in past 5 years preceding the date of survey by ANC

	ANC total	Doctor	ANM/Nurse/ Midwife/LHV	Dai/TBA	Anganwadi worker/ ICDS worker	Community health/village health worker	ASHA	Others	No ANC
Arunachal	57.9	45.4	12.5	0.1	0.1	0.1	0.7	0.4	40.8
India	79.3	58.8	20.4	0.3	2.5	0.1	1.2	0.1	16.4

Source: NHFS-IV 2015-16

From the table 6.21, in Arunachal Pradesh 57.9% of the women receives Antenatal Check up during pregnancy which is less than the national rate of 79.3%. It is seen that the 40 % of the women in Arunachal Pradesh donot at all takes ANC which is quite higher than the country's rate of 16.4%. But districtwise there is lot of variation in receiving antennal check up.

Table 6.22

Antenatal Care Indicator in Different Districts of AP

Sl no	Name of Districts	Any ANC	Government health facility		Private Health facility
			Health facility	ICDS/ Mobile unit	
1	Tawang	61.7	96.7	1.1	9.6
2	West Kameng	70.1	95.0	0.8	8.3
3	East Kameng	48.1	87.5	0.0	18.3
4	Papumpare	77.9	73.9	0.8	32.2
5	Lower Subansiri	79.3	83.5	0.0	23.1
6	Upper Subansiri	56.2	90.5	0.5	14.2
7	West Siang	71.3	89.8	0.0	15.7
8	East Siang	62.9	92.7	0.6	8.8
9	Upper Siang	28.2	97.0	1.5	6.7
10	Dibang Valley	45.6	97.7	0.0	12.5
11	Lohit	62.8	95.3	0.0	5.7
12	Changlang	63.3	93.2	0.0	8.9
13	Tirap	43.4	90.5	0.0	19.0
14	Kurung Kumey	46.9	73.1	0.0	34.6
15	Lower Dibang Valley	68.8	95.7	0.0	6.8
16	Anjaw	52.1	89.9	0.0	10.1`

Source: DHLS-4

Table 6.22 indicates the antenatal coverage in Arunachal Pradesh that ranges from the highest of 79.3% in Lower Subansiri to the lowest of 28.2% in Upper Siang. Almost in all districts, except Upper Siang more than 40% of women got some kind of antenatal check up for their last child births. The studied district of West Kameng and Tawang has high ANC rate of 70.1% and 61.7% respectively.

The extent of utilization of health facilities for antenatal check ups was much higher in Government Hospitals than that of private health facilities. The basic reason of such is non availability of Private health centres in Arunachal Pradesh.

6.10 INSTITUTIONAL DELIVERIES

Institutional delivery is another important area of maternal health care. As per NFHS-4 report poor access to health service is one of the major reasons for less percentage of people opting for institutional deliveries.

Table 6.23

Institutional Deliveries

	Urban	Rural	Total
Arunachal Pradesh	81.5	44.2	52.3
India	88.7	75.1	78.9

Source: NFHS-IV 2015-16

The table 6.23 has focused on the percentage of institutional deliveries In Arunachal Pradesh only 52.3% opt for institutional deliveries. The major reason as cited in the NFHS report for such situation is the non-availability of health facilities.

Table 6.24

Percentage of Institutional Deliveries in different Districts of Arunachal Pradesh

Districts	Percentage of Women who had Inst. Delivery	Percentage of women who had delivery at Home	Home Delivery Assisted by Skilled Persons
Tawang	37.0	62.3	4.0
West Kameng	49.4	50.3	2.6
East Kameng	34.0	59.4	2.2
Papumpare	73.9	22.6	0.8
Lower Subansiri	66.0	33.3	4.4
Upper Subansiri	43.4	56.0	0.6
West Siang	58.8	40.6	0.8
East Siang	50.2	48.9	2.5
Upper Siang	30.1	66.2	4.6
Dibang Valley	52.4	47.2	3.5
Lohit	44.9	49.4	6.5
Changlang	52.3	46.6	0.0
Tirap	30.0	68.7	6.4
Kurung Kamey	31.6	66.3	4.3
Lower Dibang Valley	60.4	38.4	2.7
Anjaw	35.0	61.9	5.1

