PART - III

DISCUSSION, CONCLUSION AND SUMMARY
CHAPTER XI

DISCUSSION

On the basis of the study of the culture of the Oraons in the three villages and in the three urban groups it can be safely asserted that there is no cultural complex which can be considered as the Oraon culture of today. The culture of Oraons is in transition. Again, even considering the interior most village of Kokorna, the way of life of Oraons living there is different in many ways from what has been described by S.C. Roy and E.T. Dalton. These findings are in line with those of Vidyardhi, Sachidananda, Oraon, Roy-Burman, Roy-Burman, Pattnaik and Mahapatra, Raha, Toppo, Schay, Sinha, Schay, Desai, Botcillo and Sharma.

In fact, there is considerable rethinking among cultural anthropologists about their approach to the study of the culture of a tribe. S.C. Roy, who can be considered as a pioneer in the systematic, scientific study of the culture of the Oraons way back in 1915 and who has thus laid the very foundation of ethnological studies in the country, had himself realized the need for studying the dynamics of change in culture by adopting the methodology of micro studies. H.K. Boco has followed this up not only by studying the various tribal cultures in transition, but also by providing a platform to a large number of younger cultural anthropologists of India to
work in this direction and in this way giving the concepts and methods of tribal cultures in transition almost in the shape of a school of thought.

This process of transition in the case of Oraons of Orissa has been very greatly accentuated because of the establishment of the Rourkela Steel Plant (RSP) in the very heart of Oraon land, because of the opening up of quarries and mines for exploitation of minerals by various agencies and because of the purposive intervention by the government to bring about changes in the culture of Oraons through various tribal development programmes, including changes in the health culture through the agency of Primary Health Centres. There is a steep gradient in the change of culture among Oraons, as manifested in the way of life of an abjectly poor Oraon in the interior village of Kokerma at one extreme and the way of life of Class I Oraon officers of the Rourkela Steel Plant, at the other. This steep gradient in culture provided a very good opportunity to study the dynamics of changes in the health culture of Oraons.

As has been mentioned earlier (page 2), the health culture of a population includes cultural perception and cultural meaning of various health problems, the various cultural mechanisms that are adopted by the community to deal with such problems, the various purposive interventions by the government
in the field of health and the behaviour of individuals in response to the various health problems. In the overall context and in the three urban groups the corresponding health culture becomes, as it were, a dependent variable. In the world view of the 12 Class I Oraons officers of RSP consultation of different types of specialists of IGH comes as a logical response when they encounter a serious health problem. Similarly, for them consultation of doctors in a sector dispensary comes as a logical response to minor illnesses. Participation without any reservation in the various programmes for prevention of disease and promotion of health is also a feature of the way of living of these Oraons. As shown earlier (Table 50, page 406), these Oraons also take active steps to limit the size of their families. Furthermore, in contrast with the other groups the ecological conditions in which they live by virtue of the position they occupy within the RSP also ensure that their exposure to the numerous health hazards is drastically reduced. However, in spite of these very remarkable changes in the way of life of these Oraons and the corresponding changes in their health behaviour, when they confront certain health problems to treat to which the capacity of the western system of medicine is very limited, they tend to go back to their heritage of traditional medical devices. Those Oraons have been observed seeking the assistance of the Kuchrain, the Pahan and the Bhagmati of their native villages when they did not get alleviation from western medicine for conditions such as asthma,
arthitis which are considered to be incurable by practitioners of western medicine.

The extreme instances of health behaviour of the 12 Class I Oraon employees of the RSP have been discussed to underline the fact that:

(a) most of the variables which influence the health behaviour of an Oraon are intimately interlinked with his social, economic and occupational status and with the degree of availability and accessibility of various medical and health institutions; and

(b) his cultural background as an Oraon becomes a major determinant when the health services available even in urban areas are found to be inadequate in alleviating his suffering.

Considerable emphasis is placed in this discussion on accessibility to health institutions as a variable which influences the health behaviour of a community. For this purpose, it is necessary to point out the differences between the terms "accessible" and "available". An institution can be available to an individual if such an institution exists and the individual knows about it. Accessibility is determined by three principal considerations: (1) whether the individual has the capacity to physically reach the institution; (2) whether
the individual has the capacity to pay for the services, if such payment is needed either overtly or covertly and also to pay for the medicines, food, and loss of wages, etc., and (3) whether an Orcon is able to communicate adequately with the personnel of the available health institutions, whether the latter has adequate communicational skills to communicate with him in the context of his Orcon world view and whether these personnel have a built-in cultural bias against Orcons.

