Chapter 1

Introduction
Health is one of such aspects, and as WHO also has indicated, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", or in short it is a multi faceted aspect. Indian society consists of immensely varied political, social, ethnic, linguistic, religious and community groups, which by and large reside in village, where poverty, misconceived religions, notions, social costumes, illiteracy, ignorance and superstitions prevail. Health and nutrition form a major thrust area of investigation among the primitive tribes. Health and its related problems are very closed to their socio-economic status. Disease and illness are one of the fundamental problems faced by every human society but tribes basically living in remote and inaccessible areas, where health care and developmental services are not up to the expected mark. So this is a urgent need to understand their concept of health their concern for ensuring a positive their traditional knowledge, their customs, religions activities and attitude regarding modern health care practices. Health and disease are a continuous process and are linked to the health seeking behaviors of a community. A number of factors have been reported to influence the health seeking behaviors of individuals among which the socio-cultural pattern of the community is the most important. The health seeking behaviors of the tribal groups is supposed to be highly associated with their beliefs, customs and practices, since majority of the
tribal population are suffering from illiteracy poor and lack of modern sense of the health and hygiene.

A significant percentage of 8.08% have been enumerated in the county (excluding J&K) as a member of scheduled tribes (Census, 1991). The Census of India (1991) enumerates 573 notified scheduled tribes in India. Out of these 573 tribal groups, government of India has identified 74 primitive tribal communities for taking of developing programs, out of which 3 belong to Madhya Pradesh. These tribal groups inhabit widely varying ecological and geoclimatic conditions in different concentration throughout the country and are distinct biological isolates with characteristics cultural and socio-economic background. Tribal groups are homogenous, culturally firm, have developed strong magico-religious health care system and they wish to survive and live in their own style.

Tribal society has certain norm values and ideal regarding the health and disease. In each level of culture the attitude of the trebles towards and cure is difference and largely governed by the very particular level. The elements of culture i.e. customs traditions values, pattern of interaction directly and indirectly affect them.

Tribal populations has distinctive problems, not because they have special kind of health, but because of special placement in difficult areas and the circumstance in which they live (Kar, 1993). Generally the entire life of tribals revolves around forest. The
major and minor produce of forest were the major resources of tribal. The income they drive from labour, wages in forest contributor merely for their survival. They have a very little attention towards their health and related problems.

Health is a function, not only of medical care but also of the over all integrand development of socio-cultural, economic education, social and political. Each of these aspects has a deep influence on health, which in turn influents all these aspects. Hence, it is not possible to raise the health status and quality of life of people unless such efforts are integrated with the wide efforts to bring about the over all transformation of or society. Good health and good society go together (Basu, 1992). This is possible only when supportive service such as nutrition, environment and education reach a higher level. People of all societies primitive or modern developed their own sets of belief and practices regarding health, disease and treatment. The association between socio-cultural factors, prevention and treatment of illness has been established by the investigation of social and medical anthropologists.

Health is a cultural aspect of life. In fact all communities especially trebles have their concepts of health, as a part of their cultural beliefs, inherent and integral pre-set ideas into over act and custom. Health status of different tribal group is influenced by their entries way of life, like culture including social and economic condition, nutrition living condition housing
education food habits taboos and superstition, social-religions beliefs and practices, socio-biological practices genetic attributes and available health services etc. These entire interacting sub-system complexes as a whole is termed as health culture. Information on health culture among tribal population is very limited and hardly any systemic data exists among the primitive tribal group regarding health and health relate aspects i.e. socio-cultural components of health seeking behavior. The socio-cultural aspect of health and disease are one of the important factors affecting the health behavior of the masses.

There is general agreement that the health status of the tribal population in India is very poor (Basu et al. 1987, 1989, 1990, Bardhan, 1989, Ray Burman, 1986, 1990, Swain et al. 1990, Mukerjee 1986, 1990, Mahapatra et al. 1990, Rizvi 1986; Haque 1990) have tried to establish this with the help of morbidity, mortality and health statistics. Low health status of tribal community is not a consequence of their ethnicity or tribalness, but closely interlined with other factor such as their poverty, illiteracy, lack of infrastructure facilities and so on. The socio-cultural aspect of health and disease are one of the important factor affecting the health behaviour of the masses (Sood et al. 1999).

These are numerous KAP (Knowledge, Attitude and Practice) studies available on the health status of the tribal in India which effect their low health properties (Arora and Chaudhury 1993), Jaiswal

The probability that an individual would take appropriate action either to prevent illness or to recover health depends upon individual perception of threat. The perception of threat includes a measure of susceptibility and severity. These perception are modify by factor like demographic variable (age, sex ethnicity), social psychological variables (peer and reference group, personality previous experiences) and structural variable (social class, access to health services etc.).

