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**HEALTH BEHAVIOURS  
OF  
THE SOLIGA TRIBE WOMEN**

**by**

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in conformity with the requirements for  
the degree of Master of Science

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## ABSTRACT

The Soliga tribe living in the Biligiri Ranga Hills of Karnataka State in India has a culture rich in traditional values and rituals. This secluded tribal community has recently come in contact with modern ideas and new health care approaches which have shaped some of their health practices. At present, primary health care services are being offered to the tribal people by Vivekananda Girijana Kalyana Kendra (VGKK), a voluntary organization. Further health programming is expected for the tribal population including a community based rehabilitation program.

This qualitative study is an exploration of the health behaviours of the Soliga tribe. In particular, the study identifies the typical practices pertaining to managing ill health and maintaining good health, as described by tribal women. Women are the natural caregivers of this community and are crucial sources of information regarding health behaviours. The qualitative approach employed to gather the women's personal experiences, (in a manner they would perceive as non-threatening), uses a purposive sample of face-to-face, non-structured interviews that are complemented by both participant observation and key informant interviews.

The results of this study indicate that the health behaviours of the Soliga are dependent on variables such as seriousness of the medical condition, availability and accessibility of health resources, culture, education, and environment. These results provide both health planners and health providers further insight into unique cultural beliefs and behaviours as they pertain to the health of the Soliga people. This knowledge may be helpful in facilitating the creation of an appropriate, effective, and culturally sensitive health and rehabilitation program for the Soliga people.

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# CHAPTER ONE

## INTRODUCTION

It has been argued that an understanding of the cultural values, traditions, beliefs, and patterns of family interaction must be incorporated into the development of health programs which can then improve health behaviours (Berry & Mishra, 1995). For the purposes of this study, health behaviours will be defined as: the representations that people hold regarding health and disability, and the ways in which they cope as individuals and as a community with regards to illness and disability (Taylor as cited in Berry & Mishra, 1995). The overall goal of this study is to gain an understanding of health behaviours in the broader context of the Soliga tribal community in order to guide the development of a Community Based Rehabilitation (CBR) program, enabling it to be more sensitive to the people's way of life. Studying the existing health behaviours, women's role in care giving, and perceptions of health and disability promote an awareness of cultural rituals and beliefs and thus facilitate a more appropriate and effective rehabilitation program. Addressing health and disability issues with Soliga women may also result in raising their self-reflection and self-awareness of these issues.

The Soliga tribe will soon be involved in a CBR program addressing the needs of people with disabilities in their communities. Prior to the implementation of such a program, it is essential to gather baseline information pertaining to the existing health

behaviours of the tribal people. Berry and Mishra (1995) state that health programs will be more successful if they are integrated with the cultural practices, beliefs and attitudes of groups and individuals. According to Twumasi and Freund (1985), it is necessary in any health development program to investigate health-seeking behaviours as well as to monitor ongoing community changes which may have an impact on health status.

Women were the focus of this study because as Dayal (1985) states, “It has been universally recognized that particular attention should be focused on improving the status of women, whose role as caretakers of family and community health has important implications for the overall socio-economic development of societies” (p. vii). Women’s roles as primary caregivers mean that both family and community health depends on their interest, ability, and behaviour as it pertains to health issues.

The role of many voluntary and government agencies in the tribal areas has often been to civilize, modernize, and reform without much thought to the tribal culture. Although acculturation is inevitable, the evolutionary direction of the tribal culture should be guided by intrinsic tribal factors rather than prompted by the external agency (Somasundram & Kibe, 1990). Using these guidelines, a CBR program must first explore the existing cultural beliefs and practices before it can incorporate these guidelines into a more culturally sensitive program.

## **1.1 Objectives of the Study**

The objectives of the study are

1. to describe the indigenous health behaviours and rituals of the tribal community including the tribal people's use of health services;
2. to describe the women's role within the family and community and, specifically, their roles in health care;
3. to describe women's beliefs and knowledge of the causes of disability and its treatment;
4. to explore understandings of tribal women's health and disability practices.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Context of the Project**

A brief description of India and its socio-political situation will be provided first in this review. Understanding the uniquely diverse cultural make up of India is essential to appreciate both the setting and the environment in which the research took place.

##### 2.1.1 India

A journey in India encompasses a variety of emotions. It challenges your strengths and works on your weaknesses, while rewarding you with its magic and mystery. Siddiqui (1997) describes India as “a bundle of contradictions, complexities and infinite paradoxes. So disturbing, yet so seductive. So chaotic, so serene. So profane, so sacred. So vulgar, so refined. So irrational, so intellectual. So....”(p.2). As India’s first prime minister, Jawaharlal Nehru, stated, it has the accumulated wisdom of traceless centuries. Stanley Wolpert (1991) suggests that India has everything in magnified form, and that the passage to India is not an easy one for Western minds.

The Republic of India is situated in South Asia between the smaller nations of Bangladesh and Pakistan. The capital of India is New Delhi, and the largest city is Mumbai. Despite India’s large size, its population of almost one billion people threatens

to outgrow it, rendering India the world's second most populous nation. Although there are vigorous campaigns to introduce modern methods of birth control, India continues to have roughly 2% annual population growth or 16 million people. India is primarily a rural society in which it is estimated that 70% of its 960 million citizens live in poverty, mostly in villages (Siddiqui, 1997).

The chief language in India is Hindi, which is spoken by approximately 30% of the people. There is a great ethnic variety comprising 16 major language groups and 1600 different languages and dialects. The exact origins of the people of India are impossible to trace because of the large variety of races and cultures that have invaded and been assimilated into the subcontinent. There are elements of three major racial groups which can be found in present-day India, the Caucasoid, the Australoid, and the Mongoloid. Approximately 7-8% of the total population belongs to more than 300 scheduled tribes. The tribal \*(the word *tribal* will be used to describe indigenous people since this is the term used by the government of India) groups are racially and culturally distinct from the mainstream Indian population and vary amongst themselves as well.

When describing groups of people in India, it is helpful to use the framework of three broad geographical divisions. The divisions are Northern and Eastern India, Middle India, and Southern India. The people of each geographic region differ in culture, religion, language, and appearance.

Southern India, the area in which this study takes place, comprises the states of

Tamil Nadu, Kerala, Karnataka, and Andhra Pradesh. Considerable variations exist in anthropological and genetic features of the people of this region; both tribal and non-tribal peoples speak one of the Dravidian languages of Telegu, Tamil, Tulu, Kannada, or Malayalam (Microsoft® Encarta ®96 Encyclopedia, 1993-1995).

### 2.1.2 Political Situation

India is a political union of 25 states and 7 centrally administered territories which has produced a multiparty democracy in which family dynasties, ethnic groups, and religion play an important role in politics (Siddiqui, 1997).

One factor causing political strife in the country is religion. In certain places, there exist bitter differences between the Hindu majority and the nation's Muslims. A civil war has been raging in Muslim-majority Jammu and Kashmir states since 1948, when India and Pakistan fought their first war over territory.

### 2.1.3 Economic Situation

Although the country suffers from internal strife, India has a powerful wide-based economy. The country is world renowned for its textiles, is the second largest country in the world in terms of arable land, and is the sixth largest economy with respect to Gross Domestic Product (GDP). In recent decades leaders have implemented drastic reforms to encourage economic growth. Reforms undertaken in 1991 have led to a strong revival of

economic growth, rapid increase in employment, reduction in poverty, a boom in exports, and a decline in inflation. Factors which India continues to face as barriers to becoming a world economic power are that almost 50% of its work force is illiterate, its roads are poor, and communication and power sources are poorly developed and ill-maintained (Online, 1997).

#### 2.1.4 Health Care in India

Article 47 of the constitution of India identifies that “the improvement of public health” is a primary duty of the state and the government of India is responsible for the provision and regulation of health care (Zelmer, 1995). In the present climate of changing population and existing economic, demographic, and social characteristics, achieving the World Health Organization’s (WHO) goal of “Health For All” is one of India’s priorities as part of its efforts to promote sustainable integrated development (Zelmer, 1995). A cornerstone of India’s health policy is the provision, primarily to low-income people, of free primary health care services, which are provided by the Family Welfare Programme and are focused toward the provision of family planning services (Masur, 1995).

The Indian health system is two-tiered, where the government facilities contribute only a small portion of health care delivery services. A network of voluntary and commercial health organisations also exists, working to improve the health status of the population. These non-government contributors consist of a range of practitioners and

facilities which are either non-profit or private enterprises (Zelmer, 1995). The challenge for India achieving “Health For All,” is to recognize and coordinate the diverse organizations, activities, and events that have an impact on population health (Raj, 1992).

## **2.2 Culture and Health**

The following section will examine how culture may effect health behaviours and the delivery of health-related programs. Since the tribal group studied has its unique culture and continues to use their traditional health system along side a modern one, it is necessary to explore the literature pertaining to both of these models of health by studying their similarities as well as their differences.

India’s extensive and unique cultural makeup demands special consideration particularly in the preparation and planning for developmental projects at the community level. M.N. Chaudhuri (1994) suggests that, if scientific medicine is to be carried to the tribal areas, it is necessary for practitioners to have knowledge about these cultures. For the purposes of this study, a community – the Soliga tribe – will be defined as a group of people with their own unique opinions, beliefs, prejudices, and experiences.

Culture plays an essential role in determining what people within a community may perceive as illness, as disablement, and as health. Health often assumes a state of being healed, in the sense of being restored or a return to a sound state (Basu, 1994). The WHO disagrees with this view and defines health as “a state of complete physical, mental

and social well-being and not merely the absence of disease or infirmity” (Basu, 1994, p. 1). Basu states that in the tribal community “a man or woman is not usually afflicted with some disease unless and until the individual feels incapable of doing normal work assigned to the respective age and sex in that culture” (p. 4). He suggests that health in the tribal communities is functional rather than clinical.

There is extensive literature focusing on the link between culture and health which has resulted from the collaboration of medical, social, and behavioural scientists (Berry & Mishra, 1995). Pokarna (1994, preface) states that, “[h]ealth of an individual and community is largely influenced by social and cultural factors which are deeply interwoven with the social fabric of life. These factors have wide variations from one community to another and within the community itself. It is, therefore, necessary to understand the community in its socio-cultural context before any health programme is implemented or evaluated.” Murphy (1982, as cited in Berry & Mishra, 1995) argues that cultural factors affect health in a number of ways including definition, recognition, symptomatology, prevalence, and behaviours. N.K. Singh (1994) also feels that there is a significant relationship between culture and the system of health, stating that culture defines the sickness, and the sick role. Simon and Hughs (1985, as cited in Berry & Mishra, 1995) suggest that culturally bound syndromes of illness exist, for example, “trances” which may be viewed as psychiatric disorders in some cultures and as healing mechanisms in others.

Anthropologists have provided many alternatives to defining culture. The most famous is Taylor's definition in which he suggests that culture is a complex whole which includes knowledge, belief, art, morals, law, custom, and all other abilities and behaviours acquired by individuals within their society (Leach, 1982). The ideational aspect of culture is expressed by Keesing (1981) who proposes that culture is composed of systems of shared ideas, concepts, roles, and meanings that form the basis for how human beings live. Levine (1987) describes culture as a common experience, shared by a group of people, that acts as a blueprint for the actions of its members. A commonality that is seen in several definitions is that culture is comprised of the beliefs, values, and customs of a group which are passed on from generation to generation. Culture is a total way of life, a learned pattern of behaviour, and a guide to daily conduct.

Krefting (1991) suggests a model in which culture is represented by four concentric circles progressing from the regional to the individual level: the outer circle represents the regional view of culture focusing on commonly held patterns of behaviour of larger groups; the middle represents the community level which defines cultural differences in a more refined manner, such as health care practices within a group; the third dimension is the family, which encompasses family structure and roles; and, the inner-most circle represents the individual, which may include personality aspects such as personal coping styles, degree of interaction with others, and food preferences. This view of culture suggests that when describing health behaviours of a tribal group one should

focus on both the regional and community level of interaction.

Anthropologists distinguish between an emic view (insider's perception) and an etic view (outsider's analysis). Problems may arise that can compromise an individual's health care if the emic perspective is not investigated. A treatment rationale may make sense in the western medical model but may not make sense to the individual and therefore will limit his/her participation and compliance. It is not adequate to just explain the etic view for that assumes the medical model is the superior model. This would lead to ignoring issues raised by the individual that may be culturally different. Parry (1984) describes an anthropological perspective that may assist in making health care more acceptable to diverse cultural groups. He suggests that the clinician (health care worker) should strive to approximate the emic view by learning his/her patient's definitions and views of the world. It is suggested that this can be achieved by posing questions that will expose the desired information and by observation of the behaviours of the cultural group.

It is clear to see that health beliefs and practices will vary with differing cultures: health can be affected by circumstances; beliefs; culture; social, economic, and political environments. Due to the differences in health-seeking behaviours all over the globe, it is necessary to explore specific cultural practices in order to avoid cultural insensitivity. While the western medical perspective is widely used, it would be naïve to assume that all cultural groups follow this model of health care delivery. In many parts of the world,

western medicine coexists with, rather than replaces the traditional health system (Ratnaike and Chinner, 1992). Traditional medicine is a broad concept and may include a variety of customs and beliefs which have been practised over centuries. It may include visiting a healer or shaman and may be a regular part of health-seeking behaviour.

