

Health Status of the Pando Tribe in Surguja District of Chhattisgarh: A Micro Study of the Accessibility and Utilization

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ABSTRACT: The life and livelihood of tribal people in Chhattisgarh is substantially influenced by the geo-physical and age-old socio-cultural institutions they live in. Under the situation the development of tribal people who almost share 32 per cent of the total state population very well determines the development pattern of the state. The present research has reflected various facets of health status of the Pando tribe of Chhattisgarh. More particularly it explores the accessibility and utilization of the health services by the Pandos. Anthropological study methods and techniques were adopted to collect primary data during the period 2018-19. The paper tries to quantify the accessibility of the Pando tribal people to the health services. More particularly it analyses their disease profile, sources of treatment, expenditure pattern made to avail health services, and also documented their perception and attitude towards modern treatment. While quantifying the qualitative responses of the Pando's, the study attempted to find out the gaps in and barriers to health service provisions. The study argues that why a community based decentralized health service delivery system based on empowerment of the tribal people is yet to be in operation? Why the tribal people as human endowment is not treated as a form of productive capital and the health services provided by the State do not treat tribal people as productive tool?

INTRODUCTION

In a globalized world, trade is one of the powerful forces that link our lives across many boundaries. It is maintained on the basis of geography, ethnicity and economic ties of the people. The fact remains that the majority of world population are poor and are away from the ambit of getting welfare benefits. The human costs for not covering this section of the population are immense. In this scenario extending opportunities to the poor is a challenging task.

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Inequalities in asset ownership, benefit sharing, access to resources and services not only serve as barriers of entry for the poor and the marginalized people in the market, but also made them more vulnerable to competitions. For the poor, livelihood issues are more concerned but directly it is depending on their good health, which is linked to the availability of and their accessibility to good health service systems. State control health service delivery system is under rapid transformation which many time throws multiple options for the stakeholders. Market forces basically lead it. The increasing cost of allopathic medicines many times neither available to, nor

affordable by the poor. In some cases, in spite of their paying capacity sometimes the poor are not accessible to alternative medical systems due to multiple factors which are not within their ambit or beyond. Of the few sectors that directly relate to livelihood and health security of millions of resource poor, private practice in the alternative system of medical service seems to be the important one. They are the essential immediate linkages between the poor patients and their good health.

It is understood that the root cause of poverty, ill health and illiteracy in India is due to the disproportionate growth of population to resources. The concept of health in common parlance means absence of morbidity for pathological conditions in body or mind and ability to function as a normal human being. Humans as biological entities constantly struggle with health and sickness combining biological and socio-cultural resources. The process of adaptation helps the members of a community to remain fit. Through the process of adaptation humans transform their physical habitats to appropriate cultural ecosystems.

Utilization of modern health care services many times is low in traditional societies and developing communities because of the prevalence of traditional coping strategies and customary caring at the community, kinship and individual levels as well as due to the availability of folk or indigenous medical knowledge and therapy evolved over centuries (Panigrahi, 2004). Belief in traditional treatments such as indigenous medical treatments and ceremonial treatments, as well as the affordable costs, draw patients to these types of treatments (Das, 2005). Investigation of different systems of indigenous medical practices including the concept of illness and diseases, ethno-medicine used for treatment and cure of different diseases is very complex as compared to the modern health delivery system (Acharya, 2007). Customary health-seeking behavior in traditional societies is embedded in specific socio-cultural milieu. cultural values, beliefs, and systems of meaning attached to life, health, sickness, pregnancy, childbirth and childcare are all culture specific (Arthur, 1980). Thus, in traditional societies subjective perceptions about perceived health is influenced by their own knowledge system. Under such situations demand

for modern health care facilities depends not only on availability of services, but more importantly on socio-cultural factors. Rural and tribal communities are more articulative with their indigenous health care system.

India has several socially disadvantaged communities among which schedule tribes are the most deprived ones. Government has notified 705 scheduled tribes in 30 different states and union territories. The total tribal population of India is 10,42,81,034, which share 8.6 per cent of the total population of the nation (Census of India, 2011), while as per the Census of India (2001) it was 8,43,26,978 which shows the decadal growth of 23.7 per cent. Although, health is one of the crucial parameters of development of a community the tribal faces many health-related problems along with poverty, illiteracy, malnutrition, lack of safe drinking water and hygienic conditions. They mainly practice the ethno-medicine but on the other hand poverty is a major cause for not adopting modern health care services.

The objectives of the present research are to examine the profile of ailments observed among the Pando tribe. It highlights the ideology of indigenous knowledge and methods of treatment adopted by Pando tribal people and their influence on access to health services. The study identifies the socio, cultural and physical factors that influence their behavior and utilization of health services; and identifies the structural, operational and ethno-cultural constraints faced by implementing agencies while delivering health services to the Pando tribal people. The study suggests various remedial measures to minimize the structural as well as the ethno-cultural barriers which influence the availability and utilization of health care services to the Pando's. Anthropological study methods and techniques like personal interview schedule, observation, case study, focused group interview and photograph have been adopted to collect primary data during the period 2018-19. The present research is of both exploratory and descriptive type. The paper while critically looking into the availability of public health infrastructure at different levels of health institutions, tries to quantify the accessibility of the Pando tribal people to the health services. More particularly, it analyses their disease profile, sources of treatment, expenditure pattern made to avail health services, and also documented their

perception and attitude towards modern treatment.

