

# Health Issues and Health Seeking Behaviour of Tribal Population

Jharkhand



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# **Health Issues and Health Seeking Behaviour of Tribal Population in Jharkhand**

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## FOREWORD

Jharkhand is home to over 30 tribes constituting 26.3 percent of the total population of the state, as per Census of India, 2001. Due to the gaps in information available on the health practices and service utilisation of the tribal population in Jharkhand, there have been constraints in addressing their requirements through appropriate policy measures and service delivery.

The second phase of the Innovations in Family Planning Services (IFPS) Project focuses on improving access to affordable quality family planning, reproductive and child health services. Creating demand for reproductive health services and products, as well as stimulating health behaviour change is one of the key focus areas of the IFPS project.

We are glad that the Government of Jharkhand in collaboration with ITAP (IFPS-II Technical Assistance Project) has taken this pioneering initiative to carry out a comprehensive qualitative assessment study to understand and analyse the health seeking behaviour of the major tribal groups, with a focus on the traditional system of healing. The study looks at identifying the key behaviours, traditional rituals, beliefs, practices and remedies (specifically related to reproductive and child health) followed by the Santhal, Munda, Oraon and Ho tribal groups, in the Santhal Pargana and South Chhotanagpur regions. There has also been an attempt to grasp the interplay of the physical and political environment within which these select tribal groups live.

The report explains the underlying barriers of geographic access, economic constraints and specific cultural issues which need to be addressed to improve health service utilisation by the tribal groups. We are confident that this study will help boost and guide the state initiatives in ensuring 'Health for all'.

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# EXECUTIVE SUMMARY

The current study intends to assess the attitude towards health among tribal groups in Jharkhand – their faith, beliefs and health seeking behaviour, as well as the available health facilities and their utilisation, in terms of maternal and child health. An attempt has also been made to look across the cultural variations of various tribes, with regard to their health seeking behaviours, which do not encompass modern medical practices.

The study was conducted among five major tribes in Jharkhand: Santhal, Munda, Oraon, Ho and Pahariya. These tribes are mainly scattered in the Santhal Pargana and South Chhotanagpur regions of the state. It was observed that these tribes still adhere to indigenous rituals, behaviour, beliefs and practices for general illness, maternal and new born care, and also for reproductive and sexual health issues. The study has tried to identify existing healing rituals, perception about the existing health system, the role of indigenous medicine among the tribal population and integration of traditional medicine with the prevailing reproductive and child health programme among the traditional service providers and providers from the mainstream health system.

Qualitative techniques were employed to learn the traditional healing practices of tribal people. Two villages comprising each of the five identified tribal groups were selected, one village being closer to an urban conglomeration and the other classified as ‘hard to reach’.

The study was conducted by five different teams with six members in each team. Each team conducted one participatory rural appraisal exercise, one focus group discussion, five key informant interviews and ten in-depth interviews with the eligible couples.

This study report deals with child health issues (specifically infant and early child care practices), family planning needs and the significance of traditional medicine in the tribal framework.

**Child Health:** Childhood morbidity and mortality, intranatal and immediate postnatal care, breastfeeding and complementary feeding, awareness and decision making regarding immunisation are some of the key topics touched upon through this study.

**Family Planning:** In Jharkhand, only 36 percent of married women use any method of contraception, compared with 56 percent at the national level. It could be even less among the tribal people, since factors like acceptance of family planning methods, availability and accessibility of services, utilisation of services and use of traditional methods play an important role.

**Traditional Herbal Medicine:** Tribal people live in forests and depend completely on the land and forest for their daily needs. Hence, for their medical problems, they prefer to be treated by the *vaid raj* or *vaidya* (traditional healer) with traditional medicine, which essentially uses extracts from herbs found in the forests. Due to their easy

accessibility and availability, these healers wield significant influence over the health seeking behaviour of the tribal groups.

The findings of the study provide an insight into the reasons why tribal people have different health issues and health seeking behaviours in the present scenario, when, as a nation, we have the most modern health system in place. The study also reflects on why these people still follow obsolete practices and why it may be necessary for them to have a separate system. The tribes, by and large, are animists, that is, they worship nature, and hence, they derive maximum comfort from organic material and methods of treatment. The community feels alienated at institutions such as district hospitals, which are generally staffed by non-tribals, who are perceived as treating the tribals condescendingly. The fact that the distances between health facilities and residences are considerable and the transport system is poor, further, adds to the community's reluctance in adopting the modern health care system.

This study can prove to be an invaluable reference point for policy-makers and implementers while developing a tribal health initiative strategy for the state of Jharkhand.

# OVERVIEW

### 1.1 INTRODUCTION

The state of Jharkhand was formed on 15<sup>th</sup> November, 2000 with Ranchi as its capital. Jharkhand has an area of 79,714 sq. km and a population of 26.9 million. The scheduled tribe (ST) population of Jharkhand, which numbers 7,087,068, constitutes 26.3 percent of the total population of the state (Census of India, 2001). Among all the states in India, Jharkhand holds 6<sup>th</sup> and 10<sup>th</sup> position in terms of ST population and the percentage share of the ST population to the total population of the state, respectively. The growth of the ST population in the state has been lower than the growth of the total population during 1991-2001. Population density of the state is 338 per sq. km, which clearly indicates that the inhabitants of the state are scattered.

The state is divided into five regions – Santhal Parganas, Daltonganj, Kolhan, North Chhotanagpur and South Chhotanagpur. Jharkhand shares its border with five states – Bihar, West Bengal, Orissa, Uttar Pradesh and Chhattisgarh.

### 1.2 TRIBAL POPULATION IN JHARKHAND

The ST population is primarily rural, as 92 percent reside in the villages. The state has a total of 30 ST groups. District-wise distribution of the ST

population shows that the majority reside in Simdega (72%), Gumla (70%), Pashchim Singhbhum (66%) and Lohardaga (56%) districts. The STs constitute more than half of the total population in Lohardaga and Pashchim Singhbhum districts.

Santhal is the most populous tribal group, numbering 2,410,509 and constituting 34 percent of the total ST population of the state. Other major tribes are Oraon (20%), Munda (15%) and Ho (11%). District-wise distribution of individual STs shows that the highest numbers of Santhals are in Dumka district, followed by Purbi Singhbhum, Pakur and Sahebganj, but they constitute the highest proportion of the total ST population in Giridih (91%), followed by Dumka (90%) and Pakur (85%) districts. The other six major tribes, namely Munda, Ho, Khairwar, Lohra, Bhumij, and Kharia are concentrated in Ranchi, Pashchim Singhbhum, Palamu, Purbi Singhbhum and Gumla districts.

Among STs, there are certain tribal communities who have declining or stagnant population, low level of literacy, pre-agricultural level of technology and are economically backward. Nine such groups exist in Jharkhand, which are identified and categorised as Primitive Tribal Groups (PTGs). Most of

these groups are small in number (numbering just over two lakhs), have not attained any significant level of social and economic progress, and generally inhabit remote localities with poor infrastructure. Therefore, they become the most vulnerable sections among the STs and priority is required to be accorded for their protection, checking the declining trend of their population and their overall development. The PTGs in Jharkhand are Asur, Birhor, Birija, Hill Kharia, Korwa, Mal Pahariya, Parhaiya, Sauria Pahariya and Savar.

### 1.3 LITERATURE ON TRIBAL ISSUES

Several studies have focused on the issues of downtrodden tribal groups, which are a major concern for social scientists, since the holistic development of society cannot be achieved, without the inclusion of these communities which are mostly illiterate, have traditional beliefs and constitute the poorest segment of the Indian population (Mutatkar R.K., 2004). Tribal populations are isolated from the general population by virtue of their own physical, socio-economic and cultural environment.

As the medical systems of any society are cultural derivatives, the traditional health care system of tribal groups persists long after

western innovations in health care are implemented (Mahapatra, 1994). In most tribal communities, there is a wealth of folklore related to health. Health and treatment are closely inter-related with the environment, particularly the forest ecology. Many tribal groups use different parts of a plant, not only for the treatment of diseases, but for population control as well (Chaudhuri, 1990). Singh (1994) highlights the effect of the changing physical environment on tribal health, which impacts their economic pursuits, access to nutrition, medicines and so on. Thus, it can be deduced that ecology and tribal health are intimately related.

Guite and Acharya (2006) have shown that the acceptance of a particular health care system among the tribal people depends on its availability and accessibility.

The health and nutrition problems of the vast tribal population of India were as varied as the tribal groups themselves, who presented a bewildering diversity and variety in their socio-economic, socio-cultural and ecological settings. The nutritional problems of different tribal communities located at various stages of development were full of obscurities and very little scientific information on dietary habits and nutrition status was available due to lack of systematic and comprehensive research investigations (Studies in Methods, U.N., 1984).

Maternal and child care is an important aspect of health seeking behaviour, which is largely neglected among the tribal groups (Basu et al., 1990). Maternal mortality was reported to be high among various

tribal groups. The main causes of maternal mortality were found to be unhygienic and primitive practices for parturition (Basu, et al., 1990). On the other hand, infant mortality is also found to be generally high among the tribal population. Conditions in the different tribes depend on their socio-cultural, economic and demographic characteristics, and on the magnitude and direction of the forces of modernisation, such as urbanisation and industrialisation (Bose, 1970). The influence of Christianity in some tribal areas has also played a significant role (Madan, 1951).

Reproductive tract infections (RTIs), especially amongst women, are a significant public health problem. 53 percent of women reported gynaecological symptoms, 38 percent had laboratory findings of RTI and 14 percent had clinically diagnosed pelvic inflammatory disease (PID) or cervicitis (Prasad, 2005). According to laboratory diagnoses, 15 percent had sexually transmitted infections (STIs) and 28 percent had endogenous infections. Two-thirds of symptomatic women had not sought any treatment; the reasons cited were absence of a female provider in the nearby health care centre, lack of privacy, distance from home, cost and a perception that their symptoms were normal. Parchure and Warvedakar (2008) have also mentioned that only 42 percent of women with RTI seek care.

The popular belief that most diseases occur due to supernatural powers led to the concept of seeking relief through *jadoo* (magic), keeping the modern medical practitioners as a last resort (Sumathy S.R., 1990).

Poverty and poor infrastructural development in tribal dominant areas have contributed hugely to the inability of the maternal and child health (MCH) programmes in reaching out to the tribal population. Mobilisation of the people in collective action for poverty alleviation will pave the way for a better and sustainable model for MCH control in these areas.

In contrast to the traditional health care system, the official state health care system is based on western science and technology, separating it from broader social and cultural influences. It is evident that the state-supported medical system does not generally recognise the traditional medical systems. John Bryant (1988) sees the involvement of the individual and the local community in primary health care not as a social nicety, but as a medical necessity. Services that are delivered from the outside have little effect, unless absorbed by the individual and the community. It has been seen that the diverse and deep-rooted social and cultural constructs of a society play an important, and often, decisive role in deciding the acceptability of a particular health care option.

Thus, a study exploring the nature and extent of acceptance of modern health care facilities among the target group was imperative, as an input towards policy planning for their overall development.

#### **1.4 RATIONALE OF STUDY**

The scenario, with respect to maternal and child health, in the state of Jharkhand calls for immediate action. According to the recently conducted National Family Health Survey (NFHS-III, 2005-06),

the **infant mortality rate (IMR) in the state is 69 per 1000 births.**

On the other hand, the **maternal mortality ratio (MMR) is 371 per 100000 live births** (SRS, 2005).

These two critical indicators of poor health were found to be higher than the national average. As for the nutritional status of children, which is a determining factor for child health, about 57 percent of children are underweight. Only 59 percent of mothers received at least one antenatal care in the last three years period, while 18 percent of pregnant women delivered their babies in some kind of institution (NFHS-III, 2005-06).

Lack of proper health care practices coupled with the traditional form of health care followed by this group renders the women and children vulnerable to adverse health implications. Indigenous healing practices have survived, evolved and are still widely practiced in the tribal areas. Today, some of these tribal healers practice a hybrid form of healing, that combines rituals with quasi-allopathic or complementary medical practices.

The study intends to assess the attitude towards sickness among the tribes, their faith, beliefs and health seeking behaviour, as well as the available health facilities and their utilisation, in terms of MCH and RTI/STI services. An attempt has also been made to look across the cultural variations of various tribes, with regard to their health seeking behaviours.

## **1.5 GOAL AND OBJECTIVES OF THE STUDY**

To identify the existing health seeking behaviour of couples in the major tribal groups, with a focus on

the traditional system of healing.

### **Objectives**

- To identify the key behaviour, traditional rituals, beliefs, practices and remedies followed during critical stages related to health and disease
- To assess the knowledge level, utilisation and traditional practices related to contraception
- To identify treatment seeking behaviour during pregnancy, delivery and post-delivery period
- To examine the rituals and practices related to newborn care and breastfeeding
- To identify the beliefs and perception about RTI/STI issues
- To identify existing healing rituals, perception about the existing health system, the role of indigenous medicine among the tribal population and integration of traditional medicine with the prevailing reproductive and child health (RCH) programme among the traditional service providers and providers from the mainstream health system.

## **1.6 METHODOLOGY**

### **1.6.1 Study design**

The study used qualitative techniques to learn about the experiences, perceptions and practices of relevant health seeking behaviour, especially the traditional healing practices of tribal people. The sample has been drawn from the Santhal, Munda, Oraon and Ho tribal groups in the Santhal Pargana and South Chhotanagpur regions. A minority tribal group such as Pahariya has been added to the list of tribal groups being studied, to check their health seeking behaviours and find any differences that exist among the tribes.

Two villages comprising each of the five identified tribal groups were selected. Selection of the villages was purposive, with one village being closer to an urban conglomeration and the other classified as 'hard to reach'. The habitations were chosen with the help of local non-governmental organisations (NGOs), who provided the logistics for the study and helped in building rapport with the community.

### **1.6.2 Qualitative methods**

The types of qualitative techniques used for this study are explained in this section.

#### **Research tools**

At each habitation, the following exercise took place:

- Transect walk and meeting key influential people of the village for consent.
- Participatory rural appraisal (PRA) tools:
  - Social mapping to list resources and utilisation of services
  - Force field analysis, listing and pile sorting for perception of health system and treatment seeking behaviour
- Key informant interview (KII) with:
  - Auxiliary Nurse Midwife (ANM)/Anganwadi Worker (AWW)/Traditional Birth Attendant (TBA)
  - Local registered medical practitioner (RMP), who practices in the village
  - Traditional healers (village-based)
- In-depth interview (IDI) with:
  - At least one woman/couple with experience of neonatal death

- At least one respondent with experience of maternal death in the household or near miss
- Focus group discussion (FGD) with eligible couples

### **Triangulation of data**

KII with one or more of the following for each selected tribal group:

- Social activists
- Herbal practitioners (specialists)
- Modern doctors/health workers (at Mission hospitals and government hospitals)

### **1.6.3 Data collection strategies**

The provisional timeline for the fieldwork was two weeks, including participatory approach, IDI, FGD and KII (such as traditional healer, ANM, TBA etc.).

Data collection in the study was carried out in a way that ensured data quality. The process of data collection started from the second week of November 2007.

There were six members in each team and these teams stayed in the village for five consecutive days to ensure quality data collection with

the help of the villagers. The six member team comprised one team leader and one facilitator from the Child In Need Institute (CINI), along with two team members who have experience in conducting qualitative research. Two members (one male and one female) from the study tribal community were included in the team, who would facilitate the whole research study and help the team understand the situation at the grassroots level. The teams conducted one PRA exercise, one FGD, five KIIs and 10 IDIs with the eligible couples.

### **1.7 TRAINING INVESTIGATORS**

The research team went through intensive training sessions for two days, where topics related to maternal and child health care, ethical issues and qualitative techniques were discussed. A field practice was carried out immediately after the training.

### **1.8 DATA ANALYSIS**

The interviews with identified couples, health service providers and traditional healers were recorded and fully transcribed with accompanying field notes. All transcribed data has

been analysed in accordance with the content analysis technique.

## **1.9 MAINTAINING ETHICAL CONDUCT**

### **1.9.1 Talking about the culture**

It is common knowledge that tribal people are protective about their cultural settings. They neither allow outsiders to enter with impunity nor do they go outside their settings too often. The research team used a participatory approach to come closer to the participants and also stayed in the village to observe the cultural practices and beliefs. The researchers came across lots of problems while interacting with respondents, especially with respect to taboos. It was very difficult for the research team to ask questions and ascertain what a person knew about his/her illness and how they felt about it. Researchers were cautioned against asking direct questions about illness, especially any related to STI/RTI and death. In order to comply with ethical norms, agreement on an informed consent form was obtained before starting the interview.

### **1.9.2 Informed consent**

Researching health issues necessarily means engaging with people (both patients and their families) who may be in extremely poor health and experiencing exhaustion, depression, or high levels of stress and anxiety. For this reason, participants were fully informed about their role in the study and about the possible risks and discomforts that might arise during the interview. Even after consent was given, its validity was regularly re-confirmed. Participants were given several opportunities to withdraw during interviews or focus groups. Investigators also ensured confidentiality during and after the interview.





# FINDINGS AND RESULTS

This report is a qualitative assessment of the health situation, the preventive health care practices, the health seeking behaviour related to RCH services, use of traditional and modern methods, and the interplay of the physical and political environment in which the selected tribal groups live.

This section describes the selected village profile, the people, their occupation and their ecosystem.