The health behaviour of the Class III and Class IV employees residing in RST (stratum-I) as also that of the Class III and Class IV employees residing in the slums and in the resettlement colony provide instances of differential access to an institution because of: (i) the distance; (ii) cultural barriers and prejudices; and (iii) religious bias. Further, although on paper Class III and Class IV employees of RST have the same degree of access to the services provided by the RSP health service system, their lower social and occupational status in comparison with the Class I employees puts them at a distinct disadvantage in terms of actual access to these services (page 320). It was observed on more than one occasion that the IGM authorities have actively discouraged admission into the hospital to women belonging to this category even when they suffered from clear cut complication of childbirth which needed immediate hospitalisation. Similarly they do not get domiciliary services from ANMs and other health
workers to the extent that is their due. In addition to the
bias shown to them because of their social and occupational
status, Oraons have to contend with an additional barrier to
their access to health services because of the cultural bias
of non-tribals against them. This was very well illustrated
in the cases of those who were treated in the isolation ward
of the IGH.

Non-Christian Oraons of RST have to face an additional
barrier to access in the form of the biased attitude and
behaviour of Christian Oraon doctors and nurses. These attitudes
and behaviour are actively cultivated in him by the church
authorities in the course of his socialization in the home, in
the schools and colleges, in the church and in church-financed
or promoted institutions for training.

For the Class III and IV employees of RSP (stratum-I)
who reside in the slums or in the resettlement colony, the fact
of their residence at a distance from the RSP Health Institutions
and the fact that they do not enjoy the privileges of being
allocated residential accommodation within the township act as
additional barriers to access to the RSP health service system.

The other residents of the slums (strata II and III)
do not have any access whatsoever to the RSP health service
system and they suffer major disadvantages in terms of access
to health institutions in times of need. Apart from the much
more intense cultural barrier, they have problems in gaining access to the DAV dispensary, the MAC dispensary and government hospital, Uditnagar as they are situated at a distance of 10 kms to 15 kms away from the slums. Because of this many have learnt to go to private practitioners of various kinds in Rourkela civil township. Even though these private practitioners charge fees, their relatively easy accessibility often compensates for the physical, and cultural distance and the inadequate medicine supply through the so called free state-run medical institutions.

The other categories of residents of the resettlement colony of Jalda (strata II and III) who are not eligible for services provided by the RSP health service system, have even greater problems of access to the state-run free hospital at Uditnagar, because the distance is longer still, even though they have the advantage of having a free Medical Aid Centre manned by a pharmacist located right within the colony. Because of this, these people have learnt to patronise unqualified, so-called registered medical practitioners in the nearby Fertilizer Township and they overcome the cost/distance barrier to go to Uditnagar or to private practitioners in Rourkela only when the condition of the patient is very serious.

The location of a Primary Health Centre at Hatibari and the availability of the TISCO hospital at nearby Korkatnasa and the RSP dispensary at Purunapani create a very special condition in terms of access to health institutions of the Oraons
of Hatibari-Baidyanathpur. The TISCO and the RSP medical facilities are available selectively to the permanent employees of the quarries and the nature of access of these eligible employees is by and large similar to what has been observed in the case of the Class III and Class IV employees of RSP residing at Jalda and at the urban slums. The FHC with its dispensary, small hospital and field staff provides a very special situation in terms of access to the non-RSP employees of Hatibari-Baidyanathpur. Theoretically, according to the instructions of the Government of Orissa, every resident in the village, every resident staying in the village of Nungaoon Tribal Development Block should have access to the various services of the FHC free of cost. But the study of this village as well as the other two villages has revealed that a variety of barriers have been erected to obstruct access of the people to the FHC. In the first place there is obvious barrier of limited technological expertise that is available at the FHC level and the limited supply of drugs and equipment there. As has been observed in the case of tuberculosis cases, inadequate understanding and diagnostic ability on the part of the FHC staff and inadequate domiciliary treatment from the FHC and its subcentres and bad referral facilities at the district and higher level, have been major causes of avoidable suffering to people who had sought services at the FHC.