While quantifying the qualitative responses of the Pando's, the study attempted to find out the gaps in and barriers to health service provisions. It tries to justify why the tribal dominated regions suffer from availability of adequate quality health infrastructure provided by the State? Why the state sponsored health services are yet to overcome the traditional health related beliefs and practices of the tribal community. The study argues that why a community based decentralized health service delivery system based on empowerment of the tribal people is yet to be in operation? Why the tribal people as human endowment is not treated as a form of productive capital and the health services provided by the State do not treat tribal people as productive tool?

Review of Literature

The World Bank (2001) is promoting the concept of the essential (or minimal) Health Package in order to limit government funded health care services to the poor to a few basic drugs and a few health interventions. Health economy studies have shown that poor people tend to spend a relatively large proportion of income on healthcare without getting value for money (Yesudian, 1994). The availability of private hospitals, private doctors and nursing homes both in rural and urban areas in Chhattisgarh is less compared to many states like Bihar, Rajasthan, Uttar Pradesh, Tamil Nadu, Orissa and Kerala (Government of India, 2014). Similarly, the sources of treatment for outpatient in urban areas under private sector are equally less (Govt. of India, 2014). It is 20.9, 40.2 and 17.3 per cent in case of Bihar, Kerala and Tamil Nadu respectively and only 4.1 per cent in case of Orissa (NSSO, 1992).

One can say that low quality healthcare services in poor populations in developing countries contribute considerably to aggravate certain important public health problems. Arthur (1980) viewed that the health providers operate on both the supply and the demand sides of the market and act as a principal agent operating with a built-in asymmetric information structure. In this situation for prevailing possible price and quality discrimination, a health insurance market has to act as a mediator between the providers and the user (Padhi and Mishra, 2000). A number of studies

shown that ".....Perceived quality is one of the principal determinants of utilization...and non-utilization of services -a major issue in several developing countries is often traced to a perceived lack of quality (Howard *et al.*, 2002; Govt. of India, 2012). However, it is concerned that there is a little consensus on how to improve the situation. Some suggests that continuing medical education (Bhat, 1999) possibly linked with continuation of license to practice (Chittawadagi, 2012), whereas, others warn that this is not likely to work due to contextual factors (Kaushal, 2004). So far, there has been little success with public policy which attempts to introduce appropriate regulatory frameworks and mechanisms to check undesirable to health consequences of the growth of the private health care sectors (Yesudian, 1994). The fact remains that the demand for health care is not entirely determined by service effectiveness, but a host of prior economic and non-economic factors operating at the individual, familial and community levels which have a bearing on health-seeking behaviors.

HEALTH STATUS OF PEOPLE IN CHHATTISGARH

The state of Chhattisgarh has an area of 1,35,191 sq km, came into existence in the year 2000. It has a total population of 25.54 million (Census of India, 2011). The State is divided into 30 districts, 146 blocks, and 20308 villages. The State has a population density of 154 per sq km. (as against the national average of 312). The population of the state is growing at a slower rate than the national rate. The life and livelihood of tribal people in Chhattisgarh is substantially influenced by the geo-physical structure and socio-cultural institutions they live in. Under the situation the development of tribal population who almost share 32 per cent of the total State population very well determines its development pattern. In Chhattisgarh the tribal people are classified in three geographical regions. The southern region consist of Kanker, Bastar, Narayanpur, Dantewada and Bijapur districts which has a total population of 30.90 lakh, where 20.69 lakh (66.94 per cent) population belongs to scheduled tribe (Census of India, 2011). The central Chhattisgarh region consists of Bilaspur, Janjgir-champa, Raipur, Mahasamund, Dhamtari, Durg,

Rajnandgaon, Kawardhadistricts which has a total population of 1.588 crore where 26.29 lakh (16.49 %) population are scheduled tribe (Census of India, 2011). The North region consists of Korja, Surguja, Jashpur, Surajpur, Raigarh and Korba districts which covers a total population of about 65.71 lakh where 31.34 lakh (47.70%) population are scheduled tribe (*ibid*). The native of this region are Oraon, Kaqar, Munda, Nageshia, Khairwar, Gond, Birhor, Hill korwa, Bharia, Bhumia, Bhuihar, Paliha and Pando etc. The total population of scheduled tribes of the state is about 66,16,596 which is nearly about 31.76 per cent of state population. The Pandos along with Bharia, Bhumia,

Bhuihar, and Palihar have a total population of 88,981 (Census of India, 2001) which is 1.34 per cent of the total tribal population of the Chhattisgarh.