Utilization of health services was affected of health centers in the premises of village, availability of, awareness about the existing health services and patient satisfaction. The problem of malnutrition, inadequate health care facilities and lack of awareness on hygiene cause a whole range of disease. These are broadly tropical diseases, water borne infections, infectious diseases and nutrition related disorders. Although the government spends a huge amount on medical education, the benefit of specialist health care services are yet to percolate down to every nook and corner of the country due to increase in the population.

practices of the Jaunsaris. Kaur and Simon (1998) study of health practices among the elderly in Haryana. Kshatriya (1997) also done his work on health care practices on Junsar-Bawar of U.P. Pawar (1983) observed that younger woman were better aware of antenatal care services than the older woman. Yesudian (1989) found that mother and child health (MCH) services are much influenced by the factors like education, occupation, income, accessibility and the like. Mandakini (1971), Kumar (1982), Caldwell (1986), Ravindran (1988) and Basu (1990) showed that a considerable proportion of women did not use either antenatal care (CARE) or delivery services due to ignorance, lake of cooperation among family members and rude behaviour of hospital staffs.

Renowned anthropologists namely River (1924) and Clements (1932) have made significant contribution in the field of concept of health and disease. Clement had tried to trace the worldwide distribution of five basic concept of disease that sorcery, breach, of taboo, object intrusion, spirit intrusion and soul lose, in the Indian cultural setting, numerous studies on the etiology, diagnosis and therapy of disease have been carried out in different communities by various scientists Gould (1957), Khare (1963), Hasan (1967), Madan (1969), Rizvi (1991), Bhat (1986), Das (1986) and Khatua (2001).

Tribal concept of health, disease, treatment, life and death is as varied as their culture and tribal
society is guided by traditionally laid down customs and every member of the society is expected to confirm to it. Tribal concept of health and disease is a vast area of research. Many studies have been carried out so far on this line. Gupta (1986) had conducted or study on various tribal population and observed a clear difference in concept of health and disease. Many others studies have been done on the same field in different area and different population (Mukharjee 1974; Sinha 1979; Pal et al. 1986; Bhattacharya et al 1986; Das 1986; Bhatt 1986; Choudhray 1986 and Sahu 1986). The fate of the individual and the community at large depends on their relationship with unseen forces, which intervene. If man offend them, the mystical power punish by sickness, death or other natural calamities. Various types of plants now the tribal of Madhya Pradesh.


Every society has its own traditional beliefs and practices related to health care. Beliefs in supernatural power i.e. God, beliefs in holy ritual salvation, offerings and sacrifices are applied at different stages of life from birth to death. People have taken pleasure in using traditional beliefs and practices for a long time and got used to it. Thus it can be made easily acceptable something that has been given by the faith healer to the community. Some practices are effective whereas others may be harmful or ineffective. These belief and practices are linked to culture environment and education.

Every culture, irrespective of its simplicity and complexity, has its own beliefs and practices concerning disease and evolves its own system of medicine in order to treat diseases in its own way. It is therefore important to study in depth the various social, cultural and ecological determinants affecting the health status of the tribal communities. In a tribal community, illness and consequent treatment is not always in individual or familiar affair, but the decision
about the nature or treatment may be taken at the community level.

In India lifestyle, dietary pattern, social behaviour as well as health behaviour is prescribed by the deep-rooted traditions. These are more pronounced in the tribal areas where outside influences, education and urbanization are minimal. The variety of sub cultures, languages, religious and economic groups with consequent variation in dietary pattern preclude the application of finding in one group to another. The traditions are thus continued from generation to generation.

Malnutrition influenced by a whole variety of factors, including lack of health care, unsanitary conditions, lake of food and poor caring practices at the family level (Engle, Dustagheer and Shrivastva, 2000). These factors are in turn influenced by a variety of social cultural and historical conditions, such as the status of women and social exclusion. A common belief is that lack of food is the reason for malnutrition; however, it is only one contributing factor. The National family health survey (NFHS, 1995) in its earlier report reflected that overall prevalence of malnutrition in 0-4 years age groups was more than 50% with higher prevalence in female children. The recent one, NFHS II (1998-99) shows 46.7% under weight children among less than 2 years age group. Malnutrition is more prevalence in under two years of age and when the family size was bigger (Sudipo et al.
2000). Tribal area and slum and pavement dwellers had much higher prevalence of malnutrition (Ray et al 2000). Providing the best star for children is a good investment in the future.

