

# Dynamics of Health Care Services in Reru Village of Arunachal Pradesh

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## Abstract

Health care services like other basic services are comparatively poor in rural areas and especially in the remote tribal areas. The same is true for Arunachal Pradesh and particularly in Reru Village. Data showed that the acute illness and chronic illness were higher in Lower Subansiri District while injury incidences were less. Further, it showed that the disease of respiratory system were slightly higher, while the disease of cardiovascular system and persons suffering from tuberculosis were lower in the district. The nutritional status of children below 5 years showed that in the state 21.4% were suffering from wasting, 39.8% from stunting and 27.3% from underweight. Anaemia status for both children and adults, proportion of pregnant women who received any antenatal check-up and who had full antenatal care were better in the district. Likewise, the situation of institutional delivery and delivery attended by skilled health personnel were also much better in Lower Subansiri than the state. Findings showed that there is only one health care centre available in the village, i.e. a Sub Health Centre (SC). It reflects the poor health care system in the Reru village. Findings also showed the non-availability of medicines and drugs in the village, as there is no pharmacy or medicine seller in the village. Relating to Health care utilization in Reru Village, it was found that 10% of the respondents were using modern health care system only, no one was using only traditional system, while 90% of them were using both modern and traditional health care system.

**Keywords:** *Health care service, Nutritional status, Health care utilization, Awareness.*

## Introduction:

Health is not only a state of physical and mental well being, but also in true sense it involves the socio-cultural and environmental factors. The complete health either of a person or of a group is an artifact of the relationship between these factors. Every culture develops its own system of medicine in order to treat diseases in its own way. Accordingly, treatments of diseases vary from culture to

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culture. To comprehend health and health-related problems in a proper perspective, it is indispensable to look into the social-cultural issues, economic dimensions, environmental aspects and political system, which is more applicable in the context of tribal people particularly living in the rural areas, like in Arunachal Pradesh. Health care system is the administration of the people, institutions and resources to meet the health needs of the people. There is a wide variety of health systems around the world.

Tribal societies, throughout the world, have their respective systems of medicines. Their concept and attitudes towards the disease and pharmacopeia are different. They also impose prohibition on some specific diets during illness and convalescence (Paul & Jain, 1998). A study in Tamil Nadu described that the village folk's medical conceptions and health practices are coherent and live, and make health by the people operational under lived conditions. Medical lore includes both knowledge and practices and the dynamic relation between the two is central to its understanding (Sujatha, 2009). Tribal and remote communities are more susceptible to health and nutrition related problems largely due to ignorance, poor socio-economic conditions, inaccessibility to modern health facilities and deep-rooted traditional beliefs and taboos (HNBGU-DA, 2006). In a cross-sectional study of tribal households of Bastar district, Chhattisgarh found that fever (72.5%), cough and cold (56.4%), skin problems (22.0%) and diarrheal diseases (32.9%) were the common health problems among all the tribal communities. Common illnesses among mothers and children were anaemia, malnutrition, diarrheal disease and skin infection. It is suggested that the development of local need-based infrastructure with low-cost technologies and involvement of personnel engaged in alternative system of medicine may help in reducing the disease burden in the tribal community to a great extent (Chopra & Makol, 2004). Another study showed that the main causes for health problems among the Juangs of Orissa were lack of cleanliness, unhygienic preparation of food, inadequate food habits, etc. It was found that Juang habitations were far from Primary Health Centres, Community Health Centres and Hospitals so they could not avail the facility of free medicines and health checkups. Further, fever, malaria, tuberculosis, bronchitis, skin diseases and stomach problems were common in their society (Mishra, 2004).

In India, there are wide gaps in health care services between the rural and urban areas. Around 75% of health infrastructure, medical man power and other health resources are concentrated in urban areas where 27% of the population resides, while only 25% of health care facilities are in rural areas where 67% of population resides. Secondly, communicable, infectious and waterborne diseases such as diarrhoea, amoebiasis, typhoid, infectious hepatitis, worm infestations, measles, malaria, tuberculosis, whooping cough, respiratory infections,

pneumonia and reproductive tract infections lead the morbidity pattern, especially in rural areas. Further, non-communicable diseases such as cancer, blindness, mental illness, hypertension, diabetes, HIV/AIDS, accidents and injuries are also on the rise. The health status of Indians is still a cause for serious concern and especially that of the rural and tribal population in the states like Arunachal Pradesh.

