CHAPTER VIII

SUMMARY AND CONCLUSIONS
Health status among the *adivasi* communities (administratively known as the Scheduled Tribes) in India is a matter of obscurity, paradox and recidiveness. On one hand, the *adivasi* are said to lead a well adapted life and enjoy good levels of health and nutrition and on the other, abject poverty and high incidence of morbidity conditions are said to pervade these communities. As the health status of these communities is not adequately examined, arriving at veracious conclusions warrants careful analytical studies. Being primordial, autochthonous, autocephalous and are also being able to survive into the contemporary times, these communities have devised their own health cultures in order to cope up with the risks threatening their health as well as survival. What constitutes this health culture and how do the *adivasi* negotiate with the conditions of morbidity and mortality continues to be elusive issues. Information on health status pertained to the *adivasis* at the national level are woefully scanty. Anthropologically, it is tempting to examine the health culture and its interface with the induced changes for assessing the health levels or status of these *adivasi* communities.

In the past 50 years of Independence, various development programmes have been launched to bring the *adivasi* into the mainstream. These developmental measures have differential impact on various *adivasi* groups. While some *adivasi* communities have benefitted, the experience of several other groups has been that of dispossession, deprivation, despondency and
alienation. Consequently in 1975, the Government of India has identified most downtrodden adivasi communities (administratively termed as Primitive Tribal Groups) for special drive for their amelioration. In Andhra Pradesh, a total of 9 communities out of 33 adivasis were identified as ‘Primitive Tribal Groups’ (PTG). These groups are identified owing to their pre-agricultural level of technology, low literacy levels and demographic decline or stagnation. A brief overview of health status of tribal people of Andhra Pradesh is discussed below.

The tribal sub-plan areas in the State of Andhra Pradesh are spread over 9 districts including 33 tribes comprising 22 lakh population. Since the First Year Plan, an amount of 894.18 crore was so far spent in these Scheduled Areas by the Tribal Welfare Department. There is no comparative data available to assess the extent to which these efforts have helped in the alleviation of poverty levels among the tribes. While some progress is said to have been achieved in terms of slight increase in income and literacy levels, the health status of the tribal communities remained dismal. The following statistics reveal the gravity of epidemiological status in tribal areas in Andhra Pradesh and unexceptionally adverse variation in comparison to more developed parts of the state. Maternal mortality is eight per 1000 (going upto 25 among some tribal groups) as against 4 per 1000 for the general population of Andhra Pradesh. Infant mortality rate is 120-150 per 1000 compared to 72
per 1000 in the state. While it is 9 per 1000 crude death rate, with 30 per cent moratility to children aged 5 years and below for the state, among some of the major tribal groups such as the Savara, the Gadaba, the Jatapu, the death rate is as high as 15-20 per 1000 with over 50 per cent of deaths to children under five. Longevity of life is lower. The sex ratio is declining very fast during the decades 1981-91 and 91-2001. The incidence of TB among the tribes is twice as much as the incidence among the general population. About 75% of total deaths due to malaria in the state is accounted from the tribal areas alone.

One interesting aspect with tribal areas compared to non-tribal areas is the creation of health infrastructure in relation to population size. There is one primary health centre (PHC) for every 7,772 tribal people as against one PHC for every 40,000 people in the plains areas. Likewise, there is one Sub-Centre for every 1251 tribal people as against every 7000 persons in the plains areas. However the positive aspects of this impressive spread of infrastructure is invalidated by the high spatial dispersion of the tribal populations. The PHCs and the Sub-Centres have been so located that the distances to be covered (mostly by foot) go up to an average of 272 kms and 37 km respectively. Similarly the average number of villages/habitations that have to be covered by a PHC and Sub-Centre are about 73 and 10 respectively. Thus physical access and distance of the infrastructure are the major barriers for the utilization of health care services.
Further, a survey of the health care service facilities in tribal areas, conducted by the Department of Family Welfare during 1994-95, revealed that none of the 29 Mobile Medical Units (MMU) were functioning; 66 per cent of the PHCs required repairs to make them usable, 30 per cent had no electricity, 62 per cent had no labour rooms or water supply and 19 per cent were located in thatched huts; 53 per cent of PHCs did not have operation theatres and the 22 per cent of the remaining operation theatres had no equipment and therefore unutilized. There was also substantial number of vacancies among the doctors, Male Health Workers and Female Health Workers which resulted in virtual non-utilization of the health care services.