Education development of tribal has emerged as a hard core area in the realization of "Education for all". It poses and even greater challenge to policy makers, planners and practitioner with the recent visible shift of emphasis from concern about access in education to equity plus quality realization (Revised Policy Formulation, 1992).

It is well known that cultural, demographic, social and economic factors play important role in shaping marriage in a society (Dixon 1971). Of the socio-economic factors female school enrolment has been widely recognized to have a major effect on marital postponement (Islam 2001). These process where by education effect the timing of marriage is not fully understood because of the complex interrelationships between education and other variables (Glick and Carter, 1970). It is argued that education, especially a women provides individuals with a new vision and normative orientation better health care, better employment opportunities outside home, better knowledge of and access of family planning methods. These include others in turn, may produce a depressing effect on fertility (Caldwell and Mcdonald, 1981).
From time to time Indian demographers have advocated that the age at marriage of girls be raised so as to reduce the reproductive span of women, and thereby, bring down the birth rate. Zachariah et al. 1964; Jain 1964; Agrawal 1967, have estimated a 10-20 percent reduction in the birth rate if the age at marriage of girls is increased to 18-20 years while Basavarajappa et al. 1967; Venkatacharyya 1969; Talwar et al. 1974 estimate it to be less than 10 percent. Despite variations is estimated and depending on the assumptions made by the researchers, it may be concluded that delaying the marriage of girls would lead to some reductions in the birth rate.

In Indian adolescent motherhood is closely associated with early marriage leading to early initiation of sexual activity. In Indian society early motherhood as well as large family size are still considered ideal to ensure that an optimum number of children, especially sons, will survive to adulthood to provide old age security for the parents. Thus both ignorance of family planning methods and the desire to compensate for child loss has promoted couples to have a large number of children. However, reproductive behaviour is controlled by many sex taboos and social and cultural norms. A number of indirect checks on the sexual lives of couples have kept down their completed family size to much below the biologically possible number. Thus, early marriage
does not necessarily help women to achieve a large family size (Pathak and Ram, 1993).

Pregnancy in the case of a woman is the midpoint of life and death. Therefore these are many such practices, rituals, beliefs and offerings which are meant to protect a mother from influence of evil spirits and supernatural powers. The intimate relationship between the physical and psychological well being of a mother and her child has always been obvious (Winikoff, 1988). This link has been affirmed for generations by traditional norm prescribing dietary practices during pregnancy and lactation, specify rituals and practices for child birth and the immediate postpartum period and defining complex rituals and folk knowledge applied to early infant care and child rearing (Kar, 1993).

Reproductive health has been conceived as a state in which people have the ability to reproduce and regulate their fertility; women are able to go through pregnancy and child birth safely, the outcome of pregnancy is successful in terms of maternal and infant survival and well being and couples are able to have sexual relations free from the fear of pregnancy and contracting diseases (IFWP, 1995). Reproductive care needs to be broadened beyond maternity care and family planning to include care for gynecological and sexual problems, safe abortion services, and sex and reproductive health education.
In India, women are a neglected lot, form times immemorial. In marriage women's sexual rights are at the mercy of their husbands. In fact in many instances they are not accepted in their husbands families until they give birth to male children. They have no autonomy over their own bodies. Women are portrayed as sex symbols in the media. Abandoned wives and ill informed and poor rural girls are lured into prostitution, where they are exposed to various infections because their clients refuse to use condoms. They get infected and spread infections to other clients who intern inject their unsuspecting wives. These poor and illiterate women do not ever realise if they have any reproductive right at all (Saha & Chatterjee, 1998).

Maternal health care and child care is an important aspect of health seeking behaviour, which are largely neglected (Basu, 1993). Majority of women do not take special care for their food even during pregnancy, this is also one of the factors for low weight babies at the time of birth.

Maternal mortality in India is unacceptably high. Ten percent of women in the reproductive ages die from pregnancy and delivery related causes (UNICE, 1991) with an estimated maternal mortality rate over 400 per 1,00,000 live births. It is said but true that majority of maternal deaths are preventable. There is a definite link between socio-economic factors and mortality. Obstetrical complication like antepartum hemorrhage (APH), postparum hemorrhage (PPH),
abnormal presentation, abortions ectopic pregnancy etc are seen in developed countries also but these complications do not end in mortality so often there possible reasons for high maternal mortality in India are lot of delay in seeking medical help, lack of man power and other facilities at first referral level to provide emergency obstetric care (EOC). It is necessary to identify and pin point these factors which take heavy toll of maternal lives (Bhatt and Hazra, 2000).