One of the most unfortunate and major obstacle to access of the FHC in Hatibari-Baidyanathpur has been that the
doctor in charge of the PHC openly indulges in the illegal practice of asking for payment from patients who come there to seek treatment. He does not even observe the formality of exercising pressure over people in distress through his private clinic located outside the PHC. He blatantly carries out his "private" practice within the PHC itself, during the working hours of the PHC and not infrequently "sells" PHC medicines openly. The district authorities have not taken any action against the doctor. Because of all this Oraon in all the three study villages have the feeling that they must make payment if they wish to get attention from the doctor at the PHC. This is a major barrier to their access to the PHC as many of them are so desperately poor that they cannot afford to pay the money demanded by the PHC doctor.

In addition to the issues concerning the ability of Oraon to communicate with health personnel, the communication skills of the latter to communicate with Oraon in Oraon's own cultural context and the built-in bias of health personnel against Oraon tribal as ignorant, superstitious, and primitive people who indulge in heavy drinking also acts as an important obstacle to access to the PHC. These cultural and communicational barriers have already been noted in the context of the health service system of the RSP. However, in the case of the PHC at Matibari, in the absence of supervision from above and in the absence of the degree of community organization, as opposed to
that manifested by the labour unions of the RSP and as the mandate to the PHC is much more diffuse than what is the case in the RSP health service system, these obstacles are much formidable here. Also, as has already been noted, the ANM and other PHC staff do not pay home visits to Oraons as they are required to do and they demand payment for services which should have been given by the ANM at their own initiative and free of cost.

Because of the numerous barriers that have been erected in the way of access of Oraons to the services of the PHC, as in the case of the urban groups, other private practitioners have sprung into existence to offer an alternative to the suffering population. There is a practitioner of ayurveda and there is a pharmacist from the TISCO hospital in Hatibari who provide services on payment.

The most remarkable feature of the health institutions within the village Hatibari-Baidyanathpur is that despite all the obstacles in the way of access to services of the PHC and despite the technologically limited nature of the services available there, in so big a village as this, there is no Kushrain, or Bhagamati residing there. There is only a Pahan who too is becoming dysfunctional as a traditional healer very rapidly. Unfortunately, this aspect of health behaviour of tribals as indeed of other peasant societies has not received adequate
and attention from cultural anthropologists / exponents of Ethno-
medicine (e.g. Hassan, 9 Sahay, 67 Garstair 13 and Harriot 12).

All the above mentioned barriers to access to the PHC -
limitations in the technology and supply of drugs and equipment,
lack of knowledge concerning accepted nationally applicable
approaches, illegal charging for services, lack of communication,
and cultural prejudices of health personnel against Oraon
tribes also apply - often to a much greater extent, to the
Oraons of Kardoga and Kokorna who seek the services of the PHC.
Over and above, all these Oraons of these two villages have to
face a very formidable barrier in the form of the distance of
their village from the PHC and the absence of virtually any means
of transport to take seriously ill patients to the PHC. In the
case of serious illnesses Oraons from these villages have to
suffer extra costs in terms of loss of wages, and all the efforts
and expenses that are needed to carry the sick patients to the
hospital on a cot which is carried on the shoulders of two or
four persons by means of ropes and bamboo poles. Besides, they
have to meet the cost of having somebody to attend to the
patient in case he/she is admitted to the PHC ward (often after
bribing the doctor and other staff). Oraons of Kardoga have
a marginal advantage over Oraons of Kokorna as they happened to
have a subcentre of the PHC in the village staffed by an ANM.
However, it was found that this subcentre does not perform most
of the tasks assigned to it and that the ANM openly discriminates
against non-Christian Oraons. Karodga also has the advantage of being nearer to Birmatrapur (6 kms), where they can get the services of various private practitioners.

The sense of helplessness is thus most acute in Kokerma. The extreme poverty of the vast majority of Oraons and the virtually insurmountable barriers to their access to the PHC and other medical institutions leave them almost no way out to be alleviated of the suffering that is caused by various health problems, many of which threaten their very lives. A very pathetic consequence of this extreme form of helplessness is that the Oraons have provided a market to a mere peddler of drugs, who visits the bi-weekly market held at Kokerma to dol out all kinds of herbs, patent ayurvedic, homeopathic and allopathic medicines. He is far worse in his medical competence than the unqualified quacks practising in Kourkela, the Fertilizer Township and in Birmatrapur. This also provides an indication of the degree to which Oraons have actively sought health services which are different from what is available to them as a component of their tribal culture.