### 2.2.1 Western Medical Model versus Traditional Medicine

Four classic characteristics of the western medical model will be reviewed and compared to traditional medicine beliefs: biomedical, reductionist, professionally driven, and individual focus.

Biomedical Approach. Historically, western medicine has attempted to understand the physical world through careful examination, separating the mind from the body (Barris, Kielhofner, & Soo, 1988). The growth of this model has relied on the steady increase of scientific knowledge of disease and its management (Dubos, 1959). The causation of illness or disability may be viewed very differently from a traditional perspective where the illness or disability may be explained by an elaborate cultural belief system. Traditional healing methods often involve ceremonies and rituals. Spirituality, prayers and ceremonies are an integral part of traditional medicine. Often tribal cultures believe in curses as the cause for illness, for example, the Rajgond tribe of Karnataka state, India, believe that sterility in a male means his wife is cursed (Raju, 1988). In this tribal community, if the woman is barren, she is believed to be a sinner.

Sinha (1994) also refers to Indian tribal people's belief that evil spirits cause disease and epidemics.

Professionally driven. The medical model recognizes physicians as authoritative healers, able to cure, ameliorate or arrest disease through recognition and change of observed symptoms (Barris et al., 1988). In traditional medicine the healer may be seen as the spirit diviner. The traditional health specialist may have a different approach to treating people, for example, viewing people holistically. However, the notion of a specialist does exist in the traditional health system. The healer is thought to have a better understanding of the cultural beliefs and attitudes of the patient. B. Chaudhuri (1994) writes that "[a]mong the tribal groups, there are a group of specialists – the priest and/or magicians or medicine men whose services are sought after depending on the cause of illness" (p. 74). Sinha (1994) also refers to specialists in tribal communities in India who treat ailments: these specialists pass their knowledge of herbal medicines on from generation to generation, and the method of preparation remains a family secret. The traditional healer may, therefore, be more successful at treating certain illnesses such as mental disturbances. The Soliga tribe of Southern India uses a traditional approach to medicine in which a tribal man or woman uses various indigenous remedies and reinforces these herbal remedies with special rituals involving religious beliefs (Somasundram & Kibe, 1990). According to Dr. Raju's (1988) study of tribal and rural people in Southern India, possessed men and women are believed to have special spiritual

powers. They believe that a female goddess enters the body and soul of the possessed person, answers their queries and offers remedies and solutions.

Reductionist. Another prominent aspect of the western medical model is its reductionist quality, where medicine deals with a diseased organ or body part rather than focusing on the patient in a holistic manner. Traditional medicine by contrast tends to look at the whole person. For example, the aboriginal people of Canada, who also have a traditional view of health, emphasize the whole person within the larger universe. Canada's aboriginals consider good health to be more than not being sick; they feel that the mind, body, emotions, and spirit must all work together for a person to be healthy (Alberta Health. 1995). Swain (1994) describes how western medicine outpatient departments have been utilized by tribal people. The tribals find "it is a strange isolated place where the relations are not allowed in large numbers, neither the treating physician sits with the patient to share his woes. The staff are more business like and at times unsympathetic. It is expensive too, at times the doctors/staff are not available"(p.21).

Individual Focus It is evident in our society that the medical model continues to be directed towards discovering and quantifying biochemical information about a patient, rather than learning about the less measurable, social, cultural, and emotional factors influencing health (Barris et al., 1988; Helman, 1994). The focus is on the individual patient, rather than on the family or community. In traditional medicine, it is not common to view only one aspect of a situation. An example from Indian tribal medicine

demonstrates the role of the shaman as nurse, friend, guide, and analyst. The traditional shaman is involved in a patient's family and community life. Rajgond tribals may explain a disability in terms of familial behaviour. For example, blindness acquired later in life is explained as being due to jealousy of a mentally disturbed mother (Raju, 1988). Dr. Anwar Islam states that the traditional system "adopts a holistic approach and considers humans to be an integral part of the totality of the environment" (1994, p. 72). Health implies a state of equilibrium among constituent elements of the environment, the individual's social, cultural, and physical environment, temperaments, constitution, and predisposition. Diet regimen, food, compatibilities, living habits, and mental composure or spiritual beliefs are considered significant in causation and cure of ill health.

The traditional system can be seen as "a system of values, beliefs, knowledge, objects, tools and techniques and an organisation of roles, activities and relationships" (Sachchidananda, 1994, p.57). It is uncommon now to find traditional societies which have been completely isolated and sheltered from the influences of a modern approach to health care. It is therefore necessary to understand the interaction of the two systems and to hopefully learn appropriate methods of integrating the two models. An approach suggested to study the traditional system is to view it in the process of interaction, the relationship between the systems of medicine and other social spheres of life such as religion and morality. This approach helps to explain why certain elements of the modern system when introduced are accepted while others are rejected, and this understanding

ultimately helps in planning strategies for positive change. Chaudhuri (1994) references a number of studies which show that the tribal people accept modern medicine. When tribals are thought to not accept modern practices in many cases it may actually be a myth. The real explanation may be that health facilities are non-existent in the area.

Swain (1994) also reports that some tribals practise their traditional system along with a western system if available “during epidemics, animal sacrifice, prayer meetings. Western drugs along with traditional medicine are all used” (p. 19). Swain states that study observations have revealed that the native method of treatment and surgery is gradually dying out. Isolation is gradually being reduced. In some areas, under the impact of modern civilization, the indigenous system is becoming extinct though the magico-religious system is persisting. Swain goes on to explain that in his study the western system of medicine, when available, was accepted. The magico-religious system did not come in conflict, rather, it was also used. This suggests that the concept that indigenous people are resistant to a modern medical care system was not true. Swain (1994) proposes that wherever health facilities are available, native systems of health seeking has tilted in favour of modern medicine.

### **2.3 Disability and Community Based Rehabilitation**

According to the World Health Organization, it is estimated that 98% of disabled people in developing countries fail to receive rehabilitation services (H. Nakajima, as

cited in Helander, Mendis, Nelson, & Goerdts, 1989) . Seventy per cent of all cases of disability in developing countries are caused by malnutrition, preventable disease, and poor perinatal care (WHO, 1981).

In the late 1970's as part of its "Health For All" campaign, the World Health Organization recognized the need for a resourceful delivery of services and therefore recommended CBR, for the provision of services and training for disabled people (O'Toole, 1991). Community Based Rehabilitation is defined as follows: "a systematised approach to helping disabled persons within their own community make the best use of local resources and helping the community become aware of their responsibility in this regard. Responsibility is also given to the disabled themselves as they are part of the community" (Murthy and Gopalan, 1992, p. 5). CBR is a practical and successful means for providing appropriate health care to a greater percentage of the disabled community (Peat, 1991a). The focus of CBR is determined by the community it serves (WHO, 1981). The CBR approach is culturally unique and geared to specific needs of individual communities (Peat, 1991a).

Wilson (1982) suggests that in actual practise, "for 'community,' we should read 'family,' and for 'family,' we should read 'women' " (p.40). The literature pertaining to CBR indicates that women play the largest role as both primary nurturers in the family and as community health workers (Peat, 1991a). The CBR model for health care provision utilizes a holistic, culturally sensitive approach which would appear to fit well

with the literature pertaining to tribal culture and health.

In the 1970s, the government in India was looking for ways to promote universalization of services in various sectors of development including health and education, which gave rise to the acceptance of CBR (Thomas, 1993). In the 1980s, the goal of CBR in India expanded to include not only better coverage but also independence, productivity, and integration of disabled people into the community (Thomas, 1993). According to the National Sample Survey (NSSO) of 1991 there are an estimated 16.15 million physically disabled persons in India with visual, hearing/speech, and locomotor impairments (Pandey & Advani, 1995). Disabled persons are identified as living primarily in rural areas.

#### **2.4 Indigenous People Of India**

The following section will initially discuss some of the political issues facing the indigenous people, or tribals, in India and their culture. Secondly, a more in-depth description of the health status and health behaviours of the indigenous people will be provided.

Article 342 of the Constitution of India defines a tribe as “an endogamous group (marrying within themselves), with an ethnic identity; who have retained their traditional, cultural identity; they have a distinctive language or dialect of their own; they are economically backward and live in seclusion governed by their own social norms, and

largely having a self contained economy” (Sahni & Xirasagar, 1990 p.4). According to the 1991 national census, the tribal population of India constitutes 7.95% of the total population of India, consisting of 427 tribal communities (Basu, 1994). Tribal people can be found in all states except Punjab, Haryana, and Jammu and Kashmir. The tribals may belong to different ethno-lingual groups, profess different faiths, and may be at different levels of socio-economic development. The areas of tribal concentration are primarily forest and hill regions.

Margaret Mead (1954) describes two basic characteristics of tribal life: (1) physical isolation, and (2) self-reliance based on ecological adjustment to their environment. It has been recognized that, in recent years, this isolation has been breaking down. Still, most tribals live in small homogenous groups confined to limited areas and lead a very simple life. Most tribals live in poverty – their lives generally centering around food quests. Tribal people of India believe in supernatural and magical powers. The tribals are described as physically strong and self-reliant due to their coping in harsh ecological environments, their exposure to adverse situations, and their ignorance of modern amenities. Although they possess a strong physical exterior, they are described as simple, innocent, and at times helpless. Tribals are often seen as rigid: their moral codes and conduct are very strict, which may be a reason they have been able to sustain themselves in spite of adversities in life (Swain, 1994).

According to Sahni and Xirasagar (1990) the tribes of India can be classified into

three types:

1. tribes which are totally isolated, untouched by civilization, living in remote forests and unaffected by the development of the rest of the country;
2. tribes which have maintained their identity and seclusion even though they have been exposed to the adverse effects of civilization such as deforestation, displacement from their original habitat, or erosion of their resource base. However, they are excluded from the benefits of development;
3. tribes which have been in contact with external civilization, mixing with non-tribals, and used for labour by others. As a result of their social customs and naïveté together with the exploitation of both the urban and rural people, a different pattern of health and development has been created.

The previous classification is relevant for planning and implementation of health and health-related programs, since each type of tribe presents their own unique set of needs and their own different problems. The second and third types will be discussed in more detail, since they best describe the Soliga tribe studied in this project. Sahni & Xirasagar (1990) describe the second type of tribal grouping as suffering specific problems resulting from a ban on shifting cultivation enforced by forest officials, deforestation by the government forest corporations as well as private interests, lack of access to forest produce, and lack of documents for land ownership. These problems have led to a high incidence of malnutrition and communicable diseases because of lack of

health coverage. The third classification of tribes is that which has adopted some non-tribal customs and food habits. The health problems of this group are related to dissociation from their traditional healthy foods and practices due to erosion of their forest resource and adaptation to a life of rural poverty. This group of tribals also suffer from a high incidence of malnutrition as well as other diseases, such as TB and venereal disease, which is not a feature found in the other two categories of tribal people (Sahni & Xirasagar, 1990).

#### 2.4.1 Tribal Culture and Health

Socio-cultural traditions of a tribal community play a role in its health and treatment practices. As discussed previously, people's beliefs, customs, and practices connected with health and disease are intimately connected with the treatment of disease. Sahni & Xirasagar (1990) describe the following characteristics of tribal societies which are strengths of their way of life: a sense of community; social cohesiveness; and sharing among members of the tribe. Most tribes have a tradition of owning, as a whole, the productive assets of the community such as land. The tribal societies show little factionalism within the tribe. Another characteristic of the tribal community is that it is simple minded, straight forward, and trusting and therefore amenable to suggestions and programs for both health and development but also economic exploitation.

Sahni & Xirasagar (1990) propose that negative aspects of the tribal culture

include their lack of personal hygiene which leads to health problems; a lack of future planning or enterprising spirit to improve their circumstances; and a reluctance to mix or exchange ideas with non-tribal populations.

#### 2.4.2 Tribal Women

There are two opposing views with regard to the status of women in tribal communities in India. Some scholars feel that women in primitive societies are generally assigned a higher status (Singh, Vyas, & Mann, 1988). On the other hand, some suggest that women are a depressed group, having low status and are oppressed under male dominance (Raju, 1988). According to Choudhury (1978), “[i]n the strongly patrilineal Indian society, women in general occupy a position lower than that of men in all spheres of life, exceptions are in child-rearing and home-management: their role and status are subservient to that of men”(p.9). Singh et al.(1988), suggest that the status of tribal women is better than that of their neighbouring non-tribal women, since there is a more favourable sex ratio, no bride burning, high participation in economic activities, and low infant mortality. Sahni & Xirasagar (1990) suggest that tribal women are usually equal, or more than equal, in their participation in economic activities. However, the tribal societies are patriarchal overall and therefore decisions are made by men. Women cannot inherit property or cultivation rights of land.

Tribal women’s roles, position, rights, and privileges may vary with the nature of

the tribal community (Singh et al., 1988). Tribal women are gaining wider involvement in diverse kinds of activities and have become essential in all programs of change and development. It has also been documented that, in some Indian tribes, women enjoy a greater amount of freedom within their community than their rural counterparts.