A maternal death is the outcome of a chain of events and disadvantage throughout a women’s life (Motashaw, 1997). In India, it is estimated that about 437 women out of every 1,00,000 women die every year due to pregnancy and its related causes (NFHS: 1992-93).

In India girls are married of at a young age sometimes as low as a 9-11 years. It is noteworthy about 43% at all female deaths are of girls between fifteen and twenty years of age and the causes of maternal mortality are pregnancy complications, early pregnancy, abortion, deaths due to bleeding anemia etc. Early marriage early conception, negligible antenatal care, general negligence of women and low social status, all lead to increased mortality rate (Manocha et al 1992).

The major causes of maternal deaths are bleeding, severe anemia of various origin, puerperal sepsis and
obstructed labour and toxemia of pregnancy. Early marriage, early pregnancies and short spaced pregnancies are also some of the factors underlying such high rates of maternal deaths. Low literacy level of mothers, low knowledge of nutrition health and education, lack of adequate maternity services and under utilization of the existing services have aggravated the problem. Therefore the safety of the life of women in her reproductive age depends on a number of factors, such as number of pregnancies, number of miscarriages/abortion and still births she has had; also antenatal, natal and post natal care she receives during her pregnancy and child birth (Nagi and Singh, 1996). According to Motashaw (1997) anemia, poverty ignorance and malnutrition, repeated pregnancy, inter current infections parasitic and helminthes infections and haemoglobinopathics are main causes of maternal mortality. Sundari (1992) also summarized the factors contributing to the high level of maternal mortality in developing countries. They are an inadequate health care system, misplaced priorities, inaccessibility of essential health information, lack of minimal life saving equipment and faculty patient management.

Several studies e.g. Basu (1990), Basu (1990), Kar, (1986, 1990), Rizvi (1986) and Sahu (1986) also reveal that socioeconomic factors, socio-cultural variants like nutritional practices (food habits) interrelated with socio-biological norms such

In the developing countries, after a downward trend till 70s breast-feeding has shown an upturn (Hendersho, 1984). Conversely in many developing countries situation is deteriorating (W.H.O.1989; Ghosh et al 1976). In urban areas, almost one third of mothers stopped breast feeds within two months (Kumar et al. 1989) inspite of recommendations to breast feed for first four to six months (ARIFGO, 1982). Breast-feeding is important for healthy growth and development of all babies. Breast milk contains all essential nutrients a healthy baby needs. It is rich in antibodies that protect against diarrhea, infections and food allergies. Breast-feeding helps to delay a new pregnancy. It creates and unique bond between mother and baby that gives warmth, affection, security as well as food and protection (WHO 1979; Khanna 1991; Plank et al. 1973). Hence it is necessary to keep this practice under continuos surveillance so that timely action could be taken at the earliest indication of

Culture plays an important role in accepting family planning methods. The adoption of family planning varies from society to society and depends upon the customs, traditions and belief existing in the society. The practice of contraception was prevalent even among tribes who practicing traditional methods of contraception like abstinence, coitus interrupts, drinking of salt water immediately after coitus etc (Bongarts, 1980). The soligas of Mysore believed that prevention of birth is against to God’s wishes (Census of India, 1961). Similarly the Sugalis of Andhra Pradesh believed that spirits too fecundate women and one of their ancestors might be sent by the God to be reborn. They also believed that spirits made her womb incapable of concieving and cause barrenness (Gurumurthy, 1986). The Jatapus considered the God controls births and deaths and they use indigenous medicines for birth control (Prasad, 1970). Kadu kurabas of Karnataka are aware of modern family planning methods they use indigenous medicines for births control mainly because of their cultural factors (Mutharayippa, 2000).

Economic status and level of education of the couples were found to affect the family planning
practices significantly. Similarly, the sex of the last child and total number of male children per couple had significant impact on the family planning practice of the couples (Sharma et al. 1997).

In a vast, multi-ethnic, multi-religious country like India, it is to be expected that we have several world views operating at the same time in people's search for health and healing. The perspectives that have dominated and permeated countrywide have been of course, Ayurveda, Unani and Tibetan medical systems. Modern medicine has been a late entrant and primarily because of colonial patronage it appears to be edging out other indigenous traditions. Local health traditions, the lok swasthya paramparas, have generated local perspectives and meaning. Changing perspectives and meaning in turn have continued to modify and change local health traditions over time (Cupta et al. 1997).