Arunachal Pradesh, one of the North Eastern states, is a heterogeneous tribal state characterized by remarkable ethnic, cultural, religious and linguistic diversity. This is predominantly a hilly state with an area of 83, 743 sq. km, having largest land area among the North-eastern states and has lowest population density among Indian states. The state has highest number of communities (26 major tribes and more than 100 sub-tribes), each having their own distinctiveness including health culture. Administratively, the state is divided into sixteen districts.

### **Methodology:**

Health system plays an important role in keeping people of an area healthy and free from diseases or illnesses. It is dependent on numbers of related factors like availability and accessibility of health care services. At Reru Village of Lower Subansiri District (LSD) in Arunachal Pradesh (AP), people are practicing both traditional and modern systems of medicine, in spite of poor health care facilities in the area, which reflects nature of socio-cultural, economic, environmental and political aspects of the people.

The objective of the study was to understand the health care system at Reru Village. The specific objectives formulated for the study were as follows:

- 1) To study the socio-economic status of people in Reru village.
- 2) To study the health problems of people in the village.
- 3) To study the availability and accessibility of health care services in the study area.

The present study is both descriptive and analytical. The data were collected both from primary and secondary sources. For collecting primary data, questionnaires were used, in addition to field observation and narrative analysis. The method for selecting the sample has been purposive random sampling. The secondary data has been collected from libraries, government departments and internet sources.

LSD covered approximately an area of 3,460 sq. km. The topography of the district is mostly mountainous terrain, where the hill range varies approximately from 1000 to 6000 meters above sea level. The district headquarters is Ziro. The

district is divided into 3 (three) Sub-division viz. Ziro, Raga and Yachuli with 8 (eight) administrative circles as per 2011 Census. Ziro is the only town in the district. The villages were having their own customary system in the form of traditional village council.

The district has recorded a population of 83,030, comprising of 41,843 (50.4%) male and 41,187 (49.6%) females. Rural population of the district is 70,224 (84.6%) and urban population is 12,806 (15.4%). The rural population spreads over 536 villages. The district population accounts for 6% of total population of the state. The average density of population is 24 per sq. km. for the district as compared to 17% for the state. The total literacy rate is 80.8 and among rural population are 79.5. The proportion of Scheduled Tribes in the district is 87.81% in compare to state's proportion of 68.79% (Census, 2011).

Table 1: Basic Indicators in Arunachal Pradesh and Lower Subansiri, 2012-13.

Indicators	AP	LSD
Population literate age 7+ years (%)	73.9	80.8
Population below age 15 years (%)	31.9	30.6
Mean household size	4.7	5.1
Sex ratio at birth (Males per 100 Females)	102	96
Households having electricity (%)	86.1	99.3
Households having improved source of drinking water (%)	91.7	97.1
Households having access to improved toilet facility (%)	63.1	76.3
Households use clean fuel for cooking (%)	34.1	32.9
Mean age at marriage for girls	21.3	22.0
Mean age at marriage for boys	24.5	24.5
Currently married women married below age 18 years (%)	13.0	7.4
Use of Any Family Planning methods (%)	48.8	57.8
Use of any modern Family Planning methods (%)	43.9	50.9
Children age 12-23 months Received full vaccination (%)	49.2	68.5
Children age 0-5 months exclusively breastfed (%)	70.2	80.6
Children with low birth weight (%)	4.8	3.2
Women know about what to do when a child gets diarrhoea (%)	73.9	91.6

Source: District Level Household and Facility Survey -4, State Fact Sheet - Arunachal Pradesh and District Fact Sheet- Lower Subansiri (2012-13), Ministry of Health and Family Welfare, New Delhi.

The table 1 shows some of the basic indicators in Arunachal Pradesh and Lower Subansiri District. It reflects that almost all of the indicators were better for the district, except household size and sex ratio at birth.