## 2.1 HABITATION

Two habitations from each tribal group were studied. A brief description of the villages visited is given in Table 1. One village with access to modern amenities and one without were included in the sample for the survey.

Most of the study population were living in the area for many generations and have been protected by two special Land Acts enacted during the British rule, whereby they have limited opportunity to buy or sell their land.

The only village in the study where the tribes have no landholdings belongs to the Mal Pahariya tribal group in Dumka district.

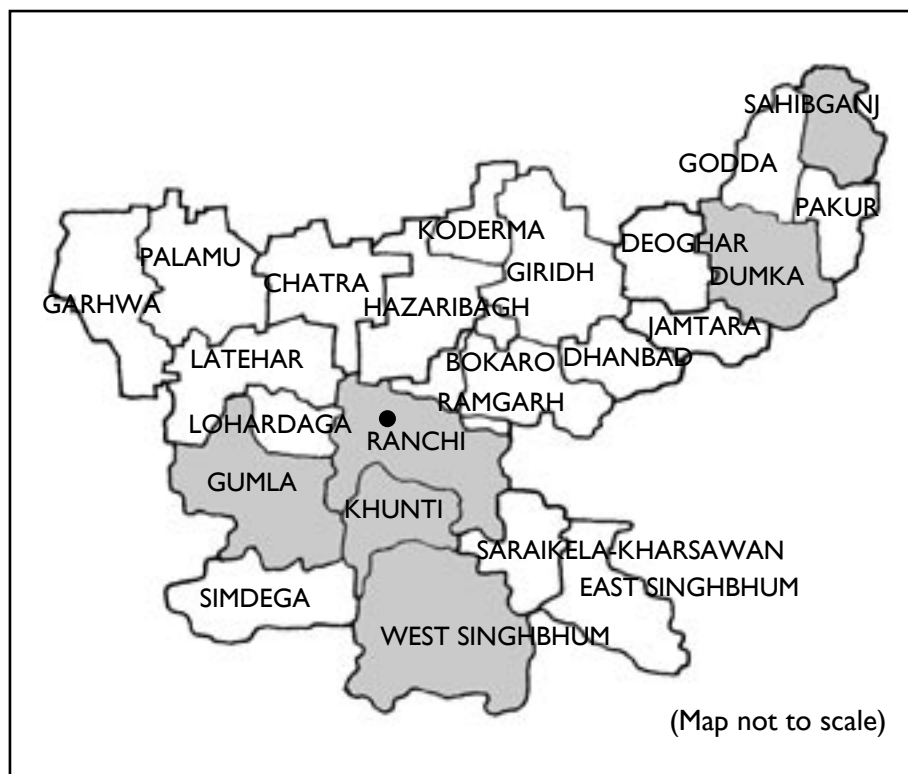
The Mal Pahariyas are a primitive tribal group and during the last Census enumeration (Census of India, 2001), their population in the state was just over 60,000. Many years ago, this tribal group was forced to leave their lands in the plains and move to the hills (*pahar*), thus the name 'Pahariya' attached with this tribal group. Some of them settled in the plains to work as daily wage labourers. The habitation size

varied between the villages and ranged from 30 to 150 households.

## 2.2 OCCUPATION

Most of the tribal groups depend solely on land for their livelihood (Table 2). They cultivate their own land and practice mono-cropping. All these villages are rain-fed areas and depend heavily on the monsoon. They have no access to modern irrigation facilities.

Figure 1: Map of Study Area



Source: [www.jharkhand.gov.in](http://www.jharkhand.gov.in)



Table 1: Description of Study Villages

Tribe	District	Block	Distance from main road	Geographical access	Remarks
Munda	Khunti	Murhu	10 km	Connected by road and is accessible.	Traditional Munda community. Religion – Sarna (Animism).
			5 km	Connected by road and is accessible.	Predominantly Christian community and people are literate.
Oraon	Gumla	Raidih	25 km	Situated in hilly area and is 25 km from main town.	Predominantly Oraon village, with poor access and facilities.
			36 km	Situated at the top of a hill and difficult to reach.	Predominantly Oraon village, with poor access and facilities.
Mal Pahariya	Dumka	Raneshwar	35 km	Situated at the top of a hill and difficult to reach.	Typical Pahariya village on the top of a hill, accessible through a 30 minute trek, non-motorable. Only one community lives there.
			15 km	Situated in the plains and is accessible.	Live with Hindus (Bengalis) and work as daily wage labourers. Have no land holdings.
Santhal	Sahebganj	Barharwa	15 km	Difficult to access but motorable road exists.	Santhal community is in majority in this village.
			Close to the Highway	Close to town and is easily accessible.	Predominantly Santhal village.
Ho	West Singhbhum	Manjari	32 km	In the interiors and is a backward village, very close to the Orissa border.	Has a mixed population and the people lack awareness and education. This village lacks basic facilities of health, education and transportation.
		Khuntpani	5 km	Easily accessible, and has transportation facility.	People are educated and aware. Missionary school present since 1934.



Paddy, *madua (ragi)* and pulses are mainly grown in these areas. The tribes also grow vegetables including cabbage, cauliflower, different kinds of beans, spinach and potatoes. Apart from agriculture, the tribes are engaged in other activities such as collecting wood from the forest and selling it in the market (carried out mostly by the Oraon tribe).

### 2.3 MIGRATION

In the studied villages, seasonal migration was common amongst the Oraon, Pahariya and Ho tribes. Since these tribal groups depend mostly on agriculture for their livelihood and are solely dependent on rain

water, the uncertainty of rain or less rainfall in particular years leads to the movement of these tribal groups to other places. The maximum migration takes place between January and May. The tribes also migrate during the winter season, but the rate of migration is much less.

The social activist of the area described various patterns of migration that take place among these tribal groups. Most of the migration is related to distress, lack of food availability and the opportunity for labour during harvesting months in neighbouring states.

Table 2: Major Occupation of the Tribal Groups in the Study Area

Tribe	Occupation		
	Summer	Rainy	Winter
Munda	Sowing vegetables	Sowing paddy	Harvesting paddy and vegetables
Oraon	Sowing paddy and vegetables	Sowing paddy	Harvesting paddy and vegetables
Mal Pahariya	Sowing paddy, <i>arhar</i> , <i>bajra</i> and corn	Sowing <i>barbatti</i> , <i>kurthi</i> and <i>madua</i>	Harvesting paddy
Santhal	Sowing paddy, mustard, <i>masoor</i> , <i>khesari</i> and <i>chana</i>	Sowing paddy	Harvesting paddy, mustard, <i>masoor</i> , <i>khesari</i> and <i>chana</i>
Ho	Sowing paddy and maize	Harvesting paddy, maize and vegetables	Harvesting vegetables like tomato and cauliflower

A social activist (45 years, graduate, unemployed) commented, “Amongst the Munda and Oraon, a massive migration of young girls aged 10 to 18 takes place, mainly to major metropolises, especially to Delhi. These girls migrate to work as domestic servants, labourers in the fields (in states like Punjab) and occasionally get into the sex trade.”

Most tribal men, who have migrated for work to other areas, return

during the harvest season to assist their family members.

## 2.4 LOCAL RELIGION AND FESTIVALS

Most of the tribes are animists, i.e., nature worshippers. Their religion is *Sarna*, though in the Census they are marked as Hindus. Most villages have a sacred grove, where the people believe the souls of their ancestors live. Some of the tribes have converted to Christianity. The

German Lutherans were the first Christian missionaries to arrive in this area in the 1870s.

Most villages have a designated place for meetings, where the traditional dance called the *akhra* is held. The *akhra* has been described by a social activist as an important local institution that needs to be revived to instill a sense of pride and bring the people together on a common platform to discuss issues related to their welfare.

Table 3: Local Festivals

Tribe	Festivals		
	Summer	Rainy	Winter
Munda	Sarhul (Baha Parv) and Holi (Fagu)	Her Puna and Rova Puna	Sukan Buru Mela, Poos Mela, Dussehra and Sohrai
Oraon	Sarhul and Good Friday	Karma and Jitiya	Katni Parv, Christmas, New Year and Her Puna
Pahariya	Holi, Surya Puja and Vishnu Puja (chadicya puja)	Harihar Puja (Nag Panchmi), Raksha Bandhan, Mansa Puja and Karma Puja	Durga Puja, Diwali, Kali Puja, Aswin Puja and Bajna
Santhal	Holi and Sarhul	Karma	Dussehra and Diwali
Ho	Sarhul and Holi	Hearo, Karma and Jomnama Parv	Madhe Parv and Baa Parv

## 2.5 LEVEL OF TECHNOLOGICAL ADVANCEMENT

All the villages in the study lacked adequate electricity. Some were well connected to the road, but most could be reached only through an unmetalled/*kuccha* road. A few villages had schools and most had Anganwadi centres (AWCs), some of which, though, were non-functional.

Regarding the health system, in most of the villages, injections were only introduced in the last five years. Allopathic medicines were also introduced to the community within the last 5-10 years.

# TRIBAL HEALTH SEEKING BEHAVIOUR

This section highlights the health seeking behaviour of each tribal group studied. The general illnesses that occur in the villages and the service providers that deal with them, are discussed, followed by the continuum of care model that begins with planning for a family to antenatal care, delivery and childcare. Preventive and curative services/behaviours were listed and probed under the following heads:

**Family Planning:** Ideal family size and sex preference, decision-making process in family planning (FP), traditional FP methods and access to FP services

**Pregnancy Care:** Means of identification of pregnancy, traditional rituals during the antenatal (ANC) period, knowledge of ANC, accessibility of ANC services, decision-making to access services

**Birth Care:** Birth preparedness, decision on place, attendant at birth, birthing traditions and rituals, accessibility to modern birthing care and emergency services

**Neonatal Care:** Initiation of breastfeeding, care at birth, access to emergency services, traditional rituals

**Child Care:** Access and usage of

immunisation services, traditional care and practices

## 3.1 MUNDA TRIBE

### 3.1.1 Common illnesses

Common illnesses found in the villages of the Munda tribe were classified according to the season they occur in (see Table 4), in order to understand the effect of weather on their health.

Malaria is the most common illness among the Munda tribe, which occurs specifically during the rainy and winter season. The tribe primarily depends on traditional healers/ojha. “*Aksar yahan bache malaria ya diarrhoea se maut ke kareeb pahunch jate hain.*” (Malaria and diarrhoea are the usual causes of child mortality) - ANM, Khunti

### 3.1.2 Availability and distance of health services from villages

The sample villages were located more than 10 km from the Government hospitals. The Primary Health Centre (PHC) is situated

at a distance of 18 km from one village and 28 km from the other, whereas the private health providers (traditional/tribal healers) are mostly located within the village itself.

### 3.1.3 Tribal perception of existing health system

Tribal perception about the health system partially depends on the availability of and accessibility to, health facilities. The perception of the Munda tribe regarding the existing health system differs in the two villages, due to a variation in the presence of health facilities.

Anganwadi workers are present in both the villages, but found to be non-functioning in one of them. No other modern medical facilities were available, resulting in a greater belief in and practice of traditional forms of treatment. Most people in both villages prefer modern methods of treatment, but due to financial problems, long hours of travel and lack of availability and accessibility,

Table 4: **Common Illnesses in the Munda Tribe**

Illnesses		
Summer	Monsoon	Winter
Itching, loo (heat/sun stroke) and white discharge from genitals	Diarrhoea, ulcer, boils, malaria, filaria, Gal fulli (mumps), white discharge and itching in genital parts	Malaria, pneumonia, cough and cold, sarfatna, and white discharge from genitals

they have to depend on traditional treatments.

### 3.1.4 Health service provider preference

The preference for health service providers differs between the two villages, due to their beliefs, the availability of health facilities, the nature of the diseases and the financial condition of the families. In case of minor morbidity like swelling of feet, vomiting or weakness, the people first consult a traditional healer, then an ANM/AWW, and lastly, doctors. In case of a normal delivery, they mostly prefer a *dai* (midwife), and only in critical cases, do they visit a hospital. For diseases like malaria, diarrhoea and white discharge, the villagers first try to get medicine from an AWW, and if they cannot get the medicine or cure, they visit the doctor.

While traditional healers/*ojhas*, AWWs and ANMs are available and accessible, doctors are hard to find in these villages.

### 3.1.5 Referral and related issues

In critical health situations, the patients are referred to the hospital/doctor at Marangada, Khunti and Murhu. However, in many cases, due to unavailability of doctors at the centres or hospitals, the patients are left unattended and untreated.

### 3.1.6 Family planning

#### Decision-making

Knowledge, awareness, perception use and myths/beliefs related to FP were discussed with the couples during the interview. Based on the information provided by the

respondents, a few important points emerged which are listed below:

- Perception that use of FP has adverse effect on health
- Low use of FP
- Decision-making on FP by both the partners
- Use of pills and condoms as birth spacing methods
- Low preference for a permanent method, i.e. sterilisation
- Initiation of FP after three to four children

#### Awareness

There seems to be a fair level of knowledge of modern contraceptives amongst the study population. Few of them had seen and used contraceptives, mostly the spacing methods. Permanent methods, however, were not too popular, because of the unavailability of such services in the immediate surroundings.

#### Home remedies

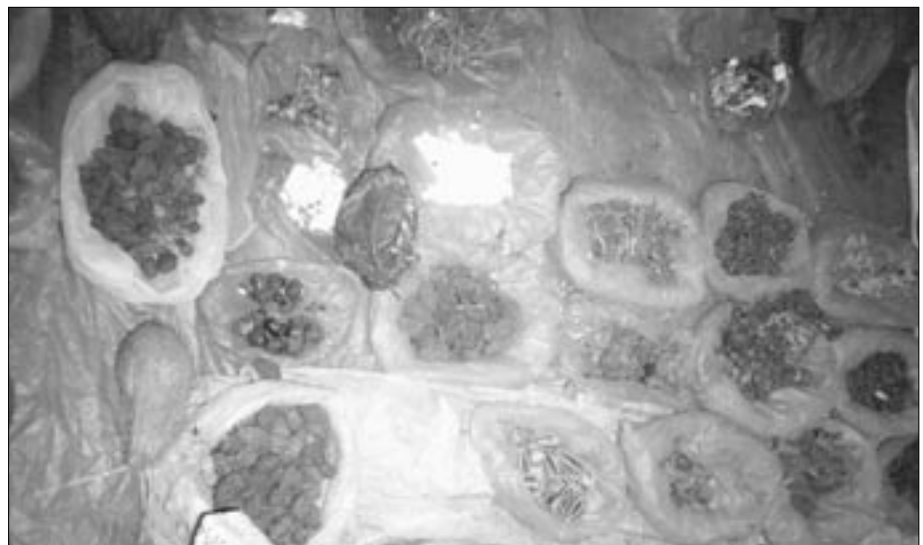
Many home remedies and traditional FP methods were mentioned during the discussion. The traditional medicine for FP is available with the *dais* as well as with traditional

healers. These remedies are used for menstrual regulation, spacing of children and for permanent contraception. The components of these traditional medicines are extracts from herbs collected from the forest areas. The community's faith in the traditional methods is high and their usage seems to be quite prevalent.

There are mainly two forms of tribal remedies found among the Mundas. One is the use of herbal medicine prepared by the *dai* and the traditional healer/*ojha*, which is quite prevalent, and the other method is rigorous massage of the abdomen of women to prevent conception.

#### Access to and utilisation of services

Access to condoms and pills depends on the presence of a functional Anganwadi or a social marketing entrepreneur in the vicinity. Intrauterine devices (IUD), such as Copper-T, were rarely used. In fact, most ANMs who were interviewed said that they were not confident in inserting a Copper-T/had never inserted one in their career.



There is a sizable population with the felt need for a sterilisation operation, but due to non-availability of services, such operations could not be performed. Some of the participants in the discussion recollected the FP drive enforced during the Emergency period in the country in the 1970s, and talked about vasectomy in this context.

### 3.1.7 Maternal health care practices

#### **Maternal mortality and morbidities**

Three cases of maternal deaths were reported from the two villages under study, but the reasons for the deaths were not known.

The Munda community has its own set of symptoms to identify morbidities that commonly occur in women during pregnancy. For instance, stomach pain along with headache is identified as *Suni Ka* disease and blood in the urine is known as *Risa Rog*, two common complaints during pregnancy.

Awareness regarding identification or detection of pregnancy among the women was found to be negligible. As quoted by most of the women during an FGD, “*Pet dikhne pur hi pata chalta hai ki woh pregnant hai...koi aur toh tareeka nahin hai.*” (They have no specific way to know that a woman is pregnant, except when her stomach starts showing.)

#### **Common maternal morbidities**

- Malaria during pregnancy
- Swelling of body
- White discharge from genitals
- Miscarriage
- Pain in lower abdomen

- Stomach ache with headache (*Suni Ka*)
- Blood in urine (*Risa Rog*)
- Minor complaints like cough, cold
- Weakness and vomiting.

Weakness during pregnancy was cited by most women, which may be the result of mild to severe anaemia.

#### **Home remedies for morbidities**

The Munda depend on traditional healers and home remedies for treatment of morbidities during pregnancies. Some of the popular home remedies are:

- *Kurti dal* (a kind of pulses) water, to protect pregnant women from *Chunko* disease
- Peppermint with water during delivery to prevent heavy bleeding from vagina
- A mix of *salukittha*, *otechampa*, *tepal*, *hessa*, *bakla* (local herbs), *jojo jam* (seed of *imli*) and sugar, thrice a day, for white discharge
- *Mududa*, *etoramda*, *tarimsura* (local herbs) and sugar mixed with water for five days for *Risa Rog*.

