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TRADITIONAL BELIEFS AND HEALTH STATUS OF BIRHOR

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ABSTRACT:

As one of India's Particularly Vulnerable Tribal Groups (PVTGs), the Birhor tribe is confronted by significant difficulties in health and nutrition yet government health facilities are available. This study focuses on Birhor, who actively participate in both household and economic activities from which they derive nutritional and health outcomes; despite which, they suffer poor health outcomes, largely due to socio-economic and cultural constraints. Malaria, gastroenteritis, typhoid, skin diseases and widespread malnutrition are some issues highlighted, plus competitors' poverty and starchy, nutrient deficient diets. The study finds Birhor children, 70% of whom are underweight, with high rates of anemia and infant mortality that require improved healthcare access and education. The descriptive research design comprised interviews with 91 respondents sampled by Krejcie and Morgan's method combined with case studies and consultations with local leaders, educators, and healthcare professionals in Jashpur and Raigarh Districts of Chhattisgarh. The findings show that the tribe has depends on faith healers and poor sanitation to plague, says Mwangangi. It proposes targeted interventions comprising combinations of health care, and development yet improvement both living standard and health of the Birhor, particularly women and children.

KEYWORDS:

BIRHOR TRIBE, PARTICULARLY VULNERABLE TRIBAL GROUPS (PVTGS), HEALTH STATUS, NUTRITIONAL CHALLENGES, MALNUTRITION, ANEMIA, INFANT MORTALITY, MATERNAL HEALTH.

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INTRODUCTION

Food and health are basic necessities of life and the Birhor tribe who is one of the PVTGs of India has many issues related to both. As illustrated in the previous sections, Birhor women are as involved as men in household and economic activities among the Birhor. They are shy, poor, illiterate and have low health and nutritional status despite the available facilities in health centers. Thakur (2009) points out that tribal women are financially productive women today in many countries but remain grossly overlooked for their succumbing health. According to Basu (1992), health work is closely tied with the social development of a country; the socio-economic status of the Birhor tribe is not lucrative making their health problems worse. ICMR (2003) mentions that the health infrastructure of tribal groups, especially the Birhor, remains nearly worthless with the majority preferring to attend faith healers before going for a doctor. Major diseases reported among Birhor women comprise malaria, gastroenteritis, typhoid, and skin diseases resulting from poor personal hygiene and absence of portable water. Malnutrition exists due to poverty and starchy diets without nutrient-dense foods such as calcium, vitamin C and protein (Sarala, 2015). According to Gupta (2012), PVTG families suffer from anaemia, and an appalling 70% of their children are underweight, giving high rates of infant mortality. This is because most Birhor women deliver at home although the Government of India has embarked on National Rural Health Mission and Janani Suraksha Yojana to fecundate institutional deliveries and decrease maternal mortality (Subha, 2012). Socio-economic causes regarding these wretched conditions include illiteracy, poor sanitation as stated by Basu (2000). The quality of health and nutrition of the Birhor women in particular demands combined healthcare education, accessibility to childcare, and socio-economic uplift for better way of living.

METHODOLOGY

The study is descriptive in nature, and an interview schedule has been employed to collect data. A few case studies were also carried out for a more thorough investigation. In the relevant study region, interviews were also conducted with Sarpanch, school teachers, and health professionals. The regions chosen for the study are the districts of Jashpur and Raigarh in the state of Chhattisgarh. The respondents for this study are the families of Birhor. The sample size of 91 was chosen using the Krejcie and Morgan method, and the lottery method of simple random sampling was employed to choose the respondents.

OBJECTIVE OF THE STUDY

In the present study to evaluate the health and nutritional status of Birhor, the study has following objectives

1. To know health status of the Birhor tribe.
2. To find health care and traditional beliefs.
3. The know the nutritional status respondents.