This study leaves no doubt whatsoever that Oraons from all walks of life in all the six study areas do have considerable felt-need for services beyond their traditional medical facilities and that because of the various barriers in their access to health institutions beyond their traditional
facilities quite often these felt needs remain unmet. As a result of their needs remaining unmet they often actively create markets for various practitioners of 'non-traditional' medicines. When even these are not accessible to them or when they do not prove to be of any use, in sheer desperation they fall back on the Pahang, Dharmanath and Khohraine whom they had abandoned earlier because they were not found to be adequate. Scholars in the field of Ethnomedicine have not paid enough attention to this cyclic process in the health behaviour of tribals and they have contented themselves with mere description - often with grossly value loaded information about some exotic aspects of health practices. This study demonstrates that if the traditional medical practices of a tribe is studied in the context of the social, economic and political relations within the community and in the context of the degree of access to other health institutions it gives an entirely different perspective to the role of traditional tribal medical practices; in this context the tribal medical practices become a more component of the dynamics of the overall health behaviour of the tribe which is regulated by factors referred to earlier.

It may be recalled that the study areas for this investigation have been specifically selected in terms of access to health services, with Rourkela Steel Township at one extreme and the village - Kokarma at the other. This was done with a view to ascertaining how far improvement in the access
to other health institutions influences the traditional health practices of a tribe. The health behaviour of the 12 Class I Oraon officers of RSP and the desperate efforts that are made even by the poorest of the Oraons of the remote village of Kokerna when they encounter a serious health problem have emply demonstrated that the culture of Oraons, including their health culture is in a state of flux in all the six study areas. In fact, the data concerning availability of health institutions within the six study areas and the degree to which Oraons have access to these institutions also throw light on cultural, social, economic and occupational factors which determine the dynamics of change in the health behaviour of Oraons under different conditions obtainable.

Even in the remote village of Kokerna it was observed that the response to serious health problems varied in terms of the social, economic, political and religious backgrounds of the individuals. It so happens that in this village, as very often is the case with the other study areas, those who have economic power also have considerable social and political control over the community and influence over the administrative machinery which is meant to provide various kinds of social and economic services to the community. While the permanent employees of TISCO, and RSP quarries of Kokerna fall in the same category as their counterparts in Hatibari-Baidyanathpur in terms of their health behaviour, by virtue of their superior economic and
social status, the well-off Oraon landowners of Kokarma have much greater access to the additional health services that are available at Hatibari, Bimitrapur, and even to far off Rourkela than the Oraons in the "poor" and "abjectly poor" strata. A remarkable finding of the study of Oraons of Kokarma is that while the well-off landowning families of the village occupy a high social position as clan leaders and ward members of the panchayat and claim themselves to be the trustees of the traditional Oraon culture and religion, in their response to serious health problems in the family, they actually allocate a much more marginal importance to the culturally prescribed Oraon healers - the Pohan, the Bhagamati and the Kushrain - than Oraons belonging to the poorer strata. This once again underlines the fact that it is the access to medical institutions rather than the cultural inertia of traditional medical practices which determines the health behaviour of an Oraon. As social, political and economic status is an important factor in determining this access, these factors should also be considered as major variables in influencing the health behaviour.

Findings from Kardoga and Hatibari-Baidyanathpur and the three urban groups have also consistently emphasised how these factors have improved access of Oraons to available health institutions.

Apart from the somewhat serious and often far-reaching political consequences pointed out by workers like Sahay, Sahay and Mahapatra, Roy-Burman and Patnaik, proselytisation
ctivities of Christian missionaries have three kinds of influence on the Oraons. Firstly, Oraons are made to see the virtue of the Christianity. Secondly, the Christians are able to acquire considerable advantage over non-Christian Oraons by using the numerous facilities and contacts offered by the missionary organisations to improve their educational (including technical training), economic and political status. Thirdly, the Christian church makes active efforts to wean Christian Oraons from secular cultural traditions such as celebration of harvest festivals, clan relationships and from the practice of traditional medicine. It has been observed particularly in the case of the poorer strata of Christian Oraons that this ejection of their past cultural heritage sometimes creates quite an agonising cultural vacuum because they do not have as much access to the alternatives offered by the Church. As can be seen from Tables 23, 25, 27, 28, 29, 30, 31 and 32, conversion to Christianity makes Oraons outward looking and much more amenable to change and manipulation by external forces. In the case of health the response of Christian Oraons is much more positive towards the health services offered by institutions of western medicine than that of non-Christian Oraons of corresponding economic and occupational backgrounds. The data from Kardega provide instances of the way the church has influenced the entire social, economic and political life of the village and in this way completely dominated the lives of non-Christian
Oraons. The reference to the linkage of the German Evangelical Lutheran Church with some of the influential West-German consultants to provide advantageous positions to Christians within the RSP organisation provides another instance of how church organizations exploit their contacts and influence to provide out of turn promotion of interest to those tribal who agree to embrace Christianity.