It can be seen clearly from the above account that health status of the tribal communities forewarn an impending danger. Such a condition prevailed in spite of launching special programmes. It is very difficult, however, to trace out precise reasons for the precarious conditions. Firstly, detailed studies are not many; the health status surveys conducted by the Tribal Research Institutes are not informative; adivasi culture itself is too diverse to draw any meaningful insights. Epidemiological conditions and etiological factors differ from one adivasi group to the other. The degree of variation in epidemiological conditions and etiology is also not adequately known.
That health and disease regimes of any population or ethnic community are culturally constructed has also not received scholarly attention it deserves. As a matter of fact, health culture among the *adivasi* is little understood and explored. While some broad generalizations are readily advanced relating health to the socio-cultural realm, their relevance to policy formulation and usefulness to chalk out meaningful interventions are largely unexplored.

Even though allopathic medicine is no longer a phobia, there is a gap in the way tribes perceive medical systems in their own terms from that practised by the allopathic practitioners. There are differences in the very expression of the symptom complex, understanding of the causation of illness and even the language used for communication.

Each cultural setting is replete with a traditionally derived ethnomedical knowledge with specific ideologies concerning health, disease and worldview. Unless different genres of health and healing systems are critically researched, developing macro-level generalities with implications for intervention may remain elusive. It is also not true to say that tradition always acts as an impediment in the promotion of modern medical/health care services. However, adoption of modern medicine does not mean giving up old medical practices. When the advantages of modern medicine are not convincingly apparent, ethnomedical praxis provide a ready frame of
Modern medicine and traditional medicine coexist in tribal India just as elsewhere.

From the review of literature, the following inferences are elicited:

1. The health status of the tribal communities in Andhra Pradesh is not satisfactory even after spending huge amounts for various development purposes;

2. Tribal areas have peculiar physical features; creating health care service facilities in these areas is not only arduous but also troublesome to sustain;

3. Epidemiological status in tribal areas differs from one area to another area and from one group of tribal populations to another population; in one context, infectious diseases (like diarrhoea) may account for the toll whereas in others it may be maternal deaths or degenerative diseases are the reasons for death.

4. Indian studies on Medical Anthropology fall under a type that is unamenable to systematic appraisal. Most of the studies are community based, that is studies conducted on specific ethnic groups. The early studies were mainly conducted in rural areas inhabited by Caste Hindus. In India, Medical Anthropological research among the tribes has a recent beginning. Possibly for this reason, the number of ethnic groups studied so far is very small. Most of the studies are confined to Bihar and West-
Bengal. In the rest of the states, the studies are sporadic. The empirical details in most of the studies are scanty.

5. A majority of the studies have focused on treatment aspect, that too on magico-religious practices and use of plant material. One very conspicuous weakness of these studies is lack of adequate inquiry into the nature of the diseases as related to its treatment procedures, choices and decision-making.

6. These studies are not addressed in the actual practice and context. Most of the information were collected by recall method. Information other than the names of diseases and name and part of the plant used is lacking. The literature is replete with statements that diseases are cured by means of magico-religious means. There was little effort to provide the substantive content of these means.

7. Concept of disease was another popular research topic in many Indian Studies. However detailed studies with critical analysis are scanty. Quite frequently the health or disease notions end up in broad statements focusing on supernatural causation of disease. Very rarely these are explained in detail. As Budiadheb Chaudhuri (1986) had pointed out that "The anthropologists, in many cases, have overemphasized the superstitious health beliefs and practices, but did not care much to examine the reasons for decay or degeneration of traditional health
culture”. He pleads for studies that brings out the bases of this traditional health cultures.

The present work is envisaged against the above backdrop to understand health, disease and treatment practices in a primitive adivasi community namely the Chenchus of Andhra Pradesh. The Chenchu is one of the nine “Primitive Tribal Groups” identified by the Government.