The Total Fertility Rate (TFR) of the state is 3.0, while the Infant Mortality Rate (IMR) is 48, and Maternal Mortality Rate (MMR) is 269 (NFHS, 2005-06) which are higher than the national average of 178. The sex ratio in the State is 991 (as compared to 940 for the country). The ST population in the state population structure is 0.66 crore. The male literacy rate in the state accounts to 81.45 per cent and that of the female is 60.59 per cent (Census of India, 2011).

TABLE 1
Health infrastructure of Chhattisgarh

Particulars	Required	In position	Shortfall
Health Sub-Centre	4904	5111	%
Primary Health Centre	776	755	21
Community Health Centre	194	149	45
Health worker (Female)/ANM at Sub Centers & PHCs	5866	6943	%
Health Worker (Male) at Sub Centers	5111	2514	2597
Health Assistant (Female)/LHV at PHCs	755	749	6
Health Assistant (Male) at PHCs	755	153	602
Doctor at PHCs	755	435	302
Obstetricians & Gynecologists at CHCs	149	18	131
Pediatricians at CHCs	149	19	130
Total pecialists at CHCs	596	71	525
Radiographers at CHCs	149	87	62
Pharmacist at PHCs & CHCs	904	611	293
Laboratory Technicians at PHCs & CHCs	904	444	460
Nursing Staff at PHCs & CHCs	1798	552	1246

Source: RHS Bulletin, March 2012, M/O Health & F.W., GOI

The 3rd National Family Health Survey 2005-06 (thus known as NFHS) reports that the fertility rate of Chhattisgarh is declined by 7.15 per cent against 2nd NFHS report. The report of 1st Common Review Missions visit to the State of Chhattisgarh to assess the performance of NRHM with emphasis on achievements and challenges of 'Community Processes' and its impact on the successful implementation of various health activities in the state during 2005-2007 found various issues of "Governance of National Rural Health Mission (thus known as NRHM)" which are critical and needs immediate attention of the State authorities to address at various levels of planning and implementation.

The Report of the 2nd Common Review Mission, of Chhattisgarh on 16th December to 22nd December 2008 based on survey, interaction with panchayat

leaders and officials showed limited capacity/idea at the local level about the scope of utilization or how to utilize the funds and poor knowledge about the status of Village Health Sanitation and Nutrition Committee (VHSNC) activities. The study found that in the assessment of Program Management structures NRHM envisages new management structures at various levels to strengthen the existing system. At State level, Mission Directorate consists of Mission Director and State programme management unit which provides technical support for the role out of Rural Health Mission. (*health.cg.gov.in*).

THE PANDO TRIBE

The Pandos are principally found in Surguja zone of Chhattisgarh. In Chhattisgarh state they are grouped with Bharia, Bhumia, Bhunihar and Paliha.

They claim descent from the Pandavas of Mahabharat. They are short in stature with light and dark brown complexion and have scanty body hair. The tribe since 2015 is proposed for consideration by the government of India as one of the Particularly Venerable Tribal Groups (thus known as PVTGs) of Chhattisgarh under the State Ministry of Tribal Affairs. The Pando's are divided into two endogamous groups known as Surguja and Uttaraha. The Surguja Pando's consider them to be superior to the Uttaraha Pandos and have two doors in their huts, viz. front and back. The back door is utilized by their women when they get polluted during menstruation and childbirth, while the Uttaraha have only one door in their house which is utilized by their women for all purposes. The sex ratio of the community according to census 2001 is 931 female per thousand males.

Pando tribe is highly illiterate and living in very poor socio-economic condition (Roy, Pandey and Tiwari, 2001). The people are superstitious to a great extent and lack proper knowledge of modern medical facilities. Their poverty and ignorance are the main reasons behind the less utilization of government provided health services (Roy, Pandey and Tiwari, 2001). They have their own perception of health, hygiene, ante-natal, post-natal care and family planning. The majority of populations to the tune of 81.1 per cent know about prevailing health facilities, but only 30 per cent visit to health worker of the local PHC (Kumar *et al.*, 2015). According to 1961 Census the amalgamated population of Pando lumped with Bharia, Bhumia, Bhunihar, including Paliha was 92,369 out of which 26,606 live in Surguja. In 1971 Census report their mixed population increased to 1,17,806 and in 1981 Census to the tune of 1,95,490, but in the Census of 2001 shows the huge decline in the population in these tribe reported as 88,981 which directly indicates low birth and high mortality rate. The fertility indicators were calculated for the period three years preceding the survey in 1991-2000 decade by Regional Medical Research Center for tribal found Pandos had higher fertility (Saha and Verma, 2006). The Crude Death Rate (CDR) of the Pandos was reported to the tune of 14.6 and Infant Mortality Rate (IMR) tunes to 159 in reference to

1996-98 computed for three-year preceding the survey (Saha and Verma, 2006).