#### **Identification of pregnancy**

The Munda tribe primarily identifies pregnancy with the bulging abdomen of the pregnant woman. They are also aware of other symptoms like cessation of the menstrual cycle, loss of appetite, vomiting, tiredness and weakness. The people identify pregnancy simply by observing the above symptoms and do not go for any kind of medical check-up for confirmation of pregnancy.

#### **Decision-making on ANC**

The decision to register the pregnancy and avail ANC services

apparently depends on the availability of services. There is a myth related to tetanus toxoid (TT) injections within this community, where they believe that taking the TT injections can lead to a large baby and, hence, entails difficult labour. “*Yahan kahte hain ki TT lene se bacha bada aur kada ho jata hai.*” - Woman (36-40 years), uneducated, Khunti.

Decision-making power with regard to ANC in tribal families lies with the husband or the in-laws (usually, the mother-in-law), and the expectant woman doesn't have much say in it. In the Munda community, knowledge and awareness of ANC varies widely. In one of the study villages, the AWW herself did not have adequate knowledge about ANC, and consequently, the villagers were ill-informed, too. On the other hand, in the second village, which has followers of Sarna and Christianity as well as a functional Anganwadi, the level of ANC knowledge and awareness is rather high. In this village, the AWW provides information and services to pregnant women, including check-ups and distributes iron and folic acid (IFA) tablets.

#### **Traditional rituals during pregnancy, delivery and postpartum period**

Among the Mundas, pregnant women are not allowed to attend any funeral ceremony, owing to the belief that it may affect the baby adversely. They also sacrifice a hen to protect the pregnant woman and child from the evil eye (*huri nazar*). In case of any complication during pregnancy or delivery, the people resort to praying to rectify matters.



Only a few cases of institutional delivery were reported within the tribe. In the study village which has a trained TBA, most deliveries are conducted by her. The TBA could identify the position of the baby in the mother's womb by examining her abdomen. If the TBA observes reduced movement in the foetus, she gives a massage to the expectant woman with *karanj* (Indian beech) oil mixed with garlic.

The TBA's key role is to assist the pregnant woman during delivery and to cut the cord with a new blade and a one rupee coin. Using the coin for severing the cord is a common practice; it was found that the people do not take any measure to sterilise the coin. The earlier practice was to cut the umbilical cord with an arrow in case of a boy, and with a knife, in case of a girl.

The newborn is usually given a bath with warm water and turmeric immediately after birth. An old cotton cloth is used to wipe the baby after birth. The TBA massages the lactating mother and the baby, till the cord turns dry. Six days after the birth, a function called *Chhatiyari* is celebrated, during which the TBA receives grain, money, cloth and *hadia* (local liquor) for her services to the mother and the child.

*“Bacha hone ke baad maa ka pet malish karte hain. Aur kuchh ek ghanta baad bache ko bakri ka dhoodh dete hain aur maa ko kacha papeeta bhaanp ke dete hain tub doodh utarta hai.”* (After the baby is born, the mother's stomach is massaged. And after an hour or so, the baby is fed goat milk and

the mother is given steamed raw papaya, so that her milk will flow.)  
- TBA, Khunti

### **Breastfeeding practices**

After delivery, the mother's abdomen is massaged and both mother and child are given bath. After an hour of birth, the child is given goat milk, instead of mother's milk, as the community believes that colostrum is harmful for the newborn. If the delivery occurs in the early morning, the milk is given after 2-3 hours. They dip cotton cloth in goat milk and put a few drops in the child's mouth. Along with milk, they also start giving water to the newborn, since they believe that only having milk will make the baby thirsty.

### **Decision-making regarding weaning**

The family elders like the mother-in-law or father-in-law and other relatives make the decisions regarding weaning practices. They guide the mother according to their experience. On the second day after birth, the baby gets to suckle. The baby is given solid food only after six months. It was found, that most children were given rice with rice water, once they crossed six months of age.

### **3.1.8 Practice and beliefs regarding immunisation**

Knowledge and awareness about immunisation varies between the two villages. Where there is a functional AWW/ANM, the people are more aware, than in the location without a service provider. The utilisation of services is quite good, depending on the availability of the service provider.

### **Decision-making regarding immunisation**

Decisions regarding utilisation of immunisation services are taken primarily by the husband and the in-laws. The woman does not have any say in the matter. Some people are aware and are coming forward for immunisation, while others do not have much faith in it.

### **3.1.9 Child health care practices Common morbidities in children**

- Cough and cold
- Loose motion
- Tongue ulcer
- Malaria and diarrhoea
- *Sarfatna* (slit on the head)
- *Naskhinchna* (shrinking of veins)
- *Rangbad* (whole body turns reddish)

### **Identification of morbidity and treatment**

High fever with shivering and lack of appetite in children are some of the symptoms for identifying malaria. If a child is suffering from loose motions and lack of appetite, then it is considered to be diarrhoea. A narrow slit on the head (open fontanelles and the crevices between the skull bones) accompanied with fever, locally known as *sarfatna*, is quite common among infants. In case of *naskhinchna* (strained nerves), a sudden movement leads to tightening and hardening of the jaws and the patient finds it difficult to open the mouth. The home remedy used to treat this problem is massaging the jaws with hot mustard oil mixed with garlic. A child stops taking milk and food in case of a tongue ulcer, which is also common among this group. A change in the colour of the face and stomach to red, described as *rangbad* by the

local people, is also found to be common in this community. This illness is also characterised by a loss of appetite, and is treated with a local medicine prepared by the traditional healer, by combining honey, pig fat and *otechamla* (a local herb found in the forest).

#### **ICDS entitlements**

The children in the villages travel extensively, sometimes to adjacent villages, to get rice, pulses and turmeric. The community agrees that government health services are good, but these need to be available in the village itself or near the village. Since the health centre is far from the village, reaching the facility at the appropriate time is difficult, and in many instances, the centre is found to be closed for the day.

People are mostly unaware about the

services provided by the Integrated Child Development Services (ICDS) to pregnant and lactating women and children under the programme, and thus either reluctant to avail the services or are confused about the services provided to them.

#### **3.1.10 Reproductive health care Knowledge of RTI/STI and health seeking behaviour**

People in this community know about RTI/STI, but are not fully aware of all the diseases which may occur in the reproductive system or are caused by sexual contact. Though keeping the body clean is practiced universally, the people are not aware about cleaning the genital area before sexual intercourse, which is not part of their lifestyle.

Adolescent girls use ordinary cloth napkins during menstruation. These

cloth pieces are usually washed and dried in the sun for reuse.

If any RTI/STI symptoms persist, for example, if they feel pain in the genitals, they consult the *vaid raj*, and if his medicine has no effect, they consult the doctors for treatment. In case of any treatment or consultation related to RTI/STI problems, the couple visits the doctor together and seeks advice. In most cases, the couples do not opt for counselling. At these times, couples avoid intercourse.

An IDI with a traditional healer reveals that the healers provide information on RTI, STI and Acquired Immuno Deficiency Syndrome (AIDS) to all their patients/clients, and if they find any symptoms of RTI and/or STI, they refer the patients to the District Hospital.

### 3.2 SANTHAL TRIBE

#### 3.2.1 Common illnesses

The villagers were asked to provide a list of illnesses they suffer from, so as to understand the pattern of illness. Table 5 describes the common illnesses within the community. Certain diseases feature prominently during different seasons. In summer, it is mostly *loo/sun* stroke which leads to a condition of dehydration, measles and skin problems; in the rainy season, diarrhoea; and in the winter, cough, cold, fever and malaria.

#### Tribal perception of existing health system

Although the Santhals accept modern medicine, they also visit traditional healers/*ojhas*, as they have complete faith and belief in them. Most villagers follow herbal or traditional healing practices, not because they do not want to take modern medicine, but because they cannot afford the cost of visiting a doctor outside the village.

*“Parivar mein bimari ityadi hone par log jadi-booti ka hi ilaj karate hain, sochte hain yadi gaon mein hi thik ho jayega*

practices. Herbs are used for children’s diseases and common illness.

- Dysentery: Lemon juice and/or a dash of lime added to milk is given to stop dysentery completely. A pulp made of the skin of mango tree, *bel* (bael tree), and skin of *amla* (Indian gooseberry) is also fed to the dysentery patient.
- *Kala azar*: The people eat *ghengha jiv*, a kind of snail found in the forest area.
- Diarrhoea: The people use *jhinuk/jhunaka* (shell) which is found in water. First, they remove the meat in the *jhinuk* (shell), burn the shell, and mix the resulting powder with sour mango, sugar and *sounf* (Indian sweet fennel).
- Tuberculosis: The patient is made to drink the fresh blood of a sacrificed dog.

Table 5: Common Illnesses in the Santhal Tribe

Illness		
Summer	Rainy Season	Winter
Malaria, mouth ulcer, <i>loo</i>	Diarrhoea, malaria, loose motion	<i>Gissi</i> , cough, cold, malaria

Santhal people identify diseases like *kala azar* on the basis of symptoms like the body turning black along with fever, while in case of jaundice, symptoms like swollen abdomen and yellowing of the body are noted. Malaria is recognised by shivering accompanied by high fever.

*to bahar doctor ke paas jane ki kya zaroorat.”* (If somebody in the family falls sick, traditional herbal medicine is generally used, as it is believed that if one can be treated within the village, then there is no need to go to a doctor outside the village) - FGD, male, village Jalalpur, Sahebganj.

#### Availability and distance of health services from villages

In the sample villages, there are no doctors available, while traditional healers/*ojhas* are easily accessible within the villages. AWWs and ANMs are available in both the villages.

Some of the respondents were critical of the government hospital and believe that the hospital always prescribes wrong medicine and gives medicines that have expired. In one of the FGDs, a participant said *“Sarkari aspatal jane se darr lagta hai, purana dawa deta hai, viswas nahi hai.”* (I fear going to the government hospital as they will give me old and expired medicine).

The PHC is located within 2 km of both the villages. As far as the district hospital is concerned, one community is located far from it (around 15 km), while the other village is located at a distance of two km from it.

#### Home remedies for morbidities

In the Santhal tribe, most people follow herbal or traditional healing

#### Referral and related issues

The sick in the Santhal community are usually taken to private medical consultants, but if they are not cured, the patients are moved to Malda or Bardhwan town in West Bengal. The people feel that the services in these towns, which are easily accessible, are better than those in the Sahebganj and Barharwa towns.

In critical cases, the community calls the doctor to their village. At night, they hire a vehicle to take the patient to the nearby Barharwa town. They do not go to the *ojha* in critical cases, because they have no faith in the traditional healers in these circumstances. As one of the villagers remarked, *“Ojha bojha hota hai.”* (*Ojha* is a burden during critical cases.)



### 3.2.2 Family planning

The size of a family is primarily determined by its economic status and also by the presence of a son in the family. An interesting issue came up in an FGD, where a respondent said “*Parivar mein jinka jamin jyada hai, usse teen se char ladka hona jaruri hai, jiska jamin kam hai ek se do ladka hone se chalta hai.*” (If the family has a large piece of land, then it must have three to four sons, but if it has a small piece of land, then one to two sons are fine.)

A typical Santhal family generally has four to five children, with at least one male child. Compared to Christians in the Santhal tribal group, the Sarna community does not accept the use of contraceptives, unless it is perceived that delivering more children has an adverse effect on the mother’s health. The TBA does not suggest any contraceptive measures to the villagers, nor does she refer them to the AWW or ANM.

#### Decision-making

On the basis of the information gathered during the discussion with couples, it was found that the wife takes the major decisions regarding use of contraception as well as the size of the family. While deciding the number of children, as mentioned earlier, the economic status of the household is the prime factor.

#### Home remedies

This tribal group depends on traditional FP methods. They do not even use condoms provided free of cost from the AWC. As an AWW stated, “*Condom ek bar diya tha, prayog nahi karte isliye nahi dete*.” (I had distributed condoms once, but they do not use them so I stopped distributing.)

The Santhal traditional healers claim to have remedies to prevent pregnancy, which have a permanent effect and can be adopted in lieu of sterilisation. However, they refused to reveal the composition of the medicine, saying that only the *dai* knows the same.

“*Bachon ke antara ke liye bhi jadi-booti hai. Aur operation toh kewal mahilayen karati hain.*” (For birth spacing, herbs are available. Only women go for operations.) - Traditional healer, Sahebganj

“*Parivar niyojan ke liye Mala-N dete hain. Condom ek baar diye the, prayog nahin karte, isliye nahin dete.*” (We give them Mala-N for family planning. We used to give them condoms, but they don’t use them, so we stopped.) - AWW, Sahebganj.

#### Access to and utilisation of services

“*Parivar niyojan ke liye Mala-N dete hain. Condom ek baar diye the, prayog nahin karte, isliye nahin dete.*” (We give them Mala-N for family planning. We used to give them condoms, but they don’t use them, so we stopped.) - AWW, Sahebganj.

### 3.2.3 Maternal health care practices

#### Maternal mortality and morbidities

Seven cases of maternal deaths were reported by the respondents from the two study villages, but they could not provide reasons for the deaths.

#### Common maternal morbidities

- Malnutrition and weakness
- Malaria
- Abdominal pain
- White discharge from genitals
- Diarrhoea

#### Identification of pregnancy

The tribal people have their own methods to identify pregnancy.

The Santhals identify pregnancy by noticing symptoms like stopping of menstrual cycle, loss of appetite, tendency to eat sour food and nausea. They say that the taste buds of pregnant women are also affected for the first five months.

#### Traditional rituals during pregnancy, delivery and postpartum period

Among Santhals, on detection of pregnancy, a *puja* is performed and a cock/hen is sacrificed for the well-being of the unborn child. The pregnant woman refrains from eating rice after conceiving and is not allowed to do any household work till delivery. The woman is made to fast (*narka upwas*) for four hours after the delivery, a ritual associated with cleanliness of child and mother. Post-delivery, the house is cleaned thoroughly.

Most of the deliveries among Santhals are performed by the *dai* (TBA). She provides necessary information on how to maintain cleanliness and hygiene at the place of delivery as well as after the childbirth. She cuts the umbilical cord of the child with a new shaving blade, by placing a one rupee coin that has been washed. The TBA massages the lactating woman for three days and also gives warmth to her stomach by putting *arandi* leaves on it.

#### Breastfeeding practice

According to a section of the community, the infant is fed the colostrum within two-three hours of birth, after both mother and child are cleaned up. Another section claims that the child is initially given goat’s milk and breastfeeding begins much later.

### **Decision-making regarding immunisation**

Both the study villages have ANMs and AWWs, and thus, the villagers are aware about immunisation, but do not really know why it is essential for the child and mother. In one village, taking decisions related to immunisation is not a task, since the ANM makes regular visits and provides her services to the people. In the other village, though, the ANM visits once a month and that too, only the houses of the wealthy. There seems to be total dependency on the ANM in both villages.

### **Child health care practices**

There were 15 cases of child death reported from the two sample villages. The reasons for the deaths are not known.

### **Common morbidities in children**

- *Puni* (the child loses weight and the stomach bulges out)

- Fever
- *Kala Dhaba* (the child's head/skull divides into three parts)
- *Pilha* (enlargement of spleen)
- Cold and cough

### **Identification of morbidity and treatment**

The Santhals identify the *Puni* disease when an infant keeps its legs crossed together for a long time, becomes very thin and is not able to suckle. A fatal disease called *Kala Dhaba*, generally found among newborns, is identified by continuous fever, breathing problem and finally, appearance of cracks on the head or deep depression on the head and chest.

### **3.2.4 Reproductive health care**

Most Santhal women suffer from anaemia. They do not discuss even minor reproductive problems with the ANM. For severe problems, they prefer the traditional healer.

Since most of the women are not registered with the health facility, they do not receive any type of treatment for reproductive health problems. As most deliveries take place at home under the supervision of untrained *dais*, proper care and cleanliness is not ensured, which results in RTI related problems.

### **Knowledge of RTI/STI and health seeking behaviour**

According to the community, if any couple shows symptoms of RTI/STI, they take suggestions from the husband's mother and use traditional as well as modern medicine. When the ANM was asked about RTI/STI, she said that she had not been approached with any such case, and emphasised that the ANMs do explain the importance of hygiene and cleanliness of the body.

### 3.3 ORAON TRIBE

#### 3.3.1 Common Illnesses

Some of the common illnesses among the Oraon tribe are given in Table 6. The diseases are categorised according to the seasons they occur in.

#### **Tribal perception of existing health system**

Most people in the community prefer to go for modern treatment, but due to absence of modern facilities in the village and high expenses associated with these, they have to depend on traditional providers for treatment. However, in one of the diseases afflicting children where the child becomes skinny and keeps his legs crossed (*pair fansna*, in local

language), the Oraons think that it cannot be cured by the doctor. “*Iss bimari (pair fansne wali) ke ilaj ke liye hum doctor ke paas nahi jate hain, kyunki doctor iss bimari ka ilaj nahi kar pate hain.*” – Male, 35 years.

There is no hospital, PHC or doctor in the village or near the village.

The faith in traditional medicine and treatment within this community is strong, not only due to the absence of modern facilities, but also due to the durability of this form of treatment, along with its easy availability and accessibility at a lower cost. For modern treatment, they need to visit Gumla, the district headquarters, which is at a distance, and thus, expensive for them to reach.