Literature on the economic status of tribal women suggests that women in primitive societies perform almost as numerous and as varied tasks as the men (Mamoria, 1969). Family responsibility forces women to take on work in order to contribute to the economic status of their families. The Rajgond tribe, similar to the Soliga tribe, is described by Raju (1988) as being dependent on forest produce, collecting honey, wood, bamboo, and gathering several varieties of fruits, roots, and tubers, seeds, yams, and mushrooms. In the Rajgond community, women are substantial contributors towards agricultural tasks. Due to women's active roles as worker, both outside and inside the home, disability may have a significant impact on a family economically by removing the woman from the labour market in order to be a caregiver.

The government of India has recognized the lack of knowledge pertaining to tribal women's issues and has dedicated a plan to concentrate on several areas of development including health, nutrition, and family welfare (Oza, 1988). This government program proposes to involve tribal women in the provision of community health services.

### 2.4.3 Tribal Health

There is agreement among several authors that the health of tribal people of India has been neglected and they suffer from a high incidence of ill-health and disease (Sachchidananda, 1994; Singh, 1994; M.N. Chaudhuri 1994; Sahni & Xirasagar, 1990). Sachchidananda (1994) feels that attention to tribal health has been inadequate and he suggests three reasons for this: first, there is a general belief that living close to nature, the tribal people enjoy an environment conducive to good health; second, the tribal people are seen as not amenable to modern medical practices, since they continue to depend on their supernatural cures; third, the terrain which they occupy is difficult to reach, causing health-service accessibility to be difficult.

Singh (1994) states that “overall, an average Indian’s health is inferior to his Western and many Asian counterparts. The health of the average present-day tribal is poorer (p. 54).” M.N. Chaudhuri (1994) describes the tribal people of India as not very knowledgeable about sanitation or hygiene, maternal and child health care, vaccination, immunization, and drug-therapies. He portrays them as having various types of nutritional deficiencies, with a range of genetic disorders because of various haemoglobinal and related abnormalities. Water-borne diseases abound with the shrinking of available clean drinking-water sources. Skin and intestinal diseases, diarrhoea, dysentery, cholera, and tapeworm are common. Malnutrition has intensified the incidence of tuberculosis, anaemia, and blindness. This dismal picture of tribal health

is thought to be compounded on one hand by the displacement of the tribals from their heartland, and on the other by the disappearance of forests and by the destruction of their physical environment.

Singh (1994) suggests that it is important to recognize tribal health as a product of a complex inter-play of several forces: (a) physical environment; (b) socio-economic state; (c) nutritional availability and dietary habits; (d) psycho-social culture; (e) health culture and health-related behaviour; (f) mortality and morbidity patterns; (g) genetic disease and disorders; (h) therapeutic systems in vogue; and (i) health delivery system.

According to the results of a seminar held in Mysore, India during May, 1990 on the "Health of the Tribal People." it was determined that there were health problems common to all groups of tribal people regardless of the influence of development around them (Sahni & Xirasagar, 1990). Similar health factors were: a marked lack of health and medical services; a high degree of inbreeding and therefore high prevalence of genetically inherited diseases; a high prevalence of goitre, particularly among women of child bearing age; cultural taboos resulting in greater maternal malnutrition and anaemia; gastrointestinal disorders, particularly dysentery and parasitic infestations; cancer of the cervix which is a major problem in some tribes; a high prevalence of fluorosis in those tribes living by large dams; and recent transmission of leprosy in a few tribes, such as the Soliga of Mysore.

Singh (1994) strongly agrees that the tribals are "the most exploited, most

neglected and most disease vulnerable with a high degree of malnutrition, morbidity and mortality. They are the people who need health care the most. Their misery is compounded by their poverty, ignorance of causes of disease and a hostile environment”(pp. 54–55).

The literature pertaining to tribal women’s role in health care is meagre, although examples of women’s care giving and shamanistic practices can be found. Verrier Elwin (1958) provides a descriptive portrayal of a tribal woman tending devotedly to her leper husband’s open sores. Elwin describes tribal women as custodians of black magic and possessing unrivalled knowledge of herbs and plants. The Soliga tribal women are intimately involved in their role as dais (traditional birth attendants) in the delivery of children. They have insisted on a position of squatting while giving birth, where the woman’s comfort takes precedence over the convenience of the attending doctor (Somasundram and Kibe, 1990). In the Rajgond tribe, a possessed women in a tribal society may be viewed as having spiritual powers. Health programs in Indochina have recognized that the success of community health programs are believed to depend largely on women’s groups (Ratnaike and Chinner, 1992). Women traditionally raise children and care for ill and disabled family members. As the primary caregiver, women have unique contributions to the health of a society.

#### 2.4.4 Influencing Factors on Health Behaviour

Swain (1994) perceives health and disease as a continuous process interlinked with the health-seeking behaviour of the community. And Basu writes that “[s]ince the concept of health occupies different meaning in different social systems, the health seeking behaviour of a community cannot be studied in isolation from the social network of a community as it is deeply interwoven into every event of social, economical and biological aspects of a population. (1994, p. 336).” Zola (1964), Mechanic (1978), and Rosenstock (1960) each have identified a number of variables to health-seeking behaviour in general. Some of the common variables are lifestyle of the person, the seriousness of the condition, the tolerance threshold of the patient, the frequency of recurrence, the financial demand, availability of treatment resources, and above all the cultural pattern of the community. Swain (1994) also suggests that the acquisition of health knowledge depends on family members, especially parents which then also depends on socio-economic, cultural, and educational backgrounds.

The following studies represent two different tribal health systems. The first tribal group does not use modern medicine due to their beliefs, and the other tribe uses it but only as a last resort. In the first case, Basu, Jindal, and Kshatriya (1994) studied the tribals in Bastar district in the State of Madhya Pradesh, India, and found that nutrition, living conditions, sanitation and hygiene, fertility, mortality, and morbidity patterns have had profound effects on the health-seeking behaviour of the tribal population groups

studied. It was observed that the tribal people had firm, rigid and well-developed systems of primitive medicine, and there was difficulty in persuading them to avail themselves of modern medical treatment. These tribal people believed that a disease is always caused by hostile spirits, ghosts, or breach of some taboo, therefore, they seek remedies through magico-religious practices to propitiate the supernatural powers. Herbal medicines were their next course of action and were obtained through local people. These tribal populations also used *ayurvedic* medicine along with the traditional indigenous systems of medicine. *Ayurveda* is the ancient Indian medical science and is a complete and whole system of diet, health, life, longevity, acceptance, and enlightenment (Chuahan, 1996).

The second study of the Kutia tribe of the Phulbani District, State of Orissa, India, determined that the tribals of this area believed that the cause of death and disease was primarily due to the wrath of their particular God. They did, however, have an indigenous system of health care which was based on the use of wild herbs obtained from the forest. This tribe considered modern medicine to be the last resort for seeking medical care. The study revealed that reasons for a very low utilization of health care were: the distant location of facilities; rough, hilly terrain; poor economic conditions and non-availability of medicines even in the health care facilities; as well as loss of time for activities related to livelihood and survival (Basu et al., 1994).

Sahni and Xirasagar (1990) describe aspects of tribal health culture which might influence the nature and strategies of health programs for tribal populations. They suggest

that beliefs in supernatural forces as the cause of disease and health are prevalent in almost all tribal groups. They also recommend that modern services be made more acceptable by integrating the traditional system with the modern system of medicine. Another factor in tribal health culture are maternal and child health practices. The tribal birth attendants have skills in delivering babies, which is an important feature of their health practice. A third factor influencing tribal health is that almost all tribes have poor personal hygiene and very little concept of cleanliness. A fourth factor is the impact of tribals' housing and living habits on health. For example, wood fires in poorly ventilated huts result in a high incidence of respiratory diseases and deaths due to pneumonia. Fifth, inbreeding among the tribals may aggravate the problem of genetically carried diseases. Lastly, the prevalence of traditional medicines influences the implementation of health programs for tribal people.

## **2.5 Summary**

In summary, it is shown in the literature reviewed that it is essential to determine and understand culturally bound health behaviours within the tribal community prior to program implementation. Women, as identified, are the natural caregivers of a community and therefore were critical sources of information for this study. The literature supports the study objectives which are: to describe the indigenous health behaviours and rituals of the Soliga tribal people; to provide an understanding of the

existing health care practices, including the tribal peoples use of health services: to describe the women's role within the family and her role in health care; and to provide a description of her interactions and knowledge of disability. This information was gathered to contribute to the planning of a suitable program of rehabilitation for the Soliga people. A qualitative methodology for this study is appropriate and effective for collecting culturally sensitive, descriptive data.

## CHAPTER THREE

### SETTING

#### 3.1 Soliga Tribe of India

The original inhabitants of India, called the *adivasis*, may be referred to as “children of nature.” The Soliga tribe in Southern India in particular describe themselves as “children of Bamboo.”

The Soliga tribe live quietly in the hilly terrain of the Biligiri Ranga Betta (B.R. Hills) and Mahadeshwara Betta of Mysore District, Karnataka State, India. The dialect of the tribe is Soliganudi. Kannada script (the state language) is used for writing. The Soligas, prior to exposure to the dominant Hindu culture, survived by hunting and shifting cultivation which was their traditional form of agriculture for centuries. This involved selecting an area with thin tree growth, cutting down a patch of the forest and burning it. Seeds were sown into the ash, which was rich in plant nutrients. After many years the area was left to regenerate into forest and the Soligas would not return to the same place for 50 to 70 years (Anubhav, 1991). This form of shifting cultivation apparently does not cause deforestation. In a survey of 60 Soliga settlements where shifting cultivation was practised, there was an exuberant growth of forest with a variety of species. By the 1950s in B.R. Hills, there was an introduction of new forest regulations and traditional tribal lands were declared reserved forests. This policy forced the Soligas to discontinue their practice of shifting cultivation, hunting, harvesting minor forest

produce, and collecting of tubers and roots. In a few decades, the Soligas lost access to the forests for their minimal requirements of nutritive food and shelter, and entered into economic and social hardship. The literacy rate of the Soliga population in 1980 was only 3%, and prevalence of malnutrition among children was close to 50%. These figures have changed for the better since the inception of health and education programs which began in 1980 (to be described in 3.2). The health status of the Soliga tribe is described in Table 1, listing health indicators in 1980, in 1990, and in comparison to the local Indian population.

**Table 1**

**Soliga Tribe Health Statistics**

	1980-81	1990	Karnataka State 1987-90
Infant Mortality	145/1000	28/1000	75/1000
Child Mortality	N/A	24/1000	61/1000
Crude Death Rate	14/1000	3.5/1000	8.7/1000
Maternal Mortality Rate	5/1000	1/1000	5/1000
Normal Nutritional Status	40%	90%	N/A
III Degree Malnutrition	20%	4%	N/A

Present day Soliga tribal livelihood depends on agriculture, and subsistence on minor forest produce like honey, tubers, fruits, and small game. *Ragi*, a grain, is the major crop cultivated, as well as maize.

As with many aspects of the Soliga lifestyle, dress is simple. Men wear a small *jotra* (cloth from waist down to knees) and a shirt, while women wear *sarees* of forest hues and like to dress up with bangles and forest flowers.

The cultural identity of the Soliga is community oriented and includes ideals of sharing and simplicity (Somasundram and Kibe, 1990). The people believe in numerous

nature gods and goddesses and strongly identify with nature. The Soliga society is caste free, and their attitudes towards sex and interpersonal relationships are liberal compared with some non-tribal societies in India, where divorce and remarriage are not permitted.

The researcher has visited several of the tribal *podus* or villages. Many are set deep in the forest surrounded by lush vegetation and beautiful hills. The Soliga *podu* is enveloped by bamboo, dense thickets, and tall trees and is situated far from civilization. Sturdy, simple and protective huts are made with the use of mud, bamboo, dried grass, and tree bark. Each *podu* is protected by an outlook which is placed high in a tree where a man can keep guard in the night, protecting the settlement from wild animals. The setting is truly majestic, and it is easy to understand why the Soligas would not want to leave their lands.

A 4x4 jeep is required to get to some of the tribal *podus* situated in the B.R. Hills area and, even so, part of the road or path is impassable and must be walked. Since this is a reserved forest, there is minimal traffic on the road because the forest is closed off by barriers and a guard restricting entrance. A local bus is allowed through the area during the day time and links the area to the two closest towns.

During the day, many children can be observed in the *podus*. Some older children are dirty and scantily dressed in ripped clothing, even during cooler winter climate. Infants crawl or walk around naked with perhaps a tattered T-shirt, even in colder winter weather. Women openly breast feed children of one year of age, while squatting on the

ground next to visitors. During the day, some mothers and grandmothers take care of young children with the help of older female children. The women perform household chores such as preparing food, grinding *Ragi*, washing clothing, collecting wood, etc.. Men generally are away at work for the day. Some men work at a nearby coffee plantation, some perform other farm/agricultural work or work for daily wages. Many of the Soliga women also work either in the fields nearby or the coffee plantation.