The study of Dolla, Meshram and Kumar (2006) on the 'Nutritional status of Pando tribe' reported that the Pando boys and girls in later age-group were lighter and shorter than another tribal group of Madhya Pradesh. According to weight for age, 52.1 per cent of pre-school children were underweight with 22.3 per cent children being severely underweight. Stunting and wasting were seen 51.9 per cent and 20.2 per cent in children respectively (*ibid*). Prevalence of chronic energy deficiency Body Mass Index (BMI<18.5) was about 53.8 per cent among adult population. The prevalence of pallor, a clinical sign of anemia seen mostly in adolescent and adult group was 54.0 per cent and that of total goiter was 13.0 per cent. They suggested that Pando tribe is nutritionally poor. However, many studies are not available to find out the reasons of health backwardness of the Pandos, their accessibility and utilization of health services.

Study Area and Sample

The tribal population in Chhattisgarh is mostly concentrated in Bastar, Raigarh, Jashpur, Surguja, Koreya, Balrampur, Korba, Kanker, Dhamtari, Janjgir-Champa, Bilaspur, Mungeli, Kabirdham and Mahasamund districts. In these districts schedule tribes live mostly in hills and dense forest area, which are not easily accessible. They are mostly backward, poor, illiterate and indebted. These people possess their own culture, a distinct way of life, multiple sources of livelihood and nature based religious beliefs, which are quite different from other sections of the Indian communities. The villages covered under the study were selected on the basis of their geographical distance from the block head quarter with a premise that geo-physical characteristics play an important role in the delivery of welfare services to the people. Thus, the study covered four villages located far away from the block headquarter and equal number of villages located nearer to the block head quarter. A detail socio-economic profile of the study villages can be viewed from Table 2.

TABLE 2
Socio-economic profile of the study villages

S. No	Indicators	Socio-economic status of study villages								Total
		Losangi	Khirhir	Pandridand	Jhingadohar	Barbaspur	Kanaknagar	Beldagi	Ghui Bhavna	
1	Total households	267	32	45	59	411	199	512	27	4691
2	Total ST households	196	28	35	47	240	140	239	19	944
3	Total SC households	15	1	—	3	1	3	166	3	192
4	Total OBC households	56	—	—	1	59	—	14	—	130
5	Total other households %	3	10	8	111	56	93	5	286	
6	Total population	1223	126	171	228	1866	812	2148	108	6682
7	Tribal population	886	112	133	189	1197	702	1029	76	4324
8	Sex Ratio adult	989	911	1085	1280	977	929	1011	992	1032
9	Sex ratio (0-6) year	970	777	1267	2105	853	880	989	989	1104
10	Number of BPL family	266	31	45	58	492	192	481	27	1592
11	Distance from District head quarter	42km	55km	41 km	38km	68km	65km	38km	39km	
12	Literate	570	72	57	96	771	350	743	85	2744
13	Illiterate	653	54	114	132	1095	462	1405	23	3983
14	Hand pump	9	03	02	05	06	04	06	05	40
15	Functioning	4	1	—	4	6	3	4	3	25
16	Dug Well for public use	—	1	—	2	2	—	—	2	7
17	Primary School	3	—	1	1	1	1	5	1	13
18	Middle school	1	—	—	—	1	1	1	—	4
19	High School	—	—	—	—	1	1	—	—	2
20	ICDS Centre	3	—	1	1	1	4	5	1	16
21	Trained Dai	2	—	1	1	1	1	4	1	11
22	Faith Healer	0	—	1	—	0	0	—	—	1
23	Un- registered practitioner	0	1	—	—	1	1	—	—	3
24	ASHA worker	3	—	1	1	8	4	12	1	30
25	Villages having <i>pakka</i> road	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
26	Public toilet	—	—	—	—	1	—	1	—	2
27	Total land area of the village (in hect.)	539.23	78.6	568.51	91.21	780.83	286.79	1191.5	59.02	

Source: Primary Survey, 2018-19 and Census of India, 2011.

Availability of Government Health Infrastructure

Availability of health infrastructure is one of the most important indicators of delivery of quality health services. Many times, tribal areas suffer due to the non-availability of health infrastructure which also forces them to adopt traditional sources of treatments. The study tried to measure the available health infrastructures at various levels and their physical distance to the villagers. It included both traditional and modern health infrastructures. In two study villages of Pandrid and Jhingajohar alternative transport adopted during rainy season to reach the health sub-centre covers a long distance due to rain affected physical barriers. Availability of the Baigas in and

around the study villages almost attracts the Pandos on preference when they suffer from any illness. Similarly, the '*jhola-chap*' health practitioners who are normally non-tribal, though live away from the study villages, but maintain a regular visit to each village on planned interval and also reach the door step of the Pandos on special call even during odd hours. This mode of health services delivery has created a confidence among the Pandos. This shows that in tribal dominated hilly regions the ecological factors are to be taken into account when planning is made for delivering the welfare services. The details of the physical distance covered by the villagers to reach the health institutions in each study village are given in Table 3.