This study is only a modest attempt to delineate health culture in a single tribal population. It does not claim to make a substantial contribution in the light of the above observations. In fact, the study only proved how difficult it is to gain deeper insights of the cultural principles, meanings embedded in the traditional health practices and to portray contextualized disease/health episodes. Further, the study brings into limelight the significance and urgency of undertaking serious medical anthropological studies.

The present study intends to understand social, cultural and behavioural aspects pertained to health and disease among the Chenchus. The overall goal is to arrive at a comprehensive picture about health status, morbidity, mortality and cultural construction of health and disease among the Chenchus. This research work is basically explorative in its design.
Objectives of the study are:

1. To understand the cultural perceptions, ideas, theories and explanations of health and disease;

2. To record the prevalence of morbidity and mortality and elicit their causes; and

3. To understand the organisation of therapy, therapeutic institutions, modes of treatment and to appraise the problems in availing the modern health care services.

The present study is conducted in ten sample settlements inhabited by the Chenchu in the Nallamala forest, in the districts of Kurnool and Prakasam Andhra Pradesh. Field work was conducted during 2000-2001.

There were altogether 82 Chenchu gudoms (settlements) in the Nallamala region falling in the districts of Kurnool and Prakasam. By means of simple random sampling, 10 settlements are selected. All these settlements were located deep inside the forest and quite far away from the caste villages or townships. However some of the villages were located by the roadside and hence could be reached by bus. There were 302 households in all the ten settlements put together with a population of 1565. All the households were covered for the present study.
The data required for the present study are identified under the following heads:

1. Socio-economic census data of the selected settlements
2. Ethnography of the Chenchu
3. Concept of health and disease
4. Morbidity and mortality conditions and their causes
5. Sanitation and hygiene
6. Inventory of medicinal plants and medicinally valued food plants and animal food.
7. Traditional treatment procedures of various diseases (supernatural; magico-religious; mechanical)
8. Patient experiences and illness episodes
9. Medical and magico-religious functionaries
10. The experiences of the Chenchu with the modern health care services

Household socio-economic census schedule, mortality and morbidity schedule, interview-guide, unstructured interviews, case studies, focused group discussion (FGD), survey of plants and other materia medica, survey schedule of physical lay-outs of settlements as well as the houses of the Chenchu were the tools employed for data collection. Diseases and their symptoms were collected through the help of a 'tracer list' and the local health
personnel. Participant observation was the chief technique employed for collection of various data.

Extensive interview guide containing questions on various aspects was prepared. The schedules contained columns for socio-economic data, mortality, morbidity and physical amenities related to sanitation and hygiene. Medicinal and food plants were identified by one or several informants in the forest. Case studies are generated in order to understand the illness episodes and their treatment.

Major Findings

The Chenchus are traditionally a hunting and gathering tribe. In the last 100 years they were in contact with the outside world. However, these contacts were intermittent and adhoc in nature. The Chenchus were exposed to agriculture, wage labour, sale of minor forest produce, animal husbandry and rural, semi-urban market system. However, their dependence on the forest is still very significant. Food gathering and hunting continues to be an important economic activity. Though they speak Telugu, the dialect is characteristic of the Chenchus. Some of their socio-cultural and economic features reflect the hunting gathering society. Of course, the Chenchus have also adopted cultural traits from the neighbouring peasant Hindu caste communities. Many of the deities of the Chenchu pantheon are actually seen in the peasant villages in Andhra Pradesh. In spite of these changes, the
Chenchu try to keep up their identity by means of endogamy, language, food-gathering and hunting way of life, polycentric leadership, egalitarianism, divination, isolated living in the forest, dependence on forest for various purposes including maintenance of health, etc.

The Chenchu medical system is a complex one. They have elaborate explanation regarding the concept of health and disease. Good health among the Chenchu is attributed to one’s deeds and attitudes towards ancestors and intake of food. The Chenchu recognize blood, semen, water and daumnu (stamina an account of good respiration) and balamu (energy on account of food intake) as the chief elements influencing the health. They also gauge health by such parameters as facial expression, body posture, body movement and physiological function like sleep, appetite, digestion, hearing, eye sight, sensitivity, etc.