Reru is a small village located in Old Ziro with a total of 279 families residing. The village has population of 1535, of which 755 are male while 780 are females,

all of whom belong to Scheduled Tribe (ST). The people of the village mainly belong to Apatani tribe. Literacy rate of Reru Village was 82.43% comparing to 65.38% of Arunachal Pradesh. The male literacy rate in the village was 88.34%, while female literacy rate was 76.54%. In the village, 459 persons were engaged in work activities, of which 88.88% were main workers and 11.2% were involved in marginal activity (Census, 2011). As per the Constitution of India and Panchayati Raj Act, Reru village is administered by sarpanch (Head of village) who is an elected representative of the village. In the village, people practice both modern and traditional system of health care.

### **Health Care System in AP and LSD:**

A look into the morbidity and illnesses in Arunachal Pradesh showed that in rural areas 1.4% morbidity was due to injury, 17.4% due to acute illness and 7.0% due to chronic illness. Similarly, in urban areas, 1.3% morbidity was due to injury, 17.6% due to acute illness and 7.1% due to chronic illness. It further showed that in the state reported prevalence of chronic illnesses due to diseases of respiratory system were 10.0%, diseases of cardiovascular system were 4.3% and persons suffering from tuberculosis were 3.5% (DLHS-4). It was also found that diseases of respiratory system and diseases of cardiovascular system were higher in rural areas.

People of the state have a rich knowledge about medicinal plants, and traditional medicines were being practised more systematically in some areas. The growth of modern health services is a comparatively recent phenomenon. In comparison to all India averages, the level of health facilities might seem somewhat satisfactory, but the conventional indicators based on availability of health services per thousand population has limited significance in a hilly state like Arunachal Pradesh because of the scatteredness of settlements and difficulties in availing health facilities in high altitude areas. An important aspect of the availability of health infrastructure in the state, as in many other parts of the country, is the rural-urban disparity.

Availability of health care institutions is vital to meet the health care needs of an area. The table 2 shows the distribution of the allopathic medical institutions in Arunachal Pradesh. It showed that there were three General Hospitals and eighteen Dispensaries, which were only located in urban area; while all the 350 Health Sub-Centres (SCs) were in rural area. In 2012, out of 13 District Hospitals, 11 were in urban and 2 in rural areas. Out of 27 Community Health Centre (CHC), 8 were in rural and 19 in urban areas; and out of 67 Primary Health Centre (PHC), 25 were in rural and 42 in urban areas. Among other 56 medical institutions, 48 were in rural and 8 in urban areas. It clearly reflects the

concentration of medical institutions in urban areas of Arunachal Pradesh, except the SCs, which are mainly for rural areas.

Table 2: Distribution of Health Institutions in Arunachal Pradesh, 2012.

Health institution	Rural (%)	Urban (%)	Total
General Hospital	-	3 (100)	3
District Hospital	2 (15.38)	11 (84.62)	13
Dispensaries	-	18 (100)	18
Community Health Centre (CHC)	8 (29.63)	19 (70.37)	27
Primary Health Centre (PHC)	25 (37.31)	42 (62.69)	67
Health Sub-Centre	350 (100)	-	350
Others	48 (85.71)	8 (14.29)	56

Source- DI.HS-4, State Fact Sheet, Arunachal Pradesh, 2012-13.

The table 3 gives information on health care scenario in AP and LSD. It shows that in the state and the district 86.8% and 79.4% villages had Accredited Social Health Activists (ASHA) and only 14.5% and 14.7% had Village Health Nutrition and Sanitation Committees (VHNSC) respectively. It also shows that 59.1% and 61.7% of Sub-Health Centres in villages were within 3 km and 59.7% and 70.6% of PHC in villages were within 10 km respectively. 92% and 85.7% of Sub-Health Centres (SCs) were found to be in government building in the state and the district. At SC level, it was seen that proportion of ANMs and male health workers were better in the district, additional ANMs were much less in the district. In the context of Primary Health Centres (PHCs), the proportion of PHCs, having Lady Medical Officers, having at least four beds, AYUSH doctor and residential quarters for Medical Officers were better in the district. On the other hand, PHCs functioning round the clock and having round the clock new born care services were better for the state. The Community Health Centres (CHCs) having round the clock delivery services, Obstetrician/Gynaecologist, Anaesthetist, designated as FRUs and having new born care services round the clock were much better in the state, while the CHCs having functional Operation Theatre was better in the district. There were no Sub-Divisional Hospitals in the state. Out of 16 District Hospitals (DHs) in the state, five has paediatrician, two each has regular Radiographer and 2D Echo facility, seven has Ultrasound facility, four has critical care area and ten have suggestion and complaint box. In LSD, the District Hospital was having only regular Radiographer, Ultrasound facility and suggestion and complaint box, without having paediatrician, Echo facility and critical care area.

