VOL. 25, 2018 ISSN 2347-1530

MAN IN SOCIETY

THE JOURNAL OF ANTHROPOLOGY DEPARTMENT

Published by

PG DEPARTMENT OF ANTHROPOLOGY

UTKAL UNIVERSITY

BHUBANESWAR, INDIA - 751004

Editorial Office:

Editor
Man in Society
P.G Department of Anthropology,
Utkal University, Vani Vihar,
Bhubaneswar, Pin-751004
Ph: 0674 2567217
Email: headanthroutkal@gmail.com
Website: www.misanthroutkal.com

PUBLICATION DETAILS

"MAN IN SOCIETY- The Journal of Anthropology Department" is an annual peer-reviewed journal with ISSN No: 2347-1530 of the P.G. Department of Anthropology, Utkal University, designed for prompt publications of origin and important articles in the field of anthropology. The contributions can be in the form of papers, shorter notes, review articles, book reviews and discussions.

All the printing process is powered by
Prasar Media Communication
B-9, Sahidnagar, Bhubaneswar
Odisha, India

Subscription: **Man in Society** is published once a year:
Annual Subscription:
Individual: INR 300
Institutional: INR 500

Printed and Published by Dr. Prasanna Kumar Patra, Head, PG Department of Anthropology, Utkal University on behalf PG Department of Anthropology, Utkal University, Vani Vihar, Bhubaneswar, Pin- 751004, Ph: 0674 2567217, Email: headanthroutkal@gmail.com, Website: www.misanthroutkal.com

CONTENTS

Editorial

Now that *Man in Society* has already achieved a modest accomplishment by regularly appearing for six consecutive years, after discontinuation for nearly two decades, it is facing a new set of challenges. Some of the challenges are; how to encourage more and more people to submit academically written standard articles, to ensure timely and professionally done peer-review of published articles, meet the financial challenges of timely publication and how to make the copies available to interested reader across local, national and global spheres.

As a policy matter it has been our attempt to give equal emphasis and opportunity to both budding and experienced writers and also to see how articles considered in a volume has a good combination of empirical as well as review works. Thorough our colleagues everywhere, we are encouraging young research scholars to submit their articles. We wish that increasingly *Man in Society* to become a platform for writings in any and every aspects of human experiences contributed by authors based at anywhere in the globe. At *Man in Society*, the peer review process is fast changing, we are trying to involve experienced and professionally equipped experts to go through the manuscripts, critically evaluate and facilitate writers to improve their articles. Getting competent and willing reviewer has been the biggest challenge. The Students' Seminar of the Department and partial contributions by authors are critical in meeting the financial need for timely publication. But to make the publication sustainable, better ways have to be found in coming times, selling of some copies of the volume could be one way. In coming days, we have to find out more takers such as libraries of universities where anthropology is taught, willing publishers to promote through purchase of bulk copies and buyers from among active researchers and faculty members. A concerted effort, keeping all the issues in mind, by stakeholders will surely make *Man in Society* emerge as a sough after journal in the field of human enquiry.

This volume contains 13 research articles, a brief communication and two book reviews. The first article by Tripathy is a discussion on the construct about how the prevalence of traditional medicine and faith healing is slowly overtaken by the biomedical entities in south Odisha. The second article by Sethi and Satapathy deals with nutritional status of tribal communities of Mayurbhanj and it reveals that the tribals are having the Chronic Energy Deficiency (CED) or under-nutrition and that females are nutritionally more vulnerable in terms of prevalence of malnutrition as compared to the males. The third article by Barik et.al. deals with prevalence of non-communicable disease risk factor among the rural Santals of Mayurbhanj district. It reveals that lower/middle socio-economic class consumption of tobacco and alcohol; less fruit and vegetable intake are found as risk factor for NCDs and the majority were males and the findings also highlights that the biological risk factor like hypertension, under weight, overweight/obese and diabetes are prevalent up to some extent, whereas the males are more affected than the females.

In his study among the *Rajdhobi* - a backward community of Bihar, Kumar highlights on how most of the development indicators such as income, education,

health, etc., are far worse among the *Rajdhobi* than other SCs of the state. It shows how they have been facing discrimination in every sphere of life. The study by Murmu on the changing dimensions of Santal shamanism from Mayurbhanj district reveals that new trends have developed in the shamanistic beliefs and practices and there is decline in curative performance but increase in preventive worships. Educated and economically sound Santals still believe in supernatural or involvement of witch in the occurrence illness as well as other problems in life. It claims that there is a process of Hinduisation of Santals by native Santal Ojha and the changing dimensions in Santal shamanism has its marked impact on the socio-cultural life of the Santals in the study area. In their work on teenage pregnancy and antenatal care practices among the Amanatya, Bhotra and Saora tribes of Nabarangpur, Baral et.al have shown how Anganwadi workers play a major role for the utilization of antenatal check-ups and how illiteracy, lack of knowledge about ANC, poverty and traditional beliefs affects the utilization of antenatal care of the mother. Kaberi Sahoo et. al highlight various facets of traditional knowledge practiced for prevention of malaria among the Santal tribe of Mayurbhanj.

Sasmita Sahoo et.al highlights how the pregnant women prefer institutional delivery because they get financial benefits from the government however, they obey their traditional restrictions during and after pregnancy. Singh and Patra in their study among the Bhumija tribe of Mayurbhanj shows the prevalence of under-nutrition among the pre-school children of and have urged for immediate public health intervention program. In their article, Nayak and Dash have highlighted little tradition of Shakti cult in Odisha revealing its constant and continuing interaction with that of Hindu great tradition. Rath and Dash in the article on social status and role of carpenters in Ganjam district reveal the complex hierarchical order of higher and lower castes which tell about their relative position in the society and their continuation of wood work tradition. Mohapatra and Satapathy in the work on blood pressure among the Desia Kondh, highlight that hypertension is an emerging health issue in the Desia Kondha community due to acceptance of modern food and consumption of alcohol is the main cause of increasing hypertension and pre-hypertensive cases in the community. In his review article, Prasant Kumar Sahoo highlights the characteristic features of ethnography, its methodological principles and the emerging trends in ethnographic research in the changed context of data collection and the underlying orientations and perspectives of a globalised world. Under the section 'Brief Communication', Laxman Sahoo narrates about the Centre for Tribal Studies that has been contributing towards the archives of North Orissa University through the collection and preservation of socio-cultural history of tribal communities. The volume also contains two book reviews done by J. Badamali and D. Barik of two contemporary books on Tribal Health and Human Growth and Development respectively.

Finally, I am hopeful that the contributions made in this volume will be useful to its users especially to young researchers, practitioners of anthropology and people keeping interest in broader areas of human sciences.

Prasanna Kumar Patra

Man in Society ISSN 2347-1530
Volume 25, 2018, pp. 1-14

Global Medicine, Local Healers
Continuity In Medical Techniques In South Odisha

Akash Tripathy

Abstract

Medical practices in the southern parts of Odisha, India, are taking a significant turn in their course of establishment in the present scenario. The introduction of modern medical commodities has influenced tremendously to the dynamics of the healing system. However, the traditional healing aspect always constitutes to specific horizon of people who have a faith and belief system in ritual healing process. Now, with the introduction of the biomedical entities in the societies, the population is more informed about biomedical practices and new medical prospects. The coming of new age medical methods challenged the conventional form of healing in a more socially – effective way. However, contemporary medicine is still searching its place for concrete establishment in the south Odishan societies. In the essay, I have tried to construct how the prevalence of traditional have tried to medicine and faith healing is slowly overtaken by the biomedical entities in south Odisha. With this concept, several notions behind the commodification of traditional medical practices have been discussed and how traditional practices in medical treatment are being side – lined with the coming of new generation.

Key Words : *South Odisha, Biomedicine, Traditional healing methods*

Introduction

As India proceeds through the 21st century, it is rapidly modernizing and transforming, socially and economically and is now going onto the global stage in a rapid and intense globalization process. The accessibility of practising different forms of medical methods are crucial in the social establishment. With the introduction of new paradigms in the medical sphere, the way of observing the medical elements have completely changed. More or less, what impacted the most, is the coming of medicine in a privatized form. This article focuses upon such introduction of modern medical methods which prevailed and developed with the time in Ganjam district, a region in southern parts of Odisha India. The modern medical methods have created structured patterns of marketing strategies within the health sector of the Indian subcontinent. Odisha lies in the geographical periphery of eastern parts of India. Sharing the coastline with Bay of Bengal on the east and bordering with Andhra Pradesh on the south, Odisha forms a close dome of habitation. The region of Ganjam is divided into two parts, hilly and plain terrains. Introduction of the modern medical facilities in the respective area is a symbol of modernization and better governmentality in the region. Over the last few decades many transnational and national drug manufacturers have started to invest in the indigenous medical field and have promoted aggressive commodity – marketing campaigns for their products, keeping in mind of the middle – class consumers as their target (Islam, 2010). Now the question arises that how the mind set varies with the coming of new generations regarding the practice of medical therapeutic methods? How the communities sustaining in the area, decide what medical therapy is better for the health prevalence? I will say, the society has splitted up. It is divided with the section of people such as those people who thought that they cannot leave traditional healing method and other ones as who opted for the biomedical facilities in a hope of a better life. A traditional healer is defined as someone who does not have any formal training but is practicing medical treatments (Madhavan & Singh, 2015). However, in the village context, there are personnel who practice such aspects of medical behaviour. The

Steingasse, 9, 69117, Heidelberg, E-mail: akash.aug.31@gmail.com

psychoanalysis of such kind of reaction is obvious, for that rituals and healing through this conventional form holds a significant position in the social function. Integral social structures are witnessing the conventional healing method as trying to focus on developing and upgrading into a rather popular and distinguished form of medicine among the society albeit contemporary medicinal practices are also searching a way of establishing among the locals.

This essay explores how the concept of duality of mind – while choosing from different therapeutic practices – are observed in south Odisha region. Nevertheless, keeping in mind that several regions in South Odisha still observe faith healing as a prioritized form of the medical method (See Carrin, 2011; Mallebrein, 2008; Guzy, 2013). However, it is modern medicine that has focused and acquired the market and commercial sector. Towards the starting of the 21stcentury, the medical progression took a step up in the local regions of South Odisha. Before this period, the communities were majorly dependent on the local healer. For example, if a person is ill with say, Jaundice, in Bellagutha block, then he would have to visit either a ritual healer in the locale (which was simply the first choice of people) or he had to travel 80 km to Berhampur block hospital. Although there is an option that he may visit the local healer or local dispensary, before the 1990's and early 2000, ideas about modern medical qualities were much dim (Carrin, 2011). Visiting a doctor in the early 1980s was not a feasible option. However, people would have considered this hard job if they had a *Maansika*[1] (Patra, 1997; Eschmann, 1978; Hauser, 2012, Roche, 2000) but before the 1990s, it was a thought that would takes a while to act upon.

Before I inspect the tendency of the people towards the medical practices that are common in the communities, I would like to mention about the health prominence in South Odisha, particularly in Ganjam district. Having a net of around 3 million population (Census of India, 2011; Govt. of India reports), it consists of people who believe in the prospects of ritual healing as well in the modern medical facilities and are setting an exemplar of development. Migratory factors are increasing the chances of introducing biomedical therapies in the community. Biomedical influence in the region was not very affluent if we consider the early 1990's and before. Communities particularly used to rely on the *Jhaada Phoonka Chikitsa* (lit. ritual healing treatments) and it was very uncommon for people to prefer doctor and clinics for the treatment. When I visited Ganjam in 2017, my primary observation was how people are following the ritual healing aspects and if it is true that still in this era, the biomedical treatment is conceptually out cast in front of the ritual healing and traditional therapeutic methods. We can blame the economic condition of the people here (Hardy, 1999). Sometimes, it is also witnessed that people consider ritual healing over biomedicine just because it is economic and keeps up with the social integrity of the village and the goddess[2].

Let us say the average daily wage earning of the community sustaining in Ganjam district[3] is Rs. 300 – 500 (Annual report; Ministry of Health and Family Welfare, 2015; Govt. of India reports). The primary concern is the daily bread for a lower – class wager and a professional doctor will charge half of the day's earning which is around Rs. 200. It can be inferred that due to backwardness in the financial condition of the people, most of them believed and still tend to shift towards the faith healing, as it pertains cheaply rather than the scientific observation of the disease. However, societies established there might have introduced themselves to the new way of medical practices today but whenever it comes to the ritual healing or faith healer, there is stimulated and respectful response for following it. It can be also inferred that cognitive factors such as fear and faith work mutually. During an interview in Bhaliakhai village in Ganjam district, an informant told me that, "if we start ignoring about communicating our health issues to the goddess, she *will get* angry and show her wrath on all in the village." Hereby it would be a great point to understand how the communities, develop a notion or rather to be precise, mind-set, to prefer which form of health care behaviour they desire for. During another interview, Krushna Dasa of Adheigaon village, Ganjam district, said, "*If the goddess holds the button for sickness, she is the one who we should turn for its treatment*". This statement signifies a lot about the faith system of the individuals alongside other cognitive behaviours such as fear, faith and sacredness. The district of Ganjam is developing at an incredible pace if we discuss in terms of biomedical entities and modern

health care facilities. Privatisation has taken the region by storm and no doubt it will continue to grow further. Nevertheless, the crucial aspect is to observe if people accept this change in the medical structure. The question arises in several conditions, if people don't accept the change, then why the medical development is still progressing? During the start of the year, 2002, census reports of Ganjam district reported that the medical care given to the individual is primarily through traditional medical entities (Census 2001, Govt. of India reports). Although the mortality rate was not that much catchy, it created a concern for the government to develop an intervention program for the improvement of health facility (Census 2001, Govt. of India reports).

Initially, it was the Public Health Centre (PHC)[4] in Bhanjanagar that used to deal with the issues on the basic health of people. Each village also has *Gramya Chikitsa Kendra*which take care of acute and basic illness of people on the village level. Such institutions are set – up during government programmes and initiatives. The matters observed in these are 1st-degree diseases, medical treatment with basic components and machines (Census 2001, 2011, 1991). For example, if a PHC had an X-Ray machine[5], it would be considered of a very good level. Thus if the health situation is too chronic or is very complicated to understand for the doctor, he recommends the patients to the district hospital for further treatments. At best, the PHC on the subdivision level deals with the family counselling and discussion. For further medical treatment which includes high cost and better medical service, say for chronic illnesses, the PHC refers to Community Health Centre (CHC) or *Zila Chikitsa Kendra*[6] (District medical Centre), which observes patients on a more efficient level. Alongside the PHC on the village level, they collaborate for medicine distribution and counselling programmes on a governmental basis to *Aanganwadi Kendra*[7] as well. These *Aanganwadi Kendras* are set up by the government and are organised as small scale units for medical and educational purposes working on primary based government programmes. They primarily focus upon reaching out with government programmes that are developed and make sure they reach in the most remote places of India. Funded by the state government, these *Kendras* typically works in spreading government intervention programmes for health and education, this benefits, and also take responsibilities from time to time distribute medicines and stationaries on the village level. For counselling, these *Kendras*, communicate with people for domestic matters and private matters among the village population for issues such as family planning, Tuberculosis, modern medicines, this use and their availability etc. and also keep medicines for free of cost.

The biomedical growth in the region took its pace in the late 1990's. Talking about a period of early 1970's, if a person is too critical with the health, he would be advised to visit the city hospital in Cuttack[8] (around 200 km from Bhanjanagar). However, the modern scenario has changed. Ganjam district is witnessing a new horizon of history written in its health sector. Now there are more than 20 private medical colleges and institutions where apart from biomedical techniques, methods of *Ayurverdic* remedies and other forms of medicines are also encouraged. However, medical students are focused on designing biomedical techniques. There are more than 100 sub-centres that primarily deals with basic health issues such as common fever, typhoid, jaundice, malaria and orthopaedics. PHC's are constructed at a fast rate with the support of more than 10 Community Health Centres. Apart from this, private hospitals, clinics and doctors are also trying their experience to settle in within the modern boundaries. This expansion in the biomedical world provides a greater extent for people to think about the modern form of medicine. I am not arguing here with a biased opinion that ritual healing is conventional and should be neglected but rather that people are opened to more options. They have a choice now. But it questioned the faith on ritual healing. Have people started doubting an older version of a health facility?

Geoffrey Samuel writes in an essay that,

"*Yet ordinary human beings, given a choice, have very commonly gone for medical pluralism, and have been frequently prepared to use personalist' idioms such as spirit - healing in tandem with evidence - based biomedicine. This suggests that a dismissal of personalist models as scientifically illegitimate may be missing something vital*" (Samuel, 2010).

Privatisation has commenced its operation in Ganjam as well. It was the year 2000 when the largest private health centre, NIDAN opened. It comprised of all – equipment – facility and as they

take pride by, '*the state of the art treatment is done*' on their website. During my visit to NIDAN health centre in Berhampur, Ganjam, in 2016. I found out that several new and high – tech hospitals are opened in the nearby town. People now have greater accessibility to biomedical entities. Since the opening of NIDAN in the year, 2000, it has provided a much greater health service to the locals than ever before. Private clinics and hospitals are now taking their time to introduce themselves to the local population so that they understand the kind of treatment done. In several communities in Ganjam district, I discussed with few elderly members in the region and they said that the concept of vaccination is just valid for Polio, Hepatitis and Small Pox[9], and nothing else. According to them, "Even after vaccinating our child, he still gets smallpox, it is nothing but just the curse of the goddess, but yet if anyone suffers from a disease that our *Jaani* doesn't recognise, we will consult to a doctor." On the other horizon, private medical institutions have significantly reformed the physical treatments among the locales. In different regions of India, be it rural or urban, modern medical facilities have remarkably changed the outlook towards health treatments such as for orthopaedic surgeries, chronic physical ailments, ENT specialists etc. (Mishra, 2013). In the modern scenario, traditional or even ritual considerations during peculiar moments such as the birth of a child, heart strokes, brain haemorrhage etc. are something that cannot be relied upon. A report mentions that a declination in maternal mortality rate and infant mortality rate is prominently observed in the last 10 years (Ministry of Health and Welfare reports, 2015, 2016, Govt. of India reports; Census of India: Odisha, 1961, 1991, 2001, 2011, Govt. of India reports). Does this commend the question that if locals are bending towards the biomedical facilities then would primarily result in longer age? It comes to the argument if ritual healing methods or indigenous medicine should be treated as secondary or even tertiary. With the introduction of new kind of diseases, no doubt government intervention programmes and their distribution of biomedical information is also a help to remote areas of India like Ganjam. Local people believe they can approach the biomedical clinics easily nowadays as they have understood the broader aspect of it, yet not all of it. Still, it is very common for them to choose traditional healing methods for several peculiar diseases than visiting private medical institutions.

During the outbreak of diseases such as Diphtheria, *Mahapuru Aasibaa* (lit. Small pox), *Haada – jwara* (lit. bone fever), the biomedical institutions in the region work actively with thecommunities to supplement the antidote of the respective diseases, however, an involuntary faith system also works within the people. Hari Dash of Banatumba village, Ganjam, described a certain instinct during the epidemic of Japanese Encephalitis in 2016 as:

"When our children (in the community) started to die, we were continuously praying to our goddess, Saarala Maa[10], to save our kids from this wrath. After several friends and their kids died, the government officials came to sympathise us that it won't happen now and asked us to visit nearest Chikitsa Kendra for free health check-ups. We still believe no one can be saved if goddess showed her wrath. Many of our neighbours still didn't go Chikitsa Kendra, even after the visit of government officials."

It is clear to understand the subtle social ethics and regulations that functions within the consciousness. Many a times, people like Haria, also have a conceptual notion about the social stigma and boundaries of facilitating these health care centres. Ritual healers are occupied with a more sacred tantrum and form of healing aspect, but they lack the physical therapy. However, for physical therapy, there resides a *Haada Daaktara*, (lit. Orthopaedic doctor) but then he is categorised as a doctor and not the healer in the village setting. Several studies have highlighted that these small scale medical practitioners are not qualified enough but are just practitioners through experiences and lineage knowledge (Mishra, 2013; Lambek, 1989; Unnikrishnan, 2010; Oths, 2004). The dynamics of choosing the medical behaviour is very sceptical in the contemporary scenario. The medical entities and ground rules of a ritual healer, has his authoritative performances that are socially unquestionable. Durga Swain, narrated his experience of biomedical question in a dilemma:

"My visit to Dr. Pradhan was a bogus incident. I still don't know on what basis he asked me questions. I didn't have faith in him initially but I got normal. I have a very bad delusion in mind that shall I visit him for future references or not."

Small clinics and *Gramya Chikitsa Kendras* are

competing the market against bigger institutions like NIDAN and newly constructed private hospitals. There are few clinics in Ganjam district that also deals with psychotherapy and consultation of it. It is done free of cost for the people who seeks a psychotherapeutic help, but only the consultation. It struck me to a point where I asked few personnel from such an institution nearby that, "Was it possible like around 40 years ago?" Narsimha Behera, aged 59, of Banatumba village, Ganjam, replied in a very assured manner that, "*No! and we still don't think they will cure much better than our*

ritual healer." The assurance about ritual healing remained there on his face and he continued, "See, there are all modern way of *'dramatics'*[11]. If Goddess enters into a person, we seek the village healer. We seek the *Gramadevati*[12]. Person is cured every time, but if even after the ritual the patient doesn't get healed, we seek consulting from this kind (the psychiatrist) of doctor." The reaction of people and their behaviour also signified a greater concern about their financial effect. Many of the families considered going to a doctor would cost way more than a ritual healer. Going by the idea, it is apparently correct if we think as a part of the respective society, as both provides methods of healing and the objective of either is same, to cure the body. Then why visit a doctor who cost around 100 rupees for consultation and medicines extra whereas you can approach a ritual healer who is satisfied with a meal and some money. People in south Odisha are very much inclined towards the cult practices and healing rituals. It is considered in the villages of south Odisha, that the *Gramadevati*, the village goddess, is the one who holds the nerve and the metabolic system of the individual.

In south Odisha, the selection of medical treatment method for the respective diseases differ with the causes of it. The locals or even the families have the tendency of spontaneous rejection of the biomedical cure as there is the belief that it may cause them more harm than they actually are going through. Anyways people now a days are contemplating new horizons of lifestyle and improvising it into their life. Although cultural changes comes first if observed in terms of ritual, traditional practices and the act of worship, but the health sector and ritualization follows a great deal of reformation, both on social stage as well as in cognitive responses of people. I can apparently argue that possibly 3 – 4 decades ago, in villages like Baragaon and neighbours in Ganjam district, could not have the spontaneous reaction as, "Oh, get a doctor" for the health issues such as, "My son is ill with Chicken Pox, Cholera or most notably, Diarrhoea." The selection of medical method, has its own significant meaning of enacting in the psychology of an individual. The possible answer for the psychoanalyses of an individual towards a disease may form a vague image about 'miracle'. It is not completely inaccurate to visualise a certain factor of response playing its role in developing a thought about a change in the body through traditional methods. I would like to elaborate the difference of opinion through my case study in south Odisha (2014, 2015 and 2017) and personal experiences I had during my fieldwork.

New Pragmatics among Traditional Healers – A Case study

During my fieldwork, I had a chance to interact with people on ground level regarding their beliefs and practices. During my stay in Bellaguntha block in Bhanjanagar subdivision of Ganjam district, I travelled frequently to the neighbouring villages for short visits to the biomedical practitioners, ritual healer, commoners and traditional medicine practitioners from outside Ganjam district and sometimes even from outside of Odisha, residing there. Each village I visited, I found that almost every village has a small scale or local pharmacy and biomedical clinics with a doctor, but not all. However, on the other hand, each village, without even missing one, has the *Jaani* (Oracle) who practices his ritual and prayers in the *Gramadevati* temple of the respective village. He practices his cult and oracular practices regularly in the temple premises. The oracle is considered to be a lower – caste person who performs devotional activities both in front of the *Gramadevati*, the Village goddess and in the primary religious shrines of the village. I am referring the commoditised temple as *the primary religious shrines* because it is much structurally sound and fancy if observed from a distance with comparison to the *Gramadevati* temple. Concrete building, fancy colourful walls, a generous amount of donations and also, the mass attendance is again higher. During an interview, Sudarsana Patra of Baragaon, a small village near Bellaguntha block of Ganjam district, described that

"Before the 1990s, no one used to go to the hospital for treatments. It was very rare that a person is immediately preferring for the hospital or biomedical treatment rather than the *Jhaada – Phoonka Bidya* (traditional healing). We had this notion that whenever a person fell sick, he would be advised to either a local *Vaidya* or to the *Jaani*." He continued further that, "we were not used to getting sick frequently during our (1970's and 1980's) times. But since these *Bidesi*(foreign) medicines are practised and used, we more often get sick." The belief system work s in a spontaneous curriculum. But the inclusion of different relative medical practices in today live may be a reason for political influence.

During my stay in Bellaguntha block, I observed that the village structure is formed with around 100 to 120 families residing on a lane with houses on both sides. Presuming[13] that the people in the region are still following an orthodoxy mindset and the majority of the population in the region do not believe the therapeutic ailment outside the ritual healing or rather, *Desi Oso* (Odia: *Ousadha,* lit. indigenous medicine). I am taking the case study of the house, which was a neighbour to my residence (two or three houses next to it) in Bellaguntha village during my fieldwork, there was a family of around 9 people, including grandparent and children. One very day, a child in the family got sick with initial symptoms of Diarrhoea or move possibly, Cholera. Now the outbreak of the treatment decision took two different psychological processes. The first, hereby I want to discuss, are the elderly decision of the house, that is of the grandparents. Firstly, since they are the authority in the house, it is the stimulus that they will advise or rather take the child themselves (if they can) to the *Jaani* (lit. oracle). Here the oracle will perform his ritual and will try to diminish the effect of the disease through his acts. Anyhow, the grandparents here, have the complete belief in him, that he will succeed in his approach and the child will be back to normal. On the other hand, in the same house and the same situation, the parents, who are from a relatively modern generation than their father's, and have a better idea about biomedical facilities, will think of getting the child to a doctor. So, the idea of self and individualism come to its role and define how a person moves in case of spontaneous necessities (Oyserman & Lee, 2007). Thus even during failures, the collective apprehension makes the oracle less guilty than the self (Buss, 2001; Carducci, 2012).

I observed a remarkable generosity of the community people towards the oracle, that in any manner, they find themselves obliged to compliment the efforts and work of the oracle. It is a reciprocated response that is indulged on the stage for the cooperation of the person who thought positively and passed the same vibes to the sick child. The ideology of self is importantly plausible here because the people who believe in it provides a great response of faith and thus more than themselves, they believe the articulations of the oracle. The shifting and switching to the modern medical techniques from a conventional form can take a good time, as adapting to change is not observed in a snap[14] (Festinger, 1957). The normative in such acceptance is a play of generations and it does qualify for its justification and prove that it beholds the significant faith but also new technologies come with advancements too[15]. I came across with a different experience that provides me with a base of another question that how the communities who were following the conventional forms and methods understand the framework of the new age medical facilities. I was in a small village, which was not settled on the highway but it was actually a bit interior from the highway. I had to visit the location on foot from the main road connecting to Bhanjanagar, Berhampur and Bellaguntha. On entering the location and after having a conversation with few elderly men[16] about the village geography and demographical aspects, I impulsively asked for the house of the oracle and respectfully nodded in the direction they advised me to march upon. I reached the house. Small yet had the essence of sacredness. It held a fragrance of cooked rice and wet clothes with freshly lit incense sticks and *Deepa* (oil lamps). The house was a small yet designed in a proper Ganjam architecture, i.e. less width yet elongated like a train bogey. The oracle was ill and could not attend me but anyways, I corresponded the wife of the oracle, also known as *Jaaniani* and started the conversation regarding health aspects that and when people seek to the local deity. Within no time, instead of me, she – being an informant – asked me around 15 or 20 questions related to my caste, class and ancestral house location. Probably this was an integral interrogation to identify if I am considerable to enter the house. Being a *Brahmin*, there was an inner

satisfaction as well a fear inside me that what if class – social complexity comes into play. Fortunately, I answered most of the questions and tried to have an interview of my set of questions, in the form of conversation. It was a pleasant interaction and I prepared to leave the house. While I was on the *Verandah*, she approached me and voluntarily suggested if I wish to visit the local biomedical practitioner of the village. I accepted her suggestion and she mentioned that it's in the immediate next door of her household. I was stunned for a moment with the irony of it. If I was not wrong, it was the house of a ritual healer and the biomedical practitioner just separated by a wall. I answered her enthusiasm positively and entered into the medicine shop in no time.

It was a small room, possible 12 ft. x 12 ft. of dimension, which was built on the extension of the house facing the road. The clinic operates with both homoeopathy as well as allopathic medicine. I volunteered myself to the clinic and asked about the year of establishment of it. Probably, I was blunt with my direct approach and made the owner scared that I came for his license and legal issues. I explained my purpose of visit to him and then he took a breath of sigh while understanding my dilemma of the question. Anyway, although he didn't have the license, he mentioned that he has been acting as a shopkeeper/doctor/medical advisor for the village members since 3 – 5 years. It was his father who started a shop by selling the ingredients for ritual healing methods. Slowly he (shopkeeper's father) learnt the value of medicinal plants and herbs and spices by himself and started attending patients on a casual basis. Nevertheless, he continued his practice and the shopkeeper learnt the medicinal identities from his father. Gradually the shopkeeper took over the business and now he sells medicine for basic health treatments such as fever, common cold, stomach aches, headaches, physical injury ointments and liquids, painkillers etc. During the conversation, I asked him if he, himself follows the modern medical practices or mostly like other, ritual healing method. Now came the answer I was not prepared for. He said, "Yes, we do follow biomedical practices but only in case of emergencies or critical illness, but my family members, mostly parents and sometimes me, goes to the village *Jaani* if something happens to our health. We still have faith in the Goddess." After this answer, I came to realise that people choose what they believe in. It doesn't matter if the primary earner of the house is a firm advisor of biomedicines to other people but sometimes he approaches the ritual healing method himself. Again what is important to understand is only during *certain times*[17], he visits the Oracle.

The healing through ritual is now limited to a certain boundary of therapeutic ailment in modern Ganjam, primarily disease that propagate on the roads, fields and environment of a village. However, the diseases which are prevalent in the regions are smallpox (now chickenpox), Cholera etc. "It is very uncommon in the house in South Odisha that has elderly parents, a child with cholera and they still prefer biomedicine", said Subas Patra, aged around 50, Baragaon village, Ganjam. The person with *Maansika*will organises a whole ritual mostly including animal sacrifice, '*Boda Bali*' (Goat sacrifices) that stands for the welfare of his child and better health of the family. However, several times, consider the health of the child deteriorates and does not get healthy with traditional healing, now will be the time for the family members to consider the option of biomedicine. It is not that biomedical options are not available, but yet it is up to people that they consider every small aspects of their lifestyle.

Commoditized Rituals, Sacred Medicines:

Nichter (1996) defines health commodification as 'the tendency to treat health as a state which one can obtain through the consumption of commodities, namely, medicine'. Indigenous medicines have been transformed into modern health products for middle-class Indians over the last few decades and quite the opposite following in the west (Bode, 2008; van Hollen, 2003)[18]. Leslie worked extensively for the revivalism of traditional medical entities in India[19]. New medicines in the market of Ganjam district has produced a more contemporary lifestyle feeling among the residents. It is quite usual that now people go to the chemist and demand for the specific drugs or medicine without even visiting the doctor. During my fieldwork, I visited few schools and colleges in Ganjam district and met their principals and teachers. They discussed how new form of medicines are being distributed among the local and government intervention programmes. *Mission Indradhanush,* targeting disease like diphtheria, malaria etc. by Ministry of Health and Welfare in 2016 (Govt. of India reports, 2016). The

modern day medicine is prevalent for minor disease and are easily available in the drug stores. The coming age of new medical practices and remedies has created a sphere of void among the locale. Now, as said, people have options. It doesn't matter if the medicine, be it from the traditional healer or the chemist shop, the main understanding behind it is the regaining the healthy body back. Sickness dwells a double minded ideology amongst the people in Ganjam district. The mind – body thought process fights continuously for the overall development. Sickness develops a notion of efforts without mistake and ultimate goal of each healer is the reduction of it. Padmanabha Swain of Baragaon village, Bellaguntha block, Ganjam district suggested during an interview that,

"Sometimes, our Jaani also is unable to heal certain disease. Last year, my grandson was serious with Typhoid and the Jaani could not do anything. We were helpless and then proceeded to district hospital. He gave us a yellow tablet for fever and one light blue pill along with it. My grandson recovered after 6 days."

The basic idea behind this concept is in what type of medicine people have faith in. yes, truly, the first choice is the conventional form of healing but the new – medical products have become a method for betterment of family members. For such incidents, most of the times, cost doesn't matter. Although government medicines are available for free but even if it costs elsewhere, it would not take a second thought. Now contemporary medicine has taken place and distribution of such components are easy rather than traditional medicines which involved physical labour. I took several interviews in Ganjam in December, 2016 which focused of availability on new medical therapies in the district. I found out that now it is a common practice that people are choosing for bio – medical entities. A conceptual notion has flared across the region that it is new, targets modern health care and is cheaper.

Somewhere, bio - medical pills are considered as sacred too. They are consumed with a pious feeling within the body and are dealt with extreme carefulness. The time of medical practices in south Odisha is changing. It is witnessing a transition phase in medical sphere. Ritual healers and faith healers are also diverting from the actual faith healing methodologies. "The time duration of the ritual performances by our healers has reduced to very extent", as said by an informant from Adheigaon village near Bellaguntha block, Ganjam district. He continued, "*We understand that we have more facilities available today than it was previously, but the faith in ritual healing method should not be lost.*" The thought behind this marks how a customary practice is being evolved. People are accepting what is coming with the time yet there is a void within their regular *Chikitsa Pranaali.* The faith healers still exist but now are observed as the alternate. These healers have been surviving with the question of sustenance. Thus a new method of medicine distribution has developed since last few years. The faith healers have upgraded to suggest bio – medical capsules and pills that are available in the drug store. However, concerned people either gets diverted due to belief reasons or they simply know the medicine already. One of the informant from Gadisapalli village, Bellaguntha block, Ganjam district narrated that,

"The faith healer is often observed to crush the bio – medical tablets into powdered form and produce a mixture with his own herb collection. Out of it, he makes a new tablet renaming it as his own. However we cannot question the authenticity of the pills and since he is a godman, so we are also scared of the Mahapuru (the deity; lit. goddess) as well."

The oracle remakes the already working tablet many a times, they agreed to it. Here what remains is the question of survival; however, the tablet surely works. Even though the person who is distributing the pills doesn't know about all the salt balance and component but he knows the quantity and dosage for its efficacy. Nevertheless, the marketing and distribution is done under the blessed umbrella of the deity. It fulfils the spiritual motif and provides a reason why people should consume it with utmost faith and care. The nuances that comes with this type of medical stimulation is of regular visits of costumers. Sometimes the oracle doesn't have enough bio – medical pills and thus has to work hard physically, such as in preparing the traditional medicine all by himself. These medicines are thus devoured without a thought of them as new medicinal pills. However, this follows the hardship, faced by the local healers whereas what they do not understand is this inclusion of bio – medical influence within the traditional medicine has developed like a bacterial infection within the social

map. The reason I say so is that now there is a complaint of side effects of indigenous medicine as well. The well mixed compound sometimes doesn't make a symbiotic relation with the body and several such incidents came up in recent times. However, when this issue is taken upto the *Jaani*, he narrates it as the deity did it and not him. The working mechanics of a medicine takes a religious ground here. Although the interesting aspect to understand here is the belief of people upon the deity and their understanding towards it. For such issues, many a times, a healing ritual is performed. However, the *Jaani* cannot be blamed here. The duo – synchronising mindset of people regarding the medicinal consumption put them on a dilemma. The rituals again include, in the end, medicines for daily usage and these are generally made by the healer himself. The new paradigms of healing rituals in south Odisha has created a genesis of altered state of mind. Regulations of such practices are changing and so are the elements of sanctity in a ritual. Singularity of selection has reduced the outreach of people to the modern forms of healing. Modern medicines has emerged right to the centre in the family.

However, the contemporary healing rituals practiced today cannot be ignored. Coming the age of visual and print media, the knowledge distribution of modern techniques and elements combined with traditional medical norms are significant (see Islam, 2010). Be it offering the toned milk straight from the packet[20] or the Cadbury chocolates [21] as *Puja Prasad* for a sweets alternate, such commoditised elements are concerned to be crucial in understanding modern healing ritual processes. The new paradigm of pluralistic health aspect in south Odisha has divided the acceptance capability of people. Surely, the question of sustenance for conventional medical practitioners will increase but it will be crucial to understand the perception of population about the both. Healing performances have been now upgraded to digital level as well. Several occasions have witnessed the ritual or the performances being done through video calling medium. Such practices challenge about its authenticity and establishment of it as a ritual performance. Although patients are being healed. Here, I am not arguing about ritual performed on a virtual medium is incorrect but it can be considered under the umbrella of new anthropology of traditional healing methodologies. Commoditised ritual and sacred medicine will work in synchronicity. However, availability of choosing the medical method, the medical pluralism, will keep its distinctive position within the boundary of social circle. Nevertheless, new paradigm of medical facilities are being introduced and are being administered out by Govt. of Odisha through social media and print media. However, non – institutionalised healing methods will remain within the faith system of local people.

Conclusion

Biomedical approaches to the places like south Odisha may influence the identification and recognition of ritual healing but still it beholds a bigger part of the social acceptance. Sudhir Kakar sees it in a way that the concepts of healing is thus believed firmly rooted in a tradition where healing is not a separate medical domain (1982). Thus, this form a wide and broad margin for the term 'ritual'[22]. It varies what cannot provide evidence for its theory, it is signified as a 'ritual' and tries to justify the validation of ritual healing comparative to modern health treatment theories (Sax; 2009).

Each short trip of mine to the villages of south Odisha made me realise the dual nature of patients on either medical aspects. The psychology of people while opting medical method, fluctuates. The general approach for the therapeutic ailments, swings like a pendulum with time. Rationalised thoughts and partial beliefs are present in both ritual aspect and the contemporary form of healthcare including biomedicines. There were several occasions that patients tried to escape or avoid the persistent use of allopathic medicine and they suggested to be cured through traditional healing methods. It may be kept in consideration to a greater range of somatic – therapy, as the ritual healing was beneficial to a broader mass when they couldn't go to governmental or private health care centres. We may believe that people are more affluent to the mystic technique of cure and we may concede the nature and tendency of faith is more towards a conventional form of treatment rather than a modern one. Witnessing several cases by being present near the healer or the oracle who performs the ritual healing during his performance, the channelling of the patient to an alter – world was significantly evident.

This step requires verification of other people, the audience (Hauser, 2014).

During my fieldwork, I observed that there was a distinctive line of choice among the people. The local population are, no doubt, trying to adapt with the modern medicinal attributes but what produces a marginal line of choice is the age group and their approach towards the treatment of the disease. In southern parts of Odisha, out of recognised population, around 50% people are illiterate and around 30 to 35% people are educated (Census 1991, 2001, 2011; Govt. of India reports). This is the segment of age group that prefers to walk into a bio – medical clinic or a government hospital rather than an oracle. Yet, the rest of the population which contribute around the age group of above 60, they prefer to visit a *Jhaada – Phoonka Jaani* or a *Vaidya* for the healing in ritualistic or a traditional form. Criticising the circumstantial processes that are still being observed as a more functional way of healing process, it can be said that with contemporary boundaries, it would be usually seen as a conventional form of healing treatment or *Chikitsa*. Nevertheless, I would like to mention here that this form of healing obeys a more or an "old school" process yet it presents a more contemporary visual while displaying medicinal prospects. Consciences play a vital part in health behaviour among the individuals. Here I can again argue how modern medicines are influencing the dosages of faith healers, but it would construct a paradigm of delusional healer and not delusional patients. On the whole, contemporary medicine and traditional patient's ideology juxtapose the arguments of health system within the society and the body[23]. The outlook of locals shifts to a broader horizon when biomedical entities are introduced. Although it takes a while to reform the thought process to make it happen. Modern dynamic conundrums in the society forms a cosmos of hesitation and uncertainty. Even if we observe about the options of doctor available now, a person habituated to biomedical treatment will get confused, however, a choice rather, to make between something that has taken the room in the houses in south Odisha, in max 25 – 30 years' time and other, (speaking metaphorically) that has been followed since forefathers, my anticipation would be to understand the significance of each aspect in the lives of the community. The historical significance and importance regarding all sorts of ritual and traditional healers will soon be observed in a different perspective. It is more probable that the commoditized medical sphere in the region will soon witness the alienation of traditional medical practices, although would not vanish completely. Though, Stefano Beggiora (2015) inspects about *Kondh* shamans of Odisha, in a way that they will be vanished soon. I proceed my understanding in somewhat similar study as in this case, the conventional forms of healing will be saturated and cocooned to a corner after a specific time though will not vanish completely. The integral meaning will challenge the ethical norms and regulations of people as, "*What shall I go for, for the better health of my family*."

Ganjam is witnessing a prolific change in its medical dynamics. In a decade or so, it will correspond to a newer section of the medical development and ethnographies from the region will include a major part of both conventional as well as contemporary healing methods. On a last assertive note, I would point out that the biomedical praxis will influence the coming of the new age on a wider scale whereas I already commented likewise, conventional healing methods will stay on a static ground of *traditionalism* and will grow on a more commercial scale. The new paradigms of modern medicine will continue to grow as it works proportionally with coming of modern age. The biomedical method will challenge by answering the counters for new age diseases, which are tough to beat by traditional healing methods (maybe it is due to advancement in disease proliferation in recent times or maybe advancement in bio - medical technology), but the dialogues with goddess and mode of healing performances will also retain its place within the communities in south Odisha as an integral part of social metabolism.

Footnotes

1. Vow to goddess; an invocation to a deity seeking blessing or prayer for the family or self (see Hauser, 2012; 2008; Misra, 1994; Otten, 2006). Hauser described the performance as invocation to goddess which is not done usually (Hauser, 2012; see also Pathy and Fischer, 1996)

2. Few of the informants said that going to a doctor is thrice up the price without medicine as compared to local healer.

3. An estimate is taken, varies accordingly to the profession and migratory factor also play the parts.

4. Within the village territory, it is known as Gramya Chikitsa Kendra.

5. "Although it is rare that a PHC have an X – ray machine", as described by Laxminath Sahu of Baragaon Village in Ganjam district.

6. The *Zila Chikitsa Kendra* is the next level of PHC. It works similarly as the structure of the governmental body in the village level. The Panchayat body of government deals with the PHC and its manifestations while the Block development administration looks after the *Zila Chikitsa Kendra*.

7. Several studies on *Aanganwadi Kendras* observes the variation of work they perform, in different locations of India (Dongre, 2008; see also Ratnawali, 2010; Sudhakar, 2007, Larson, 2018).

8. Srirama Chandra Bhanja Medical College and Hospital, also known as *Cuttack Bada Medical* (lit. Cuttack big medical), is a government hospital in Cuttack, Odisha. Medical history have been studied by several scholars to understand how the gradual development of medical organisation flourished in the state with the course of time (Pati, 1998, 2002, 2009; 2006; Sonowal, 2007; Mishra, Arima, 2011; see also Purohit, 2016; Tribal health research in Orissa: Indian Council of Medical Research, 2011, S. 41, ISSN 0377-4910)

9. Although small pox is eradicated (WHO reports, 2013), but sometimes, disease like chicken pox and measles are also referred as Mahapuru Asiba (lit. Coming of the goddess).

10. *Saarala Maa* is an epithet of Durga. Other forms of epithets of Durga are narrated extensively in different studies across Odisha (Mahapatra, 1981, focused on religious tradition of Kakatpur in Puri district. See also Kulke, 1984; Brighenti, 2001; Preston, 1983 and Fischer and Pathy, 1996. One of the major epithet of Durga is Ma Mangala (being primarily worshipped in Ganjam district). Hauser argues that *Mangala* is an epithet of Durga and Candi; is fiercely and powerful and ideal worship for the beneficial of people (See Saktism in Odisha, Brighenti, 2001). In southern Odisha accent of Odia language, the terms such as *Ma, Mahapuru, Debi, Debata* signifies towards a deity. It can be a god or a goddess.

11. By 'dramatics', it reflects the ideological functioning of asceticism within the person which develops during the course of enculturation. The channeling of the person aesthetics towards a performance is crucial. In order to understand it, it is important to see how social symbolization of rituals is done (see Hauser, 2012).

12. Gramadevati – (lit. *Grama* means village, *devati* means goddess or female deity); *the* form of deity worshipped in the villages is south Odisha. Altar is small, not fancy yet believed to be aggressive as well as kind at the same time. Few studies observe that its altar are spread everywhere (Guzy, 2014). On the side of roads, under big trees, rocks etc. For people, the aniconic form of deity is in water, river, trees, leaves, stones and so on (Guzy, 2014; see also Hauser, 2012). She is considered as the savior of the village and its people from evils, ghosts as well as sickness and diseases; considered to be the primary form of worship in a village setting.

13. Previous studies on the region (Hauser, 2004, 2007, 2012; Pfeffer, 2007, 2017; Tanabe, 1999; Eschmann, 1978) and conversation with locals in the community.

14. M.N. Srinivas (1952) mentioned the similar adaption of change in social class by generation as a step by step method in his theory of *Sanskritisation* and *Brahminisation*.

15. This was one statement I received from an Aanganwadi Didi, recognized as one of the workers in Aanganwadi Kendra.

16. They were having a discussion about political mobility in Odisha and I joined them with their permission. I followed up with few questions as well.

17. People in south Odisha visit to the oracle is only during specific condition. Sax argues, "Typical afflictions include fever, stomach ache, and lack of energy, sleeplessness, sexual problems, and behavioural disturbances like involuntary possession, bouts of fear and panic, or excessive strife within the family (Sax, 2009).

18. See Nazrul Islam's article on *Indigenous medicine as commodity – A study on Ayurveda, 2010*.

19. His ideas on '*Symbolic traditionalization*' is altogether different. Leslie's idea of '*Revivalism*' conceptualise the notion of symbolically or even

relatively using the traditional medicines under the modern understandings of medical elements (Leslie, 1969).

20. The packet of toned milk is brought directly from the shop, opened and get poured directly in the offering place in the deity's altar.

21. While my visit to shrine of the village deity in Ganjam district, I participated in the *Pusa Paraba* festival in the region. I offered my prayers and received a small piece of Cadbury dairy milk chocolate from the priest as the *Prasad*.

22. See Hailey and Laidlaw's theory of *Ritualisation*, 1994; see also Bell, 1992. For Bell, ritualization is "a matter of various culturally specific strategies for setting some activities off from others, for creating and privileging a qualitative distinction between the 'sacred' and the 'profane,' and for ascribing such distinctions to realities thought to transcend the powers of human actors" (1992, p. 74).

23. Clients who were following traditional healing methods gradually rely upon it. They do not thrive follow up with one therapist and suggest for more than one doctor (see Sax, 2009, similar ideology of triangulating in case of ritual healers).

References

Beggiora, Stefano; 2015, Journey to the Centre of the World Indigenous cosmogony of Kuttia Kondh of Odisha, In *Internationales Asien Forum. International Quarterly for Asian Studies*, Munich.

Bode, Maarten; 2008, *Taking Traditional knowledge to the Market: The Modern Image of Ayurvedic and Unani industry, 1980 – 2000,* Hyderabad, Orient Longman.

Bodding, P. O.; 1925, *Studies in Santal medicine and connected folklore,* Calcutta, The Asiatic society of Bengal.

Buss, Arnold; 2001, *Psychological Dimensions of Self,* Thousand Oaks, London, Sage Publications.

Carducci, B; 2012, *Expressions of the Self in Individualistic vs. Collective Cultures: A Cross-Cultural-Perspective Teaching Module*, In *Psychology Learning and teaching,* S. 413-417, London, Sage Publication.

Carrin, Marine and Tambs – Lyche, Harald; 2008, *An Encounter of Peripheries: Santals and Missionaries 1867 – 1900,* New Delhi, Manohar Publishers.

Carrin, Marine 2014, Recovering the Lost speech of the Gods, Reframing Discussion of Possession in Orissa and Bengal, In T. Otten and U. Skoda (eds.), *Dialogue with Gods: Possession in Middle Indian Rituals*, Vol. VI, pp 77 – 108, Printed in Germany.

Census of India: Orissa 1931; 1961; 1991; 2001; 2011, Govt. Of India Reports.