An understanding of health seeking behaviours is therefore important if STD control programs are to be effective. However, taboos and stigma related to sex and STD in most cultures mean that gaining a true picture is difficult and requires considerable cultural sensitivity. At the moment relatively little is known about whom people turn to for advice or about how symptoms are perceived, recognized or related to decisions to seek help. It is argued that such knowledge would assist programme planners in the
development of more accessible and effective services, that studies of health seeking behaviour need to include a combination of qualitative and quantitative methods, and that studies should include data collection about people who do not present to health care facilities as well as those who do (Ward, 1997).

Health seeking behaviours is one of the major issues in the health status measurement, which govern the every aspect of health. Health seeking behaviour is deeply interwoven into every event of social, economic and biological aspects of a population. The health seeking behaviour of the tribal groups is supposed to be highly associated with their beliefs, customs and practices since majority of the population in their societies are illiterate. Poor and lacking modern sense of the health and hygiene (Pandey et al. 2000). In any cultural context a precondition of most health seeking behaviour is recognition of symptoms. Of key significance therefore, is the way in which symptoms are interpreted by the individuals affected and by those around them the meaning the symptoms have, the attribution of cause, and the beliefs held about appropriate and effective treatments (Mechanic and Volkart, 1961; Scambler et al at 1981; Morrell and Wade 1976; Wadsworth et al. 1971; Ingham and Millar 1979; Calnan 1987).

Health seeking behaviour can be defined as any activity undertaken by individuals who perceive themselves to have a health problem or to be ill for the
purpose of finding an appropriate remedy. This definition borrows from Kasl and Cobb (1966) definition of “illness behaviour”. Health seeking behaviour should be distinguished from the broader concept health behaviour, defined by Kasl and Cobb as any activity undertaken by individuals who see themselves as healthy for the purpose of preventing disease or detecting it in an asymptotic stage.

Health and disease are a continuous process and are linked to the health seeking behaviour of a community. A number of factors have been reported to influence to health seeking behaviour of individuals among which the socio cultural pattern of the community is the most important (Pandey et al. 1993).

Basu et al. (1990) worked on the determinants of health seeking behaviour among the tribal population of Bastar. Pandey and Tiwary Study (1993) on Socio-cultural characteristics of health seeking behaviour of the Hill Korva and same study have been conducted by Mitra (2000) on Abujhmaria and Kamar primitive tribe of Chhattisgarh.

To achieve the set of goals of either for health or nutrition, there is a need to understand health seeking behaviour of community, so that any health planning for tribal health can be made to help them in maintaining good health. Thee results would help them
in understanding the health problem and their relevant causes of Bharia primitive tribe better and programming the future health care strategies efficiently of not only Bharia but also of the other tribe of Madhya Pradesh sharing the same eco zone.


In recent years there has been a growing concern for women health in developing countries, since family planning and mother and child health care services can improve their survival and quality of life (UNICEF, 1989). In India the National family health survey (NFHS, 92-93) carried out by the Ministry of family welfare in coordination with international institute of population science (IIPS), Bombay provided a complete
information on implementation and effectiveness a mother and child health and family planning services. In 1993 the king Edward hospital, Pune in association with Indian Council of Medical Research (ICMR) conducted action research study tittle, "Comprehensive maternal and child health care for implementation of package of interventions for improving maternal and child health services in rural area areas", through training and Supervision (Ranganthan and Rao, 1993).

While there is a broad understanding of health problems of the general population, particularly of the urban and rural communities, such information on tribal population is meager. Information on their access to and utilization of health services is also not readily available in a desegregated form. Studies pertaining to health status among different groups of India are very few, patchy and scanty. Health seeking behaviour of Bharia tribal people, especially from disease and treatment pattern are the main trust of the study. In continuation of ill health across generation results from a complex inter play of social, economic, cultural and biological factors. This cycle can be replenished at any point. Thus e.g. protecting the health of pregnant women in turn, protects the health of the children and thereby the next generation of adult women.

Keeping these facts and observation in view, an attempt has been made in the present study to
understand some relevant aspects of distribution of food within the family, the complication of pregnancy and of childbirth, practices of parturition, infant and child bearing practices, maternal mortally, infant and child mortality and their sex differentials, nature of maternal and child health care practices, breast feeding practices, attitude towards family planning, morbidity and immunization especially among the Bharia primitive tribe of Madhya Pradesh, through a look at their social structure, culture, food habits and traditional health seeking behaviour.

The objectives of the present study are

To understand their concept of health, perception and treatment of disease

To investigate the mortality and mobility pattern and associated socio-cultural factors

To investigate their knowledge and utilization of antenatal care services (ANC), maternal and child (MCH) and family welfare.