The recent perception in the community is that it's better to go for modern treatment, as there are too many diseases which traditional healers are unable to cure. The villagers say that there should be a good hospital in their village.

Tribal perception about health system depends upon the availability of, and accessibility to, health facilities.

#### **Health service providers**

The traditional healer/*ojha* was found to be functional in the study villages, along with the RMP. In one village, there were no ANMs/AWWs, while in the other, both of them were found to be functional, providing services to the community.

Table 6: Common Illnesses in the Oraon Tribe

Illness		
Summer	Rainy Season	Winter
Measles	Diarrhoea	Pneumonia
Skin problem	Boils	Malaria
Loo	<i>Puni</i>	Cough and cold
Mouth ulcer	Loose motion	<i>Sarfatna</i>
	Malaria	

### CASE STUDY

#### **Sujata Giddi (name changed), 24 years, illiterate**

My child was suffering from the *Adanjho* disease after the birth. She became very thin and used to cry a lot. Once we found that her legs were crossed and tied with each other. We understood that she is suffering from the *Adanjho* disease. I did not go to the doctor, because they would not have any medicine to cure this disease. So, I went to the local *vaidya* with a bowl of *ghee* (clarified butter) which he mixed with some local *jadi-booti* (herbs) and advised me to apply this solution on her legs and give some massage. By using that herbal medicine, gradually my child was cured, with the results showing within three days.

We have full faith in the *vaidya* and his behaviour is also very good. He gives the treatment at minimum cost, which is also a great relief to all of us. Going to doctors means lots of money and they do not always have medicine for all the problems. I earn money by farming, so we always have financial constraints. During financial crisis, we consult the Mahila Mandal about money.

#### 3.3.2 Family planning

##### **Decision-making**

Family planning decisions primarily concern the number of children and spacing between children. Most villagers mentioned that the husband and wife jointly take a decision regarding FP. The role of the mother-in-law never came up in any of the FP discussions.

The people prefer to adopt temporary methods like pills and condoms for birth spacing. Permanent methods like tubectomy and vasectomy are preferred by very few, and only when they think they have enough children. Usually, couples with three or more children, and at least one male child, decide to go for sterilisation.

##### **Awareness**

The couples in this community were found to be aware of modern contraceptives. Most of them have seen and used contraceptives or

know people who have used them. Permanent methods were not as popular, though, chiefly because such services are not available. Interestingly, the Santhal community talked about vasectomy.

It was also seen that in villages with a Christian population, the acceptance of FP measures was higher, though most of them were Catholics who are against FP. FP services are used more widely in the village with ANM and AWW services, than in the one with non-functional ANM/AWW services.

Information on contraceptives was provided by the AWW or the ANM. It is mostly women who access such information. Most villagers also have access to radios, which is an important portal for knowledge dissemination on FP services.

### **Home remedies**

The home remedies and traditional methods mentioned in the discussions are generally prepared at home, or by the *dai* and some are prepared by the traditional healers. These remedies are used for menstrual regulation, spacing of children and for permanent contraception. The composition of these medicines was not revealed by any of the traditional healers/*ojhas* or *dais* during the interviews. Faith in the traditional methods is high and their usage seems to be quite prevalent.

As stated during an interview with a traditional healer, there are traditional medicines for abortion. If a woman wants to get an abortion, a *jadi-booti* (local herbs) is kept in her birth canal for two to three days, which damages the embryo.



This method can be used for a woman who is up to three months pregnant. Another medicine used as a permanent method is prepared by boiling roots of *paan* (betel nut leaf) and old *gud* (jaggery).

### **3.3.3 Maternal health care practices**

#### **Maternal mortality and morbidities**

The villagers were asked to prepare a list of maternal deaths and critical maternal illnesses that they could recall as having occurred in the past three years. The study team was able to document one death that occurred in the last three years during our study visit. All the deaths took place in the village.

The women are rarely referred for emergency obstetric care due to non-availability of services. The unlicensed practitioner is usually summoned to the house, where he/she administers a few injections. On probing the local community, it was found that they were not aware what the injections were exactly, but said that they ensured a quick delivery. Nurses in the area mentioned that

the unlicensed practitioners usually give Oxytocin injections.

The common maternal illnesses identified are listed below. The list generated is a free list and no ranking of symptoms was attempted.

#### **Common maternal morbidities**

- White discharge from genitals
- Pain in stomach and lower abdomen
- Swelling of legs during pregnancy
- Dislocation of baby in the womb (*Bacha Khisakna*)
- Bleeding and weakness (*Pichily*)
- Malaria
- Loose motions
- Diarrhoea
- Itching in genital area

Malaria and diarrhoea seem to be common problems among pregnant women in the study area. Miscarriages were also a common phenomenon. White discharge and other RTIs were also described. Women usually suffer quietly from these illnesses. They do not consider swelling of feet as a dangerous sign, which can be inferred from an interview with a pregnant woman

who said, “*Garbhavastha mein haath-pair ke fulne ko gaon-dehat mein bimari nahi samjha jata hai.*” (During pregnancy, if there is a swelling in the hands and feet, it is not considered as a problem or as a symptom of illness.) - Surajmani Kindo, pregnant woman, Raghunathpur, Gumla.

Among the Oraons, morbidities are usually recognised by visual symptoms like thick white fluid discharge from female reproductive parts, known as *Safed pradar* in the local language.

### **Home remedies for morbidities**

Most households and women interviewed seemed to prefer home remedies, and in case of severe illness, they resort to *ojhas*. When things get critical, they consult a private doctor in the nearby town. Most of these decisions are taken by the head of the family.

The Oraon tribe has its own indigenous and traditional medicines for common pregnancy-related health problems:

- Loose motions (dysentery) – A new guava leaf is eaten early morning
- Leg pain – *Karanj* (Indian beech) oil is used
- White discharge from genitals – Medicine prepared with old gud (jaggery) and root of *juli* flower
- For removal of placenta after delivery – A *jadi* (herb) called *chirchiti* (chireta) is applied on any part of the body.

### **Identification of pregnancy**

In the Oraon community, the family elders (usually the mother-in-law) identify pregnancy by checking the stomach and noting other physical

changes. They confirm pregnancy based on symptoms like vomiting, desire for sour things (tamarind, pickles etc.), physical changes, tiredness and stopping of menstrual cycle. They occasionally consult the village *dai* too, who assists in the identification of the pregnancy.

### **Decision-making on ANC**

The Oraons are slowly catching up on ANC due to the presence of the AWW. The mindset of the people is changing and pregnant women have started coming to the AWC for TT injection, IFA tablets and advice regarding pregnancy care. In addition, at the AWC, the weight of the pregnant woman is recorded and information on a healthy and balanced diet is provided to those found to be underweight.

### **Traditional rituals during pregnancy, delivery and postpartum period**

The community does not allow a pregnant woman to cross a river or attend any funeral ceremony. Sour and hot foods are also forbidden.

Another interesting custom noted among these people was that in case of any complication during delivery, the woman is made to wash the feet of her brother-in-law and drink that water. They believe that the reason behind the complication is her lack of respect for her brother-in-law.

There is no specific diet restriction among this tribal group. The women continue with their routine work till the time of delivery, and sometimes their husbands assist them in their work.

The TBA plays a vital role during delivery in rural areas. Some of these

TBAs also receive training from agencies or through the government to gain more skill and expertise in their work. The *dai* assists in most deliveries and stays with the mother for a week after the delivery. During this time, she is expected to give the mother and baby regular baths and massages, and also wash the used clothes. Post-delivery, the mother is taken to the *vaidya* (local healer) for a disease locally known as *pet pakna*, as they think it cannot be cured by the doctor. “*Prasav ke baad ki bimari (pet pakna) mein vaidya ke paas bhejti hoon, doctor ka dawa se theek nahi hota hai.*” - Albiliya Giddi, TBA, Raghunathpur, Gumla.

Among the Oraons, the TBA’s role is similar to that among the other tribes included in this study. The community prefers TBAs for deliveries rather than going to a hospital, as they are easily accessible and their services are much cheaper. They also believe that if a delivery can be done at home, there is no need to admit a pregnant woman in a hospital.

During labour pain, the TBA first ensures whether the pain is real or merely a false alarm. She does so by pouring oil on the stomach of the pregnant woman, and observing if the oil falls straight. If it does, she confirms that the time has come. If the labour pain continues longer than the stipulated time, she administers a medicinal herb called *chirchiti*. If the TBA finds complications during the pregnancy/delivery, she then refers the case to the nearest hospital.

The *dai* is usually called at the time of delivery. Most of the *dais* are not trained, but are experienced. She attempts to identify the position of



the baby by feeling the abdomen and pours oil on the stomach of the woman, as cited earlier. During delivery, the pregnant woman lies on a jute mat and cotton cloth on the floor. A family member brings a new shaving blade, soap and oil for the delivery process. The *dai* uses the new blade to cut the umbilical cord, by putting it on a one rupee coin. After delivery, she bathes the newborn and cleans her/him properly with soap and water. She also massages both mother and child till the cord gets dry. It takes three to five days for the cord to dry.

After six days of birth, the people celebrate *Chhatiyari*, when people come to see the mother and child, and give some money or gift to the child. A day after *Chhatiyari*, a woman takes the mother to the well and sacrifices a hen. They, then, put some drops of the hen's blood in the child's mouth.

In the Oraon tribe, if a pregnant woman has a problem, they refer her to a *dai* or ANM, but for any serious complication, they take her to the Gumla Sadar Hospital or St. Joseph Hospital.

“Agar kisi mahila ko prasav dard shuru hota hai, to humein bulate hain. Hum pet par tail dalkar dekhte hain ki prasav kitni der main hoga.” (If a woman has labour pains, they call us. We put some oil on the stomach and predict the time of delivery) - TBA, Gumla

### **Breastfeeding practices**

Earlier, the community did not provide colostrum to the newborn, and fed it goat's milk instead, since they believed that the first milk is harmful to the child. Now the people

have become more aware and realise the importance of the colostrum, and have started giving the mother's first milk, as it helps build the baby's immunity. Breastfeeding is started on the first day soon after birth, but exclusive breastfeeding is still an issue, since most mothers continue to give their infants honey and sugar between feeds.

### **Practice and beliefs regarding immunisation**

The Oraon have knowledge about and are aware of immunisation. Immunisation services are mostly provided by the AWW at the centre and the ANM comes to give vaccine on a monthly basis. Apart from the AWW and ANM, no one else comes from outside for the purpose of immunisation. Polio vaccine, measles and DPT are given to children at the AWC. Some women also have cards, which contain immunisation details, and this card stays with the parents or the ANM. Some of the villagers are also aware of the benefit they can get from each vaccine. They know that by taking polio drops, a child will be safe from polio. According to the people, they get information on immunisation from the radio, television, relatives and ANM. Some did complain that after taking the injection, their child suffered from fever and swelling in the injected area.

### **Decision-making regarding immunisation**

The decision-making power resides with the husband and his parents; they decide whether to provide immunisation to the child. The woman doesn't have any say in the decision. The decision-making scenario is different in the two

villages because of differences in knowledge and awareness levels. The varying levels of exposure and knowledge about the benefits of immunisation tend to make a huge difference in its utilisation, as observed among this tribal group.

### **3.3.4 Child health care practices**

The villagers were asked to list deaths in the last one year period amongst children under five years of age. The cause of death in any of the cases was not ascertained. Most deaths took place in the village, with very few sick children being referred for care. The villagers also described certain serious childhood conditions, such as chronic malaria, *kala azar* and malnutrition.

### **Common morbidities in children**

- *Rangbad*, where the body of the child becomes reddish in colour. This disease also leads to mouth ulcers. A child is then unable to eat anything or even suck at its mother's breast.
- *Puni*, where the child stops sucking the mother's milk, as a result of which the mother's milk also goes dry.
- *Larsut*, where the upper part of the tongue doesn't function properly.
- Cough and cold, fever and pneumonia.

### **Identification of morbidity**

Among the Oraon tribal group, morbidities are generally identified based on the visual symptoms. If the body of the child gets reddish in colour and there is a loss of appetite, then the disease is identified as *rangbad*. If a child stops

## CASE STUDY

### 9 years and 6 months old son of Jailin Giddi (27 years)

My child was fine for first 15 days after birth, and then all of a sudden, he started having a problem and cried incessantly. We thought it must be *rangbad* (in which the whole body turns red in colour) and took him to a *vaidya* for treatment. The *vaidya* gave a medicine prepared from medicinal herbs, advising us to give it to the child for three days, but there was no relief for the child. We took him to Gumla to see the doctor for treatment, but unfortunately could not meet the doctor as he was not in his chamber. Without any treatment, we returned back to the village. When my child was about a month old, he started bleeding from the mouth accompanied by black coloured stool. We got frightened and took him to Gumla, and this time we consulted the doctor. After looking at the child, the doctor suggested we take our child to Ranchi for treatment. He gave one injection for the bleeding and stool, but the bleeding continued. We are poor and so we could not take him to Ranchi for treatment. The child developed another ailment called *pair chadhna* (where the legs get twisted together) and we massaged him with the oil that the local *vaidya* gave us. We again took him to the doctor at Gumla for treatment, and this time with the help of his medicine, the child was cured.

This year (2007), in the month of August, a health camp was organised by Krishna Pranami Sewadham at Ranchi. We came to hear about it and took our child there. In this camp, an operation was done on both the legs. For this operation, we did not pay anything. The child was given a pair of shoes by the organisers. The doctor instructed us that the child should always wear these shoes.

Now, we are not seeking any treatment for the child because of financial problems. However, the doctor told us that he needs to undergo an operation on his head. His mother believes that due to some curse, her child is having all these problems.

He suffers from cold and fever. We give him medicine and massages every morning and evening, but his condition is still the same.

sucking at its mother's breast, they consider it to be *puni*. If the child's tongue gets stuck to the upper part of the jaw, they call it *larsut*, which can lead to dumbness. Another

disease that's known as *chita rog* is identified by the *vaidya* by touching the ear of the child. If one ear is cold and other is hot, then it is diagnosed as *chita rog*. Apart from these

diseases, the people identify normal fever with high body temperature and a loss of appetite.

### ICDS entitlements

The Oraon community in the study villages is satisfied with the ICDS centre. They confirmed that pregnant and lactating women get rice, *dal* and oil, and also get injections and medicines from the centre.

### 3.3.5 Reproductive health care Knowledge of RTI/STI and health seeking behaviour

It was found that the complaint of white discharge (*pradar*) is quite common among the women in both the study areas. The villagers said that two types of discharge are quite common – red discharge and white discharge. To prevent the occurrence of discharge, they bathe or wash and keep themselves clean. A family elder shared all the precautions they take to maintain hygiene. The villagers know that the discharge is part of their physical change, a fact they learn from their elders. If the problem persists, they hardly visit a doctor, as there is some hesitation in describing the problem. Although to date no single case has been detected, most of them are aware about the process of transmission of diseases from husband to wife.

### 3.4 MAL PAHARIYA TRIBE

#### 3.4.1 Common illnesses

Mal Pahariya is one of the minority tribes in Jharkhand. The common illnesses they suffer from in different seasons are listed in Table 7.

*Sarfatna* (crack on the skull) is quite common throughout the year and generally occurs among infants.

#### Identification of morbidity

The community identifies morbidities by their symptoms. For instance, brain malaria starts with vomiting and loose motions, while *kala azar* is identified with the onset of fever accompanied with shivering and headache, the body turns yellow, and there is also loss of blood. In *pilia*, the body becomes weak and there is swelling of feet, hands and stomach. For any problems in the menstruation cycle, the initial symptoms are weight loss and loss of appetite.

#### Distance of health services from villages

The village situated at the top of the hill does not have easy access to any health facility. For the community living in this area, the nearest PHC/district hospital/private practitioner is at a distance of more than 50 km. The other village has a PHC located within 15 km, but here too, the district hospital and private

practitioners are at a distance of more than 50 km.

#### Tribal perception of existing health system

In the absence of modern health facilities, the Mal Pahariyas believe that traditional treatment is better than modern treatment, as it is cheaper and easily available in their village. However, some believe that modern health facilities are more effective and should be available within the village.

#### Health service provider preference

The traditional healer/*ojha* was found to be operational in both the villages, but no doctors were found in either. One study village has both AWW and ANM, but the other has neither.

The preference for service provider varies in both the villages, due to difference in available health facilities. In the absence of any health facility, the community members solely depend on the *dai* and *ojha*, who are available in the village. In most cases, the villagers first try home remedies, specifically in case of common illness, and if they are not cured, they consult an *ojha* or traditional healer. In critical cases, however, they directly visit a hospital/doctor.

There is also a lack of transport facilities to take the sick to health centres. Since one of the study villages is surrounded by hills and forests, few health personnel opt to come to this village. In the other village, however, one AWC is operational. The ANM visits only upper caste residences, and that too just once a month, and ignores the Mal Pahariya population.

The people first visit traditional healers, keep the ANM/AWW as the second choice, and only as a last option, do they go to the hospital/doctor.

#### Referral and related issues

In this community, people strongly believe that traditional healers can treat all diseases. They go to modern health providers for treatment only in critical cases. During such critical situations, the people come down from the hills to the plains and consult quacks (untrained health providers) for treatment, and if there is any complication, they go to the Siwadi Hospital.