Connor, Linda H. and Samuel, Geoffrey; 2001, Healing Powers and Modernity: Traditional Medicine, Shamanism and Science in Asian societies, Connecticut, Westport Press,

Csordas, Thomas; 1990, Embodiment as Paradigm of Anthropology, In *Ethos,* 5 – 47.

Desjarlais, Robert. R; 1992, *Body and Emotion: The Aesthetic of Illness and Healing in Nepal Himalayas*, Philadelphia, University of Pennsylvania Press.

Durkheim, Emily; 1912, *The Elementary Forms of Religious Life,* The Free Press,

Eschmann, A.; Hinduisation of Tribal Deities in Orissa: The Sakta and Saiva typology, in A. Eschmann, H. Kulke and G.C. Tripathi (eds), *The cult of Jagannath and Regional Traditions of Orissa*, New Delhi, Manohar Publishers, 79 - 97.

Festinger, Leon; 1954, Self - Evaluation as a Function of Attracting the Group, In *Human Relations*, California, Sage Publications, pp 161 - 174.

Guzy, Lidia; 2013, *Marginalised Music. Music, Religion and Politics from Western Orissa*. Lit. Berlin, Bern.

2014, Boil Ritual in Western Orissa: On Goddess Spirit possessions, Music and Healing in India religiosity. In T. Otten and U. Skoda (eds.), *Dialogue with Gods: Possession in Middle Indian Rituals*, Vol. VI, pp 137- 156, Printed in Germany.

Hardy, Adam; 1999, *Birabalabhadrapur: A Brahmin Village in Orissa*, In *South Asian Studies*, pp 67 - 82.

Hauser, Beatrix; 2006b, Tribal or Tantric? Reflection of classification of Goddess in Southern

Orissa, In Georg Pfeffer (ed.) *Periphery and Centre: Studies in Orissa History, Religion and Anthropology*, New Delhi, Manohar Publishers, 131 - 52.

- 2008, Acting like Gods? Ways to embody the divine religious play and deity possession, In *Diskus,* pp 48 – 70.

- 2011, The Topography of the Female Self in Indian Therapeutic Cults, *Ethnologies*, 33 (2) 3 – 26.

- 2012, *Promising Rituals: Performativity and Gender in Eastern India*, New Delhi, Routledge.

- 2014, (Re) Calling the Goddess: The Emergence of Divine Presence, In T. Otten and U. Skoda (eds.), *Dialogue with Gods: Possession in Middle Indian Rituals*, Vol. VI, pp 109 - 136, Printed in Germany.

Islam, Nazrul; 2010, Indigenous Medicine as Commodity - Local research of Ayurveda in Modern India. In *Current sociology*, pp 777 – 798, London, Sage Publication.

Kakar, Sudhir; 1982, *The Inner World: A psycho – analytic study of childhood and society in India*, New Delhi, Oxford Press.

Lambek, Michael; 1989, From Disease to Discourse: Remarks on Conceptualization on Trance and Spirit Possession. In Colleen Ward (ed.) *Altered State of Consciousness and Mental Health, A cross – cultural perspective,* Newbury Park, Sage Pubs. 36 – 61.

Madhavan, Harilal and Singh, Ashis; 2015, *Traditional vs. non-traditional healing for minor and major morbidities in India: uses, cost and quality comparisons*, England, Blackwell Publishers.

Mallebrein, Cornelia; 2004a, Ruler Protector and Healer: The clan god Sulia, Patkhanda and Sikerpat of Kondh Tribe. In *Journal of Social Sciences*, July, 2003. Special issue: Facets of Orissa studies, ed. C. Mallebrein and L. Guzy, 143 – 153.

- 2004b, Entering the Realm of Durga: Patkhanda, a Hinduised tribal deity. In A. Malinar, H. Frese, J. Beltz (eds.), *Text and context in the History, Literature and Religion of Orissa*, Delhi, Manohar publications.

- 2008a, Tutelary Deities in Royal courts of Orissa, In G. Berkemer and H. Kulke (eds.), *Center out there? Facets of sub regional identities.* New Delhi, Manohar Publishers.

- 2014, The Divine Play on Earth: Forms of Possessions in Orissa, In T. Otten and U.

Skoda (eds.), *Dialogue with Gods: Possession in Middle Indian Rituals*, Vol. VI, pp 31 – 76, Printed in Germany.

Ministry of Health and Welfare Reports; 2015, 2016, Govt. of India Reports.

Mishra, Arima; 2010, *Health, illness and medicine* – an ethnographic reading, Hyderabad, Orient Blackswan.

- 2013, *Multiple Voices and Stories - narratives of Health and Illness*, New Delhi, Orient Blackswan.

Nichter, Mark; *Global Health: Why Cultural perception, Social representation and bio – politics matter.* Tuscon, University of Arizona Press.

- 2010, Idioms of distress revisited, In *Culture, medicine and Psychiatry,* Special Issue:

Trauma and Idioms of Distress, pp 401 – 406, Netherland, Springer.

Oths, Katherine; 2004, *Healing by Hand: Manual medicine and Bonesetting in Global Perspective*, Alta Mira Press, Sage Publications.

Otten, Tina; 2006, *Heilung durch Rituale: Vom Umgang mit krankheit bein den Rona im Hochland von Orissa*, (English ed.) Berlin, Lit.

Oyserman, D and Lee, Spike W. S.; 2007, *Does Culture Influence What and How We Think? Effects of Priming Individualism and Collectivism,* Psychological Bulletin, American Psychological Association, 134, 2, S. 311-342.

Pakaslathi, Antti; 1998, Family Centred Treament of Mental health Problems in the Balaji temple in Rajasthan. In Asko Parpola and Sirpa Tenhunen (eds.), *changing Patterns of Family and Kinship in South Asia.* Study Orientalia, 84, 129 – 66.

Pati, Biswamoy; 2004; Opening up the Country: Patterns of Circulation and Politics of Communication in Early Colonial Orissa; In *Studies of History,* Sage Publication, pp 73-130.

Patra, Satis; 1997, *Paaramparika Thakurani Jaatra o' Ma'nka Mahima*, Berhampur, Siddhabira

Publications.

Sax, William S.; 1991, *Mountain Goddess: Gender and politics in a Himalayan Pilgrimage*, New York, Oxford Press

- (ed.) 1995a, *Gods at Play: Lila in South Asia*, Oxford university press.

Van Hollen, C; 2003, *Birth on the Threshold: Childbirth and modernity in South India*, New Delhi, Zubaan.

Man in Society ISSN 2347-1530
Volume 25, 2018, pp. 15-23

A Study on the Nutritional Status of Tribes of Shamakhunta Block, Mayurbhanj District, Odisha:

Simarani Sethi[1] and Kanhu Charan Satapathy[2]

Abstract

Odisha is one of the most backward states in India and its reflection also felt among the tribal communities. There exists scanty information of the prevalence of undernutrition and aneamia among the tribal population of Odisha. The present study was carried out in the Mayurbhanj district which is inhabited by 53 tribal communities such as Santal, Juang, Bhumij, Bathudi, Savar, Kolha, Bhuinya, etc and it constitutes 58.72 of the total population of Odisha. A cross sectional nutritional anthropometric survey was conducted among Bhumij, Bathudi and Savar communities of Shamakhunta Block, Mayurbhanj District, Odisha. A total number of 269 individuals of (Bhumij, Bathudi and Savar) were considered. The study reveals that all the three communities are socio-economically very poor, education level is low, and occupationally most of them belong to agricultural labour category. In terms of Body Mass Index (BMI), the percentage of Chronic Energy Deficiency (CED) is very high and the number of cases belong to obese category is very low. On the other hand, in terms of haemoglobin percentage they exhibit high anemic conditions. Similarly, as for as food taboos are concerned culture specific habits such as the consumption of milk is not very frequent among the Bhumij as compared to the other two communities. The study reveals that for both sexes 56.13% individuals are having the Chronic Energy Deficiency (CED) or undernutrition whereas for males it is 47.89% and for females it is 62.66%. Normal total BMI (18.5-24.9) it is 40.89% whereas for males it is 48.73% and for females it is 34.66%.Overall Obese (BMI>25) is 2.9% for both sexes, whereas for males it is 3.36% and for females it is 2.66%. It was found that females are nutritionally more vulnerable in terms of prevalence of malnutrition as compared to the males. This shows that the health condition of these communities is under serious stress and requires immediate action and implementation of health intervention programs before the situation becomes too alarming.

Key Words : *Nutritional Status, BMI (Body Mass Index), Chronic Energy Deficiency(CED), Haemoglobin, Anaemia.*

Introduction

Nutrition is one of the most important environmental factors that play an important role in the overall development of an individual. Good nutrition means, "Maintaining a nutritional status that enables the human being to grow well and enjoy good health" (WHO, 1988). Malnutrition is the condition arising due to the intake of inadequate (over/less) nutrients in diet. It includes both undernutrition (imbalanced diet and specific deficiencies) and over nutrition. *Human health is determined by the level of socioeconomic development, particularly per capita Gross National Product (GNP), education, nutrition, employment, housing, the political system of the country etc. Studies show that in many developing counties, it is the economic progress that has major*

[1]UGC RGNF Fellow, P.G. Department of Anthropology, Utkal University, Email- simun.sima1991@gmail.com
[2]Associate Professor, P.G. Department of Anthropology (CAS), Utkal University, Vani Vihar, Bhubaneswar-04.

Nutrition is one of the most important environmental factors that play an important role in the overall development of an individual. Good nutrition means, "Maintaining a nutritional status that enables the human being to grow well and enjoy good health" (WHO, 1988). Malnutrition is the condition arising due to the intake of inadequate (over/less) nutrients in diet. It includes both undernutrition (imbalanced diet and specific deficiencies) and over nutrition. *Human health is determined by the level of socioeconomic development, particularly per capita Gross National Product (GNP), education, nutrition, employment, housing, the political system of the country etc. Studies show that in many developing counties, it is the economic progress that has major factor in reducing morbidity, increasing life expectancy and improving the quality of life. Education, particularly female education which is the second most important factor closely coincides with the map of poverty, malnutrition, ill health, high infant and child mortality rate. Similarly, occupation and health are closely related.* Body Mass Index (BMI) is the most widely used method of assessing the nutritional status as it is in-expensive, non-invasive, and suitable for large scale survey (Lohman et al., 1988; Ferro-Luzzi et al., 1992; James et al., 1994). BMI is generally considered a good indicator of not only nutritional status but also the socio-economic condition of a population, especially adult population of developing countries. Anaemia is "a condition in which the number of Red Blood Cells (RBCs) ortheiron oxygen-carrying capacity is inadequate to meet physiologic demands of the body, which vary by age, sex, altitude, smoking and pregnancy status"(WHO,2008). Globally, anaemia affects 1.62 billion people, which corresponds to 24.8% of the population. Prevalence of anaemia in all groups is higher in India as compared to other developing countries (Kalaivani,2009).The problem becomes more severe as more women are affected with it as compared to men (Malhotra,2004).Tribal peoples are acknowledged to have very close association with the ecosystem and the environment because of their fulfilment of daily nutritional requirements with food foraged from nature. *Unemployment, loss of work etc. are the major causes of psychological and social damage.* Keeping in view, the present study attempted to determine the nutritional status of the Bhumij, Bathudi and Savar tribes of Shamakhunta Village in Mayurbhanj District, Odisha. The study further attempts to compare the nutritional status of the participants with the other tribal populations of Eastern India and to investigate the factors influencing nutritional status of these communities.

Area and People

There are 62 tribal communities in Odisha, 13 out of which are categorised as Particularly Vulnerable Tribal Groups (PVTG). Mayurbhanj is a land locked district with a total geographical area of 10418 Sq.km. and is situated in the Northern boundary of the state with district headquarters at Baripada. The district is bounded in the North-East by Midnapore district of West Bengal, Singhbhum district of Jharkhand in the North-west, Balesore district in the South-East and by Keonjhar in the South-West. More than 39 % of total geographical area (4049 Sq.Km.) is covered with forest and hills. The district comprises of 4 numbers of Sub-divisions with 26 nos of blocks with 382 Gram Panchayats and 3945 villages. Mayurbhanj is one of the schedule district of Orissa with different cultural and different types of food habits are traditionally practices. In this study an attempt has been done to light upon the nutritional status of the people of Bhumij, Bathudi and Savar community, who were lived in same ecological habitat of Shamakhunta block, Mayurbhanj district, Odisha. The primary occupation of the tribe of Mayurbhanj is mainly daily agricultural and manual labours. Their traditional occupation used to be settled cultivation, gathering, and fishing. To summarize, the tribes of the district are very much lagging behind in socio economic aspects and have a very low literacy rate.

Bhumij

Bhumij an Austro- Asiatic group speak Bhumij Language. As per census of India (2011) the sex ratio of the tribe is 1010 females per 1000 males. The literacy rate among the Bhumij is 52.06 per cent, out of which male comprises 63.60 per cent and female comprises 40.70 per cent. The Bhumij family is nuclear, patrilineal and patripotestal (Ota, 2015). The clan system regulates marriage and adult marriages are in vogue.

Bathudi

Bathudi an Indo-Aryan group speaks Odia language. As per census of India (2011) the sex ratio of the tribe is 1041 females per 1000 males. The literacy

rate among the Bathudi is 63.71 per cent, out of which male comprises 75.74 per cent and female 52.27 per cent. The settlements are generally uniclan and homogeneous. Family is nuclear, patrilineal and patripotestal (Ota, 2015).

Savar:

Savar speaks Sora (Mundari) or Odia (Indo-Aryan) language. They are also called Saora, Saura, and Sahara. It is a PVTG in Odisha. As per census of India (2011) the sex ratio of the tribe is 1023 females per 1000 males. The literacy rate among the Savar is 54.99 per cent, out of which male comprises 66.81 per cent and female 43.56 per cent. They are artist by nature who can compose and sing songs instantly and make beautiful wall paintings (icons) which have made them famous all over the world (Ota, 2015).

Materials and methods

The study was an investigation of both i) exploratory as well as ii) descriptive research design types. The area of my study was in the Balidiha Grama Panchayat of Shamakhunta Block of Mayurbhanj district. The village Balidiha 17 Kilometres away from the district HQs i.e. Baripada. The study was carried in three hamlets under Balidiha Panchayat namely; Bhunda sahi, Dunguri Sahi and Dehuri sahi.

Results & Discussion

Table 1 Mean height (cm) of Bhumij, Bathudi and Savar community.

Age groups	*Sex*		*Bhumij*		*Bathudi*			*Savar*		
		N	*Mean*	*Std. Deviation*	*N*	*Mean*	*Std. Deviation*	*N*	*Mean*	*Std. Deviation*
<10	Female	07	108.57	20.38	13	107.55	16.04	9	110.48	20.44
	Male	05	101.10	16.78	14	115.64	20.27	5	104.12	2.34
11-20	Female	22	143.62	14.30	14	143.69	5.28	6	143.07	10.18
	Male	09	152.78	19.37	16	150.32	13.73	4	154.53	3.77
21-30	Female	08	152.79	6.91	11	143.91	14.02	12	140.32	17.71
	Male	06	156.02	8.26	02	158.90	1.98	4	154.18	5.57
31-40	Female	06	149.12	4.83	6	146.00	7.07	3	148.33	4.65
	Male	11	158.24	8.58	03	161.20	3.76	4	154.78	2.46
41-50	Female	04	150.55	1.10	07	147.27	7.36	3	143.10	3.44
	Male	06	157.53	6.94	05	149.66	13.98	2	152.00	1.41
51-60	Female	09	146.24	6.70	03	149.00	2.69	4	147.13	1.23
	Male	05	149.50	9.06	05	156.34	5.91	1	152.50	0
61+	Female	02	148.50	0.00	01	147.40	.0	1	137.00	0
	Male	05	150.00	5.76	04	148.08	3.73	2	157.10	5.52
Total	Female	58	142.28	17.40	55	136.26	19.33	38	135.17	20.03
	Male	47	148.93	20.42	49	141.79	21.96	22	142.96	21.82
	105	**Total**	**145.26**	**19.01**	**104**	**138.86**	**20.69**	**60**	**138.03**	**20.87**

Bhunda sahi and Dunguri sahi are predominantly inhabited by the Bhumija tribe where as Dehuri sahi is exclusively inhabited by the Savar tribe. A total number of 269 individuals (>10 yrs-60yrs) were included for the study. The response rates were 95% in the three tribal groups respectively. The majority of subjects were illiterate and very low wage earning manual labourers. Thus they were belonging to the low socio-economic class. Ethical Clearance and prior permission was obtained from relevant authorities and the local community leaders, respectively. *Anthropometric measurements were made following the IBP Basic List of Measurements and standard techniques (Weiner and Lourie, 1981). Height and weight were recorded to the nearest 0.1cm and 0.5 kg, respectively.* The anthropometric measurements were taken using anthropometric rod and weight also taken by using manual weight machine. *BMI was calculated by the standard formula:* BMI=Weight (Kg)/height (m^2). The following cut-off points were utilized: CED: BMI <18.5; Normal: BMI = 18.5–24.9; Overweight: BMI ≥ 25.0. The nutritional status of the population has been judged on the basis of dietary investigation, nutritional anthropometry and observation of clinical manifestation. For the purpose of observing and grading of nutritional status several measures have been used in the present studies which are as follows: a. Dietary Survey and b. Nutritional Anthropometry (Weight for age, height for age). Haemoglobin level was estimated immediately after collecting the blood specimens using a Sahli's haemoglobinometer. The method suggested by the WHO (1968) has been followed for diagnosis of anemia of an individual in the present study, which is as given below. Adult males 13 g/dl, Adult females, non-pregnant 12 g/dl, Adult females, pregnant 11 g/dl, Children, 0-6 yrs. 11 g/dl, Children 6- 14 yrs.12 g/dl. All statistical analysis were undertaken using the SPSS 20.0 and MS-Excel.Data was collected from the study population by house-to-house visits using a pre-designed semi structured questionnaire after taking verbal consent.

From the above table (1) it shows that the mean height (cm) of Bhumij community is 145.26, the mean height of Bathudi is 138.86, whereas the mean value of height of Savar community is 138.03. So, Bhumij community have greater mean value of

Table 2 Mean Weight (Kg) of Bhumij, Bathudi and Savar Community.

Age group	*Sex*	*Bhumij*			*Bathudi*			*Savar*		*Std. Deviation*
		N	*Mean*	*Std. Deviation*	*N*	*Mean*	*Std. Deviation*	*N*	*Mean*	
<10	Female	07	18.36	9.60	13	16.55	4.82	9	14.44	3.89
	Male	05	17.68	4.00	14	21.14	9.73	5	15.76	1.44
11 -20	Female	22	40.55	10.53	14	37.75	6.93	6	35.50	10.28
	Male	09	47.49	14.08	16	41.41	11.52	4	47.15	6.35
21 -30	Female	08	46.00	9.89	11	41.28	4.70	12	38.06	11.64
	Male	06	48.00	4.15	02	53.35	4.74	4	47.65	7.91
31 -40	Female	06	47.33	6.56	06	39.48	9.00	3	38.67	10.36
	Male	11	48.55	4.39	03	53.00	11.26	4	47.95	3.76
41 -50	Female	04	39.50	4.43	07	35.51	3.79	3	37.57	6.70
	Male	06	49.33	3.14	05	46.28	14.10	2	42.80	2.55
51 -60	Female	09	40.44	4.93	03	43.93	9.74	4	37.50	3.39
	Male	05	41.00	11.40	05	46.40	12.03	1	53.00	0
61+	Female	02	34.00	0.00	01	39.80	0	1	31.60	0
	Male	05	39.80	7.66	04	39.50	5.92	2	49.05	4.60
Total	Female	58	39.01	11.81	55	33.73	11.44	38	31.84	12.85
	Male	47	43.36	12.26	49	37.67	15.13	22	40.30	14.41
	Total	**105**	**40.96**	**12.15**	**104**	**35.58**	**13.39**	**60**	**34.94**	**13.94**

height than Bathudi and Savar community. Among Bhumij community the greater mean value of height (cm) is observed among males between 11-20 yr age group i e 152.78 whereas among Bathudi community the mean value of height(cm) is observed among males between 21-30yr age group i. e 158.90 and the mean height of Savar community is 157.10.

From the above table (2) it shows that the mean weight (kg) of Bhumij community is 40.96 whereas the mean value of weight of Bathudi community is 35.58 and the mean value of weight of Savar community is 34.94. So, Bhumij community have greater mean value of weight than Bathudi and Savar community. Among Bhumij community the greater mean value of weight (kg) is observed among males between 11-20 yr age group i e 47.49 whereas among Bathudi community the mean value of weight (kg) is observed among males between 21-30yr age group i e 53.35 and Savar community the mean value of weight(kg) is observed among males between 31-40 group ie 47.95.

Table 3 Community wise distribution of nutritional status as per BMI.

Community		*CED (BMI <18.5)*	*Normal (BMI 18.5 - 25)*	*Overweight (BMI >25)*
Bhumij	Male	16 (34.04)	30 (63.83)	1 (2.13)
	Female	28 (48.28)	29 (50)	1 (1.72)
	Total	44 (41.51)	59 (55.66)	2 (1.89)
Bathudi	Male	32 (65.30)	14 (28.57)	3 (6.12)
	Female	40 (72.72)	13 (23.64)	2 (3.64)
	Total	72 (69.23)	27 (25.96)	5 (4.81)
Savar	Male	8 (36.36)	14 (63.64)	0 (0)
	Female	27 (71.05)	10 (26.32)	1 (2.63)
	Total	35 (58.33)	24 (40)	1 (1.67)
Total	Male	56 (47.46)	58 (49.15)	4 (3.39)
	Female	95 (62.91)	52 (34.44)	4 (2.65)
	Total	151 (56.13)	110 (40.89)	8 (2.97)

The rates of undernutrition among the three tribal groups are compared in Table 3. The rate of under nutrition is very high in Bathudi community. The rate of undernutrition is comparatively low as compared to Bhumijs and Savars. The highest frequency of undernutrition is found among the Bathudi female (72.72%) followed by Bhumijs (male=34.04%, female=48.28%) and Savars(male=36.36% and female=71.05%). Total population shows that 56% of overall population (including both male and female) fall under CED level. 2.97% individuals are found overweight or obese in the studied population.

Table 4 Characteristics of Nutritional status of the subjects based on BMI.

Nutritional Status	*Sex*		*Total (%)*
	Male (%)	*Female (%)*	
Chronic Energy Deficiency (BMI <18.5)	47.89	62.66	56.16
Normal (BMI 18.5 -24.9)	48.73	34.66	40 .93
Overweight or obese (BMI >25)	3.36	2.66	2.9
Total	100	100	100

From the above table (5) it shows that the total number of Chronic Energy Deficiency of both male and female were 56.16(%) whereas for males it is 47.89% and for females it is 62.66%.Normal total BMI (18.5-24.9) it is 40.93% whereas for males it is 48.73% and for females it is 34.66%.Total Obese BMI>25) is 2.9% whereas for males it is 3.36% and for females it is 2.66%.

From the above table (6) it is revealed that normal 16.98% of total Bhumij population are anaemic in which 7.54 % males and 9.43 % females are aneamic. In Bathudi it shows that total 39.3% are in anaemic whereas for males it is 18.1% and females it is 21.2 %. In Savar it shows that total 19.44 are in anaemic whereas for males it is 8.33 and females it is 19.44. The cases of anaemia were found among 24.07% of males and 27.94% females.

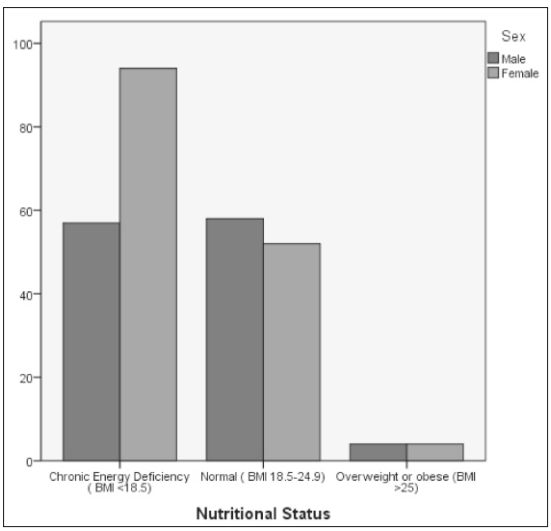


Figure 4 shows that Characteristics of Nutritional status of the subjects based on BMI.

Table 5 Characteristics of Haemoglobin concentration

Community	*Haemoglobin concentration*	*Male (%)*	*Female (%)*	*Total (%)*
Bhumij	Normal	15 (28.30)	29 (54.71)	44 (83.01)
	Anaemic	04 (7.54)	05 (9.43)	09 (16.98)
Savar	Normal	12 (33.33)	12 (33.33)	24 (66.66)
	Anaemic	03 (8.33)	07 (19.44)	10 (19.44)
	Above normal	02 (5.55)	00 (0)	02 (5.55)
Bathudi	Normal	12 (36.3)	8 (24.2)	20 (60.6)
	Anaemic	6 (18.1)	7 (21.2)	13 (39.3)
Total	Normal	39(72.22)	49 (72.1)	88 (72.13)
	Anaemic	13(24.1)	19 (27.9)	32 (26.23)
	Above normal	02 (3.7)	00 (0)	02 (1.64)
	Total	54	68	122

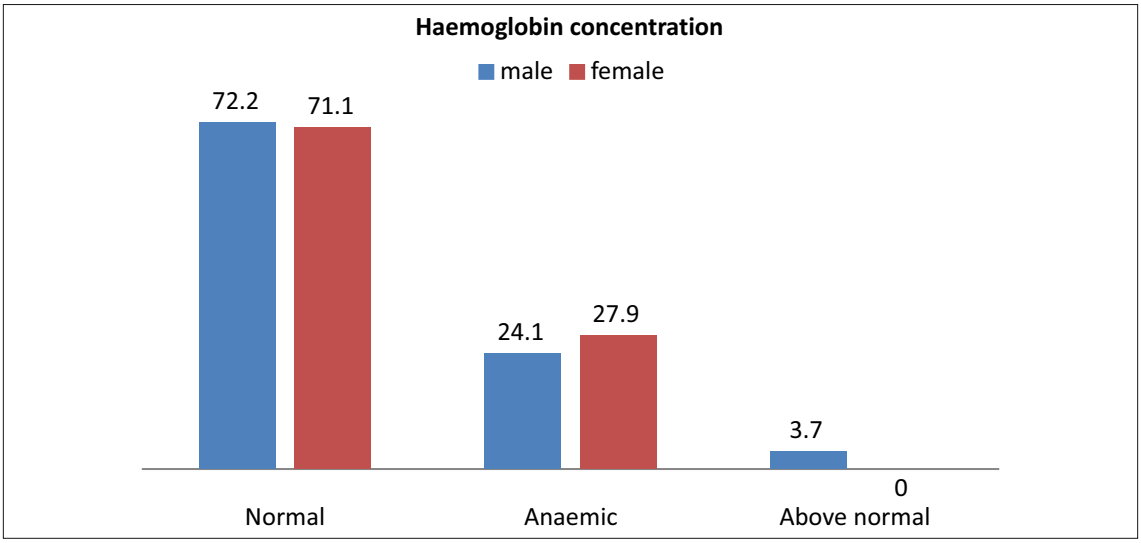


Figure 5 shows the haemoglobin concentration

Table 6 Prevalence of CED among the tribes of Eastern India

Tribe	*Sample size*	*Mean BMI*	*CED (BMI<18.5) (%)*	*Study Area*	*Reference*
Oraon	Male : 200	18.8 (2.0)	47.0	Jalpaiguri	Mittal and Srivastava, 06
	Female :150	19.7 (2.4)	31.7		
Lodha	Male :157	19.5 (2.7)	45.2	Paschim Medinipur	Mondal, 2007
	Female:199	19.3 (2.6)	40.7		
Dhimal	Male: 159	19.5(2.5)	27.0	Darjeeling	DattaBanik et al., 2007
	Female:146	19.1(2.6)	46.4		
Santal	Male:400	18.5(2.1)	55.0	Bankura	DattaBanik et al., 2007
	Female:400	18.7 (2.3)	52.5		
Bhumij	Male: 244	18.9 (2.6)	48.4	Balasore	Goswami, 2012
	Female:223	18.5 (2.0)	58.3		
Mankidia	Male:124	19.3 (2.2)	48.4	Mayurbhanj	Goswami, 2011
	Female:136	18.6 (2.8)	59.5		
Juang	Male:414	19.4 (2.7)	51.9	Keonjhar	Goswami, 2013
	Female:423	18.3 (2.9)	62.9		
Bathudi	Male:226	18.4 (1.9)	52.7	Keonjhar	Bose and Chakravarti, 2005
	Female:183	17.9 (2.5)	64.5		
Savara	Male:	19.3 (2.1)	38.0	Keonjhar	Bose et al., 2006
	Female:	18.9 (2.7)	49.0		
KoraMudi	Male:	18.7 (1.8)	48.0	Bankura	Bose et al., 2006
	Female:	18.3 (2.1)	56.4		
Amanatya	Male : 12	21.3 (1.5)	0	Nabarangapur	Sahoo et al, 2017
	Female: 16	18.6 (0.9)	50.0		
Bhotra	Male: 52	20.5 (1.8)	7.69	Nabarangapur	Sahoo et al, 2017
	Female: 48	19.7 (1.5)	16.6		

Saora	Male: 36	18.6 (2.0)	44.44	Nabarangapur	Sahoo et al, 2017
	Female: 36	18.9 (1.4)	33.33		
Bhumij	Male: 47	19.1 (3.1)	34.04	Mayurbhanj	Present study
	Female: 58	18.6 (3.2)	48.27		
Bathudi	Male: 50	17.7 (3.2)	65.30	Mayurbhanj	Present study
	Female: 54	17.6 (4.0)	72.72		
Savar	Male: 22	18.6 (2.8)	36.36	Mayurbhanj	Present study
	Female: 38	16.7 (3.5)	71.05		
Odisha (Rural)	Male:	-	21.4	Odisha(Rural)	NFHS-2015-16
Odisha (Rural)	Female:	-	28.7	Odisha(Rural)	NFHS-2015-16
Odisha (urban)	Male:	-	12.6	Odisha(urban)	NFHS-2015-16
Odisha(urban)	Female:	-	15.8	Odisha(urban)	NFHS-2015-16
Mayurbhanj (Rural)	Male:	-	18.7	Mayurbhanj(Rural)	NFHS-2015-16
Mayurbhanj (Rural)	Female:	-	33.2	Mayurbhanj(Rural)	NFHS-2015-16

From the table (7) it reveals that there is a very high prevalence Chronic Energy Deficiency (CED) among the tribes of Eastern India. Studies show that the percentage of CED is higher in males as compared to females whereas in Oraon, Lodha, Santal, and Saora (present study) the prevalence of CED is higher in case of males. The present study shows a high percentage of CED among the Bathudis and Savars. The Bhumij has a lower CED level but this cannot be neglected. The CED of odisha rural female is 28.7 which are more than males' i.e 21.4. In urban male the CED is 12.6 and urban female it is 15.8.The chronic Energy Deficiency of Mayurbhanj rural male it is 18.7 and female it is 33.2.

Table 7 shows the anaemic status of different population in India and World

population	*Percentage suffering from Anaemia(%)*	*Reference*
World(Pregnant,15 -49yrs)	29	World Health Organization, 2011
World (Non pregnant women,15 -49yrs)	38	World Health Organization, 2011
India (pregnant women)	87.00	Capoor and Grade 2 000
Odisha rural (male)	31.50	NFHS-4 2015-2016
Odisha rural(female)	51.80	NFHS-4 2015-2016
Odisha urban (male)	16.20	NFHS-4 2015-2016
Odisha urban (female)	47.60	NFHS-4 2015-2016
Mayurbhanj rural(male)	27.00	NFHS-4 2015-2016
Mayurbhanj rural(female)	42.00	NFHS-4 2015-2016
India (children, 6 -59 months)	69.50	Kotecha,2011
Madhya Pradesh (children, 6 -59 months)	74.10	Kotecha,2011
Chhatisgarh (children, 6 -59 months)	71.20	Kotecha,2011
Bihar (children, 6 -59 months)	78.00	Kotecha,2011
Jharkhand (childr en, 6-59 months)	70.30	Kotecha,2011
West Bengal (children, 6 -59 months)	61.00	Kotecha,2011
Andhra Pradesh (children, 6 -59 months)	70.80	Kotecha,2011
Mizoram(children, 6-59 months)	44.20	Kotecha, 2011
Nalgonda, Telangana (above 50 years)	29.86	Malhotra et.al, 2015
Kerala (Pallakad district tribal women, 15-49 yrs)	78.32	Sreelakshmi et.al,2012
Odisha (children, 6-59 months)	65.00	Kotecha, 2011
Odisha (Paudi Bhuyan)	85.00	Bulliya et al.1999-2000
Odisha (Kutia kondha)	91.63	Baliarsingh et al.2015
Odisha (Panocommunity)	91.64	Present study, 2015
Odisha (Mayurbhanj) (Bhumij)	16.98	Present study
Odisha (Mayurbhanj) (Bathudi)	39.30	Present study
Odisha (Mayurbhanj) (Savar)	19.44	Present study

From the above table (7), it shows that a high percentage of anaemic among the Bathudis and Savars. The Bhumij have a lower anemic level but this cannot be neglected

Conclusion

The present study among the three tribal groups of Shamakhunta village of Mayurbhanj district reveals that the prevalence of undernutrition and anemia is very much common irrespective of the tribes.Females are the worst sufferers as compared to their male counterparts. When the results of the present studies were compared with other studies among the tribes of Eastern India, it shows a similar trend in terms of undernutrition. However, this distinct inter-tribal difference is due the variation in their poor socio-economic condition, poor literacy rate, food habits and lack of awareness and health care facilities. Therefore, it is suggested that better education and employment opportunities will enhance their overall development. The government should consider culture specific programme and policies in order to increasing the socio-economic conditions and health care facilities to reduce the burden of undernutrition among the tribal groups of eastern India.

References

Baliarsing S, Mohapatra S and Satapathy KC 2015. Prevelance of Anaemia among Pano Community of Tumudibandha block,Kandhamal District,Odisha. *Man in Society* 22, 116-123.

Bulliya G, Mohapatra S.S.S, Kerketta, A.S. and Nayak, R.N. Assessment of health and nutritional profile among elderly population of Orissa primitive tribes. Annual Report, Regional Medical Research Centre, Bhubaneswar, p.40, 1999-2000.

Bose K. and Chakrabarty F. 2005. Anthropometric characteristics and nutritional status based on body mass index of adult Bathudis; a tribal population of Keonjhar district, Orissa, India. *Asia Pacific Journal of Clinical Nutrition.*14, 80-82.

Bose K, Ganguly S, Mamtaz H, Mukhopadhayay A, Bhadra M.2006 High prevalence of undernutrition among adult Kora Mudi tribals of Bankura District,WestBengal,*India . Anthropological Sciecnce,* Vol. 114, No. 1, pp. 65-68.

Capoor I. and Gade J.2000 CHETNA Team,paper presented at the World Congress on Women's Health on November 10th,11th and 12th,2000 science city,Calcutta.

Chakraborty R. and Bose K. 2007 Anthropometric characteristics and nutritional status of adult Oraon men of Gumla District,Jharkhand,India.*The Internet Journal of Biological Anthropology.* Volume 2 Number 1.

Datta Banik S, Bose K. Bisai S. Bhattacharya. M.Das S. Jana A. & Purkait P. 2007. Chronic energy deficiency among the Adult Dhimals of Naxalbari, West Bengal – Comparison with other tribes of Eastern India.*Food and Nutrition Bulletin*. 28(3), 348-352.

Goswami M. 2011 Socio-economic profile and anthropometric characteristics of the Mankidias-A primitive tribe of Northern Orissa, India. *Tribes & Tribals (Communicated).*

Socio -Cultural variables and Biological Determinants of Human Fertility in a primitive tribal community – An empirical study among the Mankirdias of Orissa, India. Man in India, Vol 91(3 - 4), 2011, pg 567 -576, ISSN : 0025 -1569.

Goswami M. 2012 Body mass index and chronic energy deficiency of adult Bhuyans: A vulnerable tribal group. *Ind. J. Phys. Anthrop. & Hum. Genet*. Vol. 31. No. 1, : 39-47.

Goswami M.2014 Body Mass Index and Chronic Energy Deficiency among Adult Male Lodhas and Kharias of Mayurbhanj,Odisha.Comparision with other tribal populations of Eastern India. *Antrocom Online Journal of Anthropology*.Vol.10,359-364.

Kalaivani K.2009.Prevalence & consequences of anaemia in pregnancy,IJMR;130:627-633.z

Kotecha,P.V.2011 Nutritional Anaemia in young children with Focus on Asia and India. Indian J Community Med.jan-mar;36(1):8-16.

Malhotra P.,Kumari S.,Kumar R. And Varma S. 2004.Prevalence of anaemia in adult rural population of north India.JAPI;52:18-20.

Sahoo D. 2017 Prevalence of Undernutrition among three Tribes of Nabarangpur, Odisha. *Man in Society* 23, 112-119..

Sethi S. 2013 A Comparative Study on the Nutritional Anthrotopometry of Savar and Bathudi Communities of shamakhunta, Mayurbhanj, Odisha.

World Health Organization (WHO), 2008. Worldwide prevalence of anaemia 1993-2005.Global Database on Anaemia.Geneva.

World Health Organization (WHO), 2011. The Global Prevalence of Anaemia in 2011.Geneva.

Man in Society ISSN 2347-1530
Volume 25, 2018, pp. 24-30

Prevalence of non-communicable disease risk factor among the rural Santals of Mayurbhanj district, Odisha

Dillip Kumar Barik[1], Prasanna Kumar Patra[2], Kanhu Charan Satapathy[2]and Laxman Kumar Sahoo[3]

Abstract

Non-communicable disease known as chronic diseases which last for long time period and generally slow progression .The non communicable diseases are usually the result of a combination of genetic, physiological, environmental and behaviors or lifestyle factors. This study aims to describe the prevalence of non-communicable disease (NCD) risk factors among the Santal Tribes of Mayurbhanj district of Odisha.The present study has carried out among the peoples Santal tribe of Mayurbhanj district, Odisha where 75 participants had participated in the study. The information on risk factors of non-communicable diseases (NCDs) like socio demographic, behavioral, physiological and physical measurements was obtained through standardized protocol by using the WHO STEPS approach.

In this study found that 48.6% were in age group of 18–47 years.73.4% were having education below secondary/higher secondary. 64% belonged to lower/ middle socioeconomic class. 52% of which are either farmers or daily labour. In the studied population 37.3% were currently using tobacco either in the form of chewing or smoking, among these 30.7% were males. 61% were currently consuming alcohol; of these males comprised 53.3% and 64% were taking less fruit & vegetables. Among them 6.7% were hypertensive, 9.3% were overweight/obese, 22.7% were under nutrition and 2.7% diabetics were found. The study revealed that lower/middle socio-economic class consumption of tobacco and alcohol; less fruit and vegetable intake are found as risk factor for NCDs and the majority were males and the findings also highlights that the biological risk factor like hypertension, under weight, overweight/obese and diabetes are prevalent up to some extent, whereas the males are more affected than the females.

Keywords: *WHO steps, Non-Communicable diseases (NCDs), Risk factors, Tobacco, Alcohol, Hypertension, Diabetes, Under weight, Over weight/obese.*

Introduction

Non communicable diseases (NCDs) are the disease which is not infectious or transmissible which are otherwise known as chronic diseases, and tends to be of long time period and generally slow progression. Non-communicable diseases (NCDs) are the leading cause of morbidity and mortality throughout the world, with the greatest burden in low and middle-income countries. The four main types of non communicable diseases are cardiovascular diseases (like heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma) and diabetes. The non communicable diseases are usually the result of a combination of genetic, physiological, environmental and behaviors or lifestyle factors are account for almost two-thirds of all deaths globally, with 80 per cent of these occurring in low- and middle-income countries (WHO, 2016 fact sheet).

According to Global Health Observatory (GHO-2017) data, non communicable disease causes about 40.5 million death which is equal to 71% of 56.9 million globally death in 2016. About 15 million people are of ages between 30 and 69 are leads to die each year and over 85% of these "premature" deaths occur in low- and middle income countries. The leading causes of NCD deaths in 2016 were cardiovascular diseases about 17.9 million deaths

[1]M.Phil Scholar, P.G. Department of Anthropology, Utkal University, Vanivihar. Bhubaneswar-04. Email- dillip448@gmail.com
[2]Associate Professor, P.G. Department of Anthropology (CAS), Utkal University, Vani Vihar, Bhubaneswar-04.
[3]UGC Post Doctoral Fellow, P.G. Department of Anthropology (CAS), Utkal University, Vani Vihar, Bhubaneswar-04.

which was nearly 44% of all NCD deaths, death due to cancers about 9.0 million, was equal to 22% of all NCD deaths, and respiratory diseases, including asthma and chronic obstructive pulmonary disease caused death 3.8 million about 9% of all NCD deaths. Diabetes caused another 1.6 million deaths. NCDs are not only the leading cause of highest level of mortality and morbidity in the world, but also the main causes of poverty and hinder the economic development of many countries. The burden is growing - the number of people, families and communities afflicted is increasing. Common, modifiable risk factors underlie the major NCDs. They include tobacco, harmful use of alcohol, unhealthy diet, insufficient physical activity, underweight, overweight /obesity, raised blood pressure, raised blood sugar and raised cholesterol.

Methods

The tribal population of India are experiencing phenomenal change on social, cultural, and economic fronts, for the past few decades and because of various developmental activities significant change in life style and dietary habits have seen among the tribal communities (Kshatriya et al.).A community Based Cross Sectional Study was carried out among the among the adults (18 years and above) of Santal Tribe in 3 villages (Changua,Talasa,Badagobra) of Tiring block of Mayurbhanj district of Odisha the where a total of 75subjects were participated in the study and the subjects were selected by using random sampling, to find out the prevalence of risk factors of non-communicable diseases (NCD) like socio demographic, behavioral, physiological and physical measurements was obtained through standardized protocol by using the WHO STEPS approach.

Pre-tested Performa included essential details of socio demographic and risk factors (B.G. Prasad's socio economic status scale was used to classify study subjects based on per-capita monthly income) for NCDs like tobacco use and alcohol consumption was used. Blood pressure was measured using inflatable mercury sphygmomanometer where two readings were taken at an interval of five minutes, and the average value of the measurements was used for the analysis and WHO standards used for blood pressure classification where Stage1 Hypertensive subjects were defined as those with systolic blood pressure $\geq$ 140 mmHg or diastolic blood pressure $\geq$ 90 mmHg and systolic blood pressure $\geq$ 150 mmHg or diastolic blood pressure $\geq$ 95 were considered as stage2 hypertensive subject. Anthropometry rod and digital weighting machine was used to measure height and weight respectively. Weight and height was measured to calculate BMI by using the formula: weight (kg)/height (m^2). BMI was categorized according to the WHO classification into following categories: underweight - <18.5, normal - 18.5–24.9, overweight - 25–29.9, and obesity - $\geq$ 30. The blood glucose has taken of the respondents by using the Glucometer and glucose strip. Raised fasting blood glucose was taken as the fasting plasma glucose level of $\geq$ 126 mg/dL according to the WHO diagnostic criteria. Diabetes mellitus was defined as those having raised fasting blood glucose levels of $\geq$ 126 mg/dL or those being treated for diabetes.

The data was analyzed by using MS word, MS excel and latest version of IBM SPSS version software and appropriate statistical tests were employed.

Aims and Objectives

The present study was carried to find out the non-communicable diseases (NCD) risk factors of behavioral risk factor as well as the biological risk factor. In which the behavioral risk factor includes the prevalence of low socio economic demographic profile, alcohol consumption, tobacco consumption, low fruit and vegetable intake, and the biological risk factor including the prevalence of high blood pressure, high blood sugar, under nutrition and overweight/ obesity.

Ethical statement

Prior the study was obtained the study was approved by the Institutional Ethics Committee from P.G Department of Anthropology, Utkal University and the purpose of the study was explained to the study participants and informed written consent were obtained .

Results

A total of 75 persons were interviewed of which 56 were males and 19 were females. Table 1 reveals about the socio demographic characters among the study population, maximum (48.6%) belong to the

age group of 18 – 37 years. 41.4% were having educational qualification below secondary/higher secondary, 45.2% belonged to lower middle and 36% belonged to lower socioeconomic class. Majority of them were farmers.

Table1: Socio-economic and Demographic Profile of Study Population

Variable	*Male N (%)*	*Female N (%)*	*Total N (%)*
Age group			
18-27	19(25.3)	7(9.3)	26(34.7)
28-37	12(16.0)	6(8.0)	18(24.0)
38-47	10(13.3)	5(6.7)	15(20.0)
48-57	8(10.7)	0(0.0)	8(10.7)
>57	7(9.3)	1(1.3)	8(10.7)
Total	56(74.7)	19(25.3)	75(100.0)
Education			
Illiterate	5(6.7)	1(1.3)	6(8.0)
Primary	16(21.3)	9(12.0)	25(33.4)
Secondary & higher secondary	30(40.0)	8(10.7)	38(50.7)
Graduate	4(5.3)	1(1.3)	5(6.7)
Post graduate	1(1.3)	0(0.0)	1(1.3)
Occupation			
Unemployed/ student	15(20.0)	0(0.0)	15(20.0)
Farmer	37(49.30)	2(2.7)	39(52.0)
Household work	2(2.7)	14(18.7)	16(21.30)
Government employee	2(2.7)	2(2.7)	4(5.30)
Religion : Hindu			
Tribe: Santal (ST)			
Socioeconomic classification			
Upper	0 (0.0	0 (0.0)	0(0.0)
Upper middle	4 (5.3)	2 (2.7)	6 (8.1)
Middle	8(10.7)	0 (0.0)	8(10.7)
Lowe middle	26(34.7)	8(10.7)	34(45.2)
Lower	18(24.0)	9(12.0)	27(36.0)

Table 2: Prevalence of Tobacco Consumption as Risk Factor of NCD

Sex	*Do you currently smoke any tobacco products, such as cigarette, gutka or bidi?*		*Total N (%)*
	Yes N (%)	*No N (%)*	
Male	28 (37.3)	28 (37.3)	56 (74.7)
Female	0 (0.0)	19 (25.3)	19 (25.3)
Total	28 (37.3)	47(62.7)	75 (100.0)

In regard to tobacco consumption as risk factor for NCDs, table 2 shows that 37.3% were using tobacco or tobacco products. Among the tobacco products consumed most common was gutka followed by bidi and cigarette.

Table3: Prevalence of Alcohol Consumption as Risk Factor

Sex	*Have you consumed any Alcohol within the past 30 days?*		*Total N (%)*
	Y es N (%)	*No N (%)*	
Male	40 (53.3)	16 (21.3)	56 (74.7)
Female	5 (6.7)	14 (18.7)	19 (25.3)
Total	45 (60.0)	30 (40)	75 (100.0)

Alcohol consumption as risk factor for NCD, the alcohol consumption status of past 30 days of the study participants have recorded and in which Table 3 represents that 60% were currently consuming alcohol, of these males comprised 53.3% and female comprises of 6.7% of them.

Table 4: Prevalence of Low Fruit Consumption among the Study Population

Sex	How many servings of fruit do you eat on one of those days? (per week)					Total N (%)
	0 N (%)	1-2 N (%)	3-4 N (%)	5 or more N (%)	Don't know N (%)	
Male	22(29.3)	10(13.3)	3(4.0)	1(1.3)	20(26.7)	56(74.7)
Female	11(14.7)	2(2.7)	0(0.0)	0(0.0)	6(8.0)	19(25.3)
Total	33(44.0)	12(16.0)	3(4.0)	1(1.3)	26(34.7)	75(100.0)

Table 5: Prevalence of Low Vegetable Consumption among the Study Population

Sex	How many servings of vegetables do you eat on one of those days? Number of servings (per week)				Total N (%)
	2-3 N (%)	4-5 N (%)	5 or more N (%)	Don't know N (%)	
Male	16 (21.3)	14 (18.7)	9 (12.0)	17 (22.7)	56 (74.7)
Female	3 (4.0)	9 (12.0)	4 (5.3)	3 (4.0)	19 (25.3)
Total	19 (25.3)	23 (30.7)	13 (17.3)	20 (26.7)	75 (100.0)

As low consumption of fruits and vegetable as one of the risk factor for NCDs, Table 4 reveals about the low fruit intake among the study participants which is 60% of the study participants are taking less than 3 serving of fruits where as Table 5 shows that 55.7% of the study participants are taking less than 5 serving of vegetables on one of those days (per week).