TABLE 3
Distance of the medical institutions from the study villages

Sl. No.	Block/Location	Gp	Distance of the medical institution from village (in km)						Total illness episode during last (year)	
			SHC	PHC	CHC	District Hospital	Baiga	Jhola Chap		
1	<i>Villages far away from block hq.</i>									
	Lakhanpur	Losagi	Losagi	4	13	12	42	3	Regular visit to the villages on interval or on request	7(100)
	Pratappur	Mayapur II	Khirhir	10	23	25	55	5	4(100)	
2			Pandridand	5,28*	8	33	41	—	10(100)	
			Jhingadohar	8,25*	4	30	38	4	10(100)	
	Pratappur	Barbaspur	Barbaspur	2	17	16	68	—	Regular visit to the villages on interval or on request	44(100)
	Lakhanpur	Kanaknagar	Kanaknagar	5	15	14	65	2	13(100)	
		Beldagi	Beldagi	5	1	8	38	4	4(100)	
			Ghuibhavna	8	10	9	38	8	1(100)	

Note: SHC- Sub Health Centre, PHC-Public Health Centre, CHC- Community Health Centre. *During rainy season.

Source: Primary Survey 2018-19.

Illness Profile of the Pando

Details of illness experienced by the *Pandos* during last one year shows that out of 97 individual illness episodes, 7.14 per cent episodes reported in Losagi village, 8.16 per cent in Khirhir village, 10.20 per cent in Pandrid and Jhingadohar village each, while 44.89 per cent of illness cases reported in Barbaspur, 13.26 per cent from Kanaknagar and 4.30 per cent from Beldagi village and 1.02 per cent from Ghuibhavna. It can be seen that 12.24 per cent of the ill population were suffering from malaria, 10.20 per cent from pain and general weakness, common cold, skin disease and typhoid covers 4.08 per cent. Serious

illness cases reported include gall bladder stone, pneumonia, paralysis and measles (3.06%). Around 5.10 per cent of the ill population were suffering from common cold along with fever, 16.32 per cent from like diarrhea, vomiting, jaundice, urine infection, headache and accidental injury covers 1.02 per cent. It can be seen that malaria and fever are still a prominent disease in the villages even after a huge level of malaria eradication programs adopted across the country. Practices of unhygienic sanitation, poor drainage system and use of stored water are the major reasons for causing certain diseases in study villages. The details of the illness episode distribution in study villages and types of illness are given in the Table 4.

TABLE 4

Illness profile of Pandos in study households

Illness type	Village far from block hq.				Village nearer to block hq.				Grand total in all villages
	Lakhanpur block		Pratappur block		Pratappur block		Lakhanpur block		
	Losagi GP	Khirhir	Mayapur II GP	Jhingad-ohar	Barbaspur GP	Kanaknagar GP	Beldagi GP	Ghuib-havna	
Malaria fever	—	1	4	—	20	3	—	—	28 (28.86)*
Pain/ general weakness	—	2	1	1	3	3	—	—	10 (10.30)
Viral fever	4	3	2	5	8	6	4	1	33(34.02)
Ortho related	—	—	—	—	2	—	—	—	2 (2.97)
Gallbladder stone	—	—	—	—	3	—	—	—	3 (3.09)
Skin diseases	1	—	1	1	1	—	—	—	4 (4.12)
Typhoid	—	—	1	—	2	—	—	—	3(3.09)
Pneumonia	—	—	—	—	2	1	—	—	3(3.09)
Paralysis	1	—	—	—	2	—	—	—	3(3.09)
Urine infection	—	—	—	—	1	—	—	—	1 (1.03)
Jaundice	—	—	—	1	—	—	—	—	1 (1.03)
Accidental injury	—	—	—	1	—	—	—	—	1 (1.03)
Vomiting	—	—	—	1	—	—	—	—	1 (1.03)
Diarrhoea	—	—	1	—	—	—	—	—	1 (1.03)
Measles	1	2	—	—	—	—	—	—	3 (3.09)
Total	7(7.14)	8(8.16)	10(10.20)	10(10.20)	44(44.89)	13(13.26)	4(4.30)	1(1.02)	97(100)

Source: Primary survey, 2018-19. *Figures in the bracket indicate percentage of total.

Adopted Illness Treatment by the Pandos

The responses of ill persons with regard to the illness treatments were collected with respect to the sources of treatment and type of health service institutions. Around 94.89 per cent ill persons have taken treatment from multiple sources, which vary from 88.57 per cent in case of far away villages and all ill persons in case of nearby villages. As regards the adoption of illness treatment by the Pandos, in faraway study villages 28.57 per cent households are still adhered to the Baigas as the only source of illness treatment, while 20.00 per cent have adopted the local unregistered practitioners popularly known as *jhola-chap* and 11.42 per cent used the private allopathic shops for their illness treatment. In case of nearby

villages around 52.24 per cent Pandos have adopted non-government sources for their illness treatment. The positive changes observed in the attitude of the Pandos towards the illness treatment seem to be influenced by the geographical factors which influence their attitude. This is visible when one finds that only 9.66 per cent Pandos have adopted *jhola-chap* or unregistered practitioners at their door steps as a source of treatment. This reflects that geographical accessibility is one of the important indicators which also influence the attitude of the tribal people in bringing a positive change towards the disease and treatment in their life. The details of various sources of treatments adopted by the Pandos to overcome their illness are given in Table 5.