### **3.2 Vivekananda Girijana Kalyana Kendra**

A unique community development project operates in close proximity to the Soliga. In 1979, Dr. Sudarshan, a medical doctor, came to B.R. Hills to provide medical service to the Soliga tribal people. Vivekananda Girijana Kalyana Kendra (VGKK) was established in 1981 with the sole aim of steering the Soliga people away from subservience. VGKK is a non-sectarian humanitarian organization dedicated to the ideal of "Service of God in Man." The project covers an approximate radius of 60 kilometres and serves a tribal population of 20 000 persons (Anubhav, 1991). Originally the objective of the organization was curative health, however, the project founder, Dr. Sudarshan, soon discovered that the most acute problems were poverty and lack of a means of livelihood. The objectives of the program were then changed to encompass community health and community development. VGKK helped establish rapport with the tribal people, and the Soliga became active participants in the VGKK organization. Over

time, VGKK established a unique model of health care provision, incorporating both western medicine practices as well as traditional medicine beliefs and practices.

VGKK consists of a tribal health centre with both in- and out-patient facilities, a tribal school, a hostel for tribal children attending the school, a vocational training centre for the tribal people, administrative offices, prayer hall, mess hall, library, dairy, and staff houses. VGKK is isolated from the rest of the world, as the closest town is 24 kilometres away.

The hospital or health centre is staffed with two full-time physicians. Up to three residents from local colleges, called “house” surgeons, may be present at any time throughout the year. The clinic is open daily to out-patients who come either by walking or by local bus. The doctor in the clinic assesses the patients and prescribes the appropriate treatment. The facility also includes a ten-bed hospital, which is overseen by the physicians and a health worker who may administer medications.

### 3.2.1 Outreach Program

The health centre coordinates an outreach program, whereby community health workers, made up of both tribal and non-tribal women, go out into the tribal *podus* to provide health instruction to ill people. When accompanied by the mobile health unit, a resident or physician may provide medications to people in their *podu*. The mobile health unit visits all the *podus* on a rotating basis so that people who do not have an opportunity

to come to the health clinic may be seen in their home. The community health workers are trained to identify problems and they provide the tribal people with ideas for managing the problems, such as visiting the physician, or providing education with regards to hygiene and diet.

During one visit to a tribal *podu* with the medical outreach team, the community health workers were observed registering children in a nation-wide health program for the eradication of polio. The community health workers' role was to register all the tribal children under a certain age and inform the parents or guardians about the polio program. When parents were present in the *podu*, it was more difficult to get the names of the children since the women and children stayed in their huts. With explanations made by the community health worker and a tribal youth who was a part of the medical team, the women were encouraged to come out with all of their children. The community health workers then provided orally administered polio drops to all the registered children. The role of the community health worker also involved documenting health information pertaining to the tribal people. By interacting with the people in their *podus*, they attempted to link modern medical practices to the local people's level of education and language.

### 3.2.2 School Program

Another program at VGKK is the primary school for tribal children and the

adjacent hostel for some of the children attending the school. This program receives funding from outside international sources. It is managed and run by teachers who are primarily non-tribal. The children attend a full day program which includes daily meals provided by the kitchen. Prayers take place regularly in the prayer hall. The school is set up to teach the regular school curriculum, however, changes have been made to the program to include items that are more in keeping with the tribal children's way of life. Older youths stay at the VGKK hostel, which is adjacent to the school. The children may stay at this hostel once they reach the age of ten; 10–12 children live in a dormitory room with bunk beds. Adjacent to this room is a teacher's room and the rooms are kept very clean. All the children and most school staff eat together at the mess hall, where they sit cross legged on the floor on straw mats and eat with their right hand. Young boys come around with food and ladle it onto aluminum dishes in front of each child. Meals consist of rice and *sambar* (curry) followed by rice with curds, or on some days, *ragi* balls. Prior to the meal the younger children sing loudly and then in preparation for the meal they sing a prayer together. A short prayer is also said at the end of the meal after which children wash their plate and hands. Shoes, left outside by the front door, are not worn in the mess. The children appear very happy and content.

### **3.3 Plan for Community Based Rehabilitation**

In conjunction with ActionAid India, Karuna Trust a non-governmental

organization associated with VGKK, intends to implement a rehabilitation program servicing all persons with disabilities who need such assistance in the Yelandur District. This project will include the Soliga people living in B.R. Hills. The project aims to provide equal opportunities to disabled people and to promote and protect their human rights. The ultimate goal is total integration of people with disabilities into the societal mainstream. The proposed objectives of this program are as follows (ActionAid, 1996):

1. to provide rehabilitation to those in need in the Yelandur Taluk;
2. to ensure community participation through awareness building in order to transfer ownership of the program to the community at a later date;
3. to promote maximal utilization of all available resources in the community for the development of disabled people in the community;
4. to promote the following interventions: health and medical rehabilitation, education, economic rehabilitation, community awareness building, prevention and nutrition programs, and community organisation;
5. to select and train local youths from the community to provide rehabilitation services and to create infrastructure in the community;
6. to prevent disability through primary, secondary, and tertiary prevention programs, and to reduce the incidence of preventable disability; and,
7. to provide a system of referral services to all those who require them at the district headquarters and other special institutions nearby.

This proposed CBR program assimilates the Soliga tribe with the rural population living in the Yelandur Taluk. Preparatory activities for the project have been initiated, including a house to house survey, needs assessment, and a community profile study as well as a knowledge, attitude, and practice study of disability and rehabilitation (Boyce & Patterson, 1997).

## CHAPTER FOUR

### METHODS

The challenging conditions when collecting research data in the field can be very different from those obstacles experienced by the traditional scientist working in a controlled environment (Lysack, 1992). Choosing the appropriate methodology to ensure reliability and validity of the study findings is important yet practically difficult. Cultural and religious sensitivity must be considered, otherwise the quality of data may be compromised.

The focus of this study is to describe and understand human behaviour, therefore, a qualitative method for data collection is employed. This methodology allows the women being studied to be active participants, suggesting their own areas of health interest. Qualitative methods for collecting data include non-structured interviews, participant observation, and key informant interviews. The utilization of multimethods is a deliberate strategy for overcoming the weaknesses and limitations of individual methods alone (Brewer and Hunter, 1989). The primary benefit of a multimethods approach in an exploratory study is the broad range of data it generates which increases opportunities for data comparison or triangulation (Webb, Campbell, Schwartz, & Sechrest, 1965). Brewer and Hunter (1989, p. 17) suggest that, “[t]riangulation measurement tries to pinpoint the values of a phenomena more accurately by sighting in

on it from different methodological viewpoints.” This study attempted to obtain multiple types of data from different sources to make the findings more trustworthy. In order to establish accuracy and trustworthiness of the qualitative data, Guba & Lincoln’s (1981) criteria of rigor including, truth value, applicability, consistency, and neutrality were considered throughout the research process by using different strategies. See Table 2 for a summary of strategies used.

**Table 2**  
**Summary of Strategies Used to Establish Trustworthiness**  
**(Adapted from Guba & Lincoln [1981] and Mulholland [1996] )**

<b>Criteria</b>	<b>Strategy</b>	<b>Technique Used in This Study</b>
<b>Truth Value</b> (internal validity or credibility)	Triangulation  Close monitoring of responses Reflexivity Peer Review	multiple data collection methods multiple data sources  field journal, daily review of transcripts  field journal Supervisor review & ActionAid & VGKK partners reviewed questions
<b>Applicability</b> (external validity/ generalizability or fittingness)	Thick description	field journal
<b>Consistency</b> (reliability or auditability)	Dependability Audit Dense description of research methods Triangulation Peer Review	Supervisor examined analysis process  field journal & thesis  see above see above
<b>Neutrality</b> (objectivity or conformability)	Triangulation Reflexivity	see above see above

This research study received approval from the Queen's University Faculty of Medicine Ethics Review Board. Non-structured interview questions (Appendix A) were developed by the researcher based on information gathered from a review of the literature

and clinical occupational therapy experience. Interview questions consisted of open-ended questions pertaining to the study objectives. Prior to the field research, the primary investigator asked a panel of experts to review the methods and, specifically, the proposed interview questions. The experts included individuals in Canada who are familiar with the conduct of research in India, research with women, and research with tribal people. This panel included an Indian national studying in Canada who had conducted research in India, and faculty members from Queen's University who had conducted research in India, two of whom were familiar with Indian tribal issues. Graduates of the Masters in rehabilitation program who had conducted similar research in India were also consulted. This panel provided suggestions for refining the data collection process to be as effective and reliable as possible. Revisions to methodology and instrument were made in Canada and then again reviewed with a selected group of knowledgeable advisors from ActionAid India and VGKK. These advisors consisted of the ActionAid CBR program coordinator for the Yelandur Taluk program and the director of VGKK.

#### **4.1 Field Arrangements**

Arrangements for the research were made from Canada with the assistance of partners in India including ActionAid India and VGKK. They ensured accommodations

were arranged prior to the researcher's arrival and appropriate support staff were available to assist in initiating the research process. The researcher lived in accommodations adjacent to the VGKK hospital and clinic. Living close to where the women worked and lived facilitated cultural sensitivity and allowed for informal observation of the tribal people. The researcher spent a total of approximately two months in the VGKK health centre collecting data from women who worked in the complex, visited the health centre, or lived in nearby *podus*. The researcher was always accompanied by a translator during data collection. A field journal documenting research related issues was kept throughout the stay to address issues of trustworthiness.

#### **4.2 Interview Process**

The researcher spent the initial week meeting with physicians, community health workers, program coordinators, translators, and other VGKK staff. During these meetings the researcher provided a written description of the study and interview questions related to the study objectives (Appendices A–C). The qualitative methods were reviewed and then personnel were asked to recruit Soliga women of all ages who were willing to participate.

#### 4.2.1 Sampling

The population for this study was purposive, including any Soliga woman who came to the B.R. hills health centre, worked somewhere in the VGKK complex, or Soliga women in neighbouring hamlets. Exclusion criteria included women who were too sick to participate. There were no specific criteria for the key informants who were chosen on the basis of their leadership and knowledge of the tribal community.

Women participants in the study were recruited by three different means; the first was through in- and out-patient clinics at the health centre; the second was through the VGKK vocational centre; and the third group of women were recruited in their *podus*.

Some women were recruited from the local vocational centre, where they worked daily. The vocational training centre included the trades of tailoring, knitting, and food processing. Women in both the health centre and the vocational centre were approached by VGKK staff or the translator. The staff would briefly explain the objectives of the study and ask if the woman was willing to answer some questions. The translators were familiar with the information/consent form (Appendix C) and used this as a basis for explaining the study.

Visits to *podus* were done on a convenience basis. The researcher was dependent on a translator/guide to take her there, as well as to facilitate the selection of women and the location and timing of each interview. If there was a woman free and willing to

participate, the woman would then be interviewed. Many beliefs and customs were observed by the researcher, such as, tribal people not inviting outsiders into their homes unless they are accompanied by a well-known person. Generally, they believe that outsiders contaminate their shrine, their home. They also do not permit any shoes in the home, especially ones made of leather.

#### 4.2.2 Data Collection

Data collection began with the researcher familiarizing herself with the local setting and by attending morning hospital rounds to observe women in the VGKK health facility. Once a woman agreed to be interviewed, a setting in which the interview would be conducted was found. The interviews took place the same day in an informal environment allowing the participant to feel at ease and to encourage openness of communication. At times interviews were conducted near the woman's hut in her tribal *podu*. During these instances the interview was conducted with many people present. Often in the tribal *podu* men, women, and children stood around during the interview, and at times they participated by directly answering questions.

The researcher chose to obtain only verbal consent from the participants since it was unfamiliar for these often illiterate women to sign a consent form (Appendix C). The researcher wanted to gain the confidence and comfort of the women in order to encourage

full, honest answers, and signing a formal paper would have inhibited the natural process of qualitative interviewing. Signing the consent form was deemed inappropriate in these circumstances.

The researcher generally initiated the interview with questions pertaining to demographic information (Appendix B) such as age, family make up, education, location of *podu*, and so on. Following these questions a rapport was established, the women appeared to be more relaxed and comfortable and then the non-structured part of the interview proceeded. Depending on the participants' answers, questions were directed to seek further information about a particular area, or the participant was probed for information in a different area related to the objectives of the study.

All interviews were tape recorded with the permission of the participant. None of the women expressed any concern with regards to being recorded. Tape recording allowed the investigator to review interviews with the translator at a later time. Handwritten notes were also taken by the investigator throughout the interview, noting any body language or questions. Following the interview, responses were reviewed with the translator to ensure proper interpretation. When the researcher was able, a second interview was conducted to seek clarification or further details about a specific area of interest. Second interviews were difficult to obtain partially due to lack of sufficient translator services, and partially due to difficulty locating the women. Different techniques were used to strengthen the data. First, the provision of the translators'

experienced interpretations about the less tangible aspects of the data collection allowed for increased trustworthiness. Second, the translators comments of the quality of the interview and of the circumstances surrounding the interaction were recorded and reviewed in the data analysis. Last, the transcribed interviews with the key informants were either returned to the respective informant or reviewed with them for a rechecking of content, which provided more assurance of the data's accuracy.

All interviews were transcribed using a laptop computer. The transcripts were reviewed with the original translator and, when a second translator was available, a second review was conducted. The data collected consisted of 16 interviews with women and 6 interviews with key informants. Each interview, when transcribed, ranged from 3 to 12 typed pages in length.

