CHAPTER II

METHOD OF STUDY

The tribals in India are in a transition after the programmes for planned change have been introduced and implemented in the desired directions. The modern health measures, for instance, have raised new waves of change among them who have retained their traditional method of cure from illness. To examine the changing health status of the tribals in general and the Santals in particular, an exploratory and qualitative design has been evolved in the present study.

THE UNIVERSE AND THE SAMPLE:

The Santals, who are the focus of the present work, constitute a significant section among the people of India and are potential human resources for development. But they are a vulnerable section of Indian society who suffer from high rates of morbidity, mortality and fertility. However, after 1947, there have been so many transformations and interventions for their overall development. As health problems have caused many causalities and concerns, there have been many measures planned and practised for them. But the tribals are known for their love for traditions and have their own indigenous system. As a result, they have found themselves at the crossroads, that is, in a dilemma between the tradition and the modernity, between the old that is difficult to abandon and the new that is too attractive and
imposing to avoid. To know this state of their's and their awareness and response, it was necessary to choose an area like Nilagiri which is covered with the health, nutrition and family welfare programmes, through a network spread over the area. Though there are other similar areas for this research, Nilagiri was selected because of the investigator's local connection and personal convenience.

The Nilagiri Integrated Tribal Development Agency (ITDA) area is a part of the Nilagiri sub-division of the district of Balasore of Orissa state. The agency area touches Udala and Kaptipada area of the district of Mayurbhanja. It covers the whole of the Berhampur and a portion of the Nilagiri Police Stations.

In the midst of the hills and forests, there are 149 villages, including 60 Santal villages, belonging to 22 Gram Panchayats (village councils) in the Nilagiri Integrated Tribal Development Agency (ITDA) that is coterminous with the Nilagiri Integrated Tribal Development Block (ITDB). After the implementation of various development programmes, the people of the area have been experiencing changes through their physical closeness and social interaction. Development of roads has not only reduced the physical distance from their home to work place but also saved their time of commuting. The spread of educational institutions, besides improving literacy and educational achievement level, have exposed different castes, communities and tribal groups to one another. They have also been benefited by the
establishment of the health infrastructures all over the area.

In Nilagiri, there is one Primary Health Centre (PHC) located at Berhampur. Under the Primary Health Centre, there are 2 Additional Primary Health Centres (APHCs), 2 subsidiary Health Centres (SHCs) and 30 Auxiliary Nurse Midwives sub-centres (ANM sub-centres). The Sub-Divisional Hospital is situated at Raj-Nilagiri to provide referral services. Thus, there are 5 types of health institutions operating in Nilagiri.

There are about 60 Santal villages benefiting from above health institutions. First of all, these villages were divided into 5 groups of 'health centre villages' on the basis of their closeness to the respective health centres which the villagers may like to visit for the first treatment. For example, a group of villages is called 'APHC Villages' where the people have directly benefited from the primary health facilities available at the APHC even though they have gone to the PHC and Hospital whenever necessary.

The sampling was done at two stages. Before the individual respondents were sampled, five villages one each being from five groups of 'health centre villages' were selected. The selected villages are (1) Sajangarh (the Hospital Village), (2) Madhupuria (the Primary Health Centre or PHC Village), (3) Betakata (the APHC or New PHC Village), (4) Garadi (the SHC or Subsidiary Health Centre Village),
and (5) Hatimunda (the ANM-SC or Auxiliary Nurse Midwives Sub-Centres Village). These villages have been selected not on the basis of any sophisticated sampling technique but on the basis of the concentration of the Santal population and their nearness to the five different health centres providing health care facilities to them. As the health centres play a very important role of the grass root level in implementing the health care programmes, these health centres were identified first and then the five closest Santals villages, one each from each type of health centre, were selected to know how the closest Santal responded to the health care centres and their services.

After the selection of the villages, the respondents were selected on the basis of the simple random sampling. First of all, complete lists of the population of different villages were prepared separately and each member was allotted a particular number and was represented in that number on a slip. The slips of a particular village were put in a container and then required number of slips were picked up on a random basis to select the respondents of that village. In this way five different samples were drawn for different health centre villages.