Table 3: Health Care Services, 2012-13

Indicators	AP	LSD
Villages having ASHA (%)	86.8	79.4
Villages having Village Health Nutrition and Sanitation Committee (VHNSC) (%)	14.5	14.7
Villages with Sub-Health Centre within 3 km (%)	59.1	61.7
Villages with PHC within 10 km (%)	59.7	70.6
Sub-Health Centre located in government building (%)	92.0	85.7
Sub-Health Centre with ANM (%)	69.4	85.7
Sub-Health Centre with male health worker (%)	46.8	57.1
Sub-Health Centre with additional ANM (%)	45.4	16.7
PHCs functioning on 24 X 7 hours basis (%)	69.5	75.0
PHCs having Lady Medical Officer * (%)	25.5	0.0
PHCs with at least 4 beds (%)	68.2	100.0
PHCs with AYUSH doctor* (%)	29.7	33.3
PHCs having residential quarter for Medical Officer (%)	65.8	75.0
PHCs having new born care services on 24 X 7 hours basis (%)	68.6	0.0
CHCs having 24 X 7 hours normal delivery services (%)	100.0	50.0
CHCs having Obstetrician/Gynaecologist (%)	2.0	0.0
CHCs having Anaesthetist (%)	3.7	0.0
CHCs having functional Operation Theatre (%)	11.3	50.0
CHCs designated as FRUs (%)	15.9	0.0
CHCs having new born care services on 24 X 7 hours basis (%)	75.5	0.0
DHs having Paediatrician	05	0
DHs having regular radiographer	02	1
DHs having 2D Echo facility	02	0
DHs having Ultrasound facility	07	1
DHs having critical care area	04	0
DHs having suggestion and complaint box	10	1

Note: \* Out of total medical officers available, PHCs - Primary Health Centres, CHCs - Community Health Centres & DHs - District Hospitals.

Source: DLHS-4, State Fact Sheet, Arunachal Pradesh, 2012-13.

A comparative look into the health indicators of the state and the district give a clear picture of health needs of people. The table 4 shows the selected health indicators in Arunachal Pradesh (AP) and in Lower Subansiri District (LSD). It showed that the acute illness and chronic illness were higher in the district while injury incidences were less. Further, it showed that the disease of respiratory system were slightly higher, while the disease of cardiovascular system and persons suffering from tuberculosis were lower in the district. The nutritional status of children below 5 years showed that in the state 21.4% were suffering from wasting, 39.8% from stunting and 27.3% from underweight. Anaemia status for both children and adults, proportion of pregnant women who received any

antenatal check-up and who had full antenatal care were better in the district. Likewise, the situation of institutional delivery and delivery attended by skilled health personnel were also much better in LSD than in the state.

Table 4: Health Indicators in Arunachal Pradesh and Lower Subansiri, 2012-13.