In terms of the ecological setting, using the word ecology in its widest sense to include also social ecology, the six study areas offer very widely different settings. Corresponding to these differences in ecological setting, there are also wide differences in the culture of the Oraons living in these six study areas. It has also been demonstrated that even within individual study areas there are widely different subcultures among the Oraons. The way of life of the "abjectly poor" Oraons of Kokoma is markedly different from that of the permanent employees of the quarries; similarly, the way of life of the RSP employees of Jalsa is basically different from that of those included in the stratum-III - construction site workers, porters, etc. Also, none of the groups or even subgroups described in the six study areas conform to the portrait of Oraons drawn by S.C. Roy in 1915. All this points to the dynamic nature of the Oraon culture both through time and space.

Corresponding to the different ecological and cultural settings, there are different degrees of availability of and
accessibility to various health institutions. As a result of the combined influence of the changing ecological settings, changing culture of Oraons and changing availability and accessibility of health institutions, there have been corresponding changing patterns of health behaviour in these six study areas. These changes constitute the components of what has been defined as the health culture.

Reference has already been made to the technological inadequacies of many of the health institutions, limitation in the supply of drugs and equipment and lack of acquaintance of the personnel in these health institutions with some very well established socially oriented technological approaches to specific health problems, for example, National Tuberculosis Programme. It has also been stated that some health workers openly betray prejudice against tribals. Even among those who are not so prejudiced against Oraons it was observed that very little efforts have been made at various organizational levels (e.g. Government of Orissa, and Rourkela Steel Plant) to bring about cultural orientation in the practice of medicine and public health. The yawning communication gap between the Oraons and personnel of various health institutions referred to earlier provides an instance of one type (human relations type) of such cultural reorientation that is required for these institutions. The very process of isolation of patients of tuberculosis and leprosy in the isolation ward of IGH provides an instance of
lack of adequate understanding of modern trends in the management of such cases. This also betrays inadequate consideration to the cultural implication of subjecting Oraons to the set pattern dictated by a westernized medical establishment. Inadequate consideration of the cultural mechanism that is adopted by Oraons to prevent or to get rid of unwanted pregnancies and almost blind implementation of the orders regarding birth control that are handed down from New Delhi and Bhubaneshwar are instances of cultural arrogance of the givers of medical technology to the Oraons. This arrogance gets further compounded when health educators who are often ill-informed, ill-trained and ill-motivated, are set loose on the tribals with a view to bringing them to the mainstream of "civilization". Promotion of baby food by the church authorities among Christian Oraons not only betrays technological arrogance but also provides yet another instance of contempt of the "saviours of souls" of Oraons towards some of the positive facets of the Oraon culture.

This study has shown that Oraons of almost all strata have benefited considerably from their migration to the three urban groups. The life of lowest stratum of Oraons in the slums holds much greater promise than that of those who belong to the abjectly poor stratum of Kokerna. However, as has been pointed out earlier, this urbanization of Oraon has not been an
unmixed blessing. The grossly substandard living conditions in the four slums, the brutally repressive and oppressive measures adopted by the contractors and their henchmen, much greater exposure to the hazards of alcoholism and poisoning due to toxic adulteration of liquor, trafficking in women and extensive prevalence of STD are some of the major facets of the seamy sides of the new way of life of Oraons in urban areas in lieu of the one which they have been living in their villages. Reference has also been made to the cultural response of Oraons to the hitherto unknown health hazards posed by STD and how they have found a mechanism to deal with them. The significant aspect of this cultural response of Oraons is that just as STD was a new "phenomenon" in the lives of Oraons who are exposed to various forces from outside, the cultural innovation developed by them was also very distinctive from those that they had developed for other types of health problems.