Participant observation was also used to describe the setting, situations, or people and to ensure trustworthiness of the data. The researcher spent several hours every day observing individuals at the health centre and in the community throughout the two-month period. The researcher was permitted to sit in the health centre in-patient clinic and observe as people came to the physicians. The physicians would often translate the patient's complaints into English and the researcher was able to ask the physicians general questions pertaining to the patient's health complaint. The observations focused on the context as well as health behaviours within the health centre and tribal *podus*. The researcher was looking for visible differences in behaviours between the health centre and

the hamlet, such as, verbalization, mannerisms, body language, and level of confidence. The researcher was able to interact on a daily basis with members of the community being studied.

Key informants were chosen based on their level of involvement in the tribal community and their knowledge of tribal issues. This was determined by the length of time they had lived and worked in the area. Key informant interviews were valuable in establishing trustworthiness of the data. The informants were able to confirm the accuracy of the data obtained from the women as well as provide additional data.

#### **4.3. Sample**

A total of 16 women were interviewed; 14 were tribal and 2 were later discovered to be non-tribal. Six key informants were also interviewed. All interviews were included in the study since even the non-tribal women provided valuable insight into health issues in the B.R. Hills area. Daily observations were made over the months of December 1996 and January 1997. Demographic data were primarily obtained from the interviews conducted with the Soliga women. The 16 women who participated in the study ranged in age from approximately 18–75 years of age (Table 3). It should be noted that, although the age of each woman was always asked, some of the women were unable to respond, indicating that they may not have had a concept of calculating age.

**Table 3**

**Participant Demographics**

Participant	Age	# of Persons in Home	Marital Status	Education	Employment
1	21	7	married	9th standard*	not known
2 (non-tribal)	30–35	5	married	no education	works in home, on family land
3	doesn't know, maybe 35–38	5	widow	no education	daily wages at coffee plantation
4	19	3	married	9th standard	works as community health worker at VGKK
5	60	4	married	no education	worker at VGKK
6	75	6	widow	no education	helps in home
7 (non-tribal)	33	2	widow	no education	worker at VGKK
8	doesn't know	8	married	no education	homemaker, agricultural work
9	mid 30s	4	widow	no formal education, but attended course on delivery at Mysore	worker at VGKK
10	40	2	married	3rd standard	worker at VGKK
11	30–35	5	married	no education	worker at VGKK
12	doesn't know	5	widow	no education	worker at VGKK
13	18	5	married	3rd standard	worker at VGKK
14	doesn't know	6	married	a little bit of 1st standard	worker at VGKK

15	27	4	married	5th standard	worker at VGKK
16	doesn't know 30-40	7	married	no education	agricultural work around the home

\*standard = the Indian school system is divided into 12 standards, the highest being equivalent of high school

All of the women were either married or widowed. Nine of the sixteen women had no formal education but seven had some education, although none had attained the 12th standard. All of the women worked in their homes and nine were involved in paid employment at VGKK including working in the vocational training centre, doing pickling, or tailoring, and cleaning or kitchen work. Only one woman was working for another employer in the area.

The key informants were all actively involved in tribal issues. Four of the key informants were non-tribal and the other two were tribal.

### Description of Key Informants

Key Informant	Status and Title
1	VGKK program director
2	University-educated tribal youth activist
3	VGKK coordinator
4	Soliga Traditional Birth Attendant
5	VGKK health supervisor
6	VGKK physician

#### **4.4 Data Analysis**

The interviews yielded qualitative data which was first transcribed using a laptop computer and the assistance of the translators. A total of over 100 pages of data was generated. Non-tribal women's data was analysed separately to support the results reported for tribal women. The first level of comparison occurred as data was collected from different women, key informants, and through observation. The outcome of this triangulation of data was the formulation of discrete categories of information such as traditional medicine and western medicine for coding data. The transcripts were then coded using the discrete categories. These data were later transferred to a computer-based software for qualitative data analysis, QSR NUD•IST®. This software was used to facilitate the coding of the data so that data derived from multiple techniques, persons, and settings over an extended period of time was analysed through multiple comparisons (Schmoll, 1993). The second level of analysis involved a comparison of these categories through developing an index tree and defining nodes. Nodes were combined, collapsed, and added to suit the data. All notes, memos, and past categories were constantly reviewed, and their relationship to the new categories assessed. The categories then led to the generation of various concepts such as the influences on health behaviours. The third level of analysis involved a comparison of the concepts. Again the concepts were modified, altered, and refined to reflect the data. This constant comparative process allowed the researcher to develop an understanding of the data and to write the results

chapter. Factors affecting the health behaviours of the sample were then identified and are presented in the discussion chapter.

## **CHAPTER FIVE**

### **RESULTS**

This chapter will present the most significant study findings related to the objectives of the study. Analysis of the data led to the organization of the findings under the following categories: Soliga socio-political environment, Soliga values, health behaviours of the tribal community, the role of women in Soliga culture and women's beliefs and knowledge of disability.

#### **5.1 The Soliga Tribe Challenges**

According to key informants, the Soliga tribe faces three challenges which include external pressures on their environment, problems with assimilation, and a lack of services. The first challenge of the Soliga tribe involves their history of being semi-nomadic and living in harmony with nature. In recent years they were driven out of their traditional forest lands due to the government's creation of wildlife sanctuaries and national parks. This policy has forced Soligas to the periphery where in some areas they are totally alienated from the forest. The traditional Soliga way of life is dependent on the forest and its resources, and in return the Soliga people worship their environment, treating it with respect and reverence. Much of their traditional system of health care and livelihood stems from the naturally grown vegetation of the forest. There is an ongoing

battle with the government to allow the tribal people to remain in the forests and become partners in the forest's development.

The second challenge which Soliga face concerns their difficulties assimilating with non-tribal societies. There is often exploitation because they are very honest, well-mannered, and non-violent. The VGKK program director explains that the Soligas, who have been forced to live at the foothills or as a part of Mysore district are alienated and they have developed all sorts of health problems, such as alcoholism, because they cannot adapt to this new environment. The project coordinator of VGKK, explains that, "the tribal community has been exploited a lot, and from the earlier stages they appear to have lived a better life. Earlier they were untouched, undisturbed by others, but as days passed by there has been an intervention of non-tribal and the tribal have always been on the losing end" (K.I.#3). Another key informant, a tribal, also feels that the Soliga are easily exploited. They appear innocent, and when outsiders come they will listen and do as they are told. The instance of bad habits, such as drinking alcohol, of the Soliga people are reported to increase when in contact with non-tribal societies.

The third challenge for Soliga involves the tradition of living in remote areas. Key informants suggested that some of the problems affecting the Soliga are poor health, social welfare, poverty, social deprivation, lack of education, as well as unequal opportunities to gain access to government financial support programs. The tribal people are fighting for an increased number of reserved seats at colleges, employment, and a fair

proportion of the goods, such as agricultural equipment which are distributed by government services. On the other hand, an advantage of their remoteness is that they “have been rewarded with certain things, they have developed some sort of relaxation in the mind and lifestyles are different, therefore no hypertension” (K.I.#3).

## **5.2 Soliga Cultural Values**

Isolation has allowed the Soliga to develop strong kinship patterns and a fraternal, caste-free environment. The Soliga culture is rich in humane values such as the absence of greed and selfishness. Marriages are based on companionship and are by mutual consent, unlike prearranged marriages elsewhere in India. Divorce is not common, however, it is permitted by paying a fine to the tribal court.

The Soliga believe that God is present in nature, in the forest, and in every blade of grass. They view the forest as life and, therefore, it is supreme in their eyes. The tribal priest is respected at worship time, however, at other times he is an equal working member of society.

One tribal informant stated that the Soliga life is “very simple, utilizing the natural resources, managing without greed, simple dress, houses simple, ecologically suited...sharing is a value as well as love of nature and the environment” (K.I.#2).

Another informant supported this view stating that the Soliga have a sharing system, where they share their harvests with God and all their neighbours. He also stated that they

live a simple lifestyle. There are beliefs and superstitions, such as disability or illness will come to those who do not follow this code of conduct.

The sense of community can be seen in the Soliga tribe and can be defined as a group of people living closely together, sharing their land and resources, working together to feed themselves, and living in harmony with the environment. Community values are evident in the health care of members of the Soliga tribe. For example, the Soliga respond as a whole when someone is having a psychotic episode, and this is viewed as a community problem.

The Soliga community have their own court of law in which both men and women are equal. For example women have the right to bring a man to the court for his faults. They try to live in non-violence, dealing with differences amongst themselves through their indigenous justice system, *Nyaya*. A key informant states that there is nothing that a Soliga could do which would cause him or her to be outcast from the community. He states that the Soliga's are non-violent people who call one another names designating closeness, such as brother or sister, even if they are not relations. One woman depicts their closeness as follows: “[w]e should be like sisters and brothers to all the people. We should not quarrel. This is as sister and brothers with community....”

(S#9)

### **5.3 Health Behaviours and Rituals**

Health behaviours include the Soliga's typical practices for dealing with ill-health and the measures they take for maintaining good health. Health behaviours of the Soliga women may be influenced by a variety of factors.

Most of the behaviours described by the Soliga women relate to coping with ill-health. The behaviours will be described according to the sub-categories: (1) traditional Soliga health beliefs and behaviours; (2) diet; (3) spiritual beliefs and behaviours; and (4) modern health behaviours.

#### **5.3.1 Traditional Soliga Health Beliefs and Behaviours**

For the purposes of this study, traditional health behaviours are defined as those health practices, remedies, and treatments which the Soliga tribe perform that are not related to modern medicine. These practices are related to health but are strongly influenced by the culture of the people and the tribe's history.

#### ***Herbal Remedies***

According to several respondents, many of the Soliga tribal people continue to use herbal medicines regardless of the existence of allopathic medicine available to them. *Kai Pandita* is a term for medication which the Soliga people make using plants, trees, and herbs. This traditional herbal medication is the most commonly cited health remedy for

curing basic ailments such as coughs or colds.

One woman suggested that all tribal people have some traditional knowledge about medicinal plants which they had learned from their parents. Many of the women knew at least one basic remedy, which was usually in the form of something ingestible, such as a soup or tea. Most women stated that they knew of a concoction that they would use to treat colds, coughs, or common ailments such as headaches or stomach aches. Beyond that, the women felt they needed to consult a local specialist, or traditional healer. The women offered various home remedies which were called *kashaya* and included such recipes as, tumeric with milk, a syrup of green leaves, and a tea of garlic, ginger, and pepper. Another woman described how she would grind certain herbs and roots, mix them with spicy foods, and try to cure her children if they were suffering from coughs, colds, or common ailments. The program director stated that when he first arrived in B.R. Hills, the Soliga people were using their traditional remedies for common ailments and he agreed that these were good, effective herbal treatments. This acceptance of Soliga health practices appeared to improve their acceptance, in time, of modern medical approaches.

### ***Traditional Birthing Practices***

A traditional health practice, which was a part of all of the women's repertoire, was delivering children at home with the assistance of a *dai* (traditional birth attendant).

Soliga women usually seek the assistance of a *dai* and other women to assist them to deliver in their own home. Deliveries are performed with the woman in a squatting position and the *dai* positioned to grab the infant. In preparation for labour, the *dai* massages the woman's stomach to help position the baby for birth.

Women also seek advice about prenatal and postpartum care from the traditional birth attendant. The *dai* has beliefs pertaining to methods of determining the sex of the child prenatally. A *dai* explained that "after four months if the child is male it starts shaking the right side and if the child is female the left side" (K.I.#4). Women are given a special concoction made of coriander powder mixed with a refined sugar during the early stages of pregnancy for giddiness and nausea. The program director also described the traditional delivery practices and was supportive of these techniques stating that the Soliga have had good success, fewer caesarean sections and low infant mortality, using their traditional approach to delivery. Only in extreme, high-risk cases was a physician involved in the delivery of an infant.

### ***Seeking Traditional Expertise***

In traditional health practices, there is often a specialization, or expertise involved. In Soliga villages, a traditional health specialist knows of many cures and will advise the women of remedies. Often these remedies involved special roots, plants, and herbs that the women stated they themselves did not know. For diseases or problems which were

more severe, women commented that they would seek the advice of a specialist. A few women stated that they did not know personally any remedies, but would use any remedies suggested to them by an elder or specialist. One woman described a treatment, which was in the form of a paste, given to her by a traditional health specialist in her *podu*, for curing a skin infection. She also explained that if the problem persisted they would go to a priest's house for help.

Two women discussed a time prior to the influence of the VGKK health centre when they relied solely on the elder's knowledge of traditional remedies to treat their children. They revealed that this was their only solution for treating their infants. Several women felt the elders maintained secrets with regards to the traditional remedies. For example, one woman stated that her mother knew herbal medicines, but, was maintaining this knowledge as a secret.

While most of the women utilized home remedies for less severe ailments, some of the women felt they were forgetting the old ways and were turning more towards the new. One woman stated that her parents used medicinal plants, but now she didn't. She came to the health clinic for everything, even coughs and colds.

A key informant, a tribal youth, suggested that the traditional specialists do not give their information or techniques away, but may pass this knowledge on to their children. They are careful about conserving the rare medicinal plants and herbs in their environment and therefore do not tell everyone about them.