Table 6 : Classification of Blood Pressure among the Study Population.

Blood Pressure	*Male N (%)*	*Female N (%)*	*Total N (%)*
Normal	19 (25.3)	8 (10.7)	27 (36.0)
Pre hypertension	27 (36.0)	7 (9.3)	34 (45.3)
Stage 1 hypertension	6 (8.0)	3 (4.0)	9 (12.0)
Stage2 hypertension	4 (5.4)	1 (1.3)	5 (6.7)
Total	56 (74.7)	19 (25.3)	75 (100.0)

Table 6 reveals the blood pressure classification among the study participants and which shows that 45.3% of the respondents are pre hypertensive where as 12% and 6.7 % of the respondents are in the position of Stage 1 hypertension and Stage 2 hypertension and it also has seen that the males are more affected than the female.

Table7: Classification of Nutritional Status among the Study Population.

	BMI classification				
Sex	Under weight (<18.5) N (%)	Normal weight (18.5-24.9) N (%)	Over weight (25.0-29.9) N (%)	Obese (>=30) N (%)	Total N (%)
Male	13(17.3)	38(50.7)	5(6.7)	0(0.0)	56 (74.7)
Female	4(5.3)	13(17.3)	1(1.3)	1(1.3)	19 (25.3)
Total	17(22.7)	51(68.0)	6(8.0)	1(1.3)	75 (100.0)

Table 7 provides the information regarding the nutritional status of the study participants and which reveals that about 22.7% of the respondents were under nourished, 8% of the respondents were overweight and 1.3% of the respondents were obese.

Table 8: Prevalence of High Blood Sugar among the Study Population

	Raised blood glucose level			
Sex	Normal N (%)	Pre diabetic N (%)	Diabetic N (%)	Total N (%)
Male	47(52.6)	7(8.3)	2(2.7)	56(74.7)
Female	18(24.0)	1(1.3)	0(0.0)	19(25.3))
Total	44(86..7)	8(10.6)	2(2.7)	75(100.0)

Result from Table 8 shows that the general prevalence of high blood sugar among the study participants is 2.7% where as nearly 10.6% of the study participants are under pre diabetic condition.

Discussion

Globally Non-communicable diseases (NCDs) are the leading cause of morbidity and mortality, According to WHO Report 2016, they account for almost 71% of globally death. In India, estimated deaths due to non-communicable diseases were double than those from communicable diseases. A progressive rise in the disease pattern of NCD foretells a serious public health issue. The major risk factors for non-communicable diseases are tobacco and alcohol abuse, a sedentary lifestyle, and an unhealthy diet. The socio demographic characters like the age group, maximum belong to the age group of 18 – 37 years, majority were having educational qualification below secondary/higher secondary. Most of them belonged to lower middle or lower socioeconomic class and majority of them was either farmer. Similar finding were seen in study done by Tondare et al. In this study the 37.3% were using tobacco or tobacco products, of these majority were males .Among the tobacco products consumed most common was gutka followed by bidi and cigarette. In similar study done by Tondare et al. showed prevalence of tobacco use as 29.93 % among rural population. In The non-communicable diseases risk factor survey 2007-08 by IDSP, Ministry of Health & Family Welfare Government of India showed that tobacco use ranged from 9%-42%.8 Studies done by Chadha et al, Gupta et al and Thankappan et al showed prevalence of smoking among rural population as 54.45%, 44.6% and 24.3% respectively and in all three studies use of smokeless tobacco like gutka was most common which is similar to the present study.

Alcohol consumption as risk factor for NCD, 60% was currently consuming alcohol. Whereas the males are of comprising 53.3% and the females are of 6.7%, which shows that the males are consuming higher alcohol than of female, And it also has seen that most of the people of the studied community are taking “handia” (local rice beer), but the younger mass of this community are much more addicted towards the alcohol available at liquor shop. The study by Deepa et al on WHOICMR surveillance conducted in six regions of India which reported that

40.5% of the males were current alcohol users is seems to be little similar to the present study. In the present study prevalence of low consumption of fruits and vegetable was found, as the findings from the result nearly 64% of the respondents taking less than 5 serving of fruits and nearly 56% of respondents were taking less than 5serving of vegetable in one of those days in per week, which shows little similarity to the present study.

Hypertension as the most important non-communicable disease, in the present study the prevalence is 18.7% in the studied population. NFHS-4 state facts sheet Odisha showed prevalence of hypertension as 21.5% but present study showed much less prevalence of hypertension among the study population. Similar studies observed by Chadha et al, showed prevalence of hypertension among rural population as 7.4% respectively.

Findings from the result regarding the nutritional status of the study participants and which shows about 22.7% of the respondents were under nourished, 8% of the respondents were overweight and 1.3% of the respondents were obese and which shows that the males are the more vulnerable in undernourished and the females are in overweight and obesity. Findings from the result the general prevalence of high blood sugar among the study participants is 2.7% where as nearly 10.6% of the study participants are under pre diabetic condition. Similar study was done by Thankappan KR et al. showed prevalence of diabetes among rural population as 63.7% which is very high compared to the present study.

Strengths and Limitations of the Study

The study had a number of strengths and limitations the present study was a community based cross sectional study carried out among the Santal tribes of Mayurbhanj district, and on the strengths of the study includes that the study was carried out on the basic of primary data and the data was collected by using anthropological tools and techniques and it was also kept in mind to maintain the quality of data. However there are certain limitations too, which include, small sample size and unreciprocated in gender of respondents because of shorter time period in which the study was conducted in 1 month. So the present study need further survey for more qualitative and for effective outcomes.

Conclusion

The study reveals the prevalence of NCD risk factors among the Santal tribes of the Mayurbhanj district, Odisha, as well and reiterates the need to address these issues comprehensively as a part of NCD prevention and control strategy was also noted that the biological risk factors were more common among males than among females. Further surveys are recommended for this area based on this approach to explore the prevalence as well as the association between various risk factors as well and to study further trends of various NCD risk factors.

References

Chadha SL, Gopinath N, Shekhawat S. Urban-rural differences in the prevalence of coronary heart disease and its risk factors in Delhi. Bull World Health Organ. 1997;75:31-8.

Cortez Pinto H, Gouveia M, Pinheiro L.D S, Costa J, Borges B, Carneiro A.V.2010. The Burden of Disease and the Cost of Illness Attributable to Alcohol Drinking—Results of a National Study.Alcolohism clinical and experimental research;34(8), Pp1442-1449.

Deepa M, Pradeepa R, Anjana R, Mohan V. Noncommunicable diseases risk factor surveillance: Experience and challenge from India. Indian J Community Med. 2011;36(Suppl 1):S50–6. [PMCID: PMC3354899] [PubMed: 22628912]

Esmailnash ,N; G. Moradi and A. Delavri. 2012. Risk Factors of Non-Communicable Diseases and Metabolic Syndrome, Iran J Public Health. 41(7): 77–85.

Gupta V, Yadav K, Anand K. Patterns of tobacco use across rural, urban, and urban-slum populations in a north Indian community. Indian J Community Med. 2010;35:245-51.

Kolbe-Alexander TL, Lambert EV (2013) Non-Communicable Disease Prevention and Worksite Health Promotion Programs: A Brief Review. Occup Med Health Aff 1:141. doi: 10.4172/2329-6879.1000141.

Kshatriya G K and Acharya S K .2016. Triple Burden of Obesity, Undernutrition, and Cardiovascular Disease Risk among Indian Tribes; PLOS ONE DOI:10.1371.

Lee IM, Shiroma EJ, Lobelo F, Puska P, Blair SN, Katzmarzyk PT. Effect of physical inactivity on major non-communicable diseases worldwide: an analysis of burden of disease and life expectancy. Lancet. 2012;380:219–229.

Mandi A, Alfyrayh N A, Aljebreen M A and Aldukhi S A. 2016. Physical activity and major non-communicable diseases among physicians in Central Saudi Arabia; Saudi Med J; 37(11): 1243–1250.

Mangal A, Kumar V, Panesar S, Talwar R, Raut D, Singh S. Updated BG Prasad socioeconomic classification, 2014: A commentary. Indian J Public Health. 2015;59:42-4.

Misra Palash Jyoti, Mini G.K, and Thankappan K.R ,2014. Risk factor profile for non-communicable diseases among Mishing tribes in Assam, India: Results from a WHO STEPs survey. Indian J Med Res. 140(3): 370–378

Mokdad AH.2016. Global non-communicable disease prevention: Building on success by addressing an emerging health need in developing countries. J Health Spec;4:92-104.

National Institute of Medical Statistics, Indian Council of Medical Research (ICMR), 2009, IDSP Non-Communicable Disease Risk Factors Survey, Phase-I States of India, 2007-08.

National Institute of Medical Statistics and Division of Non-Communicable Diseases, Indian Council of Medical Research, New Delhi, India.

Nethan Suzanne, Dhirendra Sinha, and Ravi Mehrotra.2010. Non Communicable Disease Risk Factors and their Trends in India, Asian Pac J Cancer Prev. 2017; 18(7): 2005–2010.

Olawuyi AT, Adeoye IA (2018) The prevalence and associated factors of non- communicable disease risk factors among civil servants in Ibadan, Nigeria. PLoS ONE 13(9):e0203587. https://doi.org/10.1371/journal. pone.0203587

Oommen AM, Abraham VJ, George K, Jose V J. 2016.Prevalence of risk factors for non-communicable diseases in rural & urban Tamil Nadu. Indian J Med Res 2016;144:460-71.

Parry C,Ptra J,and Rehm J.2011. Alcohol consumption and non-communicable diseases: epidemiology and policy implications.NIH Public Access Author Manuscript; 106(10): 1718–1724.

RajeevGupta[a]DenisXavier[b] GuptaRajeev, XavierDenish. 2018. Hypertension: The most important non communicable disease risk factor in India, IHJ 1409 No. of pages 8.

Seeberg J. and M. Lotte. Reflections on the spread of 'noncommunicable' diseases. Medicine Anthropology Theory, 2(2): Pp. 54–71;

Sharma K. 2013. Burden of Non Communicable Diseases in India: Setting Priority for Action. Int J Med Sci Public Health; 2:7-11.

Thakur J. S, Jee Gursimer, Pal Arnab, Singh Shavinder, Singh Amarjit, Deepti S. S,Lal Mohan,Gupta Sanjay,Prasad Rajender,Jain Sanjay and Saran Rajiv. 2016.Profile of Risk Factors for Non-Communicable Diseases in Punjab, Northern India: Results of a State-Wide STEPS Survey. PLoS One. 2016; 11(7)

Thankappan KR, Shah B, Mathur P, Sarma PS, Srinivas G, Mini GK et al. Risk factor profile for chronic non-communicable diseases: results of a community- based study in Kerala, India. Indian J Med Res. 2010;131:53-63

Tondare MB, Havale NG, Bedre RC, Kesari P. Prevalence of risk factors of non-communicable diseases among rural population of Bidar. Int J Community Med Public Health 2017;4:2681-5.

World Health Organization. 1948; no. 2, p. 100.

World Health Organization progress moniter.2017:Pp.7-93.

World Health Organization. Obesity: Preventing and Managing the Global Epidemic. Report of a WHO Consultation. WHO Technical Report Series 894. Geneva: World Health Organization; 2000.World Health Organization. STEPS manual. Geneva: WHO. 2013.s

World Health Organization. STEP wise approach to surveillance (STEPS). http://www.who.int/chp/steps/en (2015). Accessed 2016 Dec 12.

World Health Organization. The Global Status Report on Non Communicable Diseases. Geneva, 2010.

World Health Organization. STEPS Planning and

Implementation: STEPS Instruments for NCD Risk Factors (Core and Expanded Version 1.4) Geneva (CH): WHO; 2003.

https://www.who.int/diabetes/publications/Definition%20and%20diagnosis%20of%20diabetes_new.pdf accessed on January 2019.

http://www.who.int/gho/ncd/en/ (retrieved on 2018)

http://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases (retrieved on 2018)

http://www.who.int/ncds/introduction/en/ retrieved on 2018)

https://doi.org/10.1016/j.ihj.2018.02.003/ (retrived on 2018)

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5648412/(retrieved on 2018)

http://www.ijmr.org.in/text.asp? 2016/144/3/460/198668 (retrieved on 2018)

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4936739/ (retrieved on 2018)

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4248383/ (retrieved on 2018)

Man in Society ISSN 2347-1530
Volume 25, 2018, pp. 31-40

Marginalization and Discrimination of Rajdhobi of Bihar: An Anthropological Study

Rajeev Kamal Kumar

Abstract

The present study has been conducted among a backward community, Rajdhobi of Bihar. Their traditional occupation is washing clothes. In addition to their traditional occupation, they are also engaged as labourers in agriculture, forest, industry, etc. They are also known as Rajdhops. They sometimes claim Rajput origin, but during the reign of Aurangzeb were forced to become or had to declare themselves as Rajdhop. They originally belong to Dhobi caste – a Scheduled Caste in Bihar State, but the Rajdhobi caste is included in EBC list. Initially Rajdhobi were also listed as SC in Bihar. In most of the development indicators, the Dhobi are far better than Rajdhobi, but still the Govt. has shifted them to EBC category a few decades ago. Consequently the benefits which Rajdhobi have been accruing as SC in the matter of reservation and other scholarships and grants were automatically rescinded.

The main objectives of the paper are: to find the socio-economic status, occupational pattern, upward social mobility, etc., of Rajdhobi and social handicap such as untouchability, rendering forced traditional services. The study is based on primary data which is collected with the help of structured interview schedule, observation and FGDs. The study has covered the entire population of Rajdhobi caste in Bihar. Secondary sources were also used to supplement the findings. The findings reveal that Rajdhobi are still living in abject poverty. Most of the development indicators such as income, education, health, etc., are far worse than other SCs of the state. They have been facing discrimination in every sphere of life. The situation in the villages, where majority of Rajdhobi reside, is worst. Thus, they have been marginalized and suffering at both fronts, i.e. socially and politically. People in society discriminate and consider them as SC, practice untouchability, as they are involved in cleaning clothes of others, even dirty and polluted clothes of newly born baby and mother.

Key Words : *Marginalisation, Discrimination, Social and Economic wellbeing, Development, Scheduled Caste, Extremely Backward Class*

Marginalization is the process of pushing an individual or a group of people to the edge of society by not allowing them an active voice, identity, or rightful place in it. Through both direct and indirect processes, marginalized groups may be relegated to a secondary position or made to feel as if they are less important than those who hold more power or privilege in society. Individuals and groups can be marginalized on the basis of multiple aspects of their identity, including but not limited to: race, religion, caste, gender, ability, socio-economic status, religion, caste, etc. Some individuals identify with multiple marginalized groups, and may experience further marginalization as a result of their intersecting identities, for example, poor uneducated women belonging to low caste group. Marginalization can manifest in subtle or overt actions including, use of derogatory language or remarks, expecting individuals to act a certain way based on stereotypes held about another's identity, denying opportunities because of their identity, not providing equal access to certain resources based on membership in a particular group, overlooking, criticizing, or interfering with other's cultural or religious traditions and values, systemic and/or institutionalized barriers to access and support. This

Assistant Professor, Division of Sociology & Social Anthropology, A.N. Sinha Institute of Social Studies, North Gandhi Maidan, Patna (Bihar), PIN-800001, E-mail: rkamalanthro@gmail.com

is predominantly a social phenomenon by which a minority or sub-group is excluded, and their needs are ignored.

Marginalization is a slippery and multi-layered concept. Whole societies can be marginalized at the global level while classes and communities can be marginalized from the dominant social order. Similarly, ethnic groups, families or individuals can be marginalized within localities. To a certain extent, marginalization is a shifting phenomenon, linked to social status. So, for example, individuals or groups might enjoy high social status at one point in time, but as social change takes place, so they lose this status and become marginalized. Similarly, as life cycle stages change, so might people's marginalized position (Burton and Kagan, 2003). Marginalization combines social exclusion and discrimination. It insults human dignity and it objects human rights, especially the right to live effectively as equal citizens (Cornish, 2007).

The present study has been conducted among a poor and marginalized community, *Rajdhobi* of Bihar. They are listed as Extremely Backward Class (EBC) on serial number 70 of the state list, and on 107 in the central government list of EBC. They are demanding for their inclusion in SC list, so that they may acrrue the benfits of the reservation. The main reason behind their demand is their poor development status and also also their main caste *Dhobi,* who are much advanced than *Rajdhobi,* is already in SC list. Initially, *Rajdhobi* were also listed as SC in the state.

Area and People

Rajdhobi are found only in five north eastern districts, viz. Madhubani, Supaul, Araria, Purnea and Saharsa of Bihar. In the present study, all the Rajdhobi familes were surveyed in these five districts. Their maximum population is in Supaul district (population 11191 and 2291 households); whereas Saharsa district has only nine families and 50 population. It has been found during the present study that this caste has evolved in recent times, as earlier they were part of a larger caste group *Dhobi.* They consider themselves as part and parcel of *Dhobi* caste. They use surname as *Vishwas, Paikara, Manjhi, Rout, Laugi, Sant, Kapair, Das, Parmani, Parihast, Khadaga, Adhikaari, Ishar,* etc.

Since *Rajdhobi* caste has recently come into being and there is no specific study conducted on this community, it is pertinent to discuss about their main caste, which is *Dhobi*. They are mainly found in India and Pakistan. The *Dhobi* community of Bihar is about six percent of total population. Among the numerically larger castes of SC, *Dhobi* have registered the highest overall literacy rate. But the *Rajdhobi* are lagging far behind on most of the development indicators such as, education, income, job, etc.

The traditional occupation of *Dhobi* is also washing clothes. Since they have been involved in this occupation for several generations, they came to be known as *Dhobi* (*dhona*, which means to wash). *Dhobis* in various regions are likely to be of many different ethnic origins: their ancestors took the occupation of washing clothes, evolving over time into a distinct caste, bound by the rules of endogamy. Most *Dhobis* follow the customs and traditions of the region they live, so for example those in North India speak Hindi, while those in Maharashtra speak Marathi. The *Dhobi* rank them highest among the Scheduled Caste. Referred to as *Dhob* in Jammu and Kashmir and *Dhoba* in eastern India, the majority of them are traditionally washermen widely distributed in the states of Punjab, Uttar Pradesh, Bihar, West Bengal, Assam, Tripura, Orissa, Andhra Pradesh, Madhya Pradesh, Rajasthan, Gujarat, Maharashtra and in the union Territories of Chandigarh, Delhi and Daman and Diu. They are a large community reported to be distributed in 203 districts of India and as having 164 segments. While the majority of them are Hindu, there are Muslim Dhobi too in Delhi, Gujarat, Bihar, and Chandigarh. In Assam, Orissa, Tripura, Bihar, Madhya Pradesh, Uttar Pradesh and Delhi, the *Dhobi* are notified as a scheduled caste. In other cultural spheres, they show a degree of variation (Sachidanand, 1977; Singh, 1998; Gopal and Jha, 2001).

The *Dhobi* of Bihar use surnames like *Ram, Baitha* and *Prasad*. They speak their respective regional languages, such as Maithili, Bhojpuri and Angika. The *Dhobi* have several patrilineal clans. Prasad and Das are the two new surnames that have been adopted by them. A few of them own land and are engaged in cultivation. In addition to their traditional occupation of washing clothes, they are also engaged as labourers in different sectors such as agriculture, forest and industry. They worship deities like Sitalamata and Durga. Patron-client relations are maintained and they get an annual (kaman)

payment from farmers for their service (Singh, 1998).

The *Rajdhobi* are also known as *Rajdhops*. According to Bhattacharya (2008), the *Rajdhops* are a little known community of north-eastern Bihar. They sometimes claim that they were originally *Rajputs* but during the reign of Aurangzeb, forced to become or had to declare themselves as *Rajdhop*. But the neighbouring communities have a different impression; they consider *Rajdhop* as the washer men of the Maharaja (king) of Darbhanga. They speak Maithili and Hindi and write in Devanagari script.

During the present study people informed that they originally belong to the larger caste *Dhobi,* as their traditional occupation is also washing clothes. A few families were also rendering their services to the court of *Darbhanga Maharaj* and started calling themselves as *Rajdhobi* (wahermen of Royal palace). With the passage of time they were identified with the same name as people started referring them as *Rajdhobi*. According to the local educated informants, it all started with the aim to move in the social hierarchy, but later they realized that they are being devoid of the benefits of the SC after removal of their names from the State list of SC.

A few decades ago Rajdhobi were the residents of a village named *Bhardah*, which was situated at the Indo-Nepal border in the Kosi basin area and falls within the territory of India. But in due course of time, the village was denuded due to flood and changing course of River Kosi. The residents of this village *Rajdhobi*, were displaced and rehabilitated to twelve different villages in the Kosi basin area. The names of the villages are: *Mainahi, Dholi, Dighiya, Dudhaila, Moura, Jhahura, Dengrahi, Bela, Aurahi, Bhuliya, Baltharba,* and *Lalmanpatti*. Some of the villages are outside the guide dam on Kosi, but some of them are still inside the guide/check dam are in the river basin.

Rajdhobi believe in Hindu religion and also practice and perform the religious rituals like any other Hindu caste groups. They also believe and worship the Gods and Goddesses in form of nature such as some trees (mango tree, neem, peepal, banyan, etc.), rivers (Kosi and other river of the area), local mountains, which are considered as sacred by them. Therefore it may be said that they are animist to some extent. The chief clan deities are *Lakhaya Baba, Gango Gahil, Vishahri Kalibandi, Chaudah Deewan, Gauraiya, Bhairav, Panchpeer*, etc. Some of their religious and cultural practices and rituals, such as, marriage ceremony, religious festivals, death rights, etc., are being performed on very low budget by the *Rajdhobi*, as done by their neighbouring people belonging to scheduled caste. This also saves their time, cost and other hassles of social obligations. Their main religious festivals are *Chauthchand, Ghadi, Vishhari, Lakhay Baba,* etc. Some special rituals are performed on the worship. Beside these specific festivals and worship, they also celebrate regular Hindu festivals, such as, *Chhath, Jivit Putrika/Jitiya, Holi, Dashahar, Diwali,* etc.

They have only one gotra i.e. Kashyap. They are aware of the Varna system and consider themselves as Vaishya. But during the present study, it has been found that they are aware of the Varna system but have never considered themselves as Vaishya. Brahmin priests also do not officiate marriage or any other rites for Rajdhobi community. There may be a few exceptions, that too, in urban areas. In fact the oldest temple (more than 300 years old) of this community is located in *Bhuliya Dharhar* village in Supaul district, where '*Aghori'* conducts all religious rituals. The priest of this temple belonged to *Aghor Panth* and the offerings are arranged by the local Rajdhobi men.

Objectives

The present paper is part of a larger ethnographic study of *Rajdhobi* caste in Bihar state. The main objectives of this paper are: to find out the socio-economic status of *Rajdhobi*, their level of literacy, occupational structure and pattern, upward caste mobility, inter-personal relationship with fellow caste men and also with other neighbouring communities, etc. Other important objective of this study is to understand of *Rajdhobi's* social handicap, such as, untouchability, rendering forced traditional services, and their fight (plight due to removal from the reservation list of SC) for the rightful justice.

Methodology

Since the present study is ethnographic in nature, therefore it is mainly based on qualitative methods, but quantitative data were also collected. Primary data were collected from the field with the help of structured interview schedule, observation and

FGDs. As mentioned, the population of this caste group is meagre and the number of total households was only 3234 hence, the entire population was covered in the present study. Secondary sources such as the census data, Govt. reports and research papers were also used to supplement the findings. All the five districts, where Rajdhobi are residing, were covered in this study. Under this, 50 villages of 14 different blocks were covered. Special care was taken to collect quality data from the field.

Discussions and Analysis

It has been found in the present study that *Dhobi* are better than *Rajdhobi* in most of the development indicators, but the government has still shifted them to EBC category. Consequently, the benefits which *Rajdhobi* have been accruing as SC from the state in the matter of reservation and other scholarships and grants are automatically annulled. Thus, they have been marginalized politically and suffering at both fronts, i.e. social and political. On the one hand, people in society still consider *Rajdhobi* as scheduled caste and discriminate them and practice untouchability, as they are involved in cleaning the clothes of others, sometimes the dirty clothes of newly born baby and mother, which is considered polluted. On the other hand, after the removal from the list of SC, they have to suffer socially, politically, economically and fainancially as well.

The findings of the study reveal that the *Rajdhobi* people are still living in abject poverty. Most of them are engaged as agricultural labourers (63.4 percent) and casual workers (17.3 percent). They are very poor as more than 90 percent families have less than Rs. 10,000/ of monthly income. Most of the development indicators such as income, education, health, political representation, etc., are far worse than other SCs of the state, such as, *Paswan, Paasi, Dhobi, Chamar*, etc. They have been facing discrimination in every sphere of life. The situation in the villages, where majority of *Rajdhobi* reside, is worst. They are not allowed to enter into public temples. They are invited to social functions by the upper caste people, but made to sit separately, mostly on the floor. They are forced to do the work of higher castes on special occasions, such as marriage or any such ceremmony. Most of them are still illiterate, landless and earning their living by washing clothes or doing agriculture work on others' lands as labourers or share croppers. They do not have much say politically, as they are a very small group.

Socio-Economic Status

As mentioned, this study is done through census method and enumerates the entire population of *Rajdhobi*, as the population size of this caste is very small. Following table 1 presents the population covered in all the five studied districts of Bihar where *Rajdhobi* are distributed. The total number of *Rajdhobi* families is 3234, and the total population of this caste group is 15578. Of this, 8311 (53.4 percent) are males and 7267 (46.6 percent) are females. The average family size is also small, i.e., 4.8 persons per family. Maximum number of families (2291) and population (11191) are found in Supaul district of the state; while Saharsa has only nine families. Other districts where the population of this caste recoreded are : Araria, Madhubani and Purnea.

Table 1: Distrct Wise Distribution of Rajdhobi Population

Sl.No	District	Total no. of HH	Population				
			Male		Female		Total
			N	%	N	%	
1	Madhubani	221	649	50.7	630	49.3	1279
2	Supaul	2291	5961	53.3	5230	46.7	11191
3	Araria	428	1020	54.5	853	45.5	1873
4	Purnea	285	657	55.4	528	44.6	1185
5	Saharsa	9	24	48.0	26	52.0	50
	Total	**3234**	**8311**	**53.4**	**7267**	**46.6**	**15578**

A clear preference for nuclear families was observed in *Rajdhobi* community. Next table 2 shows the type of families found among *Rajdhobi.* It may be observed that out of 3234 families, most of them (85.0 percent) are nuclear families and only 15 percent are joint families. This is also due to the migration and occupational mobility. It has been ovserved that after marriage, the sons resides in a separate house or if he can not afford another house, then also he sperates the herth.

Table 2: District Wise Type of Families of Respondents

Sl.No	*District*	*Nuclear*		*Joint*		*Total*
		N	*%*	*N*	*%*	
1	Madhubani	155	70.1	66	29.9	221
2	Supaul	1986	86.7	305	13.3	2291
3	Araria	356	83.2	72	16.8	428
4	Purnea	247	86.7	38	13.3	285
5	Saharsa	6	66.7	3	33.3	9
	Total	*2750*	*85.0*	*484*	*15.0*	*3234*

The economic condition of most of the *Rajdhobi* families is very pathetic. Due to this, at least one member of most of the families is working outside the village in district headquarters or other towns and cities of the state. Some of them have also migrated outside the state. Most of them are engaged in daily wage in unorganized sector, such as, brick klins, hotels, domestic helps, farm labourers, etc. A few respondents also informed that their family members are living in local towns and other cities and enageged in any government or private job and business. Although their traditional occupation has been washing clothes, but now most of them have left the occupation as their traditional occupation is not profitable. They said that they can not run a family with the meagre income of washing clothes and hence they have started taking up other occupations, such as daily wage labour and farming. They are also engaged in rearing up cattles and goats on sharing basis (*poshiya*), as they cannot afford to buy on their own. They get either money or cattle from the well off caste groups in the village and take care of animals and the product is shared equally between the two.

Women has active role in running the household economy. In addition to looking after the children and household chores, women are also engaged in economic activities and earn for their families. They are engaged in domesticating animals, weaving mats and other activities. Children in most of the villages are still not going to school regularly as they are busy in lookin after the cattle and their younger siblings. For most of the *Rajdhobi* families, the traditional occupation has been either washing clothes (82.0 percent) or both weaving mats and washing cloths. These occupations remain no longer viable for them and became redundant, especially mat weaving. However, it is still done by a few families in the villages, but mostly for the local use. Similarly washing clothes for running the household is also not very much profitable, especially in the villages where they get ony Rs. 5-7 per cloth for washing and ironing, and Rs. 3 for only ironing. This is the main reason why people are not much happy with their traditional occupation of washing clothes. At present, only two-third (64.7 percent) is happy with their traditional occupation (table 3 & 4).

Table 3: District Wise Type of Traditional Occupation of Respondents

Sl.No	*District*	*Washing cloths*		*Washing and weaving mats*		*Total*
		N	*%*	*N*	*%*	
1	Madhubani	132	59.7	89	40.3	221
2	Supaul	1904	83.1	387	16.9	2291
3	Araria	412	96.3	16	3.7	428
4	Purnea	196	68.8	89	31.2	285
5	Saharsa	9	100.0	0	0.0	9
	Total	*2653*	*82.0*	*581*	*18.00*	*3234*

Table 4: Satisfaction of Respondents with Their Traditional Occupation

Sl.No	District	Yes		No		Total
		N	%	N	%	
1	Madhubani	139	62.9	82	37.1	221
2	Supaul	1508	65.8	783	34.2	2291
3	Araria	276	64.5	152	35.5	428
4	Purnea	163	57.2	122	42.8	285
5	Saharsa	8	88.9	1	11.1	9
	Total	**2094**	**64.7**	**1140**	**35.3**	**3234**

Due to poor economic condition, the living standard of *Rajdhobi* is also not at all satisfactory. Most of the families remain in permanent debt of the local moneylenders. Most of them (79.4 percent) are living in thatched huts, only 2.8 percent own semi-pucca and less than one percent own pucca houses (Table 5). Most of them have homestead lands but quite a few have made temporary arrangements on leased in lands. Their villages are devoid of any basic infrastructure and most of the families are also lacking basic amenities in their houses, such as, drinking water, toilet, electricity connection, etc. They fetch drinking water either from any public handpumps or from their neighbour's handpumps. Next table 6 shows the availability of drinking water, toilet and electricity connection in houses. It can be observed from the table that only 32.0 percent households have drinking water, 4.0 percent households have toilets and 33.0 percent households have electricity connection

Table 5: Distribution of Respondents According to the Type of Houses

Sl.No	*District*	*Thatched hut*		*Kacha house*		*Semi pucca*		*pucca*		*Total*
		N	*%*	*N*	*%*	*N*	*%*	*N*	*%*	
1	Madhubani	212	95.9	7	3.2	1	0.5	1	0.5	221
2	Supaul	2005	87.5	242	10.6	38	1.7	6	0.3	2291
3	Araria	201	47.0	194	45.3	26	6.1	7	1.6	428
4	Purnea	149	52.3	103	36.1	27	9.5	6	2.1	285
5	Saharsa	0	0.0	0	0.0	0	0.0	9	100.0	
	Total	*2567*	*79.4*	*546*	*16.9*	*92*	*2.8*	*29*	*0.9*	*3234*

Table 6: Availability of Drinking Water, Toilet and Electricity Connection in Houses

Sl.No	District	Drinking water		Toilet		Electricty	connection
		N	%	N	%	N	%
1	Madhubani	100	45.2	8	3.6	0	0.0
2	Supaul	602	26.3	29	1.3	701	30.6
3	Araria	199	46.5	20	4.7	209	48.8
4	Purnea	126	44.2	62	21.8	147	51.6
5	Saharsa	9	100.0	9	100.0	9	100.0
	Total	**1036**	**32.0**	**128**	**4.0**	**1066**	**33.0**

Literacy rate among *Rajdhobi* community is also vey poor. However, maximum population of this community are living in villages, the educational attainment of *Rajdhobi* in the rural areas is poorer than the urban areas. It has been observed during the fieldwork that the children are always out of school, looking after their younger siblings and cattles in the fields and some of the children are also engaged in other works. Due to their poor economic condition, they are not in a position to send their children to schools. A few respondents also opined that the quality of education in governemnt's schools is not good and they do not afford to send their children to private schools. Those families who are living in

towns and have good income are able to send their children to private schools. Some of them also said that they have enrolled their children in local government schools for availing the government schemes, but the children do not go to these schools. Some of the respondents even consider schooling as waste of time as their children will not get any job in future.

Marginalization and Discrimination

Marginalization and discrimination against the *Rajdhobi* is not new and it is starkly visible in their routine lives in the villages, where majority of their population reside. Marginalization of this caste can be observed in the apathetic approach of the Government. The policy of the Government has directly affected them, as its decision to shift them into EBC category from the SC list has rumbling impact on the community. Earlier when they were listed in the SC category, they were at least able to claim the devlopement and welfare programmes and schemes run by the Government. After their exclusion from the list they are devoid of the benefit of full affirmative action. Another important indicator of the marginalization can be observed in their political participation and representation. There is no representation of the *Rajdhobi*, even at the local level. They have no voice in the Governement and hence the process of marginalization is clearly observed.

Similarly, the discriminatory practices against them are routine thing especailly in the villages. Their houses are also located separately in a corner of the village from the mainstream castes. People of higher castes usually avoid them in social and religious functions. Although, the government has listed them in extrmeley backward castes (EBC), but they are at the bottom in the social hierarchy as their traditional occupation of washing other's clothes is seen as some sort of polluted and lowly work. Initially there were only four *Varna* in the Indian social system, and with the passage of time, people who have been engaged in this kind of activities were included in the last *Varna* order or even in the fifth social order of untouchables. The castes included into this last fold of *Varna* order were also looked down upon due to their traditional occupation and they are also considered as people of low origin. People from other castes practice discrimination and they do not accept water and cooked food from them. They are still prevented from entring into any public temple and offering worship.

Political Participation

It has been found in the study that political participation of *Rajdhobi* is also very less. However most of them are aware about the political process and development in the state, especillay educated people living in towns and cities are more aware. They are also conscious of their political rights of choosing their representatives through elections, but they take less interest in the entire process. This is also reflected in possession of voter identity card, which makes them eligible for voting during the election. Almost two-third (65.6 percent) respondents said that they do not have voter card. The major reasons behind poor political participation are their unawareness, poor educational attainment, less interest in political process, and migration for earning wages. Most of them are very poor and also numerically very less in number and hence do not have any say in the local politics. None of the community members are elected in any elections, even in local bodies (PRI).

Other important reason for poor political participation and representation is the numerical strength of *Rajdhobi* people in the state. They are numerically very small caste and hence they do not have any voice in the politics, governance and administration. Most of them are also marginalized and discriminated due to their weak social and economic status. Most of them are uneducated and their children are still not attending any formal education. They mostly live in the flood prone villages and every year they have to fight with this natural claimity as well. In this adverse situation and government's apthetic attitude towards them, they have accepted their present condition as their fate. Their life is so full of struggle that most of their time goes in managing their daily needs and in this situation political participation and activism is not their list of priority.

Discriminatory practices

As mentioned before, *Rajdhobi* people are being discriminated by other caste people especially the dominant forward caste people. In few of the *Rajdhobi* villages, some of the backward castes such as *Yadav, Baniya, Teli,* etc., who are relatively well off and numerically dominant caste in the respective villages, also discriminate and misbehave with *Rajdhobi* people. They are seen as untouchables in

their villages by their co-villagers. They informed that they have been facing this kind of discrimination and ill treatment from other caste pople since their origin. Nothing much has changed for generations. Following table 7 clearly shows that more than three fourth respondents (75.8 percent) have similar opinion. They have reported discrimination and mischiefs by other caste people. Only 11.8 percent respondents said that they have not faced any discrimination and misbehaviour by people belonging to higher caste and remaining 12.3 percent respondents said that they have faced the discrimination at some point of time in their life.

Table 7: Incidents of Discrimination and Misbehavior Faced by Rajdhobi

Sl.No	District	Yes		No		Sometimes		Total
		N	%	N	%	N	%	
1	Madhubani	204	92.3	17	7.7	0	0.0	221
2	Supaul	1900	82.9	231	10.1	160	7.0	2291
3	Araria	219	51.2	57	13.3	152	35.5	428
4	Purnea	120	42.1	78	27.4	87	30.5	285
5	Saharsa	9	100.0	0	0.0	0	0.0	9
	Total	**2452**	**75.8**	**383**	**11.8**	**399**	**12.3**	**3234**

The respondents were further probed to know about their exact inter-personal and reciprocal relationaship with other caste people in the villages. This also shows their social status in the area. They were asked about the invitation by other caste people on social occasions such as marriage, death and other important events of higher caste people in the village. *Rajdhobi* respondents accepted that they are invited on such occasions, but they are not treated properly with due respect and dignity. They are made to sit seperatley for the feast and they have to remove and clean the dirty plates after finishing their food. Some of them even said that the agenda of invitation is different and they are also called to perform minial jobs in the social functions. They are also not allowed to sit on the cahirs, benches, etc. before the higher caste people, even today, in the rural areas.

Regarding receiving invitation of any social functions, 59.6 percent respondents told that they never receive the invitation, and a little more than one- third (39.1 percent) told that it is not fixed, sometimes they receive and sometimes they not receive the invitation. Only 1.3 percent respondents told that they receive regular invitations from their neighbours and fellow residents belonging to upper caste. Those who receive regular invitations must be educated, economically sound as compared to their other fellow community men belonging to *Rajdhobi* caste and also they must be living in urban areas (table 8).

Table 8: Invitation on Any Social Occasions by the Higher Caste to Respondents

Sl.No	District	Always		Sometimes		Never		Total
		N	%	N	%	N	%	
1	Madhuban	0	0.0	120	54.3	101	45.7	221
2	Supaul	18	0.8	915	39.9	1358	59.3	2291
3	Araria	17	4.0	134	31.3	277	64.7	428
4	Purnea	3	1.1	91	31.9	191	67.0	285
5	Saharsa	5	55.6	4	44.4	0	0.0	9
	Total	**43**	**1.3**	**1264**	**39.1**	**1927**	**59.6**	**3234**

They are not treated equally and they have to face discrimination and ill treatment by the upper caste people in their rotine lives. They face this kind of situation even at the public places, especially in rural areas.They were also probed – whether they are allowed to enter into public temples of the area and allowd to worship. On this, most of the respondents (95.2 percent) said that they are not permitted to enter into these tamples and offer their prayers. Local priests of the temple are also not interested in their worship. Almost all the respondents (98.5 percent) said that the priest do not take interest in their worship (table 10 & 11).

The priests of the villages do not render their services to these *Rajdhobi* for performing the puja. DiscriminationSome of the respondents also mentioned about the discrimination in the public health facilities. They have to take the help of others in getting the treatment in government hospitals. This is especially true for taking the benefits of indoor patient services.

Table 10: Permission of Worship in Public Temples of Respondents

Sl.No	*District*	*Always*		*Sometimes*		*Never*		*Total*
		N	*%*	*N*	*%*	*N*	*%*	
1	Madhubani	3	1.4	1	0.5	217	98.2	221
2	Supaul	31	1.4	61	2.7	2199	96.0	2291
3	Araria	13	3.0	25	5.8	390	91.1	428
4	Purnea	3	1.1	13	4.6	269	94.4	285
5	Saharsa	4	44.4	0	0.0	5	55.6	9
	Total	*54*	*1.7*	*100*	*3.1*	*3080*	*95.2*	*3234*

Table 11: Priest Takes Interest in Conducting Prayers for Rajdhobi

Sl.No	**District**	**Yes**		**No**		**Total**
		N	**%**	**N**	**%**	
1	Madhubani	5	2.3	216	97.7	221
2	Supaul	27	1.2	2264	98.8	2291
3	Araria	8	1.9	420	98.1	428
4	Purnea	5	1.8	280	98.2	285
5	Saharsa	4	44.4	5	55.6	9
	Total	**49**	**1.5**	**3185**	**98.5**	**3234**

For last several generations and years, *Rajdhobi* people are facing this kind of situation in their day-to-day routine life by the upper caste people3. The benefit taken by them has also stopped pnce they were removed from the SC list.

Conclusion

Rajdhobi are very poor people and backward people of Bihar state. They are lagging behind in almost all the development indictaors such as health, economy, education, etc. On several issues, their condition is even poor than the *Dalit* castes of the state. Most of them have left their traditional occupation and started earning daily wages outside the state. They do not have basic infrastrure and necessary facilities in their houses. Most of them are either illiterate or primary educated. Most of the respondents accepted the discriminatory practices in their villages. They are not allowed to offer worship in the public temples. They are not invited by the upper caste people on the important social events.

Although *Rajdhobi* caste originally belong to *Dhobi* caste, but they are placed in the EBC category whereas; Dhobis are placed in SC category. All the customs and rituals, social status and practices of *Rajdhobi* are similar to the *Dhobi*. They face similar discrimination, like *Dhobi* caste, even more discrimination, stigma and untouchability in case of

Rajdhobi community. They have to face double discrimination- first, at the social level in caste hierarchy- as they are considered as Scheduled Caste belonging to *Dhobi* caste, and second they have to lose the benefits applicable to Scheduled Castes as they were shifted from SC to EBC category by the Government without any valid reason. All the development indicators are very low, even lower to most of the Dalit communities of the state.

References

Bhattacharya, Biplab. 2008. The Rajdhop, In *People of India, Bihar including Jharkhand*, Surendra Gopal & Hetukar Jha, (Eds) and K.S. Singh (Gen Ed.), Part-II Vol. XVI, pp 799-800.

Bihar Development Report- 2012: A Study for Prabhat Khabar, New Delhi; Indicus Analytics Pvt. Ltd.

Burton, M and C. Kagan (2003), Marginalization, In: I. Prilleltensky and G. Nelson. Community Psychology: In pursuit of wellness and liberation. London: MacMillan/Palgrave 2003.

Cornish, S. (2007), *Globalization and Marginalization: Discussion guide to the Jesuit Task Force Report*. Loyola Institute, Australian Jesuits.

Gopal , Surendara and Hetukar Jha, 2001, Part 2 Singh, K.S., *People of India, Bihar, Including Jharkhand*, Volume XVL, Calcutta; Seaguli Books.

Sachidanand. 1977, The Harijan Elite: A study of Their Status, Networks, Mobility and Role in Social Transformation. Faridabad; Thomson Press.

Singh, K.S., 1998, India Communities (A-G), People of India, National Series, Volume IV, Anthropological Survey of India., PP-830-842, Delhi: Oxford University Press.

International growth center: www.theigc.org/project/growth urbanization and rural-urban linkage in Bihar.

Demographics of Bihar, downloaded from https://en.wikipedia.org/wiki/Demographics_of_Bihar on 16.01.2017.

Bihar Population Census data 2011, downloaded from http://www.census2011. co.in/ census/ state/ bihar.html on 16.01.2017.

Bihar State Profile, downloaded from www.bihar.gov.in/biharprofile , downloaded on 15.12.2016.

http://counselingcenter.syr.edu/social-justice/impact-of-marginalization.html

Man in Society ISSN 2347-1530
Volume 25, 2018, pp. 41-46

Changing Dimensions of Santal Shamanism : A Study from Mayurbhanj District of Odisha

Suresh Chandra Murmu

Abstract

The importance of traditional values under the practices in shamanism is gradually vanishing from the society. Shamanistic knowledge system, though primarily based on magico-religious practices, has its multidimensional application for the well being of the people in a traditional society. The present study was conducted in the Mayurbhanj district of Odisha. In Odisha majority of Santal population are found in the district of Mayurbhanj. Both emic and etic approaches have been taken into consideration for interpretation of data. Primary data was collected by observation, interview methods, case study and focused group discussion. The key informants were the shamans (Ojha) of different categories, but common Santals including educated sections were also interviewed. The basic aim of the study is to understand the structure and function of shamanism and its impact on health culture of the Santal society. It further attempts to discuss various changing dimensions in the traditional Santal shamanism. Findings of the study reveal that traditional Santal shamanistic beliefs and practices are undergoing change due to the impact of modernization, modern education and growing easy access of modern health services. The role of shamans have reduced in terms of curing of disease and increased in other socio-economic life of the Santals. In due course of time, there has been mushrooming growth of different new sub-categories of shamans in the studied area which is not only affecting intra village traditional religious affairs in particular but on the Sarna religion in general.

Key words: *Shamanism, Kamru Guru, Medicine Man, Modernization*

Introduction

The study of shamanistic wisdom is losing its momentum because of modernization day by day. Though the realm of shamanic practices was of great importance in anthropological enquiries, with the change of time, and perception of people, such specialists are no more valued in the socio-economic contexts. With the decreasing importance of traditional values, such traditional practices under shamanism are on the verge of vanishing. When the world is endeavoring to look at the indigenous knowledge system to be applied for the all-round development of the people, the scope for discovering the shamanistic practices is really revamped. Shamanistic knowledge system, though primarily based on magico-religious practices, has multidimensional application for the wellbeing of the people in a traditional society.

When anthropologists started researching on shamanistic beliefs and practices, it is found that shamans in different cultures developed similar healing and ceremonial approaches (Roberts, 2008). Shamanistic powers were acquired through individual experiences of the transfer of spirit between the shaman's body and spirit-infused bodies of other things in the environment. These powers were confirmed through public installations and by tests of healing patients, again in public (Andrew, 1994). According to C.L. Johnson (1981), "like that of all healers, the shaman's work reflects the culturally approved means of attempting to restore impaired individuals to full capacity so that they can perform their social roles". Medical anthropologists and health psychologists have only recently paid attention to this aspect. We need to identify the core assumptions and principles which

Assistant Professor, Department of Anthropology, Sambalpur University, Sambalpur, Odisha

underlie the universality of these indigenous healing systems. Search of such universals is important to decipher what healing is and how does it work. At the core of these healing practices are the basic assumptions of unity, interconnectivity and harmony of the mind, the body and the soul (Ross, 2014)

Area of Study and Research Method

The study was conducted in Mayurbhanj district of Odisha. Majority of the Santal population in the state of Odisha is found in Mayurbhanj district. Besides Odisha, Santals are also found in large numbers in the states of West Bengal, Jharkhand and Bihar. First hand information was collected from three blocks of Mayurbhanj namely Kusumi, Jamda and Bahalda. Observation (participant and non-participant), interview and case study methods were used. The key informants of the study were shamans (*ojha*) of the different Santal villages of the Mayurbhanj district. Shamans were interviewed with the help of semi-structured interview schedule. For holistic understanding of the problem, data was also collected from both educated and uneducated Santals. Both emic and etic approaches have been taken into consideration for analysis and presentation of the data.

Objectives

Keeping in view the above perspective in mind, the study makes a humble attempt to:

- Discuss briefly traditional structure and function of the shamanism in the Santal society and its association with health culture.
- Explore various changing dimensions of Santal shamanism and critically analyze its impact on the Santal society.

Results

Santal Shamanism: Origin and Development

Santal Shamanism has its origin myth. The first Guru is the Sun God (*Chando Bonga*) known as *Dharam Guru*. From Sun God, shamanistic knowledge (*Birda*) was transmitted to Kamru Guru. *Dharam* Guru is the creator (*Sirjonia*) of Santal shamanistic beliefs and practices and Kambru Guru had spread it to Santal masses. Several terms are used for shaman in Santal society such as *Ojha*, *Sokha* and *Jaan*. But most common term is *Ojha*. Bodding (2001) has mentioned that shamanism in Santal society descended from Kamru guru. He has classified the work of Ojha in to six kinds such as ojhas make divination, they sow rice, they bite people or rub them with a ball of rice flour, they dig up bongas, they exorcise bongas and give medicine to people.

Shamanistic Institution, Knowledge and Hierarchy

The shamanistic institution is called "*Guru Akhra/Akhla"*. The *Guru Akhra* is usually located either at the courtyard of Ojha's house or in the middle of village with boundary made of bamboo. Certain strict rules and regulations are observed in the institution. Usually women are prohibited to step in but in some cases they are permitted. The prohibition is imposed upon to avoid entry of women during menstruation. Another reason for restriction is women who are believed to be witch can pollute the institution by malevolent powers.