Indicators	AP	LSD
Reported Prevalence of Morbidity		
Any Injury	1.3	0.8
Acute Illness	17.6	19.9
Chronic Illness	7.1	11.6
Reported Prevalence of Chronic Illness during last one year (%)		
Disease of respiratory system	10.0	10.6
Disease of cardiovascular system	4.3	2.2
Persons suffering from tuberculosis	3.5	2.9
Nutritional status of children below 5 years (%)		
Wasting (weight for height- below 2 SD)	21.4	..
Stunting (height for age- below 2 SD)	39.8	..
Underweight (weight for age- below 2 SD)	27.3	..
Anaemia Status by Haemoglobin Level (%)		
Children (6-59 months) having anaemia	64.0	57.1
Persons (20 years and above) having anaemia	47.9	38.0
Antenatal Care (%)		
Pregnant women who received any antenatal check-up	61.6	79.3
Pregnant women who had full antenatal care	13.5	22.3
Delivery Care (%)		
Institutional delivery	49.5	65.9
Delivery attended by skilled health personnel	52.6	70.2
Utilization of Government Health Services (%)		
Antenatal care	89.0	83.6
Treatment for pregnancy complications	84.1	82.3
Treatment for post-delivery complications	73.2	73.5
Treatment for vaginal discharge	59.3	68.4
Treatment for children with diarrhoea (Last two weeks)	78.4	NA
Treatment for children with ARI (Last two weeks)	69.0	NA

Source: District Level Household and Facility Survey -4, State Fact Sheet - Arunachal Pradesh and District Fact Sheet- Lower Subansiri (2012-13), Ministry of Health and Family Welfare, New Delhi. NA: percentage not shown because of less number of cases.

Utilization of health services for both rural and urban areas was different. It was found that the utilization of the government health services relating to antenatal,



pregnancy, diarrhoea and Acute Respiratory Infections (ARI) were better in rural areas than in urban AP (DLHS-4). The table 4 reflects that both in the state and in the district the utilization of government health services were quite higher. This may be due to non-availability of private services, mainly in the rural areas of AP and in LSD.

Medical and public health services are required for the fulfillment of the health care needs of the population of an area. A look into such facilities in LSD gave us the picture of health care system in the district. The table 5 shows the distribution of health care services in the district. It shows that in Ziro and Pistana Circles health care services were highest and on other hand Dullungmukh Circle had the lowest with only one Primary Health Centre (PHC). In Ziro, where the Reru Village falls, had one each District Hospital, Community Health Centre (CHC), T.B Centre/ Hospital, Ayurvedic Dispensary and Homeo Dispensary, 5 Health Unit/ Dispensaries /Sub-Centres but no PHC.

Table 5: Circle-wise Health Care Services in Lower Subansiri District, 31-03-2012.

Health facility	Name of Circle							Total
	Ziro	Yachuli	Pistana	Raga	Kamporijo	Dullungmukh	Yazali	
District Hospital	1	Nil	Nil	Nil	Nil	Nil	Nil	1
PHC	Nil	1	3	1	1	1	-	7
CHC	1	Nil	Nil	Nil	Nil	Nil	1	2
Health Unit/ Dispensaries /Sub-Centres	5	5	7	2	4	Nil	1	26
T B Centre/ Hospital	1	Nil	Nil	Nil	Nil	Nil	Nil	1
Ayurvedic Dispensary	1	Nil	Nil	Nil	Nil	Nil	Nil	1
Homeo Dispensary	1	1	Nil	1	Nil	Nil	Nil	3
Total	10	9	10	4	5	1	2	41

Source: District Medical Office, Ziro.

The table 6 shows the authorised beds and health units in Lower Subansiri District. Ziro Circle held the highest number of beds (88) of the total of 116 beds. On other hand in Kamporijo and Dullungmukh Circles there were no beds. An interaction with the District Medical Officer of the district revealed that there were 35 Doctors, one Assistant Matron, 10 Staff nurses, 21 ANM and 15 Health Assistants in the district during 2011- 2012.

Table 6: Number of authorised Beds in LSD, 31-03-2012.

Circle	Hospital/ Health unit/ Dispensary	Authorised beds in Medical institutions
Ziro	District Hospital, Ziro.	80
	CHC, Old Ziro	8
Yachuli	PHC, Yachuli	4
Pistana	Pistana PHC	-
	PHC, Deed Neelam	8
Raga	PHC, Raga	8
Kamporijo	PHC Boa-Simla	-
Dullungmukh	PHC Dollungmukh	0
Yazali	CHC Yazali	8
	PHC Poru	-
Total		116

Source- DMO, Ziro.

Table- 7: Number of Patients treated in LSD, 2009-2010.