#### Availability of services

The tribals, especially the primitive tribal groups (PTGs), have no collective voice to demand health services. Most villages lack educational facilities and there is only one primary school in each of the studied villages. Due to the absence of any health facility in these villages, the level of knowledge and awareness among the tribal people was found to be very low. However, two study villages in which the AWC is functional, the AWW/ANM provides services occasionally, and the people in these villages are found to be comparatively more aware.

Table 7: Common Illnesses in the Mal Pahariya Tribe

Illness		
Summer	Rainy Season	Winter
Cholera	Diarrhoea	Malaria
Headache	Brain malaria	Brain malaria
Brain malaria	Loose motion	<i>Sarfatna</i>
<i>Sarfatna</i>	<i>Sarfatna</i>	



### **Home remedies for morbidities**

The Pahariya tribe usually applies home remedies for some of the common morbidities, while for the rest they depend on traditional healers and doctors. Most of these home-made medicines are prepared with flowers and herbs found in the nearby forest.

- If a woman has problems related to menstruation like abdominal pain and blood clotting, she is given the juice of a leaf, *pather-kucchi* (coleus). She is also given the juice of a flower called *job*.
- For normal cuts and bleeding, they apply the juice of the *koksima* (Hygrophila) flower.

### **3.4.2 Family planning**

Per se, PTGs are not encouraged to limit their family size, since their populations are small and reducing at an alarming rate. In fact, a health care provider can be penalised, if s/he offers family planning measures to the group. Some members of the PTGs have expressed their displeasure with respect to this rule and would like to practice some form of contraception.

Child marriage is common in this tribe and the reason stated by the women of the village is, “*yahan par bada hone par sharir dikhne lagta hai aur panch log panch tarah ki baaten bolte hain.*” (When a girl grows up, her figure matures, which becomes a topic of discussion for many.)

Sex preference is not too prevalent in the Pahariya tribe. The average number of children per household is two to three. They prefer to have a small family, in order to minimise their cost of living. The tribe

believes that couples who adopt FP cannot worship the sun. It has been found that among couples with five to six children, most of the women are weak and anaemic.

### **Decision-making**

Decisions regarding family planning and birth spacing are taken jointly by the husband and wife. They also consult the *dai* and traditional healers before taking the decision. In the Pahariya tribe, couples think about family planning after having two to three children.

### **Awareness**

The couples do not know much about the modern FP methods. They prefer to go for traditional methods; modern methods have been banned in the tribe since the last 10 years, as the tribe falls in the category of PTG. The community does not go for FP surgery, as they believe that anyone who worships the sun cannot go for a surgery, and opt to use herbal medicines for FP.

### **Home remedies**

The home remedies and traditional methods mentioned by the community are generally prepared at home, or by the *dai*, while some are prepared by the traditional healers. These remedies are used for menstrual regulation, spacing of children and for permanent contraception. The study team attempted to find out the composition and names of the herbs used, but were successful in only some of the villages. Faith in the traditional methods is high and their usage seems to be quite prevalent.

The villagers take herbal medicine for both birth spacing and permanent

family planning. For birth spacing, they consult the *dai* who gives them some herbal medicine, and for a permanent FP solution, they consult with their *janguru*, whose medicine can prevent a pregnancy for four years. These medicines are meant for the woman only.

### **3.4.3 Maternal health care practices**

#### **Maternal mortality and morbidities**

The villagers were asked to prepare a list of maternal deaths and critical maternal illnesses that they could recall as having occurred in the past three years. The study team was able to document 18 deaths that occurred in the last three years during its study visit. All the deaths took place in the village; the causes were not ascertained.

Women are rarely referred for emergency obstetric care due to the non-availability of services. An unlicensed practitioner is usually summoned to the house, where he or she administers few injections. It was found that anaemia is the biggest cause of maternal death in this community.

#### **Common maternal morbidities**

- Malaria
- Diarrhoea
- Disturbance in the menstrual cycle
- Lack of blood (anaemia)
- *Kala azar*
- White discharge and itching in the groin

No ranking of symptoms was attempted in generating the above list. Malaria and diarrhoea seem to be prevalent amongst pregnant women in most of the study area. Miscarriages are also a common phenomenon.

### **Identification of pregnancy**

The Pahariya people identify pregnancy with symptoms like stopping of menstrual cycle, loss of appetite, tendency to eat sour food and nausea. The taste buds are also affected by pregnancy.

### **Traditional rituals during pregnancy, delivery and postpartum period**

Compared to the other tribal communities, the Pahariyas do not have much belief in superstitions and traditional customs during pregnancy. However, they too don't allow pregnant women to go near graveyards or attend any funeral ceremony or cross a river, as they believe that it may have a bad effect on the unborn child.

There is no specific restriction in a pregnant woman's diet. The women continue their routine work till delivery, and often the husband assists them in their work.

In this community, a typical feature during delivery is that there have to be two TBAs at hand to assist in the delivery. The TBA from the same village assists in the delivery, while the other TBA from any other or adjacent village cuts the cord. This custom is followed rigidly, and in case the second TBA is not available immediately, the family members keep waiting for her to arrive, ignoring the potential danger to mother and child.

Some peculiar practices amongst the Pahariyas are:

- After delivery, the TBA gives a massage to the newborn in the morning and evening.
- The child is first given goat milk,

and that too of a black goat (mandatory). Colostrum is not given to the child.

- After childbirth, the mother and child are kept away from the other family members for five days and treated as untouchables.
- After five days, the *bhandari* (barber) is called and the whole family cleans their nails etc., and takes a bath.
- After 12 days, the family goes to the pond to worship *Jalghari mai* with *kajal* and *sindoor*. Only after this *puja* is performed, is the mother allowed to touch water or work in the household.

### **Breastfeeding practices**

In the Pahariya tribe, people don't give colostrum to the child. Instead, they give goat milk by dipping cotton cloth in the milk and putting the drops in the child's mouth. The colour of the goat has to be black. Only after giving goat milk do they start breastfeeding, which continues almost till the next pregnancy. As a substitute for breast milk, they also give *mishri*, *sabudana* and barley to the child. In case of excess breast milk, the mother usually squeezes out the milk and discards it.

### **Decision-making regarding weaning**

The eldest member of the family guides the weaning process. Most people in this tribe start giving solid food after five months to a boy child and after seven months to a girl child. They have a ceremony called *Mukhar Bhaat* in which the maternal uncle (*Mama*) of the child feeds the baby for the first time. After *Mukhar Bhaat*, the child is given rice, pulse and some vegetables.

### **Practice and beliefs regarding immunisation**

Amongst the Pahariyas, practice and beliefs about immunisation varied between the two studied villages. In the absence of an AWC and ANM in one village, the people there were found to be unaware about immunisation. In the other village, however, immunisation is done at the AWC by the AWW and ANM, and the people here believe that due to immunisation, a child remains healthy and free from diseases like polio. They mentioned that they get information regarding the immunisation services mainly from the radio and television. They also have a *Jachha-Baccha* card, but



they do not know what is written on it.

### **Decision-making regarding immunisation**

In the Pahariya tribe, decision-making power resides with the husband and his family; the women have no say in such matters.

### **Child health care practices**

The villagers were asked to list deaths in the last one year amongst children under the age of five. The causes of the deaths were not ascertained. Most of the deaths took place in the village, with very few being referred outside for care. In all, 14 child deaths were recalled by the group in the study area in the last five years.

The villagers also described various childhood conditions that were of concern, including chronic malaria, *kala azar* and malnutrition.

### **Common morbidities in children**

- Fever
- Cough and cold
- *Pilia*
- Malnourishment
- *Kala Dhaba*
- Malaria
- *Kala azar*

### **3.4.4 ICDS entitlements**

In the Pahariya community, the villagers reported that they do get TT injections. The level of awareness and utilisation of ICDS among this community is poor.

### **Reproductive health care Knowledge about RTI/STI and health seeking behaviour**

Some of the common RTI/STI

problems are white discharge and itching in the reproductive organs as well as urinary passage ailments. For the treatment of RTI/STI, the people prefer herbal treatment. A couple goes together for treatment, if they have any problem related to RTI/STI.

One of the practices peculiar to this tribe is that after childbirth and during menstruation, the mothers are not allowed to take bath with cold water. If any problem occurs, the women usually consult their mothers. The people use both traditional as well as modern medicine for RTI/STI treatment.

### **CASE STUDY**

#### **Pannalal (name changed), Male, 28 years, Pahariya tribe, Buddidih, Dumka**

I got married in 2000 and became a father in 2001, but the child died after six days. It was the month of *Bhado* (Aug-Sept). When the child was born, he was fine, but after a couple of days he developed *Kala Dhaba* and brain malaria. I took him to the doctor. He had high fever and was crying incessantly. The doctor examined my child and said that he is suffering from brain malaria. He gave injections on the second and third days, but there was no improvement.

One old person said that the baby is suffering from *Kala Dhaba*. As per suggestion, I took the child to the *ojha* in Rebdibadi. The *ojha* gave me an ointment made of some herbs (*jadi-booti*) to apply on the child. I took him to the *ojha* whenever I felt that he is becoming serious, but I could see no change in my child's condition. On the sixth day, my son could not stand the pain anymore and died.

I spent Rs.1600 for the treatment. The behaviour of the doctor was good, but he was unable to cure my child. I am not satisfied with the treatment given by either the doctor or the *ojha*.

### **CASE STUDY**

#### **Suman Pujar, Male, 22 years, Pahariya tribe, Buddidih, Dumka**

Five years back, I got married. After three years of marriage, I became a father, but my child died after six months. The child was suffering from fever and his eyes were getting prominent. I felt that my child is getting seriously ill and took him to the *ojha*. He said, "Your child will be fine, if you give me a pair of pigeons and a pair of hens". I gave him what he wanted, just to make sure that my child gets better. The *ojha* gave a medicine made of *jadi-booti* (herbs) to be had for two days, but the situation remained the same.

So I took our child to the doctor in Astha-Joda, which is six km from our village. The doctor gave an injection and some tablets, but there was no change and most of the time my child was unconscious. I went back to the traditional healer and continued his treatment on the fifth day. But my child became critical that night and I could not take him to the doctor immediately so I took him the next morning. The doctor looked at him and declared him dead. I am not at all satisfied with the treatment of the doctor; he could not save my child.

### 3.5 HO TRIBE

#### 3.5.1 Common illnesses

The common illnesses among the Ho tribal group are given below according to the season they occur in.

##### **Tribal perception of existing health system**

There is a lack of health facilities in both villages. There is only an AWC in each village, in terms of a health facility. Both the villages have a PHC at a distance of two to five km, but one of these is not functional.

The perception regarding traditional and modern treatment differs between the two study villages, depending on the presence of health facilities. Where there are health facilities/providers, the people perceived modern facilities to be ideal.

Due to lack of transport facilities to the health centres, the community members totally rely on traditional healers, as they are available within the village itself.

##### **Health service providers**

In both the study villages, except for medical doctors, all other types of health providers were available such as traditional healer/*ojha*, AWW, ANM and RMP. In one study area, both ANM and AWW were found to inactive.

##### **Home remedies for morbidities**

In the Ho tribe, whenever someone falls ill, they first administer home remedies, and if the illness persists, the patient is taken to a traditional healer or doctor.

The community has home remedies for almost all common ailments:

- Dysentery – A guava leaf is eaten with sugar
- Itching – Powder of *kusum* fruit is applied on the affected area
- Cough and cold – A combination of *munga saag*, ginger extract/mixture of *pipri* (Indian long pepper), black pepper and *tulsi* (basil) leaves is eaten
- Fever – Mustard seed is tied on the arm of the patient
- Diarrhoea – Sugar-salt solution/extract of raw guava, pomegranate flower and plum bark is taken. Also, fresh guava leaves are consumed with sugar
- Headache – The head is massaged with warm mustard oil
- Post-delivery weakness – The woman is given a solution made from the powder of *neem* (*Margosa* tree) and *karanj* (Indian beech) bark
- If, during delivery, the vaginal opening is small, soap and surf is used for opening the mouth of the birth canal
- Liver problem – *Kuiley khada*

*saag* is used

- Cough and cold – Juice of *tulsi* (basil) and ginger is consumed
- Fever – Crushed mustard seeds are tied on the arm of the patient
- Pain – Oil massages are given for body pain

##### **Referral and related issues**

Within this community, the ill person is first taken to the traditional healer, then to the ANM and RMP. Critical cases, however, are taken to the hospital. One referral hospital which this community uses is in Orissa, as the villages are located on the border. They feel that services across the border in Orissa are of better quality, cheaper and also easily accessible.

#### 3.5.2 Family planning

##### **Decision-making**

Most of the villagers mentioned that couples take FP decisions jointly. The role of the mother-in-law never came up in any of the discussions. Tubectomy and vasectomy are not the preferred FP measures, as they fear such surgeries can affect their ability to do heavy work. As stated in one of the women's FGD, "*operation upay hai, par log darte hain ki operation ke baad bhari-bhari kaam nahi kar payenge.*" (Operation is a measure, but people fear it, as they think they would not be able to perform heavy work)

The couple also consults the AWW and doctors on FP related issues. The woman takes the initiative to do so, but the final decision still resides with the man alone.

##### **Home remedies**

The home remedies and traditional methods are generally prepared at

Table 8: Common Illnesses in the Ho Tribe

Illness		
Summer	Rainy Season	Winter
<ul style="list-style-type: none"> <li>● Loo</li> <li>● Mouth ulcer</li> <li>● Measles</li> <li>● Headache</li> <li>● Malaria</li> </ul>	<ul style="list-style-type: none"> <li>● Jaundice</li> <li>● Diarrhoea</li> <li>● Fever</li> </ul>	<ul style="list-style-type: none"> <li>● Cough and cold</li> <li>● Fever</li> <li>● Malaria</li> <li>● Pneumonia</li> </ul>

home, or by the *dai*, while some are prepared by the traditional healers. These remedies are used for menstrual regulation, spacing of children and for permanent contraception. The study team attempted to find out the composition and names of the herbs used, but were successful in only some of the villages. Faith in the traditional methods is high and their usage seems to be quite prevalent.

### 3.5.3 Maternal health care practices

#### **Maternal mortality and morbidities**

The villagers were asked to prepare a list of maternal deaths and critical maternal illnesses that they could recall as having occurred in the past three years. Four deaths were documented and all of them took place in the village.

#### **Common maternal morbidities**

- Loss of appetite
- Headache
- Vomiting
- Malaria
- White discharge
- Menstruation problems
- Miscarriages
- Weakness
- Cold and cough
- Pain in hands and feet

The Ho strongly believe in spirits and black magic and associate them with ill health. Hence, they are unable to identify specific morbidities immediately. Symptoms like loss of appetite and high temperature are identified as fever, while loose motions and vomiting are declared to be diarrhoea.

#### **Identification of pregnancy**

The Ho, like the Pahariya tribe,

identify pregnancy with symptoms like the stopping of the menstrual cycle, loss of appetite, tendency to eat sour food and nausea. Within this community, the pregnancy is confirmed after two or three months by the village *dai*, who conducts an internal examination of the expectant woman.

#### **Decision-making on ANC**

The knowledge and awareness about ANC differs across the villages and depends on the availability of a functional AWC as well as PHC.

#### **Traditional rituals during pregnancy, delivery and postpartum period**

The Ho have very strong belief in black magic and spirits. Hence, they often visit *ojhas*. Pregnant women are not allowed to attend funeral ceremonies or go near graveyards, as they believe that spirits live there which can affect the baby and the mother. During solar eclipse, the pregnant woman sleeps with a cylindrical stone (*lodha*, in the local language) beside her. In case of pregnancy or delivery-related complications, the people resort to prayers and sacrifice hens.

The TBA performs most of the deliveries. However, in contrast to other tribes, in the Ho community, the husband often assists in the delivery and also cuts the umbilical cord.

The Ho people have some peculiar traditions that apply post-childbirth:

- After the delivery, the family prays to god and sacrifices a hen or goat.
- Post-delivery, the mother does not enter the kitchen, till the cord gets dry, since the tribe

believes that their ancestors live in the kitchen.

- If the child does not cry after birth, they whisper in its ear, sprinkle water on its face or hold it upside down by the legs to make it cry.
- After delivery, the lactating mother takes only one big meal in a day, if the newborn is a boy, and takes two meals a day, if the baby is a girl.
- Six days after birth, they celebrate *chhati*, where all relatives and friends arrive to see the mother and child. A feast is also arranged on this occasion.

#### **Breastfeeding practices**

The breastfeeding practice in this group is different from other tribes. They first give honey to the newborn, and after half an hour, they start breastfeeding. If the mother's milk is not available, they prefer to give goat's milk to the child.

#### **Practice and beliefs regarding immunisation**

As with the other tribes, in the Ho tribe too, the knowledge, practice and belief in immunisation depend on the availability of health facilities. The community belonging to the village equipped with better health facilities were aware about immunisation and did immunise their children. In this village, immunisation is done in the AWC by the ANM/AWW.

Most villagers have immunisation cards and they take vaccine for polio, BCG and DPT on a monthly basis. They get information on immunisation from the radio, television and AWC.



### 3.5.4 Child health care practices

The villagers were asked to list child deaths in the last one year period.

There were four child deaths reported from the two villages. The cause of death in each case was not ascertained. Most of the deaths took place in the village, with very few being referred outside for care.

The villagers also described some childhood illnesses that were of concern to them. Most of these conditions reflected chronic malaria, *kala azar* and malnutrition. Although these diseases can be cured with the modern medicines provided by the ANM or at the AWC, the people

have a reason for not taking them.