COMMON DISEASES FOUND AMONG RESPONDENTS:

The diseases that are frequently occurring among the Birhor are malaria, typhoid, gastroenteritis, viral fever, measles etc and the identified reasons includes unsafe water, stale mosquito borne diseases, unhygienic living standard and diseases literacy. Informant interviews with ANMs working at the nearby health centres Haltu, Tawa and Wadara identified malaria, typhoid and advanced gastroenteritis, cough and cold with fever, and skin diseases as frequent ailments among Birhor women and their families alongside malnutrition and anemia. According to Chakma (2017), the female birhors suffered from acute respiratory infections 11.2% and malaria 10.5%, the next prevalent diseases are scabies 7.1 in Birhorwomen is a skin disease. Gastroenteritis that results from consumption of contaminated water and lack of rigorous hygiene measures leads to vomiting and often dysentery and diarrhoea. Despite this, Birhors depend on natural water sources such as rivers, waterfalls and nalas most of which are contaminated. They also eat food prepared in the morning and consumed till the following morning, food which is often uneaty. Cough and fever are common including the flu due to cold weather in Raigarh and Jashpur districts; most Birhor families lack warm clothing. The cultural barriers and the socially bounded shy nature of the Birhor women also do not let them go for a proper medical check up and this they rely on the baiga. Measles is more common among kids, the families of which do not turn to hospitals, but wait for a natural treatment at home. Weekly visits by ANMs consist of dispensing medicines, and for the occasions of sporadic flare-ups, medical camps are organized. Inadequate washing of the body particularly of the private parts as well as the lack of bathing, defecation without using toilet, untidy hands during eating and unpleasant dressing also affect health complications. Further, there is not much information of the use of mosquito nets in order to avoid malaria incidence. All these factors make it clear that awareness about health, quality and availability of water, and healthcare services for the Birhor requires immediate attention.

TREATMENT:

It is, as a matter of fact, culturally acceptable and almost every Birhor utilizes traditional medicine to treat diseases and illness. In this article, Birhors use their traditional healer, the Baiga, they seek medical aid from a traditional practitioner when they are sick and they prescribe to them herbs found in the nearest forest. They have the best knowledge regarding the effectiveness of these herbs in relation to healing and often are known to treat illnesses at home. According to Parsons' model of 'Social System,' the sick person in illiterate societies such as PVTGs is actually a social deviation. Culture strives to reduced sickness to ensure that population has proper health for work and business through local medical practices that derive from beliefs in the supernatural. The Birhor women, who are still closely associated with such beliefs, consider sicknesses a work of evil spirits and go in for "jhad fuk' from Baigas before approaching modern medicine. Doctor and 11 doctor options agreed that 59.6 percent of the Birhor respondent chose traditional birth attendants, 14.2 percent both self and modern health center, and 10.8 percent modern health center. But education affects treatment seeking behavior since educated Birhor women honestly express a greater propensity to seek care in the hospital than their illiterate sisters. Even though they have some confidence in today's Allopathy, Birhors seldom go to hospitals unless all other indigenous treatment methods are exhausted. The group of respondents at the age 20-25 uses both formal health care and Baigas more and more, while the elderly people rely on Baigas only. In addition, the level of vaccination against major diseases is relatively low among the Birhor women, though, they do not oppose vaccination; however, they have a fear of injection even to this date. The government's attempt in providing the primary healthcare in the distant areas, like once in a week ANM visit, have only slightly opened the door for the healthcare possibilities, but faith in own Baiga practices is strong. Prescription and reliance of Birhor population on cultural values and beliefs on supernatural healing to treat diseases is common and slow transition towards embracing modernity healthcare and medical approach to enhance their health condition indicate that traditions and culture impact the healthcare status of the Birhor.

PLACE OF DELIVERY:

The present study on the community health among the Birhor tribe reveals that antenatal and maternal health care practices are a cause of major concern as the available government schemes are not properly implemented at the grass root level. However, the National Rural Health Mission (NRHM) launched since 2005 and programmes like Janani Suraksha Yojana (JSY), which giving cash incentives for institutional deliveries, reveal that Birhor women mainly deliver their babies at home. The Chhattisgarh government pays Rs. 1400 to the institutional delivery services and different ambulances such as Mahatari Express to shift pregnant females to the health centre. But these facilities are still not fully utilized by the Birhors because of their poor knowledge and old fashion. According to surveyed Birhor, 86.1% of them delivered at home, with help from traditional birth attendants and 13.9% of them delivered in health facilities. Pre- and early-30s women were slightly more likely to have a hospital birth than those in the latter three age groups, for whom home birth was virtually the norm. Considering comfort and familiarity with home deliveries as major motives: Birhor women lacked community health workers'