TABLE 5

Distribution of various sources of illness treatments adopted by the Pandos

Sl. No.	Block/ Location	GP	Village	Sources of Treatment adopted					Total Households illness
				Allopathic Govt.	Allopathic Pvt. shop	Un- registard (Jhola chap)	Allopathic Govt. & Pvt.	Baiga	
<i>1 Villages faraway from block hq.</i>									
Lakhanpur	Losagi	Losagi	Losagi	2(28.57)	—	3(42.85)	—	2(28.57)	7(100)*
			Khirhir	3(37.5)	2(25.00)	1(12.50)	1(12.50)	1(12.50)	8(100)
Pratappur	Mayapur II	Pandri-dand	Pandri-dand	3(30.00)	2(20.00)	—	2(20.00)	3(30.00)	10(100)
			Jhingad-ohar	3(30.00)	—	3(30.00)	—	4(40.00)	10(100)
Sub Total		11(31.42)	4(11.42)	7(20.00)	3(8.57)	10(28.57)	35(100)		
<i>2 Villages nearer to block hq.</i>									
Pratappur	Barbas-pur	Barbaspur	Barbaspur	15(34.09)	5(11.36)	14(31.81)	6(13.63)	4(9.04)	44(100)
			Kanak-nagar	4(30.76)	7(53.84)	—	—	2(15.38)	13(100)
Lakhanpur	Beldagi	Beldagi	Beldagi	4(100)	—	—	—	0(00)	4(100)

Ghui-bhavna	—	1(100)	—	—	0(00)	1(100)
Sub Total	23(37.09)	13(20.96)	14(22.58)	6(9.66)	6(9.66)	62(100)
Grand Total	34(35.05)	17(17.52)	21(21.64)	9(9.27)	16(16.49)	97(100)

Source: Primary survey, 2018-19.

*Figures in the bracket are per cent to total

Financial Implications of Illness Treatment

The study tried to document the expenditures made by the *Pando* tribal households for the treatment of their illness, including transportation of the patient and towards food. This also reported various sources of arranging the fund to meet such expenses. The expenses made by the households were calculated to draw the average expenditure for various purposes. In faraway villages the average expenditure made by the *Pando* households is reported to the tune of Rs. 2627/- towards medical treatment, Rs. 1532/- towards the transportation of the patients and Rs. 616/- towards food expenses, while such expenses tune to Rs. 1955/-, Rs. 1345/- and Rs. 636/- respectively in nearby villages. On an average the study shows that a *Pando* tribal household has spend Rs. 2179/- towards treatment, Rs. 1409/- towards transport and Rs. 620/- towards food expenses during treatment of their illness.

The responses of the *Pando* household with regard to the sources of arrangement of the funds to meet the treatment expenses shows that in both categories of the study villages around 58 (59.79%) households have taken loan either from family member (43.29%) or from neighbors (16.49%) which reflect the strong belongingness maintained by the *Pando* among the kith and kin members. Borrowings from the kith and kin during illness treatment are almost equally observed in both nearby and far away villages. However, it is surprised that around 13 (13.40%) *Pando* households have mortgaged their agriculture land which tunes to 5 (14.28%) and 8 (12.92%) (for the purpose to meet the medical expenses) in both far away and nearby villages respectively. Similarly, 22 (22.68%) *Pando* households met the illness treatments from their personal saving which tunes to 9 (25.71%) and 13 (20.96%) households in distantly located and in nearby study villages respectively.

The above data reflect that *Pando* households in general are economically poor to meet sudden expenses due to their illness. The kith and kin bonds among the *Pando* is very strong who helps each other

at the time of emergencies, but the fact remains that 75(77.31%) *Pando* households took loan from various sources to meet medical expenses to treat their illness. The government health institutions available in the *Pando* dominated region provides services to a marginal level. Most of the serious cases are referred to higher level health institutions owned by private bodies. The health services available at door step from the *jhola-chap* practitioners are also costly. In such a situation the *Pando*'s many times are the financial victims of the Baigas, private doctors and *jhola-chap* practitioners. The *jhola-chap* and the Baiga practitioner because of their geographical and delivery of immediate services are more acceptable to the *Pandos* even though treatments from *jhola-chap*/Baiga are equally costly (Case study1).

Case Study 1 Radhelal Pando of Pandrid and Village has more confidence on Baiga than Allopathic system: Radhelal *Pando* was suffering from chronic disease like neuro problem and losing confidence on allopathic treatment system. He is 47 years old and is the father of one child of 17 years is a resident of Pandridand village in Mayapur II gram panchayat of Pratappur Vikas Khand under Surajpur district. Along with wife and 17 year old son Radhelal was happy enough by generating his family livelihood basket as daily wage labour. All of a sudden in 2017 he developed neuro problem which resulted feets (*mirgi*) and within 6 month the frequency of occurrence of feets increased. Initially he was ignoring to consult with the doctor but due to family and social pressure he went to local level government hospitals like PHC, CHC and district hospital located at a distance ranging from 8 to 30 kms. Geographically his village is detached from mainland of the Vikaskh and during rainy season. After four consultations with different institution and bearing almost a total amount of Rs. 42,000 towards transport, medicine and doctor consultations Radhelal realised of no improvement of the disease. Villagers motivated him to contact a particular *Baiga* located in neighboring village at a distance of 7 to 8 km. For last one and half year

Radhelal is continuing ayurvedic treatment from Baiga which is comparatively less costly and easily accessible to him. During the period he has almost spend an amount of Rs. 5000 to Rs. 7000 towards his treatment from the Baiga. As a result, the frequency occurrence of feats is reduced and Radhelal is feeling better compared to the previous allopathic treatment. Radhelal concluded that allopathic treatment is very costly and not easily accessible to common Pando people like him. Long term treatment under allopathic system is also not affordable to the poor tribals. He has developed confidence under local Baiga though health services provided are rudimentary by nature.