The health according to the Chenchus, is influenced by a drive called: Jeevam (life sensation). It is said to be an independent phenomena and different from soul. Jeevam subsumes four characteristics: Oapiri or panam (a force indicating the existence of life as opposed to non-living); Thelivi, sodinanu and buddi (terms with generalized meaning of memorized knowledge, sensation, recognizability or consciousness of the ambience respectively. The Chenchu say that jeevam, panam, thelivi, buddi and sodinanu are the basic ingredients or drives in human body.
The disease is conceived basically in terms of the nature of relationship with the supernatural-dead ancestors and the deities. However, they also hold an idea that illness also occurs as a matter of fact. They distinguish two categories of illness: *manoolu jabbulu* or *rogalu* (natural or common diseases with known causes, signs and symptoms) and *maya rogalu* (unnatural, chronic diseases). They also categorize diseases based on the source of disease viz., 'within' and 'without' the human body. These two categorizations reveal that the Chenchus attribute mechanical as well supernatural causes to disease.

In each category there are several explanations of disease causation. They hold that the body gets affected due to *madam* (imbalance in the digestion system), *pythiyamu* (excess production of yellow bile), *udaku* (excess body heat), *rompa* (heaviness in the head and nasal infection), *seethalamu* (falling in body temperature / feeling cold), *janne* (spoiling of the blood due to indulgence in sexual intercourse that is prohibited), *selti* (bodily reaction, allergy), *vayi* (excess gas accumulation), *ageethi* (in digestion).

The diseases caused by the supernatural forces are divided into three types: wrath of deities; ancestor-induced diseases and spirit intrusion. They also hold that diseases are caused due to magical means: *Chethabadi* (black magic) and *disiti* (evil eye).
The Chenchus identity various symptoms of illness; *noppi* (pain); *wanta* (burning sensation); *vedi* (hot); *chali* (cold/shivering); *majju* (dullness); *jila* (itching); *vapu* (swelling); *sachhu* (weakness); *vomu* (vomiting sensation), *vabbasu* (heaviness in stomach); *mycamu* (giddiness) etc.

Mortality level among the Chenchus is very high, in comparison to national averages. The crude death rate during the reference period (2000-01) was 26.20 per 1000 population and crude birth rate was 44.73. The infant mortality rate was 152 per 1000. The child mortality rate was 32 per 1000.

The most important causes of infant deaths were complications associate with prematurity, diarrhoeal diseases, measles and respiratory infections. The Chenchu also hold that breach of forbidden behaviour by the infant's relatives as an important reason for infant deaths.

The data on mortality history (deaths to the relatives of the respondents prior to 2000-01) revealed that more than half of the total deaths recorded was due to infectious diseases. Chronic diseases (13%) and degenerative diseases (12%) and miscellaneous reasons (18%) accounted for the rest of deaths. This retrospective data revealed that neonatal tetanus, pertussis, measles, acute lower respiratory tract infection, blue baby, premature delivery were the chief causes of infant deaths.
Maternal deaths, janni (tetanus), delivery complications, and anaemia are the important causes of death among the women. Adult males are subjected to various infections, chronic diseases and accidents.

The survey on morbidity showed that the prevalence of diseases among the Chenchus is very less. The range of disease reported during the survey was also very small. It was found that the Chenchu do not report pains, aches, skin infections, mild fevers as morbidity.

Chenchus are aware of family planning. Traditionally, Chenchus used to maintain considerable gap between successive pregnancies. They used traditional methods. In the recent past they are also using modern family planning methods particularly sterilization. Though these programmes yet to make its mark, the women seem to be favouring sterilization particularly in order to allenate themselves from the twin burden of reproduction and production. If the services at the PHC level are improved, the Chenchus will come forward to utilize these services.

The Chenchus treat the diseases by two major means: Herbal medicine and supernatural/magical means. There are several experts like divinators, shamans, midwives, herbalists. Many common diseases are cured by these experts. Use of herbal medicine is very common and many Chenchus know about these herbal medicines.
Though the allopathic medical centres (Primary Health Center) are established in the mandal headquarters, they are not easily accessible to the many Chenchu gudem. At the primary health centre, several bottlenecks discourage the Chenchus in effectively availing the medical services. Doctor absenteeism, lack adequate facilities in the health centre, communication gap between the doctor and patients are some of the problems faced by the Chenchus.