Interesting part of the teaching process is that, Guru does not transfer power to his disciples. He only teaches them the techniques of worship, which include drawing symbolic depictions, process of diagnosis, names of deities and spirits and *Jharni Mantar* (21 in number). Power comes to them by complete submission and deep meditation. Those who follow the rules and regulations of the shamanistic process strictly, get the knowledge and power directly from the deities usually in dream. It is also a fact that a person can be shaman without a guru, but common belief indicates that a young shaman has to obey someone (senior shaman) as his guru. Guru protects him from attack of witches during worship. Completion of the course ends with an examination known as '*Sid Atang'*. Transmission of Shamanistic knowledge is non-hereditary in nature. But in some cases son has to continue the shamanistic tradition of the family.

In the Santal shamanistic hierarchy topmost position is occupied by the '*Jaan Guru'* followed by the *'Sokha'*. These two have matted hair. Fundamental difference between *Jaan* and *Sokha* is that, former does not go to patients' house for worship, but Sokha goes to patients' house. The above two are followed by different categories of Ojha. Under the section Ojha, classification can be made on the basis of supreme deity they worship. They are *Kamru Guru*,

Sid Guru, *Tursi Guru*, *Kainre Guru*, *Kadku Dharam*, *Jugdahar*, *Chakar Birda*, Siba *Sadhna*, *Kali Sadhna, Sawna Dharam* and *Muni Dharam*.

Ojhas are graded by the people taking into consideration the successful cases solved by the shaman. So people call the *ojha* who has solved very complicated cases earlier. Not only successful work but being honest, good behavior, immediate response also enhances *ojha*'s popularity. Failure leads to the degradation of the shaman's position. The core distinction between shamans descended from Kambru Guru and others is that, successors of Kamru Guru do worship in any place, even in polluted houses, but other shamans usually do not worship in that situation.

The life of the shamans is always believed to be dangerous. Therefore, proper socialization, training and skill acquisition are very crucial. Disciples are expected learn all the mantras (*bakhen* in native term), skill to draw symbols (*khond*), name of deities including benevolent and malevolent spirits of the vicinity. They are trained to diagnose the disease by using array of methods, process of sacrifice and also regarding the seating posture at the time of worship. Most important one is the technique to find out the cause of the problem, whether natural or supernatural origin. They are also made familiar on the knowledge and administration of ethno-medicines by undertaking time to time expeditions to the nearby forests to collect ethno-medicines. The disciples are also given the knowledge of self protection during the worship. All the techniques are taught by the shaman during training periods.

Shaman is Multi-Functional

Shaman in Santal society plays important function in different walks of life. Starting from life cycle rituals to village level worships, Ojha's service is required in the Santal society.

In Rite de Passage:

Ojha plays a very important role in rite-de passage, though it is limited but very crucial in the Santal society. Earlier when hospitals were not available, delivery of the child used to take place in the village with the help of Dhai. When there were complications during delivery of child, people used to call Ojha as they believed that problems were caused by supernatural powers. In the study area shaman's role in this aspect has gradually decreased as a result of increased institutional deliveries in the local hospitals.

Shaman's role during marriage ceremony is considered very crucial. During the entire process of marriage certain signs or incidents are considered as "bad signs" which are called "*ere*" in native term. Santals believe that newlywed couple may experience severe problems; the result may be death of bride or bride-groom, if not worshipped by the shaman. In Santal society, it is (*Ere Bonga*) very seriously taken into consideration even by the educated Santals. All shamans cannot do this particular worship. Special shamanistic knowledge is required for this worship. Symbolic depictions are very difficult to draw and very few shamans are capable of doing this. Whether it is love marriage or arranged marriage, *ere* worship is compulsory in Santal society. Few shamans perform this worship inside the village but others perform outside the village boundary.

When death ritual (*Bhaandaan*) is observed, at the end of the village (*Dobati*), village shaman does worship. After completion of the worship by shaman, *jang baha* (bone flower) of the diseased is taken to the Damoder River, where it is finally immersed in the water for smooth journey of the soul.

In Village Rituals and Ceremonies:

In Santal society, almost all the village level rituals and ceremonies are performed by village priest (*naike*). But in few special occasions shaman's role does come. During epidemic, chicken pox, diarrhea, unusual deaths, shamans do worship for the wellbeing of all the villagers. In every tribal village (Santal) above mentioned category of problems are believed to be caused by evil spirits which are brought into the village boundary by the witches (*Dan*). Doing this kind of worship has always believed to be dangerous, as witches of the village may take revenge against the shaman. The worship to remove the spirits from the village is called "*Bonga Odok*" which is led by the shaman.

Bhujni Bonga is one of the very traditional practices observed even today in every Santal village. Earlier there was no medical facility in remote tribal areas. To avoid different disease like epidemic, Santal worship '*Bhujni Budhi'* (female demon) once in a

year as preventive measure in the month of April. Unmarried disciples (*chela*) go to forest with village the shaman to bring medicinal plants and roots. In the night they prepare sacred thread (*Dumbra*) for each and every individual in the village. In the evening, a worship is performed by the shaman at both ends of the village and also in the middle of the village, where they burry different ingredients to prevent the entry of diseases by supernatural powers.

Role of Shaman as a Medicine Man

Role of shaman as a medicine man is also very important. Shamans in Santal society administer various herbal medicines for the curing of illness and injury. As mentioned earlier, every shaman in Santal society is given the knowledge of ethno-medicines during training at the institution by undertaking time to time expeditions to forest. Data reveals that, Santal shamans administer ethno-medicines for various communicable as well as non-communicable diseases. P.O. Bodding (2016) has recorded extensive list (traditional medicines for 305 types of illness) of Santal medicines in his book "Studies in Santal Medicines and Connected Folklore" from Chhatanagpur area. In the study area, shamans not only treat humans by application of ethno-medicines, but also different ailments of domesticated animals like cattle, goat and sheep. Development and increasing easy access to modern medical services in the study area has posed potential threat to the knowledge on ethno-medicines. Shamanistic institutions are also found very rarely which are instrumental in transmitting traditional medicinal knowledge system to future generation.

Ojha as a Sorcerer:

Sorcery and witchcraft are attempts to invoke the spirits to work harm against people. Although the words sorcery and witchcraft are often used interchangeably, differentiated. Sorcery may include the use of materials objects, and medicines to invoke supernatural malevolence. While witchcraft may be said to accomplish the same ills by means of thought and emotion alone.

Ojha in Santal society also sometimes acts as a sorcerer and may cause serious problem to the people. An *Ojha* has the power to kill a person by sending evil spirit which is called "*Bonga Goj*" in Santali. Shaman in Santal society does both benevolent and malevolent work. Certain health problems to the individual are caused by sorcerer in the Santal society are *tengen, chalon, pathry, muda, baan, aha or nojor.*

Shaman's role in other sphere:

Shaman in Santal society plays not only the role to cure different diseases but also other different problems. For example; regain the lost objects (objects may be living and non-living), to do better in the examinations, to get jobs, to marry a women by applying mantras or vice -versa and to win a case in the court. For this kind of worship (*bonga*), shaman does "*mansik*" and if it is fulfilled, shaman sacrifices what he had promised to offer to specific god or spirit.

Reading and Diagnosis of Diseases:

Reading and Diagnosis of disease is called '*Khali*'. Shamans in Santal society follow several techniques to uncover the cause of illness/problems. Illness may be of somatic or psychosomatic in origin. In Santal society even today people believe that illness is caused by disobedience to deities, by witches, evil spirits or other supernatural forces.

Charej Khali (dry grass used for making broomstick) is one of the very common procedures followed by the Ojhas in Santal society. Two dry wild grasses (equal in length approximately 20 c.m.) are used. Other techniques are *Soonoom Khali* (using oil), Sindur Kahli (vermillion), Jal Nel (testing urine with oil), Adoa chaole khali (using rice) and Natka chapu (testing nerve).

Healing Practices:

Shaman cures illness by using two techniques; worship or using ethno-medicines. Worship includes sacrifices or promise to sacrifice, Jhal (chanting Jharmi mantras), Soonoom Palhao (oil reading) and Boolong Palhao (Salt reading). If the cause of illness is natural, then shaman uses ethno-medicines. But when illness is due to supernatural forces, then sacrifice of animal is must. It is also believed that, if the cause of illness is by supernatural forces, without worship other medicine does not work.

Another technique is the sucking cure (*gair*), in which the shaman goes through the motions of sucking a disease from the patient's body. Usually he

"extracts" something which he shows to the patient and other persons present as proof that the sickness has been removed. The objects extracted from the patient's body may be stones, pieces of wood, bone remains and other objects.

Trance and Spirit Calling:

The Shaman is an intermediary between the members of his society and the supernatural world with which he communicates to the spirits and listening to their replies through possession. So Trance is interpreted as possession by spirits or gods, but more commonly this state is viewed as bringing the entrance into direct communication with supernatural beings. Trance or state of trance consists of convulsive seizures, catalepsy and hallucinations. Trance and spirit calling is called "*Rum or rumuh"* in Santali term. The objective of trance and spirit calling in Santal society is to solve the problems associated with supernatural being/forces and to find out the cause of problems by communicating directly with spirits or gods. This practice is an important part of Santal society not only in shamanism but also other family and village level rituals practices.

Changing Dimensions in Santal Shamanism:

Modernization and modern education after independence has brought many drastic changes in the age old traditional practices. Rise in the literacy level and awareness regarding modern health practices has definitely weakened the practice of shamanism. Earlier not only Santals, but other tribal communities believed that most of the diseases are caused by supernatural forces. So they failed to explain the cause of disease. Gradually with the spread of modern medical practices, Santals came to understand and could explain the causes of frequently occurring diseases especially in tribal areas disease like malaria, diarrhea etc. So the role of shaman is definitely declining in this particular problem. So there is paradigm shift in the shamanistic performances. There is gradual decrease in curative worship and on the other hand increase in preventive form of worship by the shaman. So position and status which they had in the past is gradually declining in the Santal society.

In India, with the rising population, the problem of educated unemployment is also rising. There is very difficult to get a job both in private and public sector due to high level of competition. Santals do consult shamans to make worship to get success in competitive examinations. Shamans also worship for the students for good performances in the examinations. If you do not like your wife/husband or daughter-in-law and vice-versa, shaman can help you in getting rid of him/her. It is believed that shaman has the power to make disturbance in the peaceful family.

Another very interesting change in Santal shamanism is that shamans' worship is increasing in the economically well established Santal families. Many Santals are now working in both private and public sectors with handsome earnings. These are highly educated and well acquainted with modern health practices. It is a common belief that people in the villages do not tolerate one's economic growth. So, financially sound families believe that, they are the most vulnerable group to the attacks of witches. They consult shaman to perform preventive worship. Preventive form of worship may be for one year or six months. If family members remain disease free for a particular time period shaman sacrifices animals which had been promised earlier.

Mushrooming Growth of Sub-categories

As discussed in the above sections, many new categories of shaman have come up in the Santal society. The shamans descended from Kamru guru do not worship Hindu deities, but new categories worship Hindu deities like Goddess Durga, Kali and Lord Shiva as their supreme deity. These new formations of Santal shamanism are indirectly affecting the very strong age-old unity of Santal villages. There is growing divisions of villages into two or more groups due to new shamanistic knowledge and modern politics. These emerging divisions are affecting severely the social relationship in the village, decreasing clan unity, disrupting religious practices etc. In long run this may lead to decline of *Sarna Dhorom* in the Santal society. If these sub-categories persist, new generation would automatically pass on to next generation regarding new formation on religious practices and not the original *Sarna Dhorom*. Shamanism can play a very important role in maintaining unity and solidarity in the Santal society if they understand this unique practice properly.

It is also a fact that shamanism creates problems in the society. Few shamans do not maintain honesty in

the profession. Shaman is the person who brands a woman as witch without any proof. This not only decreases the social status of that woman but also to her family members. In the district of Mayurbhanj large numbers of women have been killed in the name of witchcraft. Shamans also sometimes exploit the innocent poor family. And they obey each and every words of shaman because of severity of the problem. Inter family and intra-family disputes also increases due to the verdict of a shaman. So shamanism in Santal society has both negative and positive sides.

Conclusion

The study on Santal shamanism shows that, in the traditional Santal society, role of the Ojha was instrumental in addressing different problems believed to be caused by supernatural entities. Shaman in Santal society is multi-role player. Starting from life cycle rituals to other village level occasions, shaman role is sought for. With the change of time and impact of modernization, traditional shamanistic institutions are at the verge of vanishing. This change will directly affect the other socio-cultural practices of the Santal society. Especially the indigenous knowledge on ethno-medicines which is primarily occupied by the shaman is not being transmitted. Data also reveals that new trends have also developed in the shamanistic beliefs and practices. There is decline in curative performance but increase in preventive worships. Educated and economically sound Santals also still believe in supernatural or involvement of witch in the occurrence illness as well as other problems in life. The most important finding of the study is Hinduisation of Santals by native Santal Ojha. Therefore, changing dimensions in Santal shamanism has its marked impact on the socio-cultural life of the Santals in the study area.

References

Bodding, P.O. (2001). Traditions and Institutions of the Santals. Gyan Publishing House, New Delhi.

Bodding, P.O. (2016). Studies in Santal Medicine and Connected Folklore. The Asiatic Society, Kolkata.

Roberts, L.Levy, R. (2008). *Shamanic Reiki. Expanded Ways of Working with Universal Life Force Energy.* O Books, Winchester, UK *Shaman.* Berkeley Books, New York the remaking of history. *American Ethnology* 34(1): 127–147. *the state,* 191–228. Ann Arbor: University of Michigan Press. University Press, New Jersey

Ross. R (2014) Indigenous healing. Penguin Random House, New York, USA

Strathern, A. (1994). Between body and mind: Shamans and politics among the anga, baktaman and gebusi in papua new guinea. *Oceania, 64*(4), 288. doi:http://dx.doi.org/10.1002/j.1834-4461.1994.tb02473.x

Johnson, C. L. (1981). Psychoanalysis, shamanism and cultural phenomenalow .*Journal of the American Academy of Psychoanalysis, 9*(2), 311-318. doi:http://dx.doi.org/101521jaap1198192311

Man in Society ISSN 2347-1530
Volume 25, 2018, pp. 47-51

Teenage pregnancy and antenatal care practices among the Amanatya, Bhotra and Saora tribes of Nabarangpur district, Odisha

Subhalaxmi Baral[1], K.C. Satapathy[2] and P.K. Patra[2]

Abstract

Odisha is one of the high focus states for improving maternal health and one third population of Odisha are tribes. Utilization of antenatal care (ANC) services is poor in the tribal areas, causing increased maternal morbidity and mortality. Antenatal care can help women prepare for delivery and understand warning signs during pregnancy and childbirth. Regular contact with a doctor, nurse or midwife during pregnancy allows women to receive services vital to their health and that of their future children. The threat of teenage pregnancy also causes pregnancy-related complications, and leading to high mortality. Objectives of the present study are to find out the age at 1st conception, status of Antenatal checkup, immunization of mothers, traditional beliefs and food practices during pregnancy. The present study was conducted among the Amanatya, Bhotra and Saora tribes of Nabarangpur district, Odisha. 36 mothers who had delivered within last 5 year were selected. The data was collected by interview method and analyzed by Statistical software using Ms Excel and SPSS. Teenage pregnancy is observed among all the tribes and the mean age at 1st conception is 17.23. All the mothers have preferred government hospitals and anganwadi centre for Antenatal checkups. But these tribal mothers of Nabarangpur give first priority to their traditional healer (Disari) for any health issue and they believe in black magic. However 97.22% mothers have taken Iron and Folic acid tablets.There are some food taboos during pregnancy. 63.89% mothers have taken traditional practices of foods during pregnancy. So these tribal mothers of Nabarangpur have preferred both traditional practices along with the adoption of modern health care facilities. Anganwadi workers play a major role for the utilization of ANC. Illiteracy, lack of knowledge about ANC, poverty and traditional beliefs affects the utilization of Antenatal care of the mother.

Key words : *pregnancy, ANC, Tribes, Nabarangpur, Odisha.*

Introduction

Odisha is one of the high focus states for improving maternal health and one third population of Odisha are tribes.Within the domain of reproductive health, maternal health care of Odisha is of immense significance.According to a report of Odisha Sun Times Bureau (2016), despite Janani Surakhya, MAMATA Yojana and anganwadis, the Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR) remain alarmingly high in Odisha's Nabarangpur district. A study on tribal community of Nabarangpur, Odisha shows that cultural issues, decision of family members and traditional beliefs still play a crucial role in shaping neonatal care practices among the tribes (Sanghamitra Pati, 2014). TheMothers' health has many consequences. The poor health of the mother leads to high rates of miscarriages and stillbirths along with high perinatal, neo-natal, post-neonatal and infant deaths. Often, complications lead to higher incidence of maternal mortality. According to WHO report (2014), about 16 million girls aged 15 to 19 years and two million girls under the age of 15 give birth every year. Complications from pregnancy and childbirth are the leading cause of death among girls aged 15–19 years in many low- and middle-income countries. Stillbirths and newborn deaths are 50% higher among infants born to adolescent mothers than among those born to mothers aged 20–29 years. Children born to mothers under the age of 20 years

[1] *M.Phil Scholar, and* [2] *Associate Professor, P. G. Department of Anthropology, Utkal University, Bhubaneswar-751004, Odisha*
Corresponding author's E-mail: baralsubhalaxmi94@gmail.com

are more likely to die in infancy than children born to mothers in the prime childbearing ages. As per NFHS-3, the infant mortality rate (IMR) is 91 per 1,000 for teenage mothers, compared to 60 for mothers ages 20–29. Therefore, survival of both mother and child depend upon the health status of the mother. The health status of the mother depends upon the nature of general health of the mother, age of the mother, antenatal and postnatal care, place and assistance during delivery.

Antenatal care (ANC) is potentially one of the most effective health interventions for preventing maternal morbidity and mortality, particularly in places where the general health status of women is poor. It refers to pregnancy related health care provided by a doctor or a health worker in a medical facility or at home or both. The World Health Organization (WHO) recommends a minimum of four antenatal visits, comprising interventions such as tetanus toxoid (TT) vaccination, screening and treatment for infections, and identification of warning signs during pregnancy. It also helps women prepare for delivery and understand warning signs during pregnancy and childbirth. It can be a source of micronutrient supplementation, treatment of hypertension to prevent eclampsia, immunization against tetanus, HIV testing, in addition to medications to prevent mother-to-child transmission of HIV in cases of HIV-positive pregnant women. Regular contact with a doctor, nurse or midwife during pregnancy allows women to receive services vital to their health and that of their future children.

Review of literature

According to the UNICEF data, globally, while 86 per cent of pregnant women access antenatal care with a skilled health personnel at least once, only three in five (62 per cent) receive at least four antenatal visits. Government of India has implemented different schemes for improvement of health of both mother and children. Janani Shishu Suraksha Karyakram (JSSK) was launched on 1st June 2011 and has provision for both pregnant women and sick new born till 30 days after birth are Free and zero expense treatment, free drugs and consumables, free diagnostics & Diet, free provision of blood, free transport from home to health institutions etc.

Jose et.al (2014) in their study on "Utilization of maternal health-care services by tribal women in Keral" have mentioned that, among tribal antenatal women, 85% utilized maternal health care facilities fully compared to 100% among non-tribal women. Lower levels of education and lack of transport facilities were prime factors contributing to underutilization by tribal women. Affordable, accessible and good quality of services in the public health system in Kerala and motivation by health workers were important contributing factors for better utilization of maternal care services. Negi & Singh (2018) in their review article "Tribal Health and Health Care Beliefs in India: A Systematic Review" have indicated from the analysis that traditional system of medicine and health care is diminishing among tribals and the modern health care systems are yet be adopted.

A study conducted by Irvine et.al (1997) shows that, a pregnant teenager is considered a high risk obstetric patient because she has a higher risk than normal of developing anaemia and pre-eclampsia.

Withers et.al (2011) in their study have observed that, many Asian women continue to practice a wide range of traditional beliefs and practices during pregnancy, childbirth, and the postpartum period. More information is needed on the benefits of formal maternal healthcare services; such educational programs should be geared towards not only women but also husbands, parents and in-laws.

According to Sahoo and Panda (2005), some sort of food restrictions are found during pregnancy in the Baleswar district of Odisha. It is also studied that, garlic Ingestion by Pregnant Women alters the Odor of Amniotic Fluid (Beauchamp, 1995). Due to the belief in supernatural elements and religion in matters concerning health, the rural people and the tribes are almost invariably found to response faith in diviners or the traditional medicine men, sorcerers and shamans (Rao et al. 2006).

Gupta et.al in 2018 have revealed that, maternal literacy remains a key factor in the better utilization of antenatal services. Moreover, the role of health workers in increasing awareness among mothers about the importance of ANC in general and the danger signs of pregnancy in particular is of paramount concern.

Objectives

Objectives of the present study are to find out the mean age at marriage, age at 1st conception, status of Antenatal checkup, immunization of mothers, traditional beliefs and food practices during pregnancy.

Area and people

Odisha (previously known as Orissa), being socio-economically backward but culturally sound, is one of the important states in Eastern India. The present study was carried out in three hamlets of Turunji village namely; Badagaon, Nayakguda and Domnayakguda that come under Nandahandi block of Nabarangpur district of Odisha in 2017.

Omanatya/Amanatya: Omanatya are Odia speaking cultivating tribal people who live in the north of Jeypore and south of Nabarangpur. In Nabarangpur district, they number 10746. Omanatya are largely found in Nandahandi block of Nabarangpur district.

Bhottoda/Bhotra/Bhattra: Bhotra synonymous with Bhottada or Bhattra are predominantly found in all blocks of Nabarangpur district except Raigarh and Chandahandi. Out of 4.51lakh populations in the state 3.25 Bhatra population, live in Nabarangpur district as per 2011 census.The Bhotras are one of the numerically major agricultural tribe of the district. They speak Bhatri, a nonliteracy dialect among themselves. They speak a corrupt form of Odiya language known as Desia.

Saora/Saura : The Saoras also called Savaras constitute a major tribe in the State of Odisha. In Nabarangpur.

district, their population is 7369 with a Male population of 3531 and female population of 3838. The great majorities of Saoras have lost their own language and now speak Oriya.

Materials and Methods

A detailed structured interviews schedule was taken for data collection. Data was collected from 36 mothers of Amanatya, Bhotra and Saora tribes of Nabarangapur district, Odisha. Mothers who had at least one baby or babies below 5 years age at the time of data collection were taken for interview and the Anganwadi workers were taken as the study participants. First mapping and household numbering was done before data collection. Then the data was collected through random sampling method, interview method and participant observation method. Data analysis is done through statistical softwares Microsoft Excel and SPSS 20. The primary data was compared with some secondary sources for analysis.

Results and discussion

Table 1: Mean age at marriage among the mothers of Amanatya,Bhotra and Saora tribes

Mean age at marriage			
Tribes	*Number*	*Mean*	*Std. Deviation*
Amanatya	15	15.53	1.506
Bhotra	15	15.80	1.568
Saora	6	16.33	1.033

Table 2: Mean age at 1st conception

Mean age at 1st conception			
Tribes	*Number*	*Mean*	*Std. Deviation*
Amanatya	15	17.93	5.007
Bhotra	15	16.93	1.751
Saora	6	16.83	1.169

This table shows that the mean age at marriage among all the tribes are below 18 year. However it is highest among Saoramothers which is 16.33 year followed by Amanatya (15.53) and Bhotra(15.80). As per the National Family Health Survey (NFHS-4) in Odisha, 21.3 per cent women in the age group of 20-24 years were married off before the legal age limit of 18-year. Malkangiri, Nabarangpur, Mayurbhanj, Koraput, Rayagada and Nayagarh are the top six districts which recorded more than 30 per cent women aged between 20 and 24 years married off before the legal age. Here in the present study, the percentage of marriage below 18 year among the Amanatya, Bhotra and Saoratribes is found higher than Odisha.

The table explains that the mean age at 1st conception of all the mothers is below 18 years. However in case of Amanatya it is 17.93 year followed by Bhotra 16.93 year and Saora 16.83 year. Over past decade, India has successfully reduced the proportion of pregnancy between 15-19 years to half (16% during NFHS 3 in 2005-06 and 7.9% during NFHS 4 in 2015-16).

Table 3: Classification of tribal mothers according to their age at 1st conception.

Mothers according to their age at 1st conception				
Tribes	*12-16 N (%)*	*17-21 N (%)*	*Above 22 N (%)*	*Total N (%)*
Amanatya	7(46.67)	7(46.67)	1(6.66)	15(100.0)
Bhotra	7(46.67)	8(53.33)	0(0.0)	15(100.0)
Saora	2(33.33)	4(66.67)	0(0.0)	6(100.0)
Total N (%)	16(44.45)	19(52.78)	0(0.0)	36(100.0)

The table shows that irrespective of all the tribes percentage of mothers having their 1st conception is found highest among17-21 age group (54.81%) followed by 12- 26 age group (44.45 %).

Table 4: Distribution of tribes according to the types of antenatal checkups taken by them.

Types of antenatal check-ups			
Tribes	Government hospitals and Anganwadi centre N (%)	Private hospitals N (%)	Total N (%)
Amanatya	15(100.0)	0(0.0)	15(100.0)
Bhotra	15(100.0)	0(0.0)	15(100.0)
Saora	6(100.0)	0(0.0)	6(100.0)

The table shows that irrespective of all the tribes the percentage of mothers have their 1st conception is found highest among 17-21 age group (54.81%) followed by 12- 26 age group (44.45 %).

Table 4: Distribution of tribes according to the types of antenatal checkups taken by them.

Types of antenatal check-ups			
Tribes	Government hospitals and Anganwadi centre N (%)	Private hospitals N (%)	Total N (%)
Amanatya	15(100.0)	0(0.0)	15(100.0)
Bhotra	15(100.0)	0(0.0)	15(100.0)
Saora	6(100.0)	0(0.0)	6(100.0)

From table 4, it is observed that all the tribal mothers have gone to Government hospitals and Anganwadi centre for antenatal checkups. None of them have visited private hospitals. Due to poor economic condition they prefer government health care facility.

Table 5: Distribution of tribes according to intake of Iron and Folic acid tablets by the mothers during pregnancy

Tribes	Yes N (%)	No N (%)	Total N (%)
Amanatya	14(93.34)	1(6.67)	15(100.0)
Bhotra	15(100.0)	0(0.0)	15(100.0)
Saora	6(100.0)	0(0.0)	6(100.0)
Total	35(97.23)	1(2.77)	36(100.0)

The table 5 shows the percentage of mothers who have taken Iron and Folic acid tablets. It is observed that all the Bhotra and Saora mothers have taken Iron and Folic acid tablets; however it is 93.34% among the mothers of Amantaya tribe. Among all the tribes 97.23 % mothers have taken. NFHS-4(2015-16) of Odisha showsthat, 36.5% mothers have consumed iron folic acid for 100 days or more when they were pregnant. So the present study shows higher percentage than Odisha.

Table 6: Distribution of mothers according to the types of food taken during pregnancy.

Types of food taken during pregnancy			
Tribes	Traditional N (%)	Traditional and medical N (%)	Total N (%)
Amanatya	8(53.34)	7(46.67)	15(100.0)
Bhotra	10(66.67)	5(33.34)	15(100.0)
Saora	5(83.34)	1(16.67)	6(100.0)
Total	23(63.88)	13(36.12)	36(100.0)

This table shows that the percentage of mothers consuming traditional foods during pregnancy is highest among the Saora tribe (83.34%), next in Bhotra (66.67%) and in Amanatya (53.34%). They used to have rice, *kanduldali, masuradali*, papaya, fish and green leafy vegetables during pregnancy.

Table 7: Distribution of tribes according to the types of food avoided during pregnancy

Tribes	Traditional restrictions in foods during pregnancy N(%)	Total N (%)
Amanatya	14(93.3)	15(100.0)
Bhotra	15(100.0)	15(100.0)
Sa ora	5(83.3)	6(100.0)
Total	34(94.45)	36(100.0)

This table explains that traditionally all the mothers have some restrictions in taking some foods during pregnancy. However it is highest in Bhotra tribe i.e. 100%, in Amanatya 93.3%, in Saora 83.3%. Overall 94.45 % women have obeyed food taboos during pregnancy. They avoid jackfruit, *kanda* fruits. They have belief that if they eat those, the child may have vision problem.

Cultural practices of the mothers

The mothers of the Turunji village believe their traditional local healer (Disari). They still believe in connected to black magic. So occurrence of health issue, (they think that it is due to the impact of) black magic. And they consult their traditional healer. During pregnancy they first go to their healer do some rituals remove bad to perform and impact of others.

Conclusion

Mean age at marriage is found below the legal age at marriage and teen age pregnancy is observed among the Amanatya, Bhotra and Saora tribes of Nabarangpur district, Odisha. The percentage of age at marriage and 1st conception below 18 year is found higher than the state when compared with NFHS-4. But the percentage of ANC and intake of Iron and Folic acid tablets are higher than the state percent. Due to poor socioeconomic condition, the tribal mothers of Turunji village prefer government hospitals and they have visited Anganwadi centers for ANC. Due to cultural practices, they still believe in their traditional healers for any health issues. They have consumed traditional practices of foods during pregnancy which is not sufficient for their health. Only 36.12% mothers have taken the foods prescribed by the medical practioner along with their cultural food preferences. Illiteracy, early marriage, poverty, lack of communication facility and inadequate knowledge about antenatal care are responsible for adverse health of the mother.

References

Beauchamp, J. A.(1995). Garlic Ingestion by Pregnant Women Alters the Odor of Amniotic Fluid. *Chemical Senses*, *20*(2). 207-209.

Gangadharan, K. 2015. *Maternal and child health among tribals in kerala: strategies for rational deployment of health infrastructure and health manpower .ICMR*.

Ghosh, S. & Malik, S.L. (2009). Assessment and Administration of Health in a Tribal Community of India. *The Internet Journal of Biological Anthropology*, 3(2), 1-22.

Gupta, R. K., Shora , T.N., Verma, A,. & Jan, R. (2018). Knowledge regarding antenatal care services, its utilization, and delivery practices in mothers (aged 15-49 years) in a rural area of North India

Irvine, H., Bradley, T., Cupples, M.&Boohan, M.(1997).Theimplications of teenage pregnancy and motherhood forprimary health care: unresolved issues, *British Journal ofGeneral Practice*, 47, 323-326.

Jose, J A., Sarkar, S., Kumar, S.G., &Kar, S.S.(2014). Utilization of maternal health-care services by tribal women in Kerala. *Journal of Natural Science, Biology and Medicine,*5(1).

Mekonnen, W., Hailemariam D., &Gebremariam A.(2019).Causes of maternal death in Ethiopia between 1990 and 2016: systematic review with meta-analysis. *Ethiopian Journal of Health Development,*32(4).

National family health survey (NFHS-3) 2005–06: India.(2007). *International Institute for Population Sciences (IIPS) and Macro International.*

National family health survey (NFHS-3) 2005–06: Odisha.(2007). *International Institute for Population Sciences (IIPS) and Macro International.*

National family health survey (NFHS-3) 2015–16: Odisha. *International Institute for Population Sciences (IIPS) and Macro International.*

National Institute of Health and Family Welfare. 2014. Population and development, A discourse of family planning in Odisha.

Negi, D.P. & Singh, M.M.(2018). Tribal Health and Health Care Beliefs in India: *A Systematic Review. International Journal of Research in Social Sciences,*8(5).

Pati S., Chauhan, A.S, Swain, S.& Panda, M. (2014). *Neonatal care practices in a tribal community of Odisha, India: A cultural perspective.* Vol. 60.

UNICEF Data 2018.Antenatal care. Retrieved from https://data.unicef.org/topic/maternal-health/antenatal-care/

Withers, M., Kharazmi, N.&Lim E. (2018).Traditional beliefs and practices in pregnancy, childbirth and postpartum: A review of the evidence from Asian countries. *Midwifery,* 56. 158-170.

Man in Society ISSN 2347-1530
Volume 25, 2018, pp. 52-55

Traditional Knowledge and Practices for Prevention of Malaria among the Santal Tribe of Tiring Block of Mayurbhanj District, Odisha

Kaberi Sahoo[1], Prasanna Kumar Patra[2],
Kanhu Charan Satapathy[2]and Laxman Kumar Sahoo[3]

Abstract

Traditional knowledge constitutes types of knowledge about traditional technologies of subsistence, midwifery, ethno botany and ecological knowledge, traditional medicine, celestial navigation, ethno astronomy, climate and others. This study attempts to analyze the traditional knowledge system for prevention of malaria among the Santal communities of Mayurbhanj dist. Selection of both study area and tribe are vital for research. So, I choose three villages i.e. Changua, Talasa and Badagobra of Tiring block of Mayurbhanj district which is a tribal dominated district of Odisha which is also the first district in terms of size and third in terms of population. Here I found that the maximum number of people belonged to Santal tribe. All the participants selected for this study are aged between 2-60years. Data of the present study has been collected by using a pre-tested structured questionnaire from 80 participants using by systematic random sampling. Data analysis is done by using IBM SPSS 20 and Microsoft Excel software. The result reveals that 77.5 per cent respondents have practiced their indigenous methods for the prevention of malaria. Also, some of the respondents still consult with the traditional medicine man for curing any disease. Majority of respondents use mosquito net for avoiding mosquito bites. Various health related Government programmes are conducted on a timely basis to improve the awareness about malaria prevention. Community Health Workers (CHWs) like ASHA and ANM are the major contact point for tribes in the effort to prevent malaria. And it is proved that this area is now less affected with malaria. The respondents reported to be following good health seeking practices such as keeping there surroundings clean, sanitation and also using indigenous methods and mosquito nets for prevention of malaria. In spite of the fact that have adopted traits of modernization, but still practice their traditional methods for prevention of diseases.

Keywords : *Malaria, Santal, Indigenous method, Traditional knowledge*

Introduction

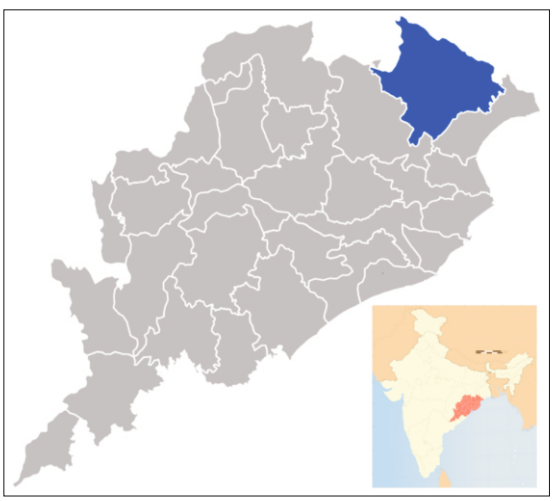
Traditional knowledge is the information that people in a given community, based on experience and adaptation to a local culture and environment, have developed over years, and which is being continued to develop and evolve. It is the totality of all knowledge and practices, whether explicit or implicit, which are used in the management of socio-economic and ecological facets of life. TK is generally described as information existing in the society which has been passed on by previous generations. This knowledge is used to sustain the community and its culture and to maintain the genetic resources necessary for the continued survival of the community. A disease is any condition which results in the disorder of a structure or function in a living organism that is not due to any external injury. It may be caused by external factors such as pathogens. Malaria is a mosquito-borne infectious disease affecting humans caused by protozoan parasite belonging to the Plasmodium species. The disease is widespread in the tropical and subtropical regions that exist in a broad band around the equator. In 2016, there were 216 million cases of malaria worldwide resulting in an estimated 731,000 deaths. Rates of disease have decreased from 2000 to 2015 by 37% but increased from 2014 during which there were 198 million cases. Malaria is commonly associated with poverty and has a major negative effect on economic development.

[1]*M.Phil Scholar, P.G. Department of Anthropology, Utkal University, Vanivihar. Bhubaneswar-04. Email-kaberisahoo016@gmail.com*
[2]*Associate Professor, P.G. Department of Anthropology (CAS), Utkal University, Vani Vihar, Bhubaneswar-04.*
[3]*UGC Post Doctoral Fellow, P.G. Department of Anthropology (CAS), Utkal University, Vani Vihar, Bhubaneswar-04.*

This knowledge constitutes crucial elements of the holistic approach towards both the natural and man-made livelihood of these peoples. TK embraces belief systems that play a fundamental role in people's livelihood, health care and sustainable development. Generally, this term is employed to cover a broad range of indigenous subject matters including the communities' medicinal knowledge, folklore and various teachings. Malaria mortality rates have fallen by more than 25% globally since 2000. The poor socio-economic condition of the people (59.43% of the population below poverty line) and insufficient health care facilities in rural areas have worsened the situation.

Area and people

Mayurbhanj is a tribal dominated district of Odisha where 58.70% of total population of the district are tribes. Out of 62 tribal subgroups of Odisha, 18 live in Mayurbhanj. This research was carried out among Santal tribes of three villages namely; Changua, Talsa, Badagobra of Tiring block of Mayurbhanj dist of Odisha, India. Mayurbhanj is the 1st district in terms of size and 3rd in terms of population. According to 2011 census, total population of the district is 25, 19,738 which account for 6% of the state population. 68.84% of the population live in rural areas and 31.16% live in the urban areas. Literacy rate is 63.17%. It has an area of 10,418sq km. It has 3950 villages (including 202 uninhabited villages) covering 26 blocks, 26 tehsils and 4 sub-divisions. The people of this village are mostly agriculturists by occupation.



(Figure: Location of Mayurbhanj District, Odisha)

Methodology

By using anthropological fieldwork technique, first household census was filled up where we collected the socio-economic conditions of the tribe by using a pre-structured schedule. The schedule included information regarding socio-economic conditions such as age, sex, clan, marital status, types of marriage, family size, education, occupation, expenditure/income etc followed by household numbering and mapping of that study area. Then I collected information about the traditional knowledge practices toward malaria. Data was collected from 80 participants by systematic random sampling. The total participants selected for this study were aged between 2-60 years. Major data was collected through primary sources with the help of schedule, observation, interview, discussion among ASHA, Anganawadi workers, ANM, School Teacher, medical officer and medicine man like OJHA GUNIA. Additional information was collected from secondary sources through literature review. Both qualitative and quantitative data were collected. Necessary ethical clearance was made at the institutional level to conduct this research. Data analysis was done by using SPSS 20 and Microsoft Excel software. A cross-sectional study was assessed with malaria related traditional knowledge and practices such as, what were their traditional practices for curing malaria, how many patients were suffering from malaria in the past one year, to whom were they consulting with for curing the disease, personnel protection measures etc.

Result & Discussion:

Table:1- Age group and gender wise distribution (Socio-demographic data)

Age group	Sex		Total N (%)
	Male N (%)	Female N (%)	
60+	3(3.8)	8(10.0)	11(13.8)
19-59	30(37.5)	32(40.0)	62(77.5)
10-18	0(0.0)	5(6.2)	5(6.2)
2-9	1(1.2)	1(1.2)	2(2.5)
Total	34(42.5)	46(57.5)	80(100.0)

This table shows the socio-demographic characteristics of the participants. The sample size of the present study was 80. Majority (77.5%) of the participants were in the age group of 19 to 59 years.

And minority (2.5%) of the participants were in the age group of 2-9 years. Out of 80 it was found that 46(57.5 %) respondents were female and 34 (42.5%) were male.

Table:2- Distribution of malaria patients w.r.t age this year 2017

	Distribution of malaria patients	
	Yes	No
AGE	N (%)	N (%)
60+	1 (1.2)	10 (12.5)
19-59	3 (3.8)	59 (73.8)
10-18	2 (2.5)	3 (3.8)
2-9	1 (1.2)	1(1.2)
Total	7 (8.8)	73 (91.2)

This table shows that a smaller number of people (8.8%) suffered from malaria in 2017 as compared to previous years. Most people (91.2%) weren't suffering from malaria.

Table:3- Consultation of patients

Consultation of patients	N (%)
doctor	67 (83.8)
ojha	4 (5.0)
Asha Didi	9 (11.3)
Total	80 (100.00

This table shows that most patients (83.8%) were consulting with the doctors as compared to the traditional medicine man OJHA (5%). Dusing an some of them were consulting with the Asha Didi (11.3%) whom the malaria kit was available.

Table: 4- Number of people practised indigenous method for prevention of malaria w.r.t age

	knowledge of indigenous method for prevention of malaria	
	Yes	No
Age	(%)	(%)
19 -59	58.4	33.0
10 -18	5.0	1.2
2 -9	1.2	1.2
Total	64.6	35.4

This table shows that about 64.6% respondents practised some kind of knowledge. But 35.4% respondents didn't practice any type of indigenous method for prevention of malaria. These respondents only prefered to go to the hospital for curing any type of disease.

Table-5: Indigenous method for prevention of malaria

Indigenous method for prevention of malaria	*Percent (%)*
Saparam	26.1
Kalibahu	11.2
neem leaves	7.3
Sinduari	16.5
mustard oil	3.5
Nothing	35.4
Total	100.0

This table indicates that Saparam (Nyctanthes arbour-tristis), Kalibahu (a type of local greens) and Sinduari (Vitex negundo) leaves were mostly used by the respondents. 26.1% respondents used saparam leaves in liquid form or powder form for precaution of malaria. 11.2% respondents used kalibahu as their food also for precaution. 23.8% respondents used to burn Sinduari and Neem leaves to avoid mosquitos. Some respondents used mustard oil massage for protection from mosquito bites.

Table- 6: Distribution of personnel protection measures to prevent mosquito

Personnel protection measures to prevent mosquito	*Percent (%)*
Spraying insecticide	11.3
Use mosquito net	85.0
Mosquito coil	3.7
Total	100.0

This table indicates that about 85% respondents used mosquito nets as best precaution method from mosquito bities which leads to malaria. Mosquito nets were provided by the Government through ASHA for regular use. Also spraying insecticide (11.3%), mosquito coils (3.7%) were used as protective measures against of mosquitos which causes malaria.

Various Government health programmes such as Spray programme, Mosquito net distribution programme, Pala programme, MDD (Malaria Dengue Diarrhea), Mamata Divas, RDT (Rapid Diagnostic Test), Gambusia fish hatchery etc were carried out by the health workers regularly to promote awareness among the people.

Conclusion

Traditional knowledge has been used for centuries by indigenous and local communities under local laws, customs and traditions. It has been transmitted through and gradually evolved from generation to generation. From the above discussion, I found out that very few people were suffered from malaria in 2017 and that area was less malaria affected. The awareness about malaria was significantly higher among these tribal groups. The respondents reported to be following good health seeking practices such as keeping surroundings clean, sanitation and also using indigenous methods and mosquito nets for prevention of malaria. Here knowledge and practices of the tribal people was a proxy indicator for the available social support or work done by the community health workers (CHWs) like ASHA and ANM. Although they adopted the modern healthcare practices they still practiced their traditional customs. Traditional knowledge played an important role in vital areas like medical treatment. It was the only affordable treatment available to poor people in remote communities.

References

A Amato R, Pearson RD, Almagro-Garcia J, et al. Origins of the current outbreak of multi drug resistant malaria in southeast Asia: a retrospective genetic study. Lancet Infect Dis 2018 (published online Feb 1) m J Trop Med Hyg Sep 2017 supplement; 97(3).

Abreha T, Hwang J, Thriemer K, et al. Comparison of artemether-lumefantrine and chloroquine with and without primaquine for the treatment of Plasmodium vivax infection in Ethiopia: a randomized controlled trial. Plos Med 2017 May 16; 14(5):e1002299.

Hill AV, Allsopp CE, Kwiatkowski D, Anstey NM, Twumasi P, Rowe PA, Bennett S, Brewster D, McMichael AJ, Greenwood BM (1991) Common West African HLA antigens are associated with protection from severe malaria. Nature.352: 595–600.

Lacerda MV, Zackiewicz C, Alecrim WD, Alecrim Md (2007) the neglected Plasmodium vivax: are researchers from endemic areas really concerned about new treatment options. Revista da Sociedade Brasileira de Medicina Tropical. 40(4):489-90.

Snow RW, Guerra CA, Noor AM, Myint HY, Hay SI (2005) the global distribution of clinical episodes of Plasmodium falciparum malaria Nature.434:214–217.

Trape JF, Rogier C, Konate L, Diagne N, Bouganali H, Canque B, Legros F, Badji A, Ndiaye G, Ndiaye P, Brahimi K, Faye O, Druilhe P, Pereira da Silva L (1994) The Dielmo project: a longitudinal study of natural malaria infection and the mechanisms of protective immunity in a community living in a holoendemic area of Senegal. The American Journal of Tropical Medicine and Hygiene.51: 123–137.

Mugabe J., "Intellectual Property Protection and Traditional Knowledge - an International

Policy Discourse," Bio policy International, No. 21, 1999, p. 3.

Martine Koning, "Biodiversity Prospecting and the Equitable Remuneration of Ethno biological Knowledge: Reconciling Industry and Indigenous Interests", "Intellectual Property Journal, No. 12, 1998, p. 265.

Traditional knowledge – Wikipedia, available at<https://en.wikipedia.org/wiki/Traditional Knowledge>, visited on February 28, 2019.

Chapter2 traditional knowledge- Shodhganga available at <shodhganga inflibnet.ac.in/ bitstream/ 10603/22605/9/09 chapter2.pdf>, visited on February 28, 2019.

Man in Society ISSN 2347-1530
Volume 25, 2018, pp. 56-59

Maternal Health among the Santals of Tiring Block of Mayurbhanj District, Odisha

Sasmita Sahoo[1] Prasanna Kumar Patra[2], Kanhu Charan Satapathy[2]and Laxman Kumar Sahoo[3]

Abstract

The health of the mother and child constitutes a major part of the community health. Maternal health among the Indian tribes remains an important area and is influenced by several factors which is related with culture. They are vulnerable to morbidity and mortality due to poor socio-economic condition, unhygienic atmosphere, lack of education, awareness and inaccessibility to healthcare systems. The present study aims to understand the maternal health care system among the Santal women of Tiring Block of Mayurbhanj District, Odisha. The present study is a community based cross-sectional study. In all 68 women data relating to maternal and child health care which were collected from the Santal women, whose youngest child was less than or equal to 5 years of age and analyzed statistically. The mean age at marriage was 16.72years. The mean age of 1st conception of this tribe was 18.32 year. Around 94.10% women had normal delivery and 5.90% had caesarian delivery. Antenatal practices were very good with 98% of the women visited for antenatal check up and 98% women who received TT injection during pregnancy. 94% women was normal delivery. 82% was Institutional delivery due to intervention of different health scheme and financial benefits. The ASHA and Anganwadi workers are playing a crucial role for immunization of mother . The result suggests the early marriage of this tribe, which can affects the women's social and physical health and mother was immunized due to the dedication of ANM, ASHA, AWW.

Keywords: *Pregnancy, ANC, Tribes, Mayurbhanj, Odisha*

Introduction

Maternal health care remains a major challenge to the global public health system, especially in developing countries. In India, considerable attention has been paid to estimates of maternal mortality, but mere has been reserved to the issue of adolescents pregnancies requires paramount attention which have been consistently associated with increased risk of adverse health outcomes, low birth weight, premature deliveries, high neonatal and post neonatal as well as infant morbidity and mortality. The adolescents often lack experience, tend to be psychologically as well as emotionally less mature, all of which lead to poor maternal health outcome. However, marriage at a very young age is the major reason for early pregnancy in India(Singh, Rai, Singh 2012).

Maternal health care include ante-natal care (ANC), intra-natal and post-natal care. According to NFHS-4 Odisha the proportion of women who gave birth in the five years preceding the survey, 83% received antenatal care for their last birth from a skilled provider among them 76% from a doctor and 7% from an auxiliary nurse midwife (ANM), lady health visitor (LHV), nurse, or midwife. 6% did not receive any antenatal care. The women who gave birth in the five years preceding the survey, 95% registered the pregnancy for the most recent live birth. Among the registered pregnancies, 97% received a Mother and Child Protection Card (MCP Card). 64% of women received antenatal care during the first trimester of pregnancy. For 91%of their last births, mothers received iron and folic acid (IFA) supplements. 95% of last births were protected against neonatal tetanus through tetanus toxoid vaccinations given to the mother. More than 85% take place in a health facility (mostly a government facility) and 14 percent take place at home(NFHS-4 Odisha). The determinants of utilization of maternal care services among tribal

[1]*M.Phil Scholar, P.G. Department of Anthropology, Utkal University, Vanivihar. Bhubaneswar-04.*
[2]*Associate Professor, P.G. Department of Anthropology (CAS), Utkal University, Vani Vihar, Bhubaneswar-04.*
[3]*UGC Post Doctoral Fellow, P.G. Department of Anthropology (CAS), Utkal University, Vani Vihar, Bhubaneswar-04.*

women were early registration of pregnancy, better general awareness regarding medical services for mothers, affordable, accessible and good quality of services in the public health system. Motivation by health workers emerged as an important contributing factor for better utilization (Jose et al 2014).

