Research Paper

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Health Seeking Behaviour of the Tribal Communities in Southern Rajasthan

Sociology

KEYWORDS : Tribal health, culture, traditional customs, disease, exploited, neglected, morbidity, mortality, blind beliefs.

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ABSTRACT

About 635 tribal groups and subgroups including 75 primitive tribes live in India. The state of Rajasthan occupies sizeable position in the tribal map of India having five major tribes i.e., Bhil, Meena, Garasia, Damor, Sahariya. The tribes comprise one of the most excluded sections of the society. They are excluded in social, cultural, economic and political areas of development. Health though is a social concept but in a tribal society it has its cultural dimensions also. The common beliefs, traditional customs, myths, practices related to health and disease influence the health seeking behavior of autochthonous people. The health of an average Indian tribal is found to be much poorer compared to the non-tribal counterpart because of the isolation, remoteness and being largely unaffected by the developmental process going on in India. Tribal communities in general and primitive tribal groups in particular are highly disease prone. Also they do not have required access to basic health facilities. They are most exploited, neglected and highly vulnerable to diseases with high degree of malnutrition, morbidity and mortality. Their misery is compounded by poverty, illiteracy, ignorance of causes of diseases, hostile environment, poor sanitation, lack of safe drinking water and blind beliefs, poor maternal and child health services, ineffective coverage of national health and nutritional services, etc. are the major contributing factors for dismal health in tribal communities.

INTRODUCTION:

In this study, an attempt has been made to investigate the health seeking behaviour of the tribal communities in four tribal districts of Rajasthan, India, namely Banswara, Dungarpur, Udaipur and Sirohi. It was observed that people generally do not pay much attention to the routine problems. In the case of reproductive health problems and general health problems like fever and malaria, at the first stage some treatment is administered at home, followed by a visit to the bhopa (the local faith healer) and a herbalist in that order. The next stage involves visiting a nurse or an ill-qualified or unqualified medical practitioner, depending upon availability. It is only in very advanced stages of the problem that the help of a qualified medical person is sought. In the case of dental problems, as well as for cough and cold, the problem is ignored till the last minute, until the pain becomes unbearable. In the case of children's problems, they are mostly treated by giving some indigenous treatment, and in case the problem should persist after a certain period, the help of a medical practitioner is sought, who may or may not be qualified. In some specific problems like poisoning, all people reported visiting faith healers and claimed that their treatment is very effective.

Results:- The results of the study are presented in the following two sections.

Health Seeking The problems necessitating health seeking among the tribals can be broadly classified into three groups:

- General Problems
- Children's Problems
- Problems of Females

II. Issues and Challenges:

- Utilisation of Government Facilities
- Problems Faced while Accessing Health Services
- Community Needs
- Community Participation

III. CONCLUSION

I. General Problems

(i) Fever (Bukhar / Taav) : The first stage of treatment normally is giving the patient some tea. Then, people seek the help of the bhopa, the faith-healer (also called jhare wala). If it does not get cured, then people resort to allopathic medicine

Likewise, in the case of Malaria (Malaria taav) also, which is very common during and after the rainy season, the treatment sought is the same. This was the general trend in case of most of the villages, but at certain places located on the highways and where health facilities existed, non-tribal people directly went to the hospitals after the home treatment. In the villages with 100% tribal population, and located off the main roads, people normally went to the bhopas. Since most of them could not afford to visit towns or cities for treatment, they stuck to the treatment offered by the faith healers for a relatively longer period. It is only in very advanced stages that a qualified allopathic doctor is consulted.

(ii) Poisoning (Jahar, Vish):

In case of poisoning as a result of snake bite, scorpion sting, etc., and ingestion of poisonous material, in all the discussions, the help of the bhopa was mentioned as the only effective treatment. It was claimed that over 80 per cent of the problems related to poisoning were cured by the faith healer. None, except in one CHC village, mentioned taking the help of a nurse/doctor in the case of poisoning.

(iii) Dental Problems :

The dental problems identified were caries (keera), tooth-ache (dant dard), swelling (sujan) and pyorrhoea (peek). It was observed that people do not attach much importance to dental problems. They apply i.e. rub tobacco (tambacoo) to the aching parts. It was reported that most of their problems got cured by tobacco, and none was reported going to a hospital for dental treatment in any of the villages.