For selecting the respondents and collecting data, only the adult members of the villages were targeted. As the samples were drawn on the basis of random selection, any one who was 18 year of age and above had an equal chance of being chosen for data collection. However, the sample
consisted of 8 percent of the total population of every village. Thus, from Sajangarh consisting of 447 persons 37 respondents were selected. Out of the total population of 439 persons in Madhupuria, the sample consisted of 35 persons. As 543 persons lived in Betakata, its sample was constituted by 43 persons. There were 34 Santals selected from Garadi with a population of 430 persons. From Hatimunda with a population of 654 persons 52 respondents were selected. Thus, out of the total population of 2513 persons in all the five villages 201 persons were selected to be the respondents for the purpose of data collection.

NATURE OF DATA

The nature of the data collected for the present study is predominantly qualitative. To look at health in a comprehensive way, it was necessary to collect data not only on the specific issues of health but also on the general context of health and illness. Thus, the nature of data collected concerning each of the five selected villages focussed on the following -

(i) The physical characteristics of the selected villages in terms of their location, physical surroundings, climate and soil, patterns of housing, sanitation and water supply, transport and communication, cropping patterns, trade, commerce and location of industries.
(ii) Tribal and non-tribal composition of population, historical and cultural background of the Santals, and their social structure in terms of nature of the pattern of their family, clan, lineage, kinship and other social organisations, traditional authority, their religious values, beliefs, norms, customs, festivals and fairs, etc.

(iii) Economic condition of the Santals in terms of their landholding, occupation and income.

(iv) Nature of their traditional and modern polity or political system, culture and activities.

(v) The level of literacy and educational achievement.

(vi) And finally, nature and adequacy of health infrastructures in forms of health institutions, medicines, equipments and health personnel working for the health of the Santals. Data have also been collected on the Santals' traditional systems of healing consisting of Ojhaism, sorcery and witchcraft, their customs and practices relating to death and birth, their awareness and response to the services provided by various health institutions located in the area under study.

TECHNIQUES OF DATA COLLECTION:

The relevant data have been collected through observations and in-depth interviews besides extracting
necessary data from the documentary and bibliographical
studies and general surveys etc. The investigator visited
different government offices and health institutions located
in the study area as well as in the adjoining areas. The
beneficiary villages and their people were observed while
performing their work and activities, dance and drama,
participating in fairs and festivals, marriage ceremonies,
community feasts, worshiping and offering sacrifices to the
deities for bringing cure to the diseased. The investigator
had also got a few opportunities to observe the doctors and
patients' interaction in hospital and health centres.

In the beginning, the survey method was adopted to
obtain the census of the Santal villages pertaining to their
total population, the number of households, their caste and
tribal composition and religious orientations. The data on
geographical location of the health centres and the Santal
villages, their historical and cultural background along
with socio-economic structures were also collected through
the method of general survey. This method, coupled with
brief interviews with some Santal leaders and modern health
personnel, was also helpful in collecting data on the
traditional healing practices, role of priests and faith-
healers, and tribals' response to the modern health care
programmes. Thus, the bulk of secondary and primary data on
the Santal population, their principal characteristics,
community amenities, social conditions, economic and
religious activities, physical environment and health status
were gathered through the observation and survey methods.
But the minute details of data were collected though the personal, probing and in-depth interviews with the selected respondents.

Three different types of interview schedules - one each for the Santal respondents, the folk-healers and the modern health personnel, were prepared for the present study. Though the schedules for the modern and traditional health personnel aimed at knowing their experiences and expertise along with necessary infrastructures, they were especially designed to cross-check the information given by the Santal respondents. The Oriya version of the interview schedule for the tribal respondents was designed and piloted to explore the conventional perceptions and contemporary possibilities of their participation in the modern health promoting programmes.

More specifically, the interview schedule for the Santal respondents was broadly divided into two parts. The first part dealt with their general socio-economic, cultural and religious aspects and the second part with the aspects of health. The 'interest-catching' and 'easy to answer' questions were constructed in the beginning to create conditions conducive to interview. The questions in this 'stage-setting' section were related to the socio-personal background of the respondents. Then, a few questions were framed on their socio-economic, educational and environmental aspects treating these as the holistic context of their health and illness. A few questions were also
related to the recent changes occurred in their villages and their exposure and interaction with the outsiders. Finally, a few questions in this part were related to their understanding of the concepts of development and their opinion on the government and the NGOs working there.