About half of the total world's indigenous people referred to as tribal group/scheduled tribes live in India. The tribal population constitutes 22.21% of state total population. Odisha occupies 2nd place in term of tribal population in the country. The study was intended to assess the maternal health status of Santal women in the Tiring block of Mayurbhanj district Odisha. This paper attempts to assess the factors associated with maternal health and to assess the knowledge, attitudes and opinion of the women's regarding their own health.

Methods

Mayurbhanj district is endowed with a fascinating assortment of tribes and their colourful culture and tradition. The district is one of the northern districts in the State of Odisha and is the home to about 18 tribal communities, among them 43.13% are Santal. The present study was conducted in the Tiring block of Mayurbhanj district, Odisha. The data was collected through field investigation carried out among the Santal tribe. Primary data was collected by using anthropological fieldwork techniques like mapping, scheduled, questionnaire, interviews, personal observation method, case studies and group discussions. The maternal health care data which were collected from the Santal women, whose youngest child was less than or equal to 5 years of age. . I have taken 68 households for the study of maternal health. I have also taken the interviews of the local Anganwadi worker, ANM and ASHA. The quantitative data was analysed by using SPSS .

Results

Table 1: Distribution of respondents as per their age at Marriage

Age at marriage	*N (%)*	*Mean*
11-15	28 (41.2%)	14.25
16-20	34 (50.0%)	17.53
21-25	5 (7.4%)	23.20
26-30	1 (1.5%)	26.00
Total	68 (100.0%)	16.72

The main objective of the study was to know about the age at marriage, their age of conception, to study the trends of home delivery, institutional delivery, antenatal and postnatal care and their traditional restrictions during and after pregnancy.

Table 1 shows that the categories of respondents with the greatest frequency of those aged 16-25years with mean age 16.72years. According to Ministry of Statistics and Programme Implementation data Women's mean age at all India level is in 2016 is at 22.2 years and the same in rural and urban areas are 21.7years and 23.1years respectively.

Table 2: Distribution of respondents as per their age at 1st Conception

Age at 1st conception	*N(%)*	*Mean*
12 -16	20 (29.4%)	15.05
17 -21	38 (55.9%)	18.34
22 -26	8 (11.8%)	23.50
27 -31	1 (1.5%)	28.00
31ab ove	1 (1.5%)	32.00
Total	68 (100.0%)	18.32

Table 2 shows that among the women, 55.9% had conceived at the age between 17-21years, where the mean age at conception was 18.32years.

Table 3: Distribution of respondents as per on the basis of antenatal check up

Antenatal checkup	*N (%)*
Yes	67 (98.5%)
No	1 (1.5%)
Total	68 (100%)

Table 3 shows 98.5% women were visited Anganwadi for antental checkup by ANM where according to NFHS-4, 73% receiving ANC.

Table 4: Distribution of respondents as per TT immunziation and intake of IFA tablet during pregnancy

TT immunization	IFA tablet
67(98.5%)	67(98.5%)

Table 4 indicates the intake of IFA tablets and immunization status of the Santal women, 98.5% were received minimum 100 IFA tablets and immunized during the pregnancy. The NFHS-4 data shows 95% of last births were protected against TT.

Table 4 indicates the intake of IFA tablets and immunization status of the Santal women, 98.5% were received minimum 100 IFA tablets and immunized during the pregnancy. The NFHS-4 data shows 95% of last births were protected against TT.

Table 5: Distribution of respondents as per the type of Delivery

Type of delivery	*N (%)*
Normal	64 (94.10)
Caesarean	4 (5.90)
Total	68 (100.0)

Table 5 shows 5.9% were deliverd by caesarean section among the Santal Women where NFHS-4 data shows 14% of births during the past five years were delivered by caesarean sections.

Table 6: Distribution of respondents as per place of Delivery

Place of delivery	*N(%)*
Home	12(17.68)
Hospital	56(82.32)
Total	68(100.0)

Table 6 indicates the place of delivery preferred by the Santal women, 82.32% of births at hospital and 17.68% were home delivery where according to NFHS-4 85% on the importance of institutional delivery.

Discussions

The mean age at marriage was 16.72years. According to the respondents, a girl should marry 3-4year of after maturation. The age at first conception was 18.32years. In the present study the conception of newly married girl influenced by different interrelated factors such as age at marriage, health conditions and sometime also due to the desire of in-laws and relatives.

According to NFHS-4, the antenatal check up in rural area of Mayurbhanj is 73.4% . In present 98.5% women preferred antenatal checkup. The specific reasons related to government health facilities that favored utilization were free treatment and good quality of services.

The influence of health workers(ANM, ASHA and AWW) as the sole reason for receiving health services during pregnancy, at the time of delivery and after pregnancy. The ASHA and AWW are playing a crucial role for immunization and distribution of IFA tablets. Their motivation among the Santal women, about the awareness regarding medical services for mother and child was the prime factors to accept the health care system over their traditional practices.

Out of women interviewed 82.32% were delivered at hospital and 17.68% at home because of free treatment and financial benefits. The Santal women who did not utilize health care services were of the opinion that ANC and delivering at the hospital were unnecessary. They believed that medicines and injections are harmful to health and will cause other health problems.

Conclusion

In concluding habitually tribes are live in areas with follow the traditional norms, socially and economical weak and conservative in nature. This needs lots of efforts to change their behavior, modify their life style and improve their overall quality of life.The study revealed the mean age at marriage is 16.72year of the women because they don't give more emphasis on the girl child education. 98.5% women intake IFA tablets, immunizations and antenatal check-ups, because of the proper utilization of Govt. programmes by ANM, AWW and ASHA. ASHA workers are working in efficient way in taking pregnant women to institutional delivery. The pregnant women prefer institutional delivery because they get financial benefits from the Govt. They were obey their traditional restrictions during and after pregnancy. The lower level of education may have the reason behind the old beliefs and practices of Santal women.

References

Agunwa, C-C, Obi, I.E, NDV, A.c, Omotowo, C.A, Ido, K.O, Umeobieri, A.K and Aniwada, E.C (2017). Determinants of pattern of Maternal and Child Health service utilization in a Rural community in South eastern Nigeria. BMC Health Services Research.

Kumar D, Goel A.K, Ghonghoria V. (2016). A qualitative Study on Maternal and Child Health Practices among Baiga Tribe of Madhya Pradesh state in central India. The Journal of community health management.2016;3(1):23-27.

Jose JA; Sarkar S; Kumar SG; Kar, SS. Utilization of Maternal Healthcare Services by Tribal Women in Kerala. J Nat Sc Biol Med 2014;5:144-7

Marphatia AA, Ambale GS and Reid AM. Women's

Marriage Age Matters for Public Health(2017): A Review of the Broader Health and Social Implications in South Asia. Front. Public Health 5:269. doi: 10.3389/fpubh.2017.00269.

Mohanty S.K, and Srivastava .A (2013). Out pocket Expenditure on Institutional Delivery in India, Health Policy and Planning;28:247-262.

National Family Health Survey (NFHS-4), India, 2015-16: Odisha. Mumbai.

Singh P, Yadav RJ. Antenatal care of pregnant women in India. Indian J Community Med 2000;25:112-7.

Shailja Sharma, O.P. Ghosh, K.K . Srivastava, Kuwar Alok Singh Yadav, Ravi Kumar(2018). Ministry of Statistics and Programme Implementation. Government of India.

S. Sumithra et al. Maternal and child health services utilization in married women of age 15-45years. J.Commun. Dis.38(1)2006:102-105.

Singh PK, Rai RK, Alagarajan M, Singh .Determinants of Maternity Care Services Utilization among Married Adolescents in Rural India L (2012). PLoS ONE 7(2): e31666. doi:10.1371/journal.pone.0031666

Tej Ram Jat, Nawi Ng and Miguel Sen Sebastian(2011). Factors affecting the use of Maternal health in Madhya Pradesh state of India: a multilevel analysis. International Journal for Equity in Health.

Man in Society ISSN 2347-1530
Volume 25, 2018, pp. 60-66

Assessment of Nutritional Status among the Bhumija Pre-school Children of Mayurbhanj District of Odisha

Kalandi Singh[1] & Prasanna Kumar Patra[2]

Abstract

This paper is based on a community-based, cross-sectional study to determine undernutrition and malnutrition among the Bhumija pre-school children in Mayurbhanj district of Odisha. Nutritional status is a sensitive indicator of community health and nutrition. The objective of this paper is to assess the prevalence of underweight, stunting, and wasting in preschool children of 0 to 6 years old and analyze factors associated with malnutrition. A total of 100 children aged 0-6 yr studied for anthropometry from three selected villages. The study found that there is no significant difference between boys and girls for nutritional status. According to weight-for-age, 43.0 per cent of children are suffering from underweight (<median 2SD). Height-for –age and weight-for-height data shows that 33.0 per cent of children suffered from stunting and 18.0 per cent from wasting. The study reveals the prevalence of undernutrition among the pre-school Bhumija children of Mayurbhanj district and it suggests for immediate public health program to be initiated to reduce the prevalence of nutritional status in this area.

Keywords : *Nutritional status, Bhumija,Underweight, Stunting, Wasting, Odisha*

Introduction

Pre-school children constitute the most vulnerable segment of any community. Their nutritional status is a sensitive indicator of community health and nutrition(BNFI 1995) . Undernutrition among them is one of the greatest public health problems in developing countries. About 128 million (70%) of the world's 182 million stunted children aged under five years live in Asia (Allen and Gillespie, 2001). Nutritional status plays a vital role in deciding the health status particularly in children. Nutritional deficiencies give rise to various morbidities, which in turn, may lead to increased mortality. Undernutrition is a known factor closely associated with child mortality rates (Pellitier, Frongillo, Schroeder and Habicht, 1995) (Scrimshaw, Taylor and Gorden, 1968). An analysis of six longitudinal studies by World Health Organization (WHO 1995) revealed a strong association between severity of weight for age deficits and mortality rates: 54 per cent deaths of under five children in developing countries were accompanied by low weight for age 5 . Attempts to reduce child mortality in developing countries through selective primary health care have focused primarily on the prevention and control of specific infectious diseases, with less effort being directed to improving children's underlying nutritional status.(Geographical isolation, primitive agricultural practices, socio cultural taboos, lack of formal education, poor infrastructure facilities, improper health seeking behaviour, poverty etc. has always lead to the development of various morbidities and under-nutrition. In general, data are scanty on the anthropometric and nutritional status of various tribal populations of India (Yadav et al. 1999; Yadu et al. 2000; Khongsdier et al. 2002; Gogoi et al. 2002; Bose and Chakraborty 2005). Knowledge of the nutritional status of a community or a region is necessary to have a comprehensive idea about it development process, as under nutrition is one of the major health problems in developing countries. It has been recently suggested (Bose and Chakraborty 2005) that there is an urgent need to evaluate the nutritional status of various tribes of India as each tribal population has its unique food habits (Mandal, 2002). Three most commonly used

[1]*Ph.D Scholar (NFHE Fellow) and* [2]*Associate Professor, PG Department of Anthropology, Utkal University, Vani Vihar-751004, Odisha, Email: kalandi123singh@gmail.com*

internationally recommended indicators are stunting (low height-for-age), underweight (low weight-for-age) and wasting (low weight-for-height) (WHO 1995) (Lee and Nieman; 2003) Children with z-scores < -2.00 are said to be underweight. Among all the states Odisha is a tribal dominated state with the largest number of tribal communities (62), representing major linguistic groups like Dravidian, Austro-Asiatic and Indo- Aryan. Almost 44.21% of the total land area in Odisha has been declared as scheduled area. The total tribal population of the State is 8.15 million, who constitute 22.13% (Sahoo, 2011).

Objectives

This study has the following objectives:

(1) To assess the prevalence of underweight, stunting, and wasting in pre-school children of 0 to 6 years old.

(2) To analyze factors associated with malnutrition in pre-school Bhumija children.

Materials and Methods

The present study was a cross-sectional study conducted in three villages of Khunta Blocks of Mayurbhanj District, Northern Odisha, India. The study was carried out during a peroid from January 2018 to February 2018. A total of 100 preschool children aged 0-6 years (54 boys; 46 girls) were assessed. Data was collected after obtaining necessary approval from the parents, villages and the block authorities. Parents were informed about objectives of the present study and their consent was obtained. Information on age, gender, weight and height was collected on a structured pre-tested schedule by house to house visit following the interview method and examination. Anthropometric measurements were taken on each subject following the standard techniques. Technical errors of measurement were found to be within reference values. Children were considered as underweight, stunting and wasting if their weight-for-age, height-for-age and weight-for-height Z-scores are below -2.0 SD of the National Center for Health Statistics (NCHS) (Lohman,Roche and Martorell; 1988). Severe undernutrition was assessed as Z-score below -3.0 SD. Thus three commonly used undernutrition indicators, i.e. stunting (low height-for-age), underweight (low weight-for-age) and wasting (low height-for-age) were used to evaluate the nutritional status of the subjects.The WHO classification was also followed for assessing severity in malnutrition by rate prevalence ranges of these three indicators among children (WHO 1995).The classification is shown in table-I. Children's t-test was undertaken to test for sex differences in means of height and weight. Statistical significance was set at p<-2SD), underweight (WAZ<-2SD) and stunted (HAZ<-2SD) students were assessed. The children on the basis of the z-score were then categorized as per the subgroups of Svedberg's model in order to arrive at the CIAF to get the overall prevalence of under nutrition (WHO 2006).The z-score for different nutritional indices were calculated in reference to WHO international guidelines and the prevalence of underweight, stunting and wasting were calculated at cut-off level < 2SD or Z - score < -2 (WHO 2006). The present data on antrhropometric measurements were analyzed using Z score test with the help of Emergency Nutrition Assessment (ENA) software.

Table I: Classification of prevalence ranges of malnutrition by (WHO,1995)

Prevalence group	Prevalence ranges (% of children below-2 Z scores)		
	Low height for age (stunting)	Low weight for age (wasting)	Low weight for height (underweight)
Low	<20	< 10	<5
Medium	20-29	10-19	5-9
High	30-39	20-29	10-14
Very high	>40	>30	> 15

Results

Regarding nutritional status, prevalence of underweight (long duration malnutrition) and stunting was found to be the highest in age group 3-5 yrs (43%) (Table II), and 2-4 yrs(33%) (Table III) respectively whereas maximum prevalence of

wasting (short duration malnutrition) was found in age group 1-3 yrs (18%) (Table IV). In all age groups most of malnourished children belonged to the underweight category. The percentage of underweight in the studied group was found to be 43 per cent. Gender difference was observed as the incidence of underweight was among boys (50%) than girls (34.8%) (Table II). The percentage of stunting in the studied group was found to be 33 per cent.gender difference was observed as the incidence of stunting was among boys (38.9%) than girls(26.1%) (Table III).The percentage of wasting in the studied group was found to be 18 per cent and gender difference was observed as the incidence of stunting was among boys (20.4%) than girls (15.2%) (Table IV).The nutritional status was positively correlated to age indicating poor nutritional status of preschool children. No significant association was found between gender and nutritional status of preschool children. The results highlighted the higher prevalence of malnutrition among preschool children; therefore, preschool age groups should be the main target for nutritional surveillance and interventions (Table II)

Table II: Prevalence of underweight based on weight-for-age z-scores by sex

Weight -for-age (Underweight)	Boys n = 54	Girls n = 46	All n = 100
Prevalence of underweight (<-2 z-score)	(27) 50.0 % (37.1 - 62.9)	(16) 34.8 % (22.7 - 49.2)	(43) 43.0 % (33.7 - 52.8)
Prevalence of moderate underweight (<-2 z-score and >= -3 z-score)	(20) 37.0 % (25.4 - 50.4)	(12) 26.1 % (15.6 - 40.3)	(32) 32.0 % (23.7 - 41.7)
Prevalence of severe underweight (<-3 z-score)	(7) 13.0 % (6.4 - 24.4)	(4) 8.7 % (3.4 - 20.3)	(11) 11.0 % (6.3 - 18.6)

Table II shows distribution of pre-school children according to standard deviation (SD) classification. High prevalence of underweight (below 2SD) in terms of underweight (43%), moderate underweight (32%) and severe underweight (11%) was observed among both the sexes.

Table III: Prevalence of stunting based on height-for-age z-scores and by sex

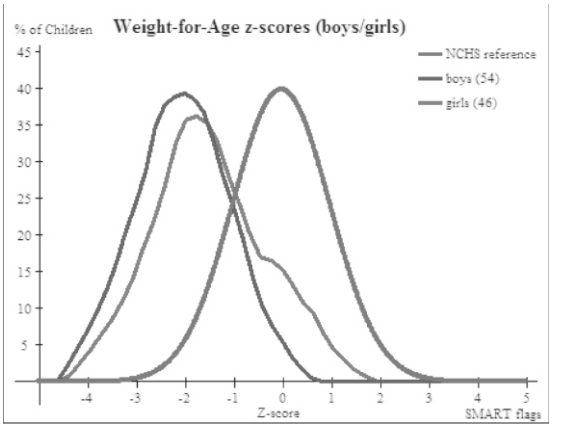
Height-for-age(Stunting)	*Boys* *n = 54*	*Girls* *n = 46*	*All* *n = 100*
Prevalence of stunting (<-2 z-score)	(21) 38.9 % (27.0 - 52.2)	(12) 26.1 % (15.6 - 40.3)	(33) 33.0 % (24.6 - 42.7)
Prevalence of moderate stunting (<-2 z-score and >=-3 z-score)	(13) 24.1 % (14.6 - 36.9)	(4) 8.7 % (3.4 - 20.3)	(17) 17.0 % (10.9 - 25.5)
Prevalence of severe stunting (<-3 z-score)	(8) 14.8 % (7.7 - 26.6)	(8) 17.4 % (9.1 - 30.7)	(16) 16.0 % (10.1 - 24.4)

Table III shows distribution of pre-school children according to standard deviation (SD) classification. High prevalence of stunting (below 2SD) in terms of stunting (33%), moderate stunting (17%) and severe stunting (16%) was observed among both the sexes.

Table IV: Prevalence of acute malnutrition based on weight-for-height z-scores by sex

Weight/height (Wasting)	Boys n = 54	Girls n = 46	All n = 100
Prevalence of global malnutrition (<-2 z-score)	(11) 20.4 % (11.8 - 32.9)	(7) 15.2 % (7.6 - 28.2)	(18) 18.0 % (11.7 - 26.7)
Prevalence of moderate malnutrition (<-2 z-score and >=-3 z-score)	(10) 18.5 % (10.4 - 30.8)	(7) 15.2 % (7.6 - 28.2)	(17) 17.0 % (10.9 - 25.5)
Prevalence of severe malnutrition (<-3 z-score)	(1) 1.9 % (0.3 - 9.8)	(0) 0.0 % (0.0 - 7.7)	(1) 1.0 % (0.2 - 5.4)

Table IV shows distribution of pre-school children according to standard deviation (SD) classification. High prevalence of malnutrition (below 2SD) in terms of malnutrition (18%), moderate malnutrition (17%) and severe malnutrition (1%) was observed among both the sexes.



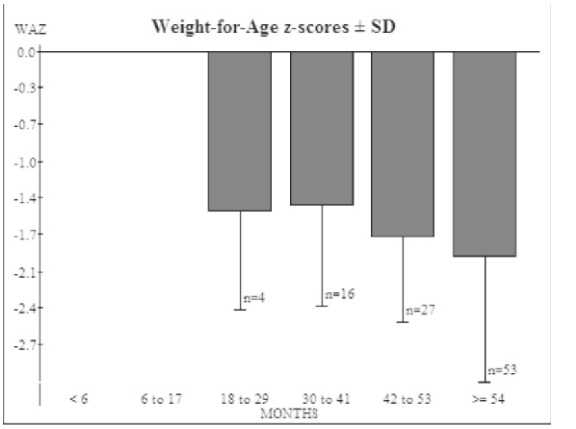
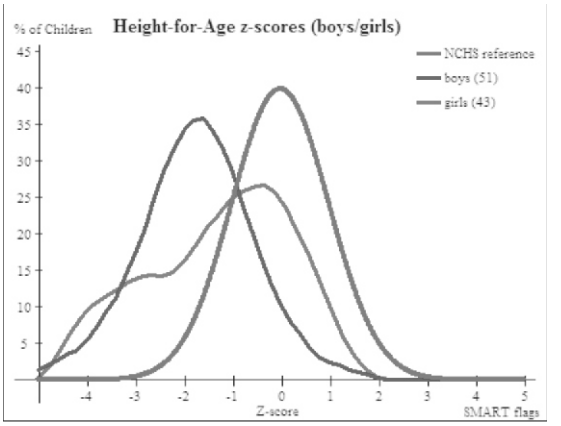


Fig 1: Prevalence of Underweight (%) among the Bhumija Children



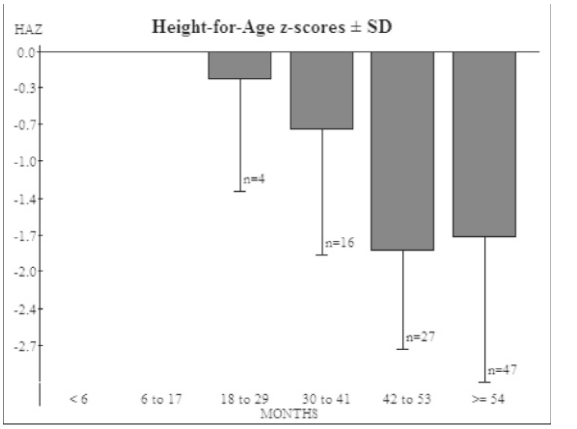
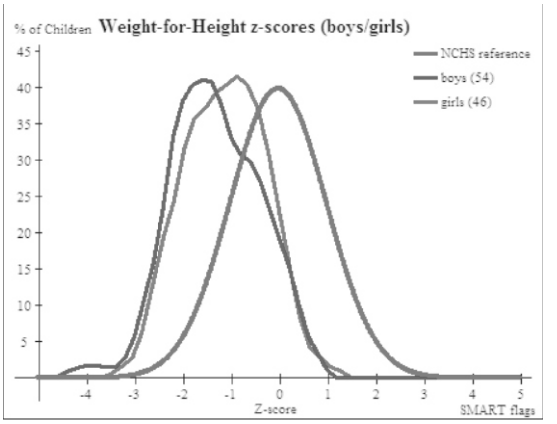


Fig 2: Prevalence of Stunting (%) among the Bhumija Children



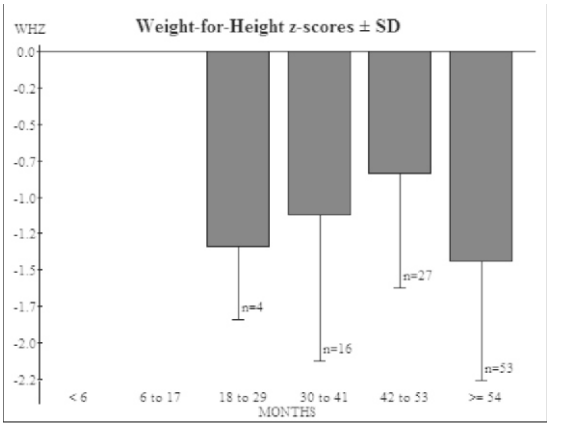


Fig 3: Prevalence of Malnutrition/Wasting (%) among the Bhumija Children

Discussion

Table V: shows the Prevalence (%) of under nutrition among various tribal children in India

Tribe	*State*	*Age group*	*Sample size*	*Underweight (%)*	*Stunting (%)*	*Wasting (%)*	*Reference*
Kawar	Chattisgarh	1-5	199	48.2	47.7	48.2	Mitra et al. 2007
Gond	Madhya Pradesh	0-5	1022	61.6	51.6	32.9	Mitra et al. 2007
Kodaku	Madhya Pradesh	1-5	182	59.8	43.0	35.0	Dolla et al. 2005
Tribal children	Maharastra	0-6	40	68.7	60.4	30.2	Khandare et al. 2008.
Saharia	Rajasthan	1-5	193	72.1	67.8	13.4	Rao et al. 2006
KoraMudi	West Bengal	2-5	47	61.7	51.1	27.7	Bisai and Mallick 2011
Lodha	West Bengal	1-5	74	47.0	35.0	20.0	Bisai et al. 2008
Sabar	Odisha	0-5	`101	32.5	39.5	18.6	Chakrabarty et al 2005
Bhumija	Odisha	0-5	62	32.5	39.5	9.9	Joshi et al 2016
Bhumija	Odisha	0-6	100	43.0	33.0	18.0	Present study 2018

Table V. Prevalence (%) of under nutrition among various tribal children in India Compares with present study Compares the prevalence of underweight, stunting, wasting of tribal children in different parts of India along with present study. It is observed that the prevalence of underweight is similar to the rates of underweight of Gond (Rao et al. 2005), Kodaku (Dolla et al. 2005) Koramudi (Bisai and Mallick 2010) tribal preschool children. However, the prevalence was higher than the Lodha (Bisai et al. 2008) and Kawar (Mitra et al. 2007) tribal children. The rates of underweight were lower than the Saharia (Rao et al. 2006) and tribal children from Maharastra (Khandare et al. 2008). When compared to the prevalence of stunting with other tribal children in India, it was observed that prevalence of stunting is similar to Lodha children (Bisai et al. 2008), lower than Gond (Rao et al. 2005), Kodaku (Dolla et al. 2005), Kawar (Mitra et al. 2007), Koramudi (Bisai and Mallick 2011) and Saharia (Rao et al. 2006) tribal children studied in different parts of India. Moreover, the prevalence of wasting was higher than all those studies conducted among different tribal communities (Dolla et al. 2005, Rao et al. 2005, Rao et al. 2006, Mitra et al. 2007, Bisai et al. 2008, Khandare et al. 2008, Bisai and Mallick 2011). Since, wasting is a composite indicator of immediate and chronic or long term nutritional deficiency, the children in the present study have been experiencing both instant and prolonged nutritional stress. An earlier study reported the rates of underweight, stunted and wasted among Bhumija children to be 32.5%, 39.5% and 9.09%, respectively (Joshi et al 2016) (Table v). When compared to the prevalence of under nutrition with scheduled caste (Bhumija) children in Mayurbhanj District of Odisha, results indicated that prevalence of stunting was approximately similar in both tribe and caste (Bhumija) pre-school children. However, the rates of underweight and wasting were higher in tribal children than the caste (Bhumija) children.

Similarly, third lowest rate of undernutrition among tribal children than caste and other groups have also been reported in a recent Indian national survey (IIPS 2007). In the present study, the prevalence of under nutrition using the Shaker's cut-off point for MUAC measurement was 43.0%, out of whom 33.0% and 18.0 % children were found to moderately and severely undernourished, respectively.

Conclusion

The present study reflects that the high prevalence of under nutrition (43.0%,) and low prevalence of malnutrition (18.0 %) is seen in the (0-6 yrs) children of the Bhumija Community of Mayurbhanj district of Odisha. Therefore, tribal communities need much greater access to health care information, opportunities and resources to improve their children's nutritional status.

References

Allen LH, Gillespie SR. 2001 What works? A review of the efficacy and effectiveness of nutrition interventions. United Nations. Administrative Committee on Coordination/Sub Committee on Nutrition, Geneva. Asian Development Bank, Manila. ACC/SCN Nutrition Policy Paper No.19. ADB Nutrition and Development series Geneva No.5, p. 24-5.

Bose, K. and Chakraborty, F. 2008. "Anthropometric characteristics and nutritional status based on body mass index of adult Bathudis: A tribal population of Keonjhar District, Orissa, India", Asia Pacific Journal of Clinical Nutrition, 14,2005,pp. 80–82. Bisai S, Bose K, Ghosh A. Nutritional status of Lodha children in a village of Paschim Medinipur district, West Bengal, India. Indian Journal of Public Health 52: 203-206.

Bisai S, Bose K. 2009. Under nutrition in the Kora Mudi tribal population, West Bengal, India: A comparison of body mass index and mid-upper-arm circumference. Food and Nutrition Bulletin 30: 63-67.

Chakrabarty S, Ghosh R, Bharati P. 2006 Breastfeeding practices and nutritional status of preschool children among the Shabar tribal community in Orissa, India. Pp 227-234. Proceedings of National Symposium, Regional Medical Research Centre for Tribals, ICMR, Jabalpur.

Chakrabarty, S., Ghosh, R. and Bharti, P. 2005 "Breastfeeding Practices and Nutritional Status of Preschool Children among the Shabar Tribal Community in Orissa, India".. In: Proceeding of National Symposium on Tribal Health.

Chatterjee S, Saha S. 2008 A study on knowledge and practice of mothers regarding infant feeding and nutritional status of under-five children attending immunization clinic of a medical college. Internet J Nutrition Wellness:5(1).

Dolla C.K, Meshram P, Karforma C, Das S, Uike M. 2005 Nutritional status of Kodaku pre-school children in central India. Journal of Human Ecology 17: 229- 231.

Hanumantha Rao D, Mallikharjuna Rao K, Radhaiah G, Pralhad Rao N. 1994 Nutritional status of Tribal preschool children in three ecological zones of Madhya Pradesh. Indian Pediatrics; 31:635-640.

Jelliffee, D.B. 1966 'Assessment of the Nutritional Status of the Community". WHO Monograph Series No. 53,. Genava: WHO

Khandare AL, Siruguri V. Rao A, Venkaiah K, Reddy G, Rao GS. 2008 Diet and nutrition status of children in four tribal blocks of Thane district of Maharastra, India (nutrition status of children). Pakistan Journal of Nutrition 7: 485-488.

Mitra M, Sahu PK, Chakrabarty S, Bharati S, Bharati P. 2007 Nutritional and health status of Gond and Kawar tribal pre-school children of Chhattisgarh, India. Journal of Human Ecology 21: 293-299.

Physical status: the use and interpretation of anthropometry. 1995 Report of a WHO Expert Committee. World Health Organ Tech Rep Ser; 854: 1-452

Lee RD, Nieman DC. 2003 Nutritional assessment. New York:: McGraw Hill.

Lohman TG, Roche AF, Martorell R. 1988 Anthropometric Standardization Reference Manual. Chicago: Human Kinetics Books

Mandal GC, Bose K. 2009 Assessment of overall prevalence of under nutrition using Composite Index of Anthropometric Failure (CIAF) among preschool children of West Bengal, India. Iran J

Pediatr, 19: 237-243

Pellitier DL, Frongillo EA Jr, Schroeder DG, Habicht JP. 1995 The effects of malnutrition on child mortality in developing countries. Bull World Health Organ; 73 : 443-8.

Rao KM, Kumar RH, Venkaiah K, Brahmam GNV. 2006 Nutritional status of Saharia—a primitive tribe of Rajasthan. Journal of Human Ecology 19: 117-123.

Rao VG, Yadav R, Dolla CK, Kumar S, Bhondeley MK, Ukey M. 2005 Undernutrition and childhood morbidities among tribal preschool children. Indian Journal of Medical Research 122: 43-47.

Sachdev HPS. 1995 Assessing child malnutrition - some basic issues. Bull Nutr Foundations India; 16 : 1-5.

Scrimshaw NS, Taylor CE, Gorden JE. 1968 Interactions of nutrition and infection. WHO Monograph Series 57, Geneva, World Health Organization; p. 3-329

World Health Organization 1995, Physical status: the use and interpretation of anthropometry. Technical report series no 854. : World Health Organization, Geneva.

Man in Society ISSN 2347-1530
Volume 25, 2018, pp. 67-78

The Little Tradition of Shakti Cult in Odisha in the Context of Hindu Great Tradition

Hiranmayee Nayak[1] and Jagannath Dash[2]

Abstract

Since the dawn of Indian civilization, the early man was recognizing the power of the nature and after realizing the power of the 'power', man was propitiating the power of the nature and conceptualize the power and Shakti in the Hindu world of religious practices. In the Hindu great tradition, several sacred literature starting from the Vedas to all the 18 'purans' have mentioned in detail the rise and development of Shakti worship in Hindu India. The localized offshoots of the practice have formed several local or little tradition of Shakti worship in different parts especially different states of India. The paper has vividly discussed the little tradition of Shakti cult in Odisha revealing its constant and continuing interaction with that of Hindu great tradition.

Key words : *Cult, Great Tradition, Hindu, Little Tradition, Odisha*

Introduction

The practice of Shakti worship in India is as old as the human civilization here. *Hindu* sacred scriptures usually advocate the Great Traditional practice of *Hindu* India. According to Encyclopedia Britannica, "Mother goddess is any of a variety of feminine deities and maternal symbols of creativity, birth fertility, sexual union, nurturing, and the cycle of growth. The term has been also applied to figures as diverse as the so called Stone Age Venuses and the Virgin Mary. Because motherhood is one of the universal human realities, there is no culture that has not employed some maternal symbolism in depicting its deities."

The women as a vital member of society play the most crucial role for establishing family, propagating the members of the linkage and members in the family as well as society. "All cultural traits, including habits, norms of behaviors, inherited traditions, etc., were formed by and transmitted through the females. The woman thus, was not only the symbol of generation, but the actual producer of life. Her organs and attributes were thought to be endowed with generative power, and so they were the life-giving symbols. In the earliest phases of social evolution, it was this maternity that held the field, the life-producing mother being the central figure of religion." (Bhattacharya,1977: 1). There are many mother goddesses are present in every part of world in different time periods in different forms. When we come to Indian society specifically for the *Hindu*'s, the worship of mother goddesses is named as *Shakti worship*.

Shakti worship is most fundamental to the religious tradition of India. Though *Shakti* refers to 'Power' or 'Energy' very broadly, it is usually a feminine power and as such *Shakti* Worship in India is nothing but the worship of mother goddess in different forms. "*Shakti"* is a Sanskrit word, which means "power, ability, strength, might, effort, energy, capability, etc." Archaeological excavations in *Harappa and Mohenjo-Daro* civilization have provided some scientific grounds for *Shakti Worship* during post-Neolithic period.

Shakti Worship in Human Society

Human society at first worship the mother goddess as she is the symbol of fertility and vegetation. In Paleolithic period, the female figurines can be assumed to have a wider emphasis on fertility. Neolithic community has worshipped a mother goddess who is connected with plant life and served

[1]*Ph.D Research Scholar, P.G. Department of Anthropology, Utkal University, Vanivihar, Bhubaneswar-4.*
[2]*Professor (Retd.), P.G. Department of Anthropology, Utkal University, Vanivihar, Bhubaneswar-4.*

by male attendants. Beyond India, *Shakti* is also conceptualized in different countries of the world. In Europe, there is a mother goddess named as "Corn mother". In Egypt, *"Tefnut*" is the goddess of moisture and "*Nut"* is the goddess of sky. In Egypt there is another most important goddess present, named as "*Isis".* Goddess *"Alexandria*" was worshipped by both the Egyptians and Greeks. Her cult was also popular in Cyprus as well as in Syria and Asia Minor. *"Atargatis*" was more popular in Roman Empire. In Rome, the goddess "*Aphrodite"* was transformed into the goddess "Venus", who was worshipped as the guardian deity of marriage and agriculture. Augustus made the goddess *"Venus*" as the "*Magna Matar* of Rome". In Greece, the goddess "*Rhea"* was the *Titanis (Titaness*) mother of the gods and goddesses of female fertility motherhood and generation and the goddess "Hera" is the goddess of birth, marriage, menstrual cycle and maternity. According to Alexandra Silver, in Sumerian mythology, the goddess "*Ninhursaga"* the goddess of "Nu Gua" was the patroness of matchmakers. "*Chang'e",* the goddess of the moon, was another of the most popular deities in ancient China. In Africa, *"Oshun*" is the goddess of beauty, love, prosperity, order, and fertility. It is said that *Oshun* is beneficent and generous and very kind by nature. In Irish mythology, the goddess "*Danu*" was the mother of the earth, the gods, fertility wisdom, wind and of all the Celtic people (http : Wikipedia.org.wiki/Danu-(Irish_goddess)).In Norse (Nordic tradition) mythology, the goddess "*Frigga*" was associated with the hearth-the mead hall (feasting hall), childbirth, motherhood, wisdom, household management, weaving and spinning.

There many goddesses in the different parts of the world. Here we highlight only few of them from different parts of world. When we come to South West Asia, first of all, Harappa and Mohenjo-Daro civilization came to our sight. We find some female figurine and with jewelry consisting of elaborate neck collars, long chains, armlets, bangles, anklets, ear-rings, etc. Some references made the connection between the mother goddess *Astarte of Semitic*, who was the great goddess of vegetation and fertility. Many of the Mother Goddess figurines from Mohenjo-Daro are painted with a red slip or wash, as in ancient Egypt, Mesopotamia and Malta.

After Harappa Civilization, there is another civilization flourished in North-Western and Northern India, i.e., *Vedic* Civilization / Age. Some of the mother goddesses like *Ambika, Uma, Katyayani, Durga* etc. from non-*Vedic* stream were able to make their way into the later Vedic Pantheon. A very large number of post-*Gupta Mahishamaridni* images are preserved in different museums of India.

"The gods and goddesses of early *Buddhism* were borrowed from the existing religious systems of India. The *Buddhist Siri-Lakkhi* for example, was conceptually a combination of *Brahmanical "Lakshmi and Saraswati".* She is also a goddess of wisdom. There is also a separate goddess called *Saraswati*. The *Chulavamsa* also mentions about *Viralakkhi,* the goddess who gives success to warriors." (Bhattacharya,1977:111)

"The *Mahayana* pantheon is based on a conception of the *Adi Buddha* and *Adi-prajna*; also called *Pragya-parmita*. The universal father and universal mother, from this pair emanate the five *Dhyani Buddha*."(Dubey, 2017:174-175)

"The *Buddhist* pantheon is also rich in a varied range of fascinating female divinities; these range from tree spirits to compassionate healers and from wrathful protectors to a cosmic mother of liberation. These female *Buddhist* divinities can be broadly grouped in two categories. It represents cosmic power in a feminine form leading to the highest truth and attainments of liberation, often tagged as '*Female Buddhas'*. This group includes *Mahayana* goddesses such as *Prajnaparamita* and tantric goddesses such as *Vajrayogini and Nairatmya.* The other group consists of goddesses who are invoked to accomplish a range of practical aims such as protection from diseases and examines pursuit of knowledge, mental purification and for promoting a gradual progress towards awaking. The iconographic traits and rituals differ according to the contrasting roles and statues of these goddesses".(Samdarsi, 2014:94)

According to Bhattacharyya, Tara is the most popular goddess of the *Buddhist* religion. The *Buddhists* consider Tara to be the great Mother Goddess, the symbol of primordial female energy. In *Jainism "Ambika*" is the presiding goddess or *Kula Devi* of *Jain*. In *Jain* community she is also

known as *Ambai, Amba, Kushmandini and Amra Kushmandini.* She is often shown with one or more children and often sitting under a tree. A sculpture of *Ambika* was discovered at *Karajagi* village in *Haveri taluk* (Bhattacharya,1977).In Christianity, though the body of Mary is holy but she is not conceived as a Goddess. She may be honoured but should not be worshipped. "In *Islam* there is no mother goddess worshipped. But "*Al-lat"* was the pre-Islamic Arabian goddess worshipped under various associations throughout the entire peninsula, including Mecca, often alongside *Manat and al-Uzza*. In Islamic tradition, her worship ended when her temple in *Ta'if* was demolished on the order of *Muhammad*". (Al-Lat – Wikipedia)

Starting from *the Vedic* times onwards during ancient India, India was mostly occupied by the Hindus who were primarily *Shakti* Worshippers. Therefore, starting from the *Vedas,* Various *Shakti* forms were conceptualized in different forms and identities.

The Great Tradition of Shakti Worship in India

Hindu scriptures which laid the foundation of the great tradition of *Shakti* worship started here and numerous examples are seen in various *Puranic* descriptions in this regard. *Shaktism* is the major tradition of *Hinduism*. *Shaktism* is known for its various sub-traditions of *Tantra*, as well as a galaxy of Goddesses with their respective systems. According to the Vedic literature there are many goddesses named as *Usha, Vac, Saraswati, Prithivi, Nirriti, Shraddha*. Goddess such as *Uma* appear in the *Upanishads* as another aspect of *Brahman*. The literature of *Shakti* theology grew in ancient India, climaxing in one of the most important texts of *Shaktism* called the '*Devi Mahatmya'*. There are 51 or 108 *Shakti peethas* by various myths. Most of these *peethas* of *Shakti* worship are in India, but there are seven in Bangladesh, three each in Pakistan and in Nepal, one each in Tibet and in Sri-Lanka. Various legends explain how the *Shakti Peethas* came into existence in India. According to Das, there is a popular story behind this. There was a great king called *Daksha Prajapati* who was the son of Lord *Brahma*. He had 27 daughters and *Sati Devi* is one among them. *Sati Devi* got married to Lord *Shiva*. When *Dashka* entered the arena of a *Yajna* performed by *Agni*, everyone except Lord *Shiva* stood up as a mark of respect. *Daksha* felt insulted by Lord *Shiva*'s behavior. Later when *Daksha* conducted a *Yajna* himself, he did not invite his daughter *Sati* and his son-in-law. Though *Sati* felt bad because of the non-invitation, she wanted to attend the *yajna* against the wish of Lord *Shiva*. When *Sati*, attended the *yajna*, nobody has cared for her and she felt insulted by the actions of her sisters and parents. When her father started abusing her husband she could not control her feelings and sacrificed herself at the place of *yajna* by creating fire from earth with her right thumb of her foot. Knowing this Lord *Shiva* removed one bunch of '*Jata*' (bunch of hair) from his head and hit it on the earth. From that Lord *Veerabhadra* was born and rushed to *Yajna* spot and killed *Daksha* by cutting his head. Later *Shiva* went to the spot and took the sacred body of *Sati* from the fire and started dancing with it. The world was terrorized by his '*Tandava Nritya'* and to stop this *Nritya*, Lord *Vishnu* used his *Sudarshan Chakra* and completely cut the *Sati's* body into pieces. These body parts have fell at various places. Wherever these parts have fallen the places are called sacred *Shakti peethas*. To complete this massively long task, Lord *Shiva* took the form of *Vairava ,*as mentioned in "Sakta Pithas:- A Study" (Das,1999:1-26;Mohanty,2006:212).

"According to *Shiva Charita* the of *Shakti Peethas* are 51, according to *Kalika Puran*, the number of *Shakti peethas* are 26, according to *Devi Bhagwat Puran*, the number of *Shakti Peethas* are 108, and according to *Tantra Chudamani and Durga Saptasati,* the number of *Shakti Peethas* are 52." (tarapithatemple.blogspot.com).

As mentioned in the table below, 51 places have been presented where *Sati's* body part and ornaments had fallen within the territory of India.

Great Tradition and Little Tradition

The whole of Indian culture can be studied with the help of these two concepts 'Little tradition' and 'Great tradition'. These two concepts are based on the basic idea that every civilization and social organization has a cultural tradition at the back drop.

Civilizations start from a primary or orthogenetic level of cultural organizations. But, gradually they are divided through two processes that are, internal growth and external contact. But more important is

Sl. No.	Peetha name	Body parts Ornaments	Place Name	Vairava	Deity in the form of
1.	Hinglaj	Brahmarandhra(top of head)	Baluchistan province of Pakistan	Bhimlochan	Kottari Shakti
2.	Shivaharkaray / Karavipur	Eyes	Near Karachi in Pakistan	Krodish	Mahishamardini
3.	Sugandha	Nose	Shikarpur, of Bangladesh	Tryambak	Sunanda or Tara or Ekjata
4.	Mahamaya	Throat	Pahalgam District in Jammu & Kashmir	Trisandhyeswar	Mahamaya
5.	Jwala	Tongue	30km south of Kangra Valley in Himachala Pradesh	Unmatta	Ambika or Siddhida
6.	Tripura Malini	Left chest	Jalandhar in the state of Punjab	Bhishan	Tripura Malini
7.	Ambaji	Heart	Surrounded by Araveli Hill range, 42km from Shri Amrigarh on Gujurat-Rajasthan border	Batuk	Amba
8.	Guhyeshwari	Both the knees	Near Pashupati Nath Mandir in Kathamandu, Nepal	Kapali	Mahashira
9.	Dakshayani	Right hand of Sati	Near Kailash M ountain, Mansarovar in Tibet, China	Amar	Dakshayani
10.	Biraja	Naval	Jajpur, Odisha	Ishaneswara	Viraja / Girija
11.	Gandaki Chandi	Forehead	Muktinath, Dhawalagiri, in Nepal	Chakrapani	Gandaki Chandi
12.	Bahula	Left hand	Ketwa of Bardhaman District in West Bengal	Bhiruk	Bahul
13.	Mangala Chandika	Right wrist	Guskara of Barddhaman District in West Bengal	Kapilambar	Mangal Chandi
14.	Tripura Vairavi	Right foot	55km from Agartala town of Tripura	Tripuresh	Tripureswari / Tripur Sundari
15.	Bhawani	Right arm	Chittagong in Bangladesh	Chandra Shekhar	Bhawani
16.	Bhramari	Left leg	Vodaganj of Jalpaiguri of West Bengal	Ambar	Bhramari / Trisrota
17.	Kamakhya	Vagina	Neelgiri of Guwahati in Assam	Umanand	Kamakhya
18.	Mahakali	Except big toe four other fingers of Right foot	Kali-Ghat in Kolkata West Bengal	Nakuleswar	Maha-kali
19.	Jugaadya	Big toe of Right foot	Mangalkot block, of Barddhaman District in West Bengal	Ksheer Khandak	Jugaadya
20.	Lalita / Alopi / Prayag	Fingers of both hands	Near Akshay Vat, Allahab ad in Uttar Pradesh	Vabh	Lalita Shakti
21.	Vimla	Crown	Near Lalbagh Court road Murshidabad District in West Bengal	Samvart	Vimala
22.	Jayanti	Left thigh	Near Jaintia-pur Sylhet District, in Bangladesh	Kramadeeshwar	Jayanti Shakti
23.	Vishalakshi	Ear-ring	Varanasi, Uttar Pradesh	Kal-Vairav	Vishalakshi
24.	Sravani	Spine of Sati	Kumari Kunda, Chittagong District in Bangladesh	Nimish	Sravani
25.	Savitri / Bhadra Kali	Ankle bone	Kurukhetra, Haryana	Sthanu	Savitri / Bhadrakali
26.	Gayatri	2 bracelets	Ajmer of Rajasthan	Sarvananda	Gayatri

27.	Mahalakshmi	Neck	Sylhet town, Bangladesh	Shambara-anand	Maha-Lakshmi
28.	Devgarbh	Bone	Birbhum district in West Bengal	Ruru	Kankaleswari
29.	Kali	Left buttock	Shahdol district in Madhya Pradesh	Asitang	Kali
30.	Narmada	Right buttock	Shahdol district in Madhya Pradesh	Variabha	Narmada
31.	Shivani	Right breast	Chitrakut district in Uttar Pradesh	Chand	Shivaini
32.	Uma	Ringlets of Sati's hair	Mathura district in Utap Pradesh	Bhootesh	Uma
33.	Narayani	Teeth of upper jaw	Near Kanya-Kumari of Tamilnadu	Sanhar	Narayani
34.	Varahi	Teeth of lower jaw	Sangli district in Maharashtra	Maha Rudra	Varahi
35.	Aparna	Left Anklet	Bagura district in Bangladesh	Vaaman	Aparna
36.	Sundari or Bala - Tripur Sundari	Right Anklet	Near Srishailam in Andhra Pradesh	Sundaranand	Sundari or Bala -Tripur Sundari
37.	Kapalini	Left ankle	Medinipur district in West Bengal	Sarvananda	Kapalini
38.	Chandrabhaga	Stomach	Junagarh district in Gujurat	Vakratunda	Chandrabhaga
39.	Avanti	Upper lip	Ujjain in Madhya Pradesh	Lamba Karan	Avanti
40.	Bhramari	Both parts of Chin	Nasik district in Maharashtra	Vakrakataaksh	Bhramari
41.	Vishwaswari	Cheeks	Rajahmundry district in Andhra Pradesh	Vatsaambha	Vishwaswari
42.	Ambika	Fingers of of left feet	Bharatpur district of Rajasthan	Amriteswar	Ambika
43.	Kumari	Right shoulder	Krishanagar of Hooghly district in West Bengal	Shiva	Kumari
44.	Uma	Left shoulder	At Mithila, near Janakpur Railway Station, (near Indo Nepal Border) in India	Mahodar	Uma or Neel Saraswati
45.	Nalhateswari or Kalika	Vocal pipe	Birbhum district in West Bengal	Yogesh	Nalhateswari
46.	Chamundeswari / Durga	Both ears	Chamundi hills of Mysore of Karnataka	Abhiru	Jai-Durga
47.	Mahishamardini	Centre portion of eye-Brows	Birbhum district of West Bengal	Vakranath	Mahishamaridni
48.	Yogeswari	Feet and Hands	Khulna district in Bangladesh	Chanda	Yogeswari
49.	Fullora	Lower lip	Birbhum district in West Bengal	Viswesh	Fullora
50.	Nandini or Nadikeswari	Neck bone	Birbhum district in West Bengal	Nandikeswar	Nandikeswari
51.	Indrakshi	Anklet	Nallur in Sri Lanka	Raksaseswar	Indrakshi

Country wise locations of '*Shakti Peethas'* are mentioned below for reference:

In Sri Lanka	:	One
In Pakistan	:	Two
In Tibet (China)	:	One
In Bangladesh	:	Six
In Nepal	:	Two
In India	:	Thirty nine

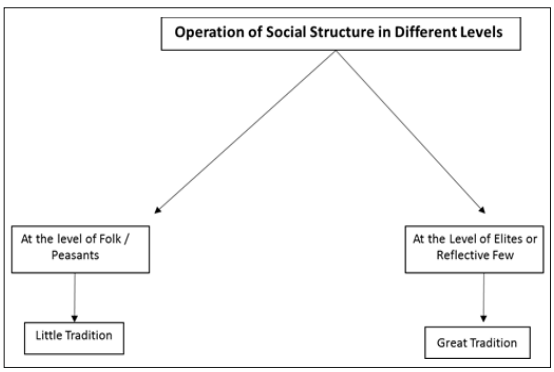
cultural contact with outside or other cultures, which give rise to the distinction of cultural tradition at the local as well as national level.

