Quite apart from the health practices that are ingrained in the traditional Oraon culture, this study has shown that Oraons are aware of other more efficacious health services that are available from various institutions within their own village/city and outside and that they make special efforts to have access to these institutions, particularly when they face serious health problems and they find that their own traditional health practices are not efficacious. The present study provides enough data to show that, contrary to earlier beliefs - e.g. Hassan, Carstairs, and Harriot - even Oraons living in a remote village have considerable felt-needs for services other than what is available within their own culture and despite very strenuous efforts made by them they are unable to have access to such services, thus often leaving many of those felt-needs unmet. Therefore, for health administrators working among tribals, the problem is not so much of bringing about changes in the culture of tribals to make health services acceptable to them, but the problem is to increase the access of the tribals to an appropriate package of medical technology which is oriented to the social and cultural background of the tribals and which meets the pre-existing unmet felt-needs for health services among them.
The data from the study population of RST has shown that when Oraons are offered access to good health institutions and are given facilities to develop their potential through better facilities for housing, civic amenities, education, occupational organisation, etc., their tribal culture does not come in the way of their acceptance of the health services. Indeed, it was difficult to find any aspect of the behaviour of Oraons towards various health problems which can be considered to be distinctly inferior to that of non-tribal belonging to the corresponding economic and occupational stratum. The issues concerning the health behaviour of Oraons thus revolve round the question of the degree of access the Oraons of different study areas have and how social, economic and political considerations influence the access of Oraons to health institutions.

In the remote village of Kokorna where the access of Oraons to health institutions is severely restricted, it was observed that traditional Oraon practices concerning pregnancy, childbirth, childrearing and childhood diseases were extensively prevalent. However, whenever these practices were found to be inadequate, they have made efforts to have access to other institutions and that the degree of their success in this is determined by the resources they could mobilise for this purpose.

The response of the Oraons of Kokorna towards chronic communicable diseases like tuberculosis and typhoid and other
major chronic illnesses has followed a similar pattern. When they found that their traditional healers are unequal to the task, they mobilised resources to seek the services of the drug peddler in the bi-weekly market at Kokarma or that of the private practitioners at Birmitrapur or the doctor at the PHC. Those who have a higher social, economic and political status are able to pay the cost for getting complete treatment for their ailments, which may even include seeking additional medical services from Rourkela and Sundergarh. However, those who are unable to muster the needed resources are forced to call off their efforts when their resources are exhausted and they are compelled to fall back on the services of the traditional healers of their own village.

The cultural heritage of Oraons in the form of their traditional healing becomes very meaningful in the context of psychosomatic illnesses, incurable chronic illnesses like asthma, arthritis and minor illnesses, and treatment of smallpox. The Oraons find their own cultural practices in dealing with psychosomatic conditions much more preferable to what they get from various health agencies. Similarly, in the case of treatment of smallpox they have stood by their cultural healing practices as they found no better alternative in other institutions. It is significant that when it comes to acceptance of smallpox vaccination, as the successful smallpox eradication programme has revealed, cultural barriers have not come in the
way at all. Reference has already been made to the very significant phenomenon of the Class I officers of RSP trying to rediscover their own cultural practices when they fail to get adequate relief for conditions like asthma and arthritis from the doctors of IGH.

In between the two extremes represented by Kokorna and RST, Kardega, Hatibari-Baidyanathpur, Jalda and the four slum areas represent ascending degrees of access to various health institutions. Study of these populations of Oraons has shown that corresponding to those ascending degrees of access, there has been corresponding shifts in the health behaviour of Oraons towards an entire spectrum of health problems mentioned in the case of Kokorna. Apart from the shifts in health behaviour, it was also observed that presumably because of urban influence and because of their organization within the trade union, Oraons have also learnt to demand preventive services. The demand of RSP employees living in Jalda, and the slums for antenatal services from the IGH is one example of such a demand for preventive services.

On the basis of the study it can be asserted that the health behaviour of Oraons is similar to what was observed by Banerji in peasant societies. Banerji has summed up his findings as follows:

There are numerous instances of adoption of these healing practices (i.e., practice of the indigenous systems). But among those who suffer
from major illnesses, only a very tiny fraction preferentially adopt these practices, by positively rejecting facilities of the western systems of medicine which are more efficacious and which are easily available and accessible to them. Usually those practices and home remedies are adopted: (i) side by side with western medicine; (ii) after western medicines fail to give benefit; (iii) when western medical services are not available or accessible to them due to various reasons; (iv) most frequently, when the illness is of a minor nature.

Data from this study have shown that all the components of health behaviour of peasant populations, mentioned by Banerji are equally relevant in the context of the healing practices adopted by the six population groups of Oraons. The fact that there is such a close similarity between the health behaviour of a wide range of Oraon populations as observed by the author and that observed by Banerji in the context of peasant societies spread over in 19 villages in 8 states of the country, indicates that the trends in health culture presented by these two studies are also relevant to a much larger section of the population of the entire country, and indeed, to similar populations in many other countries of the Third World.