Overall, it was apparent that most of the women continued to use their knowledge of traditional remedies for common ailments such as coughs and colds. Most felt confident about the traditional medicines for healing basic problems, however, there were a few of the women who stated that their first course of action was to go to the hospital. A trend that emerged was that the traditional health practices focused on curing ill health, rather than preventing illness. Two women even stated that there was nothing that can be done and disease comes no matter what they do.

#### 5.3.2 Diet

The traditional diet of the Soliga is typical of the vegetation in the area. When asked about what people do to stay healthy, the most frequently cited response pertained to their diet.

#### ***Preventative Foods***

There was overall agreement by the women interviewed that good food was necessary to prevent ill health. Different foods mentioned by the women as “healthy” included: *ragi* ball, *sambar*, rice, both vegetarian and non-vegetarian foods, green vegetables, greens, honey, spicy foods, vegetables, rhizomes, and roots. One woman elaborated, stating that hygienic food was necessary to stay healthy, and referred to covering cooked food and cleaning plates. Many of the women also stated that eating

leafy greens was important to be healthy, especially during pregnancy. One of the key informants, suggested that the Soliga living in the traditional core forest areas had better nutrition because they ate wild roots and tubers, and led a healthier lifestyle.

### *Curative Foods*

Some women also replied that food was a way of taking care of the sick. Other women stated that to prevent disease and treat ailments like coughs, colds, and common stomach problems they ate more spices, such as chillies, ginger, and pepper in soup.

### 5.3.3 Spiritual Beliefs and Behaviours

Spiritually influenced health behaviours were mentioned frequently. Although people trusted in a particular doctor's treatment or followed the advice of an elder, they also supplemented this course with a spiritual treatment, perhaps believing, as one woman mentioned, that no matter what, disease will come. The Soliga's religious belief was that certain things in life are inevitable such as certain diseases and disabilities.

One woman described her belief about black magic, which could be brought on by quarrelling: when a person "has this black magic, it is not cured in this hospital, but they are to go to some God. They have to go and it gets better that way" (S#3). She differentiated the types of things the doctors at the hospital could and could not cure, based on spiritual, religious belief, or superstitions. Other tribal people present appeared

to support her statements and even gave their own comments pertaining to this idea. Another older woman suggested that if she did not like a particular person or was jealous of them, she could do some superstitious thing, like keep some medicinal plants in the name of the devil. It was felt that this would destroy the family or person and they would suffer from a bad disease. For this type of a curse, specific medicines from the forest were required. To cure the evil spirits they used the bark of a specific red-coloured plant and kept it near the affected person.

#### 5.3.4 Modern Medicine

Throughout many of the interviews, it was apparent that the Soliga tribes people have attempted to maintain many of their traditional health practices. However, all of the women had either tried some of the western remedies or had turned completely to the western methods after leaving their traditional methods behind. More than half of the women stated that they came to the hospital or health clinic for everything, while the others preferred to first use their traditional knowledge, and as a second course of action, come to the hospital or health clinic. A referral bias may have been operating, however, since the women were recruited primarily at the VGKK complex rather than in their villages.

### ***Primary Use of Modern Medicine***

A majority of the women interviewed expressed that their first course of action in dealing with illness was to use modern medicine. A young woman who was seen in the health clinic with her ten-month old baby stated, “we are not using herbal medicine, we come here only [to VGKK health clinic]” (S#1). Her husband worked as a social worker at the VGKK health centre and she has a 9th standard education. On the other end of the age spectrum, an older woman with no formal education who worked in agriculture stated that she did not use traditional remedies any longer. She stated, “Now there is doctor for that, tablets and medicines are there in the hospital. That is better” (S#16). These examples showed that among the Soliga tribe living in the B.R. Hills area, there was acceptance of newer ways. Many women were now completely accustomed to using the health centre for themselves and their families. Many of the workers at VGKK also felt the health centre was easily available and therefore used it.

These women who used only the modern medical system, may have been influenced by the non-tribal culture that existed around VGKK. Many were workers in the complex or lived close by. The chief physician felt that “the more accessible a *podu* is to a non-tribal culture, the more free is the attitude of the women in seeking medical advice” (K.I.#6). A non-tribal woman living in the B.R. Hills area who was interviewed while she was staying at the hospital for asthma treatment, stated that she came to the hospital for everything, including coughs and colds. She was also accustomed to

purchasing over-the-counter remedies, in the local shops. She also stated that she had not learned anything from the centre questioning why should she learn when there was a doctor who should know. This response differed from some of the tribal women who were younger and had some formal education. These women went predominantly to the physician, but they indicated that they were also learning about healthy foods to eat, cleanliness, and immunization. This suggested that accessibility may influence the use of modern health facilities, but educational levels also impact on learning.

### ***Modern Medicine as a Second Course of Action***

Some of the women who stated that they used traditional remedies as a first course of action indicated that they would come to the clinic for allopathic medication to treat scabies, fever, an accident related injury, disease, or pain. Thus, it appears that many of the women used the clinic depending on the severity of their condition. For example, an older worker at VGKK, stated that when her husband fell from a tree, he was treated at the hospital, and she cared for him there. Other VGKK workers with some education, stated that they used some traditional methods, but when someone was very sick they came to the hospital.

### ***Physician Rapport***

Some younger women and children approached the doctor in the VGKK clinic

hesitantly. On their second or third visits they appeared more at ease since they knew the routine and how to physically react to the doctor's commands. Many women commented that they trusted the doctors and would do as they were told. The trust in particular doctors appeared to be significant. For example, women mentioned going to the hospital to see one particular physician and if he was not there they would leave and come back another time.

### ***Preventative Measures***

One older Soliga woman mentioned preventative measures of cleanliness which were taught by the teachers at the school. This lesson was transmitted to elders through children. Another woman, who worked at VGKK and lived with non-tribal people, learned about cleanliness, diet and cooking. She also knew what a woman should do when pregnant – come to the hospital for injections. Another young woman, working as a community health worker, stated that her preventative health practices included taking check-ups at the hospital and eating good food. As a part of her job she advised mothers about immunization. It is significant to note that this woman also had a 9th standard education.

One woman portrayed an interesting example of the integration of old and new practices. This woman admitted that she used the modern health facility for herself and for her children. However, she was also a traditional birth attendant and assisted

women's deliveries as well as provided prenatal and postpartum care. She delivered infants, advised women to eat good food, and taught them about cleanliness and immunization. Although this woman did not have formal schooling, she had been sent for a training course on delivery techniques at a city hospital.

Overall it is evident that all women in this study reflected some western medicine health behaviours, such as going to the doctor and taking the treatment prescribed. The women that had more contact with non-tribals, worked in VGKK, or had greater education, indicated a greater acceptance of the modern medical system and also indicated more knowledge of preventative health behaviours, such as cleanliness and proper food. Most women interviewed were comfortable going to the health centre, and trusting in whatever treatment or advice they were given.

#### **5.4. Soliga Women's Roles**

The Soliga women were primarily responsible for looking after the home including cooking, cleaning, getting water, washing dishes and clothes, and looking after young children. All the women interviewed, except one elderly woman, also worked either in the VGKK centre or in the fields doing agricultural work. Looking after the sick was also their responsibility.

Most women did not complain about their responsibilities. Some of the Soliga women appeared to respect the role of the husband or man and felt it was their duty to

look after them as well as their children without complaint or questioning. An older VGKK worker felt that “married women give more emphasis on her husband...in the tribal community women they think that the men are hard workers and they are protecting the woman, so they obviously give them respect, they’ll even look after their daily affairs, like preparing food” (S#5).

Protection from wild animals and other dangers by the men of the community had its costs. Men served on the tribal councils making decisions for the Soliga tribal community. For this reason one key informant stated, “Soliga women are not equal to men.” He did however state that women had rights and could take a man to court. Other women felt that they were equal to their husbands. One woman stated there was no difference between the roles of men and women. Another stated that her husband supported her if she chose to go to meetings or women’s groups. One woman described her role as a Soliga woman: “as a mother, we should give better food, on time and if we don’t have anything, and even if I am hungry, I should give something to my children. As a wife we should not quarrel with each other, even if there is some disagreement or misunderstanding. We should live together even if he beats we should not go outside the house, we should not run away” (S#9). It is interesting to note that although most women did not feel unequal to the men, the non-tribal project coordinator stated that they were not equal in their status.

### **5.5. Views on Disability**

The following findings will examine the beliefs and behaviours about disability in the Soliga community. Similar to general health behaviours and practices, disability was influenced by the Soliga culture, their beliefs, values, and religion. Women often reported superstitions with regard to why children were born with a disability or why adults acquired a disability or severe illness. For example, the Soliga women believed that when a woman was pregnant and saw a solar eclipse her child would be born blind. Another common belief was that if a person was disturbed or gave trouble to innocent people, then, during birth time his or her child would be affected by disablement. Thus, the notion of a person doing wrong to a fellow tribe member was believed to cause harm both to the children and the individual. A few of the women described devils as causing the disabled to suffer. One woman described her belief that when Vidayamma, the female God, created a child, she took soil to make a doll. If there was a shortage of soil there would be disablement. Many other women felt that God created everything including disabled children.

Only two women described beliefs about the cause of disability which appeared to be influenced by the modern medical system. One woman explained that a child was born disabled because a pregnant woman did not take polio drops. Another woman felt that there was disability due to a lack of (modern) medical treatment.

Despite the prevalence of superstitious beliefs on the causes of disability, attitudes

towards disabled persons were tolerant and accepting. Disabled individuals were considered to be members of the community, and were brought to festivals, marriages, and other events. Children born with severe disabilities were cared for by the community. The project coordinator explained that despite disability, people were accepted – even leprosy patients who are often shunned elsewhere in India. The chief physician also commented that people were sympathetic and caring towards people with disability and that even the mentally disabled were accepted. One of the women stated that “the child is among all of us” (S#5).

With regard to traditional disability practices, one woman explained that her disabled brother’s leg was massaged with oil rather than taking him to the large urban hospital in Mysore, 80 kilometres away. Some women described children with some form of disability who were active in their households, helping with simple chores. However, another woman described a blind man who made his living by begging. Many of the women commented that people with disabilities did nothing to contribute to their communities.

Interestingly, disabilities were not looked on as conditions which required medical treatment. Possibly due to a lack of knowledge, they felt there was nothing that could be done. Overall, questions pertaining to disability evoked responses about causal beliefs, but few behaviours which dealt with this issue were well described. Many women stated that they knew very little about disability and therefore did not have ideas about how

people with disabilities should be cared for. This finding could be very relevant for planning a CBR program for the tribal people.

## **CHAPTER SIX**

### **DISCUSSION**

The results of this study indicate a pattern of health behaviours of the Soliga tribal women which is consistent with the existing literature pertaining to the health of tribal people in India. The results of this study are also consistent with the findings of Sahni & Xirasagar (1990) describing tribal classifications and the unique sets of health program needs these different tribal groups present. The Soliga tribe appear to best fit the second classification of tribes. This type of tribe has maintained its identity and seclusion even though it has been exposed to adverse effects of civilization such as deforestation, displacement from its original habitat, and erosion of its resource base. The Soliga tribe suffers socially and culturally from the results of a ban on shifting cultivation and other government reforms to their lands. Until the arrival of VGKK, the Soliga had high levels of malnutrition and various other health problems. The study results imply that a change in health behaviours occurred as a result of the influence of the modern medicine facilities, which were brought to the tribal area in the past decade. The integration and acceptance of a modern health care system has made an impact on the health and health practices of the tribal people in the B.R. Hills area. The findings also reveal that tribal women were more knowledgeable about measures taken to manage ill health, rather than strategies for prevention of ill health. Curative health behaviours were particularly

noticeable with the traditional health practices. Preventative measures appeared to be influenced by the provision of a modern health system and increased education.

The findings of this research indicate that health behaviour of the Soliga women is dependent on: the seriousness of the condition; the availability and accessibility of resources; the cultural pattern of the community; the educational level of the individual; and environmental influences. These identified variables influencing health behaviours are discussed in more detail in the following sections.

### **6.1 Seriousness of Medical or Health Condition**

The Soliga women described a graded approach to their dealing with ill health. Many of the women stated that first they attempted to cure a common ailment by themselves in the home with known traditional herbal remedies. The second course of action was then to go to a specialist, which in most cases was the modern health clinic. They based this decision primarily according to the seriousness of the illness. Many women specified that if it was a cough, cold, or other common ailment, they took a home remedy or would ask a traditional health specialist in the *podu* for an herbal concoction. If the person suffered from an accident or fever, however, they went directly to the modern medical facility. A key informant supported this idea, commenting that “[i]f any child or person is suffering from any disease, whether it is headache or cough, first they try the local herb, almost all common minor problems they can cure using the herbal medicine. If

it is major, if it is necessary, very urgent, they can go to the clinic nearby the hospital....” (K.I.#4). The seriousness of a condition also determined the amount of spiritual assistance sought: one elderly woman reported that if the disease was more severe they went to the priest who prayed to the God on behalf of the people.