Source: Primary survey, 2018-19

PERCEPTION OF THE PANDOS ON DISEASE AND CURATIVE MEASURES

Pando Belief System on Disease

The Pandos are the numerically dominant community in the study villages. The Pandos consider that the treatment of patients is as per the requirement of the age, sex and nature of the ailment. Belief system of the Pandos is reflected as an organized body of ideas, attitudes and convictions centered on values and are considered as the part of life processes. They consider that it is a community product through experiences and the society does not question their validity. The Pandos explain disease related beliefs as good and bad, right and wrong, and by and large links to natural and supernatural powers, which are both religious and magical by nature which guides their attitude and behavior. For example: they strongly believe that serious diseases like leprosy and TB are due to the curse of human being. The worldview of the Pando consists of nature and natural objectives which determines their life processes and influences their behavior pattern about life and death, health and sickness. The Pandos say why some germs attack few people and not others? This provides them acceptable explanations to believe in witchcrafts, evil spirits, evil eyes, anti-social action and taboos related to living.

The folk world of the Pandos can also be classified on the basis of secular and non-secular belief pattern. The secular beliefs causing diseases include physical

and natural factors like effects of different seasons like hot, cold, rain, sunray, food pattern, addiction etc., while the non-secular beliefs can be classified as karma, sins, wreath of evil eyes, demons, evil spirits, religious events, etc. The Pando belief pattern is strongly based on nature and natural objects. They consider health as a state of physical and mental fitness in which person can able to perform his/her natural responsibilities. The state of fitness of human health is interpreted as free of diseases. They consider any form of weakness as preliminary stage of disease, but the inability of a person to perform the natural responsibilities is only considered as disease.

Pandos pointed out various physical, dietary, natural factors as causes of disease which may be based on multi-causal or mono-causal explanations. However, they believe that specific disease occurs due to specific reasons. It was observed that poor and unhygienic sanitation and polluted environment received less priority among the Pandos as proximate causes of disease. However, the villagers spontaneously linked illness to traditional and supernatural factors. The socialization processes of the younger generations through oral transmission bears greater impact to believe on these factors. It is also important to know how the tribal belief becomes responsible for the spread of diseases. The Pandos believe that the disease needs a medium to spread from one place to another. They consider these mediums as natural like water, air and mosquito, as well as man-made factors like pollution of natural sources, animal contact, evil spirits, etc. Diseases, like TB, asthma and other organic deformities are hereditary in nature. Diseases like cholera, diarrhea, cough and cold, are transmitted through contamination of air and water.

Disease like malaria is caused due to polluted water and flies. Change of weather also results in certain diseases, which is basically due to incompatibility of body with changing environment. More or less the religious beliefs of Pando people influence their understanding and behavior pattern towards health and diseases. Very few are partly closer to the modern understanding that diseases are caused due to both natural and man-made factors. Thus, the Pandos have a holistic and integrated understanding on their life processes as a whole.

Impact of Physical Environment on Disease

Small cultivation and non-timber forest products are the major sources of livelihood for the Pandos. Once upon a time the Pando villages were uni-clan and therefore, marriages were not allowed within the village. The ethnic compositions of the village are more or less homogeneous. The new settlements gave scope for generating new coping mechanisms and adoption processes to these changing environments. Tube-wells, dug wells and pandos are the sources of water for washing, cooking, drinking and other purposes. Defecations by the Pandos made in open field are common. This has enough contribution in contaminating water sources and resulting water borne diseases like dysentery, diarrhea and skin diseases. The animal sheds of Pandos attached to the house breeds mosquitoes, flies, and insects and makes poor sanitary situations. Animal dung, free movement of pigs and poultry largely pollutes while urine of animals and human being swamps. Creation of worms and other intestinal parasites of these livestock many times infest their poor immune system. Spitting and urination by Pando children in front of their house pollutes the environmental sanitation of the village.