(iv) Other Problems:

Other problems mentioned during the discussion included cough and cold. The common treatment mentioned for this problem was taking honey, crushed tulsi leaves (sacred basil) and tea with black pepper. Again, as in the case of dental problems, not much attention was paid to them. People believe that these problems are part of one's life, and carry on as normally as possible in such cases.

In the case of Jaundice (peelia), another problem identified, the sufferer is given sugarcane juice as local treatment. This, people believe, is an effective treatment and none mentioned going to a hospital for treatment of jaundice. Bhopas or faith-healers (Jhare wala) were especially called in for removing the ill effects of 'evil eye' (nazar), spells of black magic (tona), etc. Though some people were initially reluctant to admit this, later on they admitted that though they knew the treatment was not as effective as allopathic treatment, it was still being used by poor people owing to the very high cost of allopathic medicine. Constipation (kebjee), abdominal pain (pet dard) and head-ache (sar dard) were other health problems mentioned during the discussions.

2 Children's Problems:

Diarrhoea (dast) was the main problem faced by children under 5 years of age. The local treatment administered at home was giving some water with lemon (nimbu paani) and salt, milk with sugar (doodh) or a kind of soup. Some people in the CHC vil-

lages mentioned ORS (Oral Rehydration Solution) being administered. If things did not improve with this, the help of a qualified person, ANM or qualified doctor, was sought in that order.

Acute Respiratory Infection (ARI) (Saans chalna):
After Diarrhoea, Acute Respiratory Infection (Pneumonia) was the second most common problem among the children. The domestic treatment included giving nutmeg (jaiphal), clove (long) and saffron (kesar) at the first stage. People living in remote areas would also take children suffering from ARI to the local herbalist, who administered some herbs. In some areas, mention was made of applying a hot iron rod by the faith healers to cure respiratory problems. This process is called daam. Only at the third stage was the help of a qualified practitioner or ANM sought.

3. Problems of Females.
(i) Role of Females in Using FP Services:
It was observed during the discussions that the need for family planning is widely felt by the tribal women, though the men, by and large, are not very keen on it. Men folk maintained that it was the female who had the final say on family planning matters; but the females asserted that though they played an important role in FP matters, it was their husbands who took the final decisions. In case a female has two or three daughters and wishes to undergo tubectomy, she cannot do so without the consent of her husband. In such cases, the husbands mostly are keen on having at least one male child, and they continue to reproduce till they get the desired number of male children. In case a female is reluctant to co-operate, her husband threatens to acquire another woman, who could bear him sons. In such cases, say the females, they have to yield to their husbands. It was observed that, people are not very keen on family planning. Whenever somebody felt the need for it, she would ask for the help of the local TBA, who mostly would direct her to the nearest available ANM.

(ii) Awareness about HIV/AIDS and the Help Sought:
At most places, both the community leaders, and the women were not aware of AIDS. At some places, people mentioned having heard about AIDS, but they could not say what it is and how it is transmitted, except at two one in a CHC village and the other in a PHC village. Though prevalence of sexual contacts with non-tribals and the level of promiscuity among tribals are high, people are not aware of the potential dangers of AIDS and STDs. None among the community leaders and women, who participated in the discussions, admitted that they had knowledge of anyone suffering from AIDS

II. ISSUES AND CHALLENGES:
1. (i) Utilisaton of Government Facilities:
Government health institutions were used by the people at the third stage, after home remedies and the faith-healers, for seeking health care. The people mentioned going to health centres first and said that though check-ups at the government clinics were free, the cost of allopathic medicines prescribed by the doctors was high, and the treatment too prolonged. Owing to their inability to pay for such long treatment, they opted to go to unqualified doctors, popularly called "Gujarati Doctors" or "Bengali Doctors". (Most of them belong to these two states.) According to the villagers, the duration of the treatment by them was shorter and effective, and the cost less as compared to the full course prescribed by a government doctor.

Another reason for the popularity of PMPs (Private Medical Practitioners) is their sympathetic attitude towards the patients, and their willingness to listen to the patients, and in some cases, deferring of the payment to a later date, a facility not available in the case of allopathic treatment. It was mentioned that the attitude of the doctors posted at the government institutions was not very sympathetic during duty hours. Similar perceptions were shared regarding the Para-medical staff posted in the **re**mote villages, as well as the PHC and CHC villages. However, after duty hours, the doctors continue to see patients at their private clinics for a fee, during which, their attitude towards the patients is more sympathetic.