The severity of the condition as a variable in health seeking behaviour is described in the literature by Zola (1964), Mechanic (1978) and Rosenstock (1960). Rosenstock suggests that the health behaviour is determined by the extent to which a person sees a problem as having serious consequences. Zola proposes five “timing triggers” which affect a person’s decision to seek medical advice. The first is “interpersonal crisis,” when a person calls attention to the symptoms and dwells on them. This may be the stage when simple home remedies are used. The second trigger is called “social interference,” when the symptoms threaten a valued social activity, for example, when an individual is unable to go to work. Next is the “presence of sanctioning,” when others tell the person to seek care. The fourth trigger is “perceived threat” and finally “nature and quality” of symptoms. Zola’s (1964) triggers are appropriate explanations of tribal women’s behaviour, showing that the degree of severity, level of trigger, influences their health action. This perspective supports the notion of seeking professional advice based on severity or one’s perception of severity. The Soliga women have chosen to deal with certain ailments in one way, and as the symptoms are recognized as more serious they choose to seek outside advice.

Since the Soliga women are accustomed to seeking outside help when the condition is more serious, a rehabilitation program, which services people with disabilities would likely be utilized. Disabilities caused by accidents were already being treated at the health centre.

### **6.2 Availability and Accessibility of Resources**

The Soliga health behaviours include a combination of both traditional and modern medical practices. The Soliga's tendency to use one or another health system is influenced by the availability and accessibility of both. The Soliga people living in *podus* nearby VGKK appear to have little hesitation in using the available health centre. Many of the people interviewed who worked in the VGKK centre, displayed no hesitancy and even some trust in using the western facility. Many of these people have forgotten the traditional health practices or rely on traditional home remedies only for dealing with simple ailments.

Most of the women interviewed at the health centre were from the neighbouring area of approximately a three kilometre radius. This accessibility to the western system of health care provided them with an alternative to traditional health care techniques. One woman stated that when she had a leg infection it was too painful to walk to the health centre so she took the advice of local elders. Once the leg healed a little and she was able to walk, she then went to VGKK. This suggests that the accessibility of a particular

service is key to determining the behaviour with regards to coping with ill health. When people have access to the modern health centre, they choose to use this facility. However, when access is more difficult, they may resort to a local specialist who is more convenient.

A study described by Basu et al. (1994) of the Kutia tribe of Orissa, suggests that due to a lack of accessibility there was low utilization of a modern facility. B. Chaudhuri (1994) agrees that the reason for tribal people not using certain modern facilities is due to a lack of close facilities. Swain (1994, p. 23) also states that “ the Western system of medicine, when available, was accepted and the magico-religious system did not come in conflict with Western system.”

These findings suggest that a community based rehabilitation service, which would be accessible to the Soliga tribe, would be utilized. If the necessary steps have been taken to ensure cultural sensitivity, and if there is an understanding of the typical health behaviours of the people, a community based service should be accepted. The Soliga are accustomed to having a modern medical system available to them, and it may therefore be easier to integrate further community health practices. Since CBR is designed to be accessible and culturally sensitive, it has the potential to be easily integrated with existing health services.

### **6.3 Cultural Patterns of the Community and Individual**

The role of culture is described extensively in the literature as a significant feature of tribal life impacting on health and health behaviours (Sahni & Xirasagar, 1990; B.Chaudhuri, 1994; Singh, 1994; Mechanic, 1978).

A discussion of cultural influences on health behaviour will be divided into three areas focusing on the tribal use of traditional and modern health practices, the Soliga dependence on expertise, and spirituality.

#### **6.3.1 Integration of Traditional and Modern Culture**

The integration of two systems, traditional and modern, is described by the women and key informants as a mechanism of coping with ill health. The Soligas believe in their own nature Gods. They have their own explanations for disease and disability usually involving curses and superstition. These traditional beliefs and rituals are a part of the Soliga way of life. The modern medical facility in the B.R. Hills accepted their need for superstition by respecting “the wisdom of the people”, and thus the founder was able to establish a trust. This involved respecting and accepting the cultural uniqueness and spirituality of the people. The founder of VGKK supported the concept of not promoting too much western medicine but rather trying to reduce the quick administration of allopathic medicines. The success of VGKK indicated that continuance of the traditional system integrated with a modern medicine structure is compatible.

As indicated in the literature, it is now uncommon to find traditional societies which have been completely isolated and sheltered from the influences of a modern approach to health care. This integration of traditional and modern systems into the Soliga culture is similar to other tribes of India. Swain (1994) and Chaudhuri (1994), describe how some tribal groups have kept their traditional values, beliefs, and rituals, however, they have also taken advantage of the modern techniques and expertise offered by the modern system. Swain (1994) found that some tribals practised their traditional system along with a western system “during epidemics, animal sacrifice, prayer” (p. 19).

The implication for a new community based program is positive. The Soliga people have adapted to newer ways and may therefore be accustomed to the influences of unfamiliar perspectives and ideas. The community based services intended for the B.R. Hills area, which provides a holistically integrated approach, may therefore lend itself well to the cultural patterns of the area. In particular, the Soliga people’s strong community values may be utilized to strengthen a health program such as CBR.

### 6.3.2 Expertise

The traditional Soliga pattern with regards to health care has included a hierarchical approach with a specialist at the head, providing treatment and advice to his followers. In this vertical model, those with specific knowledge, such as the traditional birth attendant, traditional healer, bone setter, or priest are considered to be health experts. Since the modern

medical system is structured in this manner, there has been an easy acceptance into the Soliga cultural scheme.

The results of this study reveal that in both traditional and modern health behaviours, the Soliga people chose to go to a specialist for their expertise. B.Chaudhuri (1994) also found that “among the tribal groups, there are a group of specialists – the priest and/or magicians or medicine men whose services are sought after depending on the cause of illness”(p. 77). The Soliga women described consulting with an expert, a person more knowledgeable than themselves for medicine, health advice, or some form of treatment. There is a strong similarity between the Soliga traditional approach to health and that of the modern system in that both value experts as the knowledgeable ones in their society to whom they can turn to and trust with their health and medical needs. They rely on these people to solve their health related problems.

In Soliga traditional medical practices, women described going to someone in the village who knew the plants well. Many people expressed that they did not know the traditional medications because they were held secret by the ones who knew. There is a protection of the traditional healer’s art, separating him or her from the others. Thus, with the expertise of the healer also comes the notion of secret information which may be passed on to their children. This finding was also reported by Sinha (1994), who explains that the specialists in tribal communities pass on their traditional knowledge from generation to generation, maintaining family secrets.

The results of this study also provide evidence of women trusting specific individuals in the modern health facility. Trust and developing rapport are equally important concepts to the tribal people. Gould (1965) studied modern medicine in peasant societies in India and found that there was a great deal of meaning placed on personal relationships and social interaction. The people Gould (1965) observed did not trust or understand professionals because of their lack of socialization. It is evident that the Soliga women had socialized to outsiders and were able to develop personal relationships with particular doctors. This socialization and rapport building allowed for the successful integration of the modern health practices at VGKK.

In summary, there was an acceptance by the community and the individuals of the modern medicine techniques, and there was a trust in certain doctors. This cultural acceptance shaped the health care behaviours and could be viewed as cultural “conditioning.” Community acceptance of VGKK gave the women permission to use the modern facility freely without going against cultural or community values.

CBR is designed to involve and teach the community. It is a model where the community members are active participants and become the bearers of rehabilitation and disability knowledge. This program does not have the top down approach of a typical western health program. Due to the participatory nature of CBR, it may initially be a difficult concept for the Soliga people to accept and understand. The Soliga people are passive recipients of health, as seen in the doctor-patient relationship. The Soliga have

not shown that they are active participants in their health care, and rely on the knowledgeable ones in their society, whether traditional or modern. These findings have some serious implications in the planning of a CBR program. The CBR approach will need to be adapted to the existing patterns of health behaviour of the Soliga people, and may initially involve the designation of rehabilitation experts who can build rapport and gain the trust of the people.

### 6.3.3 Spirituality

Spirituality is another great influence on health practices of the Soliga people. The spiritual attitudes of the Soliga, influenced by their culture which is rich in religious beliefs and rituals, indicates another variable to their health behaviour. The Soliga women described a general acceptance of “the way things are” with regards to disability and health, stating they felt there was little they could do because it was the will of God. This spiritual belief impacts on their coping and management of certain diseases and disabilities, and may also explain why many of the women had very little knowledge of preventative measures to avoid ill health. They did very little to prevent illnesses, other than know that they should try to eat good food. Supporting the spiritual role in the Soliga society appears to be one method of achieving successful integration of health care systems. The Soliga trust the doctors to a certain extent, however, their strong spiritual beliefs and traditions are still there and need to be acknowledged and allowed. As the

project director of VGKK states, “the priests have an important role we have seen in terminal cases. We will ask the priest also to come. There is tremendous value.”

In some areas under the impact of modern civilization, the indigenous system is becoming extinct though the magico-religious system is persisting (Swain, 1994). Mahapatra (1994) discusses health in tribal people being affected not only by the spirit but also by persons emanating evil or mystical powers. Spirituality is an obvious element in dealing with ill health, however, Mahapatra also suggests that tribal people very clearly believe in physical factors producing better health. Gould (1965), concluded that ‘rustic pragmatism’, where the people resort to whatever system of medicine is available and seems valuable, is a valuable pathway to the acceptance of modern health approaches. He explained that this was a more successful mechanism for integration than a program with the goal of transforming thoughts or beliefs concerning sickness and disability. This acceptance of spiritual beliefs and ideas about illness or disability may need to be incorporated into CBR program. Although education in new concepts is a goal, acceptance and integration of the people’s beliefs also needs to occur.

#### **6.4 Environmental and Political Influences**

According to Margaret Mead (1954), important characteristics of tribal life are physical isolation and self-reliance, based on ecological adjustment to the environment. Lately, Soliga isolation is becoming less pronounced. However, the tribe does tend to

live in small homogenous groups confined to limited areas and leads a very simple life. The cultural and environmental characteristics of the Soliga people impact on their knowledge of health and thus their methods of coping and dealing with ill health. Environmental changes, such as being forced to move out of forest lands and to live and work closer to areas where non-tribals live, have had an impact both socially and culturally for these people. As a result, behaviours may continue to change with regards to health. As the Soliga people are exposed to more western practices, they may adapt some of the modern rituals and behaviours as their own. This is already seen in the VGKK health centre where Soliga women workers accept the hospital and health care with virtually no hesitation.

A healthy diet is greatly affected by the environment and changes to the Soliga's livelihood. Their access to particular healing foods is decreasing. Although most women commented that diet is important for good health, their resources are limited, and thus they have little choice in the diet they eat or serve to their children. Diet is affected by the changes to their political situation, and alienation from the forest has caused changes in their traditional healthier lifestyle, behaviours and thus brought on more health problems. M.N. Chaudhuri (1994), states that the "...dismal picture of the tribal health is thought to be compounded on one hand by the displacement of the tribals from their heartland and on the disappearance of forests and carnage of environment" ( p. 308). Assimilation of the tribal and non-tribal people has also led to problems such as alcoholism. As Swain

(1994) warns, the traditional value system solved a lot of conflicts, and in the new situation the tribal people may become more vulnerable to modern vices.

### **6.5 Education**

The results of this study indicate that the education level of the women resulted in different health behaviours. The Soliga women who had a formal education were able not only to describe curative health practices but also preventative health techniques. The influences of a western school system are changing the behaviour of the Soliga youth. Tribal people living in proximity to non-tribals may also be influenced by their ideas and knowledge of different health practices. Although very few of the women were well educated, these women were better able to verbalise preventative health measures. Swain (1994) suggests that the acquisition of health knowledge depends initially on family members, especially parents, but also depends on socio-economic, cultural, and educational background. In childhood the learning is habitual, and as the child matures he or she is further influenced by the social environment. As more Soliga children attend school where they are taught about preventative health measures such as good hygiene, the health behaviour of the generations to follow may change.

It is apparent from the results of this study that the Soliga people's health would benefit from increased education. Since a large component of community based rehabilitation focuses on providing education, there may be a significant impact on the

tribal community.

## **CHAPTER SEVEN**

### **CONCLUSION**

The purpose of this chapter is to review the study findings, to identify limitations of the study, and to explore the implications for VGKK programming and CBR planning for the tribal population.

#### **7.1 Summary**

The objective of this research was to describe the health behaviours of tribal women and thus provide insight into existing health patterns for the benefit of future health projects. The B.R. Hills area will soon be involved in an elaborate community based rehabilitation program, and the Soliga tribe will be included in this scheme. The results of this study can provide planners and health providers with greater insight and understanding into the health of the Soliga tribe.

The results of this qualitative study have outlined a number of factors which influence the health behaviours of the Soliga tribe. The findings revealed that the health of the Soliga people living in the B.R. Hills area close to the VGKK health centre are influenced by the variables of culture, accessibility and availability of resources, the seriousness of the condition, educational level of the individual, and the environment. These variables are similar to those described of other tribal groups elsewhere in India

(B.Chaudhuri, 1994; Swain, 1994; Sahni & Xirasagar, 1990)

It has been stated many times that culture has a significant impact on the health behaviours of a community. The results of this study strongly support this concept (Pokarna, 1994; Berry & Mishra, 1995; Singh, 1994). Culture influences the tribal people's decisions and everyday practices. The Soliga tribe functions as a close-knit community where their culture has a great impact on their behaviour. Due to their homogenous, isolated setting, they are still able to practise their spirituality as well as maintain their beliefs and their rituals. The Soliga continue to practise traditional health by using herbal medicines, delivering infants in the traditional way of squatting with the assistance of a birth attendant in their home, and believing in nature gods. Since the Soliga people live very close to nature, their rituals and beliefs often revolve around nature. They are people who believe in sharing everything with their neighbours. They share in the work of the *podu* and in the food they gather as a community. They help one another with looking after the children, the sick, or the disabled. This strong influence of tribal culture differentiates the Soliga tribe from other non-tribal people. Due to this different culture it is essential for planners and practitioners to acknowledge, to attempt to understand, and to ultimately respect this uniqueness.