Source: DLHS-4

The table 6.24 has focused on the percentage of institutional deliveries in different districts of Arunachal Pradesh. Compared to the institutional deliveries, deliveries at home are more common in all the districts of Arunachal Pradesh.Out of 16 districts, eight districts (Tawang, West Kameng, East Kameng,Upper Subansiri,UpperSiang, Tirap,Kurung Kamey, Anjaw) births are by delivery at home is more than 50% . In all the districts, more than half of the births took place at home. Percentage of home deliveries which were attended by a health professionals in all the districts range from 2% to 7%.

Table 6.25

Reasons for not Using Govt Health Facilities

		Reason for not using				
	Percentage of households that donot use health facilities	No nearby facility	Facility timing not convenient	Health personel often absent	Waiting time too long	Poor quality of care
Arunachal Pradesh	12.3	50.5	18.8	11.6	30.9	32.6
India	55.1	44.6	26.4	14.8	40.9	48.0

Source: NHFS-IV 2015-16

The table 6.25 shows that due to non-availability of near by health facility (50.5%), poor quality of services (32.6%) and waiting too long (30.9%) are the main reasons for not using health facilities in Arunachal Pradesh.

It seems that in Arunachal Pradesh though the health infrastructure exist as per population norm,data provided by National Family Health Survey-IV, DHLH-2 and Human Development Report viewed the state has poor health conditions in the country. It is evident that a large percentage of people donot avail the modern health care facilities. This may be due to the fact that the faith in traditional medicinal practices is very strong in the state apart from infrastructural ill functioning of modern health institutions.

6.11 AVAILABILITY AND ACCESS TO HEALTH CARE IN THE VILLAGES

The nature and extent of acceptance of a particular type of Health Care System by a cultural group depends on a number of factors. It is commonly accepted that the tribal communities are relatively more tradition bound and prefer their traditional systems. But, notwithstanding the importance of socio-religious beliefs, practices and attitude as well as the economic

background, availability of the different types of healthcare services in the areas and the degree of the people's accessibility to the same also play a significant role in this regard.

The prevailing health practice among the Monpas of the 5 surveyed villages can be categorized as (i) Traditional, (ii) Tibetan system of Medicine and (ii) Modern. Modern health institutions are public ones. Keeping these facts in mind, the resource available in the micro-field is discussed.

In the sample villages the situation is not very different. The access of the Monpas of the 5 studied village to health care through these health resources are quite defunct.

In the study it has been found that out of the five sample villages, only 2 villages have medical sub-centres. It was found that in these sub centers the health facilities were inadequate. These sub-centres do not cater the needs of the village and nearby villages. None of the five villages has doctor either government or private. For doctors they visit the nearest PHC. Out of the 5 surveyed villages, only 2 villages, namely, Senge and Sangti have Sub-Centres. The Seru village under Tawang circle though does not have sub-centre but the PHC is very close by to the village.

Usually the people of the three studied villages have to come to CHCs located in Dirang in case of any ailment. The people of Seru village also have to go to Tawang District Hospital for treatment as there is no sub-centre in their village. Dirang is the nearest town with reference to Sangti, Senge and Khassow. The people during field survey expressed dissatisfaction on the functioning of modern health institutions.

The utilization of health center was depends upon the ability to deliver services. The dissatisfaction towards public sector was largely because of non-availability of medicines or lack of proper attention. Deficiencies persist with respect to access, affordability, efficiency, quality and effectiveness of health services.

Table 6.26

Reasons for not using Modern Health Services

Reasons	No of respondents
No medicines/facilities	54
Doctor/staff not available	76
Lack of faith/confidence	32
Inaccessibility / Facility timing	86
Lack of information	2

The table 6.26 shows the major reasons for not using Modern health services. The major reasons cited by the respondents for not using Modern health services are inaccessibility/ facility timing, non-availability of doctor/staff and lack of medicines in the health institution.. Though the distance of modern health centres are not very far, but hilly terrain and non availability of proper transport facility, act as a barrier in accessing health facilities. The other condition for non availing modern Health facility are hilly terrain, population in dispersed habitation, poor communication, and non- availability of required manpower etc.