The second part of the schedule was prepared to find out the lay health behaviour and beliefs of the respondents. The questions were related mainly with the tribals' understanding of health and illness, diseases and death in the context of their old and new world-views. Besides questions about knowing the attitudes and behaviour of the medical and para-medical personnel in the health centres, a few questions also focussed on the respondents' views related to both public health and family welfare.

The schedules were modified and simplified after pre-testing over a representative sample. More precisely, after pre-testing, some of the questions were further simplified and more familiar and friendly words were used for better understanding. The uses of the Santal words like 'bonga', 'Ojha', 'dikku', etc. by an outsider created further interest in them. Then some questions found to be irrelevant and unwanted were replaced by new set of relevant questions. The questions with 'All or None' response were omitted and those with a high proportion of 'don't know or don't understand' responses were rearranged. That is how the errors in the interview schedules were eliminated and
proper structured versions were administered on the respondents.

Accepting the establishment of rapport with the respondents not as an end but as a means to collect the relevant data, the investigator moved around the study areas, participated in their fairs and festivals, visited the tribal households, leaders and the educated youths and explained the purpose of the visit for winning over their confidence. He made many friends and explained the nature and purpose of the study. Initially, they were unwilling and antagonistic as the investigator was mistaken for the 'notorious' politician or government official or the modern health personnel. But the investigator was able to allay their fears and suspicions, anxieties and expectations. They were made to feel that the researcher wanted to learn from them about their culture and traditions, life and problems, and the study was an academic necessity. Then they were happy to speak about them as they were proud to know that something really was going on about them in a distant place like Delhi, unlike the exploitation by the nearest outsiders or the Dikkus's. As a result, the grounds were clear and the interviews were successfully conducted.

Besides, the selected officials of the government development offices, NGOs and social workers, modern health personnel including the doctors, auxiliary nurse midwives (ANMs), Anganwadi workers and members of the village panchayats and panchayat samiti, village priests and faith
healers were interviewed at their convenience. On many occasions, the 'candle-light interviews' were also conducted as the respondents were out to work during the day time and the villages were not supplied with electricity. As the schedule for the tribal respondents was a long one, the interviews were conducted in two or three sessions. However, after all the interviews were successfully and systematically conducted, the collected informations were checked and cross-checked to take care of errors and omissions.

Besides the interview schedule, four other types of records were maintained: field notes, daily diary, weekly reports and village reports. Basic informations, observations and informal chats were written down in the field notes which were properly processed in the field diary. Weekly reports were written on the basis of the daily diary. Taking all the above three into account, separate village reports were prepared.

TABULATION AND ANALYSIS OF DATA

For the purpose of coding or quantifying the qualitative data, the edited answers were properly studied and a code-book was prepared by listing the answers and assigning code numbers to each one of them. Then the coded informations were transferred to the transcription or code sheets. With 143 items listed in the code manual, simple tables were prepared for meaningful interpretations and
analysis of data. The statistical measures like frequency distribution, average and percentage were calculated. Thus, both the quantitative and qualitative data were organised and integrated for the purpose of the present thesis.

LIMITATIONS OF DATA:

The pilot study was synchronized with the time of the elections for the state legislative assembly on the one hand and the harvest season on the other. The already delayed pilot study was conducted during this period with an additional intention of observing the political participation of the tribals, some quick development activities carried out for them on the eve of the elections and a few harvest festivals featured with dance, drinks and community feasts.

But the limitation was that people were largely preoccupied and suspicious initially as stated earlier. As a result, the choice of sample suffered in the form of not going for a more representative stratified random sampling. But this procedure required an up-to-date and reliable sampling frame with the readily available information on age, sex, occupation and education of every member of the population. More so, such information were not available in the beginning as different offices, over-busy with the election works, had kept the information 'confidential'. The tribals too were busy in making money, drinking, singing, and dancing as a part of election campaigning. So,
the simple random selection was done for the purpose of identifying the respondents and collecting data from them. The other limitation was the investigator's physical location and commuting long distance through the hills and jungles to reach the field of research. This in turn constrained him from continuous observation of the day-to-day happenings in the field of study. All these do have some reflections on the nature and quality of the data used in the present study.

Lastly, the presentation of data lacks any theoretical or conceptual sophistication as the study deals with the evaluation of a development programme and the tribals' response to it. However, on the healthier side, it has a positive bias towards understanding the practical issues of health care programmes encountered by a backward community like the Santals of Orissa.