As described in the literature, traditional and modern health care systems can and do coexist (Swain, 1994). The findings of this study suggest that this is the reality of the Soliga tribal living in the B.R. Hills area. The VGKK health centre is accessible and

available to the Soliga in this area. Therefore, they have incorporated this modern medical facility into their repertoire of health behaviours. The health behaviours described by the participants of the study indicate that both the traditional and the modern systems of health provide the women with options for managing their health. The traditional system appears to provide the women interviewed with primarily curative medicine, while the modern system provides the people with curative as well as knowledge of preventative health techniques.

The findings of this study help to explain why certain elements of the modern system are accepted while others are rejected. For example, the practice of going to a doctor fits in with the tribal culture of going to a specialist for their expertise. The tribal people are accustomed traditionally to going to a healer, birth attendant, priest, or bone setter. On the other hand, behaviours with regard to birthing have remained traditional. The birthing rituals are culturally accepted as the norm, since women are comfortable with this, and as a tribe their techniques have been successful. Therefore, the techniques are continued in the traditional manner. The Soliga women have described different uses of each system depending on the seriousness of the illness. The integration of the two medical systems is evident, in which, a careful balance of new and old ways is being practised.

Education was revealed as another important influence on the health behaviour of the participant. The study showed that the women who had a formal education were more

likely to know more about preventative health measures which were learned either at school, through the doctors at the VGKK clinic, or from non-tribal people. This group of women tended to also work within the VGKK complex and were tending to use the modern medical facility more readily than traditional home remedies or the traditional healer.

Environment was described by the key informants as a significant issue in the health behaviours of the Soliga people. The environmental changes the tribe has endured over the past few decades have caused a change in their traditional way of life, particularly their livelihood, resulting in the Soliga's diet being affected. A consequence is that they are now facing problems with assimilation, such as alcoholism.

## **7.2 Study Limitations**

The limitations of this study relate to the challenges involved in conducting short-term research in a cross-cultural context. A significant research challenge was language translation and the organization of appropriate translators for conducting qualitative research. The researcher was confronted with the first fieldwork challenge when, upon arrival at the VGKK health centre, there was no available translator. This reflected a general problem of communicating with the remote area of B.R. Hills. Since the staff at B.R. Hills was not familiar with the nature of a qualitative study, the lack of understanding created delay and technical challenges for the researcher. The staff and

people living in the area were familiar with quantitative studies including in-depth surveys of health and government-initiated surveys. Initially time was spent educating the staff as to the objectives of the study and the methods intended to be used. The process of finding and educating an appropriate translator took a few weeks. Once a regular schedule of interviewing was established, the interviews were successfully completed, audiotaped, and later reviewed with the translator.

A second limitation of the study relates to the validity and reliability of self-reported data. In self-report research, the participants are asked to report their opinions and statements about the way things are. This becomes an issue of reliability because of the instability of participant's opinions over time and across situations. Methodological rigor was used to increase the probability that this self-reported data would be reliable. As suggested by Guba and Lincoln (1981), dense description of the topic, context, and the establishment of an audit trail are ways of increasing the probability that criteria for dependability have been met. The study utilized these methodological controls for increasing the trustworthiness of the data.

Although generalizations about the topic were not a goal, it should be noted that these findings may not apply to other tribal people nor can they apply to people of the Soliga tribe living further away from the VGKK centre (greater than walking distance). The sample was purposive, including women who were at the VGKK health centre or lived in proximity. The purpose of the study was to explore health behaviours and to

generate a greater understanding of how the health centre was being used. In this regard, the research approach was appropriate to the study purpose.

It should be realized that this study was the first step to understanding the health behaviours of the Soliga tribe. This research was significant since it identified some of the influencing variables on the health behaviour of the Soliga tribe; information unavailable in literature. Further research is necessary to develop a greater understanding of the Soliga people living in even more remote areas as well as those who are integrated with non-tribal societies.

### **7.3 Implications**

After conducting several interviews and meeting with various different key figures in the VGKK centre as well as living in the surroundings for two months, the researcher feels she has a greater understanding of the tribal culture. As an outsider, I would never be able to understand fully the culture nor could I communicate completely with the people, which placed a barrier to gaining greater insight. Even so, through observation, interviews, and participation in activities as well as everyday life events, a richer more meaningful picture was able to be painted. The tribal women are very innocent; they are welcoming, eager, and at times appear timid and immature. A system of honesty and trust appears to prevail: I have felt completely safe in this area. The vulnerability of the tribal people is apparent. They are interested in seeing a foreigner and

are eager to receive a special treat, however, they do not ask, or beg for anything. It is with these understandings that the following implications for further health planning and research are made.

It is well documented that in order to carry out health programs with tribal people it is necessary for the practitioners and planners to have knowledge about the culture (B.Chaudhuri, 1994). Therefore, in preparation for the CBR program, non-tribal planners and practitioners need to be taught, exposed, and made aware of the unique culture of the Soliga people. This will be essential in the successful inception of a program which is usually implemented in non-tribal areas. As Parry (1984) suggests, from an anthropological perspective, health workers must learn the emic or insider's perspective. They must learn the patient's definitions and view of the world. Knowledge of the tribal beliefs and values could be added to the training of CBR workers. Information with regard to cultural beliefs, rituals, and spiritual practices should be provided by tribal people for the non-tribal practitioners and planners. Respect for the tribal way of life needs to be initiated through planning interventions. Fortunately, CBR is meant to adapt a culturally sensitive approach to the provision of health services. This component of the community based program will be valuable in ensuring its success with a tribal population.

Although CBR is a program meant to integrate community values and ideals, it is necessary for the planners and implementers of any modern health programs to consider

assimilation difficulties. It has been often noted that tribal values are lost due to the influences of modern ideas of non-tribal societies. As Swain (1994) warns, a vacuum is created where old ways are lost due to the tribal people being more vulnerable to newer vices. This is an important consideration for planning in a tribal area. Planners must be aware of what influences, both positive and negative, are being brought to the tribal people.

The findings of this study indicate that the Soliga living in the B.R. Hills area are accustomed to modern programs and have in fact accepted the more passive role of patient from the western model of medicine. The Soliga seek expertise and guidance in their health care. CBR is a program involving the people as active participants. The Soliga's present behaviour with regards to health may be an obstacle to the success and acceptance of the CBR program. However, the results do suggest that, with education, some of the women may be able to take on a more active role in their health care, such as utilizing preventative health measures. This suggests that a CBR program must first allow for the people's existing pattern of behaviour, whereby they go to one trusted expert for advise or treatment. Establishing trust and rapport must be incorporated into the first stage of a CBR program with education following. A gradual process should be considered to allow the Soliga people to develop relationships with community rehabilitation workers. This involves socialization as well as an interest and consideration of tribal beliefs and values.

The results of this study suggest that the modern system, where a physician is an expert, whom the people can go to for help, is a familiar concept to the Soliga tribal people and therefore should be considered for future health programming. The notion of trusting a particular individual and knowing they can go to this person for help appears to work successfully in the case of the VGKK in-patient clinic. The mobile outreach program may be less successful due to the fact that people do not feel this connection to one doctor or one expert because the medical team which goes out to the *podus* is not always the same, and their time is limited, thus decreasing inter-personal contact. People may be unable to develop the necessary rapport and trust in this manner of health servicing. The health service should be made more available to the people through more frequent programming, including education in the *podu* performed by a consistent specialist. Introducing new people requires preparation of both the people and the specialist. The tribal people must be given time and opportunity to develop a trust of the individual. The specialist must be made aware of and respect the ways of the people.

In other CBR programs, women have been actively involved in the rehabilitation program due to their close involvement in child rearing and caring for the sick. The CBR program developed for the Soliga people can also utilise the women's interest in family and community health. The Soliga women can, as in other CBR programs, become a part of the health worker team. The findings of this study suggest that, since education has shown to provide the women with greater knowledge of preventative health practices, it

would be critical to provide the women, who are the primary care givers, further health education. All the women who participated in the study indicated an interest in participating in meetings and groups for women. If organised effectively, this would be an excellent method of improving health in the Soliga community.

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## **Appendix A**

### **Non Structured Interview Possible Questions Related to Topic Areas**

#### **Objective: 1: Indigenous health behaviours of the tribal community:**

What are the typical health practices of the tribe?

What do people do when they are sick?

When is traditional medicine used?

#### **Existing health care practices:**

How do you use the BR Hills health centre?

What types of illness are brought to the health centre?

Have you been to the health centre before?

What have you learned from the people at the health centre?

#### **Objective 2: Women's role in health care**

Can you describe your role with regards to your own health care?  
your family's?

Are you responsible for looking after your family's health?

What do you do to stay healthy?

When do you visit the doctor at the health centre and when would you visit  
the traditional healer?

**Objective 3: Disability in the tribal community**

What do you consider to be a disability?

Are any disabilities considered worse than others? If so which?

What happens when a child is born with a disability?

What happens when someone acquires a disability later in life?

How are disabled people involved in the tribal community?

What do the disabled people do during the day?

How do people with a disability get treated in the community?

What would you do if you had a disabled family member?

**Key Informant Interview**

What are the existing political conditions/difficulties facing the Soliga tribe's health and social welfare?

## APPENDIX B

### Demographic Information

**Interview date:** \_\_\_\_\_

**Translator:** \_\_\_\_\_

**Interview#:** \_\_\_\_\_

**Location :** \_\_\_\_\_

1. Gender (circle) M F

2. Age : \_\_\_\_\_

3. Position in the Family/Marital status: Roles: Mother, Wife, Daughter, Grandmother

4. Number of people eating in your household? Describe who/ roles.

Number of people sleeping in your household? Describe who/ roles.

5. If children how many? male or female? any disabled children?

6. Any disabled family members? Walking, talking, seeing, hearing impaired? mental disturbances?

4. What is the highest level of education you have attained?

1. No regular schooling
2. Education outside the regular school system (informal)
3. Some primary schooling, not completed
4. Completed primary schooling
5. Some secondary (not completed)
6. Completed secondary
7. Vocational/technical post-secondary
8. Some/completed university
9. Other (specify) \_\_\_\_\_

## **APPENDIX C**

### **Information Form/Consent Form**

You are being asked to participate in a research study directed by Talya Zaraska to describe the health behaviours of the Soliga tribe women. Ms. Zaraska will read through this consent form with you and describe procedures in detail and answer any questions you may have. This study is being sponsored by Karuna Trust.

The aim of this study is to gain an understanding of health behaviours in the Soliga tribe community. This information will guide the intended Community Based Rehabilitation program, making it more sensitive to the Soliga tribe's way of life.

#### **Invitation to Participate**

You are invited to participate in a research study of health behaviours of Soliga tribe women.

#### **Basis of Subject Selection**

The reason you are invited to participate in this study is that you are a women and a member of the Soliga Tribe.

#### **Purpose of Study**

The purpose of this study is to describe the health practices of the Soliga Tribe to facilitate the implementation of a Community Based Rehabilitation project in the B.R. Hills area.

#### **Explanation of Procedures**

You will be asked to speak freely about your health practices and rituals. This will be done on a face-to-face basis with the researcher and with the assistance of an interpreter. The interview will take place at the health centre. The total time required is approximately 1 hour and possibly another hour at another time, either at the health centre or at your hamlet.

#### **Potential Benefit**

The results of this study will contribute to future health care planning for your community.

#### **Assurance of Confidentiality**

Any information obtained in connection with this study will be held in confidence. Any information obtained in this study may be published or presented at professional meetings.

In such publications or presentations, your identification will be kept confidential.

**Withdrawal from Study**

Participation is voluntary. If you decide to participate you are free to withdraw your consent and discontinue at any time.

**Offer to Answer Questions**

If you have any questions, please do not hesitate to ask. If you think of questions later, please feel free to contact the researcher or one of the investigators listed below. As well you may contact the collaborating agency ActionAid India, Bangalore directly.

YOU ARE VOLUNTARILY MAKING A DECISION WHETHER OR NOT TO PARTICIPATE IN THIS RESEARCH STUDY. YOUR SIGNATURE CERTIFIES THAT YOU HAVE DECIDED TO PARTICIPATE HAVING READ (OR HAVING THIS READ TO YOU) AND UNDERSTOOD THE INFORMATION PRESENTED.

Signature of Participant \_\_\_\_\_ Date \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_

I, or one of my colleagues, have carefully explained to the subject the nature of the above research study. I certify that, to the best of my knowledge, the subject understands clearly the nature of the study and the demands, benefits, and risks involved to participants in this study.

Signature of Principal Investigator \_\_\_\_\_ Date \_\_\_\_\_

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