Hospital/ Health units/ Dispensary	Diarrhoca/ Dysentery	Respiratory Disease	Malaria	Others	Total
District Hospital, Ziro	112	42	275	32437	32866
CHC Yazali	54	-	80	4446	4580
PHC Raga	11	-	7	51	68
PHC Boa- Simla	189	-	-	1832	2021
PHC Yachuli	23	12	10	609	654
PHC Deed Neelam	77	1	11	9732	9821
PHC Pistana	50	-	60	110	317
Sub Centre Bulla	12	-	3	37	52
Sub Centre Hari	30	-	7	350	387
Sub Centre Hong	30	-	6	200	236
Sub Centre Joram	5	-	6	45	56
Sub Centre Talo	80	-	15	900	995
Sub Centre Mia	2	-	2	131	135
Sub Centre Sito	5	-	-	127	122
Sub Centre New Pania	17	-	-	232	249
Sub Centre Dem	3	-	-	93	96
Total	710	55	482	51,332	52,655

Source- DMO, Ziro.

A look into patients treated in government hospitals and health units of Lower Subansiri District (table 7), shows that the highest numbers of patients were treated in District Hospital, Ziro (32,866) followed by PHC Deed Neelam (9821)

and CHC Yazali (4580) during 2009-2010. Further, patients treated for suffering from diarrhoea/dysentery, malaria and respiratory diseases were 710, 482 and 55 in the district. Among the PHCs, highest numbers of patients treated were in PHC Deed Neelam (9,821) and lowest in PHC, Raga (68). At SCs level, highest numbers of patients treated were in SC Talo (995) and lowest in SC Bulla (52).

### **Findings from Reru Village:**

- Out of the total 50 respondents, 38% belonged to 38-40 years age group, 30% to 20-30 years age group, 16% to 51-60 years age group, 12% to 41-50 age group and 4% to 61-70 years age group.
- Most of the respondents were married (80%) and only 20 % were unmarried. Doni Polo, an indigenous religion (85%) and Christianity (15%) were practiced by the respondents.
- Among the respondents, 84% were literate and 16% were illiterate. Among the literates, 24% were educated up to primary level, 16% secondary and 22% each higher secondary and graduation levels.
- Data shows that 60% of the respondents' source of income was agriculture, 26% was business, and remaining 14% was government employee. It shows that the majority were engaged in Agriculture.
- A look into the monthly income of the respondents shows that 26% had monthly incomes of Rs. 1,000-5,000/, 30% had Rs. 6,000-10,000/, 18% had Rs. 11,000-15,000/, 14% had Rs. 16,000-20,000/ and 12% had Rs. 21,000-30,000/.
- Common Health problems of the people showed that 26% were facing eye problems, 20% tuberculosis, 16% fever, 12% skin problem and 26% facing others health problems.
- Data shows that 88% were aware of HIV/AIDS and 12% were not. 36% of the respondents were aware of health schemes, who are mainly the literate group of people, and on other hand 64% of respondents were not aware of such schemes. It was also found that 74% of respondents are not aware of health camp organized in the village, because some of the respondents' family members are too young or are staying and studying outside Reru Village; while only 26% are aware of the health camp.
- Data shows that there was only one health care centre available in the village, i.e. a Sub Health Centre (SC). It reflects the poor health care system in the Reru village. Findings also showed non availability of medicines and drugs in the village, as there is no pharmacy or medicine seller in the village.
- Relating to Health care utilization in Reru Village, it was found that 10% of the respondents were using modern health care system only, no one was using only traditional system, while 90% of them were using both modern and traditional health care system.

- Among the traditional health care treatment seekers, 40% were spending Rs. 100-400/, 36% Rs. 500-800/, 12% Rs. 900-1100/, 7% Rs. 1200-1500 and 5% Rs. 1600-2000/ annually. On the other hand, among modern health care treatment seekers, 33% were spending Rs. 600-1,000/, 29% Rs. 1100-1500/, 10% Rs. 1600-2000/, 8% Rs. 2100-2500/ and 6% Rs. 2600-3000/ annually. It is therefore clear that the cost of traditional health care treatment was lower than the modern treatment, is one of the reasons why people were still practicing traditional health care services. Of course, the traditional socio-cultural values were also playing its vital role in such practices. Further, the choice for a particular type of treatment also depends upon the particular disease or illness. For some diseases or illnesses, people have higher levels of confidence and satisfaction on traditional treatment, while for some other diseases the vice versa. At the same time, for some other diseases people were resorting to both.