It may be mentioned here that the sub-centers provide vaccination only. Most of the people in the sample villages complained that doctors in the Hospitals only prescribe medicine and they have to buy most of the medicines from outside by spending money from their own pocket. The people further complain that there is non-functional testing facility in the CHC, Dirang as a result of which people have to visit District Hospital, Bomdila which is far away from their locality; and the lack of transportation makes the situation worse. In-door facility or emergency hospitalization in PHCs is not very feasible. Though the infrastructure exists in most areas, it is grossly underutilized because of poor facilities, inadequate supply of medicines, and insufficient manpower.

Several studies have pointed out that in different parts of the country, most of the HCs and sub-centers are underutilized and inaccessible due to several reasons like non - availability

of service providers and inaccessibility of services due to transport and communication, especially in tribal areas etc.

Table 6.27

Distance of the villages from nearest Medical Services centres

Sl No	Name of the village	Distance of Medical sub-centre	Distance of Primary Health Centre /Community Health Centre
1	Sangti	Within village	10 km
2	Khassow	2 km	12km
3	Senge	Within village (Non functional)	21km
4	Seru	Within village	20 km
5	Kitpi II	1 km	Within village

From the table 6.27 though it appears that the distance of the nearest sub-centre ,PHC and CHC are not very far but due to the hilly terrain , climatic condition and non-availability of transport system it is very difficult to admit the patients to the nearest health services. Even if the health care facility is not present in the village, one can reach easily to the nearest health care services through good communication facility. In the sample village health care facility, both private and public, are not accessible inadequate transport services in case of emergency. Morever communication during rainy and winter season is very difficult. In all these villages there is no means of public transport. Thus though the distances of the nearest health care facilities are not very far, due to poor road connectivity and inadequate communication services, the people face lot of hardship to have access to the available health facility.

One of the reasons of the people of the sample villages approaching traditional medicine man is the poor condition of modern health services. Although the families have faith in modern medical treatment, at the same time, they have a strong faith in traditional health practioners like *Bonpu* and *Lama* etc. In case of any ailment they first approach to the

traditional practioners. If they donot get relief then they approach the modern medical treatment. In most cases when the condition of the patient gets critical the patient is then shifted to the hospital. The doctors of Dirang Community Health Centre informed that in such cases it is difficult on their part to give treatment to such patients. Sometimes the patient dies on the way to hospital.

It was found that the people of the sample villages believe that the Modern medical facility cannot provide adequate treatment and services to them. The people of the sample area complained that sometimes the doctors are not available at the time of emergencies. After travelling from their village they reach Community Health Centre and the non-availability of doctor creates more problems. On the other hand, the traditional practioners are mostly available in the village and they get quick treatment in case of emergency. This reveals one of the reasons of depending on traditional medical system.

Lack of infrastructure like roads, transportation and communication facilities have also created lot of problems for the people of the villages in availing health care services. In case of emergency, particularly at night it is very difficult to find a doctor in their locality. Because of the poor transportation facilities, it is also difficult to take the patient to the nearest hospital. To reach hospital and poor communication links also stands as an obstacle in receiving health care services for the people. Because of such difficulty, the people are reluctant to go to the hospital.

To sum up, the chapter reveals the pathetic state of affairs of modern health care facility provided by the Government. This compels people to stick to their traditional health care services. Both the affordability of and accessibility to health care facility are difficult for the people of the studied villages. Various reasons have been cited from different studies for such situation. The establishment of public health institution on the basis of population norms doesnot serve the purpose of better health care services for small populous state like Arunachal Pradesh. In Arunachal Pradesh the density of population is 13 per sq km and considering the geographical terrain the people's accessibility to modern health institution is low. Here, for providing health services decentralised planning involving community will ensure better health services. Mobile units with health workers may be provided for better services for sparsely distributed population.

The traditional medicine practioners are not only filling up the gap left by the inadequate modern health care services but is also playing an important role in service provision. In order to ensure universal access to health care, it is important to recognize the knowledge and skill of these traditional medicine practioners and work towards intregating all systems.