encouragement as well as awareness regarding JSY or Mahatari Express. Of the rare few who were able to access the institutional facilities, most did not actually get the cash/transfers because of lack of bank accounts or because of delays with procedures. It was observed to inform from interviews that many women from the Birhor community are not even aware of safe institutional births or about ASHA workers and ANMs, serving maternal care. Besides, they stick to cultural values as well as have little trust in the conventional system of health. Fortification regarding institutional deliveries among Birhor ladies were viewed as somewhat relatively higher among youthful as well as slightly educated women having a generation in addition to education perform. In order to advance the health of the birhor tribe's women of child bearing age it is crucial to bridge that awareness gap and make maternal health services accessible.

PLACE OF TREATMENT DURING PREGNANCY:

Their prenatal care exhibition is a matter of concern that the Birhor women community failed to recognise the availability of health facilities to avail themselves. The governments targeted interventions offer fundamental antenatal interventions, including iron-folic acid and calcium tablets, tetanus toxoid vaccines and bio chlorine, and health facility-based checks by a trained birth attendant during the weekly clinic visit. Of these, however, the uptake of the services still varies across the regions. Though Birhor women are not afraid of injections and they willingly take vaccines and medicines, they have full faith in spirits; for pregnant treatments they also prefer Baigas and Guniyas only. This traditional belief persists even though the people involved have a measure of education about improved health facilities.

The study also shows that only 6.5% of the Birhor women attended health centre during pregnancy while 34.3% availed themselves of home bour treatment, traditional birth attendants. Factors including cultural and logistical constraints, contracting HC services, geographic isolation and restricted mobilization of HC services enhance this trend. While, the percentage of women from Birhor community, who accept modern medicines, is slightly higher than men, they still prefer supernatural remedies. Unfortunately, the figures of prenatal care receiving from doctor by the Scheduled Tribe mothers in India were found much low compare to total national average, where only 50.2 percent of mothers receive such care; the present study reveals that only 32.8 percent mothers of this category in India received pre-natal care from doctors (Statistical Profile of Scheduled Tribes in India, 2013).

It was found out that anemia, malnutrition and susceptibility to diseases which are prevalent during certain seasons of the year are some pregnancy complications that affect the Birhor women. The situation is worsened by poor dieting habits, as well as irregularity in the taking of prescribed supplements. Thus, while engaging pregnant women and their families as clients, most health workers find out that many pregnant women have no knowledge of the available modern prenatal care, or they are unable to seek it because of socio-economic reasons. Cherishing the mentioned above cultural taboos are the biggest hurdle for better prenatal care among Birhor women; in addition, increasing outreach and ensuring the regular availability of healthcare for such covered tribes should also be maximized.

COMPLICATION DURING DELIVERY:

Pregnant, Birhor women have a worrying situation to live in because they generally opt for delivery at home by older female family members using unhygienic instruments and unsafe delivery methods, making delivery unsafe, prone to infections and complications and leading to possibly even maternal and neonatal deaths. A study further shows that the number of Scheduled Tribe (ST) women, that is Birhor women, who received antenatal care of their respective most recent births is just 32.4% and given advise on where they can go in case of complications (Statistical Profile of Scheduled Tribes in India 2013). Common complications include anemia, infections, and seasonal diseases among 46.5% Birhor respondents who reported difficulty. Though it is well recognized that professional obstetric care is important, only 17.1 percent of ST and Birhor women received aid from a physician at giving birth (Statistical Profile of Scheduled Tribes in India, 2013). Additionally, unhealthy habits, such as pregnancy alcohol and tobacco use and poverty, cause people in this community continue to suffer from high maternal and neonatal death rates.