### **Conclusion:**

This study reveals some important information regarding the socioeconomic condition and its relation with the health status of the people of the Reru village in LSD of AP. The findings shows that though 84% of the respondents were literate but a mere 22% of them had graduation degree and as many as 16% were illiterate. Hence their wanting status of literacy is reflected in their lack of the awareness of the various health awareness schemes and the health camps organized in the village and even as many as 12% of the respondents were not aware of HIV/ AIDS.

Their poor economic status of the people who are mostly dependent on agriculture for their household income was reflected in the popularity of the traditional health care system which was much cheaper than the modern scientific health care system, though the preference for a particular system of medicine was also found to be dependent on the kind of the health problem. Hence for most ubiquitous health problems in village as eye problem, fever and skin problems the villagers preferred to opt for traditional health care system, whereas for problems like tuberculosis they preferred the modern scientific health care system.

The existence of a very poor health care infrastructure was also exposed from the study. The study confirmed that only one health care centre was available in the village, i.e. a Sub Health Centre. To add to it there was also paucity of medicines and drugs not only in the Sub Health Centre but also in the village as a whole, as there was no pharmacy or medicine seller. This had compelled the villagers to go to the nearby town for seeking health care facilities. Therefore, a close link between the literacy rate, education and health was well-established in the study.

### **Suggestions:**

Recognizing the overriding importance of health in the well-being of the people, it is imperative that policy actions be taken to improve health services across the state. Eradication of disease, especially vector-borne diseases or those spread by infection, is a necessary first step but, this needs to be accompanied by initiatives to improve the health status of the people; especially the nutritional status of women and children. A holistic approach is called for – an attempt to reduce the incidence of disease, combined with health consciousness and awareness generation, an improvement in the nutritional levels of disadvantaged groups and improved access to healthcare. Some of the important actionable issues that have been brought to the fore are highlighted below:

- a. Areas with low Life Expectancies at birth and high Infant Mortality Rates require special attention. Resources need to be directed to address the specific requirements of disadvantaged areas and people, as reflected in the lower health indicators.
- b. The close link between the literacy rate, education and health is well-established. Public sanitation and safe drinking water are two areas where intervention by the government, together with villagers, can make a big difference. Steps should be taken to improve the public sanitation systems, especially in the urban areas. Development of proper drainage systems will improve hygiene levels and reduce the incidence of malaria as well as water-borne diseases.
- c. More specifically, the government needs to tackle the issue of absenteeism and inefficiency in the delivery of services. The way forward Many Primary Health Centres (PHCs) in the remote areas of the State are non-functional due to absenteeism of doctors, compounders, and nurses.
- d. Another problem in remote areas was the distance to the nearest medical centre. The problem of overstaffing of PHCs in the more accessible areas, especially in semi-urban and suburban areas, and understaffing of PHCs in the inaccessible areas, needs to be addressed immediately. The government should take steps accordingly.
- e. Non-availability of medicines is another common complaint, again voiced more in the remote areas. The concentration of government medical services in urban areas, where people can afford private medical services, contributes to the growth of inequality – the richer, better-off sections of the society were being catered, while the less well-off people were neglected in both the rural and the remote areas.

Some of the suggestions put forwarded by the medical staff of PHC and General Hospital and Gaonbura were:

- In PHCs they need more staff like ANM nurses, the supply of medicines should be available and should be in proper time, there must organised health camps in the village and proper Government attention in the field of better Health care system.
- The staff members of General Hospital Hapoli- want uplifting the general infrastructure of the hospital, including Provision for ICU, Proper medical equipments, Community Health education programmes, and Proper training sessions for nurses.
- The staff members of General Hospital also want availability of common medicines to be provided by the government and more doctors, nurses and paramedical staff should be available. Modern OT and ICU and modern equipment should be available. There should be more awareness camps.
- The Gaonbura of the village suggested for proper electricity, good water supply, availability of doctors, nurses and medicines, and cleanness to be maintained.

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