Pando Personal Hygiene and Disease

Pando children below the age of 6 years rarely clean the teeth like that of adult members. All the children and adult members use to take hot water bath during winter and rainy seasons. Pando male members use a piece of loin cloth and normally do not use any upper garment when they are in the village. The women use a piece of *saree* which covers up to the knee. However, a group of Pando women are also wearing full sarees. Because of their poor economic conditions, the Pandos normally have two pieces of clothes for each member of the family. The washing of all clothes (apart from the daily bath) is made during the occasion of pollution and purity due to birth and death ceremony. A few of the Pandos use white powder (ash) of kitchen to clean their clothes and a few have started using soap. Smoking of locally made raw *pika* or cigarettes (*chungi*) are popular among both males and old females. The Pandos consume various types of liquor made up of *raggi*, and *rice*, known as *pendum*, *landa*, and palm juice. Both men and women

from their early age of 9 to 10 start drinking liquor. Excess consumption of liquor has resulted in many diseases even among adolescent groups. The personal hygiene of the Pandos is very much influenced by their traditional customs and practices. Above all the hygienic aspects of the Pando tribal community are largely influenced by socio-cultural factors. It is commonly observed that the low level of education, poor awareness and lack of outward mobility makes their practices more traditional.

Role of Traditional Healers or Baiga

Traditional tribal healers or magico-religious specialists play a very important role in health-related issues. They are popularly known as Baiga who is also a specialist in ethno-medicine. All Baigas do not play the role of traditional healer, The Baigas adopt the process of divination to invoke deities and spirits by chanting spells so as to ascertain the cause of affliction. In almost all cases they prescribe certain food taboos and instruct to arrange for the prophylactic rites. Patients suffering from diseases caused due to physical and environmental factors have been treated directly with ethno-medicines.

An attempt was made to carry out in-depth interviews with 08 numbers of Baigas or traditional healers. The socio-economic background of these Baigas reflects that around 90.00 per cent of them belong to ST groups and were within the age group of 41 to 50 years. Around 50.00 per cent of them were illiterate, while another 50.00 per cent of them were literate. Around 80.00 per cent provide health services within 5 to 10 number of villages, in a distance of 6 to 10 kms. Four Baigas (50.00%) have treated 11 to 15 patients each, while four (50.00 %) of them have treated more than 25 cases during last year. The Pandos have an understanding of symptoms and treatment regime for each disease. The ingredients adopted for treatment includes herbal products and they follow specific procedures for treatment. They have also treated complex diseases like white leprosy, measles, malaria, snakebites, dog bite etc. However, the use of herbal medicines in different diseases is subject to scientific verifications.

The study indicates that the ethno-practitioners are still playing important roles in the disease treatment regime of Pando society. The transfer of

skill on hereditary basis justifies the contribution of these agents to maintain good health in the village. The Baigas enjoy a substantial influence in and around the villages, which goes beyond ethnic boundaries. These traditional practitioners as a community of health service providers can be given training from time to time so as to infuse certain basic scientific knowledge pertaining to health and hygiene.

CONCLUSION

The Pandos recognize both natural and super natural factors as responsible for causing diseases. They are more influenced by their belief patterns. The common diseases Pandos suffered includes malaria and fever followed by skin diseases and diarrhea. The extension workers engaged in delivery of health services in Pando dominated area do not have a holistic understanding of diseases suffered by Pando people. In this process Pando community normally do not accept the prescriptions made by the allopathic health functionaries. It was observed that the operational linkages in whatever form were observed functioning between the Multi-Purpose Health Workers and local functional institutions like Baigas do not contribute much for better functioning of local health institutions and outreach health service delivery.

In case of few serious ailments, which cannot be treated by private sources, the patients are depending on PHIs, but their poor economic conditions do not allow them to avail specialized treatments from outside. Quacks are the first person in Pando dominated region to provide health services. Gram Panchayats are empowered to review all the development programmes within their area every month. It was observed that review of health programmes is not adequately carried out in Gram Panchayat level meeting. Training in the form of orientation and transfer of special skills on recurring basis were lacking in the health service delivery system. This has affected the functioning of the health personnel and the health service delivery system.

Major Suggestions

The health infrastructure development in the interior Pando dominated regions may be emphasized more in order to develop the access of the tribal people

and to develop their quality of life. Selected Baigas/ Traditional Healers and local quacks who have community acceptance may be provided with basic orientation training on both common and special diseases. They may be entrusted to carryout identification of patients affected due to serious diseases and timely need of treatment. Health related training module may include some of the health issues of local Pandos with respect to their belief pattern, culture and practices. This may help health personnel to have a holistic understanding of the tribal people and their problem.

In the Gram Panchayat level monthly review meetings, the status of health programs may also be reviewed. The local level health functionaries like Multi-Purpose Health Workers should attend these meetings at GP level. Along with other health related data the health worker should be made responsible to provide the data regarding the status of various diseases in their own operational areas. In villages the traditional leaders and the Ward Members may be involved in monitoring the implementation status of various health programmes in Pando villages. The ICDS centers, Panchayat Offices, schools, and village community centers may be furnished with IEC messages on basic health related issues through wall painting and durable attractive pictorials. The folk dance, folk drama may also be adopted as means for disseminating special health programs in weekly *haats* and festive gatherings in the Pando dominated region. Laboratories for pathological testing may be established and strengthened in government health institutions. Joint management of primary health services may be made to deliver services in villages and GPs can supervise the role of health extension personnel, NGOs, members of PRI and local traditional leaders.

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