Conclusions

It has been opined that traditional societies adapt well to their environment and enjoy good levels of health and nutrition. Especially the food base of the tribal people inhabiting the forest areas is said to be wide comprising several varieties of species whose availability is spread over different seasons. The settlement pattern, population density and the ecosystem features have health benefits in these societies.

The settlements of the Chenchus are considerably spread from each other. Within the settlements, the huts are widely dispersed in small clusters. The population density is comparatively low ranging from 0.8 to 6 persons per square kilometre. These conditions facilitate isolation of certain pathologies. Certain places in the forest are also avoided fearing that the visitors may be subjected to some malignant effect.
The Chenchus traditionally depended on a number of forest based food items. Presently many of these food plants are not easily available. Rice and millets are now being used increasingly. This change in the diet has resulted in nutritional deficiency which is evident among the people. Nutritional disorders such as kwashiorkor, Angular Stomatitis, pale conjunctivae, pale and flabby tongue, dull and dry hair, are commonly seen among the children and adults. In spite of these changes, it is noteworthy that the Chenchu show considerable interest in the collection and consumption of forest based food items.

The Chenchu settlements are clean in comparison to many peasant agricultural villages in the neighbouring plain areas. Flow of sewage water, sewage pits, garbage heaps are not conspicuous, though they are not totally absent. In the recent past, dung heaps are coming up in the settlements on account of live-stock rearing. Almost all households keep goats and goat sheds are part of the hut. Very few people keep bovine animals - cows and oxen and rarely buffaloes. Fowl keeping is also very common. Very few Chenchus rear pigs. The dung of the live-stock is piled either within the cattle shed or in the courtyard of the hut or just outside. These are the potential places of breeding grounds for mosquitoes, flies, bugs etc. Children play in these dung heaps and come in contact with microorganisms. Another potential source of infection is standing water holes in the forest.
which are visited by children either to drink water or to catch fish. The residential Ashram schools also generate garbage and an important breeding place for various insects and parasites. Children are vulnerable to skin infections and gastro-intestinal infections malaria and viral fevers, etc.

They coexisted with microorganisms, vectors, life-supporting fauna and flora since a long time. They maintained ecological complexity, and exploited resources on a day-to-day basis for their subsistence needs. Most of the traditional food gathering and hunting techniques were oriented towards ensuring subsistence needs. Traditionally, over exploitation, destruction of natural resources were consciously avoided. Technological improvements, endogenously, is very much restricted. Use of nets is consciously avoided. Food gathering techniques have not changed. All these practices ensured them adequate nutrition, and restricted the disease vectors. Traditionally the Chenchus were subjected to accidents and degenerative diseases. When the Chenchus came in contact with outsiders, several changes have taken places. Firstly, the Chenchus life styles were ridiculed by the outsiders. The outsiders raised a basic question namely 'what life it is to wander around in the forest in search of food'? The outsiders demeaned food gathering and likened it to eraka thinadamu literally means eating by scavenging or random picking. This phrase has several meanings. It means irresponsibility and foresight. It means laziness. It means poverty. It means surviving by

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begging. It also means lack of strong will power and unable to generate wealth and private property. Finally it means leading a mean life; a life of desperation and despondency. The Chenchus reacted to these differentially: They tried to substitute some cultural elements from the neighbouring peasants; at the same time they also reasserted their identity. Food-gathering is getting reduced mainly to depletion of forest resources and the strict prohibitions laid by the Forest Department. They retained all their cultural prescriptions.

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The new diet is imbalanced. Almost all economic programmes are male oriented and women have only subservient roles and earned much lesser wages than their men. Salaried employment are also available to men and men are preferred to various jobs than women because, it is held, that women have to look after the home and the women are not capable to cope up with transfers. Due to these developments, the women were sidelined. Their menfolk also now started ill-treating them. They took several wives and did not bother to fend them. Because of these reasons, the women suffer from various angles. Though gender discrimination towards girl-child is not consolidated are exhibited, women are now being subjected to harassment and neglect. Women during their pregnancies are vulnerable to various infections. Mortality among the children is high mainly due to infections and lack of adequate medical facilities.