IF YES THAN PLACE OF TREATMENT:

44.9 per cent of Birhor tribe women having complications during pregnancy or delivery prefer being treated at home or seeking advice from a local healer, the Baiga Guniya, rather than going to a health centre, with only 0.9 per cent opting for professional medical care. This dependency on conventional methods can lead to harmful health results for both mother and kid as a result of a deficiency of wellness consciousness and relevant clinical intervention. Auxiliary nurse midwives (ANMs), supposed to act as skilled birth attendants, visit the village weekly to give calcium and folic acid tablets to pregnant women and counsel them on institutional deliveries. Although these ankles and awareness and support are only a few of many villages, the ANMs' visits are mainly a routine without serious follow-up or education. There is a lack of awareness about ANC services provided by the government attended by respondents hardly knowing where they can access these services. Besides, the situation in the region is made worse by poor road and transport infrastructure that consequently hampers Birhor women's ability to reach health centers. Some women know about ANC services but they want to deliver in the home rather than in an institution. Basu studied tribal groups in the Bastar district of the state of Chhattisgarh and discovered that maternal and child care is often neglected: over 90 percent of deliveries occur at home, typically with the assistance of elderly female members of the household (1989). This points to how deeply rooted in tradition, and at the same time, how hindered from accessing formal

healthcare are the Birhor community

WEAKNESS OCCURRED IN NEW BORN AFTER DELIVERY:

Among the Birhor tribe, breastfeeding is practiced and traditional ways of increasing milk secretion are employed. But goat milk is sometimes used instead if the mother's milk does not supply enough. Although immunization, a balanced diet, regular check overs and institutional deliveries are all practices important to having a healthy pregnancy and childbirth, the Birhor women do not engage in many of these practices and the complications with their newborns are born of it. Among the Birhor, no special precautions are taken during delivery and many Birhor newborns are weak and underweight. The study found that 50.9 percent of respondents said that their child was found weak after delivery. The children of the Birhor often suffer from growth retardation and weakness, have malnutrition and anemia in the mothers which directly impacts the health of the newborn. 60% of the children deaths under five years of age are death related to malnutrition, this is strongly associated with the mother's poor nutritional status (Jang Bahadur, 2015).

TOTAL NUMBER OF CHILD BIRTHS:

Early marriage is common among the Birhor tribe, where girls get married between the age of 12 and 14, but get pregnant between 14 and 16 years. It is very important in terms of maternal and newborn health for this early marriage. The number of children among Birhor women proves that there are 25.2%, 3, 24.8%, 2, 17.4%, 4, 5.7% more than 7 children. Birhor women on an average have 2 – 3 children. Correspondence shows that Birhor women tend to have more children because they tend to marry early. The mean age of marriage of Birhor female is 14.76 years with the age range of 10 – 30 years (Sandeep Sharma, 2007). Data shows women who marry at a young age between 10 and 12 years old have more children than those who marry between 16 and 18 years of age or older. Higher fertility rate from early marriage and childbearing on the other hand leads to poor health status of Birhor women and consequently complications for both mother and child. The pattern of early marriage and childbearing puts these women at risk for maternal and infant health problems that make it difficult for them to obtain the care during pregnancy and childbirth that they need. Studies indicate that early marriage is associated with poor maternal health (Kerketta, 2002) and a combination of factors around the age of marriage and fertility rate, both of which are high, is also a major contributing factor to the health outcome challenges faced by Birhor women. Because mothers who are married early and begin bearing children early are at greater risk for complications and health outcomes, such early marriage and child bearing results in worse outcomes for both mothers and their children.

CAUSES FOR CHILDREN'S (UNDER FIVE YEAR) DEATH:

The reason for the high level of child mortality in the Birhor tribe has been attributed to malnourished pregnancies, non-institutional childbirths, child malnutrition, lack of vaccinations, dependency on traditional healers and unhygienic living conditions. Of the 30.4% of child deaths attributed by the Birhor respondents to weakness or lack of vaccination, other causes were birth complications, measles and devil spirits. During field work, a child had died from high fever for two days before he got any medical care at the time of measles spread in Gutkiya Village, which shows the lack of timely healthcare. Although immunization against diseases such as tuberculosis, diphtheria, whooping cough, tetanus, polio and measles (Statistical Profile of Scheduled Tribes in India, 2013) is of universal importance, the vaccination coverage in Birhor is low. Another important issue is lack of nourishment because children attending Anganwadi centers are not getting proper nourishment. Respondents reported some Anganwadi centers are only open one day in a week and provide very limited food items, which only add to the problems children below five are facing to survive and thrive.