Diagrammatic Presentation:

At the level of folk (rural / tribal) society which is known as "Little tradition".

At the level of elite or 'reflective few' which is known as "Great tradition".

Diagram 1

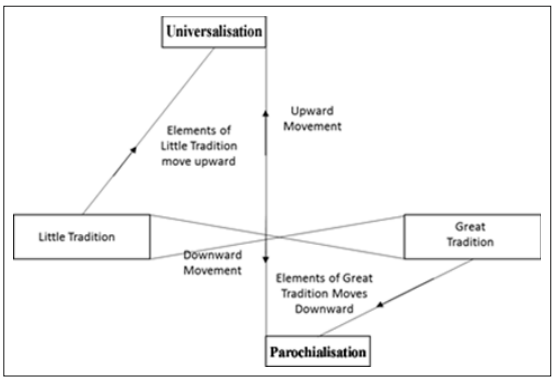


(Source: Nitisha, Indian Culture, Little tradition and Great Tradition)

McKim Marriot(1955) and MIlton Singer(1955) have conducted some of the studies following the above mentioned model. McKim Marriot says that in the structure of the village culture and its social organization elements of both the Little tradition and Great tradition are found. He has conducted his study at *Kishan Garhi* village in North India. He found that there is constant interaction between Little tradition and Great tradition. Little tradition consists of local customs, rites, rituals, dialects and Great tradition contains legitimate form of all these things, at the higher or national level.

McKim Marriot (1955) found that when little and great traditions interact with each other two types of movements are observed-upward and downward. When the elements of Little tradition move upward, Marriot calls it as 'Universalization; and when some elements of Great tradition move downward it is called as 'Parochialization".

Diagram 2



(Source: Nitisha, Indian Culture, Little tradition and Great Tradition)

In any society specifically in India, all major religions have their own cultural traditions. Each one has a primary traditional beginning. Each one gradually developed or established on a ground cultural structure which is documented well through the respective sacred scriptures. However, anthropologists explain them as great tradition in a scientific way. Such sacred scriptures formulate and set all kinds of cultural ethics and principles to be followed by the people under the concerned religion. However, coming specific to *Hinduism* in India, almost all *Hindu* societies while following the great traditional principles as laid down in the sacred scriptures, they also develop their own cultural ethics derived out of the interaction with the local environment as well as cultures. Anthropologists usually denote such tradition at the local level as little traditions. It is needless to mention here that everywhere in *Hindu* India and beyond, among all Hindus, the great tradition becomes the guiding factor to influence the people at the local level as regards their ritual celebration and maintenance of cultural tradition. Though local variation is visible everywhere, so far as the major principles are concerned, both the traditions are observed to tread on the same path towards *Hinduism*.

In the table mentioned earlier, all the 51 Great traditional *Shaktis* or Goddesses refer to the main

stream *Hinduism* but in the localities where they are placed and worshipped, local impacts are quite visible amidst the presence of great traditional elements. In the comparative study I have made in the context of Odishan culture, the following associations of great and little traditional elements have been observed. In the *Hindu* great tradition, *Shakti* cult has always been mentioned here that the so called *Khyatriya* people especially the Kings were always *'Shakti'* worshippers mainly for fighting out the enemies. The common people, none other than, mainly propitiate the goddesses mainly because of their well being with specific reference to self and community.

Coming to our empirical findings, out of 32 '*Shakti shrines'* we have studied, everywhere the great traditional affinity is very clearly visible when we take the references from the great traditional literature like *Sapta-sati Chandi Patha,Devi Mahatmya, Devi Bhagabata, Chandi Purana, the Ramayana* etc. Everywhere the great traditional relationship is mostly established through the celebration ofseveral annual cycle of rituals around the year, out of which scholars gives utmost importance to *Dusahara* . Though several other celebrations also join the arguments and analysis ,*Dusahara* celebration is found to be most elaborate and it maintains substantial affinity with almost all *Shakti shrines.*

In the *Ramayana, Dusahara* is also known as *Vijaya Dushami* and Lord *Rama* established its ritual procedures. Similar factors of great tradition are also noticed in *Devi Mahatmya* where every ritual and incidence have been very critically mentioned. In the local level, our empirical investigation reveal that almost all *Shakti shrines* under study, follow the *Dusahara* festival by referring to the rituals as the above mentioned in the great tradition text .Though there are several local variations we have noticed , in the context of *Dusahara* both the great tradition and little tradition come to a very close interaction .In our study of 32 *Shakti shrines* as per the local practice we have divided the *Dusahara* into 2 types , namely , *Sharadiya Dusahara* and *Basantiya Dusahara*. Our empirical data shows that *Sharadiya Dusahara* is celebrated by all the Hindus equally, whereas *Basantiya Dusahara* is confined mostly to the warrior caste, mainly non-*Brahmins*. Very interestingly, it is also observed that at some local *Shakti shrines*, the celebration is continued for 10 days and in other places it is continued for 16 days. Anthropologically speaking, both the local traditions maintain similar rituals though in different names. It is also observed that out of 32 *Shakti shrines* only in 8 cases *Brahmin* priests are employed as the main priest and in 17 cases they are non-*Brahmins* and in 7 cases the priests are Tribals. Besides the *Brahmin* priests, among the rest other 24 cases though the ritual is strictly followed as per the great traditional instructions, in specific rituals which the devotees demand, a non-*Brahmin* can never utter the recitation of *Chandi*, following the great traditional instructions. On the whole, it is analyzed that the principle of the great tradition of *Shakti* worship is more or less followed in almost all rituals in the state. As already mentioned, in case of all *Shakti* shrines, 8 incidences strictly employ full time *Brahmin* priests where as in rest other cases, *Brahmins* are especially invited only when the great traditional literature - the *Chandi* is recited.

In a similar order, regarding the ritual offering of the meat/fish(non-vegetable food item), it is marked that the *Shakti* shrines of Eastern Odisha, animal sacrifice and meat/fish offerings are numerous. In most other *Shakti shrines*, vegetarian food is usually offered. Another interesting feature is that in addition to *Sharadiya Shakti* worship which is most common everywhere in Odisha. In tribal areas the celebration of first eating ceremony known as '*Nuakhai'*, is also celebrated as a local tradition. Another ritual variation also indicates the continuity of local traditions. In the month of *'Chaitra'* (Mar-Apr), the tribal and rural people of coastal and north Odisha also propitiate '*Shakti shrines'* in addition to *Sharadiya* celebration during *'Ashwina'* (September-October) month. It is therefore, worth mentioning that though all of the '*Shakti shrines'* in Odisha follow more or less some great traditional principles, at the same time, all maintain their local traditions along with it. Thus, interaction between the great and little tradition is obviously taking place in almost all '*Shakti shrines/peethas'* of Odisha. In the following table from among the selected 17 cases out of 32 shrines, such Great and Little traditional interactions have been presented for reference.

Table 2: The Little Traditional Practice of Shakti Cult in Odisha

Sl. No.	Name of Shakti Shrine	District	Sacred Offerings		Occasion	Caste of Priest	IDOL	Occasions of Animal Sacrifice
			Veg.	Non-Veg.				
1.	Maa Tara Tareni	Ganjam	Pana, Chuda Ghasa, Bela Bhoga / Fruits, Laddo, Rice, Dal, Khechudi, Khiree Curry & Saag	Nothing	Chaitra Mela, Saradiya & Basantiya Durga Puja, Dipawali, Sankranti, all including Pana), Dolapurnima	Mali Mohapatra	Two pieces of stone	Male goat & Kushmanda (Buffalo) in Sandhi time of Astami of Sharadiya Durga Puja
2.	Chaushathi Yogini (Hirapur)	Khurda	Rice, Khechudi, cake, Dal, Cury, Khata, Saag	Poda Macha or Smoked fish and Ushuna double boiled rice, fish curry in Mahastami	Dolapurnima, Kalipuja, Yogini Festival Mainly conducted during December Month.	Brahmin	64 pieces of Black granite idols. All are in standing posture	Fish, Hen, Goat, sand Fox in Astami of Sharadiya Durga Puja
3.	Maa Vimala	Puri	Balabhoga (Khai, Ukdhua, Fruits, Sweets) Rice, Dal, Besara, Mahura Saag, Khechudi, Dalma, different cake , (all the foods sensed to Lord Jagannath)	Nothing	Sharadiya Durga Puja & Basantiya Durga Puja	Suara (Brahmin)	Black granite with standing posture on a lion thrown	Male goat, sheep during Sandhi time of Astami of Sharadiya Durga Puja.
4.	Maa Bonda Bagha	Jaypore	Coconut & Sugar, Anna, Dal, Curry	Nothing	Basantiya Durga Puja & Mesha Sankranti	1st Worshipped by Joypore king himself, (now there are priest appointed by public of any caste)	Structure of cannon which is made up of Iron material	Male goat and sheep during Sharadiya Durga Puja
5.	Maa Charchika	Cuttack	Curd water rice, Khechudi, Dalma, Khata, Saag, Kheeri, Kakara Peetha, Fruits, Paneer	Nothing	Basantiya & Sharadiya Durga Puja & Specially in Kumar Purnima	Brahmin (only doing Sankhudi Bhoga)	Is seated on a postrate human body and wearing a garland of human skull made up with Black granite stone	Male sheep and Kushmanda during Sandhi time of Sharadiya Durga Puja.
6.	Viraja	Jaipur	Magaja Ladoo, Malpua, Motichur ladoo, Khechudi, Dal, Saag, Anna, Curry	Nothing	Ratha Yatra occurred during Sharadiya Durga Puja time known as Simhadhwaja, Basantiya durgapuja, Navanna (Nuakhai), Sabitri Amabasya, Nakshatra, Sharvana purnima, Prathamastami, All Sankranti	Brahmin	In a standing position. One of her feet is on a lion & the other is on Mahishasura's Chest of made up of with Black granite stone	Podha (Male Buffalo) and male sheep & goat. During Sandhi time of Sharadiya Durga Puja.
7.	Mauli Maa	Malkanagiri	Sported Moong, Khai with Sugar, Banana, Coconut Kheeri	Nothing	Bada Yatra during Basantiya Durga Puja which is a & Sharidiya Durga Puja	Khyatriya	Standing position Sculpture made up of with Astha Dhatu (8 materials)	Male Black Goat, Cock and Egg (During Chaitra month Bada Yatra) and a male goat in Sandhi time of Sharadiya Durga Puja
8.	Samaleswari	Sambalpur	Lia, Ukhuda, Anna, Dal, Curry, Kheeri	Nothing	Nuakhai, Mahalaya, Kumar Purnima, Kalipuja, Basantiya & Shardiya Durga Puja, Maragasira Month Laxmi Puja	Khyatriya (Rajput) appointed by King Balaram Dev who is also a Rajput king.	Black granite piece cover with Vermilion with ornament ear, eye, Mangtika, Mouth etc.	In Early days a Podha has been Sacrificed during Sandhi time, of Sharadiya Durga Puja. But now it has been stopped.
9.	Maa Sarala	Jagatsinghpur	Chudaghasa, Anna, Khechudi, Dal, Curry, Khatta, Khiree, Puri, Ladoo, Curd rice water & Mahaprasad (of Lord Jagannath)	Nothing	Maha Visuva (Pana Sankranti) or Nuakhai, Basantiya & Sharadiya Durga Puja	Sabara tribe (Daita Pati)	In a standing posture with Black Granite stone	- Male Goat - During Sandhi time of Astami and Navami of Sharadiya & Basantiya Durga Puja.
10.	Maa Kichakeswari	Mayurbhanj	Ukhuda, Khechudi, Dalma, Sweet, Fruits	Nothing	Maha Shiva Ratri, Ashokastami, Rama-navami, Basantiya & Sharadiya Durga Puja	1st Worshipped by Bhuyan tribe. But now by Brahmin	Seated on a dead body, half Padma ashana left leg, right leg rest on lotus with comes from the naval of dead body. (Black granite)	- Male Sheep - During Astami of Sharaidya and Basantiya Durga Puja
11.	Maa Tareni	Keonjhar	Coconut, Ukhuda, Sweet, Anna, Khechudhi, Dalma, Saag, Chakuli Peetha	Nothing	Chaiti Parba (Celebrated between last 5 days of Chaitra month first & 2 days of Baishakha month) Ashadi Parba (last Thursday of month of Ashadha), Putual Yatra (Month of April), Tarani Vrata, Raja & Makara Sankranti	Dehuri (Kondh)	A stone piece covered with Road Vermilion	- Only male sheep and goats are being offered, not sacrificed. - During Astami of Sharadiya Durga Puja.
12.	Kanaka Durga (Batrisha Singhashana Nandapur)	Koraput	Curd rice (on Friday) rest of the day Banana and Sugar	Nothing	Basantiya & Shardiya Durga Puja	Rana caste (Mali Mohapatra)	Standing position	- In early age Human sacrifices were held on, but not now. - In Basantiya Durga Puja - A Pig - In Sharadiya Durga Puja - 3 male sheep & a male goat.
13.	Maa Khambeswari	Sonepur	Rice Prasad & Any Fruits	Nothing	Baliyatra held in Shukla Pakhya Navami tithi of month of Aswina	Mali Mohapatra	Wooden log (Stamba shape) covered with orange Vermilion	- Male sheep - During Astami of Sharadiya Durga Puja.
14.	Maa Vairavi	Boudh	Anna, Khechudhi, Ukhuda, Curd, Curry, Dal, Kheeri, Fruit, Kakara, Puskar (Fruit of lotus)	Smoked fish	Sharadiya Durga (16 days) & Kalipuja	Mali Mohapatra	A stone piece covered with Red Vermilion	- Cock, male sheep, male goat, Podha. - During Sandhi time of Sharadiya Durga Puja.
15.	Maa Bhagawati	Khurda	Dahi Pakhala (Curd water rice), Kheeri, Gaja Mua, Khechudi, Veg. fry, Dal, Mahura Pana	Fish fry & Bali poda (Smoked fish)	Basantiya & Sharadiya Durga Puja, Makara Sankranti, Tribani Amabasya, Shiva Ratri	Puja Panda Brahmin	In a standing posture one foot is on lion and other one is on Bufalo	In Astami of Sharadiya Durga Puja– 3 male goat and fish. - In Maha Navami – Podha, Sheep, Goat and Bali jena (Human) - But now days these are stopped by goat.
16.	Maa Rama Chandi	Puri	Fruits, Khai, Sweet, Curd, Anna, Dal, Besara, Peetha, Pana, Dahi Pakhala + Mahaprasad	Smoked fish without onion & garlic & fish poda Bali (Smoked fish) Fish Mahura	Sharadiya Durga Puja, Last thrusday of month of Baishakha, Magha mela	Mali Mohapatra	In a standing posture on Lion. - Made up of Black Chlorite	- Male sheep - Sharadiya Durga Puja Astami Tithi.
17.	Maa Ugra Tara	Khurda	Chuda Ghasa, Anna, Dal, Khata, Banana, Coconut and Mahaprasad	Smoked Fish	Sharadiya and Basantiya Durga Puja	- 1st worshipped by Rishi Vasistha. - Then by Sabara - Now by Brahmin	- In a standing position. - Made up of Black Chlorite	- Male sheep. - During Saptami, Astami & Navami tithi of Sharadiya Durga Puja.

Out of 32 case studies, I have presented only 17 selected cases here to discuss about the instances of the localization of great traditional *Shakti* cult. In the great tradition of *Shakti* cult vegetarian and non-vegetarian offerings have not been given any importance. Rather ritual procedures have been emphasized with priority. In this regard I also marked out of 32 cases , among 13 *Shakti shrines*, that though *Brahmins* usually serve as priest, in 6 cases priest belong to *Khyatriya verna*, in 6 other cases the main priest belongs to *Mali*(gardener) caste, in 4 cases the priests are tribal and in rest other case studies the priest belong to the caste other than mentioned here. In Odisha all the 30 districts have been covered up in the study. Though I have not studied *Shakti shrine* from each newly formed district, I have taken all the undivided districts and thereby the major and known deities have been covered up. In view of the historical importance of the deities I have taken 5 cases of *Shakti shrines* from Khurda district; 3 each from undivided Ganjam and Puri districts and 2 each from Cuttack, Jajpur, Mayurbhanj and Sonepore.On the whole we observed that everywhere in the context of society and culture, people either tribal or non-tribal worshipped the goddess first as *Gramadevati*, a very localized form of mother goddess as described in the great traditional literature.

With reference to the historical information as collected from the local experienced people, except tradition and little tradition. In most of the cases except few in coastal Odisha we have empirically verified that tribals have accepted *Hindu* gods and goddesses in some places and in other local Odia. On the other hand Hindus especially the caste societies have also accepted also the tribal deities. Therefore, it is empathetically stated that the deities worshipped by non-*Brahmin* priests are of tribal origin and even though the local *Hindus* come in numbers to participate in ritual celebrations, the priest remains non-*Brahmin*.

Shakti cult is a great traditional ritual practice and at the local levels all over the country, though all of them reveal affiliation to Great traditional practice , accordingly celebrate *Dusahara, Kali puja, Laxmi puja*,ect.as per the combined order of great tradition and little tradition. At the same time, the local traditions which from the little tradition go on adding all the local elements as per the immediate environment, society and culture of self and neighborhood. By the process of sanskritization such interaction between great and little tradition has been greatly facilitated which can be estimated from the following table.

Table 3: The Little Traditional Variation of Shakti Worship in Odisha

Sl. no.	**Name of Goddesses**	**District**	**Caste of Priest**	**Major Occasions**	**Variation**
1	Maa Tara Tareni	Ganjam,near Berhampur city	Mali Mahapatra	Basantiya & Sharadiya Durga puja,Chaitra Mela,Kali puja,Dola Purnima	Pana bhoga offered , all veg.,main festival - Chaitra mela
2	Chaushathi Yogini	Khordha,Hirapur	Brahmin	Kali puja,Dola Purnima,Yogini Festival (December)	Smoked fish offered,main festival - Yogini mela
3	Maa Vimala	District Puri, jagannath Temple premises	Suara	Sharadiya & Basantiya Durga Puja	Pure veg food offered,main festival - Saradiya Durga puja
4	Maa Bhagawati	Khurdha at Banapur	Brahmin	Sharadiya & Basantiya Durga Puja,Makar Sankranti,Triveni Amabasaya,Shiva Ratri	Non-veg food offered , main festival - Saradiya durga puja
5	Maa Mangala	Puri at Kakatapur	Brahmin	Sharadiya & Basantiya Durga Puja,Jhamu jatra,Pana sankranti	Pana bhoga , veg food offered , main festival Chaiti paraba(jhamu yatra)
6	Maa Ramachandi	Puri at Konarka	Brahmin	Sharadiya & Basantiya Durga Puja,Magha Mela,Last Thrusday of Baishakha month	Smoked fish offered ,main festival - Last Thursday of Baishakha month
7	Maa Ugra Tara	Khordha, Bhushandapur	Brahmin	Sharadiya & Basantiya Durga Puja	Smoked fish offered ,main festival - Bashantiya Durga Puja
8	Maa Narayani	Ganjam	Brahmin	Sharadiya & Basantiya Durga Puja,Ashokastami,Kali puja	Only veg food offered, main festival – Ashokastami

9	Maa Bonda Bagha	Jeypore	Any Caste	Basantiya Durga Puja & Mesha Sankranti	Veg food offered,main festival - Bashantiya dusahara
10	Maa Charchika	Cuttack, Banki	Brahmin	Saradiya & Basantiya Durga Puja,Kumara Purnima	Veg food offered, main festival - Kumara purnima
11	Maa Viraja	Jajpur	Brahmin	Saradiya & Basantiya Durga Puja,Nakshaktra,Pana Sankranti, Mahalaya, Savitri, Navana	Veg food offered , main festival Mahalaya, Nuakhai, Simhadhwaja (ratha yatra during Saradiya Durgapuja)
12	Maa Cuttack Chandi	Cuttack Jhanjirmangala	Brahmin	Saradiya & Basantiya Durga Puja,kali puja, Margasira month Thursday, kartika purnima, Radhastami	Smoked fish, main festival - Margasira month thursday
13	Maa Maulima	Malkanagiri	Khyatriya	Sharadiya & Basantiya Durga Puja,Bada Jatra in Basantiya durga puja (Binnial)	Veg food offered, main festival - Bada yatra
14	Maa Gouri(Kedar Gouri)	Khurdha, Bhubaneswar	Brahmin	Sharadiya & Basantiya Durga Puja,Chadan jatra,Magha Saptami,Shiva ratri,Sitala sasthi	Veg food offered, main festival - Sitala sathi
15	Maa Kanak Durga (Batrisha Singhashana)	Koraput, Nandapur	Mali Mahapatra	Sharadiya & Basantiya Durga Puja	Veg food offered, main festival - Saradiya and Bashant iya Durga Puja
16	Maa Dangara Dei	Koraput, Jeypore	Paraja Tribe	Sharadiya Durga Puja	Veg food offered, main festival - Saradiya durga puja
17	Maa Shikharachandi	Khordha, Bhubaneswar	Non	Sharadiya Durga Puja, Raja sankranti, Magha sasthi	Veg food offered, main festival - Raja sankranti and Magha sasthi
18	Maa Samaleswari	Sambalpur	Khyatriya	Sharadiya & Basantiya Durga Puja , Sitala sasthi, Mahalaya, Nuakhai, Kali puja, Margasira gurubar (Wednesday),	Veg food offered , main festival Nuakhai, Mahalaya, Margasira month Thursday
19	Maa Sarala	Jagatsinghpur, Chaiti-Kanakpur	Sabara	Saradiya & Basantiya Durga Puja , Sitala sasthi , Mahalaya , Nuakhai , Kali puja , Margasira gurubar (Wednesday) ,	Veg food offered , main festival Nuakhai, Jhamu Yatra, Maha bishuva Sankranti
20	Maa Kichakeswari	Mayurbhanj Khiching	Brahmin	Sharadiya & Basantiya Durga Puja , Sitala sasthi , Mahalaya , Nuakhai , Kali puja , Margasira gurubar (Wednesday) ,	Veg food offered , main festival - Shiva ratri for 7 days
21	Maa Tareni	Keonjhar,Ghata gaon	Kondh tribe (Dehuri)	Sharadiya Durga Puja, Basantiya Durga Puja (chaiti paraba for 7 days), Ashadhi paraba, Raja, Patua Yatra	Veg food offered , main festival - Chaiti paraba for 7 days, Patua yatra, Ashadhi paraba
22	Maa Pataneswari	Bolangir, about 38km. away from Bolangir at Patanagarh.	Khyatriya	Sharadiya & Basantiya Durga Puja , Boyal yatra	Smoked fish offered, main festival - Boyel yatra
23	Maa Sureswari	Sonepur	Khyatriya	Sharadiya &Basantiya Durga Puja , Nuakhai,Bali yatra	Mustard fish curry offered , main festival - Nuakhai , Bali yatra
24	Maa Khambeswari	Sonepur	Mali Mahapatra	Bali yatra (Month of aswina sukla pakhya navami tithi)	Veg food offered, main festival - Bali yatra (Aswina month of shukla pakhya navami tithi)
25	Maa Vairavi	Puruna Kakata	Mali Mahapatra	Sharadiya & Basantiya Durga Puja , Kali puja	Smoked fish offered, main festival - 16 days of Saradiya Durga Puja
26	Maa Barala Devi	Kandhamal at Balaskumpa Village	Khyatriya	Saradiya durga puja , Nuakhai , Bahuda,Pausa purnima and Gamha purnima	Veg food offered, main festival - Nuakhai, Bahuda, Pausha purnima, Gamha purnima
27	Maa Byaghra Devi	Bhanjanagar, Kuladagram (Village)	Brahmin	Sharadiya & Basantiya Durga Puja , Kartika purnima, Dola purnima and specially Kanduli yatra by Kondh tribe	Veg food offered , main festival - Kanduli yatra (by Kondh tribe in Dola purnima)

28	Maa Khambeswari (Asika)	Ganjam, Asika	Mali Mahapatra	Saradiya & Basantiya Durga Puja , Bada yatra (4th Tuesday of month of Chaitra),Dasandhi (Nabakalebara)	Veg food offered , main festival - Bada yatra (4th tuseday of Chaita month),Dasandhiya(in every 10 year, Navakalebar)
29	Maa Budhithakurani	Berhampur	Barika	Sharadiya and Basantiya durga puja,Ghata/Thakurani yatra	Veg food offered , main festival - Ghata / Thakurani yatra (in every 2 year)
30	Maa Ambika(Devk und)	Mayurbhanj	Brahmin	Sharadiya and Basantiya durga puja,Raja,Makara and Pana sankranti	Veg food offered
31	Maa Bhadrakali	Bhadrak, Village- Aharapada	Brahmin	Kali puja, Sahani mela in raja sankranti,Basuli mela	Veg food offered ,main festival - Basuli mela in Chaitra purnima
32	Maa Hingula	Angul,Talcher, Gopal Prasad Village	Khyatriya	Sharadiya durga puja , Nabakalebara and Hingula yatra	Veg food offered , main festival - Hingula yatra(9 days in chaitra month) ,Nava Kalevara.

Conclusion

After mentioning about the Little traditional practices of *Shakti* cult in Odisha in the context of *Hindu* Great tradition of India, we like to conclude that all the goddesses in the localized form are believed to emanate from the Great traditional *Shakti* cult, which identify in several names like *Jagatjanani, Jagadamba, Maa Durga, Maa Saraswati, Maa Laxmi, Maa Kali, Maha Shakti, Maha Maya, Jogomaya, etc.* Out of our empirical observations we confirmed that all the local goddesses are identified as a special form of Great traditional goddess. In their form, structure and functional abilities, both the categories of goddesses are found to be inseparable from each other and one. The local people either in rural or tribal areas who worship the goddesses at both levels (great traditional and little traditional), believe that they are all propitiating ultimately the main goddess of *Hindu* Great tradition. Then, automatically a question comes –why the people worship the Great traditional goddess in different name and different structures at the local level ? Though all people do not answer appropriately, our empirical observation confirms that as the Great traditional explanation says, Mother goddess is one, but for several functions when she is playing the role, accordingly she is addressed with an appropriate name. In a similar manner people of different communities while worshipping the Mother goddess for the well-being and prosperity, they follow locally available cultural traditions and accordingly give a local name to the same Mother goddess of the Great tradition.

As a result, it is quite obvious that from locality to locality a lot of variations are observed because of variations in local environments and cultures. However, it is found that all the local goddesses basically follow the principles of the Great traditional Mother goddess or *Shakti* in toto and at the same time go on adding several local traditions to it. Great traditionally all the local goddesses observe special festivals on the occasion of the Great traditional ritual celebration, i.e., *Saradiya Durga puja.* But many of them do not observe their main festival during this occasion of *Saradiya puja*. They usually refer to some major tribal/rural occasions during the month of *Chaitra* (Mar-Apl) and consider it to be the main festival of the local goddesses. Analytically, if we consider, the interaction between both the traditions, we may conclude that some local goddesses may have more affinity to the Great traditional Mother goddess and rest others reveal little affiliation to the Great tradition. But on the whole, one can take a third person's view that with more or less affiliation, all the local goddesses maintain constant/equal interaction with the Great traditional rituals of Mother goddess. In a similar manner, if we shall analyze the local goddesses further on the basis of the sacred offerings, we can very well conclude that though with all the local goddesses animal sacrifice is directly practiced, but in daily rituals except *Chaushathi Yogini, Maa Vairavi(Boudh), Maa Bhagawati(Khurda), Maa Rama*

Chandi(Puri), Maa Ugra Tara(Khurda), other local goddesses are offered with vegetarian sacred food every day. One more interesting thing is that except few goddesses like *Chaushathi Yogini, Maa Bhagawati, Maa Ugra Tara, Maa Vimala, Maa Charchika, Maa Viraja, Maa Mangala, Maa Rama Chandi, Maa Narayani, Maa Cuttack Chandi, Maa Kedar-Gauri, Maa Kichakeswari, Maa Byaghra Devi, Maa Ambika, Maa Bhadra Kali,* the rest other local goddesses out of 32 are all worshipped by non-*Brahmin priests* and most of them maintain connection to the tribal culture. All such information have been very well presented in the Table 2 and 3 of this paper on the basis of which, we justify finally these intricate interaction pattern between the goddess of Little tradition with that of Great tradition.

References

Alexandra Silver, Top 10 Earth Goddesses- TIME, content.time.com, 10th March 2019.

Bhattacharyya, N. N.(1977). The Indian Mother Goddess, Manohar Book Service, New Delhi.

Das, H. C.(1999). Sakta Pitha: A Study, Bharati Prakashan, UP.

Dubey, Dhar, R.K. (2017). Worship of Mother Goddesses in Buddhism, IJCRT-Vol:5.

http://tarapithtemple.blogspot.com/ 2014/04/51-shakti-peeth-of-sati.html?m=1,12th July 2019.

Marriott, M. (1955).Village India ,Studies In the Little Community. The University of Chicago Press, London.

Mohanty, R.K.(2006). Odishara Devi Peetha(in Odia), Mahavir Prakashan, Bhubaneswar.

Nitisha, Indian Culture: Little Tradition and Great Tradition,www.yourarticlelibrary.com,3rd Mach 2019.

Redfield,R. and Milton, S. (1955). The Little Community, The University of Chicago Press, London.

Samdarshi, P.(2014). Goddesses in Budhist Tantra Traditions. The Delhi University Journal of the Humanities and Social Sciences, Vol-1:94.

Man in Society ISSN 2347-1530
Volume 25, 2018, pp. 79-87

Social Status and Role of Carpenters in Ganjam District with Specific Reference to Their Wooden Craft

Stitadhi Rath[1] and Jagannath Dash [2]

Abstract

Out of all forms of art and craft, wood craft is most common mainly because of its personal use both by the poor and rich. But so far as the public wood structures or monuments are concerned, it is not so common due to the perishable nature of the raw material, i.e. wood. Except few Buddhist structures, majority of monuments around the world are either of stone, metal or concrete. Therefore, the wood craft in the form of public monuments which are very rare to to-day, have been the subject matter, of the paper. Such wooden monuments are observed more in Ganjam District of South Odisha and its craftsmen are skilled carpenters. In view of this, the paper has concentrated specifically on the social status and role of the carpenters and examined their origin, typology, distribution and artistic contribution to the making of wooden monuments in South Odisha, especially Ganjam District.

Key words: *Art, Carpenter, Ganjam, Social Status, Wood Craft, Odisha*

Introduction

Art is an expressive form of various esthetic manifestations in different media. By nature, man bears aesthetic impulses in various forms. Art and Craft most often go together to reveal such creative impulses in the human society. All over the world in almost all cultures man used various types of material objects which are studded with different artistic designs as per the local culture. In our daily life we are using different materials objects without any art design on them. Putting a design on the material objects we are using, does not make any difference in the utility of the material objects. But drawing a design on it mostly reflects the aesthetic sense of the culture and nothing more. Here the paper proposes to present a discussion on wood crafts of south Odisha especially in the Ganjam district where kings in the past have patronized the aesthetic designs on the wooden objects. We have to remember here that the wood craft makers are none but the skilled carpenters. A Carpenter is an artisan who makes wooden appliances for the use of people in the society. Therefore, looking at the financial capacity of the consumer, the carpenters have to make wooden objects with or without artistic designs on them. Usually common people are mostly poor and cannot pay for the extra labor charge towards the making of artistic designs. Because of this, in normal situations we do not get enough evidence regarding the highly valued wood crafts in the society. But when we look at the patronization of the kings, *Jamidars* or well to do people in the society for the wooden-craft, we find a good numbers of artistic wooden objects in the society. With this view point, we have inquired about few public wooden monuments like the temples, doors and windows of the temples and outer hall of temples with a lot of artistic wood carvings and images.

Importance of Wood Carving

Since pre-historic times, man has revealed various aesthetic manifestations specifically on the prehistoric tools, weapons and cave walls. In the beginning, clay was moulded to make various

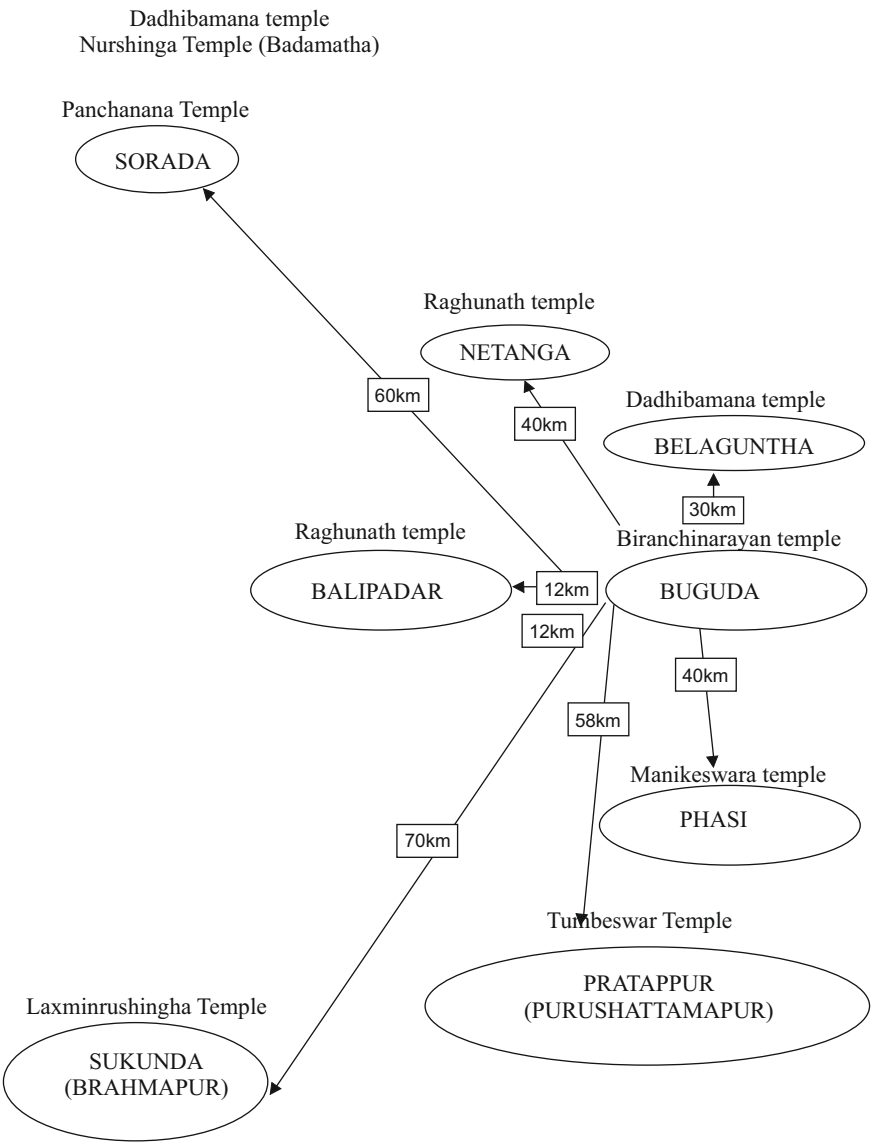
[1]*Research scholar, Department of Visual Art, Utkal University of Culture, Bhubaneswar*
[2]*Former Professor and Head, Department of Anthropology, Utkal University, Bhubaneswar*

appliances with artistic designs to make it useful as well as beautiful. However, the clay materials came much later than the stone and bone tools. Therefore, only after Neolithic period, the use of clay or making of various appliances and art objects came to human society. The use of wood for making art objects are not reported during this period. Even though wooden objects were used by early man, as they are highly perishable, the evidence of wooden objects is not reported from the archaeological sites. It is also to be remembered that for making wooden art / objects, metal especially iron tools are very much required and therefore, wooden craft came to human civilizations only after metal age. But we have remembered that raw wood was very much in use for making fire and cooking proposes since pre-historic times. The polished wooden craft came after the pre-historic time, especially around proto-historic or ancient period of human history. One more striking factor is that wooden craft can never be thought of without the contribution of the craft makers who are commonly known as *Badhei* or carpenter. In view of this, whenever one will think of wood craft, the case of carpenters will come automatically and vice versa. Mainly because of this we have taken the social status of carpenters and their wooden craft together. Very interestingly, it is noticed that all kinds of crafts either on stone, metal, clay or wood, it will take a lot of time, money and skilled artisanship to produced a finished artistic object. Therefore, making a simple wooden, stone or metal appliance will be less costly than the appliances with various artistic designs. As a result, poor or common people usually do not go for such objects with a lot of artistic designs but in egalitarian society where people do not employ any craftsman and do the designs on the tools and appliances themselves. One will find such artistic objects in almost all families. Such examples are mostly found in tribal societies where everybody knows about the basics of craftsmanship and they do not depend on any specialized carpenter or craftsman, but in non-tribal societies where social inequality and specialized division of labour is present, people always depend on specialized experts for making useful tools and utensils for daily activities. The more artistic designs are reflected on the materials objects, more labour cost they have to bear. Under such basic requirements of art and craft, usually the rich people or the kings make monumental artistic constructions either in the form of temples, palaces along with various usable appliances for personal or public use.

Under such requirements and view points, we have specifically attempted to make a scientific observation of various forms of artistic activities in the society today especially in the field of woodcraft. So many studies have been undertaken on the stone carvers and metal craftsmen in Odisha and outside. But as no scientific study have been undertaken yet in the field of wooden craft in our state, we intend to make a scientific enquiry about such wooden crafts in Odisha.

As in South Odisha, especially in Ganjam district, various wooden crafts are observed in monumental form, we swelected Ganjam and its wooden craft under our study. Some such monumental wood craftsmanship are usually found in the Biranchinarayan temple (Buguda), Tumbanath Mahadev temple (Pratappur), Raghunath temple (Netenga), Manikeswara temple (Phasi), Laxminrusingha temple (Sukunda), Raghunath temple (Balipadar), Dadhibamana temple (Belaguntha) etc.. All of them are selected for scientific study of analyzing the artist skill and talent of the wooden craftsmen along with the assessment of the social status of the carpenters.

Diagram No.1 : Location of Temples around Buguda



Skilled Carpenters in Ganjam District

The district of Ganjam occupies a unique position in Odisha in the field of wood craft. In all districts of Odisha, wood craft is very much found but excellence in wood craft is only visible in Ganjam district mainly because the local kings here were very much fond of it and constructed few temples with wood which is a very rare monumental activity in Ganjam district. Everywhere around the world the kings, *jamidar* and well to do persons make highly decorative wooden appliances at personal level but very rarely they go for any wooden monument as it will not last like metal or stone built monuments. As already mentioned, because of this only we selected the wooden monuments of Ganjam district for research.

When ever we go for wooden craft research, the context of the carpenter is bound to come. It is taken for granted that the past kings of Ganjam district have procured carpenters from neighboring states of South India for developing wooden craft in the district. At present, because of this we find carpenters of two different dynasties, namely "*Angira*" and "*Somabansi*" here. It is said by the local carpenters that from the river Rushikulya towards south"*Somabansi*" carpenters are found where as from north side of river Rusikulya *Angira* category of carpenters usually inhabit. Very peculiarly is it noticed that the *Angira* carpenters of north belong to the *Dravid* category and towards south of Rushikulya the *Somobansi* carpenters belong to Indo-Aryan category. Our field investigation reveals that the *Somobansi* carpenters are distributed from Sorada to Balipadar, Brahmapur, Digapahandi and further south. In a similar manner the *Angira* category of craftsmans are found distributed from Buguda up to Puri.

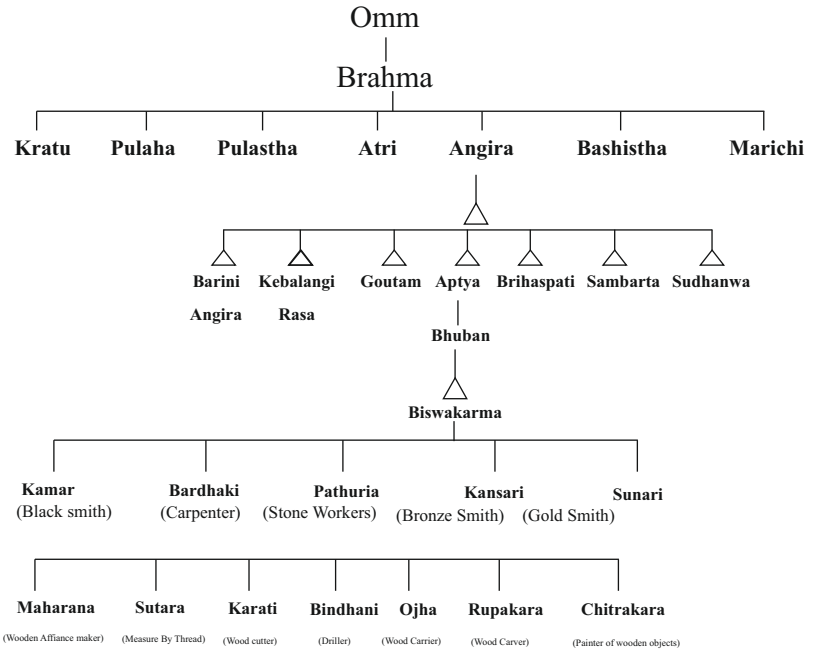
Table No. 1: Tools for Wood Carving in Ganjam District

Sl No	*Local Name of tools*	*English equivalent*	*Purpose*
1	Nihana	Chisel	For digging and carving
A	Kholam	'U' shape chisel	For digging and carving
B	Eknasi	'V' shape chisel	For digging and carving
C	Muna	Pointed chisel	For marking
D	Tagi	Small chisel	For carving
E	Sreni	Big chisel	For carving
2	Mugura	Wood hammer	For striking on the tools
3	Barshi	Flat axe	For cutting
4	Palu/randa	Hand plane	For smoothing plane
5	Agara	Hand drill	For making holes
6	Bhanra	Hand drill	For making holes
7	Karata	Hand saw	For cutting
8	Hatudi	Hammer	For striking on the tools
9	Gunia	Rulers/Scale	For marking/measuring
10	Khatuasa/ Khatkhasas	Line Marker	For line marking on wood

The Origin Myths of Carpenters

Both the category of carpenters as mentioned above trace their origin from the deity *Viswakarma*. But prior to *Viswakarma* and after *Viswakarma* the genealogies are different in different areas. The Angira category of carpenter trace their origin from *Maharshi Angira*, who is a well known member of the *Saptarshi* group of stars in the northern sky who are *Kratu, Pulaha, Pulasta, Atri, Angira, Basista and Marichi. Maharshi Angira* had 7 sons and his 4th son is *Aptya* whose son is *Bhubana* and grand son is *Biswakarma*. According to local carpenters,Viswakarma created five artisan categories and one among them is "*bardhaki*" or carpenter. From among the 7 types of carpenters , the decorative designs are especifically made by a special category of carpenter know as "*Rupakara*".

Diagram No 2: Origin and Types of Carpenters



Similarly the *Somabansi* craftmen also follow a simple category of carpenters who belong to Indo-Aryan category. Usually *Somabansi* carpenters have their mythological origin from the God Moon in the sky. However, they do not follow the detailed category of carpenters as mentioned by the *Angiras.* It is to be remembered here that both groups of carpenters have contributed to the wood-carving tradition of Ganjam.

The Distribution of Carpenters around Buguda

During ancient time, the kings were procuring Brahmins as well as other service castes from different areas outside Odisha. As already mentioned, the *Angira* category of carpenters were procured from south and *Somabansis* mostly from north. Both categories of carpenters have novice as well as expert categories of carpenters to meet the needs of the royal and common people. We are presenting below the distribution of both the categories of carpenters in the locality of Buguda and outside, in the following table.

Table No. 2: Distribution of Angira Category of Carpenters

Sl No	*Taluka*	*Village*	*No. of Families*	*No. of Carpenters*
1	Seragada	Padmapur	10	72
2	Seragada	Magura	01	04
3	Sanakhemundi	Valiajhola	16	80
4	Ghumusara	Ramagada	06	30
5	Ghumusara	Dengapadara	07	25
6	Ghumusara	Arakhapur	01	05
7	Ghumusara	Barata	03	09
8	Ghumusara	Paelipada	03	14
9	Ghumusara	Gobara, Basudebapur	02	07
10	Ghumusara	Adipur	24	58
11	Ghumusara	B. Brahmapur	01	07
12	Ghumusara	Dhumusahi	01	02
13	Ghumusara	Buguda	01	13
14	Ghumusara	Kachuri	01	12

(Source: Angira Biswakarma Maharana Samaja,2018)

Table No. 3: Distribution of Somabanshi Category of Carpenters

Sl No	*Via*	*Village*	*No. of Families*	*No. of Carpenters*
1	Digapahandi	Kaithakhandi	07	19
2	Digapahandi	Talasari	08	21
3	Bhismagiri	Nimakhandi Pentha	03	07
4	Bhismagiri	Panata	14	35
5	Padmanavapur	Boripadara	01	05
6	Digapahandi	Kamameripalli	02	08
7	Digapahandi	Dherendi	01	05
8	Padmanavapur	Dwaragaon	09	30
9	Padmanavapur	New Dwaragaon	01	03
10	Digapahdi	Padmanavapur	11	22
11	Padmanavapur	Kaithata	02	02
12	Padmanavapur	Kalyanpur	03	05
13	Padmanavapur	Guhalapur	04	13
14	Bamakoi	Manikyapur	08	24
15	Bamakoi	Sumanathpur	01	03
16	Bamakoi	Kumarada	01	01
17	Chikiti	Visasinghalaxminarayanapur	01	01
18	Surangi	Koliala	03	08
19	Khariaguda	Khariaguda	03	07
20	Digapahandi	Bhismagiri	02	07
21	Digapahandi	Chanameri	05	12
22	Digapahandi	Kholadi	01	02
23	Digapahandi	Digapahandi	03	06
24	Patapur	Sahaspur	05	12
25	Seragara	Dharmrayapur	01	01
26	Seragara	Baramundali	01	02
27	Seragara	Padmapur	01	04
28	Konkarada	Dengadi	04	09
29	Patapur	Khalangi	01	04
30	Brahmapur	Langaladeipur	02	03
31	Nuapada	Bhramarapur	01	01
32	Brahmapur	Brahmapur	04	07
33	Chikiti	Chiladi	02	03
34	Srikakulam (A.P)	Ichapuram	02	03
35	Srikakulam (A.P)	Manjusa	03	03
36	Aska	Aska	02	04
37	Aska	Baragaon	01	03
38	Aska	Balipadara	12	20
39	Buguda	Motabadi	03	06
40	Balipadar	Ekadala	10	20
41	Balipadar	Jholari	06	06
42	Balipadar	Khaida	04	06
43	Chirikipada	Bhabarada	03	11
44	Polasara	Kalamba	04	06
45	Kalinga Ghati	Galari	04	05
46	Bhubaneswar	Bhubaneswar	03	03
47	Koraput	Koraput	06	10
48	Indrabati	Kumbariput	02	02
49	Malkangiri	Indrabati	01	04
50	Malkangiri	Korakunda	05	05
51	Malkangiri	Malkangiri	03	04

(Source: Dakhina Odisha Viswakarma Samaj, 2014)

Nature of Payment of Carpenters

In the above mentioned table we discussed about the distribution of *Angira* and *Somavanshi* carpenters, their origin and distribution in *Ganjam* district. After they are settled in Ganjam district, some of their family members are now living in other districts like Koraput, Malkangiri and in the other state like Andhra Pradesh for availing various employment opportunities. However, we are discussing about the carpenters those who were living in and around Buguda.