“*Anganwadi Kendra se dawai nahi lenge, kyunki waha kewal tablet milta hai aur bachche tablet nahi kha sakte hain.*”

(Only tablets are available at the Anganwadi Centre, and small children are unable to consume tablets) - Sukamati Gop, mother of an ill child, Bhoya village, West Singhbhum

#### **Common morbidities in children**

- *Sarfatna* (narrow slit in child's head)
- Cold
- Fever
- Malaria
- Diarrhoea

#### **Identification of morbidity**

In the Ho tribe, morbidities within children are identified based on specific symptoms for each disease:

- Fever – High body temperature and loss of appetite
- Cough and cold – Discharge from nose and eyes
- Measles – Body is covered with pimples
- Diarrhoea – Loose motions and vomiting
- Jaundice – Body becomes yellowish in colour
- *Sarfatna* – Slit appears on the head of the child.

# SUMMARY: MATERNAL HEALTH CARE AMONGST THE TRIBAL POPULATION

Maternal and child care is an important aspect of health seeking behaviour, which is largely neglected among the tribal groups. Wide disparities in ANC among tribal populations may be due to certain socio-economic variables like low level of education and lower economic condition (Deb, 2008). In some tribal areas of India, maternal mortality was observed to be very high with 992 maternal deaths per one lakh live births (Mallikharjuna, 2008). Besides medical causes, several social factors play an important role as determinants of maternal mortality, the chief among these being, delivery by untrained *dais*, poor environmental sanitation, communication and transport facilities, and certain social customs (Park, 2005). The health of mothers and their children bear an integral relationship with one another.

In this study, an attempt was made to assess the attitude towards sickness among five tribal groups in Jharkhand, their faiths, beliefs and health seeking behaviour, and the utilisation of health facilities with particular reference to the care of pregnant and lactating mothers.

## 4.1 PRESENT PRACTICES

### 4.1.1 Institutional care

Registration of pregnancy and

availing ANC services seems to be largely dependent on the availability of services. The distance from the nearest town and the availability and quality of health services in the village (AWC, ANM etc.) also play a role in the selection of health services. Wherever available, antenatal examinations were, for the most part, perfunctory, detailed examinations were rare. Blood pressure was seldom measured, and for most women, getting a TT injection was equivalent to ANC.

The ICDS scheme assures each pregnant mother a hot cooked lunch, but none of the sites visited mentioned that they received the same. Instead, rationed food was provided to women in villages that had an AWC. Villages in remote areas across all tribes, especially the Mal Pahariya tribe, did not get to even register at the AWC.

An important development in recent times has been the presence of the Sahiyya and the institution of the Janani Suraksha Yojna (JSY), a maternal benefit scheme for pregnant mothers. However, the cash benefits are almost always made available to the woman after her delivery, making no contribution whatsoever to her nutrition during pregnancy.

Moreover, in spite of cash benefits, most deliveries still continue to be conducted at home.

Geographically isolated tribal villages are also neglected vis-à-vis schemes like JSY. These communities are not aware of such schemes due to lack of information, and hence, there is no demand for such facilities.

### 4.1.2 Care at home

Apart from sundry social restrictions and rituals for pregnant women, in most tribes, there are no major changes in the lifestyle and diet of these women as compared to the pre-pregnant state. There may be some respite from household activities, if there is another lady in the house. Else, she carries out her daily duties as usual, and these tasks may involve heavy physical labour, such as fetching firewood or carrying water from the well. Husbands seldom assist them during this period.

### 4.1.3 Care during delivery

The TBA/*dai* plays a vital role during delivery in rural areas. The *dai* assists in most of the deliveries and is present with the new mother for a week after the delivery. It was noted that even if a woman wants to have an institutional delivery, the

final decision rests with the husband, who may as well refuse, as was reported in one case.

In the Pahariya community, a typical feature during TBA-assisted deliveries is that while a TBA from the same village assists during delivery, another TBA from a different village cuts the umbilical cord.

#### **4.1.4 Maternal mortality and morbidity**

The common maternal illnesses identified by free listing include malaria and diarrhoea. Miscarriages, weakness and swelling of legs or body, menstrual irregularities, white discharge and other RTIs were other common ailments. Maternal deaths were known to have occurred in these villages, but the exact time (with respect to period of gestation/postnatal period) and the cause of death could not be ascertained.

#### **4.1.5 Treatment modalities employed and preference of service provider**

It was observed that the preference for health service provider depends on the nature of the disease and the financial condition of the family. In case of illnesses considered to be minor (swelling of feet, vomiting, weakness etc.), the tribal people first contact the local traditional healer, then the ANM/AWW, and lastly, doctors. Most deliveries are conducted at home by the TBA (*dai*), and in critical cases, the pregnant woman is taken to a hospital.

Most of the tribal community feels alienated at institutions such as district hospitals, which are usually staffed by non-tribals, who they feel

treat them condescendingly. The fact that distances are considerable and transport is poor is another factor for the tribal groups' reluctance to embrace modern medicine.

The tribals usually bring in a complicated delivery case on a cot carried by four able-bodied men. Getting these men and ensuring their stay at the hospital is usually difficult. At Dumka District Hospital, a place has been designated for caretakers to rest, which has proved popular. The space provided is simple and clean and the caretakers sleep on the floor.

#### **4.1.6 Making maternal health a reality in the tribal community**

There have been several changes over time with regard to health seeking behaviour for ANC among tribal populations in Jharkhand. Over the years with the advent of educational facilities, the presence of mass media and the government health facilities has led to an increased awareness, as well as an increase in availability of maternal care services in rural areas. The level of acceptability of modern health facilities and treatment modalities has also increased compared to earlier times. More women are accessing ANC services including TT immunisation, IFA supplements and institutional deliveries. In villages that were difficult to reach, and did not have a functional AWC, or where the ANM did not make regular visits, women went without ANC of any kind.

However, in spite of education, awareness and the presence of health service providers, a large number of women still have their deliveries conducted at home by

*dais*. The proportion of institutional deliveries is almost negligible; in fact, there are villages where an institutional delivery has never ever taken place, even in cases of complications during delivery. There are also villages where home deliveries are the norm and hospitals are resorted to only in cases of difficult labour. The ultimate decision-making power rests with the husband of the pregnant woman.

One of the reasons mentioned for preference of home deliveries was the fact that women find the familiar surroundings of their home more comfortable compared to the alien atmosphere of a health facility. Moreover, a relative or a lady from the same village (*dai*) is regarded as a matronly figure, whose years of experience and advice are held in high esteem. A Sahiyya mentioned that it is difficult to change the mindset of these women, who are unwilling to break norms and take the trouble to seek modern health services. The poor quality of services at government hospitals and the lack of means to avail services of private hospitals are also key factors.

In some villages, TT immunisation during pregnancy is believed to result in a large baby, which could lead to difficult labour, hence the women opt not to get immunised. The practice of having the umbilical cord cut by a particular *dai* (who might belong to a different village) may cause undue delays in case of a complication (retained placenta, haemorrhage etc.).

There are several restrictions that the women have to follow post-



delivery. Several vegetables and fruits are forbidden. There is no special/extra food for children or pregnant and lactating mothers. They usually consume two large meals a day. Among the Pahariyas, the mother is given two meals a day, if the newborn is a female and one meal a day, if the child is male.

The loopholes in the referral complex such as absence of connectivity by roads, lack of transportation and means of communication, force women living in remote areas to have their deliveries at home. At the same time, though, the presence of modern communication and transport facilities are no guarantee that deliveries will not take place in the home.

The funds provided in the maternal benefit scheme, JSY, which was later renamed as Mukhyamantri Janani Shishu Swasthya Aayan (MMJSSA), are almost always inadequate for referral and transportation, whenever such a contingency arises. These funds are given to the woman after delivery, by which time the cash benefit has no impact on the nutritional status of the pregnant woman or her developing foetus. The popularity of home deliveries proves that providing cash benefits need not ensure institutional deliveries; it is the quality of services in government institutions that makes a difference.

Among tribal populations, low percent of early registration and low coverage of antenatal check ups indicate the need for improving health care during pregnancy.

Tribal population are willing to access and avail modern health facilities and are not averse to it. They just want the health service providers to be friendly, culturally sensitive and welcoming.

Some of the steps that can be taken to improve the tribal health care scenario are listed below:

#### ***Ensuring availability of services***

Across all tribes, those who stay near the main road head or town are more dependent on health services, compared to those in difficult to reach areas. Institutional norms for health Sub Centre (SC), PHC and Community Health Centre (CHC) in tribal areas are not adhered to, and at present, are not staffed adequately. The community is not assured of services, even if they do make the effort to access the services, and so seldom take the trouble to do so.

#### ***Ensuring accessibility to services***

- a. Geographical access – The Government through various schemes has been working on improving rural connectivity to economic hubs like the weekly markets. The health and the public works department need to prepare a micro-plan for connectivity between every village and a point for emergency obstetric care.
- b. Economic access – The costs involved in reaching the hospitals for delivery and bribes at the hospitals are some of the main deterrents to accessing services. The JSY scheme had been launched with an aim to minimise these costs, but the implementation of the scheme

is poor and not been monitored seriously.

- c. Cultural access – Most health institutions are not tribal-friendly, since they are staffed with non-tribals. A long term effort in ensuring local tribal staff at the health facilities needs to be taken up. TBAs from tribal communities could be trained through a six month apprentice course to become ANMs and manage the health SC. The tribal group's cultural practices need to be respected and encouraged at the health facilities, such as handing over the placenta to the relatives so they can bury it in their backyard or at their threshold. Delivery positions practiced by tribals need to be promoted through the skilled birth attendant training imparted to the ANMs, so that the expectant mothers need not deliver on the labour table.

## **4.2 CHILD HEALTH CARE AMONGST THE TRIBAL POPULATION**

Studies among tribal populations in India have shown poor indicators relating to immunisation coverage and initiation of breastfeeding. Infant mortality and prevalence of under-nutrition also remain high (Sharma, 2007). Poverty and poor infrastructural development in tribal dominant areas have been the main reasons contributing to inability of the MCH programmes from reaching out to tribal populations. The scenario with respect to MCH in Jharkhand calls for immediate redress.

According to the recently conducted National Family Health Survey III

(2005-06), the infant mortality rate (IMR) in the state is 69 and 57 percent of children under the age of five are underweight. The survey also reported that about one-third (34 percent) of children in the state, aged 12-23 months, are fully vaccinated against the six major childhood illnesses and only 19 percent of pregnant women delivered their baby in any kind of institution.

Behavioural and socio-cultural conditions, environmental and socio-economic conditions are important determinants of health (Park, 2005). The use of medicinal herbs is still a tradition adopted by ethnic communities in central India (Navaneetham, 2000).

#### **4.2.1 Morbidity and mortality in childhood**

The common morbidities among children reported in these tribes included symptoms suggestive of upper and lower respiratory infection, diarrhoea, febrile illnesses, malnutrition, jaundice, malaria, *kala azar*, reddish discoloration of skin on entire body. Of special concern to these tribal people was the non-union of the skull fontanelles of infants. The causes of child deaths reported in the study could not be ascertained.

#### **4.2.2 Intranatal and immediate postnatal care**

Most deliveries are conducted at home by untrained TBA (*dai*), except among the Ho tribe, where sometimes the husband occasionally assists in the delivery and cuts the cord. The *dai* uses a new blade to cut the umbilical cord, by placing the cord on a one rupee coin. Soap is used to wash the hands *after*

the delivery. The sixth day after birth is an occasion of community celebration (*Chhatiyari*), till such time the mother and child are kept separate from the family and the mother is exempted from household work.

#### **4.2.3 Breastfeeding and complementary feeding**

Feeding the child with goat's milk prior to initiation of breastfeeding is common among all the tribes interviewed. Breastfeeding is also not exclusive; water may also be fed to the suckling child, as it is believed that just having milk may make the child thirsty. Colostrum is either discarded entirely or fed after two or three days, as it is considered harmful for the child. Even in communities where awareness is increasing regarding the importance of colostrum feeding (i.e., the Oraon community), the child is still given goat's milk to begin with. Honey may also be given as a pre-lacteal feed (as observed in the Ho community). Goat's milk, *mishri* (candy sugar), *sabudana* (oats) and barley may be given as supplements to breast milk. Breastfeeding is continued till the next childbirth.

Complementary feeding is usually initiated after the child reaches six months of age. The feed may comprise locally available foods such as rice, rice water, pulses and vegetables. Among the Pahariyas, complementary feeding is started at five months for boys and after the seventh month for girls.

#### **4.2.4 Immunisation – Awareness, decision-making, practices and beliefs**

Awareness regarding need for and

availability of immunisation services for children varies among the different tribes and villages. There were more mothers in the Oraon community with knowledge about maintenance of immunisation cards and the benefits of immunisation, than among others.

While ICDS centres are functioning well in some villages, in most instances, they only provide supplementary nutrition, and that too, in insufficient quantities. In some villages, there is no AWC at all. The religion of the tribal people may also affect awareness levels, probably owing to education, as was seen among Christian communities, where there was higher immunisation coverage. Overall, immunisation of children is not considered a necessity by tribal people in remote areas (such as the Pahariya and Munda tribes), where several completely un-immunised children were found, even up to the ages of five and more. The decision regarding immunisation rests with the husband and his family, and not with the mother. In any case, a child is immunised only if, and when, an ANM visits the village. Tribal parents do not actively seek immunisation.

#### **4.2.5 Care in illness**

##### **a. Identification of morbidity**

Health care for sick children is sought in case of any of the following symptoms: fever, shivering, diarrhoea, lack of appetite, stiffening of limbs (*nas tan na*), scissoring of limbs (*puni*), and non-closure of fontanelles (*sarfatna*), tightening of jaws with difficulty in opening the mouth and reddish discoloration of skin with loss of appetite (*rangbad*)

and jaundice (*pilia*). These and other symptoms described may be suggestive of respiratory infection and other febrile illnesses such as malaria, cerebral palsy (*puni*), and possibly, febrile seizures (*nas tan na*).

#### **b. Treatment modalities**

Indigenous and home remedies are used for several diseases among the tribal population. Diseases for which home remedies are used include: stiffness of limbs, reddish discoloration of skin (*rangbad*), diarrhoea, cold, cough, fever and body pain. Often, these remedies are used for symptomatic relief rather than cure. For instance, although the people are aware that *puni* (cerebral palsy) is not curable by herbal or modern medications, they still opt for oil massages to strengthen the stiff limbs. Herbal remedies and traditional medications are also used in case of *kala azar*, diarrhoea, dysentery and malaria. For fever and malaria, Calpol (paracetamol) and anti-malaria drugs are procured from the AWC.

#### **c. First preference for service provider**

In villages that lack modern health facilities, the tribal people resort to traditional healers and indigenous medicine. This is often the first port of call. Moreover, there is a tendency to wait and watch for a day or two to see what course the illness takes, before seeking any medical help at all. With changing awareness levels and attitudes, more tribal people are seeking modern methods of treatment since these are gradually being perceived as more effective, compared to other methods.

#### **4.2.6 Reasons for poor child survival**

Various factors determine tribal health seeking behaviour in childhood illnesses. The choice of provider depends on the duration and severity of symptoms. While newer treatment modalities are gaining acceptance, traditional treatment methods have been in place for generations, and the people strongly believe in them.

In these tribal populations, increasing knowledge and awareness levels regarding immunisation do not always translate into practice. The presence of a pro-active and motivated health care provider (AWW, ANM or Sahiyya) and their rapport with the villagers plays an important role in accessing immunisation services. The closeness to a health facility, access to road and transport are also key factors. The Sahiyya can have a tremendous impact as an agent of change, as observed in a Pahariya village with no health facilities or visiting ANM. On her own initiative, she takes the children down the hill once a month for immunisation.

The preference for service provider differs from village to village and is influenced by factors like the nature, duration and severity of illness, availability of and access to service provider, transport facilities and economic considerations, among others. On further probing, it was learnt that when it came to illnesses in children, most parents preferred to seek modern treatment facilities and were willing to travel to hospitals, as compared to illnesses

in adulthood. This was particularly true when the illnesses were perceived to be of a serious nature.

Besides distance, religion and caste are important variables in accessing and utilising maternal health care services. The Oraon population which has seen conversions to Christianity may have higher awareness levels about modern health care. Studies in Southern India have shown that Christian women are more likely to receive antenatal care than women of other faiths (Navaneetham, 2000).

There are some peculiar practices among tribals during and after child birth. For instance, calling a specific *dai* from another village for cutting the cord (as practiced by the Pahariyas) may cause unnecessary delays and have serious consequences, in case of a complicated delivery. Mothers are usually given only one or two meals a day in the postnatal period, and there are several restrictions on the intake of certain fruits and vegetables. Separating the mother and child from the rest of the family till the sixth day following birth gives the mother temporary respite from household activities and can also help prevent exposure to infections.

#### **4.2.7 Ensuring child survival amongst the Tribal Community**

Addressing health and nutrition issues is crucial to ensure that children in the tribes survive, especially amongst the PTGs.

- ICDS should be universalised and tribal areas should get priority in the universalisation process. Each tribal hamlet

should have its own AWC, managed by a worker from its own community. Norms on the number of children for a Mini AWC need to be reduced for PTGs.