DELIVERY IN HOSPITAL:

In the Birhor tribe the overall proportion delivering in institutions is low contrary to government sponsored program like the Janani Suraksha Yojana, under with BPL women are offered cash incentives to deliver in institutions. The corresponding figures regarding institutional delivery in the case of the Birhor women are 20.7%, and 50 % of the institutional deliveries were first order. Another problem is the absence of means of transport leading to confinement to hospitals; and yet 6.3% of Birhor women died with their newborns during and or after delivery, in health facilities. Research disparities reveal that though the actual management provided by skilled birth attendants are effective in the prevention of deaths related to mothers and neonates, only 17.1% of births to ST women, including Birhor have been helped by a doctor in contrast to births in other social groups, 47.4%. Furthermore, only 17.7% Silai Toor (ST) mothers, in which health factor is compromised severely, deliver their babies in health facilities, while other categories have 51% delivery (Statistical Profile of Scheduled Tribes in India, 2013).

STATUS OF ROUTINE ANTENATAL CHECKUPS:

According to cultural practices in the Birhor tribe, ANC is received from the ANM or ASHA who comes to the village once a week to log cases of pregnancy and give calcium and folic tablets, iron tablets and tetanus injection. From an analysis of the data table, 77.4% percent of the Birhor respondents reported to have received antenatal care from the ANM/ASHA, 70.4% received the vaccination, 71.7% received calcium and IFA tablets, 69.2% reported having had their blood pressure and weight checked. But only 15.4% of respondents get advised on institutional delivery,

cash incentives or the ambulance facility known as Mahatari Express from the government. One important problem found during the study is a lack of knowledge about governmental health facilities among Birhor women, especially Janani Suraksha Yojana which provides cash to women and ambulance services in case of institutional delivery (Statistical Profile of Scheduled Tribes in India, 2013).

NUTRITIONAL STATUS AND DIETARY HABITS:

lnadequate nutrition is still a major concern among the Birhor tribe, especially in the management of maternal and children illnesses. Prolific economic challenges inclusive of poverty do curb their abilities to buy uh healthy foods such as vegetables and fruits. They mostly feed on products from the forests including yams, fruits and leaves as well as occasionally birds and game. Some families are farmers, where they cultivate rice and pulse, but these facilities are scarce. More than three fourths Birhor respondents are unable to afford vegetables for a daily mixture and 35% of the respondent do not cook pulses regularly. They only prefer rice and pasiya which is cooked rice extract Or in some cases, big unripe jackfruit can be had for the whole meal. The last and most important is malnutrition which results from inadequate balanced diets leaving the body deficient in calcium, vitamins A and C, proteins. A majority of the respondents (67.9%) use it with dal , however only a small minority (15.4%) use pulses/ vegetables in their diet; and of these 23.1 percent are Birhor women. This leads to their ability to produce scarce agricultural produce, as well as budgetary constraints, which hinders their ability to always properly provide for their people by ensuring they consume a constant supply of such nutrients. This malnutrition is further aggravated by the fact that the Birhor women never consume milk and milk products that provide a major part of required protein in their diet, a situation emphasizing the dreadful nutrient deficiency problems of the Birhor community (Kshatriya, 2014) .

FOOD SUFFICIENCY FOR PREGNANT AND LACTATING WOMEN:

It is shocking to note that the nutritional status of the pregnant and lactating Birhor women is very poor and raw material for infections as well as for delivering low birth weight baby which pose potential threats to both the mother and child. Among the Birhor women, 73% women get adequate food whereas, 27% the women suffer from nutritional deficiency. Out of them 45 % of women receive prepared food from Anganwadi centres where they are served ready to eat food packets and Mura Laddu. But problems exist, heard 17.1% depend on home cooked food alone and 6.7% never received food from Anganwadi centres because they were closed or providing insufficient rations. In addition, 7.9% of Birhor women said they face extreme poverty in access to food; 18.8% claimed that they had ever starved and had no food but water and sleep, a rate higher than that among Birhor women (20.9%). This explains Malnutrition among pregnant and lactating women in Birhor community as despite all support that is offered through Anganwadi centers (Vaishnav, 2012).

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