In this paper we are mostly discussing on the wood carving works of Biranchi Narayana Temple (at Buguda, built around 1790), Tumbeswar Mahadev temple (Pratappur, Purusottampur, built around 1790), Raghunath temple (Netanga, Bhanjanagar, built around 1790), Manikeswar temple (Phasi, Kodala, built around 1790 – 1810), Raghunath temple (Balipadar, built around 1808), Dhadhibamana temple (Sorada, built around 1790 – 1810), Dhadhibamana temple (Belaguntha, built around 1909), Panchanan temple (Sorada, started in 1300, but renovated around 1960), Laxminrusingha temple (Sukunda, Brahmapur, built around 1910-1930), Nrusingha temple (Bada Matha, Sorada, built around 1790). Some temples are more than 200 years old and rests of them are more than one hundred years old. In the past as the carpenters say, the nature of payment was always in kind. Some of the carpenters in Buguda/Biranchinarayan temple, Pratappur/Tumbeswar temple, and Netanga/ Raghunath temple, were given some grant of land (*Jagirland*) for the construction of temple as well as its maintenance in future. At present though the occupation of *Jagiriland* is also continuing for this service but the service is not properly regulated as in the past. Such *jagir* holders were permanent carpenters usually known as 1st category of carpenters for the temple service. The 2nd categories of carpenters were working as assistants to such permanent carpenters. The 2nd categories of carpenters were mostly paid in kind and it was always through paddy or rice. However, at present nobody exactly remembers the quantity of payment for daily work in the past. At present, whenever any repairing or construction work is done, the local carpenters mostly do either on daily payment or on contract basis. The contract rate has no bound amount, it is a kind of bargaining, but in daily payment basis, all the skilled carpenters demand Rs 600/- per day and the duration of work is from 9 am to 5 pm. In case of overtime of work, extra charge is demanded by the carpenters. In the past, the permanent carpenters were provided one mid-day meal from the temple, but now a days the carpenters are taking care of their own food. For both permanent and assisting carpenters, another group of helping assistants are also there who are now getting Rs 300/- per day.

Role and Status of The Carpenters

To derive the role and status of a caste croup in India as well as Odisha, first of all, it is important to understand the relative position of the concern caste group in the local social system. All over the state, the *Varna* orders of Hindu caste system is very much applied more or less in a similar manner. However, because of local variations, some changes are observed from locality to locality. In Buguda area where we are working for our research, the local caste hierarchy based on food commensalism shows that *Brahmins* occupy the top most position in the local caste hierarchy. Next comes the *Kshetriyas* who were the kings and rulers of the area. Though they hold the political power and are very much dominating, they occupied the position next to *Brahmins* considering their religious status. In the next position come the *Karan*, a local caste group who serve the kingdom either as minister/advisor, the *Karji (Zamindar) or Gumastha* (Accountant). In the ladder, next comes the *Baishyas*, the business group known in different names like *Kumuti* (business man), *Teli* (oilman), and *Patara* (cloth businessman). The next caste group is *Khandayata* who are popularly know as *paikas* and soldiers and known in different names like *Banayat odiya, Kuruma* and *Kalinji*. The next caste group comes is *Chasha* or farmers who are identified as *Alia chasa* and *Odia chasa*. After the position of farmers, mostly the service caste come who are again divided into 4 types, namely service caste - I, service caste - II, service caste - III and service caste –IV. Such categorization is very critically found in Ganjam district. The caste group under study in the paper is *Badhei* otherwise known as carpenters. They come under the service caste - I category in which caste groups like *Gouda* (milkman), *Kamara* (black smith), *Badhei* (carpenters) and *Tapia* (mason) usually come. Such service caste groups including

the carpenters though come below the position of *Khadayata* and farmers, they are considered touchable caste in the society but as per the practice of food commensalism they can take food from all the higher castes above them but not vice versa. In the hierarchy ladder, all caste groups under *Baishya, Khadayata* and farmer can also take food from all the caste groups of service caste category I, but in service caste group category-II there are three caste groups namely *Mali* (gardner), *Bhandari* (barber) and *Rajaka* (washerman) who can take food from all the caste groups above them including service caste group – I, but not vice versa because of their lower position as presented in the table of caste hierarchy (Table No. 4). The next caste groups in the ladder are *Keuta* (fisherman) and *Khadala* (wood cutter). Both the caste groups are untouchables for the higher castes of the society. Next to service caste category II, comes service caste category III under which *Tanti* (weavers), *Ramuni* or *Rangani* (colour specialist) and *Koli* (thread maker) usually come. All the 3 caste groups are untouchables and very peculiarly, among them Tanti is a scheduled caste, *Ramuni* is an o.b.c. and *Koli* is a scheduled tribe. It is very interesting to note that *Kolis* are connected with thread making and thereby they assist the *Tanti* or weavers but very peculiarly considered as a scheduled tribe. It is a mistake due to the fact that *Koli* is a tribal community in Maharashtra and getting the same name in the local caste society, Government officials in Odisha have committed such a mistake without any scientific verification. The service caste - IV comes with 5 caste groups known as *Jhadudar* (sweeper), *Jaguali / Dandasi* (night watchman) and *Mochi* (cobbler), *Malla and Pana*. All the caste groups under points number 8, 9 and 10 are untouchables those who can receive food from all the higher castes but can never offer food to them. Even such untouchable groups cannot sit on the outer *varanda* or enter into the houses of all the higher caste members.

Table No. 4: Caste Hierarchy in Buguda Area

Sl No	*Caste*	*Sub caste*	*Works*
1	Brahmin	Samanta Danika Haladhara Saraswata	Royal priest Jajman priest Priest (pujari) Priest (pujari)
2	Kshatriya	King, ruler	
3	Karana	Minister, Karji, Gumasta	
4	Vaishya	Kumuti Teli	Businessman Oilman
5	Khandayata	Kalinji, Balasi, Kuruma,Banayata	Group leaders, Solders
6	Farmer	Chasa, Aalia	Cultivation/Agriculture
7	Service caste I	Gouda Kamara Badhei Tapia	Milkman Black smith Carpenters Mason
8	Service caste II	Mali Bhandari Rajaka	Gardner Barber Washerman (untouchable in morning and touchable in afternoon)
9	Fisherman caste	Keuta	Fishing (untouchable)
10	Wood cutter caste	Khadala	Collect wood from forest (untouchable)
11	Service caste III	Tanti Ramuni/Rangani Koli	Weaver Colour specialist Thread maker
12	Service caste IV	Hadi, Jhadudar Jaguali/Dandasi Mochi Mala, Pana Dama	Sweeper Night watchman Work with dead animals (remove hide from carcass) Work with dead animals (remove hide from carcass) Work with dead animals (remove hide from carcass)

Role always refers to the activities performed by any person as the member of a caste group. Status on the other hand, refers to the relative position of a person as the member of caste group in the society. The role of the carpenters especially the *Rupakars* under study here are highly skilled carpenters, who are mostly employed by the kings, rulers, zamindars and other well to do persons for making various wooden structure with artistic designs. In all the 10 temples we have mentioned earlier about such artistic wooden works the cost of which can never be afforded by the common people.

We have made it clear that all the carpenters are not of similar ability. There are 6 other categories of carpenters who are specialized in different stages of activities related to carpentry. Out of 7 types of carpenters (Diagram No. 2) wood carvers *(Rupakara)* along with the painters *(Chitrakara)* enjoy higher status in comparison to rest 5 types of carpenters. Mainly because, the wood carvers are highly specialized in making different artistic figures, motifs, designs on the wooden panel, they are highly respected in the society and also among other category of carpenters. In the society, in and around Buguda, thus, the specialized carpenters like the wood carvers are considered a clean caste. They can enter into the houses of all the higher caste people. The higher caste people also can receive water from them. As they are connected with very specialized and skilled wood carving work which the rich persons can only afford, their status in the society is enhanced accordingly. They also get higher remuneration as well as respect by all members.

As regards their artistic excellence, it is observed that in Biranchinarayana temple the wood carvers have made an wonderful temple simply out of wooden planks. All over the temple, every part on the ceiling, wall, windows, doors and pillars, finest wood carvings have been attempted and for their protection various traditional colours have been also applied. Among the decorative wood carvings, various images of gods, goddesses, human figures, animals, plants especially the creepers and flowers have been made with artistic design. Very interestingly and uniquely the tall standing idol of lord Biranchinarayana is made up of a single piece of wood.Because of its excellent wood carving work, the Biranchi Narayan Temple is popularly known as the WOODEN KONARK or Second Konark of Odisha today. In the temple of Tumbanath except the idol, the rest other wood carvings are similarly designed and carved like that of Biranchinarayana temple. The rest 8 temples have revealed very fine wood carvings related to various *Puranic* themes and characters. In nut shell, one can conclude that such wood carvings are rare, unique and excellent in Odisha today. Soon after the departure of the kings who patronized them for a long time, at present, such artistic creativity has come to a dead point. The people in modern society though value artistic wood carvings, it is mostly confined to personal appliances and furnitures, nothing in monumental form.

Conclusion

The depiction of wood carving in monumental form is vanishing very fast in Odisha to day.Whatever excellent carving works we have found to-day; almost all of them are patronized by the kings in the past. The wood carvers are continuing their activities as before but due to lack of patronization, no monumental wooden structures are possible at present. However, our main concentration is on the wood carvers along with their role and status in the society. Very interestingly we have presented the social status of the carpenters in relation to the complex hierarchical order of higher and lower castes which tell about their relative position in the society and their continuation of wood work tradition in Ganjam district.

References

Angira Viswakarma Maharana Samaja. 2018. Angira Bransabali (Odia), Laxminarayana, Printers, Buguda, Ganjam.

Dakhina Odisha Viswakarma Samaja. 2014. Badakhemundi, 3rd Edition.

Mahapatra Bansa. 2016. Dakhina Odisha Viswakarma Samaj, 1st Edition.

Maharana, G, Maharana, G. K Maharana, G.C. 2006. Dhamanakhola Rathbansa Ra Bansabali, Dhamanakhola Rathbansa, Athagada Tluka

Mishra, G. S. 2003. Ganjam Itihasa Parikarma (Odia), Radiant Process, Brahmapur.

Tripathy, R. P. 1996. Dwitiya Konark (Odia), Mahabir Enterprises, Bhubaneswar.

Viswakarma Badhei Bhainka Saamilani. 1966. Somabansa (Odia), Gopinatha Press, Brahmapur

Man in Society ISSN 2347-1530
Volume 25, 2018, pp. 88-92

Blood Pressure: An Emerging Health Issue among the Desia Kondha of Sarakui Village, Phulbani, Kandhamal District of Odisha

Sambit Kumar Mohapatra[1] and Kanhu Charan Satapathy[2]

Abstracts

Hypertension (HTN) is an important public health problem in both economically developed and developing nations. The global report on hypertension shows low and middle income countries at higher risk of blood pressure. The present study carried out in Sarakui village of Kandhamal District. Objective: the aim is to estimate the prevalence of hypertension among Desia Kondha. Methodology: A community based cross sectional study on 314 individuals, the systolic and diastolic blood pressure was recorded thrice using a standard mercury Sphygmomanometer. Results: The mean Systolic Blood Pressure and the mean Diastolic Blood Pressure is 123 and 81.28 respectively. The mean arterial pressure is 72.45. Out of total population the prevalence of hypertension is 4.45% while 13.37% are in Pre-hypertension stage. Conclusion: Hypertension is an emerging health issue in the Desia Kondha community due to acceptance of modern food and consumption of alcohol is the main cause of increasing hypertension and pre-hypertensive cases in the community.

Key Words : *Desia Kondha, Hypertension, Pre-hypertension*

Introduction

Hypertension is one of the most significant public health problem and the most prevalent disease states that occur in approximately one in three adults and it is the common lifestyle disease today in India. In 90% patients, the cause is idiopathic (Kayce et al., 2015. and Gupta et al., 2016). The global report on hypertension shows low and middle income countries at higher risk of blood pressure (WHO, 2013). In developing countries, high blood pressure is one of the risk factors for cardio vascular diseases, and the estimated 7.1 million deaths especially among middle, and old-age adults is due to high blood pressure(Gupta et al., 2017). According to ICMR survey report 2007-08, the prevalence of hypertension was varying from 17-21% in all the states with rural-urban differences (NHR, 2011). Most of the studies of blood pressure carried out in different population have shown a rise of blood pressure with age and obesity (WHO, 2005).

In a study conducted among the undergraduate medical students of medical college shows that the pre-hypertension and hypertension percentage was 67%. In an another study among Kondha and Sounti population of Kondha district shows that Kondha (9.9%) shows slightly high percentage of hypertensive than Sounti (7.3%) (Mohapatra et al.,2015) similarly in a another study among adolescent school going children of Berhampur shows that 3.68% students showing sustained hypertension(3.68%) while in girls it is 4.47% and in boys it is 3.2% (Bagudai et al., 2014)

Area and People

The word 'Kandha' is derived from the Telugu word Konda which means a small hill as well as the hill men. Originally they were hill dwellers. On the basis of the socio-economic and striking cultural characteristics features the Kondha can be broadly divided in to Desia Kondha, Kutia Kondha, Dongria Kondha, Bura Kondha, Sitha Kondha, Pengo Kondha etc.

The present study deals with the Desia Kondha community of Sarakui village of Kandhamal district. They speak 'Kui' or 'Kuvi' language belonging to Dravidian linguistic group. The settlements of Desia Kondha and Kutia Kondha villages are linear type but Desia Kondha villages are slightly different from Kutia Kondha villages. Desia Kondha is mainly agriculturist, they cultivated rice, Turmeric, cerals, pulses and some vegetables, they collect different varieties of green leave, shoots, tubers, roots, stems, flowers, fruits, seeds, mango, jackfruit etc. Nuclear family is common and joint family is rarely found. They organize themselves into strong clan groups. They

[1]*Ph.D. Scholar, Department of Anthropology Utkal University, Bhubaneswar*
[2]*Associate Professor, Department of Anthropology Utkal University, Bhubaneswar*

speak in Kui dialect (Dravidian language) (Kandhamal Gazetteer, 2011, SCSTRTI, 2013).

Methodology

The present study based on Desia Kondha of Sarakui Village, Phulbani, Kandhamal District, Odisha. For the assessment of the individual with hypertension or borderline hypertension mercury Sphygmomanometer and stethoscope was used and the recommendation of Indian Guidelines on Hypertension (Shah, 2013) I.G.H.-III 2013 was adopted for hypertension classification which is shown in table 1. The period of field investigation spanned from 7th October 2016 to 30th November 2016.The systolic and diastolic blood pressure was recorded thrice using a standard mercury Sphygmomanometer. Descriptive statistics such as mean, Standard deviation, Mean Arterial Pressure (MAP) are calculating by using Microsoft Excel and SPSS version 20.0.

Table no 1 shows the classification of Hypertension

Classification	*SBP (mmHg)*	*DBP (mmHg)*
Normal	< 130	<85
Pre-hypertension	130-139	85-89
Stage I hypertension	140-159	90-99
Stage II hypertension	>160	>100

According to Indian Guidelines on Hypertension (I.G.H-III)

Result

Table no 2 Shows the Mean DBP in Desia Kondha

Sex	*Age Group*	*N*	*Mean SBP*	*Std. Dev*
Male	15-20Yrs	25	114.88	6.16
	21-30 Yrs	30	120.47	6.90
	31-40 Yrs	33	121.58	6.59
	41-50 Yrs	25	124.64	7.41
	51-60 Yrs	20	130.90	7.29
	61 & above	14	128.43	8.95
	Total	147	122.65	8.55
Female	15-20Yrs	22	116.64	6.54
	21-30 Yrs	41	120.00	5.17
	31-40 Yrs	33	121.39	8.62
	41-50 Yrs	29	126.97	7.18
	51-60 Yrs	22	128.36	7.62
	61 & above	20	131.80	10.75
	Total	167	123.56	8.89

df-1, F-0.837, Mean-123.10

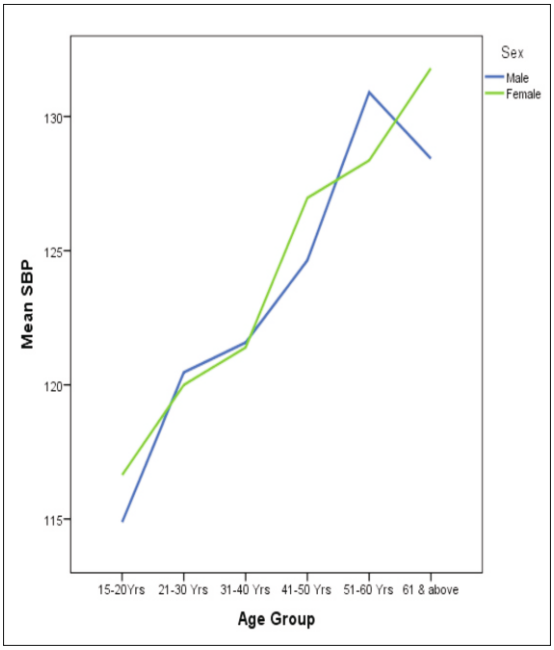


Figure no 1 Shows the Mean SBP in Desia Kondha

Table no 2 and Figure no 1 show the Mean SBP of Desia Kondha is 123, in male it is 122.65 while in female it is 123.56.

Table no 3 Shows the Mean DBP in Desia Kondha

Sex	Age Group	N	Mean	Std. Dev
	15 -20Yrs	25	77.12	3.876
Male	21 -30 Yrs	30	80.60	3.719
	31 -40 Yrs	33	80.61	3.445
	41 -50 Yrs	25	81.84	4.616
	51 -60 Yrs	20	85.70	4.953
	61 & above	14	84.57	3 .956
	Total	147	81.29	4.779
Female	15 -20Yrs	22	76.55	4.459
	21 -30 Yrs	41	79.17	3.376
	31 -40 Yrs	33	80.55	3.545
	41 -50 Yrs	29	83.31	4.319
	51 -60 Yrs	22	83.73	3.869
	61 & above	20	86.40	5.826
	Total	167	81.28	5.045

df-1, p<0.05, Mean-81.28

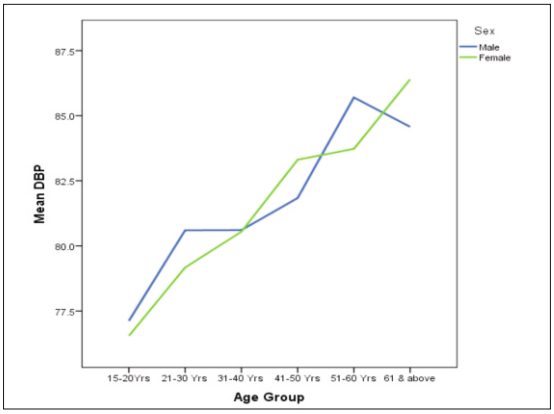


Figure no 4 shows the Mean DBP in Desia Kondha

Table no 3and Figure no 2. Shows the Mean DBP of Desia Kondha is 81.28, in male it is 81.29 while in female it is 81.28

Table no 4 Shows the Mean Arterial Pressure:

Sex	*Age Group*	*N*	*Mean*	*Std. Dev*
Male	15-20Yrs	25	89.70	4.55
	21-30 Yrs	30	93.88	4.59
	31-40 Yrs	33	94.26	4.38
	41-50 Yrs	25	96.10	5.43
	51-60 Yrs	20	100.76	5.52
	61 & above	14	99.19	5.49
	Total	147	95.07	5.91
Female	15-20Yrs	22	89.90	4.77
	21-30 Yrs	41	92.78	3.86
	31-40 Yrs	33	94.16	5.08
	41-50 Yrs	29	97.86	5.18
	51-60 Yrs	22	98.60	5.06
	61 & above	20	101.53	7.35
	Total	167	95.37	6.19

df-1, F-0.184, p<0.05, Mean-95.22

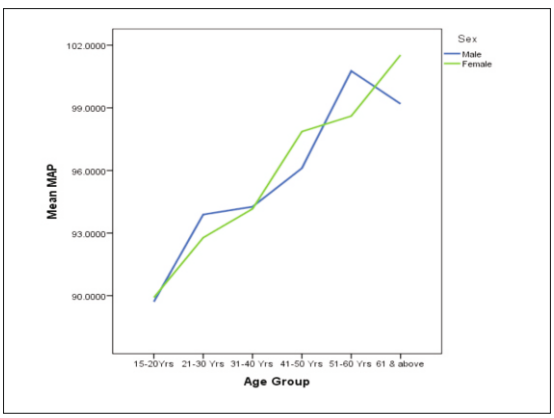


Figure no 3. Shows the Mean Arterial Pressure:

Table no 4 and Figure no 3 shows the Mean Arterial Pressure of Desia Kondha is 95.22, in male it is 95.07 while in female it is 95.37.

Table no 5 Shows the Mean Heart Rate of Desia Kondha:

Sex	*Age Group*	*Std.N*	*Dev*	*Mean*
Male	15-20Yrs	25	72.00	2.449
	21-30 Yrs	30	71.47	1.479
	31-40 Yrs	33	71.82	1.895
	41-50 Yrs	25	72.48	3.754
	51-60 Yrs	20	73.50	4.199
	61 & above	14	72.14	2.656
	Total	147	72.15	2.800
Female	15-20Yrs	22	71.45	1.654
	21-30 Yrs	41	71.46	1.614
	31-40 Yrs	33	71.82	2.663
	41-50 Yrs	29	73.66	3.667
	51-60 Yrs	22	72.45	3.143
	61 & above	20	74.20	3.995
	Total	167	72.37	2.959

df-1, F-0.461, p<0.05,Mean-72.26

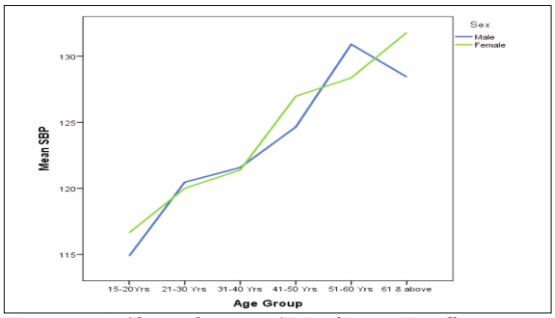


Figure no 4. Shows the mean SBP of Desia Kondha

Table no 5 and figure no 4 shows the Mean Heart Rate of Desia Kondha is 72.26, in male it is 72.15 while in female it is 72.45.

Table no 6 shows the Age wise distribution of Blood Pressure in Desia Kondha

Blood Pressure	Age Group	Sex				Total (%)
		Male	%	Female	%	
Normal	15-20Yrs	24	20	22	15.94	46 (17.82)
	21-30 Yrs	27	22.5	41	29.71	68 (26.35)
	31-40 Yrs	31	25.83	28	10.28	59 (22.86)
	41-50 Yrs	20	16.66	21	15.21	41 (15.89)
	51-60 Yrs	10	8.33	16	11.59	26 (10.07)
	61 & above	8	6.66	10	7.24	18 (6.97)
	Total	120	46.41	138	53.48	258 (100)
Pre-Hypertension	15-20Yrs	1	4.34	0	0	1 0(2.38)
	21-30 Yrs	3	13.04	0	0	3 (7.51)
	31-40 Yrs	2	8.69	5	26.31	7 (16.66)
	41-50 Yrs	4	17.39	6	31.57	10 (23.80)
	51-60 Yrs	8	34.78	4	21.05	12 (28.57)
	61 & above	5	21.73	4	21.05	9 (21.48)
	Total	23	54.76	19	45.24	42 (100)
Hypertension	41-50 Yrs	1	25	2	20	3 (21.42)
	51-60 Yrs	2	50	2	20	4 (28.57)
	61 & above	1	25	6	60	7 (50)
	Total	4	28.57	10	71.43	14 (100)

df-5, p<0.05

Table no 7 shows the sex wise distribution of Blood Pressure in Desia Kondha

Blood Pressure	Sex				Total (%)
	Male	%	Female	%	
Normal	120	46.51	138	53.48	258 (82.16)
Pre-Hypertension	23	54.76	19	45.23	42 (13.37)
Hypertension	4	28.57	10	71.42	14 (4.45)

df-2, p<0.05

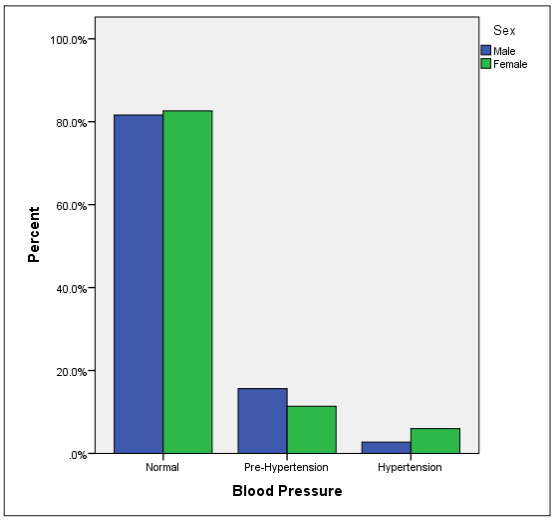


Figure no 5. Shows the Blood Pressure distribution of Desia Kondha

Table no 6, 7 and figure no 5 shows the distribution of blood pressure in Desia Kondha which shows that out of total population 82.16 % are normal , 13.37% are in Pre-hypertensive condition and 4.45% are in Hypertensive condition.

Table no 8 shows Mean Arterial Pressure of Desia Kondha

MAP	*Sex*				*Total (%)*
	Male	*%*	*Female*	*%*	
Normal	143	97.27	163	97.60	306 (97.45)
HTN	4	2.72	4	2.39	8 (2.55)

df-1,p<0.05

Table no 8 and figure no 6 shows the Hypertension status according to Mean Arterial Pressure, which shows that 97.45% are showing normal Blood pressure and only 2.55% are HTN (based on Mean arterial Blood Pressure)

Discussion

Hypertension is a major public health problem in both developed and developing countries. It is responsible for 9.4 million deaths worldwide. Many

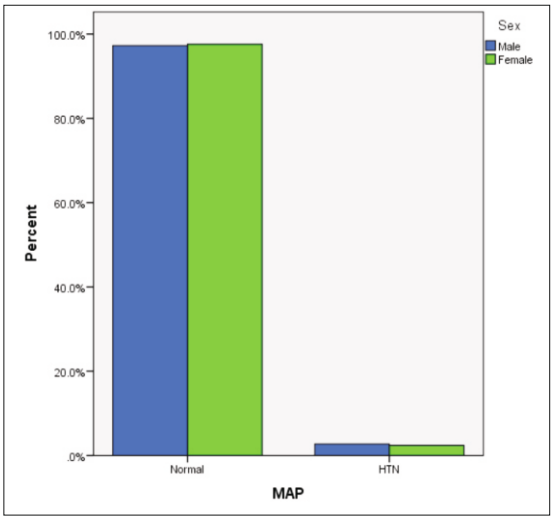


Figure no 6 shows Mean Arterial Pressure of Desia Kondha

past research studies have also found the prevalence of hypertension to be lower in native tribal populations than the general population, but a recent meta-analysis has pointed out a change in this scenario with an increasing trend in prevalence of hypertension. According to National Family Health Survey-4 (NFHS-4) 4.3% females and 4% males are suffering from hypertension.

Table no 2 and Figure no 1 show the Mean SBP of Desia Kondha is 123, in male it is 122.65 while in female it is 123.56. In males 51-60 years age group shows higher mean SBP than (130.40) other age group similarly in females 61 and above age group shows higher (131.80) in females. Table no 3 and Figure no 2 Shows the Mean DBP of Desia Kondha is 81.28, in male it is 81.29 while in female it is 81.28. In males 51-60 years age group shows higher mean SBP (85.70) than other age group similarly in females 61 and above age group shows higher (86.40) in females. Table no 4 and Figure no 3 shows the Mean Arterial Pressure of Desia Kondha is 95.22, in male it is 95.07 while in female it is 95.37. In males 51-60 years age group and in females 61 & above age group shows higher MAP, 100.76 and 101.53 respectively. Table no 5 and figure no 4 shows the Mean Heart Rate of Desia Kondha is 72.3, in male it is 72.15 while in female it is 72.45.

Table no 6, 7 and figure no 5 shows the distribution of blood pressure in Desia Kondha which shows that out of total population 82.16 % are normal , 13.37% are in Pre-hypertensive condition and 4.45% are in

Hypertensive condition. 51-60 Years age groups show higher pre-hypertensive cases than other age group. Males show higher number of pre-hypertensive cases than females. Table no 8 and figure no 6 shows the Hypertension status according to Mean Arterial Pressure, which shows that 97.45% are showing normal Blood pressure and only 2.55% are HTN (based on Mean arterial Blood Pressure).

Population/Tribe	Prevalence (%)	Reference
Tibetans (Odisha)	34	Satapathy (2010)
Bathudi (Odisha)	6.29	Mohapatra et.al.(2015)
Bhumija (Odisha)	10.5	Mohapatra et.al (2015)
Sounti (Odisha)	7.3	Mohapatra et.al.(2015)
Kondha (Odisha)	9.9	Mohapatra et.al (2015)
Tribal Population (Kerala)	23.33	Kahkashan et.al. (2017)
Delhi	14.1	Kishore et.al.(2016)
Nellore (Andhra Pradesh)	36.48	Singh et.al. (2016)
Desia Kondha (Odisha)	4.45	Present study

Conclusion

It has long been believed that the blood pressure levels of tribal people are lower than the general population as they are isolated from the modern lifestyle and may have a lower prevalence of risk factors of hypertension. However, there are hypertension cases observed among the Kandha and is due to changing lifestyle, unhealthy diet, obesity, mental stress, tobacco and alcohol intake and the study shows that females are suffering more than their male counterparts.

References

Bagudai S., Nanda P., Kodidala S.R., 2014.Prevalence of Obesity and Hypertension in Adolscent school Going Children of Berhampur,Odisha, India. *Int J Physiother Res,* Vol2 (6): 777-80.

Gupta Rajeev et al., 2016. Strategies for Better Hypertension Control in India and Other Lower Middle Income Countries,. *Journal of the Association of Physicians of India*; 64.

Gupta, R., Gupta S. 2017. Hypertension in India: Trends in prevalence, Awareness, Treatment and Control. *RUHS Journal of Health Sciences, Volume 2 Number* 1.

Kahkashan1, A., Ismail, I.m Blood pressure pattern and hypertension rates among selected tribal population of Kerala, 2017. National Journal of Physiology, Pharmacy and Pharmacology, Vol 7, Issue-6, Pp-577-581

Kandhamal Gazetteers 2011, Odisha District Gazetteers, Gopabandhu Academy of Administration, General Administration Department Government of Odisha.

Kayce, B., Twiggs, J. and Olin B.R., 2015. Hypertension: The Silent Killer: Updated JNC-8 Guideline Recommendations. *Continuing Education.*

Kishore J., Gupta N, Kohli C.,and Kumar N., 2016. Prevalence of Hypertension and Determination of Its Risk Factors in Rural Delhi, International Journal of Hypertension Volume, Article ID 7962595,

Mohapatra S., Satapathy K.C., Patra P.K. and Das P.K., 2015. Epidemiology of blood pressure among some tribes of India Bhumij, Baathudi and Savar, The Tribal Tribune.

Mohapatra, S.K., Satapathy K.C., Mohapatra S., 2015. An Assesment of Health Status of Kondha and Sounti tribe of Niladriprasad, Khordha District, Odisha. *Man in Society,* Vol.22, Pp-124-141.

National Family Health Survey (NFHS-4), 2015 - 16, District Fact Sheet Kandhamal Odisha, International Institute for Population Sciences, Ministry of Health and Family Welfare

National Health Report, 2011.Ministry of Health and Family Welfare (MHFW), Govt. of India. New Delhi.

Satapathy K.C., 2010. Refuges Health: A Bio-Anthropological study on Emerging Health problems of Tibetan Refuges of Chandragiri of Odisha, Bhubaneswar, Athena Books.

Scheduled Caste & Scheduled Tribes Research and Training Institute (SCSTRTI), 2013. Kandha, Bhubaneswar.

Shah S.N., 2013. Special Issue on Indian Guidelines on Hypertension (I.G.H.)-III. J Assoc Physicians India. 2013 Feb; 61(2 Suppl):6-36.

Sing M.K, Singamsetty B., Kandati V., *2016.* An epidemiological study of prevalence of hypertension and its risk factors in a rural community of Nellore, Andhra Pradesh, India, *Int J Community Med Public Health. Dec; 3(12):3408-3414*

World Health Organization (WHO), 2005. WHO is preventing chronic disease: a vital investment, *World Global Report*, Geneva.

World Health Organization. A Global Brief on Hypertension WHO/DCO/WHD/2013.2. Geneva: WHO; 2013.

Man in Society ISSN 2347-1530
Volume 25, 2018, pp. 93-101

Emerging Trends in Ethnographic Research

Prasant Kumar Sahoo

Abstract

Anthropology is as famous for its unique theme, i.e. culture, as for its unique research methodology, i.e. ethnography. Ethnography is the hallmark of any anthropological research which many other sciences borrowed from anthropology. In the process the researcher undergoes rigorous pain in indulging him/herself to study a particular people and its culture. Further ethnography involves a research cycle, i.e. the researcher will be occupied in the research still he/she gets the same data and same kind of response from the empirical observation. There are essentially two criteria at the core of ethnography. It is a field-orientated activity and it has cultural interpretations. This paper therefore thoroughly highlights the characteristic features of ethnography, its methodological principles and the emerging trends in ethnographic research in the changed context of data collection and the underlying orientations and perspectives of a globalised world.

Key words: *Anthropology, Ethnography, Method, Ethno-Science, Emic, Culture*

Introduction

Ethnography is the work of describing a culture. The central aim of ethnography is to understand another way of life from the native point of view (Spradley, 1980). More anthropologically orientated writers distinguish between ethnography as process and ethnography as product. 'Ethno' refers to people and 'graph' to a picture, then the challenge of presenting a picture of a group of people seems to provide direction enough for many a researcher. For the anthropologically orientated researcher, ethnography has always been associated with, and intended for, studying culture (Wolcott, 1999). Ethnography is a method of collecting, describing and analyzing the ways in which human beings categorize the meaning of their world. In other words, ethnography attempts to learn what knowledge people use to interpret experience and mould their behavior in the context of their culturally constituted environment (Aamodt, 1991). At its simplest level, 'ethnography' can refer to a way of collecting data (a set of research methods); the principles that guide the production of data (a methodology); and/or a product (the written account of a particular ethnographic project) (Savage, 2006). Ethnography is a collaborative, participatory methodology. The representation you build is neither 'theirs' nor is it 'yours' (Agar, 1996).

Ethnography, emerging from anthropology, and adopted by sociologists, is a qualitative methodology that lends itself to the study of the beliefs, social interactions, and behaviors of small societies, involving participation and observation over a period of time, and the interpretation of the data collected (Denzin and Lincoln, 2011; Reeves, Kuper and Hodges, 2008; Berry, 1991). In its early stages, there was a desire by researchers to make ethnography appear scientific and with this in mind a manual was produced for people in the field, with a set of instructions as to how ethnography should be 'done' (Denzin and Lincoln, 2011). As such it was seen to be more accurate than the descriptions of travellers, although not in the sense that scientific experiment or quantitative measurement is deemed accurate. A feature of positivism is that results can be tested, and the researcher is separate from the research. This was seen by ethnographers as failing to capture aspects of the way humans behave, the setting being artificial (Atkinson and Hammersley, 1994). On the other hand a naturalist approach is more interpretive, cannot be verified by tests, and the researcher's own interpretation is part of the process (Mackenzie, 1994). The goal of ethnography then was to give an analytical description of other cultures (Barbour, 2007), an exploration of a particular phenomenon, rather than

Assistant Professor of Anthropology, F.M (Autonomous) College, Balasore. Email: sahoopk1989@gamil.com.

the testing of an hypothesis (Atkinson and Hammersley, 1994). The data consisted of unstructured accounts and the analysis, which provided interpretation of meaning, was done by the researcher, using observation, description and explanation (Reeves, Kuper & Hodges, 2008).

There was no attempt in the nineteenth century to represent the point of view of the people being observed, ethnography was conducted by outsiders providing a view of the actions of the people under study (Reeves, Kuper and Hodges, 2008; Denzin and Lincoln, 2011). It was etic, rather than emic, the difference between a wink and a blink. The functional significance of an action was ignored, the 'raw facts' simply described 'objectively'. Malinowski is credited with creating a shift in ethnography, when he sought to introduce into his accounts the point of view of those being studied, and the cultural significance of the actions described (Denzin and Lincoln, 2011), going so far as to say that the researcher must immerse himself in the culture so that 'they' becomes 'we' (Elliott and Jankel-Elliott, 2003). Abu- Lughod (2000) applauded, in ethnographic research, "the use of the poignant pronoun: we", seeing it as symbolic of the importance of location. Rather than represent cultures as alien, by creating hierarchical discourses that excluded the familiar, accentuating differences and distance, it is important to identify with those being studied rather than turning them into objects. Hence, immersion within a culture means being able to discern the significance of the blink in that culture, and becomes the 'thick' description of ethnography (Rosen, 1991).

Ethnography thus is the naturalistic, scientific study of human behavior in context. Using various social science research methods, ethnography combines systematic data capture and rigorous analysis to provide a detailed, nuanced, and more complete picture of what people actually do and experience beyond just what researcher say and they do. This reveals people's real practices, tacit knowledge, and unmet needs or desires with respect to products, services, or processes. *Ethnography* deals with the study of the diversity of human cultures in their particular cultural settings. This method has developed in early anthropological field research carried out in non-western cultures. In the last decade ethnographic research, which has established itself predominantly within anthropology, has become incorporated into other social sciences. It has become widely used in sociology, social work and pedagogy, but also in medical and mental health studies for working with individuals with severe mental health problems.

Characteristic features of ethnographic research

Ethnographic research seeks to gain an emic perspective.

Ethnographers seek to highlight the native's point of view of a specific culture (Hammarsley and Atkinson, 2007). This means that they try to look at the culture under study from the inside; through the meanings that the members of that culture live with. Therefore, ethnographers avoid imposing conceptual and theoretical frameworks on empirical data at the beginning of the research process.

Ethnographic research conceptualizes language as a social practice

While ethnographers are interested in the emic perspective, that is, how members of a culture give meaning to the world, they are also interested in language practices. In ethnographic research, language is conceptualized as a social practice: what people say and what they keep silent about produce meaning and value in social life. Language practices are socially constituted because they are shaped by social and historical forces, which are beyond the control of individuals. At the same time, however, language practices constitute people's lives together by specifying, creating, maintaining and changing the frames of their action.

Ethnographic research shows the social and the symbolic context of the service consumer

The contextualization of activities and behaviors is extremely important. The underlying belief is that human behavior cannot be studied in isolation or independently from the environment or context in which it occurs (Lincoln and Guba, 1985, Hammersley and Atkinson, 2007). Contextualizing the data enables the researcher to place it in a larger perspective and capture a more holistic view (Boyle, 1994). This involves extensive fieldwork in naturalistic settings for prolonged time periods in which the researcher has direct personal face-to-face contact with participants (Boyle 1994, Christensen 2004) and enables researchers to capture more than a

snapshot of activity and assists in recognizing routine, repeated and patterned social practices and processes (MacPhail 2004). This contextual-based knowledge includes the actual and the symbolic, the socially constructed knowledge as well as the transmitted memories of social phenomena. As an example, in many social services the people with disabilities are seen either as a-sexual or as over-sexualized, but in both cases cannot escape sexual violence which is not aberration but is intrinsic to the social construction of disability.

Ethnographic research gives a holistic view instead of reductionist picture

It does not touch the listeners but makes sure that people distance themselves from concrete life experiences of service users. Instead of positivist objectivity, which is most often achieved with formal knowledge and descriptions, critical ethnographic research encompasses several characteristic of feminist research.

Ethnographic research focuses on cultural differences

It makes possible to see a phenomena that would be most of the time seen only within the pathological framework, as part of cultural patterns. Ethnographic approach can look at the questions such as: what is the culture of heroin users, what are the rituals within the medical diagnosis of eating disorders, what is the culture of a particular public institution, etc. It also shows how someone is culturally positioned and what the social consequences of such positioning are. For example, mental health service users for instance, are in many cultures, neither completely ordinary human beings nor non-humans.

Ethnographic research values the personal involvement of the researcher

It gives an insight into how much does the story of the informant influences the view of the researcher and vice versa, how much the perspective of the researcher influence the story of the interviewee. Ethnographic method never discloses only the world of the subject of the research, but always also shows our world and the place between us and the other. The ethnographer is always positioned as a subject within a certain context, time, space and ideology as well as the locality of gender, age, ethnic group and class. The principles of ethnographic research try to bridge the gap of this ambivalent tradition and advocate for the reflexive use of one's own subjectivity within professional practice.

Ethnographic research promotes reciprocity

Another aspect of the creation of a "common space" of the researcher and the interviewee is the issue of reciprocity. Reciprocity is an intrinsic human condition which is often neglected in the social welfare institutions. During the ethnographic research process, the researcher receives a "gift" in a form of information, data and sharing of personal stories. At the same time the researcher gives back the gift in a form of listening, witnessing, and empathy.

Ethnographic research can create relationships based on advocacy work for people, the subjects of research

The need for advocacy (independent, civic, peer, collective, citizen, parent etc.) has come from the understanding that seeking help and support in social welfare institutions, does not necessarily improve the conditions of the individual person, but can degrade and oppress the individual person as well. Therefore, the researcher, who is often confronted with inequalities and injustice while doing ethnographic research, gets involved as an advocate for people who are the subjects of research.

Ethnographic research gives an insight into the life history of a person as well as life histories of social institutions, professionals and communities

Sometimes a formal entrance in the institution can already be insightful information of a particular institution. A researcher, who has to wait for months to get a permission to enter the public institution, already gets the message of the boundaries which make the "world inside" and the "world outside", a rigid sphere which are difficult to transgress.

Methodological Principles in Ethnographic Research

There are three methodological features of ethnographic research, which have differing philosophical backgrounds. 'Naturalism' has its roots in the realist research tradition, which seeks to discover a true or authentic description of the world. Understanding and induction, in turn, are related to

the social constructionist research tradition, which suggest that there are several descriptions, or versions, of the reality, the trustworthiness of which depends on what we believe is true, and how relevant the description is.

Naturalism

According to naturalism, the aim of research is to capture the objective nature of naturally occurring human action (Lincoln and Guba, 1985). The argument is that this can only be achieved through intensive, first-hand contact and not through what people do in experimental and artificial settings, or by what people say in interviews. This is why ethnographers carry out their research in natural settings, which exist independently of the researcher. They also try to explain social events and processes in terms of their relationship to the context in which they occur. According to naturalism, objective description requires you to minimize your influence on the activities of the people that are studied.

Understanding

A counter argument to naturalism entails that you can explain human action only if you have an understanding of the culture in which action takes place (Rosen, 1991). This is rather obvious if you study something that is completely alien to you. However, some ethnographers argue that it is just as important when you are studying more familiar settings. Indeed, when a setting is familiar, the danger of misunderstanding is especially great. You should not assume that you already know other people's perspectives, because specific groups and individuals develop distinctive world views. This is especially true in large complex societies; therefore, it is necessary to learn the culture of the group that you are studying before you can give explanations for the actions of its members. This is why participant observation, conversations and open interviews are central to ethnographic research.

Induction

Ethnographers argue in favor of inductive and discovery-based research processes focusing on 'local interpretations' (Geertz, 1973). It is argued that if the researcher approaches a community with a set of predefined theoretical models, concepts or propositions, they may fail to discover the distinctive and contextual nature of it. This is why ethnographers typically start their research with just a general interest in a community, group of people, type of social action, or a practical problem. The research problem will then be refined, and sometimes even changed, as the research project proceeds. Similarly, theoretical ideas are developed over the course of the research process. These are regarded as valuable outcomes of the research, not as its starting points.

Emerging Trends in Ethnographic Research

There are distinct versions of ethnographic research. This is why, if you plan to do an ethnographic study, you will need to specify what kind of ethnographic research you wish to perform. Besides the basic approach outlined in this chapter, there are also more specific alternatives. Critical ethnographies and feminist ethnographies are examples of theoretically informed approaches relying on the principles of critical theory and feminist theory while auto ethnography refers to an approach where the researcher's personal and reflective perspective is part of the analysis. The expansion of the Internet and social media has boosted researchers to perform virtual ethnography. Virtual ethnography rests on the argument that the ethnographer should experience the social life of the research subjects regardless of how those experiences are mediated. Related to this, ethnography can be global, multi-sited and mobile in the sense that researchers follow people around physical and virtual places. Let's discuss some emerging trends in ethnographic research.

Multi-scalar/Multi-sited ethnography

It delineates how movements are constituted at different scales. Scale here means the spatial reach of actions. It is an abstraction aimed at capturing actor's strategies and internal dynamics of social change. The concern is that how can we conduct multi-scalar field-work before knowing what multiple scales we may discern. For example when a would-be migrant mobilizes money among the extended family to finance the journey, it entails activities on a particular scale; when the migrant contacts friends to approach prospective employees there, it is another scale of operation. Actions at different scales bear different patterns, logics, rationalities. Thus multi-scalar ethnographies is first

of all concerned with how social phenomena, such as transnational migration are constituted through actions at different scales. Further it tries to understand how frictions appear between different scales. And relations across multiple scales provide us to understand connections actually work, and what the sites mean to each other. As a result it explains why certain changes take place and others don't. It does not at all discount the important of sites, but articulates the meaning of sites to the actors.

Multi-sited ethnography similarly is a method of data collection that follows a topic or social problem through different field sites geographically and/or socially. While many methods can be used on their own, multi-sited ethnography typically requires use of additional methods like structured interviews, surveys, or other methods of data collection. To G. Marcus (1995), multi-sited ethnography solves the need for a method to analytically explore transnational processes, groups of people in motion, and ideas that extend over multiple locations. Since multi-sited ethnography is concerned with movement of ideas, people, and commodities, it is heavily related to a world-systems theory.

Multi-sited ethnography also allows for researchers to understand how power structures from seemingly disconnected spaces ultimately impact a specific population. On a macro level, policies from one nation impact people in another. In the example of tracing corn as a commodity above, multi-sited ethnography allows for understanding all of the interactions a commodity has through various levels of powerful decision makers and commodity user. For medical anthropology, multi-sited ethnography is helpful in revealing social influents of health or barriers in accessing care. For example, a multi-sited ethnographic approach to migrant health can reveal how policies that exclude undocumented migrants from accessing health services have negative health impacts. Similarly, a multi-sited ethnography can reveal how global policies may harm one nation's economy and provide motivations for labor migration. Following the idea of migration reveals motivations and may also show how the act of migrating may expose migrants to infectious diseases or environmental hazards they would not have been exposed to if they had not migrated.