- Most of the malnourished children are found amongst the tribal population. ICDS data needs to be dis-aggregated so as to understand and inform policy and action.
- Each tribal hamlet should have its own Sahiyya and village health committee (VHC) and should not be forced to merge with the larger village. Sahiyyas and AWW of a particular community must be trained in their own dialect on child care practices and in Integrated Management of Neonatal and Childhood Illnesses (IMNCI).
- The Health SC/PHC and the CHC need to be fully prepared for admitting sick children and be responsive to their needs.

### 4.3 FAMILY PLANNING NEEDS OF THE TRIBAL POPULATION

In Jharkhand, only 36 percent of married women currently use some method of contraception, compared with 56 percent at the national level and 34 percent in Bihar (NFHS-III). Contraceptive prevalence is considerably higher in urban areas (60 percent) than in rural areas (28.2 percent). Female sterilisation is, by far, the most popular method 23.4 percent of currently married women are sterilised. By contrast, only 0.4 percent of women reported that their husbands are sterilised. Overall, female sterilisation accounts for 66 percent of total



contraceptive use. Other methods of contraception practiced by married women include the pill (4 percent), IUD (1 percent), condom (3 percent), rhythm (2 percent), withdrawal (2 percent) and folk methods (1 percent).

#### 4.3.1 Situational analysis

##### *Ideal family size*

The size of the family, which is a determining factor in the usage of contraceptive methods, is mostly determined by the economic status of family, as also by the presence of a son in the family. A typical Santhal family generally has four to five children, and a couple, as mentioned earlier, would attempt to have at least one male child. The Christian community (Oraons) prefers to have two to three children, whereas in the Sarna community, the average number of children is four to five. The Pahariyas prefer to have small families (two to three children) in order to minimise their cost of living.

##### **Acceptance of family planning methods**

There seems to be a healthy awareness of modern contraceptives amongst the study population. Most of them had seen contraceptives, have used it themselves or know people who have used them. Permanent methods were not popular, mostly because such services are not available.

Family planning is banned in the Pahariya tribe, since they belong to a PTG which is considered as becoming extinct. The tribe adopts traditional methods for birth spacing and permanent family planning. The tribals described home remedies and traditional methods, which are prepared at home, or by the *dai*, or procured from traditional healers. These remedies are used for regularisation of the menstrual cycle, spacing of children and for permanent contraception. The study team attempted to find out the recipe and names of the herbs used,

but these are closely guarded by practitioners of traditional medicine.

Across the study population, the decision to use a contraceptive is a collective one taken by the couple. In villages with a Christian population, the acceptance of FP measures was higher, though most of them belong to the Catholic faith, which abhors FP.

**Note:** The ban on the usage of contraceptives among the Pahariyas is to be questioned. The fact that their numbers are dwindling is of no concern to the tribals themselves, since for them the need to limit their family size is a real need, and they resort to traditional methods to achieve this end. Imposing such a ban without considering the needs of the people, the effect that large families could have on the health of mothers who come from an underprivileged background, are poor in nutritional and health status and have little or no access to health care facilities to provide them antenatal and critical intranatal care, is regrettable.

#### **4.3.2 Availability and accessibility of services**

It was also noticed that in villages with active ANM and Anganwadi services, the use of FP measures is high. Several AWWs and Sahiyyas reported having a stock of contraceptive pills and condoms, and also stated that people approach them for these services without any apprehensions or hesitation. This could point to an acceptable level of awareness regarding availability of modern contraceptive methods. Access to condoms and pills was related to the

presence of a functional Anganwadi or a social marketing entrepreneur in the vicinity. Copper-T was rarely used, in fact, most ANMs interviewed were not confident in inserting a Copper-T/ had never inserted one in their career.

#### **4.3.3 Utilisation of services**

Awareness of contraceptive methods was not seen to translate into practice, however, none of the health functionaries were able to give actual numbers of women or couples accessing such services. Direct questioning of men and women, falling in the category of eligible couples, did not yield any convincing information as to the usage of modern methods. It was interesting to note that while the tribals interviewed were not forthcoming in their responses regarding the usage of contraceptives, most of the families had only two or three children. This probably points to the usage of alternative methods, namely traditional methods of contraception. Some respondents did admit finding traditional methods more acceptable. Faith in the traditional healers and methods employed by them were major deciding factors in the usage of traditional methods of contraception.

#### **4.3.4 Traditional methods**

Traditional herbal remedies are available for spacing or pregnancies, which are closely guarded by practitioners of traditional medicine. There are several reasons for this. The foremost among these is the fact that the knowledge of herbal medicines and the number of practitioners specialising in these

methods is dwindling with the advent of modern medicines and shrinking forests where these herbs are available. Traditional healers who make such methods available have a deep belief in the fact that the usage of methods of contraception (whether herbal or allopathic) is akin to going against the laws of nature. Wherever such methods are employed, they are preceded by elaborate rituals and sacrificial offerings to appease the gods. This is especially true when the methods are used for permanent family planning. Traditional methods are almost never attempted for abortion of a conceived foetus.

### **4.4 TRADITIONAL MEDICINE AND ITS SIGNIFICANCE WITHIN THE TRIBAL FRAMEWORK**

The term 'traditional medicine' (indigenous or folk medicine) describes medical knowledge systems, which were developed over centuries in societies across the world, much before the era of modern medicine. The genre includes herbal, Ayurvedic and Unani medicine, acupuncture, spinal manipulation, Siddha medicine, traditional Chinese medicine, South African Muti, Yoruba Ifá, as well as other medical knowledge and practices all over the globe.

The World Health Organization (WHO) defines traditional medicine as the health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being.



#### 4.4.1 Tribal medicine and practitioners in Jharkhand

The tribes use herbs and medicinal plants available in the forest for treating sickness and pain. Local traditional practitioners, notably Dr. Hembrom, refer to Jharkhand's traditional medicine as 'horropathy'- 'horro' translates as the local tribals or 'us', as opposed to 'Dikus' or 'the others' who are outsiders.

Tribal people depend totally on the land and forest for their daily needs. Their first preference is always traditional medicine and their first choice of health service provider is the *vaid raj*. Traditional healers are generally divided into two categories – those who serve the role of diviner-diagnostician (or diviner-mediums) and those who are healers (or herbalists). The diviner provides a diagnosis usually through spiritual means, while the herbalist chooses and applies relevant remedies. Colonial powers and structures have played an overpowering role in changing the cultural landscape and practices of traditional healers and their patients, and have disrupted the distinction between diviners and herbalists. Additionally, with the encroachment of Western health care systems, the roles of the diviner and herbalist have become increasingly blurred. Traditional healers are, thus, undergoing a strange process of mutation, as Jharkhand modernises.

Poor health infrastructure coupled with mistrust in the existing health system has ensured that local traditional healers continue to

play a meaningful role in the tribal society. They are mainly challenged by the unlicensed allopathic practitioner (commonly known as the 'RMP'). Traditional medicine is still preferred because the practitioners reside in the village and provide 24 hour services. They charge very nominal or no fees, can be paid back with kind or with the exchange system, and also provide an instalment arrangement for payment of huge expenses. Hence, there is a lot of goodwill and tremendous faith reposed in the system by the people.

There is a steady decline in the use of traditional medicine. With rapid deforestation and gradual extinction of some medicinal plants, it is proving difficult for the traditional healers to procure the required herbs, and thus, they now have to buy the same. These practitioners are also unable to find apprentices to hand down their skills to.

The government has, till date, only been paying lip service to traditional medicine. Ayurvedic clinics have been opened in certain areas, but they do not use local herbs. There is a pressing need for the government to recognise and encourage traditional herbal remedies as an important system of healing.

Some steps that can be taken to institutionalise traditional/tribal medicines are listed below:

- This study found that in every second village, there is a recognised tribal healer, who is easily accessible and

available 24 hours. However, his technique and the herbs he uses are getting outdated and less effective. If the traditional healers' technique and knowledge can be studied, documented and disseminated amongst them for a more systematic, cohesive and uniform approach, these service providers can prove valuable to the government and the doctors in providing first aid and primary health care to the tribal groups. The traditional healers can join the state to discuss issues, work on cures and strengthen the system.

- Tribal healers use herbs found in the forest, but due to industrialisation and deforestation, much of the forest area and the herbs it is home to have been destroyed. These herbs are presently available only in some forests or with some institute/ individuals, who cultivate these plants. The herbs used by these healers, thus, are not easily available or come at a heavy price, which reduces the efficiency of the healers. If these herbs can be cultivated by the government and then distributed to the *vaid rajs*, as is done in the case of allopathic medicines, then these healers can prove more productive and help the government directly.
- The government needs to promote scientific verification and documentation of traditional medicine, so as to help legitimise and thus, standardise this health care genre.

# CONCLUSION

Change is the only constant. The tribal society has seen a lot of change in the last century, but still retains some of its basic characteristics. The main change agents were:

1. Industrialisation: In the early 1900s, the British penetrated the forests of Chaibasa for timber to cater to the growing railway expansion. The Santhals later migrated to the tea estates for work.
2. Advent of missionaries: Lutheran and Jesuit missionaries have been operating in Jharkhand since the early 1900s, proletysing and educating the local tribal people.
3. Jharkhand Movement  
– A political consciousness movement was started just before Independence by Mr. Jaipal Singh Munda, which culminated in the formation of

the Jharkhand state, more than 50 years later.

Through all this change, the tribals have continued to lead impoverished lives and the state is ranked in most development rankings at the bottom of the list.

Barely 10 percent of the villages are electrified, roads do not exist in the hinterland and institutions in the health, education and women and child department are few.

Tribal people differ from other communities by virtue of cultural settings. Their health care problems stem from illiteracy, poor infrastructure, poor sanitation, and also, from some customs and traditions peculiar to these groups.

Despite a number of welfare measures undertaken by the

Government of India to improve their general welfare, including health, the tribes still consider modern health care system as alien. However, they have been showing willingness to engage with the system, if such opportunities are made available.

For the tribes, the most common face of modern medicine is the RMP, who provides services at their doorstep or at *haats* (local markets). ANMs are rarely present in hard to reach areas. Occasionally, tribal ANMs do stay in the villages, but their availability at the time of need is not reliable. AWWs are present but are not considered health providers, as they are not well trained or educated in most health care cases. *Vaid raj* and *dai* are available in the village 24 hours a day, but the Government seems unwilling and unable to integrate with the traditional healing systems.



# RECOMMENDATIONS

The need of the hour is to ensure quick availability and accessibility of health care services to the tribal and rural people, and institute tribal-friendly health services in hard to reach areas.

With regard to FP, there seems to be considerable unmet need in the population. Tubectomy and intrauterine contraceptive devices (IUCD) need to be propagated and promoted. There is a need to reconsider the PTG policy, in terms of banning FP in tribes considered as getting extinct.

In case of child health care facilities, ICDS must be universalised and quality output needs to be monitored. ICDS data must be disaggregated to understand and inform policy and action.

Other suggestions include:

- Empowering local population to plan for health:
  - VHC at hamlet level
  - Local Sahiyyas at hamlet level
  - Community monitoring
- Ensuring functional health and nutrition facilities in every village:
  - AWCs in each village
  - Adequate and efficient SCs
  - CHC/PHC for tribal areas in all scheduled districts
- Ensuring all health care facilities are tribal-friendly institutions:
  - Personnel to be from the tribal community
  - Staff fluent in local dialect
  - Local tribals in charge of public relations

- Institutionalising traditional healing practice:
  - University and research institutes to actively work on herbal medicine
  - Work with and promote *vaid raj* in each village, document and set up platforms for sharing and dialogue

Policy-makers need to consider these suggestions before formulating a new policy and strategy for the tribal people. Since the tribes prefer to function in their own habitat, they should not be forced to come out and accept health systems that are unfavourable to them. Instead, we must cater to their needs, respecting their requirements, and create a more secure and healthy environment for these groups.

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# LIST OF ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BCG	Bacillus Calmette-Guérin
CHC	Community Health Centre
CINI	Child In Need Institute
DPT	Diphtheria, Poliomyelitis and Tetanus
FGD	Focus Group Discussion
FP	Family Planning
ICDS	Integrated Child Development Services
IDI	In-Depth Interview
IFA	Iron and Folic Acid
IUCD	Intrauterine Contraceptive Device
IUD	Intrauterine Device
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMR	Infant Mortality Rate
JSY	Janani Suraksha Yojna
KII	Key Informant Interview
MCH	Maternal and Child Health
MMJSSA	Mukhyamantri Janani Shishu Swasthya Aayan
MMR	Maternal Mortality Ratio
NGO	Non-Governmental Organisation
PHC	Primary Health Centre
PNC	Postnatal Care
PRA	Participatory Rural Appraisal
PTG	Primitive Tribal Group
RCH	Reproductive Child Health
RMP	Registered Medical Practitioner
RTI	Reproductive Tract Infection
SC	Sub Centre
ST	Scheduled Tribe
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
VHC	Village Health Committee
WHO	World Health Organization

## INSTRUMENT IA

### PRA – SOCIAL MAP

Manpower : Facilitator – 1  
Assistants – 3

Time Expected : 2 hours

#### STEPS

1. The local NGO facilitator gathers the people together.
2. The facilitator explains the reason for the exercise.
3. The group then prepares a social map<sup>1</sup> which lists the following:
  - a. All households
  - b. Houses who have had:
    - i. Recent child birth (in the

- ii. last three years) – Use blue marker
- iii. Houses with maternal deaths/near deaths/severe maternal illness (last three years) – Use red marker
- iv. Houses with under 5 deaths/near deaths/severe childhood illness (last one year) – Use yellow marker
- v. Houses of traditional healer/TBA – Use green marker and write down
- vi. Drinking water/sanitation/nutrition (ICDS)/Health

centres/FP depots – Use green marker and write down

#### NOTE

- This exercise will take at least one hour.
- Facilitate the villagers to do it themselves (the adolescent and youth are usually the first to come forward).
- Take a photograph of the social map and leave it behind. Data is collated in the format.

### Fill the following Format No: I

Child Birth in the last three years

Name – Head of Household	Mother's Name	Date of Birth (at least month)	Sex (M or F)	Place of Birth (Home, Institution – mention name)	Birth Attended By (Relative <sup>2</sup> , TBA, Nurse, RMP, Doctor)	Present Status (Well, Sick or Dead)

Maternal Morbidity/Mortality in the last three years

Name – Head of Household	Mother's Name	Date of Illness or Death (at least month)	Present Status (Well, Sick or Dead)

Child Morbidity/Mortality in the last one year

Name – Head of Household	Mother's Name	Child's Name	Sex	Date of Illness/Death (at least month)	Present Status (Well, Sick or Dead)

<sup>1</sup> To draw a Social Map, you will need chart papers and markers. A map of the roads/paths of the village are drawn along with major land marks. Each house is denoted with a square and the name of the head of the household is written next to it. If there are a lot of households, then divide the area and make more than one map.

<sup>2</sup> Mention relationship like husband/mother-in-law/neighbour

# INSTRUMENT 1B

## PRA – TIME ANALYSIS

Manpower : Facilitator – 1  
                  Assistants – 3  
Time Expected : 2 hours  
Material : Chart paper,  
                  markers

Three groups will be doing this simultaneously. Facilitators will divide themselves and assist the groups.

1. Activities done during pregnancy, child birth to child rearing until age 5.
2. Timeline of major village events in the past, followed by introduction of various technology including electricity, modern water delivery mechanisms (hand pump), roads, transport, modern drugs, injections, first modern medicine practitioner, school, etc.
3. Seasons mapping for work in village, agricultural practices, food availability and childhood illnesses.

## STEPS

1. The local NGO facilitator gathers the people together.
2. The facilitator explains the reason for the exercise and

does the exercise in three stages.

### Group One – Pregnancy, Child Care and Family Planning

- Draw a line across the chart paper and mark the following points:
  - Detection of pregnancy
  - Pregnancy
  - Delivery
  - Breastfeeding
  - Weaning
- List traditional practices/rituals taking place in each period – Free listing and later, pile sorting.
- Discuss practices and rituals for birth spacing and family planning.

### Group Two – Introduction to Technology

Timeline of major village events in the past, followed by introduction of technologies in the following fields:

- Farming
- Crafts (if applicable)
- Amenities – Includes electricity, modern water delivery mechanisms (hand pump), roads, transport etc
- Education – First school, first student, first high school pass out, first graduate etc

- Health – Modern drugs, injections, first modern medicine practitioner etc

The assistant takes down notes on when, how and who introduced modern technology and the perceived benefits of the introduction of technology.

### Group Three – Annual Timeline

- Mark the annual festivals out on a straight line
- Mark the agricultural practices and mark points on another line relative to the annual festivals
- Mark food availability on the next line
- Mark illness that occur episodically, like malaria, diarrhoea, measles, respiratory tract infection (cold, cough, pneumonia), white discharge (reproductive tract infection)

## NOTE

- Take photographs of the chart papers and leave them behind.
- Assistants must maintain notes of discussion. Final notes are to be prepared on the first day itself and shared with the group.



# INSTRUMENT 1C

## PRA – HEALTH RESOURCE LISTING

Manpower : Facilitator – 1  
                  Assistants – 3

Time Expected : 2 hours

Material : Chart paper,  
                  markers

*Note: To be done on the second or third day.*

**Objective:** Listing health resources in the village and beyond, as well as symptoms that treatment is sought for and ranking of service providers.

### STEPS

1. Get a group of eligible couples and traditional leaders together.
2. Explain the objective of the

study and get their consent. Mention that the exercise will take a little more than an hour.