The present study reveals that the Chenchus have devised a complex health managing system. They are not particularly averse to the allopathic treatment. However they believe in plural medical systems and negotiate their health through different types of therapies.

The Chenchu concept of disease causation seem to resemble the miasmatic theory of disease and the notion of causal sufficiency. This notion eminuates that a particular effect or disease might occur after exposure to one
or more causal influences. A particular effect might be caused by several different conditions and diseases might blend into one variety. The disease theory of the *Chenches* do not be support the notion of causal necessity which enunciates that in the absence of a necessary cause, a particular effect cannot occur. The *Chenches* explicitly hold that most diseases are the indirect outcome of a constellation of circumstances rather than the direct result of a single determining factor.

Rosenberg (1979) observed that “the model of the body and of health and disease was all inclusive, capable of incorporating every aspects of man’s life in explaining his physical conditions. Just as man’s body interacted continuously with his environment, so did his mind with his body, his morals, with his health. The realm of causation in medicine was not distinguishable from the realm of meaning in society generally”.

This holds good with the *Chenches*. To them health and disease, mind and body, morality and the external environment - all constitute one unified whole.

The medical scientists viewed that public health interventions controlled local sources of “Physical Pollution” and rationalized by the monist or fifth theory of diseases. Although contagion was recognized as a real
phenomenon, it was also argued that disease could develop from local sources and spread through the air in the form of miasmas.

In the above conceptualization only physical factors were taken into account. Miasma was understood in terms of Physical/Biological noxious exhalation from putrescent organic matter. The Chechu are also cognizant about physical pollution. They take special care in matters of bodily cleaning, washing various body parts as well as garbage disposal and maintenance of cleanliness of the physical environment. However they are also concerned about the moral realm and their relationship with the supernatural. The highest virtue for the Chechu, just as for other human societies, is to observe the cultural prescriptions enunciated in their own society. Some of these prescriptions are: sharing food with others; restriction on hoarding; respect toward the forest; avoidance of wasting/damaging the forest resources; restraint in cutting trees and animals; respect towards the ancestors and deities. Ill-health is attributed to the breach of these prescriptions.

Frankenberg and Leeson (1976) give four generic components in folk healing:

(1) A special place or setting for healing;

(2) A rational or myth that provides a plausible explanation for suffering;

(3) Rituals or procedures to overcome suffering, relieve distress and regain well being; and

(4) A relationship based on a patient’s trust and confidence in the healer.
Among the Chenchus all the four components are seen. The Chenchu
ardently desires that he should get cured within his/her own village. The
whole village is a place for healing. The greatest psychological relief to a
sick person is the presence of his/her relatives. Further they also desire to
spend their last days in their own village instead of alien places. Each disease
episode usually chronic and prolonged diseases - have an explanation within
the Chenchu socio-cultural milieu. Divination and disti are the common
ritual procedures to overcome suffering and establishment of cordial relation
with the supernatural. Further the Chenchus use herbal medicine and animal
substances for curing the diseases.

The healers and the patients have mutual trust in each other. The
herbalist will plainly discloses whether he knows about a particular disease
and whether he is capable of curing. Thus many herbalists are known for
curing particular types of diseases only. The healers do not exhibit
professional pride and exclusiveness. On the other hand the patients and
healers stand in some kinship relation which further strengthens the trust in
each other. These conditions also contribute to the social cohesiveness.

The modern health care system is based on different premise. It is
largely a citadel of hierarchy, aristocratic exclusiveness, rule-oriented (as
against service-oriented bureaucratic institution. The PHC failed to give an impression that it is a setting for healing.

Due to lack of congenial social environment and a sense of service orientation in the PHCs, the Chenchu feel alienated. Even then the Chenchu avail modern medical services for various difficult ill-health conditions. On the other hand many minor ailments are cured using herbal medicines. The development planners and Health Department Officials have to selectively encourage application of herbal medicines and substituting other systems of medicine Ayurveda, homeopathy and allopathy wherever needed. All the more the CHW’s are to be given intensive training and make them capable of handling several infections diseases. Some basic amenities such as dormitories, sufficient number of beds, and other basic medical facilities at the PHC are to provided. A patient hearing and detailed examination of the patients will create a lot of confidence among the Chenchus.