Digital and hypermedia ethnography

The advent of digital technologies has the enormous potential to open new vistas in ethnographic research. Generally, four new methods- online questionnaire, digital videos, social networking sites and blogs-have brought a sea change in ethnographic research. Consumer grade digital cameras provide ultra-sharp images and videos of ethnographic sites, enabling not only the recording of interviews and research sites, but also the possibility of webcams and video conferencing. Web-questionnaires have enabled large scale multi-site international surveys that would have exhausted the whole departmental budgets in the days of postal research. E-mail interviews have gathered rich bilateral streams of data from otherwise inaccessible respondents. The ethical grounds pose certain questions such as the high level of invisibility of digital ethnography visa-a-visa the systematic field research, and face-to-face interactions and observations, of everyday life along with issues of privacy, informed consent, online pseudonyms, and documentation etc.

Hypermedia ethnography stresses on how ethnographers might use hypermedia in planning, design, analysis, and presentation of ethnographic work and to exploit new media technologies so as to allow a new integration of visual and "textual" ethnography that bridges the current boundaries between the two. Hypermedia technology offers researchers the potential to exploit a range of media in ethnographic projects and to appreciate how each medium-whether printed word, sound, video, still image, or audio- directly help collect and analyze ethnographic data.

Analytic ethnography

Analytic ethnography articulates how it can contribute to theoretical development through conceptual refinement and theoretical extension as well as the more traditional development of grounded theory. It seeks to produce systematic and generic propositions about social process and organizations. There are mainly two criticisms that persistently dogged ethnographic research: i) the tendency for ethnographers to neglect theoretical relevance; and ii) relatively dearth of systematic procedures of analyzing field data in a fashion that facilitates theoretical orientation.

Ethnography and theory are mutually informative in that theory focuses and sharpens ethnography while ethnography grounds theory in the richness of social life. Also, theoretically-engaged ethnography can promote ethnographically-based contribution to policy intervention. Else whatever the empirical content ethnography may have, it won't provide any theoretical implication. On the other hand theoretical-engaged ethnography can be useful in their own right for theoretician, practitioners, and policy-makers who need much detailed knowledge of people's activates at particular places and times. Further, many ethnographers neglect the analytic phase of the research i.e. they either gloss over the practices and procedures of analysis or fail to articulate them in their final report. As a consequence it generates impression that qualitative analysis is a haphazard enterprise, and it subsequently undermines the prospects of theoretical developments. This analytic interrupts' fittingly describes a part of qualitative field research. Through proper research the existing theory can be extended and refinement can be done through modification which may lead to reconstruction of extant theory. And this can be applied in research literature.

Urban ethnography

Urban ethnographers can contribute by tracking the interactions through which people make money out of the distinctive phenomena of urban life. Cities constantly and inadvertently throw up potentially valuable views of their communities that may be grasped as treasures by the shrewd. For the ethnographer, urban alchemy raises the political economic question: who gets to appropriate the universally appreciated value of observing the city and about the evolution of the current market framework for transactions that exchange view rights. It also studies city neighborhoods because 'globalization' and 'deindustrialization' have created a radically different framework for city life. When we emerge from a systematic analysis of substantively diverse cases of neighborhood creation and transformation, we will see different social mechanisms, different power dynamics, and a different formative historical era than have been imagined by previous urban sociologies. Simultaneously we can analyze how current social patterns took shape and to understand how people economically exploit a city's public life.

Critical ethnography

Critical ethnography, according to Nugent (2007), in particular, is a form of scientific writing in which the authors carefully present characters within a narrative compelling sympathetic feelings in the reader. The reader imagines what the characters are going through and by reading these accounts he is invited to experience sympathetic feelings toward these characters. It covers the relation between the reader and the characters. Thus there is subjective involvement of the reader in the experiences of these characters. The sympathy of the reader is deflected from the Character and directed toward society in general. It is in this form of ethnography that we would like to explore more deeply the way in which ethnographers build social and sympathetic relationships between the reader and the characters in their stories and, more importantly, how this rhetorical move supports their narrative/critical aims. Social-psychological feelings such as obligation and reciprocity may also be compelled by texts. This offers us a means to more fully explore the 'practical,' as opposed to purely 'cognitive' or 'aesthetic' facets of textual rhetoric, by framing reading as an imaginative social activity. We believe that it is fruitful both to approach the social world as a text and also to approach texts as social worlds.

The aim of critical ethnography is the roots of critical thought spread from a long tradition of intellectual rebellion in which rigorous examination of ideas and discourse constituted political challenge. Social critique, by definition, is radical. It implies an evaluative judgment of meaning and method in research, policy, and human activity. Critical thinking implies freedom by recognizing that social existence, including our knowledge of it, is not simply composed of givens imposed on us by powerful and mysterious forces. This recognition leads to the possibility of transcending existing forces. The act of critique implies that by thinking about and acting upon the world, we are able to change both our subjective interpretations and objective conditions.

New Ethnography

New Ethnography is a recent development in the field of Anthropology. It is also known as Cognitive Anthropology or Ethno-science. It accords special importance to empirical data as well as theoretical abstraction. The goal of new ethnography is to arrive

at a description and analysis of a culture as a member of that culture would see it, free from the biases of the outsider. It tries to achieve the precise and highly paradigmatic renderings of cultural phenomena which have come to be associated with the linguist's description of phonology and grammar. The cultural behavior is studied and categorized in terms of the inside view of human events. The ethno scientist seeks to understand a people's world from their point of view. Many ethno- scientists think that if we can discover the rules that generate correct cultural behavior we can explain much of what people do and why they do it. Ethno-science thus accounts for cultural items and cultural relationships in terms of the information used by members of a culture in their own linguistic categories.

Team Ethnography

Team ethnography is a new ethnographic research method used in Social Anthropology. It is very famous in present days. Team ethnography is very important in a field work. When we work as a team then whole things have been organized by the team members. In this method, each member of a team is tasked with focusing on a specific cultural category or domain to research during the area. For example, one member may focus all her research on the linguistic aspects of the people. Another may research the family structures. Yet another will tackle religion and myth in the culture. The team can be formed according to each individual's strength or background with the assigned category. And if anyone gets other team member's relating data then it is the opportunity to the researcher to share with other teammates. And group discussion is most important part of team ethnography because it helps every researcher to build methodological concept. Each researcher has a specific focus and as the days progress, the research/informant base builds. The most helpful research is often done several days into the trip as the researcher has had a few days to build a general knowledge of the people and has been introduced to knowledgeable informants in the area. Each researcher also has an ear and eye open to informants with knowledge in other cultural categories.

Auto Ethnography

Auto ethnography seeks to demonstrate that when personal experiences clash with histories it challenges previous meanings and understandings (Denzin, 2006). It is defined by a reflexive writing as in a narrative of experiences with other cultures or experiences of other social contexts, whereby the physical, personal presence of the researcher is political. In this context auto ethnography was used to challenge hegemonic discourses and therefore, validates the experiences of others whatever these may be. Auto ethnography seeks to communicate the mechanisms of the "inner world" (Holt, 2003) of an individual from the perspective of the researcher. It is important to recognize that auto ethnography not only places the researcher within the experience of an individual or group, but it sees the researcher reflecting upon their own, personal experience of the experience being researched. The process involves writing the 'self' into the history and projecting it into the present, by using various writing and communication techniques and forms (Denzin, 2006). It is a study of the 'self' as 'other' and when linked with culture, involves a negotiation between the ethnographer stories (us) and their relevance to culture. It exposes the hidden 'I' in the accounts, to allow for a more authentic process (Berry, 2011). The aim of auto ethnography is always to challenge the norms of methodological practices in order to achieve a more egalitarian and just society, making clear where power, privilege and biases lie (Berry, 2011), in the process of studying those who have been hidden or represented as "abject, abnormal, exotic, and uncivilized", and to critique the master narratives of western white history writers.

Transcendent ethnography

The term 'transcendence' in the context of ethnography operates on two levels. Most significantly, it refers to the context in which the study takes place –a culture of conflict. Transcendence is obtained in ethnography by transcending one level of social identification to focus on a *Meta* cultural level. It seeks to elicit and expand a shared cultural identification, which we will call *Meta culture*, between individuals whose primary cultures are in conflict. *Meta* culture in the transcendent ethnographic sense can be defined as the flexible reordering of cultural identity within the context of a culture of conflict to privilege an identity that fosters an environment of peace. In utilizing traditional methodologies of ethnography that seek to sharpen and explicate cultural

differences, intergroup tensions will most likely be heightened and conflicts intensified. Transcendent ethnography seeks to blur and obfuscate cultural differences, seeking instead a shared level of identity that participants may inhabit together. The transcendent ethnographer also transcends traditional concepts of academic success. These reordered academic priorities allow the possibility for research to go on subtly and confidentially, and for researchers to carry out research with their success unsung among colleagues. In many cultures of conflict, where confidentiality may be a matter of life and death, these re-ordered priorities are requisite to the success of research. Transcendent ethnographers need to be willing to work quietly and even anonymously, allowing the primary participants of their research both the glory and the benefits of success.

Visual Ethnography

Visual ethnography, the 'field' of ethnography where the study and production of ethnographic visuals are being emphasized, such as the usage of photography and film as a mean to develop a research, or as an outcome of an ethnographic research. While the term is sometimes used interchangeably with ethnographic film, visual anthropology also encompasses the anthropological study of visual representation, including areas such as performance, museums, art, and the production and reception of mass media. Visual representations from all cultures, such as sand paintings, tattoos, sculptures and reliefs, cave paintings, scrimshaw, jewelry, hieroglyphics, paintings and photographs are included in the focus of visual anthropology. Human vision, its physiology, the properties of various media, the relationship of form to function, the evolution of visual representations within a culture are all within the province of visual anthropology.

Summary and Conclusion

Ethnography, as discussed comprehensively, helps not only in getting the underlying thought process of the people being studied and their culture in detail but also it enhances a better understanding of a particular people and culture. Based on series of ethnographic researches a number of governmental actions were been undertaken for the development of the natives since the British times. Further ethnographic histories help better understand towards a consolidation of different ethnic communities and cultures which proves very effective in solving the crucial issues of ethnicity. In this pretext, the current trends of ethnographic research, developed in late 19th century, are not only followed traditional ethnography those started in Bronisław Malinowski time, but also the new generation anthropologist or other social scientist developed new methods of ethnographic research those are easy use in fieldwork. There are so many current ethnographic trends and researcher followed those as example, ethnography of communication, virtual ethnography, multi-sited ethnography, public ethnography etc. And those methods are critically examined then use in research work. Thus in a nutshell ethnographic papers, crucial to extract worldviews of the natives, should be dedicatedly studied. As Franz Boas says, if we wish to generalize or bring out the abstract of social actions and societal functions, we have to first collect as much ethnography as possible which can only be feasible through a batch of trained anthropologists.

References

Aamodt, A. M. 1991. Ethnography and epistemology: generating nursing knowledge. In Morse JM (Ed) *Qualitative Nursing Research: A Contemporary Dialogue.* London: Sage Publication. 41 - 53.

Agar, M. H. 1996. *The Professional Stranger: An Informal Introduction to Ethnography.* London: Academic Press.

Baines, S. A. 1976. *Ethnography*. Delhi: CPC.

Bernard, H. R. 2008. *Research Methods in Anthropology*. Delhi: CPC.

Berry, K. 2011. The Ethnographer's Choice: Why Ethnographers do Ethnography. *Cultural Studies - Critical Methodologies, 11* (2)*:* 165-177.

Boyle, J. S. 1994. Styles of Ethnography. In Morse, J. M. (Ed) *Critical Issues in Qualitative Research Methods. London:* Sage Publications, 159-185.

Brewer, J. D. 2000. *Ethnography*. Buckingham: Open University Press.

Christensen, P. H .2004. Children's Participation in Ethnographic Research: Issues of Power and Representation. *Children and Society.* 18 (2): 165-176.

Denzin, N. K. 2006. Analytical Auto ethnography, or Déjà Vu all Over Again. *Journal of Contemporary Ethnography. 35* (4): 419-428.

Geertz , C .1973. *The Interpretation of Cultures*. London: Fontana.

Hammersley, M. 1996. Ethnography. London: Routledge.

Hammersley, M. and P. Atkinson. 2007. *Ethnography: Principles in Practice. London:* Routledge.

Holt, N. L. 2003. Representation, Legitimation and Auto ethnography: An auto-ethnographic writing story. *International Journal of Qualitative Methods, 2* (1): 1-10.

Iyer, A. K. 1925. *Lectures on Ethnography*. Calcutta: UOC.

Katz, J. 2010. *Time for new urban ethnographies*. London: Sage publications.

Lincoln, Y. S and E. G. Cuba. 1985. *Naturalistic Inquiry. London:* Sage Publications.

Lowie, R. H. 1937. *The History of Ethnological Theory*. New York: HR & W.

MacPhail, A. 2004. Athlete and Researcher: Undertaking and Pursuing an Ethnographic Study in a Sports Club. *Qualitative Research.* 4 (2): 227-245.

Marcus, G. E. 1995 Ethnography in/of the World System: The Emergence of Multi-Sited Ethnography. *Annual Review of Anthropology*, 24: 95-117.

Mason, B. 2001. *Going beyond the code: the production of Hypermedia Ethnography*. London: Sage publications.

Murthy, D. 2008. *Digital ethnography: An examination of the use of New Technologies for social research*. London: Sage publications.

Nugent, P. D. 2007. *The Rhetoric of Hidden Emotions in Critical Ethnography*. London: Sage publications.

Rosen, M. 1991. Coming to Terms with the Field: Understanding and Doing Organizational Ethnography. *Journal of Management Studies.* 28.

Sabba, T. B. (Ed). 2005. *Between Ethnography and Fiction*. Delhi: OL.

Savage, J. 2006. Ethnographic evidence: the value of applied ethnography in healthcare. *Journal of Research in Nursing.* 11 (5). 383-393.

Snow, D. A, C. Morrill and L. Anderson. 2003. *Elaborating analytic ethnography: Linking fieldwork and theory*. London: Sage publications.

Spradiey, J. P. 1980. *Participant Observation*. London: Thompson Learning.

Wolcott, H. F. 1999. *Ethnography: A Way of Seeing.* Lanham: Alta Mira Press.

Xiang, B. 2013. *Multi-scalar ethnography: An approach for critical engagement with migration and social change*. London: Sage publications.

http://arj.sagepub.com/content/2/3/326

http://www.eastern.edu/publications/emme

www.sagepub.com/upm-data/4957_Madison_I_Proof_Chapter_1.pdf

http://en.wikipedia.org/wiki/Visual_anthropology

http://www.sociologyguide.com/anthropology/New-Ethnography.php

Man in Society ISSN 2347-1530
Volume 25, 2018, pp. 102-108

Brief Communication

Centre for Tribal Studies of North Orissa University, Baripada, Odisha

Laxman Kumar Sahoo

Introduction

This brief communication is about the centre for tribal studies of North Orissa University, Baripada, Odisha. The writer of this brief communication was the first appointed faculty to teach anthropology and tribal studies during the period 2004-November to 2014-August. During 2001, the then Vice Chancellor Prof. P.K. Mishra of North Orissa University established the Centre for Tribal Studies. The Centre for Tribal Studies of North Orissa University is first of its kind in Odisha. North Orissa University from its own source and from MPLAD fund of former Rajyasabha MP Sj. Birabhadra Singh of Mayurbhanj district of Odisha constructed a building for the Centre for Tribal Studies. The said building costs around Rs.60 lakhs. The building was being inaugurated by Hon'ble the then Chief Minister of Odisha Sj. Naveen Pattanaik in February-2004. The Centre for Tribal Studies building housed the department of anthropology and tribal studies, museum, having an auditorium to organize cultural programs, established a heritage corner in 2010 in collaboration with Indira Gandhi Rashtriya Manav Sanghrahalaya (*IGRMS*), Bhopal. The Centre for Tribal Studies also contributing towards the archives of North Orissa University to collect and preserve socio-cultural history of tribal communities and lot of tribal literature books also preserved.

Rationale

With autochthonous primitiveness tribes have inhabits almost all forest-based regions of our country. For centuries they have been living a simple life in the lap of nature and have developed culture patterns congenial to their physical and the consequent social environment. Being nature-oriented and kin-based, they have set their social structure and life style in such an ideal manner that, study of their society and culture will reveal nothing but human values in the most realistic form. When modern man has adopted all artificial means (*as a result of modernization*) and shifted far away from the natural/ cultural human base in its beginning and forgotten its culture, the mere empirical study of tribal societies will essentially provide the nature, feature and structure of a human society its idealistic form. In a sense, the tribal societies not only preserve the cultural heritage of mankind, they also signify the justifications for the study of the contemporary or the living societies. Their socio- economic systems were in primordial forms and even the political institutions, though rudimentary and non-explicit, were present with definite roles and functions. However, they live in a relatively static state and before so much of transformation in their traditional institutions, they need to be properly studied, documented, otherwise like that of the so-called modern societies, the cultural background of such societies will be forgotten forever. Though the rich assemblage of myriad cultures and languages of tribal people has attracted scholars and academics over the decades, very little headway has been made in the proper preservation, promotion and projection of their treasured cultural heritages and invaluable and incredible rich indigenous knowledge system, etc. Besides the academic and research fields of interest, the most vital of all is that such tribals are vulnerable to economic backwardness and of their all-round simplicity. They need proper protective measures revealed through scientific studies or researches.

Thus, with a bi fold objective to understand and explain the nature-based human life in its primordial from as well as to develop it from the economic backwardness through welfare or developmental measures, there is certainly an urgent need to go for tribal societies. Mainly because of this anthropologists around the world have ventured their approach to mankind invariably through the study of tribal societies.

UGC Post Doctoral Fellow, P.G. Department of Anthropology
Utkal University, Bhubaneswar-4, Odisha, Email: laxman.sahoo2@gmail.com

Regional Perspective

Since the dawn of human civilization, the so called tribals have been playing the most vital role in shaping the background as well as subsequent developmental stages of mankind. They have been rightly designated as the 'original people', 'indigenous people', 'first people' etc to testify their contribution to the human civilization around the world. In the world society, in general, and India as well as Odisha, in specific, though they have been distinguished from the non-tribal or caste societies in terms of economic backwardness, isolated habitat, more dependency on nature, they are not actually isolable from Indian society/Odishan society. Rather in view of their significant cultural contribution to Indian society, they may be observed to maintain socio-cultural continuity in all respect with the rest part of Indian society. With 8.06 per cent population of the total Indian population who occupy 15 per cent area of the country and 22.08 per cent population of the total population of Odisha (Census,2011), they claim an essential structural part of Indian society.

In Odisha, they not only show a dominating demographic profile, but also in number as well as cultural contribution, they have set an exemplary profile. With the largest number of tribal communities (62) in Odisha, representatives of the major linguistic communities like Dravidian, Austro-Asiatic and Indo-Aryan, they have been found at varied levels of acculturation, integration and assimilation with the caste Hindus of the state. Looking at their cultural richness, participation in freedom movement, relative isolated habitat, greater dependence on nature and economic backwardness, both the Governments of India and Odisha have expressed grave concern about their socio-economic development. Several plans and policies have been profusely implemented to achieve such ends for the purpose of bringing them to mainstream of national life without destroying their indigenous culture. However, such efforts basically need clear cut understanding as well as explanation of such tribal societies in India/Odisha in general and in North Odisha in particular.

Despite rich cultural heritages of tribal communities, poverty, hunger, malnutrition, impoverished health condition, economic and social deprivation, genetic disorders used to plague large section of tribal communities of Northern districts of Odisha. The rise of Naxalism/Maoism in the area further posed a serious threat to peace and harmony in the state. The tribal people of Odisha in general and Northern districts of Odisha in particular are now passing through a process of rapid transformation. They have been adversely impacted by the rapid process of globalization, industrialization, urbanization, and the like. The recent rapid technological advancement and unrivalled economic and political strength of world capitalism have created conditions for the invasion and extraction of natural resources from this region. The penetration of market economy and the ongoing process of industrialization resulting in massive deforestation and resource depletion have completely destabilized the economy of these underprivileged and marginalized people. These have irretrievably mutilated the indigenous knowledge and distinguishing socio-cultural cognitive framework of the weaker sections. In this backdrop the centre for tribal studies of North Orissa University aims to justify the establishment, relevance and scope in Northern region of Odisha.

No culture is static. Change is inevitable, and in the process of change, several communities of the North Odisha have sacrificed and abandoned some of their traditional cultural mores and patterns due to impact of culture contact with alien cultures and large scale development initiatives. The role of cultural values and attitudes as obstacles to or facilitator of progress has been largely ignored by government and aid agencies. The concept that culture as “human resource” in the development is not realised in the planning process and the positive ingredients of culture are never integrated and harnessed in the processes of development. What is the call of the day is to take efforts for the preservation, documentation and rejuvenation of diverse cultural treasures of the people like age-old indigenous knowledge systems, languages, values, narratives, ethno-science and technology, ethno medicine, ethno music, dance, handicrafts, ethno-farming etc. as insignia of cultural identities of tribal communities of North Odisha and the North Orissa University as the harbinger of knowledge of diverse fields has the moral responsibility to promote the essence of cultural pluralism as inputs

of development. Furthermore, the North Orissa University can play a role model in developing methodology to integrate the positive elements of local knowledge and indigenous technologies with the development action programmes sponsored by the Central and State Government within the frame work of the human sustainable development and economic advancement with human face, keeping in harmony with natural resources of the area.

In the light of foregoing narration, the North Orissa University because of its strategic location in the tribal dominated district of Mayurbhanj with headquarters in Baripada established a centre for tribal studies in 2001 with an objective to understand and explain tribal values, and document their indigenous culture as well as language on one hand and to assess as well as evaluate the implementation of various welfare measures on them for their economic development.

Empirical Perspective

Keeping in mind the empirical perspective of tribal population of Northern region of Odisha, North Orissa University established a centre for tribal studies. North Odisha comprises four districts viz: Balasore, Bhadrak, Keonjhar and Mayurbhanj. Out of these four districts, Bhadrak given least importance because of its lesser tribal population i.e. 2.02 per cent of the total district population (Census,2011). The tribal communities both advanced and vulnerable such as Santal, Bathudi, Bhumij, Kolha, Munda, Ho, Juang, Bhuniya, Mankidia(*Birhor*), Hill Khadia, Lodha, Mahali, etc known for their distinctive age old cultural ethos, life styles, material cultures, social organizations, etc along with different caste communities symbolize a harmony of cultural orchestra of North Odisha. In addition to rich cultural heritages, the splendid and unique bio-diversity of North Odisha especially the very presence of Similipal Biosphere Reserve in Mayurbhanj district and Kuldiha Wildlife Sanctuary in Balasore district greatly influence and nurture the natural order and social living of the people of North Odisha. The whole district of Mayurbhanj, part of Keonjhar and Nilagiri block of Balasore district being declared as "Scheduled Area" as per the constitution of India.

Mayurbhanj

The tribes constitute 58.72 per cent of total population of the district (Census,2011) and Mayurbhanj houses 30 tribes (Census, 2001). Linguistically tribal population of Austric and the Indo-Aryan language groups are dominated in Mayurbhanj. In Mayurbhanj three tribal communities developed their own script.The Hill Kharia, Birhor (*Makirdia*) and Lodha are the vulnerable tribes deserves special mention in the district. The Hill Kharia and Birhor(*Makirdia*) are the only hunting and gathering communities of Eastern India concentrated in the hilly area of Similipal in Panchapirha sub-division particularly in Jashipur block. For Socio-economic development of tribes of Mayurbhanj four Integrated Tribal Development Agencies (ITDAs) have been functioning in Baripada, Udala, Karanjia and Rairangapur.

Keonjhar

The Keonjhar district has a high percentage of tribal population i.e. 45.45 per cent of the total population (Census,2011) and there are 25 types of tribes reside in the district (Census,2001). Out of 13 blocks Banspal, Champua, Harichandanpur, Joda, Jhumpura, Keonjhar (*Sadar Block*), Telkoi and Ghatgaon are tribal dominated blocks and educationally quite backward. Keonjhar, Telkoi, Champua, and Barbil Tehsils are declared scheduled areas. For socio economic development of tribal people in the district two Integrated Tribal Development Agencies (ITDAs) have been functioning, one in Keonjhar and other in Champua. Linguistically tribal population of Austric and Mundari language groups have dominated in Keonjhar district.

Balasore

The tribes constitute 11.88 per cent of total population of the district (Census,2011). Tribals only residing in Nilagiri Subdivision of Balasore district. The major tribes inhabiting in Nilagiri Subdivision of Balasore are Santal, Kolha, Bathudi, Bhumij, Munda, Mahali and Mankirdia. Tribal population of Nilagiri block accounts 57.75 per cent (Census,2011). For socio economic development of tribal people in the district one Integrated Tribal Development Agency (ITDA) has been functioning

in Nilagiri.

Scope of The Centre

1. The name of the centre is proposed to be the **Centre for Tribal Studies**. It promises a greater scope to address the issues of cultural identities and problems of underdevelopment of the region. The vision of the centre is to undertake research and teaching on tribal studies in an interdisciplinary perspective.

2. Tribal studies are no more remained the only domain of anthropology although anthropologists were the pioneers to promote ethnographic studies among tribal communities in the colonial periods. Since the problems of tribes are varied in nature, no single academic discipline may be able to comprehend and address the issues properly. What is required is to prepare a platform for dialogue and discourse among scholars having expertise and experience of working on problems of tribal people and devise methods to alleviate their problems and sufferings.

3. The proposed centre may take a lead role to integrate the perspectives of natural, biological, health and social sciences in addressing the issues of promotion and preservation of tribal ethnic elements and their respective knowledge system and issues of poverty, unemployment, hunger, malnutrition, morbidity and mortality, social and economic empowerment, social justice, peace and harmony etc. Both teaching, research and action programmes are necessary, as research has a limited audience and consumption. In teaching-learning and action process both tribals and non-tribals can have more participation than only in research activities.

4. Against the backdrop, this centre for tribal studies will try to address different development issues relating to tribal communities form an inter-disciplinary perspective. Being located in a geographical area dominated by the tribal population, the proposed centre will follow a bottom-top approach and thereby bridge up the existing gaps between tribal communities and the state. It will help the State in understanding the socio-economic and political causes of many unrest movements recently launched by tribal people of North Odisha/ in different parts of the Odisha.

Importance of The Centre

The centre has its importance due to its location in a tribal belt of Odisha. There is no denying to the fact that tribal issues in Odisha in general and in Mayurbhanj, Keonjar districts in particular have drawn governmental and non-governmental attention both from inside and outside the state/country. Still tribals have not come up to the expectations on development scale. They are marginalised and deprived in the process of development. Poverty is rampant, hunger and malnutrition with recurrent infections is a regular phenomenon. Mortality and morbidity rates are still very high. Illiteracy is very high. Genetic disorders are equally adding health burdens to people. Alcoholism is a serious problem in tribal areas of Odisha. Obviously, tribal studies has assumed independent importance to address the above issues in a holistic perspective, because if tribal issues are clubbed with issues of other communities then the thrust areas will go on shifting and the focus will be diluted. That is why in spite of all the sincere efforts no much headway has been achieved in the holistic development of tribes in all these years.

Thrust Areas of The Centre

1. Understanding tribal society and culture in North Odisha/Odisha.
2. Understanding tribal heritage of North Odisha/Odisha.
3. Understanding the study of economic development of tribes.
4. Understanding tribal rights over land and forest.
5. Understanding social change and development in tribal societies.
6. Understanding tribal health and nutritional status.
7. Understanding tribal rights and customary law.
8. Understanding tribal language and literature.
9. Understanding the problems of classification, enumeration and reservation issues of tribal people.

10. Understanding indigenous knowledge system of tribal people and its development perspectives.
11. Understanding displacement among the tribal people.

Objectives of The Centre

The prime objectives of the Centre for Tribal Studies will be teaching, research and training for capacity building among students, researchers and others at all level.

The objectives include the following:

1. To develop the centre as centre of excellence in tribal studies and research.
2. To produce highly skilled manpower in tribal studies and place them in different sectors in regional and national level.
3. To conduct seminars, workshops, conferences on various areas of tribal society, culture and development.
4. To make collaboration with other universities, research institutions inside the country for the achievement of academic excellence in the field of tribal studies.
5. To take up research projects on tribal life, society and culture, and their publication.
6. To organise memorial lecture on tribal freedom fighters of Odisha and India.
7. To felicitate those personalities who have excelled in the field of tribal art, language literature and social work.
8. To establish the centre as an institution at national level for teaching, research, and training in the field of tribal studies.
9. To equip the centre with adequate teaching staff, counseling and placement cell for students.
10. To sign with universities of India and other countries for student registration, faculty exchange, etc.
11. To establish a chair in the name of Pandit Raghunath Murmu (Inventor of Santali script Ol Chiki) in tribal studies.
12. To publish a national level journal in tribal studies.
13. To conduct Bio-social mapping of the tribes of North Odisha/Odisha.
14. To establish a tribal history museum and archives.
15. To create a tribal website and database.
16. To conduct training programme for capacity building of officials, NGO activists, village leaders, women activists, etc working in tribal areas.
17. To develop plan of action for creation of sustainable livelihood support system for particularly vulnerable tribal communities.
18. To develop eco-tourism and ethnic tourism road map in collaboration with central and state Government.
19. To document tangible and intangible cultural heritage including traditional knowledge systems of tribal populations living in and around North Odisha.
20. To secure and accept endowments, grant-in-aid, donation or gifts on mutually agreed terms and conditions.
21. To publish occasional papers concerning emerging tribal issues of the State.
22. Creation of tribal genome data banks for the promotion of research in the field of tribal health, disease and infection in collaboration with International /National/State institute or Universities.
23. Screening of genetic disorders and offering counseling to couples before marriage.
24. Conduct studies on social and environmental impact analysis.
25. Conduct studies on ethno archaeology of tribal communities.
26. Consultation work on tribal affairs.

Educational Objectives of The Centre

The centre for tribal studies of North Orissa University from 2001-02 academic session started M.A. in Tribal Studies course on self financing

mode. The M.A. in Tribal Studies renamed as M.A/M.Sc. in Anthropology & Tribal Studies from 2009-10 academic session and the curriculum changed accordingly. M.Phil in Anthropology & Tribal Studies introduced from 2010-11 academic session. The M.A./M.Sc and M.Phil course of Anthropology & Tribal Studies also imparted in semester and CGPA system, and adopted choice based credit system (CBCS) as per the UGC guide line. The centre wishes to introduce Ph.D and other diploma programmes in future.

Museum of The Centre

Under the umbrella of centre for tribal studies a museum was established for the preservation of tribal culture and heritage in Northern region of Odisha. The museum was inaugurated on 13.07.2010 by Sj. P. Bhanjdeo, the then Minister of state for sports and youth affairs, Government of Odisha in presence of the then Vice Chancellor Prof. S.P. Rath.

The museum having the following objectives:

1. Collecting, classifying and preserving a large variety of natural and cultural objects;
2. Making this material accessible for research and education;
3. Publication of the materials, including databases;
4. Organizing exhibitions of the collections;
5. Promoting of research related to the collections.

The museum specimens were collected through the students during fieldwork and purchased by the help of university. The museum kept 16 specimen on material culture of different tribal communities of North Odisha, 18 stone tools (6-handaxe,4-neolithic,5-microlithic, 3-mesolithic), 42 photo graphs of different tribal communities of North Odisha, 30 photo plates purchased , 01 skeleton and different human skeletal materials purchased like mandible, humorous, clavicle, tibia and fibula, skull, radius, ulna, etc.

Field Studies Undertaken by The Centre

As a requirement in the course curriculum of P.G. and M.Phil in Anthropology and Tribal Studies, at North Orissa University, Baripada during 2005 to 2018 fieldworks were conducted in tribal villages of Northern Odisha for the students' dissertation preparation. Ethnographic studies conducted on tribal communities like Santal, Kolha, Mahali, Munda, Bhumij, Bathudi, Hill Khadia, Birhor, Lodha, Rajuar etc. The broad topics covered up for ethnographic studies like social organization, economic organisation, political organisation, religion, inter-ethnic interaction, customary law and social control, folklore, material culture and technology, demography, traditional health practice, social change and development, health seeking behaviour, infant and child mortality, safe motherhood, child rearing practices, etc. At M.Phil level fieldworks conducted on the topics like: Micro Project and Socio-economic Development of The PTGs: A Study Among The Lodhas of Mayurbhanj District, Odisha; Impact of Self Help Groups(SHGs) On The Socio-Economic Aspects of The Lodha Tribe in Mayurbhanj District of Odisha; Status of Women Among The Lodhas of Mayurbhanj District, Odisha; Changing Demographic Scenario of Baripada Town Since 1961, Odisha; Radio Broadcasting and Tribal Development: A Case Study of All India Radio, Baripada; Maternal and Child Health Care Among The Santals of Khiripada, Mayurbhanj District, Odisha; Sacred Geography of The Santals: An Anthropological Exploration.

Academic Progress of The Centre

The centre for tribal studies so far progressed mentioned below for reference:

1. Conducted a national seminar on “Socio-Economic Perspectives of Detribalization in North Orissa (2002)".
2. Established a museum for the preservation of tribal culture and heritage.
3. Established a wet laboratory.
4. Established a seminar library.
5. Established a heritage corner.
6. Published two books: 1. Violence Against Women-2011, 2. Santal Shamanism-2012.

Extension Activities of The Centre

M.A./M.Sc., M.Phil students of Anthropology and Tribal Studies have been participating in various activities of National Social Service (NSS) wing of North Orissa University relating to health, education, sanitation, awareness on witch hunting, etc in rural and tribal villages of Keonjhar and Mayurbhanj districts. Students teaching to drop out tribal children in campus school in every Sunday. Students also participated in various activities of 'Gyanlok' programme.'Gyanlok' programme initiated by the then Governer of Odisha M.C.Bhandare, aimed to adopt tribal villages and transform the villages from health, education and infrastructure point of view. North Orissa University adopted tribal villages in Keonjhar, Mayurbhanj districts and with the help of district administration carried out extension activities. The centre helps to the students and scholars of other universities/ institutions as and when required to carry out fieldwork and conduct research among the tribes of North Odisha.

Challenges of The Centre

Though the centre is unique of its kind in the state, it is facing the following challenges both in teaching and research:

1. Even though the centre for tribal studies has a very nice building of its own from the very inception, it is quite unfortunate that it is still continuing as on self financed mode, not a full-fledged centre. As a result, more students are not feeling attracted to take admission.

2. Among other things North Orissa University has taken exemplary steps of opening the centre for tribal studies to focus more on the tribal people of the state. In this venture not only the students belonging to tribal community but also the caste community students have got a scope to pursue their higher education in tribal studies. This unique feature of North Orissa University should not be discontinued; least the tribal community may feel neglected.

3. Without regular teaching faculty the centre became handicapped to pursue adequate research in tribal studies.

The Road Ahead

The above mentioned facts are a testimony to make the centre for tribal studies as a full-fledged centre in North Orissa University. The center would go a long way in future by imparting degree and diploma courses relating to their unique cultures, language, social change and economic development, health and nutritional hazards and their remedies, indigenous knowledge system, forest-dependency, movements and aspirations, status of women, their rights and customary law. If the centre would function properly it is not only expected but also assured that, such a centre for tribal studies definitely be of immense help to students, officials, NGOs, planners/policy-makers and many others to have a clear cut understanding of the tribal societies from academic and applied perspectives.

References

Census of India, (2001). Scheduled Castes and Scheduled Tribes, Odisha

Census of India, (2011). Scheduled Castes and Scheduled Tribes, Odisha

Man in Society ISSN 2347-1530
Volume 25, 2018, pp. 109-110

Book Review

Tribal Health: A Regional Perspective; Edited by: Dr. Laxman Kumar Sahoo, 2018, pp-i to xxiii and 1 to 326; Serials Publications Pvt. Ltd.: New Delhi, ISBN: 978-93-86611-11-6. Price:1595.

In this ambitious work by Dr. Laxman Kumar Sahoo endeavors to ascertain the indigenous practice of medical pluralism among the tribal group from a regional perspective. The tribal groups have been sparsely distributed all over the nation by constituting 8.6% or 104 million people (Census, 2011), having a simple culture and mostly indigenous in nature.

But as a result of modernization, some of them have step forwarded from agrarian type culture to industrialization and have to some extent given up their indigenous practice or culture. In this process of transformation they are going to forgetting their culture or indigenous practice. Now their culture is in endangered stage. This is a good step and initiative taken by Dr. L.K. Sahoo and their colleagues to document these cultures of medical pluralism, cultural heritage and this preservation can have an invaluable promotion for their indigenous health care knowledge system. This volume contains 19 articles and has an in depth analysis of the incredible rich indigenous health care knowledge system of tribal health from a regional perspective. Beyond the focus title of the book there are some chapters highlighted general health perspectives than regional context like Tribal health: A Genomic Perspective, Molecular Diagnostic of Tribal health, etc.

In these accounts this volume explains about tribal health situation of Odisha, the socio legal rights of tribal health, ethno medicinal, ethno pharmacological practices of tribes, tribal medicinal use of insects, and medicinal value of indigenous beverages, menstrual hygiene and molecular study of indigenous tribal's. An overall epidemiological study was conducted in the tribes of Odisha by using various methodologies.

The tribal health situation of Odisha reveals the knowledge variation of diseases in the shaman, ojha like medicine man in indigenous medicinal knowledge system. Then the author has empirically studied important medicinal plants and tree cults of tribes of similipal biosphere region. Here he has given special emphasis on Bhumij, Kol and Birhor of SBR, an enthusiastic reflection on the conservation of biodiversity both in In-situ hybridization without destroying the indigenous and traditional tribal culture.

The Demographical study reflects contribution of fertility is greater than mortality. Similarly the Ethno botanical study illustrates that 26 plant species to 26 genera and 21 families found to be used for diabetes mellitus by the people of similipal forests. Here the process by which they are preparing this, their indigenous methods of preparation and their chemical constituents of doses should have included, which shall have a great contribution for mankind. Then the menstrual hygiene reflects the awareness and knowledge of the subject as it is very sensitive culture of a society and in India the female are the neglected one.

The tribal beverages rice-bear is an integral part of aboriginal communities' through-out the world. In India from an immemorial time both fermented and distilled beverages have been used and in Odisha also this indigenous instance is observed. Use of insects traditional for traditional medicinal values like Ethno zoological practices have been very much usable resource in near future. Epidemiological study was also carried out by Dr. K.C. Satapathy which reveals that hypertension instances is being increasing among the tribal's of Odisha, molecular study like DNA analysis sequencing illustrates that we have a good tribal diversity and variability. Sickle cell and beta thalassemia disorder are also seen in differed magnitude regions of Odisha. This defines the homozygous disease cases of Odisha.

Functioning of Odisha a government policy plans reveals that lack of uniform approach like RNTCP could not take into account in the regional diversities results DANTB intervention observed that certain areas and a sizeable population was not covered under the programme. The main result what did I observed by reviewing this book is the economically sound tribal's are not that much suffering in this transformation process but the tribal's who are not

economically sound are the main sufferers of this transformation process.

On the whole the book would be helpful in future in the field of health research in general and tribal health in specific. The price of the book may be difficult for the students to purchase as hard copy, so the publisher may go for paperback edition to meet the felt need of the student community at large.

Jagatdarshi Badamali
M. Phil Research Scholar, P.G. Department of Anthropology (CAS), Utkal University, Vanivihar, Bhubaneswar-4

Man in Society ISSN 2347-1530
Volume 25, 2018, pp. 111-112

Book Review

Human Growth and Nutration: A Biocultural Synthesis, by Rajesh K. Gautam and Prasanna K. Patra, 2016, pp 284; Kalpaz Publications, Delhi, ISBN: 978-93-5128-204-4, Price: ₹990

The status of health and development of a population or a community is reflected in the growth of its children and, the pattern of that growth is shaped by the dynamic correlation between biological and cultural phenomena. The book edited by the Dr. Gautam and Dr. Patra grapples with the variegated areas of the research, innovative ideas and advance techniques in the field of growth and development which can be implemented in the management of research focusing on human variations, adaptation and morpho-physiological dynamics.

This book provides a fascinating reading with the diverse and the unique example of bio-social perspective into growth and nutritional based on empirical evidence from varied bio-physical, socio-cultural and demographic backgrounds. The author has tried to reveal several factors such that include the wider coverage to topic related to and factor that shape human growth and nutrition. It includes contributions that cover wider geographical, ecological and regional variations.

There are 16 chapters divided into 6 different themes, having comprehensive information on growth pattern from early embryonic stage to adulthood, under nutrition, puberty, body mass index, physical activity and body composition, nutritional status and associated factors and the last theme is food security and health care.

The first theme was categorized in to 6 chapters under 'Human growth and Development' which deals with human growth and development from its very inception till adulthood among contemporary Indian population. The first chapter entitled "Ultrasonographic Prenatal growth Study of Human Foetuses among the Meitei of Manipur " by T. Ursa and S. Jibonkumar Singh , highlighted that the reason for the progressive secular growth inside uterus had been taken as due to genetic, change in maternal lifestyle and nutrition and better access to antenatal care programmes. The second chapter entitled 'Growth pattern of stature and body weight during childhood and adolescence: A cross sectional study among School boys of Guwahati, Assam, India' carried out by Baruah etal., which indicates the growth pattern of human child during its school age and result reveals that the boys are heavier and taller than our national average and they are lighter and shorter than NCHS reference. The third chapter is on 'Pattern of growth among Homozygous Sicklers : Cross sectional Study among Meher a Scheduled caste of Mandla district, Madhya Pradesh' by J.Jhariya et al., highlighted that homozygous children for sickle cell gene have delayed growth and development at all ages specially after five years age. The fourth chapter developed by K.C Satapathy which highlights the growth and nutritional status of adolescent Tibetans born and brought up in costal Odisha and has compared that data with high altitude studies by using standard anthropometric technique. The fifth and last chapter of the first theme was contributed by Chittaranjan Mandal entitled on 'Growth pattern of the Adolescent: A cross-sectional study among the Bhotia of Uttaranchal, India'. In this chapter the author has trying to show a comparative growth pattern of human child during adolescent with special reference to Bhotias and other ethnic groups from central Himalayan region.

The central focus of second theme of this volume was on 'Under nutrition and Disease'. In this theme on chapter 6 was contributed by Mandal et al,. On the prevalence of thinness, overweight and obesity among Karbi tribal children of aged 5-12 years Karbi Anglong, Assam, Northeast India. Chapter 7 focused on 'Co- Prevalence of high rate of undernutrition and hypertension among six tribal population groups of India' by Gautam K Kshatriya and Subhendu K A charya, which highlights the findings of trend in height and weight among 40-50 years and 50-60 years age group in males and all the four age groups in females. Chapter 8 entitled 'Prevalence of Anemia among Tribals in Mayurbhanj district of Odisha' by M. Mohapatra, K.C Satapathy and P.K Patra which results the abnormal hematological profile among the study participants.

The third theme contains two chapter i.e. chapters 8 and 9 respectively on 'Adult Nutrition, BMI and Puberty'. Chapter 9 contributed by Rachna Thakur and R.K Gautam highlights the mean age of menarche, BMI, and the problem of under nutrition and obesity among the adult females of two ecological zones. The second chapter under third them was contributed by Harshdeep Dhanjal in chapter 10 which describes adult nutrition among a central Indian tribe on the basic of BMI and CED.

The fourth theme focused on 'Physical activity and body composition' in chapter 11 and 12. In chapter 11 was focused on relationship between body composition, cardio-respiratory health and habitual physical activity among Rajput women of district Kangra, Himachal Pradesh by Dhal and Mungreiphy. Chapter 12 which is under fourth theme was based on a cross-sectional study, information related to different activities performed by them for two consecutive days were noted with the time duration.

The fifth theme of this volume dealing with 'Nutritional status and Associated factors' and it it consisting of three chapter i.e 13, 14, and 15 respectively. Chapter 13 is dealing with the nutritional status of the children below six years of age belonging to Kinnaura, Bhill and Dhodia tribal population groups from Himalayan, Desert and coastal district of Himachal Pradesh, Rajastan and Gujurat which is authored by S.K. Kolay. In chapter 14 Dr. J.R. Ghosh highlighted the prevalence of under nutrition in terms of stunting, wasting and underweight among Santal tribal children in Birbahanpur district of West Bengal, India. Chapter 15 entitled on 'Nutritional and hematological status of migrant Pano community of slums in Bhubaneswar, Odisha' contributed by S.K. Gouda. In this chapter the author has tried to show how the studied community is still nutritionally vulnerability by using Anthropometric tools and techniques.

The sixth and last theme of the volume is on 'Food Security and Healthcare' contains in the chapter 16 and entitled on 'Role of Self-help groups in providing food security and health care with reference to children : a study in Andhrapradesh' which was contributed by M.Sreevidya . the author has suggested in this study that how gender programmes helps preventing discrimination against girl child, trafficking, domestic violence help women to increase their understanding of intra-family equity issues, decision making levels, free mobility and necessity of building safe environment.

Finally this edited book has focused more on different issues among variety of people from North-East to South and East to West on Indian continent on human growth, development.. There is information about pre-natal and post natal growth of human child as well growth from infancy to adulthood. This can also be helpful for the policy maker to formulate guideline and implementation of different types of programmes for in the field of human growth and nutrition in different ethnic group and in general. This book is very much helpful for those working in the fields of human growth and development but its authors in many occasion fails to pay attention to the fact that the socio-occupational status of the studied community or group with which the growth and nutritional health effects.

Dillip Kumar Barik, M. Phil Research Scholar, P.G. Department of Anthropology (CAS), Utkal University, Vanivihar, Bhubaneswar-4

INSTRUCTIONS TO THE AUTHORS

Manuscripts for MAN IN SOCIETY must be prepared in accordance with the following guidelines for prompt action.

EDITORIAL POLICY: The manuscripts should be typed with line-spacing of 1.5, including notes on A4 paper, in Times New Roman, font size 12. Within the text the tables should be referred to by their numbers. Use single quotation marks while quoting sentences or a single word/phrase and double quotation marks for use within single quotes. All words in languages/dialects other than English should be in italics. The manuscript should be approximately 6000 to 8000 wards: in any case it should not exceed 10000 wards, original unpublished work and should not have been submitted for publication elsewhere The manuscripts should be sent only in Microsoft Word to the Editor Man in Society, or the soft copy of article can be uploaded through the website.

P.G Department of Anthropology, Utkal University, Vani Vihar, Bhubaneswar, Pin-751004
Ph: 0674 2567217
Email: headanthroutkal@gmail.com
Website: www.misanthroutkal.com

REFERENCES: These should be listed at the end of article, as per the Chicago style of references practiced in the *Current Anthropology* Journal. Following are the examples for the proper style of references from various sources:

Journals:

Nayak, P.K. 2013. Shamanism in Tribal India: Dimensions of an Everyday Religion. *Man in Society,* 20: 11-32.

Books:

Mahapatra, L.K. 2003. *State, Society and Religion: Culturehistorical Comparative Perspectives of Southeast Asia*. Chennai: Emerald Publishers

Sections of Books:

Cohen, C.P. 1998. United Nations convention on rights of the child: relevance for indigenous children. In: D.K. Bherea (Ed.): *Children and Childhood in Contemporary Societies*. Delhi: Kamla-Raj Enterprises, pp. 173-187.

Newspaper / Magazine:

Bhasin, V. 1982. Ecology and Gaddi Culture. Hindustan Times, Weekly, August 29, 1982, P. 9

Meeting Paper:

Bhasin, V., Bhasin M.K., Singh, I.P. 1978. Some problems in the education of Gaddis of Bharmour, Chamba District, Himachal Pradesh. Paper presented in Seminar on Education and Social Change in Himachal Pradesh (H.P.) in H.P. University, Shimla, November 13 to 16, 1978.

Report:

Work "in press":

Das, K.C. 2004. Economic pursuits and strategies of survival among Birhor of Odisha. *J Hum Ecol,* (in press).

Website:

From <https://deepblue.lib.umich.edu/ bitstream/ handle/2027.42/66329/aa.1999.101.1.23.pdf> (Retrieved on 18 March 2016).

REFERENCES IN THE TEXT: References citations in the text should be in parentheses and include author name(s) and year of publication. Text citations of two or more works at the time should be given in chronological order. When citing a paper written by three or more authors, write the name of the first author title plus "et al". (However, all authors must be given in the Reference section). Where there are two or more papers by the same author in one year, distinguishing letter (a, b, c....) should be added to year. All references should be carefully crosschecked. It is the author's responsibility to ensure that references are correct.

Disclaimer

This publication contains information obtained from authentic and highly regarded sources. Reasonable effort has been made to publish reliable data and information, but the author and the publisher cannot assume responsibility for the validity of all materials or for the consequences of the use.

CONTENTS