3. List the common and serious illnesses that occur in the village. Probe mostly for illnesses that affect children and women.
4. Choose two minor and one or two major illness and for each illness, probe the following:
  - a. How do they recognise the illness?
  - b. Home remedies suggested or tried out?
  - c. At what stage of illness would they decide to see a health provider?
  - d. First choice of health provider. Why? What is

it that is expected? (List various first choices of the group, even if only one person prefers it.)

- e. Second opinion – When is second opinion sought? Who is the second choice? Why? What is expected?
- f. Traditional medicine over modern medicine – When do they prefer either? Why? List service providers and rank them by popularity and perceived understanding of competence. (This has to be done in detail. Spend equal time on this – probe for reasons for preference, availability and practice).

# INSTRUMENT 2A

## FGD – ELIGIBLE COUPLES

Manpower	: Facilitator – 1 Reporter – 2 Observer – 1
Time Expected	: 2 hours
Material	: Probe Questionnaire, consent form, writing pad, pens, recorder, camera, chart paper, markers

## INTRODUCTION

Introduce yourself and the accompanying note takers and explain the purpose of your visit. You may mention the name of the facilitating NGO and CINI. Mention that the government would like to prepare a plan for tribal health and their inputs could be used to prepare the same.

## CONSENT

Take consent after reading out the form.

## Issues to be covered

The issues listed below should not be treated as questions to be asked one after the other. They do not have to be covered in any particular order. They are to be used only as guidelines. The key is to carry on as much of a natural

conversation with the interviewees as possible and to probe issues that the interviewees bring up (even if that issue is not listed below). The interviewer needs to use his/her skills to draw out the interviewee and to decide on the spot what areas of conversation might be relevant and when to divert the topic. The entire purpose of the focus group discussion will be lost if the guidelines are used like a survey question-answer session.

The interview should also be documented verbatim with full details.

### Section A: Marriage

- Start with type of marriage
- Age at marriage appropriate for boys and girls in their community as well as actual practice
- Involvement of probable groom and bride for decision regarding marriage and choice of partner
- Belief and customs related to marriage

### Section B: Family planning

- I. List the common family planning methods known to the people in the area:
  - What does the community feel is an ideal family size? Probe gender preference.

- Do couples know the common family planning methods?
- What methods are commonly used by the couples and the reasons for using them? Probe for spacing, limiting and for delaying first pregnancy.
- Where do couples go for FP or contraception?
- What are the traditional contraception/family planning methods known and used by the couples? Probe for the spacing, limiting and for delaying first pregnancy.
- Effectiveness of traditional vs. modern methods of contraception.
- Is there an unmet need which hasn't come in the findings related to the use of contraception among the couples in the community?
- Who generally decides on when and which method to use?
- What is the desired number of children among most couples?
- Where do couples go for FP or contraception?
- Is there any source of information regarding the FP methods among the couples: Individual or organisation?

### **Section C: Maternal and child health**

Start the discussion with rituals, beliefs and practices during pregnancy. Ask specifically by trimester, accompanied by the following information on health seeking behaviour. (This will facilitate a frank and well placed discussion among the group members with very little probe and direct involvement of the Moderator)

List the services that are available in the area:

- List the MCH services that are available in the area.
- Ask them about the utilisation pattern of those services that are available.
- Are they satisfied with the kind of services they get?
- Who influences their decisions about when to seek care, where to seek care or what practices to follow?
- What traditional practices do they follow in the pre delivery period?
- What traditional practices do they follow at the time of delivery?
- What traditional practices do they follow during new born care?
- What practices do they follow if any kind of complications arise during and after pregnancy?
- The interviewer should be open to the responses about traditional practices as well as modern practices, i.e. from the sub-centre or public health system.

### **Section D: RTI/STI**

To assess information on their hygiene and sexual health practices

- What is the general practice: related to menstruation: Say when a girl starts her first period (MC), what's her mother's role, how do women keep themselves clean during those days, and what do the women use (napkin, cloths etc.)
- Do they clean their genitals during bath and after going to the toilet? Should be worded thus: Now let us discuss about how people usually clean themselves during bath as well as when they go for toilet, and before going to sleep?
- Who initiates the sexual activity among couples? Do couples usually plan it?
- Do you think couples usually clean their genitals before and after intercourse?
- Have they ever seen/ experienced any itching, ulcer, pain and discharge in their genitals or heard about this from their people?
- What do women/men generally do when they see/experience such symptoms?
- Do they seek any medical help (traditional or modern)? If yes, where?
- Do they seek treatment along with their sexual partner? (Ask: Who do you think should initiate treatment? Do any of you know a woman/man who took treatment for a problem such as .....

### **Section E: Child Care**

Health seeking behaviour on child care

List the various steps that they take in case of health related problems in children:

- What do most of the people do when a child gets ill? (Discuss home remedies)
- Where do they usually take them and why?
- Are people in this community satisfied with the kind of services provided at this place?
- How much money do parents/ others spend during such instances?

### **Immunisation**

Probe questions on practices and belief on child immunisation

- Do people know about immunisation?
- Is it really needed?
- Where do people take their child for immunisation?
- What, if they can not reach the immunisation centre?
- Does anybody come to their village to administer immunisation?
- Where do they get information about the Immunisation day? How is the message communicated in the village regarding immunisation?
- Do people know which vaccine protects the child from which disease? Who usually has this knowledge in your community?
- How do parents/others track which vaccine is to be given next and when?
- Do parents with small children have cards?
- Does any one of you know any incident or have a negative experience of immunisation of children in your community? (What happens after BCG and DPT? Like fever, scar, which deter them from going for immunisation/full immunisation)

**Section F: Health Providers**

- Do you know about Sahiyya? (If yes/no, what about the other members of the community?)
- Does she visit you and your other community members?
- What do they feel about the attitude/behaviour of the ANM? (She is friendly, not friendly, does counselling before and after immunisation)
- If friendly/not friendly, do you think she behaves in a similar way with everyone?

- Who else in the village mothers and young couples? (Probe about different Women's Group etc.)

**Section G: Mortality/morbidity**

Recall deaths/near deaths that have occurred in the village or nearby village in the last three years (both maternal and child). (Plan for in-depth interview later, but get basic details.)

- Describe the experience
- How did he/she recognise the problem?

- Did they seek care, if so what type of care and where did they seek care?
- How much money did they spend, did they have to spend extra money?
- Were they happy with the kind of care they received?

Thank the participants and invite them to ask you questions. Attempt to answer their questions to the best of your knowledge. If you are not sure, say that you will get back to them through the facilitating NGO with the correct response.

# INSTRUMENT 2B

## IDI – CARETAKER<sup>3</sup> OF SEVERELY ILL CHILD

Manpower : Facilitator – 1  
Reporter – 1  
Time Expected : 2 hours  
Material : Probe  
Questionnaire,  
consent form,  
writing pad, pens,  
recorder

### INTRODUCTION

Introduce yourself and the accompanying note takers and explain the purpose of your visit. You may mention the name of the facilitating NGO and CINI. Mention that the Government would like to prepare a plan for tribal health and their inputs could be used to prepare the same.

### CONSENT

Take consent after reading out the form.

### Issues to be covered

The issues listed below should not be treated as questions to be asked one after the other. They do not have to be covered in any particular order. They are to be used only as guidelines. The key is to carry on as much of a natural conversation with the interviewees as possible and to probe issues that the interviewees bring up

(even if that issue is not listed below). The interviewer needs to use his/her skills to draw out the interviewee and to decide on the spot what areas of conversation might be relevant and when to divert the topic. The entire purpose of the interview will be lost if the guidelines are used like a survey question-answer session.

The interview should also be documented verbatim with full details.

### PROBES

#### 1. *Illness*

- a. Ask the care taker to describe the child's illness. Allow them to describe the experience.
- b. How did he/she recognise the problem?
- c. Was any home remedy used, if so what, why was it used, and what was the result?
- d. Did they seek care, if so what type of care and where did they seek care? Probe for preference and reasons.
- e. If care was delayed, probe for reasons – distance, safety (night travel), uncomfortable to go for modern medicine treatment.
- f. How much money did they spend and did they have to spend extra money?

- g. Was money a constraint?
- h. Were they happy with the kind of care they received?

#### 2. *Service providers*

- a. If they used traditional or modern medicine, why did they do so?
- b. Behaviour of the service provider – Rude or pleasant? Probe for their understanding of Government service providers/private providers/traditional providers.
- c. Were preventive services for children available? Probe for immunisation. Were AWW visiting mothers and sick children during postnatal periods?
- d. Has she met the ANM and does the ANM live nearby?
- e. Does the AWW or ANM stock any medicines in the village?

#### 3. *Health System*

- a. What are their suggestions for improving health care services in the area?

Thank the person for the interview and answer any questions posed to the best of your ability.

<sup>3</sup> Could be mother, father or any close relative that was involved with the decisions of care during illness.

# INSTRUMENT 2C

## IDI – CARETAKER<sup>4</sup> OF SEVERELY ILL MOTHER

Manpower : Facilitator – 1  
Reporter – 1  
Time Expected : 2 hours  
Material : Probe  
Questionnaire,  
consent form,  
writing pad, pens,  
recorder

### INTRODUCTION

Introduce yourself and the accompanying note takers and explain the purpose of your visit. You may mention the name of the facilitating NGO and CINI. Mention that the Government would like to prepare a plan for tribal health and their inputs could be used to prepare the same.

### CONSENT

Take consent after reading out the form.

### Issues to be covered

The issues listed below should not be treated as questions to be asked one after the other. They do not have to be covered in any particular order. They are to be used only as guidelines. The key is to carry on as much of a natural conversation with the interviewees as possible and to probe issues that the interviewees bring up (even if that issue is not

listed below). The interviewer needs to use his/her skills to draw out the interviewee and to decide on the spot what areas of conversation might be relevant and when to divert the topic. The entire purpose of the interview will be lost if the guidelines are used like a survey question-answer session.

The interview should also be documented verbatim with full details.

### PROBES

#### 1. *Illness*

- Ask the caretaker to describe the maternal illness. Allow them to describe the experience.
- How did he/she recognise the problem?
- Was any home remedy used, if so what, why was it used, and what was the result?
- Did they seek care, if so what type of care and where did they seek care? Probe for preference and reasons.
- If care was delayed, probe for reasons – distance, safety (night travel), uncomfortable to go for modern medicine treatment.
- How much money did they spend and did they have to spend extra money?
- Was money a constraint?

- Were they happy with the kind of care they received?

#### 2. *Service providers*

- If they used traditional or modern medicine, why did they do so?
- Behaviour of the service provider – rude or pleasant? Probe for their understanding of government service providers/private providers/traditional providers.
- Were preventive services for mothers available? Probe for ANC at village level, IFA tablets and TT, AWW visiting mothers during postnatal periods.
- Has she met the ANM, does the ANM live nearby?
- Does the AWW or ANM stock any medicines in the village?

#### 3. *Health System*

- What are their suggestions for improving health care services in the area?
- Was she enrolled in the JSY scheme? If yes, describe the entitlement received and the experience.

Thank the person for the interview and answer any questions posed to the best of your ability.

<sup>4</sup> Could be the mother herself, husband, father or any close relative that was involved with the decisions of care during illness.



# INSTRUMENT 3

## IDI – AWW/ANM/TBA/ DOCTOR/TRADITIONAL HEALER

Manpower	: Facilitator – 1 Reporter – 1
Time Expected	: 2 hours
Material	: Probe Questionnaire, consent form, writing pad, pens, recorder

### INTRODUCTION

Introduce yourself and the accompanying note takers and explain the purpose of your visit. You may mention the name of the facilitating NGO and CINI. Mention that the government would like to prepare a plan for tribal health and their inputs could be used to prepare the same.

### CONSENT

Take consent after reading out the form.

### Issues to be covered

The issues listed below should not be treated as questions to be asked

one after the other. They do not have to be covered in any particular order. They are to be used only as guidelines. The key is to carry on as much of a natural conversation with the interviewees as possible and to probe issues that the interviewees bring up (even if that issue is not listed below). The interviewer needs to use his/her skills to draw out the interviewee and to decide on the spot what areas of conversation might be relevant and when to divert the topic. The entire purpose of the interview will be lost if the guidelines are used like a survey question-answer session.

The interview should also be documented verbatim with full details.

### PROBES

1. What services are you providing to pregnant and lactating women?
2. What services are you providing to children (0–5 years)?
3. What are the major health related issues regarding women

and children in the area?

4. What are the major morbidities among children and what treatment do you provide for the same? (Please provide information with age band 0-6 years, 6-10 yrs. and 11-16 yrs.)
5. Where do women go to seek treatment and advice on pregnancy related problems?
6. What are the major problems faced by the community in seeking treatment for common morbidities?
7. Who assists deliveries mostly and who takes the decisions at the place of delivery?
8. What traditional beliefs and practices regarding pregnancy and lactation are prevalent within the community?
9. What are the traditional healing practices and what is the preference for them vis-a-vis modern medicine?
10. Do tribal couples seek advice on family planning and sexual health from you? If no, where do they go for the same?

# INSTRUMENT 4A

## KII – SOCIAL ACTIVIST

Manpower : Facilitator – 1  
Reporter – 1  
Time Expected : 2 hours  
Material : Probe  
Questionnaire,  
consent form,  
writing pad, pens,  
recorder

### INTRODUCTION

Introduce yourself and the accompanying note takers and explain the purpose of your visit. You may mention the name of the facilitating NGO and CINI. Mention that the government would like to prepare a plan for tribal health and their inputs could be used to prepare the same.

### CONSENT

Take consent after reading out the form.

### Issues to be covered

The issues listed below should not be treated as questions to be asked one after the other. They do not have to be covered in any particular

order. They are to be used only as guidelines. The key is to carry on as much of a natural conversation with the interviewees as possible and to probe issues that the interviewees bring up (even if that issue is not listed below). The interviewer needs to use his/her skills to draw out the interviewee and to decide on the spot what areas of conversation might be relevant and when to divert the topic. The entire purpose of the interview will be lost if the guidelines are used like a survey question-answer session.

The interview should also be documented verbatim with full details.

### PROBES

1. Ask the activist about the number of years s/he has been working with the tribal community and in which field? Allow the person to describe his/her experience.
2. Is the person from the same tribal community or from another community? Mention the community and reason for

working with the community.

3. Probe his/her general impression of the health status of the people and the health care that they can access.
4. What are the most important health issues/illnesses faced by the people?
5. Where do they seek care and what are the hurdles faced in seeking care?
6. Are there any examples of the government, NGO, mission addressing access to health care?
7. What are the effective traditional medicines and treatments that according to him/her are being offered in the locality as per the tribal customs? Describe in detail.
8. Are there any ecological factors that affect the health of these tribes? Probe – Forests (malaria), mines, drought, roads etc.
9. What are his/her suggestions to address the above issues?
10. Note his/her suggestions for improving tribal health in the region, especially within the cultural specifications.

# INSTRUMENT 4B

## KII – HERBAL MEDICINE SPECIALIST

Manpower : Facilitator – 1  
Reporter – 1  
Time Expected : 2 hours  
Material : Probe  
Questionnaire,  
consent form,  
writing pad, pens,  
recorder

### INTRODUCTION

Introduce yourself and the accompanying note takers and explain the purpose of your visit. You may mention the name of the facilitating NGO and CINI. Mention that the government would like to prepare a plan for tribal health and their inputs could be used to prepare the same.

### CONSENT

Take consent after reading out the form.

### Issues to be covered

The issues listed below should not be treated as questions to be asked one after the other. They do not have to be covered in any particular order. They are to be used only as

guidelines. The key is to carry on as much of a natural conversation with the interviewees as possible and to probe issues that the interviewees bring up (even if that issue is not listed below). The interviewer needs to use his/her skills to draw out the interviewee and to decide on the spot what areas of conversation might be relevant and when to divert the topic. The entire purpose of the interview will be lost if the guidelines are used like a survey question-answer session.

The interview should also be documented verbatim with full details.

### PROBES

1. Ask him/her about the number of years s/he has been working with herbs? How did she get interested in the study of these herbs? Allow the person to describe his/her experience.
2. Is the person from the same tribal community or from another community? Mention the community and reason for working with community now.

3. Probe his/her general impression of the health status of the people and the health care that they can access.
4. What are the most important health issues/illnesses faced by the people?
5. Where do they seek care and what are the hurdles faced in seeking care?
6. What are the effective traditional medicines and treatments that according to him/her are being offered in the locality as per the tribal customs? Describe in detail.
7. Has s/he systematically documented herbal remedies? If yes, is a copy of the same available? Has anybody else documented these?
8. Does s/he charge for any treatment provided? If yes, get the rate.
9. Are tribals still comfortable with using herbal remedies or are they showing a disinterest in it?
10. What are his/her suggestions to address the above issues?

## List of Team Leaders and Investigators

Tribe	Santhal	Ho	Munda	Oraon	Pahariya
District	Dumka	Chaibasa	Khunti	Gumla	Sahebganj
Facilitator	Rajendra	Pranav	Abhijit	Harishanker	Parker
Team Members	Sunita, Parvej	Pankaj, Pallavi Joshi, Tanvir	Sanchita Mukhopadhyay, Rakhi, Monika, Jaybanti, Shikhar	Rani Bachman, Sarita	Celin Horo, Parvej, Anuj, Saket, Sunita