(ii) The Timings of the Clinics:
Even the people living in a CHC village were not aware of the working hours of the CHC. Most people reported that it was open in the morning and again in the late afternoon. Very few mentioned that it was open between 8 AM and 2 PM, and then again for one hour between 5 PM and 6 PM. This might be due to poor sense of punctuality in the villagers. On being asked what they do in case the doctors are not available, the respondents were divided in their opinions. Some said they would wait for the doctor or go to the residence of the doctor, where doctors mostly see patients for a fee. Those coming from remote villages said that since they had to return home, they preferred to go to private practitioners instead.

(iii) Problems in Utilising Government Services:
The problems being faced by the people while utilising government health services were inaccessibility due to lack of transportation, unsympathetic attitude of the staff dispensing the health services, and shortage or non-availability of medicines at hospital and locally. The community, especially those living in remote areas, strongly felt the need for providing primary health facilities locally so as to deal with both routine and emergency cases. The personnel posted at these centres could also act as referral units. Nonavailability of essential medicines locally and the time lost in getting them from chemists located away from the locality were the problems cited. The community leaders opined that they were willing to pay for the medicines if they were made available locally, since the time saved in procuring these medicines could be used for other economically productive activities.

2 (i): Problems Faced During Referral:
On being asked what problems the people faced while using the referral system, nonavailability of conveyance, exorbitant rates charged by taxis for transportation of patients, and negligence at the big government hospitals were some of the problems mentioned. The others include anxiety of going to bigger hospitals and longer absence from home, resulting in loss of income.

(ii) Quality of Service:
It was difficult to communicate the concept of 'quality of care' to the community. Therefore, the community was asked what their idea of good service was. The response of the community was that, first and foremost, it includes civil behaviour on the part of the medical and Para-medicals personnel. The next requirement, was making more medicines available in the health institutions. Better-qualified staff should be posted at the health institutions and vacant posts of doctors and Para-medical staff should be filled.

On being asked about the hurdles the community faced while utilising the government health services, the response of the community, at all levels, was more or less the same. The traditional beliefs of the people in the indigenous systems of medicine along with inaccessibility of government services was the main reason for people not using the health services.

(iii) Using Health Facilities in the Case of RTIs and STDs:
The information on Reproductive Tract Infections (RTIs) and Sexually Transmitted Diseases (STDs) was sought, based on symptomatic approach and no examination of any kind was carried out. The discussions revealed that there was a very high prevalence of Reproductive Tract Infections (RTIs) in the area. People normally do not attend to these problems. Most of the women reported that, in some areas, almost 100 per cent women suffered from RTIs, and that nowhere was the prevalence less than 50 per cent. Even if there is some exaggeration in this, the figures are quite high. Most of the women suffer in silence and take no curative steps, regarding it as their fate. Some relatively well off women among the tribals talked about taking the help of Indigenous System of Medicine (ISM) practitioners in coping with these diseases. The reason cited most often for not using modern health facilities was the inaccessibility of the doctors for RTIs. Owing to these reasons, people in the area go to the unqualified practitioners, who, according to them, offer cheaper treatment. It was felt that besides cheaper treatment,

another factor that drives people to the private practitioners is their civil behaviour towards the client, which is something that the community does not find among the people working in the government sector.

3. Community Needs:
3.1 Additional Facilities Required:
On being asked what additional facilities they would like to have at their local centres and at their nearest PHCs and CHCs, the response of the community was very sensible. They were of the view that primary health facilities should be provided first in the villages where there are no health facilities available. They wanted provision for delivery centres, X-ray machines, well-equipped laboratories and the services of gynaecologists at the primary health centres.

4. CONCLUSIONS:
It was observed during the study that though considerable amount of money and time are spent by these tribals on health, their level of health education is extremely poor. Due to their ignorance, they visit traditional healers and ill-qualified medical practitioners. These practitioners take full advantage of the opportunity and exploit the poor tribals. Another reason for their not utilising the state health set-up is the indifferent attitude of the providers towards these people.

It was observed that the tribals do not pay any attention to problems during pregnancy, and often neglect the treatment of gynaecological problems and also found that the people of the tribal populations living in the different sets of villages adopt more or less similar methods of health seeking. Though non-tribal people living in the CHC villages as well as a few progressive tribals are adopting modern methods of health seeking, people living in the tribal region resort to indigenous methods out of compulsions like poverty and ignorance about modern methods of medicine.

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